COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

October 24, 2008

Appearances:

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

Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL

Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al

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

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. . . . . Testing Class Action

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Jennifer Newbury . . . . . Canadian Cancer Society (NL Division)
David Eaton, Q.C.. . . . Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

LIST OF EXHIBITS

TABLE OF CONTENTS

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey?

DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD, RESUMES STAND, EXAMINATION BY BERNARD COFFEY, Q.C.

COFFEY, Q.C.:

Q. 2152, please, page eight? Thank you, Ms. Chaytor. Now Mr. MacDonald and Dr. Reza, particularly Dr. Reza, we were discussing this yesterday and frankly, I apologize to you for not having taken the opportunity before you started yesterday to have shown you this, and I appreciate after we adjourned yesterday, you had an opportunity to look at this, and reflect upon it. In relation to this exhibit, which is the--we understand is a printout created by--computer printout created by the computer that was then linked with DAKO machine, and I'm going to ask you the following. If one--kind of put to you a hypothetical. If that computer was capable of recording what particular slot or slide within the machine, from time to time, was being utilized to run an ER/PR slides and if one was able to record the surgical number and the location from which that specimen came from,

Page 5

and if one was able to record the name of the physician who had ordered the ER/PR test, and if one was able to record the technologist or technician's name who was, in fact, doing the slide run, and if subsequent to the DAKO machine processing those slides, that data was stored, able to be stored on the computer, and if that data had been able to be stored and then archived and kept, okay, if all such data for the DAKO machine for all the time it was utilized in St. John's, and I gather that's probably between 1998 and 2004, if all of that data had been available to NLCHI, might that have been of some assistance to you in your task?

DR. ALAGHEHBANDAN:

A. Quite valuable.

COFFEY, Q.C.:

Q. And in relation to that, how might it have been of some use?

DR. ALAGHEHBANDAN:

A. Well, first of all, it would be a good source for creating a cross check list. The other one would have been the fact that we would have the surgical number, so we could have

Page 6

break it down by year and by regions, so that's another possibility, by the ordering physician, and you also mentioned that if the responsible technologist name being recorded there, so that would have been another source of data for us. I notice here that it does not indicate what sample was tested. However, I can see the ER/PR scores here and nevertheless most of -

COFFEY, Q.C.:

Q. These are not actually ER/PR scores.

DR. ALAGHEHBANDAN:

A. I'm sorry, that's the protocol.

COFFEY, Q.C.:

Q. Yes, protocols.

DR. ALAGHEHBANDAN:

A. So nevertheless, you know, one can assume that majority of ER/PRs, this would have been done on breast samples. So again, I must say that with all those conditions that you stated it would have been a valuable source for us to consider as a source for cross checking and listing.

COFFEY, Q.C.:

Q. Thank you, Doctor. I'm going to ask,

Page 7

Registrar, please, if we could bring up--I'm just going to--this is just one of these, almost at random, bring up Exhibit P-3473? Now Mr. MacDonald, this is the minutes of an information management committee meeting of January 9th, 2004. The acting chair at the time was a Mr. Brown, but when we look down on the left-hand side, you'll see that Mr. D. MacDonald is listed there.

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. That's yourself?

DR. MACDONALD:

A. Yes, it is.

COFFEY, Q.C.:

Q. Okay, and you've indicated yesterday that before Eastern Health was created, back in the days of the Health Care Corporation, that the Centre, as you call it, was then within the umbrella of the Health Care Corporation?

DR. MACDONALD:

A. Yes. I won't even attempt to come up with the official wording around it, but yes, we were under the Health Care Corporation Board.

Page 8

COFFEY, Q.C.:

Q. And at that time then, what would have been your role then in attending--I take it this is one particular information management committee meeting minutes. There are a number of them in the years before.

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. And they have been exhibited and there's some after this too, but what was your role at the time?

DR. MACDONALD:

A. Well, even though we were under--officially under the Health Care Corporation Board at that time, the Centre did operate independently and my role on this committee was to--as the Centre for Health Information being a provincial agency around the development of the electronic health record and around population issues with respect to information management, I brought that context to the Eastern Health table.

COFFEY, Q.C.:

Q. I take it, at the time, the Health Care

Page 9

Corporation table?
DR. MACDONALD:
A. Yes, Health Care Corporation table.
COFFEY, Q.C.:
Q. How about today?
DR. MACDONALD:
A. I'm no longer on that committee. Another individual from the Centre has replaced me.
COFFEY, Q.C.:
Q. Okay. So there is--but there is still somebody who brings that perspective that you brought in early years -
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. - to Eastern Health's information management committee or whatever the current name of that committee is?
DR. MACDONALD:
A. That's correct.
COFFEY, Q.C.:
Q. Brings that vantage point.
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:

Page 10

Q. Now Mr. MacDonald, could you tell the Commissioner, please, as we have discussed this, you and I have discussed this before, I take it that you've given--had the opportunity to give some thought to, for example, if a situation such as this was to unfold again, one had to perform a mass retesting, for example, do you have any thoughts on how it might be approached from an information management perspective?
DR. MACDONALD:
A. Yeah, I -
COFFEY, Q.C.:
Q. Under the current regime, as it exists now, and then I'm going to ask you something about perhaps where you think the regime might go in the future.
DR. MACDONALD:
A. I think they're so closely linked together, perhaps I will--because I have given it a bit of thought obviously, because it the area of my interest and the area where I worked for many years. What we've--what you've seen from yesterday and even a bit more today is a retrospective look at what happened, from what

Page 11

the Centre was able to garner from various information sources, data sources across the province and even from Mount Sinai, to try to put together a static database that identified all the patients impacted by the ER/PR testing and the communication events surrounding them, and we've mentioned that several times. But the important part, this is a retrospective look back.

So the province is moving forward with the implementation of electronic health record. We have the opportunity to probably lead the country, if not the lead the country, be one of the leaders in the country in technology in health care, in support of patient care and patient safety. But also, with respect to other uses, such as research, audits, data quality, evaluation. Some of the things--all those activities took place in the development of the ER/PR database.

With that infrastructure being created, we have the opportunity to try to mitigate against this ever happening again. Not saying that we'll ever stop it. I mean, we have to recognize too ER/PR is only one of, I don't

Page 12

know, thousands of different diagnostic tests that take place in a hospital, so we can't monitor each and every test. But what we can do is put in place--we are putting in place the infrastructure. We have missed a very important opportunity if we don't take what we've learned from here and incorporate that into what we're doing in the province now and what which will be in place in probably two or three years. By 2011, the Province of Newfoundland could have the most comprehensive electronic health record system in the world, if not the one, one of them.

One of the things that we're missing today, and I've said this, is that interface between data and information. We continue to ask our IT people to create information from data. IT people are very good at creating data through technology. There's a different set of skills required to take the data to create the information, and that is what I feel is missing in the health system right now is that piece there. And there's--like in a lot of skill sets, there are not a skill sets like this. This is not--you can't go in and

Page 13

start up a department of information management. You have to train these employees. They have to know your business. They have to be intimate with the data. All the employees at the Centre for Health Information, my department, create their own data. They understand, are intimate with the data. So it's not a technology question, it's an information question.

I wanted to say that, and I don't know if I've specifically or explicitly answered your question, but I think it lays a foundation perhaps for another question.

COFFEY, Q.C.:

Q. No, that's--that does address it, and I take it then that if right now, or tomorrow, one was to have to go--begin a look back again, you'd be met with similar sorts of problems potentially in terms of other authorities and so on that Dr. Reza has talked about?

DR. MACDONALD:

A. Yes, we've talked about the silos of Meditech systems in our hospitals. We've talked about lack of standards. We've talked about different data dictionaries used in our

Page 14

Meditech system so that a chest x-ray in Western is not necessary a chest x-ray, coded as a chest x-ray in Eastern. There's one thing that the Commission needs to recognize too is that our province is currently considering the implementation or the development of a provincial lab information system, and I've had initial discussions with the project teams and I said, if we were designing--if the lab system was in place today -

COFFEY, Q.C.:

Q. The lab information system.

DR. MACDONALD:

A. The provincial lab information, so instead of--as Reza had already noted, I think there's six lab systems in the province that don't talk to each other. We deal in paper records, we've mentioned that. If a provincial lab information system was actually in place, would our job, from a retrospective perspective, be any easier? And you know, well, it depends. "What's the functionality? What's your business?" was the question to me, and so basically what it came down to, this

Page 15

type of activity, what we might call the business of secondary use of data to do an audit, to do an evaluation, to do research, has to be brought to the project team in advance to say "we need this functionality from the provincial lab information system." So that, heaven forbid if this ever happens again, we're in a much better position to get quality information in a much more expedient time. So there is an opportunity here to have input into such activity.

THE COMMISSIONER:

Q. Is the message I'm getting from you, don't rush to do something without thinking about exactly what it is you want to accomplish. Don't build it to deal with the problem that you have now. Think about the major problems.

DR. MACDONALD:

A. The word strategy is used so often, it's--but it is, it's that advance planning. An example, obviously we build these systems for patient care and also patient safety. So quality of care could be the encompassing term for our patients, right, and then we build that around effectiveness, efficiencies and

Page 16

quality, all these things. But what we really need to start thinking about is what else can we use this data for, for planning, for supporting policy and programs, for secondary use is what we're talking about. So when they go in and build the systems, obviously the priority is to the patient, yes, but if we're in at the table and we're saying, okay, that's great, but let's also include these types of functionalities, so that we can do our jobs better on this end. It's obviously much easier to do that upfront than say in five years from now, okay, let's go back and rebuild it. It generally doesn't work that much.

And there's another important piece to all of this. Maple Leaf Foods closed down because of that scare around--like I can't get Maple Leaf bologna for my children any more. Heaven forbid, it's a big thing now. But they're able to close down. A hospital can't close down when this happened. So what we found, Reza's team had to go into a system that continued to provide patient care and we're trying to do this activity of collect

Page 17

data in a very archaic type of approach because of disparity of the data and information, and we didn't--there was no capacity in the health authorities around information management to support us. That's why we ended up working with a lot of IT people, and from where I sit, the main message that I see is that we need to get more capacity in our authority, in our health system for information management, because I feel very strongly in a couple of years, the infrastructure will be there to support it, but we're not going to have the people to create the information. We're still going to be dealing with data.

COFFEY, Q.C.:

Q. Commissioner, they're the questions I had.

THE COMMISSIONER:

Q. Thank you.

COFFEY, Q.C.:

Q. With the--perhaps--no, they are the questions I had. Thank you very much.

THE COMMISSIONER:

Q. Mr. Simmons?

DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,

Page 18

EXAMINATION BY MR. DANIEL SIMMONS

MR. SIMMONS:

Q. Thank you, Commissioner, couple of things. Good morning, gentlemen. Mr. Coffey actually has just hit right on the topic that I was most interested in asking you both about, and I understand from what you've just said, Mr. MacDonald, that you've recognized probably before you ever became involved in this project, but certainly from the work you've both done in this review project, that there has been and continues to be a real lack of this information management capacity in the four health authorities in the province. Have I captured that correctly?

DR. MACDONALD:

A. That's my belief, yes.

MR. SIMMONS:

Q. Yes, okay. Mr. MacDonald, you've been involved for at least eight years now with the Centre for Health Information, the Centre as you call it, and I understand that you've had exposure certainly through that time and would I assume longer to knowing what kind of information management systems have been used

Page 19

in health care in the province for gathering patient information?

DR. MACDONALD:

A. Yeah, from my perspective, yes, I'm somewhat familiar with the systems.

MR. SIMMONS:

Q. Okay. There was a point, of course, where there was no computerized technology for gathering patient information, when everything was done on paper, and maintained in individual patient charts, and my conception of it, maybe I'm wrong about that, is that at that point, before computers came in, the gathering of data and information about patients was confined to patient by patient by patient with very little ability to go across multiple files to extract common information about those patients. Is that kind of a fair assessment?

DR. MACDONALD:

A. Yeah, we would call that linkage.

MR. SIMMONS:

Q. Linkage, so very little opportunity for linkage. When computerization first began to be introduced into the health care system,

Page 20

would you have any comment on whether the original concept was to begin to replicate that type of system where you're collecting individual patient information in separate files or was there an original concept that there would be other uses, other linkages that would be made from it?

DR. MACDONALD:

A. No, and that's a good point, because obviously I don't think back when the Meditech systems were first being implemented across the province, and I have no idea when that was, but certainly a number of years ago, that there was any intent to think about linking across the province. So if you would think that a patient never left their own community, it wouldn't be a big issue because they would probably only go to one physician and one hospital, one pharmacy, and then you got that continuum of care. Obviously there's a lot more mobility now in today's age, and patients do transfer, especially with tertiary care in St. John's where a lot of patients come in for, let's say, cardiac care. So there's a lot of movement of our residents around the

Page 21

province and actually outside the province.
Electronic health record is really what's trying to address your question as to that continuum of care provided to a resident of Newfoundland and Labrador, no matter where they receive that care in the province. So currently today, that's very--we're moving in that direction. We have a client registry now in the province which identifies every resident of Newfoundland and Labrador when they present for services. We've just implemented a provincial archive and communication system, which is our radiology. So any exam, any report can be retrieved 24 hours a day, seven days a week, from anywhere in the province, by an authorized professional with respect to radiology treatment or radiology exams. So we're moving in that direction. Our pharmacy network is supposed to be going live in another--some time in early 2009. That'll be all prescriptions for all residents available anywhere any time. Very important in emergency rooms obviously for people who are not able to say what medications they're on. There's electronic

Page 22

medical record is another initiative underway in the province. So there's lots of activity around the infrastructure around technology in support of patient care, but also linkage. That's the critical piece is the linkage, so that we're able to say that a patient received a radiology exam on the west coast, saw a physician in Central and received these prescriptions at a hospital in St. John's, all available to the health professional.

MR. SIMMONS:

Q. Aside from the linkages from one site to another or one system to another, even within a single hospital, if we were to look at the Health Care Corporation, for example, before it became Eastern Health and the Meditech system had been implemented and my conception of it, and I may have this wrong, is that the Meditech system was not a comprehensive system to capture all patient information. There were modules within it that captured certain types of patient information from certain areas? Is that right?

DR. MACDONALD:

A. Yes.

Page 23

MR. SIMMONS:

Q. And my concept of that is that it was designed in a way to collect a patient's information so that you could look up me and knowing who I am, you could find my lab results that had been reported in Meditech and am I correct in thinking that that was the approach, the initial approach to computerizing health records?

DR. MACDONALD:

A. I would say, yes. I mean, I can't say for definite. I mean, obviously, to me, putting some of this health information of a patient available electronically made it much more efficient and effective for the health professional to get it, as opposed to the hard copy chart, which what we see a lot today when we see our family physician, they pull out the chart out of a filing cabinet, and that's fine if you've got 5,000 patients. But as the Health Care Corporation of St. John's or as Health Science Complex, I don't know, I think they have around 50,000 in-patient activity every year.

MR. SIMMONS:

Page 24

Q. And even if that GP wants to know how many of their 5,000 patients are over 50 years old, they'd have to look in every one of 5,000 charts, unless their information system has been designed in a way that's captured the ages of their patients and allowed them to search and extract the data?

DR. MACDONALD:

A. Yeah, and it's interesting you bring up that example, because to me, that's the information management piece. It goes back to my opening comment of asking everyone's age and gender here and putting it down on a piece of paper. It means absolutely nothing. But if I give you the mean age by gender, it gives you information. If that physician's charts are in electronic form, it's much more easier for them to actually go in and say "how many diabetics do I have in my clinic right now and what are their"--this type of activity. So surrounding the data with the infrastructure to provide information is the critical piece.

MR. SIMMONS:

Q. So for example, when the Meditech laboratory information system module is implemented in an

Page 25

organization like the Health Care Corporation of St. John's, if the future use of that system, as was attempted here in this case, to find everybody who had a negative ER/PR result, if that future use wasn't anticipated at the time it was set up, the people setting it up wouldn't be in a position to design it in a way that would make it easy to get that information out?

DR. MACDONALD:

A. And that's knowing your business.

MR. SIMMONS:

Q. And that's, pardon me?

DR. MACDONALD:

A. That's knowing your business.

MR. SIMMONS:

Q. Yes, right.

DR. MACDONALD:

A. That's going to the people who are building the system and say "here's the functionality I need." If it was not set up for that, it makes it very difficult to go back and get that information.

MR. SIMMONS:

Q. And I presume with these systems, too, over

Page 26

time, even people skilled in information management have gradually learned that there's more and more that can be extracted out of data? There's more things that can be done as the technology develops and as the capacity for information management develops. Is that fair to say, that the two of them have been developing over time?

DR. MACDONALD:

A. Yes, it's true. The importance of the secondary use of data is becoming more and more important, yes.

MR. SIMMONS:

Q. And when you make a change or implement an information management system, and these change from time to time, and begin capturing data in a more useful way, that would only apply to the new data you're putting in. The old data you've already captured, if it wasn't input into fields or wasn't captured in such a way that it captured the information that you decide you now want to collect, it's difficult to go back?

DR. MACDONALD:

A. Very difficult.

Page 27

MR. SIMMONS:

Q. Very difficult to go back, okay. And some of that, I'd suggest, is what was encountered here when it was necessary to go back over eight years of electronic and paper records to try and identify those people who'd had negative ER/PR results?

DR. MACDONALD:

A. The data was collected for patient care.

MR. SIMMONS:

Q. For patient care, yes, okay. You've told us a little bit about--well, you've told us pretty clearly that you think right now there's a lack of capacity in the health care system and in the authorities for information management. What do you think needs to be done, where--what kind of investment has to be made, whether it's personnel or financial, whatever, in order to create what you'd see as being the appropriate level of information management for the health authorities?

DR. MACDONALD:

A. In my experience, and it is my opinion that this is not something that can happen overnight. There's just not enough skillsets

Page 28

in Canada around information management because it's a cultural shift, and what I mean by that is technology in a lot of cases has provided the data to the decision makers. Taking that data and answering the question appropriately that the decision maker wants is the critical piece that I feel we have to start building capacity. You would not be able to recruit that skillset overnight. I firmly believe that we have to start building that capacity within the province.

MR. SIMMONS:

Q. Uh-hm.

DR. MACDONALD:

A. With our younger people, having them being mentored by more senior people. It's critical that they're intimate with the data.

MR. SIMMONS:

Q. Uh-hm.

DR. MACDONALD:

A. You cannot answer a question from the data unless you understand what the data can actually do.

MR. SIMMONS:

Q. Uh-hm.

Page 29

DR. MACDONALD:
A. And--so it's not only bringing that skillset of being able to use some statistical software we use, that's--you know, you train in that, but it's actually understanding the data, understanding the question, and able to produce information from the data that answers the question. That's the critical--that takes time. For example, Eastern Health is now moving towards--they've created a new department, a research department, and moving more in that direction, starting to build capacity on that.
MR. SIMMONS:
Q. Uh-hm.
DR. MACDONALD:
A. But I would suggest it's going to be a very long road for them to be able to build up the capacity needed to start doing the type of activities I feel are needed in the system so that we can really mitigate about what's happened here, and I'm thinking years.
MR. SIMMONS:
Q. Is there a role for the province in encouraging and facilitating the development

Page 30

of that kind of information management capacity?
DR. MACDONALD:
A. I understand that through one of the press release perhaps a year ago, the minister at the time had provided funding to each of the authorities for one position, and I'm not sure what the position was, but it was certainly around information management piece. So that's a step in the right direction. I think we have to be more systemic across the province as to what we should be looking for, what we should be--performance monitoring, for example, a lot of times the board will receive financial indicators, numbers that relate to revenues and budgets so they're able to at a high level monitor the performance of the authority from a financial perspective.
MR. SIMMONS:
Q. Uh-hm.
DR. MACDONALD:
A. We need to do that obviously for clinical indicators, and I don't want to suggest for a minute that we would have been able to stop what was happening because--like, as I said,

Page 31

this is one test, ER/PR is only one of many many diagnostic procedures occurring in a hospital, but can you imagine if we had monitored the rate of positives over every test that was done in ER/PR and monitored just the positives to see what the bar charts, and all of a sudden the bars were down here or up here that probably weren't the norm. You don't need information technology to do that. You need someone just writing on a pad of paper what the ER/PR score was and take a calculator out. So that's not technology, that's information management, but, you know, that's--you can't go back and say that.
MR. SIMMONS:
Q. Right.
DR. MACDONALD:
A. So that's--that's where we have to be, though, that's where I think we have to start heading is to, like, what are some of the things that we should probably be looking at, put the--the experts in the system might be able to say here's probably the 50 tests that we should probably be monitoring on a weekly or daily basis.

Page 32

MR. SIMMONS:
Q. And one of the lessons, I guess, learned from this whole experience has been that you can't--you have to ensure that the system is adequately resourced so that people have the capacity to recognize that those sorts of initiatives have to be taken, and the ability to take them?
DR. MACDONALD:
A. Yes. You know, there are certainly resources a piece of that, there's no doubt about it, but also train them too.
MR. SIMMONS:
Q. Yes.
DR. MACDONALD:
A. Right now there's not a lot of graduates coming out that would have--that would be able to say, okay, I can hit the ground running with this activity. So there's certainly resources for the physicians, but also there's going to be ongoing training.
MR. SIMMONS:
Q. I had a couple questions as well about the review of the actual searching methods that were used with Eastern Health to identify the

Page 33

negative ER/PR cases, and maybe Dr. Reza, maybe this is more for you.

DR. ALAGHEHBANDAN:

A. Sure.

MR. SIMMONS:

Q. And you've told us how over time it came to be recognized that not every ER/PR test performed had had an order entered in the Meditech field where the technologist or someone in the lab ticks off or notes that an ER/PR test has been ordered. You told us that. At the outset of looking for these cases, we've heard that Mr. Gulliver did the search of that field and came up with every ER/PR test that had been ordered, and then printing the pathology reports and manually reviewed them, and from what you've seen, would there have been any reason that you became aware of to suspect at the outset that that would miss ER/PR cases, that there would be ones that had not had the order entered?

DR. ALAGHEHBANDAN:

A. Well, from--let me just go back a few steps here.

MR. SIMMONS:

Page 34

Q. Sure.

DR. ALAGHEHBANDAN:

A. When I first came to be involved with this initiative, I learned that there were a number of patients who called in and self-identified themselves for the fact that they'd been diagnosed with breast cancer, ER/PR negative, never been called to be retested.

MR. SIMMONS:

Q. Yes.

DR. ALAGHEHBANDAN:

A. Obviously, at the lab, they went in and they checked the reason why these patients were not captured right at the beginning by using the ER/PR searching strategy at Eastern Health, and the reason was, as you mentioned, as I mentioned earlier, is the fact that ER/PR procedure code was not entered or ticked off by technologist. So it wasn't as a result of my exercise.

MR. SIMMONS:

Q. Oh, no.

DR. ALAGHEHBANDAN:

A. It was just basically something that surfaced.

MR. SIMMONS:

Page 35

Q. So that had been--that had happened before you became involved?

DR. ALAGHEHBANDAN:

A. That's correct, yes.

MR. SIMMONS:

Q. In the summer of 2007, last summer, but from what you were able to see about the way the Meditech system worked, and--were you aware of any reason why anyone would have suspected at the outset back in 2005 that that would turn out to be the case, that there would have been cases not--without orders entered?

DR. ALAGHEHBANDAN:

A. I'm not sure if I understand your question properly. If you could reword it, I'd appreciate it.

MR. SIMMONS:

Q. Well, the--my understanding of it is that people didn't know back in the summer of 2005 that this problem would turn out, without orders having been entered for ER/PR tests done, no order entered in that particular field in the Meditech system. I'm just asking if you encountered in your review of this whole thing any factors that might have been

Page 36

picked up back then that would have triggered that concern?

DR. ALAGHEHBANDAN:

A. Mostly human factor was involved in terms of basically ordering and performing the test. So that was the main factor.

MR. SIMMONS:

Q. Yes.

DR. ALAGHEHBANDAN:

A. And, of course, that is a factor always with any technology system.

MR. SIMMONS:

Q. Right.

DR. ALAGHEHBANDAN:

A. Something unavoidable, you can't really avoid it.

MR. SIMMONS:

Q. So aside from the risk that someone failed to do what they were supposed to do, which would be common in any system -

DR. ALAGHEHBANDAN:

A. That's correct.

MR. SIMMONS:

Q. You didn't encounter anything else that would have trigger a concern about that?

Page 37

DR. ALAGHEHBANDAN:
A. No, basically that was the main reason, actually.
MR. SIMMONS:
Q. Yes.
DR. ALAGHEHBANDAN:
A. But it could have been prevented probably by creating something within the system, once a test is being--is going to be ordered and someone forgot or someone overlooked it, you know.
MR. SIMMONS:
Q. Yes.
DR. ALAGHEHBANDAN:
A. Would have been a warning window or a message saying please check this.
MR. SIMMONS:
Q. Now the approach that's been suggested now for the review to see if there are any other missed cases that haven't turned up yet involves talking a different approach which is doing a word search of the text in all of the pathology reports in Meditech for the word "breast", I understand.
DR. ALAGHEHBANDAN:

Page 38

A. That's right.
MR. SIMMONS:
Q. And from the material we looked at yesterday, that is probably going to turn up, it's estimated, maybe as many as a couple thousand pathology reports for every year searched?
DR. ALAGHEHBANDAN:
A. That's right.
MR. SIMMONS:
Q. Now in order to identify those that were originally tested as ER or PR negative, all those are going to have to be read by someone?
DR. ALAGHEHBANDAN:
A. That's right.
MR. SIMMONS:
Q. And interpreted to determine what the original test result was said to be by that pathologist?
DR. ALAGHEHBANDAN:
A. That's correct.
MR. SIMMONS:
Q. So would I be correct that there is still a risk of human error in that approach as well?
DR. ALAGHEHBANDAN:
A. That's correct.

Page 39

MR. SIMMONS:
Q. And if we were to compare the number of pathology reports that have to be reviewed now, taking this approach, to those that were reviewed initially in '05 by using the order entry field for search, there's now an even quite a few more pathology reports to review than had to be reviewed?
DR. ALAGHEHBANDAN:
A. Including positives, basically.
MR. SIMMONS:
Q. Including the positives.
DR. ALAGHEHBANDAN:
A. Yeah.
MR. SIMMONS:
Q. So while we've got a different approach for trying to identify which pathology reports we're going to review, there's still really no guarantee that we're actually going to effectively find everybody there?
DR. ALAGHEHBANDAN:
A. And we have indicated that there is no 100 percent guarantee with respect to taking this approach.
MR. SIMMONS:

Page 40

Q. Okay.
DR. MACDONALD:
A. I'd like to point out that in this particular exercise that we're going to be undertaking with the search term "breast" and the relevant components of the pathology report, we're going to be treating this more as a research project and being using what we're calling "double blinded".
MR. SIMMONS:
Q. Yes.
DR. MACDONALD:
A. So basically it might be of value to understand this. If we find a pathology report with the term "breast", all we know is that a pathology report was generated was breast.
MR. SIMMONS:
Q. Uh-hm.
DR. MACDONALD:
A. The Centre will then remove all the identifers off this hard copy report and insert a study key. We have--Eastern Health has provided us with four nurses. Each of these nurses will review a pathology report and they will look

Page 41

through it, and all they will have is a study code on it, and they'll look first at this level for just if an ER/PR test was done.

MR. SIMMONS:

Q. Uh-hm.

DR. MACDONALD:

A. Okay. At this point, we haven't got the protocol defined whether we're going to get the ER/PR scores, but--so at this point, all we know is an ER/PR test was done, so a pile will be put over here of ER/PR, and a pile over here of non ER/PR, both had "breast" found in the pathology reports. Those will be coded into a database. The Centre will be doing that based on study code, which links back to the identifiable information. They will be all jumbled up again such that another nurse will review that pathology report again.

MR. SIMMONS:

Q. Uh-hm.

DR. MACDONALD:

A. But not the same nurse. So a nurse will never review the same pathology report again. That's what we mean by "double blinded", and so they again will fill out the sheet to say whether

Page 42

an ER/PR was actually present in the pathology report. So we hope to mitigate against human error by going over that twice.

MR. SIMMONS:

Q. Uh-hm.

DR. MACDONALD:

A. It's a very resource intense exercise, but we feel it's the most comprehensive way that we can search the available systems to as best we can identify every patient that had an ER/PR test done.

MR. SIMMONS:

Q. Yes, and once that is done then, someone I presume will have to review the reports to determine what the result of each ER/PR test was?

DR. MACDONALD:

A. Exactly, and we haven't really decided--we've got to talk to some more people to find out should the nurse actually garner that information from the charts, or should we actually have someone trained in that specific area. We don't know yet, but we certainly don't want to assume that the nurse will be collecting all the information from the

Page 43

pathology chart. It may not be the best approach.

MR. SIMMONS:

Q. Because we know that you will encounter variability in the way the results of the ER/PR -

DR. MACDONALD:

A. Exactly.

MR. SIMMONS:

Q. - scores have been reported. I'm sure, Dr. Reza, from the pathology reports you've seen, you -

DR. ALAGHEHBANDAN:

A. That's right.

MR. SIMMONS:

Q. You would agree there will be considerable variability in the way they've been reported. So there will have to be some criteria developed to use to determine which of those reports are going to be regarded as positive and negative and how those scores are going to be recorded and interpreted?

DR. ALAGHEHBANDAN:

A. Yes.

MR. SIMMONS:

Page 44

Q. And that part hasn't been done yet?

DR. ALAGHEHBANDAN:

A. Not yet. That's going to be a tool actually.

MR. SIMMONS:

Q. Okay, good. Fine, thank you. I don't have any other questions for you.

THE COMMISSIONER:

Q. Mr. Browne.

BROWNE, Q.C.:

Q. Thank you, Commissioner.

DR. MACDONALD & DR. ALAGHEHBANDAN - EXAMINATION BY PETER BROWNE, Q.C.

BROWNE, Q.C.:

Q. Good morning, gentlemen, Dr. MacDonald, Dr. Reza. You will be pleased to know most of the issues were covered this morning that I had for you. I just have one point of clarification and that's actually for Dr. Reza. Dr. Reza, when you became involved in 2007 working with Eastern Health trying to collect and move towards identifying new patients, and I think I'm looking at the regions, in particular, of Carbonear and Clarenville, do you recall whether or not Eastern Health had made request independent of

Page 45

your request to them to these areas for hard copies of both ER and PR positive results?

DR. ALAGHEHBANDAN:

A. I'm not sure actually.

BROWNE, Q.C.:

Q. Okay, so you wouldn't be able to -

DR. ALAGHEHBANDAN:

A. That would be a question for Mr. Gulliver.

BROWNE, Q.C.:

Q. Okay.

DR. ALAGHEHBANDAN:

A. Right.

BROWNE, Q.C.:

Q. Thank you.

DR. ALAGHEHBANDAN:

A. You're welcome.

BROWNE, Q.C.:

Q. Thank you, Commissioner.

THE COMMISSIONER:

Q. Mr. Eaton?

EATON, Q.C.:

Q. No questions.

THE COMMISSIONER:

Q. Ms. Newbury.

DR. MACDONALD & DR. ALAGHEHBANDAN - EXAMINATION BY MS.

Page 46

JENNIFER NEWBURY

MS. NEWBURY:

Q. Good morning, my name is Jennifer Newbury, and I represent the Canadian Cancer Society, Newfoundland and Labrador Division. I wanted to ask you first of all if you are familiar with--either or both of you are familiar with the operations of the Cancer Registry?

DR. MACDONALD:

A. Cursory.

MS. NEWBURY:

Q. Okay.

MS. NEWBURY:

Q. And are you familiar with the nature of the data collected by the registry?

DR. ALAGHEHBANDAN:

A. I am, to a certain extent. Actually, it is mostly demographic information, plus cancer diagnosis based on classification, oncology classification codes.

MS. NEWBURY:

Q. Okay, and do you know how the data is collected and maintained, sort of the mechanics of data management?

DR. ALAGHEHBANDAN:

Page 47

A. I don't know how they collect it. I believe that comes from Cancer Clinic. I understand that it is stored in a system called OPIS System.

MS. NEWBURY:

Q. An OPIS System?

DR. ALAGHEHBANDAN:

A. OPIS System.

MS. NEWBURY:

Q. And has the Centre ever had any involvement historically with the cancer registry? You're nodding your head.

DR. ALAGHEHBANDAN:

A. Yes, we did.

MS. NEWBURY:

Q. Perhaps you could explain what that involvement has been?

DR. ALAGHEHBANDAN:

A. One of the funded projects we had was with cervical cancer, provincial cancer program, an as a result of that project, we had to basically create a database using cervical cancer data, hospital data, mortality data, so we received the data from cancer registry, we link it to provincial hospital mortality

Page 48

systems.

MS. NEWBURY:

Q. Okay, is that -

DR. ALAGHEHBANDAN:

A. So that was one of the projects that I was involved with.

MS. NEWBURY:

Q. And is that a project that you dealt with Dr. Fontaine on?

DR. ALAGHEHBANDAN:

A. Yes, Dr. Fontaine was one--on the team as well.

MS. NEWBURY:

Q. And he's given some evidence about that.

DR. ALAGHEHBANDAN:

A. That's right.

MS. NEWBURY:

Q. And in terms of the data that you collected, is that something contained within the same type of system of the overall cancer registry or has a new system been set up for that?

DR. ALAGHEHBANDAN:

A. I'm not sure about that. What we requested, we requested cancer data on cervical tissues as well as PAP smears, and what we were given

Page 49

was basically access file, I think, that was extracted from OPIS System.

MS. NEWBURY:

Q. Okay. So you basically gathered some information from the OPIS System and then -

DR. ALAGHEHBANDAN:

A. No, basically, we were given the data because the data is maintained at NCTRF.

MS. NEWBURY:

Q. Okay, and then you worked with that data?

DR. ALAGHEHBANDAN:

A. And then we linked it to our provincial databases.

MS. NEWBURY:

Q. In terms of the distinction between information management and data management, do you have any observations about how the cancer registry deals with both of those aspects?

DR. ALAGHEHBANDAN:

A. That would be a question for you, Don.

MS. NEWBURY:

Q. If you can, of course.

DR. MACDONALD:

A. No, I mean--certainly I know that the Cancer Foundation puts out regular reports, to my

Page 50

understanding.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. So that's a part of information management, and we certainly work with the Cancer Foundation on a couple of other things other than the cervical cancer one. So other than from the outside looking in, I'm not really familiar with their information management capabilities or their data management capabilities.

MS. NEWBURY:

Q. So it's fair to say that the interaction has been fairly limited between the Centre and the cancer registry on an overall or global basis?

DR. ALAGHEHBANDAN:

A. Which--I'm sorry?

MS. NEWBURY:

Q. On an overall basis, aside from perhaps smaller special projects, has there been much interaction between the Centre and the cancer registry?

DR. MACDONALD:

A. I would say, you know, relative to other

Page 51

entities, we engaged probably in three or four different major projects with them.

MS. NEWBURY:

Q. Uh-hm. Are you able to make any observations about perhaps any deficiencies or any room for improvement with either the data management aspect or the information management aspect of the cancer registry?

DR. MACDONALD:

A. Well, we've had several meetings with the cancer registry on some initiatives of linkage, let's say, to mortality, but also through the ER/PR work.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. And from those meetings and discussions, it was understood that the registry is not complete and there are gaps in the data, and we've been working with them over the years on the cervical cancer project. We noted that also. We had to wait for a significant amount of time, for a year and a half to get a particular piece of information filled in because of lack of resources.

Page 52

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. So it was one of the--it was one of the reasons we didn't use the Cancer Foundation as a core source for ER/PR because we were told that it's not complete, and, therefore, we can't really say if it's not in the database, it didn't mean that they weren't done.

MS. NEWBURY:

Q. So in terms of obtaining a list of patients for cross-referencing purposes, it was your understanding that the cancer registry would not be a very valuable -

DR. MACDONALD:

A. It would not be a complete list, and, therefore, probably wouldn't provide much value to us.

MS. NEWBURY:

Q. And you just mentioned linkages, and I think you mentioned yesterday that the mortality database does provide information and it's up to date within, I think, two or three months -

DR. MACDONALD:

A. Yes.

Page 53

MS. NEWBURY:
Q. - was the information that you indicated, and are you aware that one of the, I guess, deficiencies in the cancer registry in terms of the data that it contains relates to death information for patients?
DR. MACDONALD:
A. Death clearance.
MS. NEWBURY:
Q. Death clearance, and can you explain, based on your knowledge of the mortality database how that situation could have evolved?
THE COMMISSIONER:
Q. I'm sorry, I didn't understand the question.
MS. NEWBURY:
Q. Okay.
THE COMMISSIONER:
Q. You mean--you're asking Mr. MacDonald to explain why the data on death is not in the cancer registry?
MS. NEWBURY:
Q. Yeah, if he would have any information perhaps if there was an issue with linkages between the mortality database and the cancer registry. Would you know if there's any

Page 54

impediment there, based on whatever interaction you've had with the cancer registry over the years, or perhaps arising out of your meetings?
DR. MACDONALD:
A. Well, actually, as far back as six or seven years ago, we did provide the cancer registry with death clearance.
MS. NEWBURY:
Q. Uh-hm.
DR. MACDONALD:
A. It was provided to them electronically so that they could link it directly to their systems and identify those patients identified as deceased, and I don't recall why that stopped. I know there was a change in leadership at the Foundation, and I don't know if that had anything to do with it, but it did stop.
MS. NEWBURY:
Q. Uh-hm.
DR. MACDONALD:
A. And recently, perhaps a year, year and a half ago, we began discussions again with the cancer registry to begin providing death clearance again. Now by this time, we had our

Page 55

legislation, so we have to be much more prudent in releasing it because this is identifiable data, and to my understanding, that's been resolved and death clearance will be another--will be revived in the cancer registry very soon.
MS. NEWBURY:
Q. Okay. Were there any technical impediments to providing information in an electronic form? Was there incompatibility between the cancer registry system and the system the Centre was operating?
DR. MACDONALD:
A. Well, you know, I call it horse and carriage type of approach because we don't have a direct link to the cancer registry. So basically what would happen is we would download the mortality information that they require to link to their system to a CD in electronic form. One of my staff would get in the car, drive it over to the Cancer Foundation, they would sign for it with a password when they--it worked. Obviously, there's much more efficient ways of doing that now with the technology available, but--and

Page 56

they would convert it back into their platform, so it -
MS. NEWBURY:
Q. So there's more -
DR. MACDONALD:
A. Meaning impediment as more of a pain.
MS. NEWBURY:
Q. More manual work.
DR. MACDONALD:
A. Yeah.
MS. NEWBURY:
Q. And perhaps more resources required for that.
DR. MACDONALD:
A. More than was necessary, but I wouldn't--relatively speaking, minimal resources for that particular activity.
MS. NEWBURY:
Q. And would it be your understanding that up until that process occurred, up until about six or seven years ago, would the information up until that date have been comprehensive?
DR. MACDONALD:
A. We've also had challenges with quality of our mortality system, and you have to understand the mortality system in this province, we

Page 57

have--we receive two different mortality systems. One is a Stats Canada one, which is the official one. It has cause of death, and I don't know if you want to get into that.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. Whereas the provincial system have causes of death, understanding that when a person is deceased, the physician in most cases doesn't say the person died of this, and here's the contributing factors. They basically just list them down and we would have no guarantee that the main cause is the one that they listed first. So that system is what we call the provincial system. It goes back ten years, eleven years perhaps. The mortality system for Stats Canada goes back to the 70s, but the data quality was so bad, we don't even use it back that far, and there's no way really to go back and fix that, as we talked about with Mr. Simmons. So over the last--we are comfortable, we put a lot of resources at the Centre to bring up the quality of mortality data from 1996 perhaps to today, ten

Page 58

years of data, but it was--there were significant challenges with data quality even with the mortality system.

MS. NEWBURY:

Q. Okay, but in terms of perhaps just the basic information as to whether or not a patient is deceased, would that have been fairly robust?

DR. MACDONALD:

A. No, because--well, I mean, because if we don't have the MCP number, it's a challenge to link.

MS. NEWBURY:

Q. Okay.

DR. MACDONALD:

A. There's seven Don MacDonald's in St. John's.

MS. NEWBURY:

Q. Right.

DR. MACDONALD:

A. Which one is--we need that unique identifier.

MS. NEWBURY:

Q. Uh-hm, and whether or not that was a contributing factor to the discontinuance of obtaining information from the mortality database, you have no understanding as to whether or not that's a factor?

Page 59

DR. MACDONALD:

A. I don't recall why that happened.

MS. NEWBURY:

Q. And as you alluded to earlier, it was recognized by Eastern Health that looking to the cancer registry for some information for a list of patients for cross-referencing purposes would not have been particularly valuable, and there's evidence--documents as well as evidence from Heather Predham, for example, that when she attempted to rely upon data from the cancer registry back in August of 2005, that there was some deficient information in terms of the numbers of individuals who actually had ER/PR testing, so the information was provided apparently for some patients who had ER/PR testing, but not for others, and the status of the patients in terms of whether they're living or deceased wasn't identified in many cases, so that there were some limitations there and also issues with the MCP numbers, I believe, which related to the cancer registry as well, but I'm just wondering if that registry information had been complete or fairly complete at that time,

Page 60

would the process that you were engaged in starting the summer of last year, could that have been perhaps simplified or taken less time if you could have obtained a list from the registry?

DR. ALAGHEHBANDAN:

A. I'm not sure if it could have been simpler or easier, but I would say that that would have been another source for us to make sure that the quality of the ER/PR database, you know, increases. So if that was a reliable source, we would have definitely considered it as on of so many multiple sources that we considered during the course of this exercise.

MS. NEWBURY:

Q. Okay, and would it have enabled you to do a more complete picture or view of the ER/PR testing, and you mentioned yesterday that the project that you were engaged in, because of time constraints and resource constraints, didn't include the positive tests, and they weren't retested? Would a more complete cancer registry list have enabled you to perhaps include that information?

DR. ALAGHEHBANDAN:

Page 61

A. If cancer registry had that information, it would have been valuable, but again going back to the main question, is that the database was created for the purpose of those patients who were negative and were retested at Mount Sinai.

MS. NEWBURY:

Q. Right.

DR. ALAGHEHBANDAN:

A. But, yes -

MS. NEWBURY:

Q. Okay. Has the Centre ever been asked to conduct or assist in the analysis of the retro conversions, or have there been any sort of preliminary discussions as to whether or not that would be feasible?

DR. MACDONALD:

A. I'll start with this one, and certainly Reza can add on to that. The retro conversions would go from positive to negative. We started with negative. It was just through the year and a half of working on this particular project, we did know and gave data on some positives that were sent up for retesting.

Page 62

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. And we decided to include them in the database because they were retested, so they met one of the criteria albeit they weren't negative, and it was through that exercise that some retro converted. So while it wasn't a--it wasn't a core activity that we did, we did recognize that.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. But to do an analysis on retro convertors without the full picture, to me would--could be misleading. I don't know how many positives we actually have in our database, I'm only guessing at 20, and that--a lot of them would have been because the patient wanted to be retested regardless and the physician allowed that.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. But--so that's a biased sample, we would call it.

MS. NEWBURY:

Q. Sure.

DR. MACDONALD:

A. So any analysis on that would be not appropriate.

MS. NEWBURY:

Q. Okay, and when you say 20, you're referring primarily to the ER positives?

DR. MACDONALD:

A. Yes, that's what we're referring to there.

DR. ALAGHEHBANDAN:

A. Yes, the number 20, I'm not sure whether that's -

DR. MACDONALD:

A. Just a small number.

DR. MACDONALD:

A. Just a guess, but it's small number, small proportion.

MS. NEWBURY:

Q. I think the initial number was about 18.

DR. ALAGHEHBANDAN:

A. Right.

MS. NEWBURY:

Q. Now there was some information from Dr. Denic

Page 63

Page 64

that there were just in the last year ten additional ER positive test results that were retested and that was a guesstimate on his part as to the number. Is that something that you're familiar with?

DR. ALAGHEHBANDAN:

A. In-house or at Mount Sinai?

MS. NEWBURY:

Q. I'm not sure.

DR. ALAGHEHBANDAN:

A. Okay, well, if it was Mount Sinai, we would have received it and entered into database, which I'm not aware of. I would assume that they were tests that were retested in-house.

MS. NEWBURY:

Q. In-house, okay. Now in the database, because of the way it was defined, you focused on the ER positivity, whether it was positive or negative. There are a number of ER negative/PR positive results for patients who were retested between 1997 and 2005, and again a few in 2006/2007 as well, and for those--for that category of tests, there could be results upon retesting that would include ER negative/PR positive, which would not be a

Page 65

retro conversion because you still have a PR positive?
DR. ALAGHEHBANDAN:
A. I can't make that call because that's clinical.
MS. NEWBURY:
Q. That's a clinical -
DR. ALAGHEHBANDAN:
A. Yes.
MS. NEWBURY:
Q. Okay. There have never been any discussions about that subset of your database in terms of the analysis of that?
DR. ALAGHEHBANDAN:
A. It has been, and I think in Mr. Thompson's report, there are one or two or more tables referring to that proportion that basically you're referring to.
MS. NEWBURY:
Q. Right.
DR. ALAGHEHBANDAN:
A. And I think there are some analysis been done on that.
MS. NEWBURY:
Q. Now my understanding from the tables, what I

Page 66

can glean from that, is that the purpose of looking at that is to account for the fact that some oncologists, and perhaps many or all, considered an ER negative/PR positive to be a positive test, so the analysis that was conducted in the tables, as I understand it, was to say that perhaps the number of positive tests was not--or the change test wasn't 43 percent, it might be somewhere in the 30s, if you realize that an ER negative/PR positive was tested, or was treated as positive from the outset?
DR. ALAGHEHBANDAN:
A. So various assumptions were made before those tables were created because we could not just naturally go with one assumption.
MS. NEWBURY:
Q. Uh-hm.
DR. ALAGHEHBANDAN:
A. As you said, the way that it was basically perceived and it was treated and it was handled across the board between clinicians and pathologists could have been different.
MS. NEWBURY:
Q. It could have, right.

Page 67

DR. ALAGHEHBANDAN:
A. Right.
MS. NEWBURY:
Q. And, I guess -
DR. MACDONALD:
A. We were only just trying to give different scenarios--Robert--the task force wanted to present different scenarios so that people can make their own interpretation of it, so -
MS. NEWBURY:
Q. Right.
DR. MACDONALD:
A. That's why there was a multitude of tables there.
MS. NEWBURY:
Q. Yes, I do appreciate that. I guess the one scenario that I wonder was ever addressed was the situation where you may have ER negative/PR positive results, which may or may not have been treated as positive from the outset, upon retesting becoming ER negative/PR negative, whether there was an analysis of that particular subset?
DR. ALAGHEHBANDAN:
A. I can't recall right now, but if there was, it

Page 68

would have been in the report.
MS. NEWBURY:
Q. Pardon me?
DR. MACDONALD:
A. It would have been in the report.
DR. ALAGHEHBANDAN:
A. Mr. Thompson's report, yes.
MS. NEWBURY:
Q. And again if you were to conduct an analysis of retro conversions, as you noted, the data that you have now is incomplete because of the focus of the retesting, and presumably you would have to include in the analysis all of the ER positive test results between 1997 and 2005 to come to any firm conclusions?
DR. ALAGHEHBANDAN:
A. With retro convertors?
MS. NEWBURY:
Q. Yeah.
DR. ALAGHEHBANDAN:
A. A firm conclusion, I'm sorry, on what aspect of it?
MS. NEWBURY:
Q. Upon, I guess, the -
DR. ALAGHEHBANDAN:

Page 69

A. As Dr. MacDonald mentioned -
MS. NEWBURY:
Q. Rate change of the test, for example.
DR. ALAGHEHBANDAN:
A. Right. This small proportion of people who were originally positive and retested as negative represents only a small portion. It doesn't represent an entire picture.
MS. NEWBURY:
Q. Uh-hm.
DR. ALAGHEHBANDAN:
A. So the analysis can be done, however, we have to have the limitation that that may not be representing the bigger picture.
MS. NEWBURY:
Q. Whether or not it's statistically significant and whether you can draw conclusions from that?
DR. ALAGHEHBANDAN:
A. Right.
MS. NEWBURY:
Q. If you included--if you expanded the analysis of the limited data that you do have, for example, to include not only the ER positives that convert to negative, but to include the

Page 70

ER negative/PR positives that convert to negative, would you be in any better position to extract any information from that?
DR. ALAGHEHBANDAN:
A. Again that requires some clinical, I guess, expertise to interpret whether they would consider PR positive as a hormonal pathway in considering it as a positive, or just going by ER and considering ER the main indicator.
MS. NEWBURY:
Q. Right. But that has never been discussed as a possible investigation to be done?
DR. ALAGHEHBANDAN:
A. Not that I can recall.
MS. NEWBURY:
Q. Thank you. So I assume that based on the limited information now, you're not in a position to make any comment about the reliability of the ER/PR positive test results which haven't been retested?
DR. ALAGHEHBANDAN:
A. Reliability of?
MS. NEWBURY:
Q. The ER/PR test results that have not been retested?

Page 71

DR. ALAGHEHBANDAN:
A. We don't know because they've never been tested.
MS. NEWBURY:
Q. And you haven't done any statistical analysis to make any--draw any conclusions from the very limited information that you do have?
DR. MACDONALD:
A. On the retros?
MS. NEWBURY:
Q. Yes.
DR. MACDONALD:
A. Positives?
MS. NEWBURY:
Q. Yes.
DR. MACDONALD:
A. We would say that we would not recommend any analysis be done.
MS. NEWBURY:
Q. And what's the basis for that recommendation?
DR. MACDONALD:
A. Well, bias for one purpose. They were primarily self-identified--not self-identified, but patients perhaps that wanted to be tested regardless of what their original

Page 72

was, or for some other reason had been sent up.
MS. NEWBURY:
Q. Uh-hm.
DR. MACDONALD:
A. So if it's only 18, you don't have to be a statistician to figure out you got 18 bias cases out of 2000.
MS. NEWBURY:
Q. Right.
DR. MACDONALD:
A. So we would--the Centre would not encourage any analysis on that data.
MS. NEWBURY:
Q. Right, okay, and you wouldn't -
THE COMMISSIONER:
Q. I understand why on the 18, but if your 18 at random, why are they biased?
DR. MACDONALD:
A. Well, they're not random. They're not random.
THE COMMISSIONER:
Q. But they don't know what their result is, they had no way of knowing.
DR. MACDONALD:
A. Statistically random.

Page 73

THE COMMISSIONER:
Q. Oh, okay.
MS. NEWBURY:
Q. And would an example be that if the 18 self-identified, they're 18 living patients and that you might be excluding the deceased patients, is that one perhaps example?
DR. MACDONALD:
A. Well, yeah, you would have to consider all these types of stratification, but, I mean, if you look at it, you know, and when they try to predict who's going to be the next prime minister of Canada, they interview 400 people across Canada and ask them that simple question and they're right 19 times out of 20, plus or minus 20 percent. Everyone understands that in the public. That's basic statistics, but the 400 people that they select are random. The 18 people that we're talking about here now are not random. The only way that they could be random is if we knew every--the list of all positives and systematically pick out of a hat 18 of them.
MS. NEWBURY:
Q. Okay.

Page 74

DR. MACDONALD:
A. But even 18 is too small, too small of a number.
MS. NEWBURY:
Q. And Dr. Denic had given some evidence that he had done, and he admittedly said it was a rough analysis of the 18 positive test results, plus ten that had self-identified, and he'd indicated based on his information that they were all true positive results. So basically the 18 plus the ten, and I think four out of the 18 had converted. Now he had assumed 15 would have converted, just to, I guess, be a little bit more inclusive of possibilities of retro conversions. Would that number, the total number of 18 plus the ten, would that be a sufficient number, and again the ten that Dr. Denic referred to were again self-identified patients?
DR. MACDONALD:
A. The statisticians are very good at going in and looking at your question and saying, okay, here's your population frame, your sample frame, here's the list of people I'm going to draw a sample from, here's my question. They

Page 75

can actually go in and using design modelling, blah, blah, blah, and come up and say you need this many people, and I can be comfortable in saying probably if we had 2000 positives, I'd be--anywhere from 300 to 400 would be required.
MS. NEWBURY:
Q. Okay. Thank you.
DR. MACDONALD:
A. To have any confidence that you can infer the result of your sample back to the population.
MS. NEWBURY:
Q. Okay, thank you.
THE COMMISSIONER:
Q. And randomly selected.
DR. MACDONALD:
A. And randomly -
MS. NEWBURY:
Q. Three to four hundred, okay, and perhaps maybe if you have the 18 plus ten people who self-identified, maybe they're the people who aren't doing as well and that might be--you know, might be skewing people because they're perhaps the people who are more concerned with their outcome because they -

Page 76

DR. MACDONALD:
A. Exactly.
MS. NEWBURY:
Q. Progressed in the meantime.
DR. MACDONALD:
A. Without randomization, you introduce bias.
MS. NEWBURY:
Q. Right, okay.
DR. MACDONALD:
A. And it could very well be that those 28 people had a deep concern on their original test even though it was positive, that the physician said just to calm their nerves--I'm not saying that happened, I'm just saying it does introduce bias into why the particular specimen was retested.
MS. NEWBURY:
Q. And I presume that the Centre would have the ability to do the statistical analysis if the numbers were presented to it? You have the expertise to do that?
DR. MACDONALD:
A. Yes, we have.
MS. NEWBURY:
Q. As you've alluded to earlier, I guess, in some

Page 77

of he tables there are a number of charts breaking down positivity rates based on the various cutoff points, years, and what have you, and, you know, we've heard evidence here that one method that physicians and technologists and health organization use of tracking the progress of quality of their work is to compare their outcomes with outcomes of other health organizations, and I guess looking at positivity rates is one such example, and I understand that the information is often found from the literature, journal articles, and eventually in textbooks, and, of course, the quality of the information and the quantity of information might vary, but assuming that the information is up to date and reliable, they had a large enough sample sizes and what have you, and it can be related to a particular population in question, if the expected rate of positivity for a particular test is, you know, say, between 75 and 85 percent just as an example, how would a department go about monitoring whether or not the results in a given year are acceptable or not?

Page 78

DR. MACDONALD:

A. Well, the acceptable piece obviously is a clinical decision, and my understanding is there's much debate in the literature as to what is an acceptable rate too, and you already mentioned some of the research that's been done in this area that perhaps did not really get into how good their data was actually to make the conclusions that they did, so it's kind of fraught with a lot of different questions even now, but it's a simple task to monitor the particular test results. It is a number, albeit one of the challenges we experienced in going through this exercise with the health system was that there was not a standard way of recording the ER/PR result, so a lot of times sometimes we didn't even get a number, but if, in fact, we were consistent in the system in coding a ER result as between 0 and 100, and a PR result 0 to 100, it's a very simple exercise to monitor trends over any period of time.

MS. NEWBURY:

Q. Uh-hm, and that would involve statistical analysis?

Page 79

DR. MACDONALD:

A. No.

MS. NEWBURY:

Q. Or would it be just eyeballing it?

DR. MACDONALD:

A. Well, no, it would--basically, if you introduce it into your system, let's say, your lab information system and say I want this functionality, I want to generate a graph on a monthly basis, or weekly basis, or daily basis, on ER/PR test results, and you could ask it to come up on your screen. It would be a bar chart showing you the last eight months, this current month, and the current year, or going back--it's a very simple task to do.

MS. NEWBURY:

Q. Okay.

THE COMMISSIONER:

Q. And if you're really old fashioned, you just keep a tally?

DR. MACDONALD:

A. Exactly.

THE COMMISSIONER:

Q. Divide--make the appropriate -

DR. MACDONALD:

Page 80

A. My thirteen year old son can do it.

MS. NEWBURY:

Q. In terms of the reliability of monitoring positivity rates as a primary tool to assess quality of the test results, as an example, would you have to take into account the possibility that in this particular case, for example, you could have false positives and false negatives that cancel each other out, and perhaps I can just give a hypothetical example. I'm just picking round numbers to work with. Say hypothetically you have an expected rate of positivity between 75 percent and 85 percent, and there are 100 tests that are performed and out of those tests 80 are positive and 20 are negative. So you would have 80 percent which is right in the middle of the expected range of positivity. Assume for the purpose of this hypothetical that the particular test is more prone, for whatever reason, to false negatives than it is to false positives. Could you have a possible scenario where 10 percent of the positives are false, and that would leave you with eight false positives, so 10 percent of the 80 positives

Page 81

are false--so you have eight false positives and leaving you with 72 true positives, and then 25 percent of the negatives are false because, say, this particular test is more prone to false negatives, so 25 percent of the negatives are false, and that would leave you five false negatives and 15 true negatives. So then to look at how many actual positives you have, you would have the 72 true positives, plus the five false negatives which are, in fact, positives. That would leave you with 77 positives, and then looking at how many negatives you have, you have 15 true negatives, plus the eight false positives, and you end up with 23 negatives. So even though your rate of positivity was 80, right in the middle of the range, when you get down to the detail of that particular test, it turns out that at the end of the day you should have had 77 positives, and 23 negatives, 77 percent is still in the range of positivity, but looking at that scenario, you actually have 13 false tests. You have the eight false positives and five false negatives. So 13 out of the 100 tests actually had false results, but looking

Page 82

at your rate of positivity, there may not have been any reason for alarm. Is that something that--is that perhaps the distinction between information management and data management and the need to understand the data that you're looking at?

DR. MACDONALD:

A. I'll give you a simple example.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. I'll get back to the age again. Someone is 100, and someone is one.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. The average age is 50 and a half.

MS. NEWBURY:

Q. Right.

DR. MACDONALD:

A. So you might link two 50 year old people in a room, but, in fact, because of the range, not understanding the data, you actually got an infant and a very senior person. So what you're explaining there is again getting back

Page 83

to understanding the business, understanding the data, answering the questions that's being asked with an understanding of what the data can tell you. I'm not going to sit here for a moment that I understood everything you just told me there, but I think--I understand what you mean, though.

MS. NEWBURY:

Q. Yeah.

DR. MACDONALD:

A. You do really have to understand what you're reporting back because there is a false positive, there is a false negative, there is sensitivity and specificity to incorporate into your work.

MS. NEWBURY:

Q. Right.

DR. MACDONALD:

A. And that all has to be brought back to whatever--what the question might be.

MS. NEWBURY:

Q. Right.

DR. MACDONALD:

A. Or for that matter, it might not be a question. As I said already it could be

Page 84

performance monitoring.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. So the report may not be enough to say here is the percent positives. There also has to be the part of the false negative incorporated into your interpretation of that bar.

MS. NEWBURY:

Q. Right, and so that would perhaps illustrate, you know, the need to be cautious when drawing any conclusions about--if you have information about the negative test results, drawing any conclusions about the rate of performance for the entire test if you don't have information about the positive test results?

DR. MACDONALD:

A. Yeah, and we also know that the ER/PR test is highly subjective anyway.

MS. NEWBURY:

Q. Sure.

DR. MACDONALD:

A. And so it is one of those tests that have a weak diagnostic type of outcome for it, given the false positive and false negative, but you

Page 85

have to accept that that will be a part of the test, but you also have to incorporate it into your interpretation of the results, especially if you're talking about monitoring that at a population level as opposed to an individual. I suggest that it's probably only one piece of information they would use at the clinical level.

THE COMMISSIONER:

Q. Excuse me.

CROSBIE, Q.C.:

Q. May I raise an objection, Commissioner. These gentlemen have candidly admitted they're not experts in this area of medicine. The statement was just made that it's a highly subjective test. I don't believe that's been stated by anyone who is so expert. It's been said to be a modified objective test, for example, but highly subjective is not used.

DR. MACDONALD:

A. I apologize for that then. I take that back.

THE COMMISSIONER:

Q. Okay. Carry on.

MS. NEWBURY:

Q. And in terms of the use of data for monitoring

Page 86

as a means of assuring quality, you've indicated that you can use bar charts or what have you to look at the expected--or the outcomes and compare it with the expected outcomes there, and perhaps you might see red flags if the numbers are outside of the range, and perhaps if you wanted to go further, you could do a statistical analysis to see whether or not that unexpected--expected result might be due chance or perhaps really raises a concern for those results?

DR. MACDONALD:

A. Yeah, I mean, statistics will only take--it's a very objective look at something. So, I mean, statistics will only take you so far. I mean, that's why you need that expertise in that area to interpret it, and I think when the task force report came out, we didn't try to support any interpretation of the results because, as just noted, this is not our area of expertise.

MS. NEWBURY:

Q. Right. You're involved with more the data management aspect of it and some, I guess, limited information management based on

Page 87

assumptions that have been put to you?

DR. MACDONALD:

A. Yeah.

MS. NEWBURY:

Q. And in light of that hypothetical that I just explained or proposed, I guess, to you, and the possibility of false negatives and false positives cancelling one another out to the point that you might have results that look good when you compare them with the literature, but may be masking a larger problem of false test results. If a department or an individual were to rely upon results to say, oh, looks like we don't have a problem, knowing that or suspecting that there might actually be some problem with the test, would there be a need to be more cautious in that circumstance if there's a reason to believe that a procedure may not be as reliable? Could you look to monitor results to give yourself assurances that they are, in light of that hypothetical illustration?

DR. MACDONALD:

A. As long as you're able to drill down far enough to know that you've cancelled different

Page 88

pieces out. As you said, if you're just looking at the big picture, and noting here's the percent of positives, for example, without understanding some of the underlying assumption that are brought together for that, yes, you would certainly need to -

MS. NEWBURY:

Q. So you would have to be cognizant of the fact that you may not have a full picture if you just look at the overall positivity rate?

DR. MACDONALD:

A. Exactly, and that's just from a statistical side of things, the math piece.

DR. ALAGHEHBANDAN:

A. And to be able to calculate false negative and false positive, one would need to have a gold standard because what you just explained is a two by two table calculating sensitivity and specificity in the epidemiology world, so having the results from St. John's lab is one side of it, but we need gold standard--that means those had to be retested or had to be looked at by gold standard. I don't know what gold standard definition would be in this case, but once we had that, we can make a

Page 89

conclusion whether positivity rate and false negative and false positive basically are in the same line or not.

MS. NEWBURY:

Q. Okay. Another gauge, I think, that might be used by health care providers in terms of tracking the progress of quality in their work might be to look at error rates or, I guess, false test rates more generally, and--as opposed to the positivity rate, might be looking at, well, what are the outcomes, but if you have a reason to test either an ad hoc or part of a regular monitoring program to retest results randomly, for example, and then look at what are the numbers of the results that stay the same and what are the number of results that change, if one were to look at the expected, we'll call it error rate, I guess, for lack of a better word, I assume would there have to be a statistical analysis of that, would you have to get a large enough number to be able to say, well, that this actually tells us something about the part of the group that we haven't retested?

DR. MACDONALD:

Page 90

A. There's clinical significance and statistical significance.

MS. NEWBURY:

Q. Uh-hm.

DR. MACDONALD:

A. Statistical significance basically means the difference did result as a result of chance. So it's a true difference within, as I said earlier, the example that the public is more familiar with, 19 times out of 20, plus or minus 3 percent. So they're never 100 percent sure of anything, but given the range, this is 99 times out of 100 it will fall within that range; one time out of 100, it will not. That's statistical. Clinical really doesn't use statistical significance. Clinical is more into patient care, so it's--I think maybe on the clinical side they can use statistics as just a guide, but ultimately at the end of the day it will be the clinical decision.

MS. NEWBURY:

Q. Right, so they don't have to necessarily get down to the crunching of numbers in order to glean some information from the retesting?

DR. MACDONALD:

Page 91

A. I think where statistics or epidemiology or performance monitoring, or whatever we want to call it that play a role, is more at a population level.

MS. NEWBURY:

Q. Okay, and just perhaps to clarify some terminology that might be used in this circumstance, if you have--if you want to look at or calculate what your rate of false positives is, for example, what would the numerator and denominator be for that particular rate?

DR. ALAGHEHBANDAN:

A. False positive. So basically we would have all the positive retested, and then the denominator would be the total number of positives, and then we would have the results of retest based on those.

MS. NEWBURY:

Q. Okay. So the--would you limit it to the number of the positive tests that were retested?

DR. ALAGHEHBANDAN:

A. So we're talking here about false positive rate?

Page 92

MS. NEWBURY:

Q. Yeah, upon retesting.

DR. ALAGHEHBANDAN:

A. Upon retesting. So we have a population of those patients who were tested originally as positive.

MS. NEWBURY:

Q. Uh-hm.

DR. ALAGHEHBANDAN:

A. You would send them to gold standard centre, whatever the case might be.

MS. NEWBURY:

Q. Uh-hm.

DR. ALAGHEHBANDAN:

A. And then we would receive results back. So out of those, let's say, 100 original positive, we came to know 95 of them are really positive and five are not, so my numerator would be five, and the denominator would be the total number of -

MS. NEWBURY:

Q. The positives back from retesting?

DR. ALAGHEHBANDAN:

A. Exactly. So you would have your false positive in this case.

Page 93

MS. NEWBURY:
Q. Would you ever include in the denominator any of the positive results that were not retested?
DR. ALAGHEHBANDAN:
A. No, you have to include the denominator as total population of positives.
MS. NEWBURY:
Q. Of the positives retested?
DR. ALAGHEHBANDAN:
A. All positives retested.
DR. MACDONALD:
A. All of them would have to be tested to be part of the false positive calculation.
MS. NEWBURY:
Q. Right, great.
DR. MACDONALD:
A. You can't (phonetic) infer that back.
MS. NEWBURY:
Q. Okay, thank you very much.
DR. ALAGHEHBANDAN:
A. You're welcome.
THE COMMISSIONER:
Q. Thank you. Mr. Crosbie, do you have any questions of these witnesses?

Page 94

CROSBIE, Q.C.:
Q. I do, thank you.
DR. MACDONALD & DR. ALAGHEHBANDAN - EXAMINATION BY CHESLEY CROSBIE, Q.C.:
CROSBIE, Q.C.:
Q. Good morning, gentlemen.
DR. ALAGHEHBANDAN:
A. Good morning.
DR. MACDONALD:
A. Good morning.
CROSBIE, Q.C.:
Q. Ches Crosbie. I represent the members of the breast cancer testing class action. I'd like to start by asking where you obtained the term "technical positive" which as far as I'm aware is not in the medical literature?
DR. ALAGHEHBANDAN:
A. I learned that term, the initial--the early days, actually, back in summer of '07 when I started working with lab staff, and the term "technical positive" was used at the time, so I came to be familiar with that at the time.
CROSBIE, Q.C.:
Q. Did this come from Mr. Gulliver?
DR. ALAGHEHBANDAN:

Page 95

A. I believe so.
CROSBIE, Q.C.:
Q. Where does the literature, or does literature say that you add in the ER positives to get the positivity rate as a lab matric?
DR. ALAGHEHBANDAN:
A. I did not study literature for that. The question regarding positivity--basically, your question is an epidemiology question.
CROSBIE, Q.C.:
Q. I'm sorry, did you say you did or did not?
DR. ALAGHEHBANDAN:
A. I did not study literature for that matter. My responsibility was to create a database.
CROSBIE, Q.C.:
Q. So you can't say whether that's the standard practice in labs?
DR. ALAGHEHBANDAN:
A. That would be a question for expert in that area.
CROSBIE, Q.C.:
Q. I understand. Again this may be beyond your ability to comment or take a position, but can you say whether you add in the clinically negative ERs with the clinically positive ERs

Page 96

to get a positivity rate as a lab matric?
DR. ALAGHEHBANDAN:
A. We did not calculate positivity rate. The positivity rate, I believe, was calculated at the lab. So given the fact that -
CROSBIE, Q.C.:
Q. By following -
DR. ALAGHEHBANDAN:
A. That we -
CROSBIE, Q.C.:
Q. By following what method, the method I just described?
DR. ALAGHEHBANDAN:
A. That's a question for Mr. Gulliver.
CROSBIE, Q.C.:
Q. Very good. Perhaps we could go to Document 3505, page six, Registrar. Somewhere along the way I believe I picked up a statistic from your evidence that the ER negative/PR positivity was 8.2 percent. I'm not sure for what period you were looking at?
DR. ALAGHEHBANDAN:
A. Could you -
CROSBIE, Q.C.:
Q. Is that the period of the Ventana machine

Page 97

before testing was ceased?
DR. ALAGHEHBANDAN:
A. I need to see the table perhaps to be able to see what the -
THE COMMISSIONER:
Q. You have a mouse there if you want to control -
DR. ALAGHEHBANDAN:
A. Sure. This is a 19 page document, so I don't know which page you're referring to.
CROSBIE, Q.C.:
Q. I'm not sure now either. I got this note, 8.2. I think that might be the period of the Ventana machine.
DR. ALAGHEHBANDAN:
A. I can't comment unless I see the table or the text.
THE COMMISSIONER:
Q. We'll do a search for 8.2. Is this the one?
DR. ALAGHEHBANDAN:
A. So it says from 1997 to 2005. That's the title of the table if you're referring to this 8.2 for ER negative/PR positive.
CROSBIE, Q.C.:
Q. So that's--includes the DAKO machine period

Page 98

then?
DR. ALAGHEHBANDAN:
A. Obviously.
THE COMMISSIONER:
Q. It may be there--just run the search again and make sure that's the only place. There we are, it's back again. Same figure, is it?
CROSBIE, Q.C.:
Q. The whole period.
DR. ALAGHEHBANDAN:
A. It seems to be for the whole period. I just want to bring one more point to--one point to your attention here. The Centre developed a database and based on the request we received from task force office, we generated raw numbers. Some of these tables are not raw numbers. For example, there is a specific table here referring to percentages and proportions, and these were basically calculated and developed by Mr. Thompson's group. So I may not be able to comment on all the tables.
CROSBIE, Q.C.:
Q. Okay. Well, what I'm getting around to is, if we can go back to page six, you quote from a

Page 99

learned author, which is Rhodes -
MR. PRITCHARD:
Q. Excuse me, Commissioner.
THE COMMISSIONER:
Q. Yes.
CROSBIE, Q.C.:
Q. - well respected article.
THE COMMISSIONER:
Q. Just a moment, please, Mr. Crosbie.
MR. PRITCHARD:
Q. Mr. Crosbie, I think it's important to realize that these reports were authored by Mr. Thompson, not Dr. Reza or Dr. MacDonald.
CROSBIE, Q.C.:
Q. Okay. Taking that into consideration that apparently you didn't write this, in any event, what I want to get to is there's a passage from Rhodes and although the article is not quoted directly in the text here, which admittedly is a draft, it is listed in an appendix. It's been mentioned before, this particular article. But specifically what I want to get to is in the middle of the paragraph, it says "for example, only approximately three percent of breast tumours

Page 100

are ER negative and PR positive." And I'm just wondering what does it suggest to have an ER negative, PR positive rate of 8.2 percent, which according to this, would appear to be almost three times the expected rate of positivity?
DR. ALAGHEHBANDAN:
A. I won't be able to comment on that. All I can see here obviously is three percent is lower than 8.2 percent being reported in this report.
CROSBIE, Q.C.:
Q. Does it suggest that there may be significant rate of false positives, PR positives?
DR. MACDONALD:
A. I mean, I think it's important to recognize that this is only one paper. When you do literature, you'd like to get a lot more supporting research to support any numbers any one author presents. Metanalysis is the term that is used for that.
CROSBIE, Q.C.:
Q. And again, you're not in a position to state, as an expert, what the literature does in fact say about that, what the consensus is, for

Page 101

example?
DR. MACDONALD:
A. No, and it doesn't say in this document either what the consensus is. What you're doing is you're quoting one paper. So it's--we didn't author the paper, and there's only one author that's stating that number. So to compare that number to your number may not be appropriate, and it's probably a question for the team of Robert Thompson, who did the lit review, who to my understanding there is a dearth of information in this area.
CROSBIE, Q.C.:
Q. Well, Rhodes is not an insignificant author, but all the same, we've got these two numbers here. Three percent is suggested by one important author, and there's a statistic of 8.2 which is almost three times as high, and it simply raises the question, perhaps you'll agree, but you can't resolve it, as to whether this suggests that there's an abnormally high number of ER--sorry, PR positives in our results.
THE COMMISSIONER:
Q. Excuse me, Mr. Crosbie. Ms. Brazil?

Page 102

BRAZIL, Q.C.:
Q. Commissioner, I believe the question has already been put to the witnesses and they've both acknowledged that they're not prepared to make the conclusion that Mr. Crosbie is attempting to have them reach, and as Mr. Crosbie pointed out in his earlier objection, they're not clinicians. So I don't think -
THE COMMISSIONER:
Q. I don't know if you have to be a clinician to answer this question.
CROSBIE, Q.C.:
Q. I'm not asking them to do other than agree, if they can, that there's an issue there to be looked into.
BRAZIL, Q.C.:
Q. Well, I believe Dr. MacDonald answered the question and said he's not familiar with Rhodes. That's one paper, and he's not prepared to comment beyond that.
THE COMMISSIONER:
Q. That wasn't the question, Ms. Brazil, frankly. I understand that Dr. Reza has said that he could not comment. He did not prepare the document. My understanding of the

Page 103

supplementary question by Mr. Crosbie, and he can correct me if I'm incorrect in this, is that he is looking for whether or not there are--taking the basic data, whether or not there are reasons why one cannot draw the obvious conclusion from the difference in the numbers, and these gentlemen may be able to say that you should not do because of these reasons, or we're not in a position to tell you whether you can draw that conclusion or not.
BRAZIL, Q.C.:
Q. (Inaudible).
THE COMMISSIONER:
Q. Am I wrong, Mr. Crosbie? Is that what you were looking for?
CROSBIE, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. Do you have an objection to that particular line?
BRAZIL, Q.C.:
Q. Well, only--I'm going to sit down because I'm not sure that I understand the question, so perhaps I'll sit down and think about it -

Page 104

THE COMMISSIONER:
Q. Well, perhaps the more important thing is does Mr. MacDonald understand the point.
DR. ALAGHEHBANDAN:
A. Could you repeat your question, please?
THE COMMISSIONER:
Q. So try it again, Mr. Crosbie.
DR. MACDONALD:
A. Yes, try it again.
THE COMMISSIONER:
Q. And then we'll figure out.
CROSBIE, Q.C.:
Q. Can you read back what the Commissioner just said? I don't know. I'm just asking does there seem to be an issue there that somebody should give some thought to?
DR. MACDONALD:
A. I can comfortably say that this would raise flags, and then further investigation would be required.
CROSBIE, Q.C.:
Q. Okay. Well that's about as far as we can get right now. Two more questions. The first is, do you know if the Cancer Registry collects statistics on DCIS?

Page 105

DR. MACDONALD:
A. I don't.
DR. ALAGHEHBANDAN:
A. Are you referring to NCTRF organization?
THE COMMISSIONER:
Q. The -
DR. ALAGHEHBANDAN:
A. Cancer Registry, Cancer Care?
CROSBIE, Q.C.:
Q. The registry.
THE COMMISSIONER:
Q. Cancer, yes.
DR. ALAGHEHBANDAN:
A. I don't know. That's a question for Cancer Registry officials.
THE COMMISSIONER:
Q. Do you know who at that organization could probably answer that question?
DR. ALAGHEHBANDAN:
A. I believe Mrs. Smith.
DR. MACDONALD:
A. Well, Sharon Smith heads up--we deal with Susan Ryan, who is in charge of the databases on an ongoing basis.
THE COMMISSIONER:

Page 106

Q. All right, thank you.
CROSBIE, Q.C.:
Q. This may be for Mr. Thompson to tell us, but I was going to ask you when you might expect to wind up your inquiries? Who will you be reporting to? And how will the results be made public? I guess I'm assuming they will be made public.
DR. ALAGHEHBANDAN:
A. Don.
DR. MACDONALD:
A. We haven't--we have to have further discussions on that. The Task Force will be winding down. Then there is the custodianship of the data and the ongoing work that we intend--we expect to do with Eastern Health. So we certainly have to resolve some of those questions. We are aware of them, but with respect to public reporting, I suspect that will come from the Ministry.
THE COMMISSIONER:
Q. I think the answer is ask your question of Mr. Thompson.
CROSBIE, Q.C.:
Q. Yes, he may be the best person to ask. Thank you very much.
THE COMMISSIONER:
Q. Mr. Pritchard, are you up or is it Ms. Brazil?
MR. PRITCHARD:
Q. No, I'm going to ask some questions.

DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,
EXAMINATION BY MR. ROLF PRITCHARD

MR. PRITCHARD:
Q. Gentlemen, just a few questions. Yesterday when you were commenting on the database, you made the observation that there were no epidemiologists involved in developing the database because it wasn't an epidemiological issue. It was, I think you said, a mathematics issue. Is that a fair summary?
DR. MACDONALD:
A. Well, the report, the Task Force, there was a mathematical exercise because basically just a table of numbers, percentages and averages. There were epidemiologists involved in creating the database and in particular, Tracy Chislett, who worked with Reza. Reza was the lead for the project. I think what I meant to say was, which has become clear this morning, we don't have any expertise around the

Page 107

Page 108

epidemiology of breast cancer.
MR. PRITCHARD:
Q. Okay, and that's a fair point, and just to follow up on that point, what I took from your evidence yesterday was that it wasn't an epidemiological exercise, but nonetheless, there were people with expertise in epidemiology who were involved around it. For example, Ms. Chislett, also Dr. Gregory.
DR. MACDONALD:
A. Yes.
MR. PRITCHARD:
Q. But their involvement in it wasn't to apply their expertise in epidemiology. Is that a fair statement?
DR. MACDONALD:
A. Yes, it is.
MR. PRITCHARD:
Q. Okay. The second thing I wanted to do was to take you back to the scoping document, which I believe is document P-3563, please? And you were being questioned yesterday and had occasion to speak to the different options that were being considered and why one option was, in the end, preferred over another, and

Page 109

as part and parcel of that discussion, part of what came out was that there was a decision made to focus on the negatives, as opposed to the positives, and you described one of the issues being a time constraint issue, as part of the reason why you focused on the negatives, and I just want to go to the first page here, and I note here, just to draw us back to something you've commented on a few times, which was the purpose, I guess, for the database, and that is summarized in the paragraph that we see here on the screen.

It says that "the database would focus on when and how patients were contacted to inform them of retesting, as well as when and how patients were informed of the subsequent test results." So that would specifically be people with negative results, or at least negative as they were understood at the time. Is that correct?

DR. MACDONALD:

A. That was the intent, yes.

MR. PRITCHARD:

Q. So in terms of that specific purpose, as it's described in the scoping document, the data on

Page 110

positive results would actually be irrelevant? Is that a fair statement?

DR. MACDONALD:

A. At that point, yes.

MR. PRITCHARD:

Q. Okay, and another document that you were shown this morning by Mr. Coffey was P-2152. Okay, and this morning we had an opportunity--we ended off the day actually, I think, with this document and we started with it this morning, and we were given to understand this was a printout or reading from the DAKO machine, and I think in your evidence yesterday, you were asked if you had seen a document like this before, and your answer was no.

DR. ALAGHEHBANDAN:

A. No.

MR. PRITCHARD:

Q. And so I gather from the evidence, as it was presented this morning, and I want to be clear on this point, you were not given this type of documentation to use?

DR. ALAGHEHBANDAN:

A. I was not.

MR. PRITCHARD:

Page 111

Q. It wasn't available to you. You weren't aware of it?

DR. ALAGHEHBANDAN:

A. I wasn't.

MR. PRITCHARD:

Q. Okay. I'd like now to go to P-0128, page 61, please? This is part of a news release that was issued on, I believe, February 22nd. I'll just scroll up to show the date. And Mr. MacDonald, you were commenting this morning, you were asked about some of the things that you thought should perhaps occur and you commented on some provincial initiatives. As you'll see here, this one is dated February 22nd, this news release. You commented on the need for an IM person to be present and I think you said you thought there had been an announcement that one was being provided for each region. I just want to take you to a point in the announcement and ask if perhaps this is what you're talking about.

All right, so here it allocates--there's some funding allocated and the second and third item down, it says "number two, 500,000 will be allocated for all regional health

Page 112

authorities to conduct information management capacity assessment," and then the last one, "270,000 will be allocated for new data management personnel." Are those the initiatives that you were talking about this morning?

DR. MACDONALD:

A. Yes, it is.

MR. PRITCHARD:

Q. Lastly, gentlemen, and you had some occasion already to do this this morning, but I wanted to invite you, if you were so inclined, if there's any further statement that you would like to make about your views on what's transpired?

DR. MACDONALD:

A. No, I've already commented on, I think, very--several times about the issues around database management and the capacity, the required capacity.

MR. PRITCHARD:

Q. And Dr. Reza, anything that you'd like to add?

DR. ALAGHEHBANDAN:

A. I just want to take a few minutes. Over the last couple of days, today, yesterday, we

Page 113

talked about data, databases, data sources, sources, etcetera, and but now I would like to take this opportunity to share with you the other side of the issue, the other side of the story, from our perspective.

Over the last year and a half, we have been reviewing pathology reports, hundreds and hundreds, probably on a weekly basis, daily basis. They were not only pathology reports to us. They were patients' lives' stories, husband and wife stories, sisters and mothers, and throughout that exercise, with each report that I read or my colleague or other people at the Department, we felt the pain, the agony, the distress that the cancer diagnosis would have caused for the families and patients and friends. It wasn't just simply entering some dry numbers into electronic software in a PC. It was just more than that, and I must say that the database that we developed, the reports and the analysis may not share with you this side of the story, which is the human side of it.

Also, I would like to say a few words with regard to my work with regions. I'd like

Page 114

to thank Eastern Health, specifically staff at the lab, staff at quality risk management department, Western, Central, Lab Grenfell, the Government, office of Task Force, Department of Health and Community Services, and I would like to thank you, Madam Justice, for giving us the opportunity to present to you the evidence and what we observed over the last year and a half, and as a proud Newfoundlander and as a proud Canadian, my sincere hope is that whatever we learn, the lessons learned from our exercise, other people's involvement, your Inquiry, improve health care system for the better good and hopefully and ultimately for our patients, for our people in the province. Thank you.

MR. PRITCHARD:

Q. Thank you. Mr. Coffey may have a few more questions for you. Thank you.

THE COMMISSIONER:

Q. Mr. Coffey, do you have anything arising?

DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,
EXAMINATION BY BERNARD COFFEY, Q.C.

COFFEY, Q.C.:

Q. Yes, actually, just to confirm something,

Page 115

Commissioner. You'll recall, gentlemen, yesterday I did mention, we did discuss the request that Ms. Jones had made some time ago about Dr. Mullen's slide examination data, and in fact, Dr. Reza, you had indicated that a similar request had subsequently been received from the Commission, and you'd explained the technical difficulties, and I'm just going to have it confirmed that this morning, before we started, you indicated that an attempt will be made to, as much as is possible, have those technical difficulties addressed in short term, and that what can or cannot be addressed, if some of them can't be addressed, then with the proviso that bearing in mind whatever those technical difficulties and the effect that might have on the results, that sometime before we clue up here, the end of next week, that what is available will be provided to the Commission?

DR. ALAGHEHBANDAN:

A. That's correct, sir.

COFFEY, Q.C.:

Q. Okay. Thank you very much, Commissioner. Thank you very much, gentlemen.

Page 116

DR. ALAGHEHBANDAN:

A. Thank you.

DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,
EXAMINATION BY MADAM COMMISSIONER

THE COMMISSIONER:

Q. Thank you. There's just a couple of points. I think probably you, Dr. MacDonald, is the person to answer this and I just want to make sure that I'm clear. This is a clarity kind of thing for me, because during the course of your evidence, you referred to a number of initiatives which are either ongoing at present or will be within the short term, in terms of information relating to health care. Some on a more narrow level. It seems to me the one that, in respect of comprehensive electronic health records, will be a massive undertaking. But first, I just wanted to ask you about the proposal regarding lab information systems.

DR. MACDONALD:

A. Yes.

THE COMMISSIONER:

Q. Do I take it from what you said that the premise of the proposal is a move to

Page 117

standardization? Is that the--standard of a--standardization, which I suppose is part of ease of access to records and the ability to access records. Is that the idea?

DR. MACDONALD:

A. It's certainly a piece of it.

THE COMMISSIONER:

Q. Okay. But it's more than that?

DR. MACDONALD:

A. Yes.

THE COMMISSIONER:

Q. Okay.

DR. MACDONALD:

A. Certainly, if--we have several lab information systems now in the province basically that were implemented based on the old board structure, the old health board structure, the eight boards. What the province now is moving towards is a provincial, one provincial lab information system. So everyone will use the same standards. The technology will allow health professionals to access lab results 24 hours a day, seven days a week, from multiple sites. So it is more enhancing the current system, the current infrastructure, to build

Page 118

on that but to make it one comprehensive lab for the whole province, lab information system for the whole province, and standards is a big piece of that, because obviously with the disparate lab systems now that exist, they do things differently.

THE COMMISSIONER:

Q. Um-hm.

DR. MACDONALD:

A. And so the standards piece is going to be the data dictionaries, for example. Everyone has to say ER/PR across the province from now on. There's no other deviations from that.

THE COMMISSIONER:

Q. That seems to me like a rather large project.

DR. MACDONALD:

A. It is part of the larger electronic health record initiative in the province.

THE COMMISSIONER:

Q. Okay, all right. That was my next question. Are all of these little tentacles going to really merge in this new comprehensive health records?

DR. MACDONALD:

A. Yes, it is.

Page 119

THE COMMISSIONER:

Q. And does this mean that Meditech will be no more or will Meditech somehow flow into this as well?

DR. MACDONALD:

A. Meditech is a hospital information system.

THE COMMISSIONER:

Q. Um-hm.

DR. MACDONALD:

A. Obviously the electronic health record extends to the community. I mentioned the pharmacy network service.

THE COMMISSIONER:

Q. Yes.

DR. MACDONALD:

A. So the hospital information system is intended to, at some level, be part of the bigger electronic health record. So for example, I think it was mentioned in some testimony the massive amounts of data that's collected in a hospital and Meditech only actually captures what we would call an abstract of that.

THE COMMISSIONER:

Q. Um-hm.

DR. MACDONALD:

Page 120

A. Of the full information that's in the patient chart, so a summary of that would be included in Meditech, and we have discharge summaries, for example. So when a patient is released from hospital, a discharge summary is created. That's probably going to be part of the electronic health record. When a patient presents at emergency rooms, which is part of our hospitals, an emergency room summary is provided. That's probably going to be part of the electronic--hopefully part of the electronic health record. So not all of what occurs in the hospital. You'll be able to get some of that summary information. The lab is going to be a separate piece. You're going to be able to have the lab piece.

THE COMMISSIONER:

Q. Okay. So it doesn't matter which emergency room in this province I walk into, if I've had lab work done anywhere in the province, they will be able to access that?

DR. MACDONALD:

A. And that's because we have a client registry in this province which actually identifies every patient in this--every resident in this

Page 121

province, so not only for lab, but for pharmacy, and for our radiology, anywhere in the province 24 hours a day, seven days a week.

THE COMMISSIONER:

Q. Okay. Now tell me whether or not these planned systems are of any value in planning for health care.

DR. MACDONALD:

A. Oh certainly. I mean, this is the--as I gave the example of Maple Leaf Foods, for example, where they can actually shut down operation, we don't have that luxury in the health system, so obviously we have to introduce these systems, first for quality of care. But we also have to start planning obviously for other uses of this data for planning for many purposes, for specialists, for example, the need for specialists in certain areas. You can use this data for identifying that. There's a lot of human resource areas that we could look at, because information systems also say how many physicians we have in the province. So these information systems for secondary purposes are critical for planning.

Page 122

THE COMMISSIONER:

Q. Okay. In respect of St. John's, I was, I think, surprised about what I would conclude is the unsophisticated nature of the data management in the organization, and I think because it's a--it has that university right next to it, I had expected that you would have a somewhat sophisticated keeping of raw data which might be able to be used for the purpose of medical research, for example, and that somebody would have thought about, "okay, what kinds of research are we doing in this province? What's our particular interest? How do we get that raw material so as to enable the researchers to get involved to be able to tap in to that raw material?" Was that just naive on my part or is there a benefit or perhaps not a benefit to being associated with a medical school, in terms of data?

DR. MACDONALD:

A. Certainly as a teaching hospital, the Health Science Complex has that added piece to it. There actually are not many clinicians in our province that actually do research. I'm going

Page 123

to--I'll throw out a number here now. There's 1,000 physicians in the province of Newfoundland and Labrador. I would suggest less than ten percent actually do research. Most of them, they only have time for patient care.

We are looking at a larger initiative for the province. We're looking towards working with the Faculty of Medicine and creating a Newfoundland Labrador network for population health research, which will actually look at the database management activities at the Faculty of Medicine to better enhance those, based on the work of the Centre and expertise of the Centre, to look at how we can better do research in this province and support research activities, whether it be genetic research or clinical trials or applied health research, all the different levels of research. So that is actually happening in parallel, and perhaps as a catalyst because of the electronic health record. Because as I noted, our province will have an electronic health record perhaps by 2011, a complete health record, electronic health record as defined by the various

Page 124

domains under it, and to take advantage of that, we have to be able to use this information for secondary purposes for research, because it's critical that we build up research capacity in this province so that we are, as you said, able to better plan for the future. So we are working towards working with the Faculty of Medicine in creating a new network and a new infrastructure to support research, given all the data that is around.

THE COMMISSIONER:

Q. Okay. Now look at this from the other perspective, putting on the sort of other kind of hat. Doesn't this raise incredible privacy issues?

DR. MACDONALD:

A. Yes, it does. That's a good point. The Centre for Health Information actually has a chief privacy officer and a lot of activity is focused on the electronic health record and issues of privacy and security, confidentiality. The Centre has been--was established in 1997 and one of the first things that we did was engage a stakeholder community to look at privacy guidelines, to

Page 125

introduce and adopt privacy guidelines and worked very closely with government around privacy legislation. So yes, it is very important that we ensure that as this data is used for other purposes, not only patient care, but for other purposes, that we protect the privacy of the individual. There has been significant work done in that area.

THE COMMISSIONER:

Q. Okay, thank you. It's been a very interesting day and a couple of hours. I thank you both very much for your contribution. I think we all recognize there's an incredible amount of work behind what you've been able to tell us about. Thank you very much.

DR. ALAGHEHBANDAN:

A. Thank you.

DR. MACDONALD:

A. Thank you.

THE COMMISSIONER:

Q. I suggest we take the morning break before we continue.

(BREAK)

THE COMMISSIONER:

Q. Please be seated. Welcome back, Mr. Thompson.

Page 126

MR. ROBERT THOMPSON, RESUMES STAND, EXAMINATION BY BERNARD COFFEY, Q.C. (CONT'D)

MR. THOMPSON:

A. Thank you.

THE COMMISSIONER:

Q. Mr. Coffey?

COFFEY, Q.C.:

Q. Thank you, Commissioner. Commissioner, there are six new exhibits. They are P-3557, 3558, 3645, 3646, 3647 and 3648.

THE COMMISSIONER:

Q. Entered.

EXHIBITS ENTERED AND MARKED P-3557 AND P-3558

EXHIBITS ENTERED AND MARKED P-3645 THROUGH P-3648

COFFEY, Q.C.:

Q. Thank you, Commissioner. Yes, Mr. Thompson, welcome back.

MR. THOMPSON:

A. Thank you.

COFFEY, Q.C.:

Q. I wanted to--and first of all, Commissioner, I did indicate yesterday that I was going to seek leave of yourself to question Mr. Thompson a little bit further, in terms of the events that have occurred since he was here, I

Page 127

believe on May 9th.

THE COMMISSIONER:

Q. Is there any objection related to that? No?

PIKE, Q.C.:

Q. I don't object.

THE COMMISSIONER:

Q. Thank you, Mr. Pike.

COFFEY, Q.C.:

Q. Mr. Thompson, and to put this in context for you, of course, the Commissioner has heard from a number of witnesses more recently about some of the events that have occurred since that time, Ms. Pilgrim, for example, and Mr. MacDonald and company.

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. First of all, in terms of the--start where the--you were acting for, in your capacity dealing with the Cabinet and adverse health events in that report?

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. Could you tell us, please, where you are with

Page 128

that?

MR. THOMPSON:

A. Okay, the Task Force on Adverse Events?

COFFEY, Q.C.:

Q. Yes, Task Force, yes.

MR. THOMPSON:

A. Okay. So just to distinguish.

COFFEY, Q.C.:

Q. Yes, I appreciate that.

MR. THOMPSON:

A. In that capacity, as chair of the Task Force and matters dealing with the Inquiry here, in my capacity as -

COFFEY, Q.C.:

Q. Yes, I appreciate that. It's two different things, and we'll come back to the Inquiry.

MR. THOMPSON:

A. That's fine, okay. So on the Task Force on Adverse Events, I think since the last time I was here, we've asked for and received an extension to our deadline for reporting, and we're substantially complete, are finalizing last minute consultations now. I expect we'll be in a position to submit the report to Government in November.

Page 129

COFFEY, Q.C.:
Q. In November of this year?
MR. THOMPSON:
A. Oh yes, indeed.
COFFEY, Q.C.:
Q. Okay, and in the report, in terms of, without asking you for any, you know, actual findings, because I appreciate it's still in draft form, it will address what subject matters?
MR. THOMPSON:
A. Okay. Well, our mandate was to look at the general category of adverse events, all the way from single patient events to multi patient, multi jurisdiction events and determine whether our health system in this province has the current capacity, the current policies and resources to respond in a timely and effective manner when events occur. So we've completed a review of existing policies and interviews and case studies and so forth, and we're going to look at, in the report, all the stages of adverse event management, from the identification of an occurrence that may be an adverse event, look at how it gets assessed at that stage and how assessment

Page 130

tools are used, if a further investigation is required into serious adverse events. We'll be looking at disclosure processes and disclosure policies. We'll also be looking at the evaluation processes, monitoring of all of those policies and systems, how they work, and so all the steps and stages between identification and the final implementation of recommendations, including, I should add, the whole area of coordination within RHAs when there's a multi patient event, the whole area of leadership and also public communications, because sometimes, of course, public concern may be engaged in regard to an adverse event and an RHA may need to develop a public communications plan. So we're trying to capture the whole breadth and make recommendations on the whole area.
COFFEY, Q.C.:
Q. Now when you were here last, and I take it that in preparing to come back here for today, you have had an opportunity to review the transcript of what you and I spoke of before?
MR. THOMPSON:
A. Yes.

Page 131

COFFEY, Q.C.:
Q. And I believe you had told the Commissioner before that there--up to the point that you testified before, that in terms of the completeness of the identification of people who should have been retested, that there had been, I believe, one back in March or so, one self-identifier as it were.
MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. And I believe, I understand from evidence we've heard since you were last here, that that has developed since.
MR. THOMPSON:
A. Um-hm.
COFFEY, Q.C.:
Q. Perhaps you could just, in an overview way, take the Commissioner through, from your perspective, how that has unfolded?
MR. THOMPSON:
A. Sure. Well, when I was here in May, it was just subsequent to the second part of the report on the database exercise, and that second part were the results of the

Page 132

communications contacts, and in that report that we provided to the Commission, it identified that in March, yes, that one additional patient had come to the attention of Eastern Health through a self-identification process and it raised the issue, well, might there be others there or are there any additional ways to do alternative searches. So we, at that time, asked NLCHI to do an examination of some alternatives and then we recommended to Eastern Health or strongly urged them to go ahead and undertake one of those alternatives. So we put it to Eastern Health, and I think that was the point at which we were when I was here in May.

I learned subsequently that they evaluated the alternative search possibilities and concluded that the likelihood of finding additional patients was low and the resource outlay would be high, and so they decided not to pursue it at that time.

In the weeks after that, getting later into May and early June, we started to hear from Eastern Health, through NLCHI, that there

Page 133

might be additional patients that had been identified for which their tests had been sent again to Mount Sinai for retesting, but we didn't have any data and we had not been advised directly by Eastern Health about these, in May. We held a meeting in June and by that time, NLCHI had put in requests to Eastern Health to obtain data so they could go in the database, and we'd understand better the circumstances around these cases. But there were delays in getting that data. So around early June, we held a meeting with Eastern Health and with NLCHI to clarify whose responsibilities it would be with to supply this data and to put some attention to the matter.

I guess by mid July, getting into our vacation period again, and when I arrived back from vacation in early August, it was evident then that the data still had not been supplied. So we started, through our office, to become more actively engaged in pulling in that data.

COFFEY, Q.C.:

Q. This is in respect of these 10 to 12 -

Page 134

MR. THOMPSON:

A. Right, that's right. By then, we were of the--well, we weren't certain of the number, because on one occasion, we were told it might be eight.

COFFEY, Q.C.:

Q. Yes.

MR. THOMPSON:

A. On another occasion, we were told it might be three. So the data was shifting around. But by early August, we said well, let's pull this together and get a very clear idea about what we have and it also started to become clear then that if--rather than just having one self-identifier, we had quite a number, and it meant that we had to go back and revisit the idea of whether an alternative search strategy is justified. So around mid August, NLCHI was able to get the data, and it turned out that we had ten. That number stabilized at ten, and we convened a conference call of the CEOs of the RHAs and put to them that we have a different situation than we had in the spring. We don't have one any longer, we have ten. So we should evaluate again and then undertake a

Page 135

new search strategy.

The first step in the evaluation of how we should approach it was to ask NLCHI to do something, actually we hadn't asked them to do before, and that was to provide us with an assessment of the quality or the completeness of the original search strategies for patients that was undertaken in 2005, and any other searches since that time. When they--so they completed that during the--I guess they started in August and completed it in September, and they did that by interviewing the pathologists and other officials in the RHAs that did those searches.

COFFEY, Q.C.:

Q. That would be Dr. Reza?

MR. THOMPSON:

A. Correct, yes, that's right. And so when they completed that, we were able to--they were able to recommend or able to tell us which RHAs had done searches for which there really wasn't a practical way to do a better search, and which RHAs or which information systems where there still may be potential, even if quite small, but nonetheless potential for

Page 136

reviewing it again, just to build confidence that no one had been missed. So that takes us right up to last week actually, because last week, or maybe it was the week before, we communicated to--it was last week.

COFFEY, Q.C.:

Q. That was last week, yes.

MR. THOMPSON:

A. Yes, it was. We communicated to the CEOs of the regional health authorities what we'd like them to do, each of them to do, in terms of this further search strategy, and I now understand that all of them are ready to go. That Eastern Health, in particular, has engaged the Centre for Health Information to work with them, because they have the most extensive amount of work to do, and whether or not we actually find any more is uncertain, of course, whether there are any additional patients out there. I suppose the likelihood is low, but our uncertainty is high because of the ten that were found earlier this year. So at least we'll have this additional search strategy completed and our confidence will be higher.

Page 137

THE COMMISSIONER:
Q. Do I take it from your comments that this is unnecessary in all of the regions or -
MR. THOMPSON:
A. There's something in each region, but it's not the same in each region.
THE COMMISSIONER:
Q. Okay.
MR. THOMPSON:
A. So would you like me to get into any of the particulars?
COFFEY, Q.C.:
Q. I'm going to take him through those.
THE COMMISSIONER:
Q. Okay.
COFFEY, Q.C.:
Q. Direct to the particular aspects.
MR. THOMPSON:
A. Great, okay.
THE COMMISSIONER:
Q. In each region, okay.
COFFEY, Q.C.:
Q. Yes, in each region. But in terms of an overview kind of, that's what I was asking about, a general overview as to what's

Page 138

happened since.
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. In the meantime, in terms of a general overview, and you just referred to, for example, in April of 2008, there had been a report provided to the Commission from your Task Force concerning the communications aspects and there had been one we've seen referred to before in March of 2008 about the patient retest results and the database itself, without the communication piece in it, or analyzed. I'm just going to ask, please, that Exhibit P-3564 be brought up? And this is a letter of April 20--I'm sorry, August 22nd, 2008, from--well, it's signed by Ms. Brazil from--prepared for Mr. Pritchard's signature but signed by Ms. Brazil, addressed to Commission co-counsel, and in particular, and the Commissioner has seen this before, but in particular, there's a reference to report having been provided to the Commission, March 18th, 2008 report. I believe, in fact, that should be--properly be March 11th, but with

Page 139

the hope that it would be valuable to the Commission when examining issues such as positivity, change rates, geographic variations and changes over time, and the tables attached to the final report were designed to enable such an analysis and you referred in earlier drafts of the report, and we have had copies of those.
MR. THOMPSON:
A. Um-hm.
COFFEY, Q.C.:
Q. They are certainly exhibited here, and then Mr. Pritchard and Ms. Brazil went on to say, "the earlier drafts show the emerging analysis, but we dropped this material from the report by March 18th. We do not endorse the interpretations or analysis in the earlier drafts," and then it goes on to say "to illustrate the dilemma, in some of the earlier drafts, we based a changed results on a change in the ER result only. We felt this approach was consistent with the original patient identification strategy, as well as some of the scientific literature. However, we later learned that some, perhaps all oncologists,

Page 140

would use the PR result as a basis for treatment decisions, even if ER was negative. Therefore, it would be difficult for us, without an expert perspective, to decide whether there was positivity or change on the basis of ER alone, or ER and PR. Another dilemma was whether our analysis should define positivity and change at the one, ten or 30 percent level and should this percentage change over time. Our solution was to provide a larger compendium of statistical tables attached to the report, so the Commission, with its own scientific advisors, could interpret the data as deemed necessary." So Mr. Thompson, I take it that this letter was sent, in effect, on your behalf?
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. And could you tell then--because this apparently has evolved of course since you were here last.
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:

Page 141

Q. Could you tell the Commissioner then about that? I mean, you've told us about--when you were here last about what the state of affairs was March/April when you were in May, but how has it evolved since?
MR. THOMPSON:
A. Okay.
COFFEY, Q.C.:
Q. And resulting in this.
MR. THOMPSON:
A. Okay. This is unrelated to the search strategy.
COFFEY, Q.C.:
Q. I appreciate that.
MR. THOMPSON:
A. Okay.
COFFEY, Q.C.:
Q. This is another topic entirely.
MR. THOMPSON:
A. Okay.
COFFEY, Q.C.:
Q. And we're going to go back then through particular exhibits relating to the search strategy.
MR. THOMPSON:

Page 142

A. Sure.
COFFEY, Q.C.:
Q. But in terms of general subject matters, in terms of broad themes that have evolved since you were here last, the search strategy is one, and this is another.
MR. THOMPSON:
A. Sure, okay. In regard to this particular letter, really there is no evolution on this reporting of the, let's call it the clinical results from the database. The report of March 11th or 18th was really our final cut at that issue, and we had all these drafts, of course, that had led up to that report and so, in August, in reviewing any analysis that had been done on the database, because there was an ongoing requirement for us to disclose all analysis, it was identified that these drafts might be pertinent and so we'd package them up and disclose them and then this letter put it in context.
COFFEY, Q.C.:
Q. And we understand, we've heard from Mr. MacDonald that, in effect, and looking at those various drafts, he has told the

Page 143

Commissioner that "look, this was Mr. Thompson's people's work, but occasionally from time to time, NLCHI were asked to provide certain tables, and we did it."
MR. THOMPSON:
A. Oh absolutely.
COFFEY, Q.C.:
Q. And to review, in fact, the text.
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. For their input. I take it then there were certain things that, from your perspective, in terms of this would be the adverse health events task -
MR. THOMPSON:
A. No. Okay, it's so it's worthwhile to clarify that.
COFFEY, Q.C.:
Q. Yes. So why were you looking for interpretations and analysis, I suppose.
MR. THOMPSON:
A. Okay, that's a good point. This work started because we had the database, okay, and the database, you'll recall, was undertaken

Page 144

initially to answer the question was everyone contacted, and that was a question that originated when I was acting deputy minister, and we were--the House of Assembly was open and there were a lot of questions arising around that issue. So one thing led to another and so the sequence would be that we identified the need for the database to answer that core question and to answer that core question, we also said well, we need to answer such questions as "is the 939 number of total patients, is that a correct number?" So let's map into this database all of the activity that Eastern Health engaged in that's sensible around those questions. So when we did that, we started to have a database that potentially could answer some additional questions.

Now, my mandate in relation to helping Government provide full and open disclosure to the Inquiry, I felt encompassed or put an onus on me to understand as well as I could the issues involved in the terms of reference, what actually happened at Eastern Health, to the best of my knowledge. So as we developed the database, you know, interesting questions

Page 145

would occur to us. For example -
COFFEY, Q.C.:
Q. Such as? Go ahead.
MR. THOMPSON:
A. Such as "what is the positivity rate over time?" Such a question is germane to the term of reference of the Inquiry. "Could the problem have been detected at an earlier date?" So it's an interesting question that we would want to pursue. So that was the impetus behind trying to analyze the data, obtain tables from NLCHI, do some literature review. So it grew sort of organically from that kernel and so at a certain point in time said well, let's package this into a report and then we started drafting a report around this. Sometimes, you don't know what you have until you actually try to write it out in a clear analysis and make sure that it makes sense and share it with people to see if it makes sense. So we started to get these drafts of reports and finally, it emerged that--well, in March, that we produced what we thought was the final state of that work, because we had other things to move onto as

Page 146

well, and we packaged it up and disclosed it to the Commission, in the hope that, of course, the Commission or co-counsel and staff would be able to use this for your own work here.
COFFEY, Q.C.:
Q. And this letter in August of 2008, the--so what then had caused you to not endorse the interpretations or analysis in the earlier drafts?
MR. THOMPSON:
A. Well, it's a strong sentence, but it's meant to make a point clear, that--which is really elaborated in the rest of the letter, that there were limitations to our ability as a task force office, without a very specialized expertise in this area, to reach certain conclusions about positivity rates or about conversion rates, and some of those--that kind of analysis was embedded in the drafts, and so rather than leave any impression that we felt that we had arrived at a satisfactory conclusion, we wanted to state strongly in this letter that these are drafts and we can't endorse those conclusions and we've taken them

Page 147

out for purposes of the draft final report.
COFFEY, Q.C.:
Q. And in that context, for example, Mr. Thompson, because we understand that the NLCHI database does not record any of the--almost none, comparatively speaking, of the original PR results, positive, the original positive PR results, ER/PR results. I'll rephrase that.
MR. THOMPSON:
A. Okay.
COFFEY, Q.C.:
Q. The NLCHI database, we understand, does not record, in any systematic way at all, those patients whose original ER and/or PR results were positive?
MR. THOMPSON:
A. It doesn't include any results for patients who are not retested, and the main criterion for retesting was to have been designated ER negative.
COFFEY, Q.C.:
Q. And the point being that there would be upwards, I understand, probably upwards of 2,000?
MR. THOMPSON:

Page 148

A. Correct.
COFFEY, Q.C.:
Q. Who had an ER/PR -
MR. THOMPSON:
A. Of course, that was--we defined the project in that manner for very specific reasons, but you're right, exactly.
COFFEY, Q.C.:
Q. And in terms then of kind of drawing conclusions, for example, and your hesitation about drawing conclusions, which is elaborated upon, articulated here in this letter -
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. - is that at all related to the fact that in terms of an analytic study, that a lot of the original patients are just not included, in terms of ER/PR?
MR. THOMPSON:
A. In part, but not in whole. That isn't the main factor. So just to make a point about the absence of positive patients in the database, that's a limitation if one wants to assess the whole population of ER/PR tested

Page 149

patients. No question. That wasn't our objective. So their absence in the database was not a limitation for the objective that we had.

Now one though can still calculate a positivity rate for--even with, even having only all of the negative patients, if you have the denominator which is simply the total number of tests that were done, because that becomes your denominator for calculating a positivity rate. You don't have to have retest data on all of the positive patients in order to know how many tests were done. But to be fair, to know with confidence that you have the true denominator, one should go through all of the effort necessary to ensure that you have every case counted and we didn't do that, so we had a proxy denominator, which was the total number of tests that were recorded as having been done in the Meditech system at Eastern Health. So whether that was ten--you know, off by ten cases or off by 50 cases, we don't know for sure. But it gave us a proxy to--so that's why in the drafts, you see some of that analysis. You see some

Page 150

positivity rates calculated with a denominator of the total number of tests. But yes, it's a limitation and it was on our mind that we didn't have as much confidence in the total number of ER/PR tests as we did in having the total number of negatives.

COFFEY, Q.C.:

Q. Now here, just looking at this, the last paragraph here on the page that's in front of us on the screen, it's written "therefore it would be difficult for us, without an expert perspective, to decide whether to present positivity or change on the basis of ER only or ER and PR."

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. Now, I'm going to suggest to you that if you look back at those original tables -

MR. THOMPSON:

A. Um-hm.

COFFEY, Q.C.:

Q. - that if you don't make the choice, if you just decide to present tables based upon ER only, that those tables are all there.

Page 151

MR. THOMPSON:

A. Oh yes.

COFFEY, Q.C.:

Q. There are quite a number of tables based upon ER only and particular cut offs, if you assume 30, if you assume, you know, 30 and 10, 10 and one, there are--those reports are replete with tables.

MR. THOMPSON:

A. Absolutely.

COFFEY, Q.C.:

Q. For ER, if you just assume on the basis of ER only.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. And if you utilize instead ER and PR combined, because again there are a number of tables that do just that, don't they?

MR. THOMPSON:

A. Oh yes, absolutely.

COFFEY, Q.C.:

Q. So in effect, in terms of without an expert perspective, the expert perspective would be simply making the choice, if one's going to

Page 152

make the choice?

MR. THOMPSON:

A. Correct, and drawing conclusions on the basis of that choice.

COFFEY, Q.C.:

Q. And but based upon what's there, without making the choice, if one decides, one can look at the ER tables and just -

MR. THOMPSON:

A. Oh yes, it's all there.

COFFEY, Q.C.:

Q. - come to your conclusions, it's there.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. And one can look at the ER/PR tables and -

MR. THOMPSON:

A. And we would hope that the Commission is in a position to make some choices based on the information that's there.

COFFEY, Q.C.:

Q. And did you ask anyone, any epidemiologist with any expertise in breast cancer, for assistance in making the choice?

MR. THOMPSON:

Page 153

A. We talked to a fair number of people about this issue. We've talked to pathologists and oncologists at Eastern Health. We have staff who are--have good training in this general area. Not in the area of ER/PR testing, but in use of health statistics. We have NLCHI's general epidemiological background. So we tried to--and we read the literature. We try to explore this area as much as we could, to understand which is the--if there is, in fact, a consensus around the best way to present it, and in the final analysis, it wasn't clear to us that there was a consensus, but certainly there are ways to present it and we've tried to present--include them all.

COFFEY, Q.C.:

Q. And in fact, that's--I'm going to suggest to you, in fact, that's exactly what the reports do. They present, if you're going to take one approach, this is what the numbers are.

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. And if from a clinical epidemiological perspective, you're going to take the other

Page 154

approach, this is what the numbers are?

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. And whether one should or shouldn't take one or other of the approach might depend upon which clinical epidemiologist one asks?

MR. THOMPSON:

A. Sure, um-hm.

COFFEY, Q.C.:

Q. In effect, because you get different opinions about whether there's a best approach.

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. In any case, all of that, I take it, all goes back to and relates to the idea of whether or not if this had been tracked at the time by someone, back in 2000, 2001, 2002, that they might or might not have recognized positivity rate problems at the time?

MR. THOMPSON:

A. From a non-expert perspective, I agree with that.

COFFEY, Q.C.:

Page 155

Q. So did you, in fact, ask or actually find, I'll call it, a breast epidemiologist?

MR. THOMPSON:

A. No.

COFFEY, Q.C.:

Q. And epidemiologist with breast expertise, expertise in breast cancer?

MR. THOMPSON:

A. Well, of all the people we talked to, I'm not sure if any of them would fit that category, no.

COFFEY, Q.C.:

Q. There's certainly no one--and Mr. MacDonald has been here and he reiterated, I believe, this morning to the Commissioner that in fact there was no one at NLCHI who actually has that particular expertise. There's a lot of epidemiologists, but no one who, in fact, focuses on breast cancer.

MR. THOMPSON:

A. Sure.

COFFEY, Q.C.:

Q. And did you ever actually find any epidemiologist who was prepared to comment upon it at all?

Page 156

MR. THOMPSON:

A. No, and we didn't exhaust all possibilities because we were--as I said, this grew organically. It wasn't clearly a part of our mandate, but we had this data and we were, if you like, following down leads. But in the end, we had a mandate that we did need to fulfil, so we wanted to make sure the Commission had access to it to track down those questions, but we didn't pursue it to hire consultants to assist us to analyze the data.

COFFEY, Q.C.:

Q. And now in terms of--if we could, please, just on--because I want to be clear on, so the Commissioner could be clear on this, just looking at this letter, if we could bring up Exhibit P-3565? I take it that's the letter of March 14th, 2008 from yourself to Ms. Chaytor and I and the second page, it's a draft, March 11th 2008. I take it this is the document you're referring to in that August letter?

MR. THOMPSON:

A. Correct.

Page 157

COFFEY, Q.C.:
Q. Okay. So it is the--when the letter says March 18th, in fact, you meant to say March 11th?
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. Okay. And just then in terms of, if we could go back then to the letter itself. So "the earlier drafts show the emerging analysis, but we dropped this material from the report by March 18th." Which emerging analysis and interpretations or analysis in the earlier drafts are you talking about having been dropped?
MR. THOMPSON:
A. What we mean, in general, is that the calculations of positivity rates and of change rates in the data and then the, I guess, the text around describing what they may be is the analysis that we dropped.
COFFEY, Q.C.:
Q. Okay, so the--if we could go back then to 3565, was there anything then in this report that, in August, you were saying to the

Page 158

Commission we drop or is it the difference between -
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. - the original reports and March 11th? I want to be clear on that.
MR. THOMPSON:
A. Sure, of course. It's everything in this report we endorse, you know, we say is the product of our work to the best of our ability. Everything in prior reports, we're saying we've dropped it from prior reports.
COFFEY, Q.C.:
Q. Okay, so that's--wanted to be clear on that. But the March 11th one, it is--and in particular, you're saying, "look, in effect, Mr. Coffey, the tables are what they are"?
MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. And "what we've written there was our views at the time," subject to, and I appreciate this, that as you've indicated, there's ten or so since that the numbers would change a little

Page 159

bit.
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. And may, in the future, change a little bit, depending upon what happens?
MR. THOMPSON:
A. Potentially, yes.
COFFEY, Q.C.:
Q. Now if we could, please, I just wanted to explore with you a little bit further about this, go back to the topic of identifying patients who were missed.
MR. THOMPSON:
A. Sure.
COFFEY, Q.C.:
Q. Apparently the first time round or before, having missed before March of 2008. Mr. Thompson, when did you--what's your understanding now about why they were missed, in a general way?
MR. THOMPSON:
A. Well, in a general way, perhaps the most frequent reason that we've encountered is that the ER/PR entry code in the Meditech system at

Page 160

Eastern Health was not filled in, yet that was the primary way that Eastern Health went about searching for the list of ER/PR tested patients.
COFFEY, Q.C.:
Q. When did you first hear that, that it was--I mean, that there was a linkage between self-identifiers and the fact that they hadn't been found because this particular code hadn't been checked off? When did you first learn about that?
MR. THOMPSON:
A. It would have been, to the best of my knowledge, just prior to submission of the April--so sometime early in the spring or in the late winter, and at least that was the first time we grappled with the concept and said "what are the implications of this?"
COFFEY, Q.C.:
Q. And that was brought to your attention by, do you recall?
MR. THOMPSON:
A. It would have been NLCHI, perhaps Reza or Tracy Chislett.
COFFEY, Q.C.:

Page 161

Q. And then arising out of that, and you've indicated--I'm not going to take you through. I take it there were three different potential approaches Dr. Reza came up with?
MR. THOMPSON:
A. Yes, that's right.
COFFEY, Q.C.:
Q. And you've indicated that you approached Eastern Health, in particular Ms. Jones, about that?
MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. What was their reaction at the time?
MR. THOMPSON:
A. Well, the -
COFFEY, Q.C.:
Q. Because I take it at that time, you were saying look, there's one.
MR. THOMPSON:
A. Yeah, that's right.
COFFEY, Q.C.:
Q. The one self-identifier.
MR. THOMPSON:
A. Well, Eastern Health generally was concerned

Page 162

as well that this was there, and is there a reasonable, feasible way to do a better search. So when we asked Reza, as well as Terry Gulliver, to evaluate three potential options, I think may have been Barry Dyer, I'm not sure. But at any rate, Eastern Health were very supportive of having that evaluation of the three options done, and then the matter was then put to them to consider this and to make a decision. So we really disengaged from the process at that point and then they made a decision, as I've said earlier, based on their assessment. I wasn't part of that assessment, but based on their assessment, that the likelihood of finding additional cases was low and that, so they decided not to do it.
COFFEY, Q.C.:
Q. Was the fact that they weren't going to do it communicated to you?
MR. THOMPSON:
A. Well, it wasn't like an action/reaction or you know, a direct response. I learned of that decision sometime within the next month, but -
COFFEY, Q.C.:
Q. So this would be May/June, I take it, of this

Page 163

year?
MR. THOMPSON:
A. Yes, yeah, that's right.
COFFEY, Q.C.:
Q. In that time frame, and at the time that you learned that they were not going to pursue it, do you recall who you learned that from?
MR. THOMPSON:
A. No, I don't.
COFFEY, Q.C.:
Q. Your reaction at the time was what, at that point?
MR. THOMPSON:
A. It's unfortunate, would have been a good to do, but I didn't think about second guessing it at that time. There was one case, important consideration, but it didn't seem to--it didn't engage me in any more active way at the time.
COFFEY, Q.C.:
Q. And Mr. Thompson, when this had been brought to your attention, you know, you'd focused on it, this lack of checking off this particular order entry, I gather, field, brought to your attention in, I gather, perhaps March of '08,

Page 164

at that time, did anyone make you aware of, according to Dr. Reza, the fact that apparently he had understood, when he first got involved, in the summer of '07, that about ten people had been--had self identified back in the summer of '07.
MR. THOMPSON:
A. I was aware -
COFFEY, Q.C.:
Q. Up to the point in the summer of '07, and not in the summer, up to the point in '07.
MR. THOMPSON:
A. I was aware of that general point. I forget exactly when, but I was aware that there were self-identifiers in that group.
COFFEY, Q.C.:
Q. So it had been--it had not only been--it was the one in March, but there had been a number before -
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. - the matter ever came to your attention.
MR. THOMPSON:
A. Yes.

Page 165

COFFEY, Q.C.:
Q. And in your dealings with Ms. Jones, do you know whether or not she understood that, the fact that it wasn't just this one, that there was a number before?
MR. THOMPSON:
A. Well, I don't know for certain whether she was aware, but I know that Eastern Health was aware, because they were the recipient of the calls.
COFFEY, Q.C.:
Q. And as then this matter went on, you know, from May into June and you've indicated that there was a number three, eight, ten, and it began, and it varied, I take it.
MR. THOMPSON:
A. Um-hm.
COFFEY, Q.C.:
Q. I think it may have made it--I think there's reference in the material, may have made it as high as 12 at one point and then kind of came back down again, but the point being that you've indicated that you dealt with the CEOs as a group?
MR. THOMPSON:

Page 166

A. Yes.
COFFEY, Q.C.:
Q. And when was that?
MR. THOMPSON:
A. I think the conference call that we had was August, well, 13th, 18th, in around that period.
COFFEY, Q.C.:
Q. Okay, and what was their initial reaction?
MR. THOMPSON:
A. Well, first of all, I should describe the proposal that I had.
COFFEY, Q.C.:
Q. Yes. Well, perhaps I'll take you to that actually.
MR. THOMPSON:
A. Okay.
COFFEY, Q.C.:
Q. Perhaps assist. One moment, please, Commissioner. Perhaps if I could, we get into that, because it'll pick up kind of the narrative, if we could bring up, please, Exhibit P-3529? And this, Mr. Thompson, at the bottom, toward the bottom of the first page of this exhibit, there's a e-mail of

Page 167

March 28th, 2008 from Dr. Reza to yourself and a number of other people, including people at Eastern Health, and it talks about a meeting that had just occurred about options for identifying missing breast cancer patients with negative ER/PR who may not have been retested, and he says "Terry has performed various search protocols in the Meditech system for the year 2002, searching approximately 90,000 specimens and below is a summary of them for your consideration" and there's a reference to the three different approaches that are set out there.
MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. So I take it that these are the three different approaches that Dr. Reza and Mr. MacDonald would have been talking about back in March of 2008 with yourself?
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. And these were the ones that you, back at that April or so, would have brought to Ms. Jones?

Page 168

MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. Okay.
MR. THOMPSON:
A. I encouraged her to adopt one in particular.
COFFEY, Q.C.:
Q. And which particular one was that?
MR. THOMPSON:
A. I think it was number three, but I'd have to--I'm not sure.
COFFEY, Q.C.:
Q. Number three, yes, I'll go on. This will help. This is the one utilizing the--okay, searching the--well, here's number two, searching the pathology module for the word "breast".
MR. THOMPSON:
A. Maybe it would be better to go to my e-mail to her because I don't remember which one of these in particular it was.
COFFEY, Q.C.:
Q. It will be there in the documents.
MR. THOMPSON:
A. That's right, sure.

Page 169

COFFEY, Q.C.:
Q. The point is you made a -
MR. THOMPSON:
A. A specific recommendation, yes.
COFFEY, Q.C.:
Q. And you left it then with herself and Eastern Health?
MR. THOMPSON:
A. Yeah.
COFFEY, Q.C.:
Q. If we could, please--just a minute, please, Commissioner. Could you bring up 3534, please. Now this is again an e-mail of August 14th, the next day, indicating that--well, it's to yourself and Ms. Gregory. Who's Ms. Gregory, I'm just -
MR. THOMPSON:
A. She's the senior researcher in our office.
COFFEY, Q.C.:
Q. And that's "our office". "Our" in this context is the task force?
MR. THOMPSON:
A. Task force and the office of--it's like this, yeah.
COFFEY, Q.C.:

Page 170

Q. And you've indicated, "Tracy and I met--he indicates, Dr. Reza indicates, "Tracy and I met with Barry this morning and performed the pilot using the various search strategies".
MR. THOMPSON:
A. Uh-hm.
COFFEY, Q.C.:
Q. "Searched for one of the patients who was on the list of eight recently sent to us by Eastern Health. Using the following search strategies, the self-identified from Health Sciences Centre from the year 2000 was found using those three different ones, and three different search approaches. In speaking with Barry, he indicated that using the word "breast" may be one of the most comprehensive search strategies with a high level of certainty in capturing breast cancer patients at each LIS. Please note that any of the above options requires a manual review of the path reports".
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. So this was the background then, I take it, to

Page 171

your -
MR. THOMPSON:
A. To the conference call, that's right.
COFFEY, Q.C.:
Q. Conference call. If we could, please, bring up Exhibit P-3541. Here there is on page three of the exhibit, there is an e-mail of August 15th, 2008, at 12:01 p.m. from Donna Brewer. Who's Donna Brewer?
MR. THOMPSON:
A. She was the Acting Deputy Minister at that time of Health and Community Services.
COFFEY, Q.C.:
Q. Okay, and it's sent out to a number of individuals. She copies herself, Mr. Peddle, Boyd Rowe, who's with Labrador Grenfell.
MR. THOMPSON:
A. Uh-hm.
COFFEY, Q.C.:
Q. Karen McGrath is -
MR. THOMPSON:
A. Central Health.
COFFEY, Q.C.:
Q. Louise Jones, Eastern Health, and Susan Gillam would be Western?

Page 172

MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. Copied to a number of other individuals, re; face to face meeting on August 18th, 2008, with CEOs and VPs Medical Services. "Further to my previous e-mail, here is the correspondence for CEOs being forwarded on behalf of Robert Thompson". I take it this is what was forwarded on your behalf?
MR. THOMPSON:
A. This was the proposal--the rationale on the proposal, right.
COFFEY, Q.C.:
Q. And you've written, or it's being conveyed on your behalf--I take it this had probably been prepared by yourself. You say, "I would like to discuss the following matter with you during your meeting on Monday, August 18th. Since mid March, eleven new ER/PR patients have come to light that should have been retested in 2005/2006. Eight of these patients were discovered through calls from the patients or their families, and three were discovered through further file searches",

Page 173

that's in Central Health. "As you know, the ER/PR database project carried out by NLCHI was a compilation of existing data, plus filling in data gaps. They relied upon the previous searches performed by regional health authorities to identify the patients who were retested. While we have known the possibility existed that new patients would come to light, the identification of eleven patients is higher than expected. The idea of performing a search for patients within Eastern Health was considered during the spring, but not undertaken because of uncertainty that it would generate any newly found patients. At that time, there was only one recently self-identified patient. Now that we have eleven new patients (seven deceased, four living) the case for conducting a new search has changed, and on the regional basis the eleven cases break down as follows; Eastern four, Central four, Western two, Labrador Grenfell one. New search strategies have been examined by NLCHI in the Meditech system in Eastern. A preliminary test for one year showed that the strategy was broad enough to include the newly

Page 174

identified case, but it would still require significant effort to review pathology reports to determine if additional cases existed. To expand this process province-wide, we propose the following three step approach. One, NLCHI will interview the pathologists or other personnel in each region who conducted previous searches. This will allow for consistent understanding of search criteria and methods. The interviews will allow for the determination of whether or not a new search process needs to be conducted for each year in each region. Two, based on the interviews, a single year test will be conducted in each site where a newly identified case exists to ensure the strategy is working. Three, all years for all sites will be reviewed. NLCHI will require the cooperation of your organizations to conduct this process. NLCHI will first discuss the process with your clinical chief of pathology at each site. They will need access to laboratory staff to participate in reading pathology reports. These staff will be provided with necessary orientation to

Page 175

identify missing cases on the same basis as other regions. The department will provide funds for any overtime incurred".

MR. THOMPSON:

A. Uh-hm.

COFFEY, Q.C.:

Q. "NLCHI will collaborate as necessary to ensure everyone is satisfied with the process". So that's what you sent out?

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. What then happened?

MR. THOMPSON:

A. You mean -

COFFEY, Q.C.:

Q. You had your conference call, I take it?

MR. THOMPSON:

A. Right. The outcome of it -

COFFEY, Q.C.:

Q. What happened during the conference call?

MR. THOMPSON:

A. Oh, I made the proposal. It was discussed. There was summary action that this was a significant effort and would be, I guess,

Page 176

regarded as a lot of effort that may turn out not to produce any result, and so there was some discussion about whether or not it was reasonable or--in that context, but we insisted that we needed to proceed on this proposal. We modified it just a little in the conference call in the sense that rather than agreeing right at that time to go all the way through A, B, and C, what we agreed to do was to take part A or part 1, have NLCHI do the assessment of the original search strategies so that we could identify and target then the next phase, which would be the actual conduct of the reading of pathology reports, and--but we said first let's do the assessment and we'll get those results back to you before we launch on to the second and third phases, but, yes, so that was the conference call.

COFFEY, Q.C.:

Q. If we could bring up, please, Exhibit P-3541, page two. Now these are notes relating to that call, telephone call, Robert Thompson, CEO and ADM, VP Medical Services, re; ER/PR follow up, and it's noted here, "Robert offered to cover any overtime costs related to

Page 177

further searching", and that's spelled out in your e-mail itself.
MR. THOMPSON:
A. Yes.
THE COMMISSIONER:
Q. Mr. Coffey, what (inaudible) again?
COFFEY, Q.C.:
Q. Well, that's -
THE COMMISSIONER:
Q. Do we know it (phonetic)?
COFFEY, Q.C.:
Q. Yes, I believe it's Dr. Jenkins. If we go back to the page before on August -
MR. THOMPSON:
A. Yes, it is.
COFFEY, Q.C.:
Q. That's Dr. Jenkins.
THE COMMISSIONER:
Q. Thank you.
COFFEY, Q.C.:
Q. And the--one particular I wanted to ask you about, it's noted here that, "wants to get alternate search strategy off the ground". Well, that would be you, and that's apparent from your memo, anyway, or e-mail, anyway. It

Page 178

says, "Karen", that would be Karen McGrath, "responded on behalf of three CEOs external to Eastern and indicated disagreement with the need for the search. I indicated that"--sorry, "indicated that government should direct and conduct review if deemed necessary". So do you recall that happening?
MR. THOMPSON:
A. Yeah. I hadn't seen these notes before -
COFFEY, Q.C.:
Q. And I appreciate that.
MR. THOMPSON:
A. But this is an accurate portrayal of what happened, yes.
COFFEY, Q.C.:
Q. So in terms of, I take it, Ms. McGrath communicated to those on the call--was it a meeting or a call?
MR. THOMPSON:
A. They were meeting. I was on the end of the phone.
COFFEY, Q.C.:
Q. Okay, and Ms. McGrath conveyed to yourself, look--she wasn't speaking for Eastern.
MR. THOMPSON:

Page 179

A. Right.
COFFEY, Q.C.:
Q. She was speaking for herself and the other two health authorities.
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. Outside Eastern, that there was--they had some reluctance about the need to go through this?
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. And if, however, it was going to be done, that from her perspective, she wanted the government actually doing it, in the sense of directing it--not doing it, but directing it?
MR. THOMPSON:
A. Directing the RHAs to do it.
COFFEY, Q.C.:
Q. Now in terms of that, what was your understanding about why that was so?
MR. THOMPSON:
A. Why -
COFFEY, Q.C.:
Q. Why her, on behalf--you're being told by her,

Page 180

look, I'm speaking for my own board and two others, why she wanted the government to direct that it be done?
MR. THOMPSON:
A. Well, what I inferred -
COFFEY, Q.C.:
Q. Yes, and that's what I take it, from your -
MR. THOMPSON:
A. You know, if--it may not be accurate, but what I inferred was that because of the burden on already overworked people in the RHAs to undertake a second search, and just the time and effort involved, because they had--the same people had already been through the searching before, and probably had concluded that they had done a very complete search, and in many cases probably had, and because that there was a general sense of anxiety around the whole issue, that there would be further demoralization and negative feedback if they directed it, but if the department -
COFFEY, Q.C.:
Q. If they directed it internally?
MR. THOMPSON:
A. Correct, correct, but if the department

Page 181

directed them to do it, then it wouldn't be them that was putting the burden on their own staff, but rather the department.

THE COMMISSIONER:

Q. So the department could be the enemy (phonetic).

MR. THOMPSON:

A. Exactly, yeah.

COFFEY, Q.C.:

Q. And as well then this does go on to note that you were asked for assurance that, look, I suppose, if the direction is forthcoming, that there will be cooperation from everybody as required, that we will provide our access, that would be "her", the boards, provide access to the lab leaders, IT, directors of pathology (audio malfunction).

MR. THOMPSON:

A. (Audio malfunction) for this first step of the evaluation step.

COFFEY, Q.C.:

Q. Which is the interviews that Dr. Reza then performed?

MR. THOMPSON:

A. Correct. yes.

Page 182

COFFEY, Q.C.:

Q. And reported on to yourself?

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. And just in that regard, if I could--we're up to 3541, I believe. Go to page three--go to the next page here. The e-mail of August 15th, 2008, that we just looked at, Mr. Thompson, you've indicated that Donna Brewer was the--at the time, and perhaps still is, the -

MR. THOMPSON:

A. No.

COFFEY, Q.C.:

Q. She's not, okay.

MR. THOMPSON:

A. No, there was a period of time when the then -

COFFEY, Q.C.:

Q. Mr. Keats was -

MR. THOMPSON:

A. Was unable to go to work and -

COFFEY, Q.C.:

Q. Okay.

MR. THOMPSON:

Page 183

A. Yeah.

COFFEY, Q.C.:

Q. And he was off for a period of time?

MR. THOMPSON:

A. A few months, yeah, that's right.

COFFEY, Q.C.:

Q. But in filling in for him then, she was the Deputy Minister of the day, as it were?

MR. THOMPSON:

A. Uh-hm.

COFFEY, Q.C.:

Q. And why was she sending this to all these health authorities as opposed to yourself?

MR. THOMPSON:

A. Well, they had a scheduled meeting. In fact, they meet regularly; that is the four CEOs, plus John Peddle, plus the Deputy Minister. So this was a regularly scheduled meeting. I asked Donna Brewer if she would introduce this agenda item onto the meeting, so I just worked through her in that regard.

COFFEY, Q.C.:

Q. If we could look, please, at Exhibit P-3555. Mr. Thompson, these are two e-mails. The one I'm going to ask you about in particular is

Page 184

the October 2nd, 2008 one from Ms. Chislett to yourself and others.

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. Saying, "I've attached a summary table of the interviews Reza and I have conducted with the regions regarding their search strategies. If you have any questions, please let me know", and if we look--and the Commissioner has been taken through this at some length. I won't say tedious length, but certainly length yesterday.

THE COMMISSIONER:

Q. Oh, we can (inaudible) tedious.

COFFEY, Q.C.:

Q. Mr. Thompson, I take it, you received this at the time, early October of this year?

MR. THOMPSON:

A. Yes, right.

COFFEY, Q.C.:

Q. And examined it. What was your reaction to this in terms of it to be--this is a summary of what had occurred originally in terms of the search approaches.

Page 185

MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. And then since the original searches. What was your own -
MR. THOMPSON:
A. In terms of--my reaction in terms of what I did next, or my reaction in terms of whether I felt that good original searches had been done?
COFFEY, Q.C.:
Q. Yes, well, actually I'm going to ask you about both. The second first?
MR. THOMPSON:
A. Well, I guess there were no big surprises. There were reasonably complete searches done in most regions--well, in all regions, actually, but that there were some recommendations for each region on an additional measure or two to be done, and it more or less is exactly as we expected.
COFFEY, Q.C.:
Q. If we could look, please--in terms of what you did do then, okay.
MR. THOMPSON:

Page 186

A. Yes.
COFFEY, Q.C.:
Q. If we could look at Exhibit P-3549, this is an e-mail of October 9th, 2008, from Mr. MacDonald to yourself and Ms. Gregory, copied to others. The subject is ER/PR search strategies, interview summary, and he writes, "At our meeting on October 3rd, we were asked to provide the task force with a brief summary of the interviews carried out to identify search strategies used with each health authority, and provide comments on these strategies". So I take it there was a meeting of October 3rd?
MR. THOMPSON:
A. Uh-hm.
COFFEY, Q.C.:
Q. With yourself.
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. To kind of review this--the results of the interview strategies?
MR. THOMPSON:
A. Correct.

Page 187

COFFEY, Q.C.:
Q. And then you asked for something in writing, in effect, as to what they would recommend?
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. And this is the recommendation?
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. Here Mr. MacDonald goes on to say, "After completing the interviews with the four health authorities, it was evident the authorities in searching for breast cancer patients employed two separate searches. This included the initial search carried out in 2005, and the 2007 search undertaken when the Centre became involved in developing the ER/PR database. The main results of the interviews are as follows", and then it spells out the results for the seven--seven different results, and it's more than four because Central is broken down into East and West, and Eastern includes Carbonear, Clarenville, and St. John's as three entries?

Page 188

MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. And he goes on then to say, Mr. MacDonald, to say that, "It is our position that an consistent electronic search using the term "breast" is considered a more robust search available, however, without more detailed information on how individual Meditech systems within each authority are designed, we cannot confirm such a search would be beneficial. of note, Eastern did not use the search term "breast" in identifying breast cancer patients having ER/PR test, however, during our interviews it was noted that it may be beneficial for St. John's to provide each health authority with a list of all of their "out of town" specimens having ER/PR ordered. For example, such a list may help with Clarenville having missed cases due to some data being lost. However, it needs to be recognized that such a list would still have the same limitations as the original search used by Eastern, i.e. ER/PR search in order entry field". Mr. Thompson, relating to the

Page 189

idea of Eastern Health providing kind of its original master list, as it were -

MR. THOMPSON:

A. Uh-hm.

COFFEY, Q.C.:

Q. Based upon the search of this order entry field that hadn't been done in 2005, to the other health authorities as particular to their--the request having come from that particular authority, when did you first become aware that this had never been done? Like, the fact that all these names, this listing of names for which ER/PR tests had been done, which apparently Mr. Gulliver and Mr. Dyer had located back in '05, and it had never been distributed, and now, of course, Mr. MacDonald is saying--he's suggesting it be done. When did you become aware that that had not been done before?

MR. THOMPSON:

A. I think perhaps at this time.

COFFEY, Q.C.:

Q. And in the context of, I take it, the overall interview results?

MR. THOMPSON:

Page 190

A. Right. Certainly in the development of the database, we were told by NLCHI about some of the procedures that had occurred for--sources that they had to tap into, and, therefore, how some searching had occurred in the RHAs outside St. John's in 2005, but as I mentioned to you before, the database exercise when it was created was only for contact and we were just trying to map the core of what had happened. We hadn't actually added to that project, please go and evaluate the quality of the original search strategies. So this is the first time we were doing that, so--in a concrete way, this is the first I understood that.

COFFEY, Q.C.:

Q. Going back--that it hadn't been done or it could be done and hadn't been done, this is the first time you would have understood that?

MR. THOMPSON:

A. Right, yes.

COFFEY, Q.C.:

Q. And in terms of the NLCHI and the task force, in terms of their involvement in relation to trying to ensure that everybody who should

Page 191

have been identified was identified, that I take it first arose really in 2008 in terms of--am I correct, NLCHI, when it first go itself, and the task force first got itself involved in the idea of trying to ensure that everyone was identified?

MR. THOMPSON:

A. That--yeah, that objective, if you like, or that activity perhaps, arose a little bit--bit by bit over time.

COFFEY, Q.C.:

Q. Over time.

MR. THOMPSON:

A. As all of the interventions to gather data were actually producing some of those questions. Whenever we saw a productive lead, if you like, to identify that there might be a gap, we would ask to get it filled.

COFFEY, Q.C.:

Q. And I appreciate--Dr. Reza, in particular, took the Commissioner through yesterday a list--Don MacDonald did. The lists were provided from time to time by NLCHI to the health authorities asking questions about particular patient situations?

Page 192

MR. THOMPSON:

A. That's right, uh-hm.

COFFEY, Q.C.:

Q. And that went back and forth, back and forth.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. But in terms of the idea of approaching it from an overall perspective -

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. That first arose when?

MR. THOMPSON:

A. Well -

COFFEY, Q.C.:

Q. Re-examination going back to first principles in terms, look, have we identified everyone?

MR. THOMPSON:

A. Well, I'm not sure exactly when we would have formulated it quite that way. I think it's--for me, it's more accurate to say that whenever we encountered a question mark that perhaps there are people that have not been included in the database that should be, we

Page 193

would pursue that question, and it would be irresponsible not to.

COFFEY, Q.C.:

Q. Uh-hm.

MR. THOMPSON:

A. And I think that's really the best--from my point of view, the best way to characterize what we did because we never added it as a formal goal of the database project to NLCHI, "now we want to ensure 100 percent completeness". We would just pursue that whenever it made sense to.

COFFEY, Q.C.:

Q. But as a goal, I take it, that's certainly--you floated it or approached Ms. Jones back in the spring of '08 -

MR. THOMPSON:

A. Yes, absolutely.

COFFEY, Q.C.:

Q. And then you've taken us--the Commissioner through then what's happened since and the current situation?

MR. THOMPSON:

A. That's correct.

COFFEY, Q.C.:

Page 194

Q. And in terms of the current current situation, if we could look at please, Exhibit P-3550. This is an e-mail of October 15th, 2008 from Mr. MacDonald to yourself. He writes, "A "manual" search is a robust approach given it implies all hard copy pathology reports were reviewed and those noted as being related to breast cancer would be further investigated. A limitation of this approach would be if the hard copy, for whatever reason, was not included in the review, while in others, human error in missing the term "breast" when it actually was in the report. Electronic search of the term "breast" might be considered the gold standard as it searches all pathology reports, but this approach would not capture cases where the test results were not entered or no longer available in Meditech. Below is a summary of the search strategies", and he summarizes; Carbonear--manual review of pathology reports, Lab/Grenfell--manual review of pathology reports, Central East--electronic search of term "breast", Central West--electronic search of term "breast" 2001 to 2005, and a manual review of pathology

Page 195

reports, 1997 through 2000, Western--electronic search using other criteria felt to be appropriate for that Meditech system. Clarenville--electronic search, but not on term "breast", also lost some data, both hard and electronic. Any lost cases only available through patient chart. St. John's--electronic search using criteria other than "breast". I take it, this was the advice then being provided in mid October to yourself from Mr. MacDonald?

MR. THOMPSON:

A. This is a summary.

COFFEY, Q.C.:

Q. A summary.

MR. THOMPSON:

A. Yes, that's right.

COFFEY, Q.C.:

Q. And then following this, you did what?

MR. THOMPSON:

A. Based on their advice, I wrote four CEOs e-mails telling them what our next expectation was, our next request, and as I mentioned earlier, it was different for each one--well, for three RHAs it was similar; for Eastern

Page 196

Health, it was different, and we did that about a week ago.

COFFEY, Q.C.:

Q. In fact, if we look at Exhibit P-3551. Now here, this is an e-mail--a series of e-mails I'm going to take you through now, October 17th, 2008, which as you pointed out is exactly a week ago. This is to Karen McGrath. It's copied to Don MacDonald and others. It's ER/PR search strategies. So Ms. McGrath would be the west -

MR. ROBERT THOMPSON:

A. Central.

COFFEY, Q.C.:

Q. I'm sorry, I apologize, Central. You write, "NLCHI has completed the assessment and search strategies used by Regional Health Authorities between 2005 and 2008 to identify patients that received ER/PR tests between 1997 and 2005 in St. John's. We'd like to thank the personnel in your organization for their co-operation with NLCHI during this process. The only additional search procedure recommended by NLCHI for you RHA is to obtain a list from Eastern Health of patients for your region who

Page 197

actually had an original ER/PR test in St. John's so that a cross-check may be done against your list of tissue blocks that were sent for retesting. We will ask Eastern Health to generate this list for you. NLCHI's continuing role will only be to update the ER/PR database should any new information result from this cross-checking process. We will look to you and your personnel to conduct the cross-check after the list is provided and make NLCHI aware if any newly identified cases are found from this process. At the end of the process we will ask NLCHI to generate a count on any new cases that have been identified. Please let me know to whom the list should be sent. Thanks and please feel free to call if you have any questions".

So, having sent this to Ms. McGrath, did you get any response from her?

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. And what was her response?

MR. THOMPSON:

A. She identified the individual who should be

Page 198

sent the list indicating to me that, okay, let's go, let's do this.

COFFEY, Q.C.:

Q. And I take it then, because the list, of course, that exists is based on the premise that that's all. If it turns out in dealing with Eastern Health you come across some other, then that would be -

MR. THOMPSON:

A. Just a point on that, because we know that there's a limitation with the Meditech system in St. John's in the context of ER/PR order entry code. So, I asked Reza about this question. Would that limitation apply equally to samples, tissues samples that originated in St. John's and to, as compared to tissue samples that originated outside? And his view was that while one can't be absolutely certain, he feels that there should be a higher level of confidence that when a tissue sample comes in from outside St. John's, originating in a different location, that the order entry code would, more than likely, always be completed. So, he couldn't quantify that, but there is a higher level of

Page 199

confidence that that would be the case. So, it's a good cross-check mechanism.

COFFEY, Q.C.:

Q. And look please then at Exhibit P-3552. And this is an e-mail again of a week ago to Boyd Rowe at Labrador/Grenfell. He's the CEO, I take it, of the organization and it's from yourself. You write "NLCHI has completed the assessment of search strategies used by RHAs between 2005 and 2008" and in effect it's the same as what you'd written to Ms. McGrath, that paragraph. And you say, "the only additional search procedure recommended by NLCHI for your RHA is to obtain a list from Eastern Health of patients from your region who actually had an original ER/PR test in St. John's, so that a cross-check can be done against your list of tissue blocks that were sent for retesting. We will ask Eastern Health to generate this list for you". And then you go on to talk about NLCHI's continuing role, the same way you had before.

So, again, we will provide you with a list we get from Eastern Health and please cross-reference it against the cases that you

Page 200

have sent to St. John's.

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. Exhibit P-3554, please.

THE COMMISSIONER:

Q. Why don't we find out what Lab/Grenfell said before we go onto that.

COFFEY, Q.C.:

Q. Pardon?

THE COMMISSIONER:

Q. Lab/Grenfell's reaction.

COFFEY, Q.C.:

Q. Oh yes, I apologize, Commissioner, yes.

MR. THOMPSON:

A. I had a quick e-mail back from Boyd Rowe saying, let's go.

COFFEY, Q.C.:

Q. Let's go, yes. Thank you, Commissioner. Exhibit P-3554 which is October 17, 2008. It's an e-mail from yourself to Susan Gillam, she would be on the west coast.

MR. THOMPSON:

A. Um-hm.

COFFEY, Q.C.:

Page 201

Q. And the first paragraph is identical to the two we just looked at, the two earlier e-mails. The second paragraph again only refers to the only additional search procedure recommended by NLCHI for your RHA is to obtain a list from Eastern Health of patients for your region who actually had an original ER/PR test in St. John's so the cross-check can be done against your list of tissue blocks that were sent for re-testing. So, in effect, it's the same thing.

MR. THOMPSON:

A. And we can tell that because the same typo is pasted to each one.

COFFEY, Q.C.:

Q. Yes, the "your", yes. And their reaction?

MR. THOMPSON:

A. They responded and said, they identified Lisa Hoddinott as the contact and so, they're ready to proceed.

COFFEY, Q.C.:

Q. And Exhibit P-3553, please. Now, this is an e-mail of October 17th from yourself to Louise Jones and Pat Pilgrim and it's copied to others. You write, "NLCHI has completed the

Page 202

assessment of search strategies used by RHAs between 2005 and 2008" and again this is a copied paragraph.

MR. THOMPSON:

A. Um-hm.

COFFEY, Q.C.:

Q. But then you go on to say, this is different, "NLCHI concluded that the best standard for electronic searching would be to use the search term "breast" and then perform a manual review of the identified files for each year to determine if there are any additional cases that were not identified in previous searches. While the probability of finding extra cases may be small, the fact that previously unidentified cases were found this spring, indicates that the additional search is worthwhile. On behalf of the Minister, I'm asking you to initiate the search process for patients of the St. John's sites. Carbonear and Clarenville sites do not require the same process, NLCHI will be available to answer any questions about their assessment and to record in the ER/PR database, any new information found in the search process. We realize the

Page 203

search process will require significant amount of time, so any overtime cost incurred for this purpose will be reimbursed by the department. Your officials will be in the best position to estimate how much time this activity will take and the number of people who will need to be directed to it. Our expectation is that it can be completed within four weeks from this start date, though we would appreciate hearing from you in this regard. In addition, NLCHI identified that other regional health authorities and the "out of town" Eastern Health sites should perform a cross-check of their files with the list generated by Eastern Health of patients who received ER/PR tests in St. John's. We understand that compilation of these lists for other RHAs and out of town patients is a straight forward matter. NLCHI can answer any questions about the target group if there is any confusion. We will supply you with a specific person in the other RHAs to whom the list should be sent. We leave it with you to identify the responsible officials in Carbonear and Clarenville. At the end of this

Page 204

process, we will ask NLCHI to generate a count of any new cases that have been identified. Please let me know if you have any questions. We are available to meet as necessary to facilitate this project. Your assistance with the above is appreciated".

So, I take it you did receive a response to this.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. If I could please, Exhibit P-3559. And this is, well a couple of e-mails. First of all, there's one of October 21st, 2008 at the top of the page here from yourself to Lorraine Barrett.

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. And I take it this is just sent to her to be sent on to the Commission.

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. There's a note there to that effect. And then

Page 205

below that there's an e-mail from Joyce Penney at Eastern Health, October 21st, 2008 to yourself and others. And the text reads forwarded on behalf of Louise Jones, "Good morning, Mr. Thompson. Attached please find Eastern Health's response to your request directing Eastern Health to conduct an electronic ER/PR search of pathology reports for the St. John's sites. Original to follow via Canada Post". If we go then to this. This, I take it, is the letter of October 20 which is Ms. Jones' response?

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. And to help the Commissioner put this in context, she writes and I'll read it out and then ask you some questions about it. "This is written as a follow-up to your request received in my office at 1200 hours on October 17th, 2008 directing Eastern Health to conduct electronic ER/PR search of pathology reports for the St. John's sites". And I'm just going to stop there at this point because your e-mail did indicate that you're directing on

Page 206

behalf on the minister, is that what your e-mail said?

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. So, this is, in effect, under the legislation, your e-mail was a directive.

MR. THOMPSON:

A. Well, that's a question mark. Although it's clear that we wanted to indicate that the Minister was approving of and wanted to see this done. But what exactly constitutes a ministerial directive under the act is we just didn't go there, didn't address that question.

COFFEY, Q.C.:

Q. Okay. So, talking about this now is, is that back in the Spring you had, as you pointed, strongly suggested that it might be a good idea to do this, in effect, conduct, in effect, the same search.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. That you're now going to go to detail.

MR. THOMPSON:

Page 207

A. That's correct.

COFFEY, Q.C.:

Q. Or you have detailed on the 17th of October. At that time, you eventually learned that Ms. Jones, on behalf of Eastern Health, was declining for the reasons you've indicated.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. Now, October 17, the language used there is more direct -

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. - in the sense of on behalf of the Minister directing this.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. So, I take it then that as of this month, what had originally, perhaps five months ago, four or five months ago being a strong suggestion has now come to the point where without determining legally whether or who within the legislation or not -

Page 208

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. - the Minister wants you to do this.

MR. THOMPSON:

A. Yes.

COFFEY, Q.C.:

Q. It goes on to say, "the letter indicates that this search should be conducted using the search term "breast" and then performing a manual review of the files to determine if there are any additional cases not previously identified. The request also indicated that this work should be completed within four weeks from the start date and if this is not possible, to notify you of your (sic.) anticipated time frame"--sorry--"of our anticipated time frame. And then your letter indicates that this search should be conducted in the broadest word search utilizing the word breast. Since we have received your request, we've had discussions with Mr. MacDonald and Dr. Reza of NLCHI, this discussion revealed that using the search methodology that approximately 1000 pathology reports per year

Page 209

will have to be manually reviewed. In my discussion with you, you also indicated the NLCHI has identified that a review of each pathology report would take approximately three minutes. We have had further discussions with Dr. Reza and Mr. MacDonald and the outcome of this discussion is that we estimate"--and that would be Eastern--"estimates given the fact that the report will need to be initially reviewed and rechecked for accuracy, that the actual time line per pathology report review will be closer to eight to ten minutes. I also remind you that one of the issues of conducting this review is that it is a manual process and as such, open to the potential for error. So, based upon Eastern Health's estimate of ten minutes to review reports alone, it would take approximately 1300 hours for this review to be completed. In addition to this, methodology used to conduct the review and the database specific for this take needs to be created prior to the start of any review of reports. Eastern Health has learned many lessons as a result of the ER/PR issue, not the least of

Page 210

which is in a process such as what is now to be undertaken that there is a need to identify and dedicate a 'team' of individuals to carry out this assignment. The team would consist of staff that are appropriately trained to read and code the pathology reports, information management specialists, identified leader responsible to ensure the test is carried out appropriately and consultant pathologist to review pathology reports that require further interpretation. We also have learned that this team should be relatively small, no more than four to five individuals who are totally released from their day-to-day operations to carry out this task. Ms. Pilgrim has had discussion with Mr. MacDonald of NLCHI and requested that NLCHI take the lead role in this review. NLCHI has agreed to establish the methodology, provide the project leader and conduct the initial search using the term 'breast'. In addition, Eastern Health's role would be to provide personnel to manually review the approximately 8000 pathology reports. To conduct this review in a four week time frame as requested, require a

Page 211

minimum of eight full time reviewers from Eastern Health as Eastern Health does not have the flexibility in its current system. To release appropriately qualified staff, I have requested if there is any assistance available from the Department of Health. In discussion with Mr. Don Keats today, he indicated they cannot be of assistance with this review. We are therefore attempting to identify and release individuals from their current job to carry out this review. At this time, we believe we will not be able to identify eight individuals and will likely only be able to identify a maximum of four individuals. Therefore the review will take a minimum of eight weeks. I will update you with respect to the anticipated time line for completion once the availability of staff is determined. I also note that carrying out this review will again delay Eastern Health's analysis related to ER/PR issues. If you require any additional information, please contact"--now, if I could, what was your response then to this?

MR. THOMPSON:

Page 212

A. I haven't responded to it.

COFFEY, Q.C.:

Q. Okay. What are your thoughts on it?

MR. THOMPSON:

A. Substantively it responds appropriately to the St. John's based request. It provides method of doing the work, it outlines a time line, indicates a willingness to do it. So, it meets our satisfaction in terms of carrying out the work.

COFFEY, Q.C.:

Q. And what then--what's the current status of it?

MR. THOMPSON:

A. Well, I know really nothing more than what's in the letter, that they've engaged NLCHI to provide this leadership or project leadership role, that that's a good thing from our point of view. So, I'd just check for updates on a periodic basis.

COFFEY, Q.C.:

Q. So, in whose hands is it right now?

MR. THOMPSON:

A. Eastern Health's.

COFFEY, Q.C.:

Page 213

Q. Eastern Health's?
MR. THOMPSON:
A. Oh yes.
COFFEY, Q.C.:
Q. And whomever from NLCHI is -
MR. THOMPSON:
A. Correct, yes.
COFFEY, Q.C.:
Q. - tasked with being the project leader.
MR. THOMPSON:
A. That's right.
THE COMMISSIONER:
Q. Mr. Coffey, it's near the lunch hour. So, wherever you can find a spot to take a break.
COFFEY, Q.C.:
Q. Yes. There's a reference here to, "will again delay Eastern Health's analysis related to ER/PR issues", do you see that?
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. Have you been told what analysis is going on.
MR. THOMPSON:
A. Well, I haven't asked the question, but I've drawn some assumptions because I've heard from

Page 214

time to time, particularly here in the hearings, that they want to conduct further analysis of the database and to add, in fact, some data into the database on issues like fixation and internal controls to learn more lessons from what's occurred over the last few years. And this is suggesting that--asking them to do this work will delay their other project by, I guess, the time frame that it takes to do this. Now, we certainly didn't intend to delay them in anything else.
COFFEY, Q.C.:
Q. Sure.
MR. THOMPSON:
A. I'm not certain that it necessarily requires the same group of people to be doing both tasks. Perhaps there is a way to open up more capacity. I don't know, but I only take it at face value that they've determined that it will cause them a delay in doing that.
COFFEY, Q.C.:
Q. Break for lunch, Commissioner.
THE COMMISSIONER:
Q. All right then, we'll meet again at 2:15. Thank you.

Page 215

(BREAK FOR LUNCH)
THE COMMISSIONER:
Q. Mr. Coffey.
COFFEY, Q.C.:
Q. Yes. I wanted to ask Mr. Thompson about a particular briefing note, Commissioner, just one moment please. If you could bring up, please, and I believe this is the final version and I stand to be corrected, but I believe this probably is, it's Exhibit P-3544. And this is a series of e-mail exchanges here, Mr. Thompson, but this is an e-mail of August 18, 2008, you'll see at the top of the page there addressed to Ms. Chaytor, copied to myself. The database note, the database update. "See the attached which addresses Sandy's inquiries". And look at page three, it's a status report on ER/PR database.
MR. THOMPSON:
A. I don't think this is the final version.
COFFEY, Q.C.:
Q. Not the final version.
CHAYTOR, Q.C.:
Q. (Inaudible).
BRAZIL, Q.C.:

Page 216

Q. (Inaudible) 3648.
COFFEY, Q.C.:
Q. Thank you, very much, yes, 3648.
THE COMMISSIONER:
Q. Thank you, Ms. Brazil.
COFFEY, Q.C.:
Q. That was just entered this morning, in fact, I believe, and this, yes, this is the one of August. It's an e-mail of August 21st, 2008 from yourself to a number of individuals, senior government officials really and the Minister, Mr. Wiseman, and actually, I'll go back to that. You say "please see attached updated briefing note on the new ER/PR patients. Key revision is that they were"--yes, there are 10 not 11 patients.
MR. THOMPSON:
A. Um-hm.
COFFEY, Q.C.:
Q. And as you pointed out to the Commissioner this morning, that kept changing a bit, even up to the last -
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:

Page 217

Q. - minute, at least, that this was drafted. And here, sir, it's a briefing note, noted to be revised, status report on ER/PR database. The issue is the ER/PR database will continue to be updated as necessary by NLCHI, based on data transfer from regional health authorities, including newly identified patients. The background is set out here as to "the ER/PR database was initiated in June 2007 by the Department with the Office of the Secretary to Cabinet, Health Issues" which is yourself, you head the office, "being the primary client. Construction and maintenance of the database was performed by NLCHI and data is provided by the four regional health authorities. On May"--I'm sorry, "April 14th, 2008, the OSC provided the second of two summary reports to the co-counsel for the Commission of Inquiry on the database results. The report stated there were 1,013 patients who met the core criteria for inclusion in the database. The core criteria were that the original ER/PR test was done between 1997 and 2005, the test result was negative and a retest was performed at Mount Sinai. After

Page 218

this report, the OSC, which is the same group that performs the work of the Task Force on Adverse Health Events, refocused its work on its adverse health event mandate and asked NLCHI to continue to provide updates to the database to the Commission based on any new data that may become available from Eastern Health." I take it that was the state of affairs at the time?

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. In April, which you described to the Commissioner earlier this morning. Then newly identified patients, you've written "the April 14th, 2008 report noted that one patient who should have been retested had recently self-identified. This person had not been identified in the Meditech system in 2005 because of the order entry field"--I'm sorry, "because the order entry field had not been completed at the time of the original test. It is noteworthy that the 2008 retest of this patient was not added to the database immediately because she was retested on

Page 219

Ventana at Eastern Health, not at Mount Sinai. Nevertheless, the case is an indicator that other patients who should be retested may not yet have been identified, despite the considerable searching and publicity around the issue. The report stated that 'these points have caused Eastern Health to examine options for alternate search strategies within Meditech to identify any possible remaining negative ER/PR patients.' Eastern Health subsequently examined these options and decided against a review exercise because it was uncertain that any of the search strategies would result in the identification of previously unidentified patients.

As of August 12th, the total number of newly identified patients that were not in the database on April 14th has grown to ten. Therefore, instead of 1,013 patients who were original ER negatives between 1997 and 2005, the new total is 1,023." And then another bullet says "discovery of these new patients occurred in the following ways: a patient called, three; daughter or son called, four; further regional health authority checking of

Page 220

pathology reports, three. Six of the ten patients are deceased. All four living patients have been informed of their retest results." Another bullet, "all of the deceased patients have been retested. NLCHI is continuing to update the database for these newly identified cases and also for several other purposes, i.e. confirmations that patients who were the subject of letters to physicians were actually contacted by physicians, completion of contact for patients with DCIS and no tumor, and any new contacts with people who could not be previously contacted."

Now it goes on about the time line, and I'll come back to this, but on this--while we're going through this, Mr. Thompson, the DCIS and no tumor, how had that--do you recall how that unfolded then in 2008?

MR. THOMPSON:

A. Well, we weren't -

COFFEY, Q.C.:

Q. From your perspective, in terms of your involvement.

MR. THOMPSON:

Page 221

A. Yeah. We do recall--or I do recall that at around, in the spring, there were--there was a focus of some attention on the fact that some of the cases that were DCIS or no tumor had been identified that way in the Mount Sinai retesting, needed further analysis to understand their implications for patient care and that Eastern Health would be doing more examination of these cases and that may cause additional data to be added to the database. So it's not very specific, but you know, that's the general outline.

COFFEY, Q.C.:

Q. And it says here completion of contact for patients with that. I take it there was an issue about -

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. - about whether or not the people, in fact, who had been reported, for example, by Mount Sinai as DCIS or no tumor -

MR. THOMPSON:

A. They may not have been told that that was their -

Page 222

COFFEY, Q.C.:

Q. - they might not have been told of that result.

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. And that was being--was followed up on during the spring and summer?

MR. THOMPSON:

A. Right.

COFFEY, Q.C.:

Q. Okay, and you're reporting here on that. and that was as that data became available, in terms of the contact issues, NLCHI, became available to NLCHI, they were incorporating it into the database?

MR. THOMPSON:

A. Correct.

COFFEY, Q.C.:

Q. Reference to new contacts that people would--could not be previously contacted, I take it, as that data became available, that was input too?

MR. THOMPSON:

A. Right.

Page 223

COFFEY, Q.C.:

Q. And the reference to "confirmations that patients who were the subject of letters to physicians were actually contacted by the physicians."

MR. THOMPSON:

A. Um-hm.

COFFEY, Q.C.:

Q. What was that about?

MR. THOMPSON:

A. Well, again, in the spring, Eastern Health committed to do a review of all of the patient cases that were the subject of panel letters. Panel letters sent to physicians where, while it was confident perhaps that a panel letter had been sent, there was not 100 percent confidence that the physician would have necessary followed through and informed the patient of the new test results. So Eastern Health undertook to fill in that missing piece of information and once captured, they would provide that data to NLCHI.

COFFEY, Q.C.:

Q. And I take it that that has been done? I take it that's -

Page 224

MR. THOMPSON:

A. Yes, I understand that it has been done.

COFFEY, Q.C.:

Q. And there's a heading here then, time line. It says "on May 9th, 2008, the OSC was informed by NLCHI about the existence of some newly identified cases. On May 23rd, the OSC was informed that Eastern Health knew of eight new patients, although NLCHI required further clarification from Eastern Health before being able to process the information. On June 4th, Eastern Health informed NLCHI and the OSC in a meeting that thus far, they had new information for three patients. The shifting and incomplete information needed to be addressed, so in the June 4th meeting, the roles and expectations regarding the future updating of the database were agreed. Eastern Health would feed data directly to NLCHI and all new cases should be added to the database, even if they were not sent to Mount Sinai. Appropriate updates to the database would be supplied by NLCHI to the Commission."

In relation to that, the idea of not--even if they were not sent to Mount Sinai,

Page 225

what was that about?
MR. THOMPSON:
A. Well, when we had the single case in March, the retest wasn't done at Mount Sinai, it was done on the Ventana system here. And so, it actually didn't meet the criteria that had been laid out for inclusion in the database and because it was a single individual, that seemed to make sense that you had to meet the criteria to actually be in the database. The database, of course, having nothing to do with patient care but just a recordkeeping mechanism. But when there were this group--a much larger group discovered, it changed our mind on that. It seemed very sensible that if they needed to be retested, it really doesn't matter where they're retested, we should count them in as part of that group.
COFFEY, Q.C.:
Q. The next bullet says, "Missed cases from 2008 were discussed in evidence at the Inquiry as follows: July 18th, Dr. Gaulton, Grand Falls, we did approximately six or eight months ago, there was one patient approached a member of the House of Assembly and said that she wanted

Page 226

to be included and we looked into her and she was one, in fact, that we had missed and we went back and combed through the system again and found one other." I take it this is in italics, and I take it this is a quote of Dr. Gaulton's -
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. - testimony here. And then there's a reference to July 25, Dr. Gallagher, Gander. "In 2008, Grand Falls identified one case and then subsequently a second one and our CEO, Karen McGrath, asked us to do another search to make sure we hadn't missed any, so we went back and did another search and we found a male with breast cancer and we realized the first search had been restricted to females." And the italics in there, I take it that's the quote from Dr. Gallagher, is that correct?
MR. THOMPSON:
A. Correct, uh-hm.
COFFEY, Q.C.:
Q. And then you go on to say "In the latter half of July, the OSC received e-mails that

Page 227

indicated the data transfer from Eastern Health to NLCHI was not complete. There was also indications that some self-identified patients existed in Central Newfoundland. On August 4th when the relevant OSC personnel returned from annual leave, a chronology was assembled and interventions were made to get the data transfer completed." I take it this would be interventions request, I take it from NLCHI to actually have it -
MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. - to the health authorities to actually send the data to them for input, is that the intervention?
MR. THOMPSON:
A. Yeah, that's right. We went back to NLCHI and said let's bring this together quickly and then they went back to the health authorities.
COFFEY, Q.C.:
Q. And the next bullet says, "NLCHI provided the Commission with a new version of the database this week with records on newly identified patients and will continue to fill in missing

Page 228

data elements in the coming weeks." And there's a reference to "next steps" as a heading and the bullet says, "Given that ten newly identified patients have emerged since the spring, it is necessary to reconsider the decision not to conduct an alternative search strategy. Art Thompson spoke with CEOs on August 18th on this matter--August 13th", now what's the -
MR. THOMPSON:
A. I don't know, I re-read that yesterday, I don't know why that's there.
COFFEY, Q.C.:
Q. Okay. And then there's a reference, it goes on to say "Preliminary work performed by NLCHI demonstrates that alternative search methodology will work within Eastern Health with some limitations. The Department has asked NLCHI to interview RHA personnel, to document the original search strategies. This information will form the basis for decision on further searches to identify patients that may have been missed in original searches. Art Thompson, August 21, 2008." So I take it this is your report to the Minister of Health

Page 229

and other senior officials -
MR. THOMPSON:
A. Right.
COFFEY, Q.C.:
Q. - about this as of that day.
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. We've looked through a lot of this. One thing I will refer you to and because it is referred to there, just look up above here on this page, "a chronology was assembled" do you see that?
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. The second last bullet on page two. If we could look, please, at Exhibit P-3336? Now this document is 36 pages long and the type is not very large. The headings are "Date"--well actually the document says "Newly identified ER/PR patients, chronology of events initiated August 5, 2008, revised August 21, 2008. The newly identified ER/PR patients' chronology of events." And then there's a column for

Page 230

"Date"; column entitled "Source"; column entitled "The Subject"; column entitled "The Item". Some things are redacted because they refer to--or would identify potentially patients, but this was prepared why?
MR. THOMPSON:
A. Well the preparation started on August 4th, as it was noted in the briefing note and I guess when we, as it says, returned from our annual leave and looked at the absence of this information having been pulled together, that is the characteristics of the newly identified patients having not been pulled together since, really since June 4th, it seemed to us that we had been document all of the steps and efforts that had been taken in the interim. And so that was the beginning and then it stretched back to March, you know, to pick up the story where it really started and then extended beyond that until August 21st.
COFFEY, Q.C.:
Q. And in relation to that, you would have, from time to time in the course of the preparation of this and at the final stage reviewed this?
MR. THOMPSON:

Page 231

A. I reviewed it a few times in draft form, yes.
COFFEY, Q.C.:
Q. And I take it then that this is as an accurate account as was available at the time?
MR. THOMPSON:
A. Yes.
COFFEY, Q.C.:
Q. Bearing in mind at this point.
MR. THOMPSON:
A. Yes, I think so, I think it's--my sense is it's a comprehensive document.
COFFEY, Q.C.:
Q. And much of it, in fact, is the details of what you've generally covered for the Commissioner today?
MR. THOMPSON:
A. Correct.
COFFEY, Q.C.:
Q. Mr. Thompson, is there anything else that you think, in terms of, bearing in mind this occurred since you last were here testifying in May, that should be brought to the Commissioner's attention?
MR. THOMPSON:
A. No, I don't have anything else.

Page 232

COFFEY, Q.C.:
Q. Thank you.
COFFEY, Q.C.:
Q. Mr. Simmons?
MR. SIMMONS:
Q. Thank you, Commissioner, I don't have any questions for Mr. Thompson.
THE COMMISSIONER:
Q. Mr. Browne?
BROWNE, Q.C.:
Q. Thank you, Commissioner. I have no questions for Mr. Thompson, thank you.
THE COMMISSIONER:
Q. Ms. Newbury?
MS. NEWBURY:
Q. Good afternoon, Mr. Thompson. Jennifer Newbury, I represent the Newfoundland and Labrador division of the Canadian Cancer Society, and I wanted to ask you first of all about your familiarity with the Cancer registry and any potential problems or deficiencies in the registry system. Can you speak to that generally or should I point you to -
MR. THOMPSON:

Page 233

A. Hardly at all. I do know--I've heard from others that the registry is an incomplete source of information and needs to be improved, but I don't have any knowledge of those details.

MR. NEWBURY:

Q. Okay, there's one particular concern and that relates to cancer statistics pertaining to death registrations for, I guess related to tumour reports that have already been filed with the Cancer Registry and we've had some evidence from the various regions in the province and it seems that while several regions do provide reports there--actually I'm mixing up two different concepts here, the first one deals with cancer--the main one I want to ask you about is the cancer registrations from the various regions and whether or not there is legislation that supports that. And we've actually had some evidence from pathologists around the province, not each and every hospital, but we've had them from several hospitals and one pathologist, Dr. Dankwa who is with the Charles Curtis Memorial Hospital in St.

Page 234

Anthony, had indicated that their hospital has not been registering tumour reports for quite a number of years and this is due to his perceived absence of legislation that would mandate the filing of such reports. Now just to clarify, Dr. Dankwa actually supports and is in favour of providing the reports to the Registry, so it's not like he felt he had to be mandated to do so, but he had advised the Commission of a situation where a patient actually raised concerns about releasing personal private health information to the Cancer Registry.

MR. THOMPSON:

A. Uh-hm.

MR. NEWBURY:

Q. And Dr. Dankwa had indicated that he tried to pursue this to see if there was some way to overcome that perceived impediment and he was not able to resolve that. So for a number of years, Dr. Dankwa has not been filing those reports.

MR. THOMPSON:

A. Right.

MR. NEWBURY:

Page 235

Q. So is that something that's ever been brought to your attention during the course of this exercise, the fact that there may not be legislation that would, I guess, mandate and authorize the registration of tumour reports?

MR. THOMPSON:

A. No, I've never had any information on that.

MR. NEWBURY:

Q. Okay. And is that a concern to you if there is such a deficiency in -

MR. THOMPSON:

A. Well, based on what you've said, it seems to me that a Cancer Registry is an important tool if there is a gap and the ability to collect information in it, it should be remedied, but, so the case that you've outlined seems to make sense.

MR. NEWBURY:

Q. Okay. And I understand that we will be hearing some evidence from someone who can speak more specifically to the Cancer Registry itself on Monday coming, but I wanted to bring to your attention in particular the information about the perceived deficiency in legislation and to see if you had any comment

Page 236

on that.

MR. THOMPSON:

A. Okay, thanks.

MR. NEWBURY:

Q. And you're not able to comment then on the other issue which is the perceived inadequacy of data and the collection of death reports to the Cancer Registry, you're not aware of any of that?

MR. THOMPSON:

A. No. This is not the same issue, is it, as the problem that Eastern Health may have had with identifying which of their ER/PR patients had deceased, is that the same issue?

MR. NEWBURY:

Q. There are similar issues, for sure.

MR. THOMPSON:

A. Okay.

MR. NEWBURY:

Q. There was, Heather Predham actually has provided evidence and we have some documentation that in the summer of 2005, she attempted to get information from the Cancer Registry with a view to, number one, identifying patients who had an ER/PR test;

Page 237

secondly, to find out what the results of the rest are so that she could identify the negative ER patients and also to find out their status of whether they were living or deceased.

MR. THOMPSON:

A. Right.

MR. NEWBURY:

Q. And in all three respects, as I understand it, the data was deficient.

MR. THOMPSON:

A. Right.

MR. NEWBURY:

Q. And it has also been apparent that there's a broader problem with the Cancer Registry capturing deaths and that has been highlighted and perhaps I can show you just for your benefit, if I could bring up Exhibit P-0789 please? This is Canadian Cancer Statistics and it shows that there's not just with the ER/PR breast cancer patients, which is all Heather Predham could possibly speak to at this particular point, but a broader concern about that which may have certainly explained why she was having some difficulties and this

Page 238

is the Canadian Cancer statistics and they are produced annually and you can see there are a number of agencies that are involved in producing these reports. And on page 16 of the exhibit, please, I wonder if you could go to page 87, this might -

REGISTRAR:

Q. Page 87?

MR. NEWBURY:

Q. 87, please. This is one reference here, there is a second reference and I can locate it right now. At the bottom of the page and I'll just read it out, "For all cancers, even those with poor survival, such as pancreas and lung, the annual number of incident cases is expected to be similar to or larger than the number of deaths. However, there are situations in which the number of deaths, either observed or projected, is larger than the corresponding number of new cases. In case of Newfoundland and Labrador, this is caused by the Registry not receiving information on death certificates that mention cancer. The limitation of not having access to death certificates is greater for cancers

Page 239

with poor prognosis." And it goes on to say that this results in an underestimate of the deaths. And perhaps I can bring up another exhibit because this has been a repetitive problem over a number of years, P-0786 please, page 24. And here's another reference and this is for, cancer statistics for 2005.

MR. THOMPSON:

A. Uh-hm.

MR. NEWBURY:

Q. And it says, "Finally there are differences in the reporting procedures used in cancer registration, example registration of secondary primary cancers and the use of death certificates. See appendix 2 regarding cancer registry methodology. For example, death certificate information has not been available for registry purposes in Newfoundland until now and this falsely lowers the number of incident cases with short life expectancies such as cases of lung and pancreatic cancer." So this has been a common theme in the last, 2004 up through 2008.

MR. THOMPSON:

A. I should note that now that I have seen this

Page 240

report, I do recall actually looking at this, whether it was 2008 or a prior year, I'm not sure.

MR. NEWBURY:

Q. Sure.

MR. THOMPSON:

A. And being struck by the fact that Newfoundland data was so substandard compared to other provinces. What we were trying to do at the time was to look at the incidents of breast cancer or deaths from breast cancer to see if in some crude way there was a relationship by year there, with some of the data we were seeing from the database by year and it was impossible to draw any conclusion from that, but that's when it was that we saw that the Newfoundland and Labrador data in this report was very--it was below par.

MR. NEWBURY:

Q. Okay, and that's not something that you've been engaged in as part of this particular process here.

MR. THOMPSON:

A. No, no.

MR. NEWBURY:

Page 241

Q. And again, I understand that we'll have some evidence from Ms. Smith who might speak to that and efforts to try and resolve these problems. Mr. Thompson, I wanted to ask you about the concept of retro conversions and starting, first of all, with your familiarity with that particular notion. Is that something that you have encountered throughout your involvement?

MR. THOMPSON:

A. Yeah, I've heard the term and I understand it to be a test that upon retest will go from positive to negative.

MR. NEWBURY:

Q. And have you had any role beyond sort of learning generally what it's about, in assessing whether this is an issue or forming any conclusions as to whether this is an issue that warrants further investigation by Eastern Health?

MR. THOMPSON:

A. No, I've not had a role in assessing, the question and we hadn't taken it up in our office as a question for analysis, but one wonders more generally whether there is any--

Page 242

if there is an error rate as well among positives and whether it's a clinically issue to examine further. So I don't have an opinion on it, it just emerges as an obvious question.

MR. NEWBURY:

Q. And have you participated in any sort of informal discussions on that, not so much to the point that you may not have reached a conclusion, but are you aware of the types of information that might be out there and the types of information that's not out there that could help lead you one way or the other?

MR. THOMPSON:

A. No, no.

MR. NEWBURY:

Q. Have you ever become aware, through perhaps observing proceedings or attending meetings or what have you, the fact that there were a number of conversions in the database from an ER negative result, PR positive result to an ER and PR negative result?

MR. THOMPSON:

A. I'm not certain I can recall that. It wouldn't surprise me if there were some

Page 243

results like that, but I can't recall in particular how many and if there were.

MR. NEWBURY:

Q. Okay, and I understand from the initial discussions about the mandate of the Centre for Health Information that there was an effort to ascertain what would be included in the database.

MR. THOMPSON:

A. Uh-hm.

MR. NEWBURY:

Q. And because the focus of the retesting had been upon ER results and not the ER positive-- ER negative results as opposed to ER positive results -

MR. THOMPSON:

A. Right.

MR. NEWBURY:

Q. That there were a few results, 18, I believe, ER positive results that had been done but were not initially intended to be included in the database that NLCHI was preparing.

MR. THOMPSON:

A. Yeah. But just to clarify that point is that the objective was to include all the activity

Page 244

that Eastern Health had actually engaged in, in terms of all the retests that they did. So that's why we included the few positives that were done as well.

MR. NEWBURY:

Q. Okay.

MR. THOMPSON:

A. So to include that, if Eastern Health had chosen to do all of the positives, they would have been in the database as well.

MR. NEWBURY:

Q. Right.

MR. THOMPSON:

A. And so the only reason I focus on it is because I think there's a sense that there's somehow a shortcoming in the database because positives aren't in it. Well that may be a clinical issue here, but from the point of view of the database itself, that's not a shortcoming of the database. If the database was meant to focus on negatives in the main, it did and so conclusions that can be reached based on that feature can indeed be reached with confidence. So, yeah, that's the point.

MR. NEWBURY:

Page 245

Q. So the data has been collected and put in a database, but not the main cohort, is that how it was done?
MR. THOMPSON:
A. Well when we--within the 1023, there are 18 positive--original positive results, including their retest results. If more positive cases had been retested up to the point when the database project started, okay, then we would have included them, but we didn't include anyone's after that because it wasn't the original intent of Eastern Health to retest that group.
MR. NEWBURY:
Q. So the database exercise didn't define what was going to be retested -
MR. THOMPSON:
A. Correct.
MR. NEWBURY:
Q. - they just captured what was being retested.
MR. THOMPSON:
A. Correct, exactly.
MR. NEWBURY:
Q. And as part of that discussion as to how to deal with those 18 other cases, you, of

Page 246

course, became aware that there were 18 positive, ER positive cases that were retested.
MR. THOMPSON:
A. Yes.
MR. NEWBURY:
Q. And did you become aware that four of those were categorized by Eastern Health as retro conversions?
MR. THOMPSON:
A. Yes, I saw that from the disclosure records.
MR. NEWBURY:
Q. Okay, and has it ever been brought to your attention how those retro conversions were defined, for example, whether or not retro conversions would have included a result going from ER positive to ER negative, but the patient was deceased, whether or not such a result would be categorized as a retro conversion?
MR. THOMPSON:
A. Well I only understand it to the extent that if there was a positive and upon retesting it was negative, then that defined retro conversion. If there were other criteria as

Page 247

well, I'm not aware of -
MR. NEWBURY:
Q. That wasn't part of any of the discussions that you had?
MR. THOMPSON:
A. No.
MR. NEWBURY:
Q. And whether or not in sort of selecting which of those 18, we'll call a retro conversion, whether or not they considered treatment, types of treatment, whether the change of treatment occurred or not?
MR. THOMPSON:
A. Well those weren't issues for the database. We read about those four cases in the disclosure documents from Eastern Health, but they weren't issues in how they were characterized within the database itself, it's just the straight results were captured.
MR. NEWBURY:
Q. And there's been no discussion about that?
MR. THOMPSON:
A. No.
MR. NEWBURY:
Q. And you're not aware of any final tally or

Page 248

list of all of the retro conversions -
MR. THOMPSON:
A. No, not beyond those four, if I was asked how many were there, I would say four based on what I read in the disclosure documents.
MR. NEWBURY:
Q. Okay. And you're aware that external review reports have identified problems with the test procedures used for ER/PR testing.
MR. THOMPSON:
A. Yes.
MR. NEWBURY:
Q. And you're aware generally that some of the deficiencies would relate to quality control, absence of expected documentation surrounding standard operating procedures -
MR. THOMPSON:
A. Yes.
MR. NEWBURY:
Q. Are you aware that there was a concern about the failure to use negative controls?
MR. THOMPSON:
A. I read that in the reports, yes.
MR. NEWBURY:
Q. And that negative controls would help to

Page 249

detect false positives?
MR. THOMPSON:
A. Uh-hm.
MR. NEWBURY:
Q. And also that there have been deficiencies identified in quality assurance and in particular, the lack of an external proficiency testing program?
MR. THOMPSON:
A. Right.
MR. NEWBURY:
Q. And in these circumstances, would you have expected a further review by Eastern Health of the issue of the positives and the potential for false positives based on that type of information being available, I guess, to Eastern Health?
MR. THOMPSON:
A. I don't think I have the expertise to render an opinion on it, it may well be that there are additional factors or factors inherent in the test itself that might be factors in making such a decision. So I really can't add to it or advance an opinion.
MR. NEWBURY:

Page 250

Q. Okay. And I think it was your evidence earlier that you rely upon Eastern Health and the Regional Health Authorities generally to ensure the quality of their own -
MR. THOMPSON:
A. That's right.
MR. NEWBURY:
Q. Is there a point in time that you have reason to be concerned about how they managed the quality and how would you decide to intervene? And when I say "you", I'm not sure if that would be the Department of Health or perhaps the task force itself -
MR. THOMPSON:
A. Are you talking about in general in relation to quality assurance in a RHA and the department or on ER/PR?
MR. NEWBURY:
Q. I think, obviously generally speaking, but in the context of when problems have been identified, this is a little bit of a unique situation where there have been a number of problems identified with the negative test results and now there are also a number of deficiencies highlighted generally about the

Page 251

test procedures for ER/PR and also the fact that there have been some retro conversions identified.
MR. THOMPSON:
A. Well, I mean, as a general matter, the Department relies upon the RHAs to put in place their own quality assurance systems, to monitor them, to make decisions based upon them, to be accredited and that as a second, I guess, line of defence, to make sure good quality systems are in place and then the Department and the Minister holds the RHA accountable in general terms for the operation and management of the organization. So the Department doesn't have a direct role in quality assurance. Now, the view of the government or there is a--the government has said that it is interested in establishing a health quality council and actually the task force will provide some information to the Minister on that as part of our mandate. And the health quality council may indeed then take some role in relation to quality issues inside of RHAs, so that would be a change from the current environment, but there is no

Page 252

current active role in monitoring and intervening in quality issues within an RHA. The only time it would happen, perhaps--I should never say "only" but what occurs to me is that it might happen in a particularly unusual case, like ER/PR, where issues engage public concern and the Department and the Minister, from a general accountability point of view, need to know about what the quality assurance practices are and may wish to render an opinion or intervene in some fashion, but it will all depend upon the circumstances of the case.
MR. NEWBURY:
Q. And you've just referred to one of the tools that you expect to be, to help to ensure the quality at the RHA level would be the accreditation process.
MR. THOMPSON:
A. Uh-hm.
MR. NEWBURY:
Q. Have you ever become aware of whether or not accreditation was available for the immunohistochemical testing during the relevant time period?

Page 253

MR. THOMPSON:
A. My understanding is that accreditation for laboratories is, if I recall accurately, was not in place--or wasn't part of the accreditation program more properly stated, yes.
MR. NEWBURY:
Q. Right, for the CC--Accreditation Canada -
MR. THOMPSON:
A. That's right.
MS. NEWBURY:
Q. And in this particular case, I think there's been very limited analysis based on the evidence of retro conversions, and Dr. Denic had indicated that he did a very rough analysis of a limited number of retro conversions, and that would be the initial group of 18, plus an additional ten that self-identified subsequently, and it would appear just from looking at the data that Dr. Denic relied upon, and the PR - that PR retro conversions would not all have been included, and perhaps retro conversions for all of the deceased or patients who had no treatment change would not have been included in his

Page 254

analysis, so it was a very limited analysis, and there was some evidence this morning actually from Dr. MacDonald that to do, I guess, an analysis of the statistical significance of whatever results have occurred to date in retro conversions, you would actually need a sample size of three to four hundred based on 2000 positive test results. So I'm not sure if resources is an issue there. Another -
MR. THOMPSON:
A. No, if Eastern Health wanted to do that study, resources would not be an issue.
MS. NEWBURY:
Q. Okay, that was the other question that I had because Heather Predham gave evidence following sort of a review with her of the various data on retro conversions, and her conclusion at the end is that, you know, it does highlight the review that we had of the various bits of data on retro conversions, including the PR retro conversions, and others that weren't on the smaller list that had been identified, that it would be important to do that as opposed to just looking at the panel

Page 255

results, and she'd also noted that a reason why such an analysis hadn't been done to date, and this is her understanding of the situation, was that they first of all had to deal with the decision about retesting of the deceased, and also that they were waiting for NLCHI to complete their data review and perhaps use the data from that.
MR. THOMPSON:
A. So let me clarify. When you said it, what I took it to mean is that it may be a costly exercise, and, therefore, maybe that's why they wouldn't do it, and it's only on that point, I think - my statement means that if Eastern Health thinks that it's a clinically appropriate thing to do, to do that retesting process, the department would certainly encourage and support obtaining the resources necessary. If they have a human resource constraint or need to wait a while, that would be a different matter, and perhaps that's what Heather Predham was talking about.
MS. NEWBURY:
Q. Okay.
MR. THOMPSON:

Page 256

A. Yeah.
MS. NEWBURY:
Q. And Dr. Denic did say that if they had to retest all the positives, it would cause the lab to shut down now. So certainly that would be a -
MR. THOMPSON:
A. Okay.
MS. NEWBURY:
Q. A human resource type issue.
MR. THOMPSON:
A. And I don't mean to diminish that. That would be considerations other than what I can speak to.
MS. NEWBURY:
Q. And is it fair to say that if a decision were made that this would be a valuable exercise, and perhaps not, you know, retesting of all the positives is not the only option, there might be a decision to perhaps do a review of slides just to verify whether or not the interpretation of the slides was correct as opposed to the underlying technical test, or perhaps a random sample -
MR. THOMPSON:

Page 257

A. Uh-hm.
MS. NEWBURY:
Q. In the lines of what Dr. MacDonald had thought might be appropriate to come up with some statistically significant conclusions, but whatever Eastern Health decided to do, if there were a resource issue, do you expect it would have the support of the Department of Health?
MR. THOMPSON:
A. I suspect that it would, given the circumstances here and the importance of pursuing all of these important questions.
MS. NEWBURY:
Q. Okay, thank you very much, Mr. Thompson. Those are my questions.
THE COMMISSIONER:
Q. Thank you. Mr. Crosbie.
MR. ROBERT THOMPSON - EXAMINATION BY CHESLEY CROSBIE, Q.C.
CROSBIE, Q.C.:
Q. Good afternoon, Mr. Thompson. I wonder if you could just recap and tell us what you expect to be the agenda for the task force and when it will wind up, who it's going to report to,

Page 258

and what mechanism will there be for releasing the information more broadly to the public?
MR. THOMPSON:
A. Okay, just to remind, the task force proper, its mandate deals with adverse event management and not with the data that we've looked at. I just want to make that distinction. The - our report on adverse management, we expect will be concluded in November, and will be made available soon thereafter to the public. So it will be available for anyone to look at and review, and I report to - I'm appointed by the Cabinet, so I report - I'll provide my report both to the Premier and the Minister of Health.
CROSBIE, Q.C.:
Q. What about specifically related to clarifying the facts and statistics surrounding the ER/PR event?
MR. THOMPSON:
A. We won't be doing any more reporting or analysis on that. The document that we provided in March to the Commission is the - while it says "draft" on it, it's the final

Page 259

cut of that analysis that we're doing. Attached to it the compendium of tables, so that further analysis could be done. We've provided the database itself, of course, to the Commission so that - and its scientific advisors could do further analysis should they wish. So that's all the work that we'll be doing on that.
CROSBIE, Q.C.:
Q. And my other topic is - could we see Document P-0287, please.
REGISTRAR:
Q. What was that number, Mr. Crosbie?
CROSBIE, Q.C.:
Q. 287. As you can see there, Mr. Thompson, this is minutes of executive management meeting, June 13, 2007, St. John's. Mr. Tilley, as chief executive officer, and others you can see being present there, and if we can go to page two, Item 1.6. It's under the title, "CEO meeting with Minister and Deputy Minister", and it goes on to say how the CEO is scheduled to have a meeting, and there are some bullet items there; education to distinguish between errors versus variation in

Page 260

medical treatment, move to a just culture, and the fourth item, HIROC's concern with full disclosure and the impact on insurability. That last item, in particular, caught my eye. Can you tell us whether such a meeting did occur, do you have any knowledge about that?
MR. THOMPSON:
A. Well, I met with Mr. Tilley several times in June, so - but I can't remember if this specific meeting occurred on that date, but likely it did. I'd have to look at my calendar to verify it.
CROSBIE, Q.C.:
Q. As to HIROC's concern with full disclosure and impact on insurability, what can you tell us about that, is there an issue with coverage from HIROC?
MR. THOMPSON:
A. I can't recall that being discussed. I don't know whether Mr. Tilley raised it with me or not.
CROSBIE, Q.C.:
Q. There is no issue about insurability raised with you?
MR. THOMPSON:

Page 261

A. In fact, on the latter part of that phrase, "the impact on insurability", I'm almost certain that that wasn't raised, but the first part of this, "HIROC's concern", I mean, I heard about HIROC perhaps for the first time in June of '07, when I was informed what their function was and that they were an insurer, and their counsel was involved in some of the communications back and forth as I was reading disclosure documents and so forth, but whether I talked about it in terms of insurability, I have no recollection of that.

CROSBIE, Q.C.:

Q. Were you ever given to understand that HIROC, who we recognize as the reciprocal insurer of Eastern Health in this situation, was counselling or arguing for less than full disclosure of any kind?

MR. THOMPSON:

A. I don't recall any discussion of that.

CROSBIE, Q.C.:

Q. Thank you, sir.

THE COMMISSIONER:

Q. Ms. Brazil.

BRAZIL, Q.C.:

Page 262

Q. I have no questions for the witness, Commissioner.

EXAMINATION BY MADAM COMMISSIONER

THE COMMISSIONER:

Q. Mr. Thompson, can you tell me a little more about what a health quality council does?

MR. THOMPSON:

A. Sure. There is five or six of these councils across Canada operating at the provincial level, and one at the federal level, and they're essentially advisory bodies, plus at times research bodies, and they typically have a mandate to undertake quality monitoring activities in the health sector. Sometimes they'll monitor a set of data or indicators or issues consistently over time and produce annual reports and report on those indicators. Sometimes they'll take on a special sector or approach a specific issue, conduct intensive research and produce quality recommendations for the hospitals, health authorities. They may as well look at the quality systems that are in place to identify recommendations for improvement and they may look at not just specific systems, but how the overall system

Page 263

works together and look at quality issues in relation to how hospitals and nursing homes may interact or how community services and hospitals may interact. So they serve as a source of expertise, monitoring and quality improvement at the provincial level.

THE COMMISSIONER:

Q. For example, would there be one of those in Ontario?

MR. THOMPSON:

A. I believe there is one in Ontario, but the western provinces have made the greatest advances.

THE COMMISSIONER:

Q. I'm just wondering how their role relates to the role of inspection groups that we know exist in other provinces for laboratories, for example, and when they would go into a laboratory to examine the laboratory and determine whether or not the procedures meet the appropriate levels, whether there are proper procedures, what the--how things are done, etcetera, etcetera. That is directed to quality and I'm wondering about how the roles mix, if they do at all, or is there something

Page 264

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MR. THOMPSON:

A. Do they take on a somewhat regulatory role as well, is that what you -

THE COMMISSIONER:

Q. Yes.

MR. THOMPSON:

A. I actually can't answer that with any detail. So, our office has though, we have a report which I haven't turned myself to yet, we hired a consultant to summarize for us the characteristics of the health quality councils across Canada. So this is certainly something we could provide you with, if that would be of assistance to you.

THE COMMISSIONER:

Q. Well, thank you, I'd appreciate that, if you could.

MR. THOMPSON:

A. Um-hm.

THE COMMISSIONER:

Q. The other thing that I would like your view on, because of your experience, which is wider than your current role, is the difficulties in this country arising out of a sort of

Page 265

Federal/Provincial roles in health -

MR. THOMPSON:

A. Um-hm.

THE COMMISSIONER:

Q. - and one of the things that you're no doubt aware that has been raised fairly often is, for example, the lack of standards in pathology for certain tests or certain aspects of tests.

MR. THOMPSON:

A. Right.

THE COMMISSIONER:

Q. And it seems to me that it would be silly of me to think that within a province in this country someone would either have the resources or necessarily the easy access to the expertise to be involved in that kind of an activity. That would have to be a national level activity, but all these things cost money and it means either the cooperation of a number of different governments or the taking on of a role by one government that maybe has more resources than the others.

MR. THOMPSON:

A. Right.

Page 266

THE COMMISSIONER:

Q. And are you able to tell me whether or not there is presently existing any kind of a body involving governments which will tackle that kind of question which is larger than one of the groups involved may be able to tackle reasonably themselves, and might involve, in fact, cooperation with those outside of the groups?

MR. THOMPSON:

A. Sure. Well, the standard way for interprovincial health matters to be tackled like that is through the Council of Ministers of Health and their mirror committees from deputy ministers and other officials. They meet regularly. They have a very substantive agenda on specific health matters to help improve coordination across the country. Sometimes they deal with reciprocal billing issues. Somebody from Alberta gets treated here in a hospital, there's a billing process, and so that would be one part of their agenda, and there are lots of other administrative components of their agenda. But often there are specific health treatment diagnosis,

Page 267

health services issues that they discuss, and quite often actually, there are issues where it's clear that interprovincial and territorial coordination would be beneficial because the group acting together would be more effective than everybody acting separately.

So one example is the establishment of the Canadian Patient Safety Institute. In that case, the Federal Government played a major role because they actually injected the financing into the idea. But nonetheless, it exists through cooperation. Health Council of Canada actually is another example. Again, the injection of Federal money was an important way to facilitate it.

But in other circumstances, provinces and territories act alone and with their own money, and with their own initiative. The Canadian Blood Services is an example of that. Canadian Council on Organ Donation and Transplantation, although I'm not sure if that actually still exists today. There was some uncertainty about its continuation. But there are examples of provincial, interprovincial

Page 268

cooperation on issues. Now those are major issues where you're creating new institutions and injecting funding.

There are other more transitory issues where if a set of standards needs to be developed, they can strike special purpose committees. They can engage not just people within their departments, but experts from their departments or from their health systems, and this is done regularly to reach a consensus on a matter, and then if that consensus needs some kind of official blessing, it can be brought back to the Council of Ministers for adoption.

So that forum actually is a very productive way, has been in my experience, at any rate, a very productive way to process some of those issues. But it won't necessarily be the best forum for every issue. I don't know if, for example, IHC standards for pathology labs is the right issue. I'd have to think about that a bit more. But if there was a -

THE COMMISSIONER:

Q. Frankly, I'm not sure that that's the right

Page 269

route.
MR. THOMPSON:
A. Sure.
THE COMMISSIONER:
Q. I'm more or less thinking in the sense of that one might naturally think of Federal, country wide organizations which might be involved in pathology as taking the lead in these things, but as I understand it, some of those organizations who one might anticipate would be involved in it have suggested that the funding to do it isn't there. So whether it's just a funding issue or whether it's an issue that requires some kind of a national support in the sense of the drive to get it done, I frankly haven't thought it through. But I was interested in your experience with trying to get things done nationally.
MR. THOMPSON:
A. I think you're right to be uncertain about it, because some issues may be important in a few provinces but not in all, and then this particular kind of forum, the Health Ministers, it may get advanced by one province, but because it's not deemed to be

Page 270

important throughout, the other--because this group has a limited budget as well to act on these things. They may say no, if that's of interest to you and maybe two others, well, go and just two or three of you sort it out. We don't want it to be--have a place on the national agenda. So not all issues will have the momentum to get to that level.

Just one other comment. Often the Federal Government is not a player in these issues because--well, the Federal Government, interestingly, has an important role in the territorial health systems but the provincial governments generally regard issues like I've talked about, like blood service and organ transplantation, as health operational issues within provincial jurisdiction, and they like to talk to each other, and then if they have--if they reach priorities, they'll deal with each other on it, without there being a Federal role. But sometimes the Federal Government will come to the table and sit independently and say "we share a concern in an area, like patient safety, and we're willing to inject some funding into this, if

Page 271

we have everyone's cooperation to go in a new direction. So it very much depends upon the issue and the dynamics at play.
THE COMMISSIONER:
Q. Okay, thank you. Mr. Coffey, was there anything arising from the questions you had.
COFFEY, Q.C.:
Q. No, Commissioner, thank you.
THE COMMISSIONER:
Q. All right. Thank you very much, Mr. Thompson, for not only your evidence, but for the assistance of you and what we call NLCHI in providing us with a great deal of data.
MR. THOMPSON:
A. Thank you. Good luck.
THE COMMISSIONER:
Q. Thank you. Now I think it's 10:30 on Monday. Am I correct?
COFFEY, Q.C.:
Q. That's correct, Commissioner.
THE COMMISSIONER:
Q. Yes, all right then. We'll adjourn until then.

Page 272

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 24th day of October, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.
Dated at St. John's, Newfoundland and Labrador this 24th day of October, A.D., 2008
Judy Moss

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