

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">October 24, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL</p> <p>Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Chesley Crosbie, Q.C... Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike, Q.C. NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) David Eaton, Q.C.. . . Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBITS P-3557 AND P-3558 Pg. 126</p> <p>EXHIBITS P-3645 THROUGH P-3648 Pg. 126</p>
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1 and if one was able to record the name of the
 2 physician who had ordered the ER/PR test, and
 3 if one was able to record the technologist or
 4 technician's name who was, in fact, doing the
 5 slide run, and if subsequent to the DAKO
 6 machine processing those slides, that data was
 7 stored, able to be stored on the computer, and
 8 if that data had been able to be stored and
 9 then archived and kept, okay, if all such data
 10 for the DAKO machine for all the time it was
 11 utilized in St. John's, and I gather that's
 12 probably between 1998 and 2004, if all of that
 13 data had been available to NLCHI, might that
 14 have been of some assistance to you in your
 15 task?
 16 DR. ALAGHEHBANDAN:
 17 A. Quite valuable.
 18 COFFEY, Q.C.:
 19 Q. And in relation to that, how might it have
 20 been of some use?
 21 DR. ALAGHEHBANDAN:
 22 A. Well, first of all, it would be a good source
 23 for creating a cross check list. The other
 24 one would have been the fact that we would
 25 have the surgical number, so we could have

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1 break it down by year and by regions, so
 2 that's another possibility, by the ordering
 3 physician, and you also mentioned that if the
 4 responsible technologist name being recorded
 5 there, so that would have been another source
 6 of data for us. I notice here that it does
 7 not indicate what sample was tested. However,
 8 I can see the ER/PR scores here and
 9 nevertheless most of -
 10 COFFEY, Q.C.:
 11 Q. These are not actually ER/PR scores.
 12 DR. ALAGHEHBANDAN:
 13 A. I'm sorry, that's the protocol.
 14 COFFEY, Q.C.:
 15 Q. Yes, protocols.
 16 DR. ALAGHEHBANDAN:
 17 A. So nevertheless, you know, one can assume that
 18 majority of ER/PRs, this would have been done
 19 on breast samples. So again, I must say that
 20 with all those conditions that you stated it
 21 would have been a valuable source for us to
 22 consider as a source for cross checking and
 23 listing.
 24 COFFEY, Q.C.:
 25 Q. Thank you, Doctor. I'm going to ask,

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1 Registrar, please, if we could bring up--I'm
 2 just going to--this is just one of these,
 3 almost at random, bring up Exhibit P-3473?
 4 Now Mr. MacDonald, this is the minutes of an
 5 information management committee meeting of
 6 January 9th, 2004. The acting chair at the
 7 time was a Mr. Brown, but when we look down on
 8 the left-hand side, you'll see that Mr. D.
 9 MacDonald is listed there.
 10 DR. MACDONALD:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. That's yourself?
 14 DR. MACDONALD:
 15 A. Yes, it is.
 16 COFFEY, Q.C.:
 17 Q. Okay, and you've indicated yesterday that
 18 before Eastern Health was created, back in the
 19 days of the Health Care Corporation, that the
 20 Centre, as you call it, was then within the
 21 umbrella of the Health Care Corporation?
 22 DR. MACDONALD:
 23 A. Yes. I won't even attempt to come up with the
 24 official wording around it, but yes, we were
 25 under the Health Care Corporation Board.

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1 COFFEY, Q.C.:
 2 Q. And at that time then, what would have been
 3 your role then in attending--I take it this is
 4 one particular information management
 5 committee meeting minutes. There are a number
 6 of them in the years before.
 7 DR. MACDONALD:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. And they have been exhibited and there's some
 11 after this too, but what was your role at the
 12 time?
 13 DR. MACDONALD:
 14 A. Well, even though we were under--officially
 15 under the Health Care Corporation Board at
 16 that time, the Centre did operate
 17 independently and my role on this committee
 18 was to--as the Centre for Health Information
 19 being a provincial agency around the
 20 development of the electronic health record
 21 and around population issues with respect to
 22 information management, I brought that context
 23 to the Eastern Health table.
 24 COFFEY, Q.C.:
 25 Q. I take it, at the time, the Health Care

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1 Corporation table?
 2 DR. MACDONALD:
 3 A. Yes, Health Care Corporation table.
 4 COFFEY, Q.C.:
 5 Q. How about today?
 6 DR. MACDONALD:
 7 A. I'm no longer on that committee. Another
 8 individual from the Centre has replaced me.
 9 COFFEY, Q.C.:
 10 Q. Okay. So there is--but there is still
 11 somebody who brings that perspective that you
 12 brought in early years -
 13 DR. MACDONALD:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. - to Eastern Health's information management
 17 committee or whatever the current name of that
 18 committee is?
 19 DR. MACDONALD:
 20 A. That's correct.
 21 COFFEY, Q.C.:
 22 Q. Brings that vantage point.
 23 DR. MACDONALD:
 24 A. Yes.
 25 COFFEY, Q.C.:

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

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1 the Centre was able to garner from various
 2 information sources, data sources across the
 3 province and even from Mount Sinai, to try to
 4 put together a static database that identified
 5 all the patients impacted by the ER/PR testing
 6 and the communication events surrounding them,
 7 and we've mentioned that several times. But
 8 the important part, this is a retrospective
 9 look back.
 10 So the province is moving forward with
 11 the implementation of electronic health
 12 record. We have the opportunity to probably
 13 lead the country, if not the lead the country,
 14 be one of the leaders in the country in
 15 technology in health care, in support of
 16 patient care and patient safety. But also,
 17 with respect to other uses, such as research,
 18 audits, data quality, evaluation. Some of the
 19 things--all those activities took place in the
 20 development of the ER/PR database.
 21 With that infrastructure being created,
 22 we have the opportunity to try to mitigate
 23 against this ever happening again. Not saying
 24 that we'll ever stop it. I mean, we have to
 25 recognize too ER/PR is only one of, I don't

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1 know, thousands of different diagnostic tests
 2 that take place in a hospital, so we can't
 3 monitor each and every test. But what we can
 4 do is put in place--we are putting in place
 5 the infrastructure. We have missed a very
 6 important opportunity if we don't take what
 7 we've learned from here and incorporate that
 8 into what we're doing in the province now and
 9 what which will be in place in probably two or
 10 three years. By 2011, the Province of
 11 Newfoundland could have the most comprehensive
 12 electronic health record system in the world,
 13 if not the one, one of them.
 14 One of the things that we're missing
 15 today, and I've said this, is that interface
 16 between data and information. We continue to
 17 ask our IT people to create information from
 18 data. IT people are very good at creating
 19 data through technology. There's a different
 20 set of skills required to take the data to
 21 create the information, and that is what I
 22 feel is missing in the health system right now
 23 is that piece there. And there's--like in a
 24 lot of skill sets, there are not a skill sets
 25 like this. This is not--you can't go in and

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1 start up a department of information
 2 management. You have to train these
 3 employees. They have to know your business.
 4 They have to be intimate with the data. All
 5 the employees at the Centre for Health
 6 Information, my department, create their own
 7 data. They understand, are intimate with the
 8 data. So it's not a technology question, it's
 9 an information question.
 10 I wanted to say that, and I don't know if
 11 I've specifically or explicitly answered your
 12 question, but I think it lays a foundation
 13 perhaps for another question.
 14 COFFEY, Q.C.:
 15 Q. No, that's--that does address it, and I take
 16 it then that if right now, or tomorrow, one
 17 was to have to go--begin a look back again,
 18 you'd be met with similar sorts of problems
 19 potentially in terms of other authorities and
 20 so on that Dr. Reza has talked about?
 21 DR. MACDONALD:
 22 A. Yes, we've talked about the silos of Meditech
 23 systems in our hospitals. We've talked about
 24 lack of standards. We've talked about
 25 different data dictionaries used in our

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1 Meditech system so that a chest x-ray in
 2 Western is not necessary a chest x-ray, coded
 3 as a chest x-ray in Eastern. There's one
 4 thing that the Commission needs to recognize
 5 too is that our province is currently
 6 considering the implementation or the
 7 development of a provincial lab information
 8 system, and I've had initial discussions with
 9 the project teams and I said, if we were
 10 designing--if the lab system was in place
 11 today -
 12 COFFEY, Q.C.:
 13 Q. The lab information system.
 14 DR. MACDONALD:
 15 A. The provincial lab information, so instead of-
 16 -as Reza had already noted, I think there's
 17 six lab systems in the province that don't
 18 talk to each other. We deal in paper records,
 19 we've mentioned that. If a provincial lab
 20 information system was actually in place,
 21 would our job, from a retrospective
 22 perspective, be any easier? And you know,
 23 well, it depends. "What's the functionality?
 24 What's your business?" was the question to me,
 25 and so basically what it came down to, this

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1 type of activity, what we might call the
 2 business of secondary use of data to do an
 3 audit, to do an evaluation, to do research,
 4 has to be brought to the project team in
 5 advance to say "we need this functionality
 6 from the provincial lab information system."
 7 So that, heaven forbid if this ever happens
 8 again, we're in a much better position to get
 9 quality information in a much more expedient
 10 time. So there is an opportunity here to have
 11 input into such activity.
 12 THE COMMISSIONER:
 13 Q. Is the message I'm getting from you, don't
 14 rush to do something without thinking about
 15 exactly what it is you want to accomplish.
 16 Don't build it to deal with the problem that
 17 you have now. Think about the major problems.
 18 DR. MACDONALD:
 19 A. The word strategy is used so often, it's--but
 20 it is, it's that advance planning. An
 21 example, obviously we build these systems for
 22 patient care and also patient safety. So
 23 quality of care could be the encompassing term
 24 for our patients, right, and then we build
 25 that around effectiveness, efficiencies and

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1 quality, all these things. But what we really
 2 need to start thinking about is what else can
 3 we use this data for, for planning, for
 4 supporting policy and programs, for secondary
 5 use is what we're talking about. So when they
 6 go in and build the systems, obviously the
 7 priority is to the patient, yes, but if we're
 8 in at the table and we're saying, okay, that's
 9 great, but let's also include these types of
 10 functionalities, so that we can do our jobs
 11 better on this end. It's obviously much
 12 easier to do that upfront than say in five
 13 years from now, okay, let's go back and
 14 rebuild it. It generally doesn't work that
 15 much.
 16 And there's another important piece to
 17 all of this. Maple Leaf Foods closed down
 18 because of that scare around--like I can't get
 19 Maple Leaf bologna for my children any more.
 20 Heaven forbid, it's a big thing now. But
 21 they're able to close down. A hospital can't
 22 close down when this happened. So what we
 23 found, Reza's team had to go into a system
 24 that continued to provide patient care and
 25 we're trying to do this activity of collect

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

16 COFFEY, Q.C.:
 17 Q. Commissioner, they're the questions I had.

18 THE COMMISSIONER:
 19 Q. Thank you.

20 COFFEY, Q.C.:
 21 Q. With the--perhaps--no, they are the questions
 22 I had. Thank you very much.

23 THE COMMISSIONER:
 24 Q. Mr. Simmons?

25 DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,

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1 EXAMINATION BY MR. DANIEL SIMMONS
 2 MR. SIMMONS:
 3 Q. Thank you, Commissioner, couple of things.
 4 Good morning, gentlemen. Mr. Coffey actually
 5 has just hit right on the topic that I was
 6 most interested in asking you both about, and
 7 I understand from what you've just said, Mr.
 8 MacDonald, that you've recognized probably
 9 before you ever became involved in this
 10 project, but certainly from the work you've
 11 both done in this review project, that there
 12 has been and continues to be a real lack of
 13 this information management capacity in the
 14 four health authorities in the province. Have
 15 I captured that correctly?

16 DR. MACDONALD:
 17 A. That's my belief, yes.

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

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1 in health care in the province for gathering
 2 patient information?

3 DR. MACDONALD:
 4 A. Yeah, from my perspective, yes, I'm somewhat
 5 familiar with the systems.

6 MR. SIMMONS:
 7 Q. Okay. There was a point, of course, where
 8 there was no computerized technology for
 9 gathering patient information, when everything
 10 was done on paper, and maintained in
 11 individual patient charts, and my conception
 12 of it, maybe I'm wrong about that, is that at
 13 that point, before computers came in, the
 14 gathering of data and information about
 15 patients was confined to patient by patient by
 16 patient with very little ability to go across
 17 multiple files to extract common information
 18 about those patients. Is that kind of a fair
 19 assessment?

20 DR. MACDONALD:
 21 A. Yeah, we would call that linkage.

22 MR. SIMMONS:
 23 Q. Linkage, so very little opportunity for
 24 linkage. When computerization first began to
 25 be introduced into the health care system,

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

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

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

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1 medical record is another initiative underway
 2 in the province. So there's lots of activity
 3 around the infrastructure around technology in
 4 support of patient care, but also linkage.
 5 That's the critical piece is the linkage, so
 6 that we're able to say that a patient received
 7 a radiology exam on the west coast, saw a
 8 physician in Central and received these
 9 prescriptions at a hospital in St. John's, all
 10 available to the health professional.
 11 MR. SIMMONS:
 12 Q. Aside from the linkages from one site to
 13 another or one system to another, even within
 14 a single hospital, if we were to look at the
 15 Health Care Corporation, for example, before
 16 it became Eastern Health and the Meditech
 17 system had been implemented and my conception
 18 of it, and I may have this wrong, is that the
 19 Meditech system was not a comprehensive system
 20 to capture all patient information. There
 21 were modules within it that captured certain
 22 types of patient information from certain
 23 areas? Is that right?
 24 DR. MACDONALD:
 25 A. Yes.

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1 MR. SIMMONS:
 2 Q. And my concept of that is that it was designed
 3 in a way to collect a patient's information so
 4 that you could look up me and knowing who I
 5 am, you could find my lab results that had
 6 been reported in Meditech and am I correct in
 7 thinking that that was the approach, the
 8 initial approach to computerizing health
 9 records?
 10 DR. MACDONALD:
 11 A. I would say, yes. I mean, I can't say for
 12 definite. I mean, obviously, to me, putting
 13 some of this health information of a patient
 14 available electronically made it much more
 15 efficient and effective for the health
 16 professional to get it, as opposed to the hard
 17 copy chart, which what we see a lot today when
 18 we see our family physician, they pull out the
 19 chart out of a filing cabinet, and that's fine
 20 if you've got 5,000 patients. But as the
 21 Health Care Corporation of St. John's or as
 22 Health Science Complex, I don't know, I think
 23 they have around 50,000 in-patient activity
 24 every year.
 25 MR. SIMMONS:

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1 Q. And even if that GP wants to know how many of
 2 their 5,000 patients are over 50 years old,
 3 they'd have to look in every one of 5,000
 4 charts, unless their information system has
 5 been designed in a way that's captured the
 6 ages of their patients and allowed them to
 7 search and extract the data?
 8 DR. MACDONALD:
 9 A. Yeah, and it's interesting you bring up that
 10 example, because to me, that's the information
 11 management piece. It goes back to my opening
 12 comment of asking everyone's age and gender
 13 here and putting it down on a piece of paper.
 14 It means absolutely nothing. But if I give
 15 you the mean age by gender, it gives you
 16 information. If that physician's charts are
 17 in electronic form, it's much more easier for
 18 them to actually go in and say "how many
 19 diabetics do I have in my clinic right now and
 20 what are their"--this type of activity. So
 21 surrounding the data with the infrastructure
 22 to provide information is the critical piece.
 23 MR. SIMMONS:
 24 Q. So for example, when the Meditech laboratory
 25 information system module is implemented in an

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1 organization like the Health Care Corporation
 2 of St. John's, if the future use of that
 3 system, as was attempted here in this case, to
 4 find everybody who had a negative ER/PR
 5 result, if that future use wasn't anticipated
 6 at the time it was set up, the people setting
 7 it up wouldn't be in a position to design it
 8 in a way that would make it easy to get that
 9 information out?
 10 DR. MACDONALD:
 11 A. And that's knowing your business.
 12 MR. SIMMONS:
 13 Q. And that's, pardon me?
 14 DR. MACDONALD:
 15 A. That's knowing your business.
 16 MR. SIMMONS:
 17 Q. Yes, right.
 18 DR. MACDONALD:
 19 A. That's going to the people who are building
 20 the system and say "here's the functionality I
 21 need." If it was not set up for that, it makes
 22 it very difficult to go back and get that
 23 information.
 24 MR. SIMMONS:
 25 Q. And I presume with these systems, too, over

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1 time, even people skilled in information
 2 management have gradually learned that there's
 3 more and more that can be extracted out of
 4 data? There's more things that can be done as
 5 the technology develops and as the capacity
 6 for information management develops. Is that
 7 fair to say, that the two of them have been
 8 developing over time?
 9 DR. MACDONALD:
 10 A. Yes, it's true. The importance of the
 11 secondary use of data is becoming more and
 12 more important, yes.
 13 MR. SIMMONS:
 14 Q. And when you make a change or implement an
 15 information management system, and these
 16 change from time to time, and begin capturing
 17 data in a more useful way, that would only
 18 apply to the new data you're putting in. The
 19 old data you've already captured, if it wasn't
 20 input into fields or wasn't captured in such a
 21 way that it captured the information that you
 22 decide you now want to collect, it's difficult
 23 to go back?
 24 DR. MACDONALD:
 25 A. Very difficult.

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1 MR. SIMMONS:
 2 Q. Very difficult to go back, okay. And some of
 3 that, I'd suggest, is what was encountered
 4 here when it was necessary to go back over
 5 eight years of electronic and paper records to
 6 try and identify those people who'd had
 7 negative ER/PR results?
 8 DR. MACDONALD:
 9 A. The data was collected for patient care.
 10 MR. SIMMONS:
 11 Q. For patient care, yes, okay. You've told us a
 12 little bit about--well, you've told us pretty
 13 clearly that you think right now there's a
 14 lack of capacity in the health care system and
 15 in the authorities for information management.
 16 What do you think needs to be done, where--
 17 what kind of investment has to be made,
 18 whether it's personnel or financial, whatever,
 19 in order to create what you'd see as being the
 20 appropriate level of information management
 21 for the health authorities?
 22 DR. MACDONALD:
 23 A. In my experience, and it is my opinion that
 24 this is not something that can happen
 25 overnight. There's just not enough skillsets

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1 in Canada around information management
 2 because it's a cultural shift, and what I mean
 3 by that is technology in a lot of cases has
 4 provided the data to the decision makers.
 5 Taking that data and answering the question
 6 appropriately that the decision maker wants is
 7 the critical piece that I feel we have to
 8 start building capacity. You would not be
 9 able to recruit that skillset overnight. I
 10 firmly believe that we have to start building
 11 that capacity within the province.
 12 MR. SIMMONS:
 13 Q. Uh-hm.
 14 DR. MACDONALD:
 15 A. With our younger people, having them being
 16 mentored by more senior people. It's critical
 17 that they're intimate with the data.
 18 MR. SIMMONS:
 19 Q. Uh-hm.
 20 DR. MACDONALD:
 21 A. You cannot answer a question from the data
 22 unless you understand what the data can
 23 actually do.
 24 MR. SIMMONS:
 25 Q. Uh-hm.

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

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

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

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

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1 negative ER/PR cases, and maybe Dr. Reza,
 2 maybe this is more for you.
 3 DR. ALAGHEHBANDAN:
 4 A. Sure.
 5 MR. SIMMONS:
 6 Q. And you've told us how over time it came to be
 7 recognized that not every ER/PR test performed
 8 had had an order entered in the Meditech field
 9 where the technologist or someone in the lab
 10 ticks off or notes that an ER/PR test has been
 11 ordered. You told us that. At the outset of
 12 looking for these cases, we've heard that Mr.
 13 Gulliver did the search of that field and came
 14 up with every ER/PR test that had been
 15 ordered, and then printing the pathology
 16 reports and manually reviewed them, and from
 17 what you've seen, would there have been any
 18 reason that you became aware of to suspect at
 19 the outset that that would miss ER/PR cases,
 20 that there would be ones that had not had the
 21 order entered?
 22 DR. ALAGHEHBANDAN:
 23 A. Well, from--let me just go back a few steps
 24 here.
 25 MR. SIMMONS:

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1 Q. Sure.
 2 DR. ALAGHEHBANDAN:
 3 A. When I first came to be involved with this
 4 initiative, I learned that there were a number
 5 of patients who called in and self-identified
 6 themselves for the fact that they'd been
 7 diagnosed with breast cancer, ER/PR negative,
 8 never been called to be retested.
 9 MR. SIMMONS:
 10 Q. Yes.
 11 DR. ALAGHEHBANDAN:
 12 A. Obviously, at the lab, they went in and they
 13 checked the reason why these patients were not
 14 captured right at the beginning by using the
 15 ER/PR searching strategy at Eastern Health,
 16 and the reason was, as you mentioned, as I
 17 mentioned earlier, is the fact that ER/PR
 18 procedure code was not entered or ticked off
 19 by technologist. So it wasn't as a result of
 20 my exercise.
 21 MR. SIMMONS:
 22 Q. Oh, no.
 23 DR. ALAGHEHBANDAN:
 24 A. It was just basically something that surfaced.
 25 MR. SIMMONS:

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1 Q. So that had been--that had happened before you
 2 became involved?
 3 DR. ALAGHEHBANDAN:
 4 A. That's correct, yes.
 5 MR. SIMMONS:
 6 Q. In the summer of 2007, last summer, but from
 7 what you were able to see about the way the
 8 Meditech system worked, and--were you aware of
 9 any reason why anyone would have suspected at
 10 the outset back in 2005 that that would turn
 11 out to be the case, that there would have been
 12 cases not--without orders entered?
 13 DR. ALAGHEHBANDAN:
 14 A. I'm not sure if I understand your question
 15 properly. If you could reword it, I'd
 16 appreciate it.
 17 MR. SIMMONS:
 18 Q. Well, the--my understanding of it is that
 19 people didn't know back in the summer of 2005
 20 that this problem would turn out, without
 21 orders having been entered for ER/PR tests
 22 done, no order entered in that particular
 23 field in the Meditech system. I'm just asking
 24 if you encountered in your review of this
 25 whole thing any factors that might have been

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1 picked up back then that would have triggered
 2 that concern?
 3 DR. ALAGHEHBANDAN:
 4 A. Mostly human factor was involved in terms of
 5 basically ordering and performing the test.
 6 So that was the main factor.
 7 MR. SIMMONS:
 8 Q. Yes.
 9 DR. ALAGHEHBANDAN:
 10 A. And, of course, that is a factor always with
 11 any technology system.
 12 MR. SIMMONS:
 13 Q. Right.
 14 DR. ALAGHEHBANDAN:
 15 A. Something unavoidable, you can't really avoid
 16 it.
 17 MR. SIMMONS:
 18 Q. So aside from the risk that someone failed to
 19 do what they were supposed to do, which would
 20 be common in any system -
 21 DR. ALAGHEHBANDAN:
 22 A. That's correct.
 23 MR. SIMMONS:
 24 Q. You didn't encounter anything else that would
 25 have trigger a concern about that?

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1 DR. ALAGHEHBANDAN:
 2 A. No, basically that was the main reason,
 3 actually.
 4 MR. SIMMONS:
 5 Q. Yes.
 6 DR. ALAGHEHBANDAN:
 7 A. But it could have been prevented probably by
 8 creating something within the system, once a
 9 test is being--is going to be ordered and
 10 someone forgot or someone overlooked it, you
 11 know.
 12 MR. SIMMONS:
 13 Q. Yes.
 14 DR. ALAGHEHBANDAN:
 15 A. Would have been a warning window or a message
 16 saying please check this.
 17 MR. SIMMONS:
 18 Q. Now the approach that's been suggested now for
 19 the review to see if there are any other
 20 missed cases that haven't turned up yet
 21 involves talking a different approach which is
 22 doing a word search of the text in all of the
 23 pathology reports in Meditech for the word
 24 "breast", I understand.
 25 DR. ALAGHEHBANDAN:

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1 A. That's right.
 2 MR. SIMMONS:
 3 Q. And from the material we looked at yesterday,
 4 that is probably going to turn up, it's
 5 estimated, maybe as many as a couple thousand
 6 pathology reports for every year searched?
 7 DR. ALAGHEHBANDAN:
 8 A. That's right.
 9 MR. SIMMONS:
 10 Q. Now in order to identify those that were
 11 originally tested as ER or PR negative, all
 12 those are going to have to be read by someone?
 13 DR. ALAGHEHBANDAN:
 14 A. That's right.
 15 MR. SIMMONS:
 16 Q. And interpreted to determine what the original
 17 test result was said to be by that
 18 pathologist?
 19 DR. ALAGHEHBANDAN:
 20 A. That's correct.
 21 MR. SIMMONS:
 22 Q. So would I be correct that there is still a
 23 risk of human error in that approach as well?
 24 DR. ALAGHEHBANDAN:
 25 A. That's correct.

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1 MR. SIMMONS:
 2 Q. And if we were to compare the number of
 3 pathology reports that have to be reviewed
 4 now, taking this approach, to those that were
 5 reviewed initially in '05 by using the order
 6 entry field for search, there's now an even
 7 quite a few more pathology reports to review
 8 than had to be reviewed?
 9 DR. ALAGHEHBANDAN:
 10 A. Including positives, basically.
 11 MR. SIMMONS:
 12 Q. Including the positives.
 13 DR. ALAGHEHBANDAN:
 14 A. Yeah.
 15 MR. SIMMONS:
 16 Q. So while we've got a different approach for
 17 trying to identify which pathology reports
 18 we're going to review, there's still really no
 19 guarantee that we're actually going to
 20 effectively find everybody there?
 21 DR. ALAGHEHBANDAN:
 22 A. And we have indicated that there is no 100
 23 percent guarantee with respect to taking this
 24 approach.
 25 MR. SIMMONS:

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1 Q. Okay.
 2 DR. MACDONALD:
 3 A. I'd like to point out that in this particular
 4 exercise that we're going to be undertaking
 5 with the search term "breast" and the relevant
 6 components of the pathology report, we're
 7 going to be treating this more as a research
 8 project and being using what we're calling
 9 "double blinded".
 10 MR. SIMMONS:
 11 Q. Yes.
 12 DR. MACDONALD:
 13 A. So basically it might be of value to
 14 understand this. If we find a pathology
 15 report with the term "breast", all we know is
 16 that a pathology report was generated was
 17 breast.
 18 MR. SIMMONS:
 19 Q. Uh-hm.
 20 DR. MACDONALD:
 21 A. The Centre will then remove all the identifiers
 22 off this hard copy report and insert a study
 23 key. We have--Eastern Health has provided us
 24 with four nurses. Each of these nurses will
 25 review a pathology report and they will look

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1 through it, and all they will have is a study
 2 code on it, and they'll look first at this
 3 level for just if an ER/PR test was done.
 4 MR. SIMMONS:
 5 Q. Uh-hm.
 6 DR. MACDONALD:
 7 A. Okay. At this point, we haven't got the
 8 protocol defined whether we're going to get
 9 the ER/PR scores, but--so at this point, all
 10 we know is an ER/PR test was done, so a pile
 11 will be put over here of ER/PR, and a pile
 12 over here of non ER/PR, both had "breast"
 13 found in the pathology reports. Those will be
 14 coded into a database. The Centre will be
 15 doing that based on study code, which links
 16 back to the identifiable information. They
 17 will be all jumbled up again such that another
 18 nurse will review that pathology report again.
 19 MR. SIMMONS:
 20 Q. Uh-hm.
 21 DR. MACDONALD:
 22 A. But not the same nurse. So a nurse will never
 23 review the same pathology report again. That's
 24 what we mean by "double blinded", and so they
 25 again will fill out the sheet to say whether

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1 an ER/PR was actually present in the pathology
 2 report. So we hope to mitigate against human
 3 error by going over that twice.
 4 MR. SIMMONS:
 5 Q. Uh-hm.
 6 DR. MACDONALD:
 7 A. It's a very resource intense exercise, but we
 8 feel it's the most comprehensive way that we
 9 can search the available systems to as best we
 10 can identify every patient that had an ER/PR
 11 test done.
 12 MR. SIMMONS:
 13 Q. Yes, and once that is done then, someone I
 14 presume will have to review the reports to
 15 determine what the result of each ER/PR test
 16 was?
 17 DR. MACDONALD:
 18 A. Exactly, and we haven't really decided--we've
 19 got to talk to some more people to find out
 20 should the nurse actually garner that
 21 information from the charts, or should we
 22 actually have someone trained in that specific
 23 area. We don't know yet, but we certainly
 24 don't want to assume that the nurse will be
 25 collecting all the information from the

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1 pathology chart. It may not be the best
 2 approach.
 3 MR. SIMMONS:
 4 Q. Because we know that you will encounter
 5 variability in the way the results of the
 6 ER/PR -
 7 DR. MACDONALD:
 8 A. Exactly.
 9 MR. SIMMONS:
 10 Q. - scores have been reported. I'm sure, Dr.
 11 Reza, from the pathology reports you've seen,
 12 you -
 13 DR. ALAGHEHBANDAN:
 14 A. That's right.
 15 MR. SIMMONS:
 16 Q. You would agree there will be considerable
 17 variability in the way they've been reported.
 18 So there will have to be some criteria
 19 developed to use to determine which of those
 20 reports are going to be regarded as positive
 21 and negative and how those scores are going to
 22 be recorded and interpreted?
 23 DR. ALAGHEHBANDAN:
 24 A. Yes.
 25 MR. SIMMONS:

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1 Q. And that part hasn't been done yet?
 2 DR. ALAGHEHBANDAN:
 3 A. Not yet. That's going to be a tool actually.
 4 MR. SIMMONS:
 5 Q. Okay, good. Fine, thank you. I don't have
 6 any other questions for you.
 7 THE COMMISSIONER:
 8 Q. Mr. Browne.
 9 BROWNE, Q.C.:
 10 Q. Thank you, Commissioner.
 11 DR. MACDONALD & DR. ALAGHEHBANDAN - EXAMINATION BY PETER
 12 BROWNE, Q.C.
 13 BROWNE, Q.C.:
 14 Q. Good morning, gentlemen, Dr. MacDonald, Dr.
 15 Reza. You will be pleased to know most of the
 16 issues were covered this morning that I had
 17 for you. I just have one point of
 18 clarification and that's actually for Dr.
 19 Reza. Dr. Reza, when you became involved in
 20 2007 working with Eastern Health trying to
 21 collect and move towards identifying new
 22 patients, and I think I'm looking at the
 23 regions, in particular, of Carbonear and
 24 Clarenville, do you recall whether or not
 25 Eastern Health had made request independent of

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1 your request to them to these areas for hard
 2 copies of both ER and PR positive results?
 3 DR. ALAGHEHBANDAN:
 4 A. I'm not sure actually.
 5 BROWNE, Q.C.:
 6 Q. Okay, so you wouldn't be able to -
 7 DR. ALAGHEHBANDAN:
 8 A. That would be a question for Mr. Gulliver.
 9 BROWNE, Q.C.:
 10 Q. Okay.
 11 DR. ALAGHEHBANDAN:
 12 A. Right.
 13 BROWNE, Q.C.:
 14 Q. Thank you.
 15 DR. ALAGHEHBANDAN:
 16 A. You're welcome.
 17 BROWNE, Q.C.:
 18 Q. Thank you, Commissioner.
 19 THE COMMISSIONER:
 20 Q. Mr. Eaton?
 21 EATON, Q.C.:
 22 Q. No questions.
 23 THE COMMISSIONER:
 24 Q. Ms. Newbury.
 25 DR. MACDONALD & DR. ALAGHEHBANDAN - EXAMINATION BY MS.

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1 JENNIFER NEWBURY
 2 MS. NEWBURY:
 3 Q. Good morning, my name is Jennifer Newbury, and
 4 I represent the Canadian Cancer Society,
 5 Newfoundland and Labrador Division. I wanted
 6 to ask you first of all if you are familiar
 7 with--either or both of you are familiar with
 8 the operations of the Cancer Registry?
 9 DR. MACDONALD:
 10 A. Cursory.
 11 MS. NEWBURY:
 12 Q. Okay.
 13 MS. NEWBURY:
 14 Q. And are you familiar with the nature of the
 15 data collected by the registry?
 16 DR. ALAGHEHBANDAN:
 17 A. I am, to a certain extent. Actually, it is
 18 mostly demographic information, plus cancer
 19 diagnosis based on classification, oncology
 20 classification codes.
 21 MS. NEWBURY:
 22 Q. Okay, and do you know how the data is
 23 collected and maintained, sort of the
 24 mechanics of data management?
 25 DR. ALAGHEHBANDAN:

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1 A. I don't know how they collect it. I believe
 2 that comes from Cancer Clinic. I understand
 3 that it is stored in a system called OPIS
 4 System.
 5 MS. NEWBURY:
 6 Q. An OPIS System?
 7 DR. ALAGHEHBANDAN:
 8 A. OPIS System.
 9 MS. NEWBURY:
 10 Q. And has the Centre ever had any involvement
 11 historically with the cancer registry? You're
 12 nodding your head.
 13 DR. ALAGHEHBANDAN:
 14 A. Yes, we did.
 15 MS. NEWBURY:
 16 Q. Perhaps you could explain what that
 17 involvement has been?
 18 DR. ALAGHEHBANDAN:
 19 A. One of the funded projects we had was with
 20 cervical cancer, provincial cancer program, an
 21 as a result of that project, we had to
 22 basically create a database using cervical
 23 cancer data, hospital data, mortality data, so
 24 we received the data from cancer registry, we
 25 link it to provincial hospital mortality

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1 systems.
 2 MS. NEWBURY:
 3 Q. Okay, is that -
 4 DR. ALAGHEHBANDAN:
 5 A. So that was one of the projects that I was
 6 involved with.
 7 MS. NEWBURY:
 8 Q. And is that a project that you dealt with Dr.
 9 Fontaine on?
 10 DR. ALAGHEHBANDAN:
 11 A. Yes, Dr. Fontaine was one--on the team as
 12 well.
 13 MS. NEWBURY:
 14 Q. And he's given some evidence about that.
 15 DR. ALAGHEHBANDAN:
 16 A. That's right.
 17 MS. NEWBURY:
 18 Q. And in terms of the data that you collected,
 19 is that something contained within the same
 20 type of system of the overall cancer registry
 21 or has a new system been set up for that?
 22 DR. ALAGHEHBANDAN:
 23 A. I'm not sure about that. What we requested,
 24 we requested cancer data on cervical tissues
 25 as well as PAP smears, and what we were given

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1 was basically access file, I think, that was
 2 extracted from OPIS System.
 3 MS. NEWBURY:
 4 Q. Okay. So you basically gathered some
 5 information from the OPIS System and then -
 6 DR. ALAGHEHBANDAN:
 7 A. No, basically, we were given the data because
 8 the data is maintained at NCTRF.
 9 MS. NEWBURY:
 10 Q. Okay, and then you worked with that data?
 11 DR. ALAGHEHBANDAN:
 12 A. And then we linked it to our provincial
 13 databases.
 14 MS. NEWBURY:
 15 Q. In terms of the distinction between
 16 information management and data management, do
 17 you have any observations about how the cancer
 18 registry deals with both of those aspects?
 19 DR. ALAGHEHBANDAN:
 20 A. That would be a question for you, Don.
 21 MS. NEWBURY:
 22 Q. If you can, of course.
 23 DR. MACDONALD:
 24 A. No, I mean--certainly I know that the Cancer
 25 Foundation puts out regular reports, to my

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1 understanding.
 2 MS. NEWBURY:
 3 Q. Uh-hm.
 4 DR. MACDONALD:
 5 A. So that's a part of information management,
 6 and we certainly work with the Cancer
 7 Foundation on a couple of other things other
 8 than the cervical cancer one. So other than
 9 from the outside looking in, I'm not really
 10 familiar with their information management
 11 capabilities or their data management
 12 capabilities.
 13 MS. NEWBURY:
 14 Q. So it's fair to say that the interaction has
 15 been fairly limited between the Centre and the
 16 cancer registry on an overall or global basis?
 17 DR. ALAGHEHBANDAN:
 18 A. Which--I'm sorry?
 19 MS. NEWBURY:
 20 Q. On an overall basis, aside from perhaps
 21 smaller special projects, has there been much
 22 interaction between the Centre and the cancer
 23 registry?
 24 DR. MACDONALD:
 25 A. I would say, you know, relative to other

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1 entities, we engaged probably in three or four
 2 different major projects with them.
 3 MS. NEWBURY:
 4 Q. Uh-hm. Are you able to make any observations
 5 about perhaps any deficiencies or any room for
 6 improvement with either the data management
 7 aspect or the information management aspect of
 8 the cancer registry?
 9 DR. MACDONALD:
 10 A. Well, we've had several meetings with the
 11 cancer registry on some initiatives of
 12 linkage, let's say, to mortality, but also
 13 through the ER/PR work.
 14 MS. NEWBURY:
 15 Q. Uh-hm.
 16 DR. MACDONALD:
 17 A. And from those meetings and discussions, it
 18 was understood that the registry is not
 19 complete and there are gaps in the data, and
 20 we've been working with them over the years on
 21 the cervical cancer project. We noted that
 22 also. We had to wait for a significant amount
 23 of time, for a year and a half to get a
 24 particular piece of information filled in
 25 because of lack of resources.

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1 MS. NEWBURY:
 2 Q. Uh-hm.
 3 DR. MACDONALD:
 4 A. So it was one of the--it was one of the
 5 reasons we didn't use the Cancer Foundation as
 6 a core source for ER/PR because we were told
 7 that it's not complete, and, therefore, we
 8 can't really say if it's not in the database,
 9 it didn't mean that they weren't done.
 10 MS. NEWBURY:
 11 Q. So in terms of obtaining a list of patients
 12 for cross-referencing purposes, it was your
 13 understanding that the cancer registry would
 14 not be a very valuable -
 15 DR. MACDONALD:
 16 A. It would not be a complete list, and,
 17 therefore, probably wouldn't provide much
 18 value to us.
 19 MS. NEWBURY:
 20 Q. And you just mentioned linkages, and I think
 21 you mentioned yesterday that the mortality
 22 database does provide information and it's up
 23 to date within, I think, two or three months -
 24 DR. MACDONALD:
 25 A. Yes.

1 MS. NEWBURY:
 2 Q. - was the information that you indicated, and
 3 are you aware that one of the, I guess,
 4 deficiencies in the cancer registry in terms
 5 of the data that it contains relates to death
 6 information for patients?
 7 DR. MACDONALD:
 8 A. Death clearance.
 9 MS. NEWBURY:
 10 Q. Death clearance, and can you explain, based on
 11 your knowledge of the mortality database how
 12 that situation could have evolved?
 13 THE COMMISSIONER:
 14 Q. I'm sorry, I didn't understand the question.
 15 MS. NEWBURY:
 16 Q. Okay.
 17 THE COMMISSIONER:
 18 Q. You mean--you're asking Mr. MacDonald to
 19 explain why the data on death is not in the
 20 cancer registry?
 21 MS. NEWBURY:
 22 Q. Yeah, if he would have any information perhaps
 23 if there was an issue with linkages between
 24 the mortality database and the cancer
 25 registry. Would you know if there's any

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

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

1 they would convert it back into their
 2 platform, so it -
 3 MS. NEWBURY:
 4 Q. So there's more -
 5 DR. MACDONALD:
 6 A. Meaning impediment as more of a pain.
 7 MS. NEWBURY:
 8 Q. More manual work.
 9 DR. MACDONALD:
 10 A. Yeah.
 11 MS. NEWBURY:
 12 Q. And perhaps more resources required for that.
 13 DR. MACDONALD:
 14 A. More than was necessary, but I wouldn't--
 15 relatively speaking, minimal resources for
 16 that particular activity.
 17 MS. NEWBURY:
 18 Q. And would it be your understanding that up
 19 until that process occurred, up until about
 20 six or seven years ago, would the information
 21 up until that date have been comprehensive?
 22 DR. MACDONALD:
 23 A. We've also had challenges with quality of our
 24 mortality system, and you have to understand
 25 the mortality system in this province, we

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1 have--we receive two different mortality
 2 systems. One is a Stats Canada one, which is
 3 the official one. It has cause of death, and
 4 I don't know if you want to get into that.
 5 MS. NEWBURY:
 6 Q. Uh-hm.
 7 DR. MACDONALD:
 8 A. Whereas the provincial system have causes of
 9 death, understanding that when a person is
 10 deceased, the physician in most cases doesn't
 11 say the person died of this, and here's the
 12 contributing factors. They basically just
 13 list them down and we would have no guarantee
 14 that the main cause is the one that they
 15 listed first. So that system is what we call
 16 the provincial system. It goes back ten
 17 years, eleven years perhaps. The mortality
 18 system for Stats Canada goes back to the 70s,
 19 but the data quality was so bad, we don't even
 20 use it back that far, and there's no way
 21 really to go back and fix that, as we talked
 22 about with Mr. Simmons. So over the last--we
 23 are comfortable, we put a lot of resources at
 24 the Centre to bring up the quality of
 25 mortality data from 1996 perhaps to today, ten

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1 years of data, but it was--there were
 2 significant challenges with data quality even
 3 with the mortality system.
 4 MS. NEWBURY:
 5 Q. Okay, but in terms of perhaps just the basic
 6 information as to whether or not a patient is
 7 deceased, would that have been fairly robust?
 8 DR. MACDONALD:
 9 A. No, because--well, I mean, because if we don't
 10 have the MCP number, it's a challenge to link.
 11 MS. NEWBURY:
 12 Q. Okay.
 13 DR. MACDONALD:
 14 A. There's seven Don MacDonald's in St. John's.
 15 MS. NEWBURY:
 16 Q. Right.
 17 DR. MACDONALD:
 18 A. Which one is--we need that unique identifier.
 19 MS. NEWBURY:
 20 Q. Uh-hm, and whether or not that was a
 21 contributing factor to the discontinuance of
 22 obtaining information from the mortality
 23 database, you have no understanding as to
 24 whether or not that's a factor?

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1 DR. MACDONALD:
 2 A. I don't recall why that happened.
 3 MS. NEWBURY:
 4 Q. And as you alluded to earlier, it was
 5 recognized by Eastern Health that looking to
 6 the cancer registry for some information for a
 7 list of patients for cross-referencing
 8 purposes would not have been particularly
 9 valuable, and there's evidence--documents as
 10 well as evidence from Heather Predham, for
 11 example, that when she attempted to rely upon
 12 data from the cancer registry back in August
 13 of 2005, that there was some deficient
 14 information in terms of the numbers of
 15 individuals who actually had ER/PR testing, so
 16 the information was provided apparently for
 17 some patients who had ER/PR testing, but not
 18 for others, and the status of the patients in
 19 terms of whether they're living or deceased
 20 wasn't identified in many cases, so that there
 21 were some limitations there and also issues
 22 with the MCP numbers, I believe, which related
 23 to the cancer registry as well, but I'm just
 24 wondering if that registry information had
 25 been complete or fairly complete at that time,

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1 would the process that you were engaged in
 2 starting the summer of last year, could that
 3 have been perhaps simplified or taken less
 4 time if you could have obtained a list from
 5 the registry?
 6 DR. ALAGHEHBANDAN:
 7 A. I'm not sure if it could have been simpler or
 8 easier, but I would say that that would have
 9 been another source for us to make sure that
 10 the quality of the ER/PR database, you know,
 11 increases. So if that was a reliable source,
 12 we would have definitely considered it as on
 13 of so many multiple sources that we considered
 14 during the course of this exercise.
 15 MS. NEWBURY:
 16 Q. Okay, and would it have enabled you to do a
 17 more complete picture or view of the ER/PR
 18 testing, and you mentioned yesterday that the
 19 project that you were engaged in, because of
 20 time constraints and resource constraints,
 21 didn't include the positive tests, and they
 22 weren't retested? Would a more complete
 23 cancer registry list have enabled you to
 24 perhaps include that information?
 25 DR. ALAGHEHBANDAN:

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1 A. If cancer registry had that information, it
 2 would have been valuable, but again going back
 3 to the main question, is that the database was
 4 created for the purpose of those patients who
 5 were negative and were retested at Mount
 6 Sinai.
 7 MS. NEWBURY:
 8 Q. Right.
 9 DR. ALAGHEHBANDAN:
 10 A. But, yes -
 11 MS. NEWBURY:
 12 Q. Okay. Has the Centre ever been asked to
 13 conduct or assist in the analysis of the retro
 14 conversions, or have there been any sort of
 15 preliminary discussions as to whether or not
 16 that would be feasible?
 17 DR. MACDONALD:
 18 A. I'll start with this one, and certainly Reza
 19 can add on to that. The retro conversions
 20 would go from positive to negative. We
 21 started with negative. It was just through
 22 the year and a half of working on this
 23 particular project, we did know and gave data
 24 on some positives that were sent up for
 25 retesting.

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1 MS. NEWBURY:
 2 Q. Uh-hm.
 3 DR. MACDONALD:
 4 A. And we decided to include them in the database
 5 because they were retested, so they met one of
 6 the criteria albeit they weren't negative, and
 7 it was through that exercise that some retro
 8 converted. So while it wasn't a--it wasn't a
 9 core activity that we did, we did recognize
 10 that.
 11 MS. NEWBURY:
 12 Q. Uh-hm.
 13 DR. MACDONALD:
 14 A. But to do an analysis on retro converters
 15 without the full picture, to me would--could
 16 be misleading. I don't know how many
 17 positives we actually have in our database,
 18 I'm only guessing at 20, and that--a lot of
 19 them would have been because the patient
 20 wanted to be retested regardless and the
 21 physician allowed that.
 22 MS. NEWBURY:
 23 Q. Uh-hm.
 24 DR. MACDONALD:
 25 A. But--so that's a biased sample, we would call

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1 it.
 2 MS. NEWBURY:
 3 Q. Sure.
 4 DR. MACDONALD:
 5 A. So any analysis on that would be not
 6 appropriate.
 7 MS. NEWBURY:
 8 Q. Okay, and when you say 20, you're referring
 9 primarily to the ER positives?
 10 DR. MACDONALD:
 11 A. Yes, that's what we're referring to there.
 12 DR. ALAGHEHBANDAN:
 13 A. Yes, the number 20, I'm not sure whether
 14 that's -
 15 DR. MACDONALD:
 16 A. Just a small number.
 17 DR. MACDONALD:
 18 A. Just a guess, but it's small number, small
 19 proportion.
 20 MS. NEWBURY:
 21 Q. I think the initial number was about 18.
 22 DR. ALAGHEHBANDAN:
 23 A. Right.
 24 MS. NEWBURY:
 25 Q. Now there was some information from Dr. Denic

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1 that there were just in the last year ten
 2 additional ER positive test results that were
 3 retested and that was a guesstimate on his
 4 part as to the number. Is that something that
 5 you're familiar with?
 6 DR. ALAGHEHBANDAN:
 7 A. In-house or at Mount Sinai?
 8 MS. NEWBURY:
 9 Q. I'm not sure.
 10 DR. ALAGHEHBANDAN:
 11 A. Okay, well, if it was Mount Sinai, we would
 12 have received it and entered into database,
 13 which I'm not aware of. I would assume that
 14 they were tests that were retested in-house.
 15 MS. NEWBURY:
 16 Q. In-house, okay. Now in the database, because
 17 of the way it was defined, you focused on the
 18 ER positivity, whether it was positive or
 19 negative. There are a number of ER
 20 negative/PR positive results for patients who
 21 were retested between 1997 and 2005, and again
 22 a few in 2006/2007 as well, and for those--for
 23 that category of tests, there could be results
 24 upon retesting that would include ER
 25 negative/PR positive, which would not be a

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1 retro conversion because you still have a PR
 2 positive?
 3 DR. ALAGHEHBANDAN:
 4 A. I can't make that call because that's
 5 clinical.
 6 MS. NEWBURY:
 7 Q. That's a clinical -
 8 DR. ALAGHEHBANDAN:
 9 A. Yes.
 10 MS. NEWBURY:
 11 Q. Okay. There have never been any discussions
 12 about that subset of your database in terms of
 13 the analysis of that?
 14 DR. ALAGHEHBANDAN:
 15 A. It has been, and I think in Mr. Thompson's
 16 report, there are one or two or more tables
 17 referring to that proportion that basically
 18 you're referring to.
 19 MS. NEWBURY:
 20 Q. Right.
 21 DR. ALAGHEHBANDAN:
 22 A. And I think there are some analysis been done
 23 on that.
 24 MS. NEWBURY:
 25 Q. Now my understanding from the tables, what I

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

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1 DR. ALAGHEHBANDAN:
 2 A. Right.
 3 MS. NEWBURY:
 4 Q. And, I guess -
 5 DR. MACDONALD:
 6 A. We were only just trying to give different
 7 scenarios--Robert--the task force wanted to
 8 present different scenarios so that people can
 9 make their own interpretation of it, so -
 10 MS. NEWBURY:
 11 Q. Right.
 12 DR. MACDONALD:
 13 A. That's why there was a multitude of tables
 14 there.
 15 MS. NEWBURY:
 16 Q. Yes, I do appreciate that. I guess the one
 17 scenario that I wonder was ever addressed was
 18 the situation where you may have ER
 19 negative/PR positive results, which may or may
 20 not have been treated as positive from the
 21 outset, upon retesting becoming ER negative/PR
 22 negative, whether there was an analysis of
 23 that particular subset?
 24 DR. ALAGHEHBANDAN:
 25 A. I can't recall right now, but if there was, it

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1 would have been in the report.
 2 MS. NEWBURY:
 3 Q. Pardon me?
 4 DR. MACDONALD:
 5 A. It would have been in the report.
 6 DR. ALAGHEHBANDAN:
 7 A. Mr. Thompson's report, yes.
 8 MS. NEWBURY:
 9 Q. And again if you were to conduct an analysis
 10 of retro conversions, as you noted, the data
 11 that you have now is incomplete because of the
 12 focus of the retesting, and presumably you
 13 would have to include in the analysis all of
 14 the ER positive test results between 1997 and
 15 2005 to come to any firm conclusions?
 16 DR. ALAGHEHBANDAN:
 17 A. With retro convertors?
 18 MS. NEWBURY:
 19 Q. Yeah.
 20 DR. ALAGHEHBANDAN:
 21 A. A firm conclusion, I'm sorry, on what aspect
 22 of it?
 23 MS. NEWBURY:
 24 Q. Upon, I guess, the -
 25 DR. ALAGHEHBANDAN:

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1 A. As Dr. MacDonald mentioned -
 2 MS. NEWBURY:
 3 Q. Rate change of the test, for example.
 4 DR. ALAGHEHBANDAN:
 5 A. Right. This small proportion of people who
 6 were originally positive and retested as
 7 negative represents only a small portion. It
 8 doesn't represent an entire picture.
 9 MS. NEWBURY:
 10 Q. Uh-hm.
 11 DR. ALAGHEHBANDAN:
 12 A. So the analysis can be done, however, we have
 13 to have the limitation that that may not be
 14 representing the bigger picture.
 15 MS. NEWBURY:
 16 Q. Whether or not it's statistically significant
 17 and whether you can draw conclusions from
 18 that?
 19 DR. ALAGHEHBANDAN:
 20 A. Right.
 21 MS. NEWBURY:
 22 Q. If you included--if you expanded the analysis
 23 of the limited data that you do have, for
 24 example, to include not only the ER positives
 25 that convert to negative, but to include the

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1 ER negative/PR positives that convert to
 2 negative, would you be in any better position
 3 to extract any information from that?
 4 DR. ALAGHEHBANDAN:
 5 A. Again that requires some clinical, I guess,
 6 expertise to interpret whether they would
 7 consider PR positive as a hormonal pathway in
 8 considering it as a positive, or just going by
 9 ER and considering ER the main indicator.
 10 MS. NEWBURY:
 11 Q. Right. But that has never been discussed as a
 12 possible investigation to be done?
 13 DR. ALAGHEHBANDAN:
 14 A. Not that I can recall.
 15 MS. NEWBURY:
 16 Q. Thank you. So I assume that based on the
 17 limited information now, you're not in a
 18 position to make any comment about the
 19 reliability of the ER/PR positive test results
 20 which haven't been retested?
 21 DR. ALAGHEHBANDAN:
 22 A. Reliability of?
 23 MS. NEWBURY:
 24 Q. The ER/PR test results that have not been
 25 retested?

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1 DR. ALAGHEHBANDAN:
 2 A. We don't know because they've never been
 3 tested.
 4 MS. NEWBURY:
 5 Q. And you haven't done any statistical analysis
 6 to make any--draw any conclusions from the
 7 very limited information that you do have?
 8 DR. MACDONALD:
 9 A. On the retros?
 10 MS. NEWBURY:
 11 Q. Yes.
 12 DR. MACDONALD:
 13 A. Positives?
 14 MS. NEWBURY:
 15 Q. Yes.
 16 DR. MACDONALD:
 17 A. We would say that we would not recommend any
 18 analysis be done.
 19 MS. NEWBURY:
 20 Q. And what's the basis for that recommendation?
 21 DR. MACDONALD:
 22 A. Well, bias for one purpose. They were
 23 primarily self-identified--not self-
 24 identified, but patients perhaps that wanted
 25 to be tested regardless of what their original

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1 was, or for some other reason had been sent
 2 up.
 3 MS. NEWBURY:
 4 Q. Uh-hm.
 5 DR. MACDONALD:
 6 A. So if it's only 18, you don't have to be a
 7 statistician to figure out you got 18 bias
 8 cases out of 2000.
 9 MS. NEWBURY:
 10 Q. Right.
 11 DR. MACDONALD:
 12 A. So we would--the Centre would not encourage
 13 any analysis on that data.
 14 MS. NEWBURY:
 15 Q. Right, okay, and you wouldn't -
 16 THE COMMISSIONER:
 17 Q. I understand why on the 18, but if your 18 at
 18 random, why are they biased?
 19 DR. MACDONALD:
 20 A. Well, they're not random. They're not random.
 21 THE COMMISSIONER:
 22 Q. But they don't know what their result is, they
 23 had no way of knowing.
 24 DR. MACDONALD:
 25 A. Statistically random.

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

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

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

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1 DR. MACDONALD:
 2 A. Exactly.
 3 MS. NEWBURY:
 4 Q. Progressed in the meantime.
 5 DR. MACDONALD:
 6 A. Without randomization, you introduce bias.
 7 MS. NEWBURY:
 8 Q. Right, okay.
 9 DR. MACDONALD:
 10 A. And it could very well be that those 28 people
 11 had a deep concern on their original test even
 12 though it was positive, that the physician
 13 said just to calm their nerves--I'm not saying
 14 that happened, I'm just saying it does
 15 introduce bias into why the particular
 16 specimen was retested.
 17 MS. NEWBURY:
 18 Q. And I presume that the Centre would have the
 19 ability to do the statistical analysis if the
 20 numbers were presented to it? You have the
 21 expertise to do that?
 22 DR. MACDONALD:
 23 A. Yes, we have.
 24 MS. NEWBURY:
 25 Q. As you've alluded to earlier, I guess, in some

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

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1 DR. MACDONALD:
 2 A. Well, the acceptable piece obviously is a
 3 clinical decision, and my understanding is
 4 there's much debate in the literature as to
 5 what is an acceptable rate too, and you
 6 already mentioned some of the research that's
 7 been done in this area that perhaps did not
 8 really get into how good their data was
 9 actually to make the conclusions that they
 10 did, so it's kind of fraught with a lot of
 11 different questions even now, but it's a
 12 simple task to monitor the particular test
 13 results. It is a number, albeit one of the
 14 challenges we experienced in going through
 15 this exercise with the health system was that
 16 there was not a standard way of recording the
 17 ER/PR result, so a lot of times sometimes we
 18 didn't even get a number, but if, in fact, we
 19 were consistent in the system in coding a ER
 20 result as between 0 and 100, and a PR result 0
 21 to 100, it's a very simple exercise to monitor
 22 trends over any period of time.
 23 MS. NEWBURY:
 24 Q. Uh-hm, and that would involve statistical
 25 analysis?

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1 DR. MACDONALD:
 2 A. No.
 3 MS. NEWBURY:
 4 Q. Or would it be just eyeballing it?
 5 DR. MACDONALD:
 6 A. Well, no, it would--basically, if you
 7 introduce it into your system, let's say, your
 8 lab information system and say I want this
 9 functionality, I want to generate a graph on a
 10 monthly basis, or weekly basis, or daily
 11 basis, on ER/PR test results, and you could
 12 ask it to come up on your screen. It would be
 13 a bar chart showing you the last eight months,
 14 this current month, and the current year, or
 15 going back--it's a very simple task to do.
 16 MS. NEWBURY:
 17 Q. Okay.
 18 THE COMMISSIONER:
 19 Q. And if you're really old fashioned, you just
 20 keep a tally?
 21 DR. MACDONALD:
 22 A. Exactly.
 23 THE COMMISSIONER:
 24 Q. Divide--make the appropriate -
 25 DR. MACDONALD:

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1 A. My thirteen year old son can do it.
 2 MS. NEWBURY:
 3 Q. In terms of the reliability of monitoring
 4 positivity rates as a primary tool to assess
 5 quality of the test results, as an example,
 6 would you have to take into account the
 7 possibility that in this particular case, for
 8 example, you could have false positives and
 9 false negatives that cancel each other out,
 10 and perhaps I can just give a hypothetical
 11 example. I'm just picking round numbers to
 12 work with. Say hypothetically you have an
 13 expected rate of positivity between 75 percent
 14 and 85 percent, and there are 100 tests that
 15 are performed and out of those tests 80 are
 16 positive and 20 are negative. So you would
 17 have 80 percent which is right in the middle
 18 of the expected range of positivity. Assume
 19 for the purpose of this hypothetical that the
 20 particular test is more prone, for whatever
 21 reason, to false negatives than it is to false
 22 positives. Could you have a possible scenario
 23 where 10 percent of the positives are false,
 24 and that would leave you with eight false
 25 positives, so 10 percent of the 80 positives

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1 are false--so you have eight false positives
 2 and leaving you with 72 true positives, and
 3 then 25 percent of the negatives are false
 4 because, say, this particular test is more
 5 prone to false negatives, so 25 percent of the
 6 negatives are false, and that would leave you
 7 five false negatives and 15 true negatives.
 8 So then to look at how many actual positives
 9 you have, you would have the 72 true
 10 positives, plus the five false negatives which
 11 are, in fact, positives. That would leave you
 12 with 77 positives, and then looking at how
 13 many negatives you have, you have 15 true
 14 negatives, plus the eight false positives, and
 15 you end up with 23 negatives. So even though
 16 your rate of positivity was 80, right in the
 17 middle of the range, when you get down to the
 18 detail of that particular test, it turns out
 19 that at the end of the day you should have had
 20 77 positives, and 23 negatives, 77 percent is
 21 still in the range of positivity, but looking
 22 at that scenario, you actually have 13 false
 23 tests. You have the eight false positives and
 24 five false negatives. So 13 out of the 100
 25 tests actually had false results, but looking

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1 at your rate of positivity, there may not have
 2 been any reason for alarm. Is that something
 3 that--is that perhaps the distinction between
 4 information management and data management and
 5 the need to understand the data that you're
 6 looking at?
 7 DR. MACDONALD:
 8 A. I'll give you a simple example.
 9 MS. NEWBURY:
 10 Q. Uh-hm.
 11 DR. MACDONALD:
 12 A. I'll get back to the age again. Someone is
 13 100, and someone is one.
 14 MS. NEWBURY:
 15 Q. Uh-hm.
 16 DR. MACDONALD:
 17 A. The average age is 50 and a half.
 18 MS. NEWBURY:
 19 Q. Right.
 20 DR. MACDONALD:
 21 A. So you might link two 50 year old people in a
 22 room, but, in fact, because of the range, not
 23 understanding the data, you actually got an
 24 infant and a very senior person. So what
 25 you're explaining there is again getting back

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1 to understanding the business, understanding
 2 the data, answering the questions that's being
 3 asked with an understanding of what the data
 4 can tell you. I'm not going to sit here for a
 5 moment that I understood everything you just
 6 told me there, but I think--I understand what
 7 you mean, though.
 8 MS. NEWBURY:
 9 Q. Yeah.
 10 DR. MACDONALD:
 11 A. You do really have to understand what you're
 12 reporting back because there is a false
 13 positive, there is a false negative, there is
 14 sensitivity and specificity to incorporate
 15 into your work.
 16 MS. NEWBURY:
 17 Q. Right.
 18 DR. MACDONALD:
 19 A. And that all has to be brought back to
 20 whatever--what the question might be.
 21 MS. NEWBURY:
 22 Q. Right.
 23 DR. MACDONALD:
 24 A. Or for that matter, it might not be a
 25 question. As I said already it could be

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1 performance monitoring.
 2 MS. NEWBURY:
 3 Q. Uh-hm.
 4 DR. MACDONALD:
 5 A. So the report may not be enough to say here is
 6 the percent positives. There also has to be
 7 the part of the false negative incorporated
 8 into your interpretation of that bar.
 9 MS. NEWBURY:
 10 Q. Right, and so that would perhaps illustrate,
 11 you know, the need to be cautious when drawing
 12 any conclusions about--if you have information
 13 about the negative test results, drawing any
 14 conclusions about the rate of performance for
 15 the entire test if you don't have information
 16 about the positive test results?
 17 DR. MACDONALD:
 18 A. Yeah, and we also know that the ER/PR test is
 19 highly subjective anyway.
 20 MS. NEWBURY:
 21 Q. Sure.
 22 DR. MACDONALD:
 23 A. And so it is one of those tests that have a
 24 weak diagnostic type of outcome for it, given
 25 the false positive and false negative, but you

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1 have to accept that that will be a part of the
 2 test, but you also have to incorporate it into
 3 your interpretation of the results, especially
 4 if you're talking about monitoring that at a
 5 population level as opposed to an individual.
 6 I suggest that it's probably only one piece of
 7 information they would use at the clinical
 8 level.
 9 THE COMMISSIONER:
 10 Q. Excuse me.
 11 CROSBIE, Q.C.:
 12 Q. May I raise an objection, Commissioner. These
 13 gentlemen have candidly admitted they're not
 14 experts in this area of medicine. The
 15 statement was just made that it's a highly
 16 subjective test. I don't believe that's been
 17 stated by anyone who is so expert. It's been
 18 said to be a modified objective test, for
 19 example, but highly subjective is not used.
 20 DR. MACDONALD:
 21 A. I apologize for that then. I take that back.
 22 THE COMMISSIONER:
 23 Q. Okay. Carry on.
 24 MS. NEWBURY:
 25 Q. And in terms of the use of data for monitoring

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1 as a means of assuring quality, you've
 2 indicated that you can use bar charts or what
 3 have you to look at the expected--or the
 4 outcomes and compare it with the expected
 5 outcomes there, and perhaps you might see red
 6 flags if the numbers are outside of the range,
 7 and perhaps if you wanted to go further, you
 8 could do a statistical analysis to see whether
 9 or not that unexpected--expected result might
 10 be due chance or perhaps really raises a
 11 concern for those results?
 12 DR. MACDONALD:
 13 A. Yeah, I mean, statistics will only take--it's
 14 a very objective look at something. So, I
 15 mean, statistics will only take you so far. I
 16 mean, that's why you need that expertise in
 17 that area to interpret it, and I think when
 18 the task force report came out, we didn't try
 19 to support any interpretation of the results
 20 because, as just noted, this is not our area
 21 of expertise.
 22 MS. NEWBURY:
 23 Q. Right. You're involved with more the data
 24 management aspect of it and some, I guess,
 25 limited information management based on

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1 assumptions that have been put to you?
 2 DR. MACDONALD:
 3 A. Yeah.
 4 MS. NEWBURY:
 5 Q. And in light of that hypothetical that I just
 6 explained or proposed, I guess, to you, and
 7 the possibility of false negatives and false
 8 positives cancelling one another out to the
 9 point that you might have results that look
 10 good when you compare them with the
 11 literature, but may be masking a larger
 12 problem of false test results. If a
 13 department or an individual were to rely upon
 14 results to say, oh, looks like we don't have a
 15 problem, knowing that or suspecting that there
 16 might actually be some problem with the test,
 17 would there be a need to be more cautious in
 18 that circumstance if there's a reason to
 19 believe that a procedure may not be as
 20 reliable? Could you look to monitor results
 21 to give yourself assurances that they are, in
 22 light of that hypothetical illustration?
 23 DR. MACDONALD:
 24 A. As long as you're able to drill down far
 25 enough to know that you've cancelled different

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1 pieces out. As you said, if you're just
 2 looking at the big picture, and noting here's
 3 the percent of positives, for example, without
 4 understanding some of the underlying
 5 assumption that are brought together for that,
 6 yes, you would certainly need to -
 7 MS. NEWBURY:
 8 Q. So you would have to be cognizant of the fact
 9 that you may not have a full picture if you
 10 just look at the overall positivity rate?
 11 DR. MACDONALD:
 12 A. Exactly, and that's just from a statistical
 13 side of things, the math piece.
 14 DR. ALAGHEHBANDAN:
 15 A. And to be able to calculate false negative and
 16 false positive, one would need to have a gold
 17 standard because what you just explained is a
 18 two by two table calculating sensitivity and
 19 specificity in the epidemiology world, so
 20 having the results from St. John's lab is one
 21 side of it, but we need gold standard--that
 22 means those had to be retested or had to be
 23 looked at by gold standard. I don't know what
 24 gold standard definition would be in this
 25 case, but once we had that, we can make a

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1 conclusion whether positivity rate and false
 2 negative and false positive basically are in
 3 the same line or not.
 4 MS. NEWBURY:
 5 Q. Okay. Another gauge, I think, that might be
 6 used by health care providers in terms of
 7 tracking the progress of quality in their work
 8 might be to look at error rates or, I guess,
 9 false test rates more generally, and--as
 10 opposed to the positivity rate, might be
 11 looking at, well, what are the outcomes, but
 12 if you have a reason to test either an ad hoc
 13 or part of a regular monitoring program to
 14 retest results randomly, for example, and then
 15 look at what are the numbers of the results
 16 that stay the same and what are the number of
 17 results that change, if one were to look at
 18 the expected, we'll call it error rate, I
 19 guess, for lack of a better word, I assume
 20 would there have to be a statistical analysis
 21 of that, would you have to get a large enough
 22 number to be able to say, well, that this
 23 actually tells us something about the part of
 24 the group that we haven't retested?
 25 DR. MACDONALD:

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1 A. There's clinical significance and statistical
 2 significance.
 3 MS. NEWBURY:
 4 Q. Uh-hm.
 5 DR. MACDONALD:
 6 A. Statistical significance basically means the
 7 difference did result as a result of chance.
 8 So it's a true difference within, as I said
 9 earlier, the example that the public is more
 10 familiar with, 19 times out of 20, plus or
 11 minus 3 percent. So they're never 100 percent
 12 sure of anything, but given the range, this is
 13 99 times out of 100 it will fall within that
 14 range; one time out of 100, it will not.
 15 That's statistical. Clinical really doesn't
 16 use statistical significance. Clinical is
 17 more into patient care, so it's--I think maybe
 18 on the clinical side they can use statistics
 19 as just a guide, but ultimately at the end of
 20 the day it will be the clinical decision.
 21 MS. NEWBURY:
 22 Q. Right, so they don't have to necessarily get
 23 down to the crunching of numbers in order to
 24 glean some information from the retesting?
 25 DR. MACDONALD:

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1 A. I think where statistics or epidemiology or
 2 performance monitoring, or whatever we want to
 3 call it that play a role, is more at a
 4 population level.
 5 MS. NEWBURY:
 6 Q. Okay, and just perhaps to clarify some
 7 terminology that might be used in this
 8 circumstance, if you have--if you want to look
 9 at or calculate what your rate of false
 10 positives is, for example, what would the
 11 numerator and denominator be for that
 12 particular rate?
 13 DR. ALAGHEHBANDAN:
 14 A. False positive. So basically we would have
 15 all the positive retested, and then the
 16 denominator would be the total number of
 17 positives, and then we would have the results
 18 of retest based on those.
 19 MS. NEWBURY:
 20 Q. Okay. So the--would you limit it to the
 21 number of the positive tests that were
 22 retested?
 23 DR. ALAGHEHBANDAN:
 24 A. So we're talking here about false positive
 25 rate?

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1 MS. NEWBURY:
 2 Q. Yeah, upon retesting.
 3 DR. ALAGHEHBANDAN:
 4 A. Upon retesting. So we have a population of
 5 those patients who were tested originally as
 6 positive.
 7 MS. NEWBURY:
 8 Q. Uh-hm.
 9 DR. ALAGHEHBANDAN:
 10 A. You would send them to gold standard centre,
 11 whatever the case might be.
 12 MS. NEWBURY:
 13 Q. Uh-hm.
 14 DR. ALAGHEHBANDAN:
 15 A. And then we would receive results back. So
 16 out of those, let's say, 100 original
 17 positive, we came to know 95 of them are
 18 really positive and five are not, so my
 19 numerator would be five, and the denominator
 20 would be the total number of -
 21 MS. NEWBURY:
 22 Q. The positives back from retesting?
 23 DR. ALAGHEHBANDAN:
 24 A. Exactly. So you would have your false
 25 positive in this case.

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1 MS. NEWBURY:
 2 Q. Would you ever include in the denominator any
 3 of the positive results that were not
 4 retested?
 5 DR. ALAGHEHBANDAN:
 6 A. No, you have to include the denominator as
 7 total population of positives.
 8 MS. NEWBURY:
 9 Q. Of the positives retested?
 10 DR. ALAGHEHBANDAN:
 11 A. All positives retested.
 12 DR. MACDONALD:
 13 A. All of them would have to be tested to be part
 14 of the false positive calculation.
 15 MS. NEWBURY:
 16 Q. Right, great.
 17 DR. MACDONALD:
 18 A. You can't (phonetic) infer that back.
 19 MS. NEWBURY:
 20 Q. Okay, thank you very much.
 21 DR. ALAGHEHBANDAN:
 22 A. You're welcome.
 23 THE COMMISSIONER:
 24 Q. Thank you. Mr. Crosbie, do you have any
 25 questions of these witnesses?

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1 CROSBIE, Q.C.:
 2 Q. I do, thank you.
 3 DR. MACDONALD & DR. ALAGHEHBANDAN - EXAMINATION BY
 4 CHESLEY CROSBIE, Q.C.:
 5 CROSBIE, Q.C.:
 6 Q. Good morning, gentlemen.
 7 DR. ALAGHEHBANDAN:
 8 A. Good morning.
 9 DR. MACDONALD:
 10 A. Good morning.
 11 CROSBIE, Q.C.:
 12 Q. Ches Crosbie. I represent the members of the
 13 breast cancer testing class action. I'd like
 14 to start by asking where you obtained the term
 15 "technical positive" which as far as I'm aware
 16 is not in the medical literature?
 17 DR. ALAGHEHBANDAN:
 18 A. I learned that term, the initial--the early
 19 days, actually, back in summer of '07 when I
 20 started working with lab staff, and the term
 21 "technical positive" was used at the time, so
 22 I came to be familiar with that at the time.
 23 CROSBIE, Q.C.:
 24 Q. Did this come from Mr. Gulliver?
 25 DR. ALAGHEHBANDAN:

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1 A. I believe so.
 2 CROSBIE, Q.C.:
 3 Q. Where does the literature, or does literature
 4 say that you add in the ER positives to get
 5 the positivity rate as a lab matric?
 6 DR. ALAGHEHBANDAN:
 7 A. I did not study literature for that. The
 8 question regarding positivity--basically, your
 9 question is an epidemiology question.
 10 CROSBIE, Q.C.:
 11 Q. I'm sorry, did you say you did or did not?
 12 DR. ALAGHEHBANDAN:
 13 A. I did not study literature for that matter.
 14 My responsibility was to create a database.
 15 CROSBIE, Q.C.:
 16 Q. So you can't say whether that's the standard
 17 practice in labs?
 18 DR. ALAGHEHBANDAN:
 19 A. That would be a question for expert in that
 20 area.
 21 CROSBIE, Q.C.:
 22 Q. I understand. Again this may be beyond your
 23 ability to comment or take a position, but can
 24 you say whether you add in the clinically
 25 negative ERs with the clinically positive ERs

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1 to get a positivity rate as a lab matric?
 2 DR. ALAGHEHBANDAN:
 3 A. We did not calculate positivity rate. The
 4 positivity rate, I believe, was calculated at
 5 the lab. So given the fact that -
 6 CROSBIE, Q.C.:
 7 Q. By following -
 8 DR. ALAGHEHBANDAN:
 9 A. That we -
 10 CROSBIE, Q.C.:
 11 Q. By following what method, the method I just
 12 described?
 13 DR. ALAGHEHBANDAN:
 14 A. That's a question for Mr. Gulliver.
 15 CROSBIE, Q.C.:
 16 Q. Very good. Perhaps we could go to Document
 17 3505, page six, Registrar. Somewhere along
 18 the way I believe I picked up a statistic from
 19 your evidence that the ER negative/PR
 20 positivity was 8.2 percent. I'm not sure for
 21 what period you were looking at?
 22 DR. ALAGHEHBANDAN:
 23 A. Could you -
 24 CROSBIE, Q.C.:
 25 Q. Is that the period of the Ventana machine

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1 before testing was ceased?
 2 DR. ALAGHEHBANDAN:
 3 A. I need to see the table perhaps to be able to
 4 see what the -
 5 THE COMMISSIONER:
 6 Q. You have a mouse there if you want to control
 7 -
 8 DR. ALAGHEHBANDAN:
 9 A. Sure. This is a 19 page document, so I don't
 10 know which page you're referring to.
 11 CROSBIE, Q.C.:
 12 Q. I'm not sure now either. I got this note,
 13 8.2. I think that might be the period of the
 14 Ventana machine.
 15 DR. ALAGHEHBANDAN:
 16 A. I can't comment unless I see the table or the
 17 text.
 18 THE COMMISSIONER:
 19 Q. We'll do a search for 8.2. Is this the one?
 20 DR. ALAGHEHBANDAN:
 21 A. So it says from 1997 to 2005. That's the title
 22 of the table if you're referring to this 8.2
 23 for ER negative/PR positive.
 24 CROSBIE, Q.C.:
 25 Q. So that's--includes the DAKO machine period

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

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

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

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1 example?
 2 DR. MACDONALD:
 3 A. No, and it doesn't say in this document either
 4 what the consensus is. What you're doing is
 5 you're quoting one paper. So it's--we didn't
 6 author the paper, and there's only one author
 7 that's stating that number. So to compare
 8 that number to your number may not be
 9 appropriate, and it's probably a question for
 10 the team of Robert Thompson, who did the lit
 11 review, who to my understanding there is a
 12 dearth of information in this area.
 13 CROSBIE, Q.C.:
 14 Q. Well, Rhodes is not an insignificant author,
 15 but all the same, we've got these two numbers
 16 here. Three percent is suggested by one
 17 important author, and there's a statistic of
 18 8.2 which is almost three times as high, and
 19 it simply raises the question, perhaps you'll
 20 agree, but you can't resolve it, as to whether
 21 this suggests that there's an abnormally high
 22 number of ER--sorry, PR positives in our
 23 results.
 24 THE COMMISSIONER:
 25 Q. Excuse me, Mr. Crosbie. Ms. Brazil?

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

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1 supplementary question by Mr. Crosbie, and he
 2 can correct me if I'm incorrect in this, is
 3 that he is looking for whether or not there
 4 are--taking the basic data, whether or not
 5 there are reasons why one cannot draw the
 6 obvious conclusion from the difference in the
 7 numbers, and these gentlemen may be able to
 8 say that you should not do because of these
 9 reasons, or we're not in a position to tell
 10 you whether you can draw that conclusion or
 11 not.
 12 BRAZIL, Q.C.:
 13 Q. (Inaudible).
 14 THE COMMISSIONER:
 15 Q. Am I wrong, Mr. Crosbie? Is that what you
 16 were looking for?
 17 CROSBIE, Q.C.:
 18 Q. Yes.
 19 THE COMMISSIONER:
 20 Q. Do you have an objection to that particular
 21 line?
 22 BRAZIL, Q.C.:
 23 Q. Well, only--I'm going to sit down because I'm
 24 not sure that I understand the question, so
 25 perhaps I'll sit down and think about it -

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

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1 DR. MACDONALD:
 2 A. I don't.
 3 DR. ALAGHEHBANDAN:
 4 A. Are you referring to NCTRF organization?
 5 THE COMMISSIONER:
 6 Q. The -
 7 DR. ALAGHEHBANDAN:
 8 A. Cancer Registry, Cancer Care?
 9 CROSBIE, Q.C.:
 10 Q. The registry.
 11 THE COMMISSIONER:
 12 Q. Cancer, yes.
 13 DR. ALAGHEHBANDAN:
 14 A. I don't know. That's a question for Cancer
 15 Registry officials.
 16 THE COMMISSIONER:
 17 Q. Do you know who at that organization could
 18 probably answer that question?
 19 DR. ALAGHEHBANDAN:
 20 A. I believe Mrs. Smith.
 21 DR. MACDONALD:
 22 A. Well, Sharon Smith heads up--we deal with
 23 Susan Ryan, who is in charge of the databases
 24 on an ongoing basis.
 25 THE COMMISSIONER:

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1 Q. All right, thank you.
 2 CROSBIE, Q.C.:
 3 Q. This may be for Mr. Thompson to tell us, but I
 4 was going to ask you when you might expect to
 5 wind up your inquiries? Who will you be
 6 reporting to? And how will the results be
 7 made public? I guess I'm assuming they will
 8 be made public.
 9 DR. ALAGHEHBANDAN:
 10 A. Don.
 11 DR. MACDONALD:
 12 A. We haven't--we have to have further
 13 discussions on that. The Task Force will be
 14 winding down. Then there is the custodianship
 15 of the data and the ongoing work that we
 16 intend--we expect to do with Eastern Health.
 17 So we certainly have to resolve some of those
 18 questions. We are aware of them, but with
 19 respect to public reporting, I suspect that
 20 will come from the Ministry.
 21 THE COMMISSIONER:
 22 Q. I think the answer is ask your question of Mr.
 23 Thompson.
 24 CROSBIE, Q.C.:
 25 Q. Yes, he may be the best person to ask. Thank

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1 you very much.
 2 THE COMMISSIONER:
 3 Q. Mr. Pritchard, are you up or is it Ms. Brazil?
 4 MR. PRITCHARD:
 5 Q. No, I'm going to ask some questions.
 6 DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,
 7 EXAMINATION BY MR. ROLF PRITCHARD
 8 MR. PRITCHARD:
 9 Q. Gentlemen, just a few questions. Yesterday
 10 when you were commenting on the database, you
 11 made the observation that there were no
 12 epidemiologists involved in developing the
 13 database because it wasn't an epidemiological
 14 issue. It was, I think you said, a
 15 mathematics issue. Is that a fair summary?
 16 DR. MACDONALD:
 17 A. Well, the report, the Task Force, there was a
 18 mathematical exercise because basically just a
 19 table of numbers, percentages and averages.
 20 There were epidemiologists involved in
 21 creating the database and in particular, Tracy
 22 Chislett, who worked with Reza. Reza was the
 23 lead for the project. I think what I meant to
 24 say was, which has become clear this morning,
 25 we don't have any expertise around the

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

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1 as part and parcel of that discussion, part of
 2 what came out was that there was a decision
 3 made to focus on the negatives, as opposed to
 4 the positives, and you described one of the
 5 issues being a time constraint issue, as part
 6 of the reason why you focused on the
 7 negatives, and I just want to go to the first
 8 page here, and I note here, just to draw us
 9 back to something you've commented on a few
 10 times, which was the purpose, I guess, for the
 11 database, and that is summarized in the
 12 paragraph that we see here on the screen.
 13 It says that "the database would focus on
 14 when and how patients were contacted to inform
 15 them of retesting, as well as when and how
 16 patients were informed of the subsequent test
 17 results." So that would specifically be
 18 people with negative results, or at least
 19 negative as they were understood at the time.
 20 Is that correct?
 21 DR. MACDONALD:
 22 A. That was the intent, yes.
 23 MR. PRITCHARD:
 24 Q. So in terms of that specific purpose, as it's
 25 described in the scoping document, the data on

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1 positive results would actually be irrelevant?
 2 Is that a fair statement?
 3 DR. MACDONALD:
 4 A. At that point, yes.
 5 MR. PRITCHARD:
 6 Q. Okay, and another document that you were shown
 7 this morning by Mr. Coffey was P-2152. Okay,
 8 and this morning we had an opportunity--we
 9 ended off the day actually, I think, with this
 10 document and we started with it this morning,
 11 and we were given to understand this was a
 12 printout or reading from the DAKO machine, and
 13 I think in your evidence yesterday, you were
 14 asked if you had seen a document like this
 15 before, and your answer was no.
 16 DR. ALAGHEHBANDAN:
 17 A. No.
 18 MR. PRITCHARD:
 19 Q. And so I gather from the evidence, as it was
 20 presented this morning, and I want to be clear
 21 on this point, you were not given this type of
 22 documentation to use?
 23 DR. ALAGHEHBANDAN:
 24 A. I was not.
 25 MR. PRITCHARD:

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1 Q. It wasn't available to you. You weren't aware
 2 of it?
 3 DR. ALAGHEHBANDAN:
 4 A. I wasn't.
 5 MR. PRITCHARD:
 6 Q. Okay. I'd like now to go to P-0128, page 61,
 7 please? This is part of a news release that
 8 was issued on, I believe, February 22nd. I'll
 9 just scroll up to show the date. And Mr.
 10 MacDonald, you were commenting this morning,
 11 you were asked about some of the things that
 12 you thought should perhaps occur and you
 13 commented on some provincial initiatives. As
 14 you'll see here, this one is dated February
 15 22nd, this news release. You commented on the
 16 need for an IM person to be present and I
 17 think you said you thought there had been an
 18 announcement that one was being provided for
 19 each region. I just want to take you to a
 20 point in the announcement and ask if perhaps
 21 this is what you're talking about.
 22 All right, so here it allocates--there's
 23 some funding allocated and the second and
 24 third item down, it says "number two, 500,000
 25 will be allocated for all regional health

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1 authorities to conduct information management
 2 capacity assessment," and then the last one,
 3 "270,000 will be allocated for new data
 4 management personnel." Are those the
 5 initiatives that you were talking about this
 6 morning?
 7 DR. MACDONALD:
 8 A. Yes, it is.
 9 MR. PRITCHARD:
 10 Q. Lastly, gentlemen, and you had some occasion
 11 already to do this this morning, but I wanted
 12 to invite you, if you were so inclined, if
 13 there's any further statement that you would
 14 like to make about your views on what's
 15 transpired?
 16 DR. MACDONALD:
 17 A. No, I've already commented on, I think, very--
 18 several times about the issues around database
 19 management and the capacity, the required
 20 capacity.
 21 MR. PRITCHARD:
 22 Q. And Dr. Reza, anything that you'd like to add?
 23 DR. ALAGHEHBANDAN:
 24 A. I just want to take a few minutes. Over the
 25 last couple of days, today, yesterday, we

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1 talked about data, databases, data sources,
 2 sources, etcetera, and but now I would like to
 3 take this opportunity to share with you the
 4 other side of the issue, the other side of the
 5 story, from our perspective.
 6 Over the last year and a half, we have
 7 been reviewing pathology reports, hundreds and
 8 hundreds, probably on a weekly basis, daily
 9 basis. They were not only pathology reports
 10 to us. They were patients' lives' stories,
 11 husband and wife stories, sisters and mothers,
 12 and throughout that exercise, with each report
 13 that I read or my colleague or other people at
 14 the Department, we felt the pain, the agony,
 15 the distress that the cancer diagnosis would
 16 have caused for the families and patients and
 17 friends. It wasn't just simply entering some
 18 dry numbers into electronic software in a PC.
 19 It was just more than that, and I must say
 20 that the database that we developed, the
 21 reports and the analysis may not share with
 22 you this side of the story, which is the human
 23 side of it.
 24 Also, I would like to say a few words
 25 with regard to my work with regions. I'd like

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1 to thank Eastern Health, specifically staff at
 2 the lab, staff at quality risk management
 3 department, Western, Central, Lab Grenfell,
 4 the Government, office of Task Force,
 5 Department of Health and Community Services,
 6 and I would like to thank you, Madam Justice,
 7 for giving us the opportunity to present to
 8 you the evidence and what we observed over the
 9 last year and a half, and as a proud
 10 Newfoundlander and as a proud Canadian, my
 11 sincere hope is that whatever we learn, the
 12 lessons learned from our exercise, other
 13 people's involvement, your Inquiry, improve
 14 health care system for the better good and
 15 hopefully and ultimately for our patients, for
 16 our people in the province. Thank you.
 17 MR. PRITCHARD:
 18 Q. Thank you. Mr. Coffey may have a few more
 19 questions for you. Thank you.
 20 THE COMMISSIONER:
 21 Q. Mr. Coffey, do you have anything arising?
 22 DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,
 23 EXAMINATION BY BERNARD COFFEY, Q.C.
 24 COFFEY, Q.C.:
 25 Q. Yes, actually, just to confirm something,

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1 Commissioner. You'll recall, gentlemen,
 2 yesterday I did mention, we did discuss the
 3 request that Ms. Jones had made some time ago
 4 about Dr. Mullen's slide examination data, and
 5 in fact, Dr. Reza, you had indicated that a
 6 similar request had subsequently been received
 7 from the Commission, and you'd explained the
 8 technical difficulties, and I'm just going to
 9 have it confirmed that this morning, before we
 10 started, you indicated that an attempt will be
 11 made to, as much as is possible, have those
 12 technical difficulties addressed in short
 13 term, and that what can or cannot be
 14 addressed, if some of them can't be addressed,
 15 then with the proviso that bearing in mind
 16 whatever those technical difficulties and the
 17 effect that might have on the results, that
 18 sometime before we clue up here, the end of
 19 next week, that what is available will be
 20 provided to the Commission?
 21 DR. ALAGHEHBANDAN:
 22 A. That's correct, sir.
 23 COFFEY, Q.C.:
 24 Q. Okay. Thank you very much, Commissioner.
 25 Thank you very much, gentlemen.

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1 DR. ALAGHEHBANDAN:
 2 A. Thank you.
 3 DR. REZA ALAGHEHBANDAN AND DR. DONALD MACDONALD,
 4 EXAMINATION BY MADAM COMMISSIONER
 5 THE COMMISSIONER:
 6 Q. Thank you. There's just a couple of points.
 7 I think probably you, Dr. MacDonald, is the
 8 person to answer this and I just want to make
 9 sure that I'm clear. This is a clarity kind
 10 of thing for me, because during the course of
 11 your evidence, you referred to a number of
 12 initiatives which are either ongoing at
 13 present or will be within the short term, in
 14 terms of information relating to health care.
 15 Some on a more narrow level. It seems to me
 16 the one that, in respect of comprehensive
 17 electronic health records, will be a massive
 18 undertaking. But first, I just wanted to ask
 19 you about the proposal regarding lab
 20 information systems.
 21 DR. MACDONALD:
 22 A. Yes.
 23 THE COMMISSIONER:
 24 Q. Do I take it from what you said that the
 25 premise of the proposal is a move to

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1 standardization? Is that the--standard of a--
 2 standardization, which I suppose is part of
 3 ease of access to records and the ability to
 4 access records. Is that the idea?
 5 DR. MACDONALD:
 6 A. It's certainly a piece of it.
 7 THE COMMISSIONER:
 8 Q. Okay. But it's more than that?
 9 DR. MACDONALD:
 10 A. Yes.
 11 THE COMMISSIONER:
 12 Q. Okay.
 13 DR. MACDONALD:
 14 A. Certainly, if--we have several lab information
 15 systems now in the province basically that
 16 were implemented based on the old board
 17 structure, the old health board structure, the
 18 eight boards. What the province now is moving
 19 towards is a provincial, one provincial lab
 20 information system. So everyone will use the
 21 same standards. The technology will allow
 22 health professionals to access lab results 24
 23 hours a day, seven days a week, from multiple
 24 sites. So it is more enhancing the current
 25 system, the current infrastructure, to build

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1 on that but to make it one comprehensive lab
 2 for the whole province, lab information system
 3 for the whole province, and standards is a big
 4 piece of that, because obviously with the
 5 disparate lab systems now that exist, they do
 6 things differently.
 7 THE COMMISSIONER:
 8 Q. Um-hm.
 9 DR. MACDONALD:
 10 A. And so the standards piece is going to be the
 11 data dictionaries, for example. Everyone has
 12 to say ER/PR across the province from now on.
 13 There's no other deviations from that.
 14 THE COMMISSIONER:
 15 Q. That seems to me like a rather large project.
 16 DR. MACDONALD:
 17 A. It is part of the larger electronic health
 18 record initiative in the province.
 19 THE COMMISSIONER:
 20 Q. Okay, all right. That was my next question.
 21 Are all of these little tentacles going to
 22 really merge in this new comprehensive health
 23 records?
 24 DR. MACDONALD:
 25 A. Yes, it is.

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1 THE COMMISSIONER:
 2 Q. And does this mean that Meditech will be no
 3 more or will Meditech somehow flow into this
 4 as well?
 5 DR. MACDONALD:
 6 A. Meditech is a hospital information system.
 7 THE COMMISSIONER:
 8 Q. Um-hm.
 9 DR. MACDONALD:
 10 A. Obviously the electronic health record extends
 11 to the community. I mentioned the pharmacy
 12 network service.
 13 THE COMMISSIONER:
 14 Q. Yes.
 15 DR. MACDONALD:
 16 A. So the hospital information system is intended
 17 to, at some level, be part of the bigger
 18 electronic health record. So for example, I
 19 think it was mentioned in some testimony the
 20 massive amounts of data that's collected in a
 21 hospital and Meditech only actually captures
 22 what we would call an abstract of that.
 23 THE COMMISSIONER:
 24 Q. Um-hm.
 25 DR. MACDONALD:

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1 A. Of the full information that's in the patient
 2 chart, so a summary of that would be included
 3 in Meditech, and we have discharge summaries,
 4 for example. So when a patient is released
 5 from hospital, a discharge summary is created.
 6 That's probably going to be part of the
 7 electronic health record. When a patient
 8 presents at emergency rooms, which is part of
 9 our hospitals, an emergency room summary is
 10 provided. That's probably going to be part of
 11 the electronic--hopefully part of the
 12 electronic health record. So not all of what
 13 occurs in the hospital. You'll be able to get
 14 some of that summary information. The lab is
 15 going to be a separate piece. You're going to
 16 be able to have the lab piece.
 17 THE COMMISSIONER:
 18 Q. Okay. So it doesn't matter which emergency
 19 room in this province I walk into, if I've had
 20 lab work done anywhere in the province, they
 21 will be able to access that?
 22 DR. MACDONALD:
 23 A. And that's because we have a client registry
 24 in this province which actually identifies
 25 every patient in this--every resident in this

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1 province, so not only for lab, but for
 2 pharmacy, and for our radiology, anywhere in
 3 the province 24 hours a day, seven days a
 4 week.
 5 THE COMMISSIONER:
 6 Q. Okay. Now tell me whether or not these
 7 planned systems are of any value in planning
 8 for health care.
 9 DR. MACDONALD:
 10 A. Oh certainly. I mean, this is the--as I gave
 11 the example of Maple Leaf Foods, for example,
 12 where they can actually shut down operation,
 13 we don't have that luxury in the health
 14 system, so obviously we have to introduce
 15 these systems, first for quality of care. But
 16 we also have to start planning obviously for
 17 other uses of this data for planning for many
 18 purposes, for specialists, for example, the
 19 need for specialists in certain areas. You
 20 can use this data for identifying that.
 21 There's a lot of human resource areas that we
 22 could look at, because information systems
 23 also say how many physicians we have in the
 24 province. So these information systems for
 25 secondary purposes are critical for planning.

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1 THE COMMISSIONER:
 2 Q. Okay. In respect of St. John's, I was, I
 3 think, surprised about what I would conclude
 4 is the unsophisticated nature of the data
 5 management in the organization, and I think
 6 because it's a--it has that university right
 7 next to it, I had expected that you would have
 8 a somewhat sophisticated keeping of raw data
 9 which might be able to be used for the purpose
 10 of medical research, for example, and that
 11 somebody would have thought about, "okay, what
 12 kinds of research are we doing in this
 13 province? What's our particular interest?
 14 How do we get that raw material so as to
 15 enable the researchers to get involved to be
 16 able to tap in to that raw material?" Was
 17 that just naive on my part or is there a
 18 benefit or perhaps not a benefit to being
 19 associated with a medical school, in terms of
 20 data?
 21 DR. MACDONALD:
 22 A. Certainly as a teaching hospital, the Health
 23 Science Complex has that added piece to it.
 24 There actually are not many clinicians in our
 25 province that actually do research. I'm going

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1 to--I'll throw out a number here now. There's
 2 1,000 physicians in the province of
 3 Newfoundland and Labrador. I would suggest
 4 less than ten percent actually do research.
 5 Most of them, they only have time for patient
 6 care.
 7 We are looking at a larger initiative for
 8 the province. We're looking towards working
 9 with the Faculty of Medicine and creating a
 10 Newfoundland Labrador network for population
 11 health research, which will actually look at
 12 the database management activities at the
 13 Faculty of Medicine to better enhance those,
 14 based on the work of the Centre and expertise
 15 of the Centre, to look at how we can better do
 16 research in this province and support research
 17 activities, whether it be genetic research or
 18 clinical trials or applied health research,
 19 all the different levels of research. So that
 20 is actually happening in parallel, and perhaps
 21 as a catalyst because of the electronic health
 22 record. Because as I noted, our province will
 23 have an electronic health record perhaps by
 24 2011, a complete health record, electronic
 25 health record as defined by the various

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1 domains under it, and to take advantage of
 2 that, we have to be able to use this
 3 information for secondary purposes for
 4 research, because it's critical that we build
 5 up research capacity in this province so that
 6 we are, as you said, able to better plan for
 7 the future. So we are working towards working
 8 with the Faculty of Medicine in creating a new
 9 network and a new infrastructure to support
 10 research, given all the data that is around.
 11 THE COMMISSIONER:
 12 Q. Okay. Now look at this from the other
 13 perspective, putting on the sort of other kind
 14 of hat. Doesn't this raise incredible privacy
 15 issues?
 16 DR. MACDONALD:
 17 A. Yes, it does. That's a good point. The
 18 Centre for Health Information actually has a
 19 chief privacy officer and a lot of activity is
 20 focused on the electronic health record and
 21 issues of privacy and security,
 22 confidentiality. The Centre has been--was
 23 established in 1997 and one of the first
 24 things that we did was engage a stakeholder
 25 community to look at privacy guidelines, to

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1 introduce and adopt privacy guidelines and
 2 worked very closely with government around
 3 privacy legislation. So yes, it is very
 4 important that we ensure that as this data is
 5 used for other purposes, not only patient
 6 care, but for other purposes, that we protect
 7 the privacy of the individual. There has been
 8 significant work done in that area.
 9 THE COMMISSIONER:
 10 Q. Okay, thank you. It's been a very interesting
 11 day and a couple of hours. I thank you both
 12 very much for your contribution. I think we
 13 all recognize there's an incredible amount of
 14 work behind what you've been able to tell us
 15 about. Thank you very much.
 16 DR. ALAGHEHBANDAN:
 17 A. Thank you.
 18 DR. MACDONALD:
 19 A. Thank you.
 20 THE COMMISSIONER:
 21 Q. I suggest we take the morning break before we
 22 continue.
 23 (BREAK)
 24 THE COMMISSIONER:
 25 Q. Please be seated. Welcome back, Mr. Thompson.

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1 MR. ROBERT THOMPSON, RESUMES STAND, EXAMINATION BY
 2 BERNARD COFFEY, Q.C. (CONT'D)
 3 MR. THOMPSON:
 4 A. Thank you.
 5 THE COMMISSIONER:
 6 Q. Mr. Coffey?
 7 COFFEY, Q.C.:
 8 Q. Thank you, Commissioner. Commissioner, there
 9 are six new exhibits. They are P-3557, 3558,
 10 3645, 3646, 3647 and 3648.
 11 THE COMMISSIONER:
 12 Q. Entered.
 13 EXHIBITS ENTERED AND MARKED P-3557 AND P-3558
 14 EXHIBITS ENTERED AND MARKED P-3645 THROUGH P-3648
 15 COFFEY, Q.C.:
 16 Q. Thank you, Commissioner. Yes, Mr. Thompson,
 17 welcome back.
 18 MR. THOMPSON:
 19 A. Thank you.
 20 COFFEY, Q.C.:
 21 Q. I wanted to--and first of all, Commissioner, I
 22 did indicate yesterday that I was going to
 23 seek leave of yourself to question Mr.
 24 Thompson a little bit further, in terms of the
 25 events that have occurred since he was here, I

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1 believe on May 9th.
 2 THE COMMISSIONER:
 3 Q. Is there any objection related to that? No?
 4 PIKE, Q.C.:
 5 Q. I don't object.
 6 THE COMMISSIONER:
 7 Q. Thank you, Mr. Pike.
 8 COFFEY, Q.C.:
 9 Q. Mr. Thompson, and to put this in context for
 10 you, of course, the Commissioner has heard
 11 from a number of witnesses more recently about
 12 some of the events that have occurred since
 13 that time, Ms. Pilgrim, for example, and Mr.
 14 MacDonald and company.
 15 MR. THOMPSON:
 16 A. Right.
 17 COFFEY, Q.C.:
 18 Q. First of all, in terms of the--start where
 19 the--you were acting for, in your capacity
 20 dealing with the Cabinet and adverse health
 21 events in that report?
 22 MR. THOMPSON:
 23 A. Right.
 24 COFFEY, Q.C.:
 25 Q. Could you tell us, please, where you are with

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1 that?
 2 MR. THOMPSON:
 3 A. Okay, the Task Force on Adverse Events?
 4 COFFEY, Q.C.:
 5 Q. Yes, Task Force, yes.
 6 MR. THOMPSON:
 7 A. Okay. So just to distinguish.
 8 COFFEY, Q.C.:
 9 Q. Yes, I appreciate that.
 10 MR. THOMPSON:
 11 A. In that capacity, as chair of the Task Force
 12 and matters dealing with the Inquiry here, in
 13 my capacity as -
 14 COFFEY, Q.C.:
 15 Q. Yes, I appreciate that. It's two different
 16 things, and we'll come back to the Inquiry.
 17 MR. THOMPSON:
 18 A. That's fine, okay. So on the Task Force on
 19 Adverse Events, I think since the last time I
 20 was here, we've asked for and received an
 21 extension to our deadline for reporting, and
 22 we're substantially complete, are finalizing
 23 last minute consultations now. I expect we'll
 24 be in a position to submit the report to
 25 Government in November.

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1 COFFEY, Q.C.:

2 Q. In November of this year?

3 MR. THOMPSON:

4 A. Oh yes, indeed.

5 COFFEY, Q.C.:

6 Q. Okay, and in the report, in terms of, without

7 asking you for any, you know, actual findings,

8 because I appreciate it's still in draft form,

9 it will address what subject matters?

10 MR. THOMPSON:

11 A. Okay. Well, our mandate was to look at the

12 general category of adverse events, all the

13 way from single patient events to multi

14 patient, multi jurisdiction events and

15 determine whether our health system in this

16 province has the current capacity, the current

17 policies and resources to respond in a timely

18 and effective manner when events occur. So

19 we've completed a review of existing policies

20 and interviews and case studies and so forth,

21 and we're going to look at, in the report, all

22 the stages of adverse event management, from

23 the identification of an occurrence that may

24 be an adverse event, look at how it gets

25 assessed at that stage and how assessment

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1 tools are used, if a further investigation is

2 required into serious adverse events. We'll

3 be looking at disclosure processes and

4 disclosure policies. We'll also be looking at

5 the evaluation processes, monitoring of all of

6 those policies and systems, how they work, and

7 so all the steps and stages between

8 identification and the final implementation of

9 recommendations, including, I should add, the

10 whole area of coordination within RHAs when

11 there's a multi patient event, the whole area

12 of leadership and also public communications,

13 because sometimes, of course, public concern

14 may be engaged in regard to an adverse event

15 and an RHA may need to develop a public

16 communications plan. So we're trying to

17 capture the whole breadth and make

18 recommendations on the whole area.

19 COFFEY, Q.C.:

20 Q. Now when you were here last, and I take it

21 that in preparing to come back here for today,

22 you have had an opportunity to review the

23 transcript of what you and I spoke of before?

24 MR. THOMPSON:

25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. And I believe you had told the Commissioner

3 before that there--up to the point that you

4 testified before, that in terms of the

5 completeness of the identification of people

6 who should have been retested, that there had

7 been, I believe, one back in March or so, one

8 self-identifier as it were.

9 MR. THOMPSON:

10 A. Right.

11 COFFEY, Q.C.:

12 Q. And I believe, I understand from evidence

13 we've heard since you were last here, that

14 that has developed since.

15 MR. THOMPSON:

16 A. Um-hm.

17 COFFEY, Q.C.:

18 Q. Perhaps you could just, in an overview way,

19 take the Commissioner through, from your

20 perspective, how that has unfolded?

21 MR. THOMPSON:

22 A. Sure. Well, when I was here in May, it was

23 just subsequent to the second part of the

24 report on the database exercise, and that

25 second part were the results of the

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1 communications contacts, and in that report

2 that we provided to the Commission, it

3 identified that in March, yes, that one

4 additional patient had come to the attention

5 of Eastern Health through a self-

6 identification process and it raised the

7 issue, well, might there be others there or

8 are there any additional ways to do

9 alternative searches. So we, at that time,

10 asked NLCHI to do an examination of some

11 alternatives and then we recommended to

12 Eastern Health or strongly urged them to go

13 ahead and undertake one of those alternatives.

14 So we put it to Eastern Health, and I think

15 that was the point at which we were when I was

16 here in May.

17 I learned subsequently that they

18 evaluated the alternative search possibilities

19 and concluded that the likelihood of finding

20 additional patients was low and the resource

21 outlay would be high, and so they decided not

22 to pursue it at that time.

23 In the weeks after that, getting later

24 into May and early June, we started to hear

25 from Eastern Health, through NLCHI, that there

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1 might be additional patients that had been
 2 identified for which their tests had been sent
 3 again to Mount Sinai for retesting, but we
 4 didn't have any data and we had not been
 5 advised directly by Eastern Health about
 6 these, in May. We held a meeting in June and
 7 by that time, NLCHI had put in requests to
 8 Eastern Health to obtain data so they could go
 9 in the database, and we'd understand better
 10 the circumstances around these cases. But
 11 there were delays in getting that data. So
 12 around early June, we held a meeting with
 13 Eastern Health and with NLCHI to clarify whose
 14 responsibilities it would be with to supply
 15 this data and to put some attention to the
 16 matter.
 17 I guess by mid July, getting into our
 18 vacation period again, and when I arrived back
 19 from vacation in early August, it was evident
 20 then that the data still had not been
 21 supplied. So we started, through our office,
 22 to become more actively engaged in pulling in
 23 that data.
 24 COFFEY, Q.C.:
 25 Q. This is in respect of these 10 to 12 -

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1 MR. THOMPSON:
 2 A. Right, that's right. By then, we were of the-
 3 -well, we weren't certain of the number,
 4 because on one occasion, we were told it might
 5 be eight.
 6 COFFEY, Q.C.:
 7 Q. Yes.
 8 MR. THOMPSON:
 9 A. On another occasion, we were told it might be
 10 three. So the data was shifting around. But
 11 by early August, we said well, let's pull this
 12 together and get a very clear idea about what
 13 we have and it also started to become clear
 14 then that if--rather than just having one
 15 self-identifier, we had quite a number, and it
 16 meant that we had to go back and revisit the
 17 idea of whether an alternative search strategy
 18 is justified. So around mid August, NLCHI was
 19 able to get the data, and it turned out that
 20 we had ten. That number stabilized at ten,
 21 and we convened a conference call of the CEOs
 22 of the RHAS and put to them that we have a
 23 different situation than we had in the spring.
 24 We don't have one any longer, we have ten. So
 25 we should evaluate again and then undertake a

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1 new search strategy.
 2 The first step in the evaluation of how
 3 we should approach it was to ask NLCHI to do
 4 something, actually we hadn't asked them to do
 5 before, and that was to provide us with an
 6 assessment of the quality or the completeness
 7 of the original search strategies for patients
 8 that was undertaken in 2005, and any other
 9 searches since that time. When they--so they
 10 completed that during the--I guess they
 11 started in August and completed it in
 12 September, and they did that by interviewing
 13 the pathologists and other officials in the
 14 RHAS that did those searches.
 15 COFFEY, Q.C.:
 16 Q. That would be Dr. Reza?
 17 MR. THOMPSON:
 18 A. Correct, yes, that's right. And so when they
 19 completed that, we were able to--they were
 20 able to recommend or able to tell us which
 21 RHAS had done searches for which there really
 22 wasn't a practical way to do a better search,
 23 and which RHAS or which information systems
 24 where there still may be potential, even if
 25 quite small, but nonetheless potential for

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1 reviewing it again, just to build confidence
 2 that no one had been missed. So that takes us
 3 right up to last week actually, because last
 4 week, or maybe it was the week before, we
 5 communicated to--it was last week.
 6 COFFEY, Q.C.:
 7 Q. That was last week, yes.
 8 MR. THOMPSON:
 9 A. Yes, it was. We communicated to the CEOs of
 10 the regional health authorities what we'd like
 11 them to do, each of them to do, in terms of
 12 this further search strategy, and I now
 13 understand that all of them are ready to go.
 14 That Eastern Health, in particular, has
 15 engaged the Centre for Health Information to
 16 work with them, because they have the most
 17 extensive amount of work to do, and whether or
 18 not we actually find any more is uncertain, of
 19 course, whether there are any additional
 20 patients out there. I suppose the likelihood
 21 is low, but our uncertainty is high because of
 22 the ten that were found earlier this year. So
 23 at least we'll have this additional search
 24 strategy completed and our confidence will be
 25 higher.

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1 THE COMMISSIONER:
 2 Q. Do I take it from your comments that this is
 3 unnecessary in all of the regions or -
 4 MR. THOMPSON:
 5 A. There's something in each region, but it's not
 6 the same in each region.
 7 THE COMMISSIONER:
 8 Q. Okay.
 9 MR. THOMPSON:
 10 A. So would you like me to get into any of the
 11 particulars?
 12 COFFEY, Q.C.:
 13 Q. I'm going to take him through those.
 14 THE COMMISSIONER:
 15 Q. Okay.
 16 COFFEY, Q.C.:
 17 Q. Direct to the particular aspects.
 18 MR. THOMPSON:
 19 A. Great, okay.
 20 THE COMMISSIONER:
 21 Q. In each region, okay.
 22 COFFEY, Q.C.:
 23 Q. Yes, in each region. But in terms of an
 24 overview kind of, that's what I was asking
 25 about, a general overview as to what's

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1 happened since.
 2 MR. THOMPSON:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. In the meantime, in terms of a general
 6 overview, and you just referred to, for
 7 example, in April of 2008, there had been a
 8 report provided to the Commission from your
 9 Task Force concerning the communications
 10 aspects and there had been one we've seen
 11 referred to before in March of 2008 about the
 12 patient retest results and the database
 13 itself, without the communication piece in it,
 14 or analyzed. I'm just going to ask, please,
 15 that Exhibit P-3564 be brought up? And this
 16 is a letter of April 20--I'm sorry, August
 17 22nd, 2008, from--well, it's signed by Ms.
 18 Brazil from--prepared for Mr. Pritchard's
 19 signature but signed by Ms. Brazil, addressed
 20 to Commission co-counsel, and in particular,
 21 and the Commissioner has seen this before, but
 22 in particular, there's a reference to report
 23 having been provided to the Commission, March
 24 18th, 2008 report. I believe, in fact, that
 25 should be--properly be March 11th, but with

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

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

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1 Q. Could you tell the Commissioner then about
 2 that? I mean, you've told us about--when you
 3 were here last about what the state of affairs
 4 was March/April when you were in May, but how
 5 has it evolved since?
 6 MR. THOMPSON:
 7 A. Okay.
 8 COFFEY, Q.C.:
 9 Q. And resulting in this.
 10 MR. THOMPSON:
 11 A. Okay. This is unrelated to the search
 12 strategy.
 13 COFFEY, Q.C.:
 14 Q. I appreciate that.
 15 MR. THOMPSON:
 16 A. Okay.
 17 COFFEY, Q.C.:
 18 Q. This is another topic entirely.
 19 MR. THOMPSON:
 20 A. Okay.
 21 COFFEY, Q.C.:
 22 Q. And we're going to go back then through
 23 particular exhibits relating to the search
 24 strategy.
 25 MR. THOMPSON:

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

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1 Commissioner that "look, this was Mr.
 2 Thompson's people's work, but occasionally
 3 from time to time, NLCHI were asked to provide
 4 certain tables, and we did it."
 5 MR. THOMPSON:
 6 A. Oh absolutely.
 7 COFFEY, Q.C.:
 8 Q. And to review, in fact, the text.
 9 MR. THOMPSON:
 10 A. Correct.
 11 COFFEY, Q.C.:
 12 Q. For their input. I take it then there were
 13 certain things that, from your perspective, in
 14 terms of this would be the adverse health
 15 events task -
 16 MR. THOMPSON:
 17 A. No. Okay, it's so it's worthwhile to clarify
 18 that.
 19 COFFEY, Q.C.:
 20 Q. Yes. So why were you looking for
 21 interpretations and analysis, I suppose.
 22 MR. THOMPSON:
 23 A. Okay, that's a good point. This work started
 24 because we had the database, okay, and the
 25 database, you'll recall, was undertaken

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1 initially to answer the question was everyone
 2 contacted, and that was a question that
 3 originated when I was acting deputy minister,
 4 and we were--the House of Assembly was open
 5 and there were a lot of questions arising
 6 around that issue. So one thing led to
 7 another and so the sequence would be that we
 8 identified the need for the database to answer
 9 that core question and to answer that core
 10 question, we also said well, we need to answer
 11 such questions as "is the 939 number of total
 12 patients, is that a correct number?" So let's
 13 map into this database all of the activity
 14 that Eastern Health engaged in that's sensible
 15 around those questions. So when we did that,
 16 we started to have a database that potentially
 17 could answer some additional questions.
 18 Now, my mandate in relation to helping
 19 Government provide full and open disclosure to
 20 the Inquiry, I felt encompassed or put an onus
 21 on me to understand as well as I could the
 22 issues involved in the terms of reference,
 23 what actually happened at Eastern Health, to
 24 the best of my knowledge. So as we developed
 25 the database, you know, interesting questions

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

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

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1 out for purposes of the draft final report.
 2 COFFEY, Q.C.:
 3 Q. And in that context, for example, Mr.
 4 Thompson, because we understand that the NLCHI
 5 database does not record any of the--almost
 6 none, comparatively speaking, of the original
 7 PR results, positive, the original positive PR
 8 results, ER/PR results. I'll rephrase that.
 9 MR. THOMPSON:
 10 A. Okay.
 11 COFFEY, Q.C.:
 12 Q. The NLCHI database, we understand, does not
 13 record, in any systematic way at all, those
 14 patients whose original ER and/or PR results
 15 were positive?
 16 MR. THOMPSON:
 17 A. It doesn't include any results for patients
 18 who are not retested, and the main criterion
 19 for retesting was to have been designated ER
 20 negative.
 21 COFFEY, Q.C.:
 22 Q. And the point being that there would be
 23 upwards, I understand, probably upwards of
 24 2,000?
 25 MR. THOMPSON:

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1 A. Correct.
 2 COFFEY, Q.C.:
 3 Q. Who had an ER/PR -
 4 MR. THOMPSON:
 5 A. Of course, that was--we defined the project in
 6 that manner for very specific reasons, but
 7 you're right, exactly.
 8 COFFEY, Q.C.:
 9 Q. And in terms then of kind of drawing
 10 conclusions, for example, and your hesitation
 11 about drawing conclusions, which is elaborated
 12 upon, articulated here in this letter -
 13 MR. THOMPSON:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. - is that at all related to the fact that in
 17 terms of an analytic study, that a lot of the
 18 original patients are just not included, in
 19 terms of ER/PR?
 20 MR. THOMPSON:
 21 A. In part, but not in whole. That isn't the
 22 main factor. So just to make a point about
 23 the absence of positive patients in the
 24 database, that's a limitation if one wants to
 25 assess the whole population of ER/PR tested

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1 patients. No question. That wasn't our
 2 objective. So their absence in the database
 3 was not a limitation for the objective that we
 4 had.
 5 Now one though can still calculate a
 6 positivity rate for--even with, even having
 7 only all of the negative patients, if you have
 8 the denominator which is simply the total
 9 number of tests that were done, because that
 10 becomes your denominator for calculating a
 11 positivity rate. You don't have to have
 12 retest data on all of the positive patients in
 13 order to know how many tests were done. But
 14 to be fair, to know with confidence that you
 15 have the true denominator, one should go
 16 through all of the effort necessary to ensure
 17 that you have every case counted and we didn't
 18 do that, so we had a proxy denominator, which
 19 was the total number of tests that were
 20 recorded as having been done in the Meditech
 21 system at Eastern Health. So whether that was
 22 ten--you know, off by ten cases or off by 50
 23 cases, we don't know for sure. But it gave us
 24 a proxy to--so that's why in the drafts, you
 25 see some of that analysis. You see some

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1 positivity rates calculated with a denominator
 2 of the total number of tests. But yes, it's a
 3 limitation and it was on our mind that we
 4 didn't have as much confidence in the total
 5 number of ER/PR tests as we did in having the
 6 total number of negatives.
 7 COFFEY, Q.C.:
 8 Q. Now here, just looking at this, the last
 9 paragraph here on the page that's in front of
 10 us on the screen, it's written "therefore it
 11 would be difficult for us, without an expert
 12 perspective, to decide whether to present
 13 positivity or change on the basis of ER only
 14 or ER and PR."
 15 MR. THOMPSON:
 16 A. Right.
 17 COFFEY, Q.C.:
 18 Q. Now, I'm going to suggest to you that if you
 19 look back at those original tables -
 20 MR. THOMPSON:
 21 A. Um-hm.
 22 COFFEY, Q.C.:
 23 Q. - that if you don't make the choice, if you
 24 just decide to present tables based upon ER
 25 only, that those tables are all there.

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1 MR. THOMPSON:
 2 A. Oh yes.
 3 COFFEY, Q.C.:
 4 Q. There are quite a number of tables based upon
 5 ER only and particular cut offs, if you assume
 6 30, if you assume, you know, 30 and 10, 10 and
 7 one, there are--those reports are replete with
 8 tables.
 9 MR. THOMPSON:
 10 A. Absolutely.
 11 COFFEY, Q.C.:
 12 Q. For ER, if you just assume on the basis of ER
 13 only.
 14 MR. THOMPSON:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. And if you utilize instead ER and PR combined,
 18 because again there are a number of tables
 19 that do just that, don't they?
 20 MR. THOMPSON:
 21 A. Oh yes, absolutely.
 22 COFFEY, Q.C.:
 23 Q. So in effect, in terms of without an expert
 24 perspective, the expert perspective would be
 25 simply making the choice, if one's going to

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1 make the choice?
 2 MR. THOMPSON:
 3 A. Correct, and drawing conclusions on the basis
 4 of that choice.
 5 COFFEY, Q.C.:
 6 Q. And but based upon what's there, without
 7 making the choice, if one decides, one can
 8 look at the ER tables and just -
 9 MR. THOMPSON:
 10 A. Oh yes, it's all there.
 11 COFFEY, Q.C.:
 12 Q. - come to your conclusions, it's there.
 13 MR. THOMPSON:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. And one can look at the ER/PR tables and -
 17 MR. THOMPSON:
 18 A. And we would hope that the Commission is in a
 19 position to make some choices based on the
 20 information that's there.
 21 COFFEY, Q.C.:
 22 Q. And did you ask anyone, any epidemiologist
 23 with any expertise in breast cancer, for
 24 assistance in making the choice?
 25 MR. THOMPSON:

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

16 COFFEY, Q.C.:

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

21 MR. THOMPSON:

22 A. Correct.

23 COFFEY, Q.C.:

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

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1 approach, this is what the numbers are?

2 MR. THOMPSON:

3 A. Right.

4 COFFEY, Q.C.:

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

8 MR. THOMPSON:

9 A. Sure, um-hm.

10 COFFEY, Q.C.:

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

13 MR. THOMPSON:

14 A. Correct.

15 COFFEY, Q.C.:

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

22 MR. THOMPSON:

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

25 COFFEY, Q.C.:

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

3 MR. THOMPSON:

4 A. No.

5 COFFEY, Q.C.:

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

8 MR. THOMPSON:

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

12 COFFEY, Q.C.:

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

20 MR. THOMPSON:

21 A. Sure.

22 COFFEY, Q.C.:

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

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1 MR. THOMPSON:

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

13 COFFEY, Q.C.:

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

24 MR. THOMPSON:

25 A. Correct.

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1 COFFEY, Q.C.:

2 Q. Okay. So it is the--when the letter says

3 March 18th, in fact, you meant to say March

4 11th?

5 MR. THOMPSON:

6 A. Correct.

7 COFFEY, Q.C.:

8 Q. Okay. And just then in terms of, if we could

9 go back then to the letter itself. So "the

10 earlier drafts show the emerging analysis, but

11 we dropped this material from the report by

12 March 18th." Which emerging analysis and

13 interpretations or analysis in the earlier

14 drafts are you talking about having been

15 dropped?

16 MR. THOMPSON:

17 A. What we mean, in general, is that the

18 calculations of positivity rates and of change

19 rates in the data and then the, I guess, the

20 text around describing what they may be is the

21 analysis that we dropped.

22 COFFEY, Q.C.:

23 Q. Okay, so the--if we could go back then to

24 3565, was there anything then in this report

25 that, in August, you were saying to the

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1 Commission we drop or is it the difference

2 between -

3 MR. THOMPSON:

4 A. Yes.

5 COFFEY, Q.C.:

6 Q. - the original reports and March 11th? I want

7 to be clear on that.

8 MR. THOMPSON:

9 A. Sure, of course. It's everything in this

10 report we endorse, you know, we say is the

11 product of our work to the best of our

12 ability. Everything in prior reports, we're

13 saying we've dropped it from prior reports.

14 COFFEY, Q.C.:

15 Q. Okay, so that's--wanted to be clear on that.

16 But the March 11th one, it is--and in

17 particular, you're saying, "look, in effect,

18 Mr. Coffey, the tables are what they are"?

19 MR. THOMPSON:

20 A. Right.

21 COFFEY, Q.C.:

22 Q. And "what we've written there was our views at

23 the time," subject to, and I appreciate this,

24 that as you've indicated, there's ten or so

25 since that the numbers would change a little

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1 bit.

2 MR. THOMPSON:

3 A. Correct.

4 COFFEY, Q.C.:

5 Q. And may, in the future, change a little bit,

6 depending upon what happens?

7 MR. THOMPSON:

8 A. Potentially, yes.

9 COFFEY, Q.C.:

10 Q. Now if we could, please, I just wanted to

11 explore with you a little bit further about

12 this, go back to the topic of identifying

13 patients who were missed.

14 MR. THOMPSON:

15 A. Sure.

16 COFFEY, Q.C.:

17 Q. Apparently the first time round or before,

18 having missed before March of 2008. Mr.

19 Thompson, when did you--what's your

20 understanding now about why they were missed,

21 in a general way?

22 MR. THOMPSON:

23 A. Well, in a general way, perhaps the most

24 frequent reason that we've encountered is that

25 the ER/PR entry code in the Meditech system at

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1 Eastern Health was not filled in, yet that was

2 the primary way that Eastern Health went about

3 searching for the list of ER/PR tested

4 patients.

5 COFFEY, Q.C.:

6 Q. When did you first hear that, that it was--I

7 mean, that there was a linkage between self-

8 identifiers and the fact that they hadn't been

9 found because this particular code hadn't been

10 checked off? When did you first learn about

11 that?

12 MR. THOMPSON:

13 A. It would have been, to the best of my

14 knowledge, just prior to submission of the

15 April--so sometime early in the spring or in

16 the late winter, and at least that was the

17 first time we grappled with the concept and

18 said "what are the implications of this?"

19 COFFEY, Q.C.:

20 Q. And that was brought to your attention by, do

21 you recall?

22 MR. THOMPSON:

23 A. It would have been NLCHI, perhaps Reza or

24 Tracy Chislett.

25 COFFEY, Q.C.:

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1 Q. And then arising out of that, and you've
 2 indicated--I'm not going to take you through.
 3 I take it there were three different potential
 4 approaches Dr. Reza came up with?
 5 MR. THOMPSON:
 6 A. Yes, that's right.
 7 COFFEY, Q.C.:
 8 Q. And you've indicated that you approached
 9 Eastern Health, in particular Ms. Jones, about
 10 that?
 11 MR. THOMPSON:
 12 A. Right.
 13 COFFEY, Q.C.:
 14 Q. What was their reaction at the time?
 15 MR. THOMPSON:
 16 A. Well, the -
 17 COFFEY, Q.C.:
 18 Q. Because I take it at that time, you were
 19 saying look, there's one.
 20 MR. THOMPSON:
 21 A. Yeah, that's right.
 22 COFFEY, Q.C.:
 23 Q. The one self-identifier.
 24 MR. THOMPSON:
 25 A. Well, Eastern Health generally was concerned

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

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1 year?
 2 MR. THOMPSON:
 3 A. Yes, yeah, that's right.
 4 COFFEY, Q.C.:
 5 Q. In that time frame, and at the time that you
 6 learned that they were not going to pursue it,
 7 do you recall who you learned that from?
 8 MR. THOMPSON:
 9 A. No, I don't.
 10 COFFEY, Q.C.:
 11 Q. Your reaction at the time was what, at that
 12 point?
 13 MR. THOMPSON:
 14 A. It's unfortunate, would have been a good to
 15 do, but I didn't think about second guessing
 16 it at that time. There was one case,
 17 important consideration, but it didn't seem
 18 to--it didn't engage me in any more active way
 19 at the time.
 20 COFFEY, Q.C.:
 21 Q. And Mr. Thompson, when this had been brought
 22 to your attention, you know, you'd focused on
 23 it, this lack of checking off this particular
 24 order entry, I gather, field, brought to your
 25 attention in, I gather, perhaps March of '08,

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1 at that time, did anyone make you aware of,
 2 according to Dr. Reza, the fact that
 3 apparently he had understood, when he first
 4 got involved, in the summer of '07, that about
 5 ten people had been--had self identified back
 6 in the summer of '07.
 7 MR. THOMPSON:
 8 A. I was aware -
 9 COFFEY, Q.C.:
 10 Q. Up to the point in the summer of '07, and not
 11 in the summer, up to the point in '07.
 12 MR. THOMPSON:
 13 A. I was aware of that general point. I forget
 14 exactly when, but I was aware that there were
 15 self-identifiers in that group.
 16 COFFEY, Q.C.:
 17 Q. So it had been--it had not only been--it was
 18 the one in March, but there had been a number
 19 before -
 20 MR. THOMPSON:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. - the matter ever came to your attention.
 24 MR. THOMPSON:
 25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. And in your dealings with Ms. Jones, do you

3 know whether or not she understood that, the

4 fact that it wasn't just this one, that there

5 was a number before?

6 MR. THOMPSON:

7 A. Well, I don't know for certain whether she was

8 aware, but I know that Eastern Health was

9 aware, because they were the recipient of the

10 calls.

11 COFFEY, Q.C.:

12 Q. And as then this matter went on, you know,

13 from May into June and you've indicated that

14 there was a number three, eight, ten, and it

15 began, and it varied, I take it.

16 MR. THOMPSON:

17 A. Um-hm.

18 COFFEY, Q.C.:

19 Q. I think it may have made it--I think there's

20 reference in the material, may have made it as

21 high as 12 at one point and then kind of came

22 back down again, but the point being that

23 you've indicated that you dealt with the CEOs

24 as a group?

25 MR. THOMPSON:

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1 A. Yes.

2 COFFEY, Q.C.:

3 Q. And when was that?

4 MR. THOMPSON:

5 A. I think the conference call that we had was

6 August, well, 13th, 18th, in around that

7 period.

8 COFFEY, Q.C.:

9 Q. Okay, and what was their initial reaction?

10 MR. THOMPSON:

11 A. Well, first of all, I should describe the

12 proposal that I had.

13 COFFEY, Q.C.:

14 Q. Yes. Well, perhaps I'll take you to that

15 actually.

16 MR. THOMPSON:

17 A. Okay.

18 COFFEY, Q.C.:

19 Q. Perhaps assist. One moment, please,

20 Commissioner. Perhaps if I could, we get into

21 that, because it'll pick up kind of the

22 narrative, if we could bring up, please,

23 Exhibit P-3529? And this, Mr. Thompson, at

24 the bottom, toward the bottom of the first

25 page of this exhibit, there's a e-mail of

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1 March 28th, 2008 from Dr. Reza to yourself and

2 a number of other people, including people at

3 Eastern Health, and it talks about a meeting

4 that had just occurred about options for

5 identifying missing breast cancer patients

6 with negative ER/PR who may not have been

7 retested, and he says "Terry has performed

8 various search protocols in the Meditech

9 system for the year 2002, searching

10 approximately 90,000 specimens and below is a

11 summary of them for your consideration" and

12 there's a reference to the three different

13 approaches that are set out there.

14 MR. THOMPSON:

15 A. Right.

16 COFFEY, Q.C.:

17 Q. So I take it that these are the three

18 different approaches that Dr. Reza and Mr.

19 MacDonald would have been talking about back

20 in March of 2008 with yourself?

21 MR. THOMPSON:

22 A. Correct.

23 COFFEY, Q.C.:

24 Q. And these were the ones that you, back at that

25 April or so, would have brought to Ms. Jones?

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1 MR. THOMPSON:

2 A. Yes.

3 COFFEY, Q.C.:

4 Q. Okay.

5 MR. THOMPSON:

6 A. I encouraged her to adopt one in particular.

7 COFFEY, Q.C.:

8 Q. And which particular one was that?

9 MR. THOMPSON:

10 A. I think it was number three, but I'd have to--

11 I'm not sure.

12 COFFEY, Q.C.:

13 Q. Number three, yes, I'll go on. This will

14 help. This is the one utilizing the--okay,

15 searching the--well, here's number two,

16 searching the pathology module for the word

17 "breast".

18 MR. THOMPSON:

19 A. Maybe it would be better to go to my e-mail to

20 her because I don't remember which one of

21 these in particular it was.

22 COFFEY, Q.C.:

23 Q. It will be there in the documents.

24 MR. THOMPSON:

25 A. That's right, sure.

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1 COFFEY, Q.C.:

2 Q. The point is you made a -

3 MR. THOMPSON:

4 A. A specific recommendation, yes.

5 COFFEY, Q.C.:

6 Q. And you left it then with herself and Eastern

7 Health?

8 MR. THOMPSON:

9 A. Yeah.

10 COFFEY, Q.C.:

11 Q. If we could, please--just a minute, please,

12 Commissioner. Could you bring up 3534,

13 please. Now this is again an e-mail of August

14 14th, the next day, indicating that--well,

15 it's to yourself and Ms. Gregory. Who's Ms.

16 Gregory, I'm just -

17 MR. THOMPSON:

18 A. She's the senior researcher in our office.

19 COFFEY, Q.C.:

20 Q. And that's "our office". "Our" in this

21 context is the task force?

22 MR. THOMPSON:

23 A. Task force and the office of--it's like this,

24 yeah.

25 COFFEY, Q.C.:

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1 Q. And you've indicated, "Tracy and I met--he

2 indicates, Dr. Reza indicates, "Tracy and I

3 met with Barry this morning and performed the

4 pilot using the various search strategies".

5 MR. THOMPSON:

6 A. Uh-hm.

7 COFFEY, Q.C.:

8 Q. "Searched for one of the patients who was on

9 the list of eight recently sent to us by

10 Eastern Health. Using the following search

11 strategies, the self-identified from Health

12 Sciences Centre from the year 2000 was found

13 using those three different ones, and three

14 different search approaches. In speaking with

15 Barry, he indicated that using the word

16 "breast" may be one of the most comprehensive

17 search strategies with a high level of

18 certainty in capturing breast cancer patients

19 at each LIS. Please note that any of the

20 above options requires a manual review of the

21 path reports".

22 MR. THOMPSON:

23 A. Yes.

24 COFFEY, Q.C.:

25 Q. So this was the background then, I take it, to

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1 your -

2 MR. THOMPSON:

3 A. To the conference call, that's right.

4 COFFEY, Q.C.:

5 Q. Conference call. If we could, please, bring

6 up Exhibit P-3541. Here there is on page

7 three of the exhibit, there is an e-mail of

8 August 15th, 2008, at 12:01 p.m. from Donna

9 Brewer. Who's Donna Brewer?

10 MR. THOMPSON:

11 A. She was the Acting Deputy Minister at that

12 time of Health and Community Services.

13 COFFEY, Q.C.:

14 Q. Okay, and it's sent out to a number of

15 individuals. She copies herself, Mr. Peddle,

16 Boyd Rowe, who's with Labrador Grenfell.

17 MR. THOMPSON:

18 A. Uh-hm.

19 COFFEY, Q.C.:

20 Q. Karen McGrath is -

21 MR. THOMPSON:

22 A. Central Health.

23 COFFEY, Q.C.:

24 Q. Louise Jones, Eastern Health, and Susan Gillam

25 would be Western?

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1 MR. THOMPSON:

2 A. Right.

3 COFFEY, Q.C.:

4 Q. Copied to a number of other individuals, re;

5 face to face meeting on August 18th, 2008,

6 with CEOs and VPs Medical Services. "Further

7 to my previous e-mail, here is the

8 correspondence for CEOs being forwarded on

9 behalf of Robert Thompson". I take it this is

10 what was forwarded on your behalf?

11 MR. THOMPSON:

12 A. This was the proposal--the rationale on the

13 proposal, right.

14 COFFEY, Q.C.:

15 Q. And you've written, or it's being conveyed on

16 your behalf--I take it this had probably been

17 prepared by yourself. You say, "I would like

18 to discuss the following matter with you

19 during your meeting on Monday, August 18th.

20 Since mid March, eleven new ER/PR patients

21 have come to light that should have been

22 retested in 2005/2006. Eight of these

23 patients were discovered through calls from

24 the patients or their families, and three were

25 discovered through further file searches",

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

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

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1 identify missing cases on the same basis as
 2 other regions. The department will provide
 3 funds for any overtime incurred".
 4 MR. THOMPSON:
 5 A. Uh-hm.
 6 COFFEY, Q.C.:
 7 Q. "NLCHI will collaborate as necessary to ensure
 8 everyone is satisfied with the process". So
 9 that's what you sent out?
 10 MR. THOMPSON:
 11 A. Correct.
 12 COFFEY, Q.C.:
 13 Q. What then happened?
 14 MR. THOMPSON:
 15 A. You mean -
 16 COFFEY, Q.C.:
 17 Q. You had your conference call, I take it?
 18 MR. THOMPSON:
 19 A. Right. The outcome of it -
 20 COFFEY, Q.C.:
 21 Q. What happened during the conference call?
 22 MR. THOMPSON:
 23 A. Oh, I made the proposal. It was discussed.
 24 There was summary action that this was a
 25 significant effort and would be, I guess,

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1 regarded as a lot of effort that may turn out
 2 not to produce any result, and so there was
 3 some discussion about whether or not it was
 4 reasonable or--in that context, but we
 5 insisted that we needed to proceed on this
 6 proposal. We modified it just a little in the
 7 conference call in the sense that rather than
 8 agreeing right at that time to go all the way
 9 through A, B, and C, what we agreed to do was
 10 to take part A or part 1, have NLCHI do the
 11 assessment of the original search strategies
 12 so that we could identify and target then the
 13 next phase, which would be the actual conduct
 14 of the reading of pathology reports, and--but
 15 we said first let's do the assessment and
 16 we'll get those results back to you before we
 17 launch on to the second and third phases, but,
 18 yes, so that was the conference call.
 19 COFFEY, Q.C.:
 20 Q. If we could bring up, please, Exhibit P-3541,
 21 page two. Now these are notes relating to
 22 that call, telephone call, Robert Thompson,
 23 CEO and ADM, VP Medical Services, re; ER/PR
 24 follow up, and it's noted here, "Robert
 25 offered to cover any overtime costs related to

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1 further searching", and that's spelled out in
 2 your e-mail itself.
 3 MR. THOMPSON:
 4 A. Yes.
 5 THE COMMISSIONER:
 6 Q. Mr. Coffey, what (inaudible) again?
 7 COFFEY, Q.C.:
 8 Q. Well, that's -
 9 THE COMMISSIONER:
 10 Q. Do we know it (phonetic)?
 11 COFFEY, Q.C.:
 12 Q. Yes, I believe it's Dr. Jenkins. If we go
 13 back to the page before on August -
 14 MR. THOMPSON:
 15 A. Yes, it is.
 16 COFFEY, Q.C.:
 17 Q. That's Dr. Jenkins.
 18 THE COMMISSIONER:
 19 Q. Thank you.
 20 COFFEY, Q.C.:
 21 Q. And the--one particular I wanted to ask you
 22 about, it's noted here that, "wants to get
 23 alternate search strategy off the ground".
 24 Well, that would be you, and that's apparent
 25 from your memo, anyway, or e-mail, anyway. It

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1 says, "Karen", that would be Karen McGrath,
 2 "responded on behalf of three CEOs external to
 3 Eastern and indicated disagreement with the
 4 need for the search. I indicated that"--
 5 sorry, "indicated that government should
 6 direct and conduct review if deemed
 7 necessary". So do you recall that happening?
 8 MR. THOMPSON:
 9 A. Yeah. I hadn't seen these notes before -
 10 COFFEY, Q.C.:
 11 Q. And I appreciate that.
 12 MR. THOMPSON:
 13 A. But this is an accurate portrayal of what
 14 happened, yes.
 15 COFFEY, Q.C.:
 16 Q. So in terms of, I take it, Ms. McGrath
 17 communicated to those on the call--was it a
 18 meeting or a call?
 19 MR. THOMPSON:
 20 A. They were meeting. I was on the end of the
 21 phone.
 22 COFFEY, Q.C.:
 23 Q. Okay, and Ms. McGrath conveyed to yourself,
 24 look--she wasn't speaking for Eastern.
 25 MR. THOMPSON:

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1 A. Right.
 2 COFFEY, Q.C.:
 3 Q. She was speaking for herself and the other two
 4 health authorities.
 5 MR. THOMPSON:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Outside Eastern, that there was--they had some
 9 reluctance about the need to go through this?
 10 MR. THOMPSON:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. And if, however, it was going to be done, that
 14 from her perspective, she wanted the
 15 government actually doing it, in the sense of
 16 directing it--not doing it, but directing it?
 17 MR. THOMPSON:
 18 A. Directing the RHAS to do it.
 19 COFFEY, Q.C.:
 20 Q. Now in terms of that, what was your
 21 understanding about why that was so?
 22 MR. THOMPSON:
 23 A. Why -
 24 COFFEY, Q.C.:
 25 Q. Why her, on behalf--you're being told by her,

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1 look, I'm speaking for my own board and two
 2 others, why she wanted the government to
 3 direct that it be done?
 4 MR. THOMPSON:
 5 A. Well, what I inferred -
 6 COFFEY, Q.C.:
 7 Q. Yes, and that's what I take it, from your -
 8 MR. THOMPSON:
 9 A. You know, if--it may not be accurate, but what
 10 I inferred was that because of the burden on
 11 already overworked people in the RHAS to
 12 undertake a second search, and just the time
 13 and effort involved, because they had--the
 14 same people had already been through the
 15 searching before, and probably had concluded
 16 that they had done a very complete search, and
 17 in many cases probably had, and because that
 18 there was a general sense of anxiety around
 19 the whole issue, that there would be further
 20 demoralization and negative feedback if they
 21 directed it, but if the department -
 22 COFFEY, Q.C.:
 23 Q. If they directed it internally?
 24 MR. THOMPSON:
 25 A. Correct, correct, but if the department

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1 directed them to do it, then it wouldn't be
 2 them that was putting the burden on their own
 3 staff, but rather the department.
 4 THE COMMISSIONER:
 5 Q. So the department could be the enemy
 6 (phonetic).
 7 MR. THOMPSON:
 8 A. Exactly, yeah.
 9 COFFEY, Q.C.:
 10 Q. And as well then this does go on to note that
 11 you were asked for assurance that, look, I
 12 suppose, if the direction is forthcoming, that
 13 there will be cooperation from everybody as
 14 required, that we will provide our access,
 15 that would be "her", the boards, provide
 16 access to the lab leaders, IT, directors of
 17 pathology (audio malfunction).
 18 MR. THOMPSON:
 19 A. (Audio malfunction) for this first step of the
 20 evaluation step.
 21 COFFEY, Q.C.:
 22 Q. Which is the interviews that Dr. Reza then
 23 performed?
 24 MR. THOMPSON:
 25 A. Correct. yes.

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1 COFFEY, Q.C.:
 2 Q. And reported on to yourself?
 3 MR. THOMPSON:
 4 A. Right.
 5 COFFEY, Q.C.:
 6 Q. And just in that regard, if I could--we're up
 7 to 3541, I believe. Go to page three--go to
 8 the next page here. The e-mail of August
 9 15th, 2008, that we just looked at, Mr.
 10 Thompson, you've indicated that Donna Brewer
 11 was the--at the time, and perhaps still is,
 12 the -
 13 MR. THOMPSON:
 14 A. No.
 15 COFFEY, Q.C.:
 16 Q. She's not, okay.
 17 MR. THOMPSON:
 18 A. No, there was a period of time when the then -
 19 COFFEY, Q.C.:
 20 Q. Mr. Keats was -
 21 MR. THOMPSON:
 22 A. Was unable to go to work and -
 23 COFFEY, Q.C.:
 24 Q. Okay.
 25 MR. THOMPSON:

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1 A. Yeah.
 2 COFFEY, Q.C.:
 3 Q. And he was off for a period of time?
 4 MR. THOMPSON:
 5 A. A few months, yeah, that's right.
 6 COFFEY, Q.C.:
 7 Q. But in filling in for him then, she was the
 8 Deputy Minister of the day, as it were?
 9 MR. THOMPSON:
 10 A. Uh-hm.
 11 COFFEY, Q.C.:
 12 Q. And why was she sending this to all these
 13 health authorities as opposed to yourself?
 14 MR. THOMPSON:
 15 A. Well, they had a scheduled meeting. In fact,
 16 they meet regularly; that is the four CEOs,
 17 plus John Peddle, plus the Deputy Minister.
 18 So this was a regularly scheduled meeting. I
 19 asked Donna Brewer if she would introduce this
 20 agenda item onto the meeting, so I just worked
 21 through her in that regard.
 22 COFFEY, Q.C.:
 23 Q. If we could look, please, at Exhibit P-3555.
 24 Mr. Thompson, these are two e-mails. The one
 25 I'm going to ask you about in particular is

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1 the October 2nd, 2008 one from Ms. Chislett to
 2 yourself and others.
 3 MR. THOMPSON:
 4 A. Right.
 5 COFFEY, Q.C.:
 6 Q. Saying, "I've attached a summary table of the
 7 interviews Reza and I have conducted with the
 8 regions regarding their search strategies. If
 9 you have any questions, please let me know",
 10 and if we look--and the Commissioner has been
 11 taken through this at some length. I won't
 12 say tedious length, but certainly length
 13 yesterday.
 14 THE COMMISSIONER:
 15 Q. Oh, we can (inaudible) tedious.
 16 COFFEY, Q.C.:
 17 Q. Mr. Thompson, I take it, you received this at
 18 the time, early October of this year?
 19 MR. THOMPSON:
 20 A. Yes, right.
 21 COFFEY, Q.C.:
 22 Q. And examined it. What was your reaction to
 23 this in terms of it to be--this is a summary
 24 of what had occurred originally in terms of
 25 the search approaches.

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1 MR. THOMPSON:
 2 A. Right.
 3 COFFEY, Q.C.:
 4 Q. And then since the original searches. What
 5 was your own -
 6 MR. THOMPSON:
 7 A. In terms of--my reaction in terms of what I
 8 did next, or my reaction in terms of whether I
 9 felt that good original searches had been
 10 done?
 11 COFFEY, Q.C.:
 12 Q. Yes, well, actually I'm going to ask you about
 13 both. The second first?
 14 MR. THOMPSON:
 15 A. Well, I guess there were no big surprises.
 16 There were reasonably complete searches done
 17 in most regions--well, in all regions,
 18 actually, but that there were some
 19 recommendations for each region on an
 20 additional measure or two to be done, and it
 21 more or less is exactly as we expected.
 22 COFFEY, Q.C.:
 23 Q. If we could look, please--in terms of what you
 24 did do then, okay.
 25 MR. THOMPSON:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. If we could look at Exhibit P-3549, this is an
 4 e-mail of October 9th, 2008, from Mr.
 5 MacDonald to yourself and Ms. Gregory, copied
 6 to others. The subject is ER/PR search
 7 strategies, interview summary, and he writes,
 8 "At our meeting on October 3rd, we were asked
 9 to provide the task force with a brief summary
 10 of the interviews carried out to identify
 11 search strategies used with each health
 12 authority, and provide comments on these
 13 strategies". So I take it there was a meeting
 14 of October 3rd?
 15 MR. THOMPSON:
 16 A. Uh-hm.
 17 COFFEY, Q.C.:
 18 Q. With yourself.
 19 MR. THOMPSON:
 20 A. Correct.
 21 COFFEY, Q.C.:
 22 Q. To kind of review this--the results of the
 23 interview strategies?
 24 MR. THOMPSON:
 25 A. Correct.

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1 COFFEY, Q.C.:
 2 Q. And then you asked for something in writing,
 3 in effect, as to what they would recommend?
 4 MR. THOMPSON:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. And this is the recommendation?
 8 MR. THOMPSON:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. Here Mr. MacDonald goes on to say, "After
 12 completing the interviews with the four health
 13 authorities, it was evident the authorities in
 14 searching for breast cancer patients employed
 15 two separate searches. This included the
 16 initial search carried out in 2005, and the
 17 2007 search undertaken when the Centre became
 18 involved in developing the ER/PR database.
 19 The main results of the interviews are as
 20 follows", and then it spells out the results
 21 for the seven--seven different results, and
 22 it's more than four because Central is broken
 23 down into East and West, and Eastern includes
 24 Carbonear, Clarenville, and St. John's as
 25 three entries?

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

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1 idea of Eastern Health providing kind of its
 2 original master list, as it were -
 3 MR. THOMPSON:
 4 A. Uh-hm.
 5 COFFEY, Q.C.:
 6 Q. Based upon the search of this order entry
 7 field that hadn't been done in 2005, to the
 8 other health authorities as particular to
 9 their--the request having come from that
 10 particular authority, when did you first
 11 become aware that this had never been done?
 12 Like, the fact that all these names, this
 13 listing of names for which ER/PR tests had
 14 been done, which apparently Mr. Gulliver and
 15 Mr. Dyer had located back in '05, and it had
 16 never been distributed, and now, of course,
 17 Mr. MacDonald is saying--he's suggesting it be
 18 done. When did you become aware that that had
 19 not been done before?
 20 MR. THOMPSON:
 21 A. I think perhaps at this time.
 22 COFFEY, Q.C.:
 23 Q. And in the context of, I take it, the overall
 24 interview results?
 25 MR. THOMPSON:

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1 A. Right. Certainly in the development of the
 2 database, we were told by NLCHI about some of
 3 the procedures that had occurred for--sources
 4 that they had to tap into, and, therefore, how
 5 some searching had occurred in the RHAS
 6 outside St. John's in 2005, but as I mentioned
 7 to you before, the database exercise when it
 8 was created was only for contact and we were
 9 just trying to map the core of what had
 10 happened. We hadn't actually added to that
 11 project, please go and evaluate the quality of
 12 the original search strategies. So this is
 13 the first time we were doing that, so--in a
 14 concrete way, this is the first I understood
 15 that.
 16 COFFEY, Q.C.:
 17 Q. Going back--that it hadn't been done or it
 18 could be done and hadn't been done, this is
 19 the first time you would have understood that?
 20 MR. THOMPSON:
 21 A. Right, yes.
 22 COFFEY, Q.C.:
 23 Q. And in terms of the NLCHI and the task force,
 24 in terms of their involvement in relation to
 25 trying to ensure that everybody who should

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1 have been identified was identified, that I
 2 take it first arose really in 2008 in terms
 3 of--am I correct, NLCHI, when it first go
 4 itself, and the task force first got itself
 5 involved in the idea of trying to ensure that
 6 everyone was identified?
 7 MR. THOMPSON:
 8 A. That--yeah, that objective, if you like, or
 9 that activity perhaps, arose a little bit--bit
 10 by bit over time.
 11 COFFEY, Q.C.:
 12 Q. Over time.
 13 MR. THOMPSON:
 14 A. As all of the interventions to gather data
 15 were actually producing some of those
 16 questions. Whenever we saw a productive lead,
 17 if you like, to identify that there might be a
 18 gap, we would ask to get it filled.
 19 COFFEY, Q.C.:
 20 Q. And I appreciate--Dr. Reza, in particular,
 21 took the Commissioner through yesterday a
 22 list--Don MacDonald did. The lists were
 23 provided from time to time by NLCHI to the
 24 health authorities asking questions about
 25 particular patient situations?

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1 MR. THOMPSON:
 2 A. That's right, uh-hm.
 3 COFFEY, Q.C.:
 4 Q. And that went back and forth, back and forth.
 5 MR. THOMPSON:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. But in terms of the idea of approaching it
 9 from an overall perspective -
 10 MR. THOMPSON:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. That first arose when?
 14 MR. THOMPSON:
 15 A. Well -
 16 COFFEY, Q.C.:
 17 Q. Re-examination going back to first principles
 18 in terms, look, have we identified everyone?
 19 MR. THOMPSON:
 20 A. Well, I'm not sure exactly when we would have
 21 formulated it quite that way. I think it's--
 22 for me, it's more accurate to say that
 23 whenever we encountered a question mark that
 24 perhaps there are people that have not been
 25 included in the database that should be, we

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1 would pursue that question, and it would be
 2 irresponsible not to.
 3 COFFEY, Q.C.:
 4 Q. Uh-hm.
 5 MR. THOMPSON:
 6 A. And I think that's really the best--from my
 7 point of view, the best way to characterize
 8 what we did because we never added it as a
 9 formal goal of the database project to NLCHI,
 10 "now we want to ensure 100 percent
 11 completeness". We would just pursue that
 12 whenever it made sense to.
 13 COFFEY, Q.C.:
 14 Q. But as a goal, I take it, that's certainly--
 15 you floated it or approached Ms. Jones back in
 16 the spring of '08 -
 17 MR. THOMPSON:
 18 A. Yes, absolutely.
 19 COFFEY, Q.C.:
 20 Q. And then you've taken us--the Commissioner
 21 through then what's happened since and the
 22 current situation?
 23 MR. THOMPSON:
 24 A. That's correct.
 25 COFFEY, Q.C.:

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1 Q. And in terms of the current current situation,
 2 if we could look at please, Exhibit P-3550.
 3 This is an e-mail of October 15th, 2008 from
 4 Mr. MacDonald to yourself. He writes, "A
 5 "manual" search is a robust approach given it
 6 implies all hard copy pathology reports were
 7 reviewed and those noted as being related to
 8 breast cancer would be further investigated.
 9 A limitation of this approach would be if the
 10 hard copy, for whatever reason, was not
 11 included in the review, while in others, human
 12 error in missing the term "breast" when it
 13 actually was in the report. Electronic search
 14 of the term "breast" might be considered the
 15 gold standard as it searches all pathology
 16 reports, but this approach would not capture
 17 cases where the test results were not entered
 18 or no longer available in Meditech. Below is a
 19 summary of the search strategies", and he
 20 summarizes; Carbonear--manual review of
 21 pathology reports, Lab/Grenfell--manual review
 22 of pathology reports, Central East--electronic
 23 search of term "breast", Central West--
 24 electronic search of term "breast" 2001 to
 25 2005, and a manual review of pathology

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1 reports, 1997 through 2000, Western--
 2 electronic search using other criteria felt to
 3 be appropriate for that Meditech system.
 4 Clarenville--electronic search, but not on
 5 term "breast", also lost some data, both hard
 6 and electronic. Any lost cases only available
 7 through patient chart. St. John's--electronic
 8 search using criteria other than "breast". I
 9 take it, this was the advice then being
 10 provided in mid October to yourself from Mr.
 11 MacDonald?
 12 MR. THOMPSON:
 13 A. This is a summary.
 14 COFFEY, Q.C.:
 15 Q. A summary.
 16 MR. THOMPSON:
 17 A. Yes, that's right.
 18 COFFEY, Q.C.:
 19 Q. And then following this, you did what?
 20 MR. THOMPSON:
 21 A. Based on their advice, I wrote four CEOs e-
 22 mails telling them what our next expectation
 23 was, our next request, and as I mentioned
 24 earlier, it was different for each one--well,
 25 for three RHAs it was similar; for Eastern

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1 Health, it was different, and we did that
 2 about a week ago.
 3 COFFEY, Q.C.:
 4 Q. In fact, if we look at Exhibit P-3551. Now
 5 here, this is an e-mail--a series of e-mails
 6 I'm going to take you through now, October
 7 17th, 2008, which as you pointed out is
 8 exactly a week ago. This is to Karen McGrath.
 9 It's copied to Don MacDonald and others. It's
 10 ER/PR search strategies. So Ms. McGrath would
 11 be the west -
 12 MR. ROBERT THOMPSON:
 13 A. Central.
 14 COFFEY, Q.C.:
 15 Q. I'm sorry, I apologize, Central. You write,
 16 "NLCHI has completed the assessment and search
 17 strategies used by Regional Health Authorities
 18 between 2005 and 2008 to identify patients
 19 that received ER/PR tests between 1997 and
 20 2005 in St. John's. We'd like to thank the
 21 personnel in your organization for their co-
 22 operation with NLCHI during this process. The
 23 only additional search procedure recommended
 24 by NLCHI for you RHA is to obtain a list from
 25 Eastern Health of patients for your region who

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1 actually had an original ER/PR test in St.
 2 John's so that a cross-check may be done
 3 against your list of tissue blocks that were
 4 sent for retesting. We will ask Eastern
 5 Health to generate this list for you. NLCHI's
 6 continuing role will only be to update the
 7 ER/PR database should any new information
 8 result from this cross-checking process. We
 9 will look to you and your personnel to conduct
 10 the cross-check after the list is provided and
 11 make NLCHI aware if any newly identified cases
 12 are found from this process. At the end of
 13 the process we will ask NLCHI to generate a
 14 count on any new cases that have been
 15 identified. Please let me know to whom the
 16 list should be sent. Thanks and please feel
 17 free to call if you have any questions".
 18 So, having sent this to Ms. McGrath, did
 19 you get any response from her?
 20 MR. THOMPSON:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And what was her response?
 24 MR. THOMPSON:
 25 A. She identified the individual who should be

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1 sent the list indicating to me that, okay,
 2 let's go, let's do this.
 3 COFFEY, Q.C.:
 4 Q. And I take it then, because the list, of
 5 course, that exists is based on the premise
 6 that that's all. If it turns out in dealing
 7 with Eastern Health you come across some
 8 other, then that would be -
 9 MR. THOMPSON:
 10 A. Just a point on that, because we know that
 11 there's a limitation with the Meditech system
 12 in St. John's in the context of ER/PR order
 13 entry code. So, I asked Reza about this
 14 question. Would that limitation apply equally
 15 to samples, tissues samples that originated in
 16 St. John's and to, as compared to tissue
 17 samples that originated outside? And his view
 18 was that while one can't be absolutely
 19 certain, he feels that there should be a
 20 higher level of confidence that when a tissue
 21 sample comes in from outside St. John's,
 22 originating in a different location, that the
 23 order entry code would, more than likely,
 24 always be completed. So, he couldn't quantify
 25 that, but there is a higher level of

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1 confidence that that would be the case. So,
 2 it's a good cross-check mechanism.
 3 COFFEY, Q.C.:
 4 Q. And look please then at Exhibit P-3552. And
 5 this is an e-mail again of a week ago to Boyd
 6 Rowe at Labrador/Grenfell. He's the CEO, I
 7 take it, of the organization and it's from
 8 yourself. You write "NLCHI has completed the
 9 assessment of search strategies used by RHAS
 10 between 2005 and 2008" and in effect it's the
 11 same as what you'd written to Ms. McGrath,
 12 that paragraph. And you say, "the only
 13 additional search procedure recommended by
 14 NLCHI for your RHA is to obtain a list from
 15 Eastern Health of patients from your region
 16 who actually had an original ER/PR test in St.
 17 John's, so that a cross-check can be done
 18 against your list of tissue blocks that were
 19 sent for retesting. We will ask Eastern
 20 Health to generate this list for you". And
 21 then you go on to talk about NLCHI's
 22 continuing role, the same way you had before.
 23 So, again, we will provide you with a
 24 list we get from Eastern Health and please
 25 cross-reference it against the cases that you

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1 have sent to St. John's.
 2 MR. THOMPSON:
 3 A. Correct.
 4 COFFEY, Q.C.:
 5 Q. Exhibit P-3554, please.
 6 THE COMMISSIONER:
 7 Q. Why don't we find out what Lab/Grenfell said
 8 before we go onto that.
 9 COFFEY, Q.C.:
 10 Q. Pardon?
 11 THE COMMISSIONER:
 12 Q. Lab/Grenfell's reaction.
 13 COFFEY, Q.C.:
 14 Q. Oh yes, I apologize, Commissioner, yes.
 15 MR. THOMPSON:
 16 A. I had a quick e-mail back from Boyd Rowe
 17 saying, let's go.
 18 COFFEY, Q.C.:
 19 Q. Let's go, yes. Thank you, Commissioner.
 20 Exhibit P-3554 which is October 17, 2008.
 21 It's an e-mail from yourself to Susan Gillam,
 22 she would be on the west coast.
 23 MR. THOMPSON:
 24 A. Um-hm.
 25 COFFEY, Q.C.:

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

12 MR. THOMPSON:

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

15 COFFEY, Q.C.:

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

17 MR. THOMPSON:

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

21 COFFEY, Q.C.:

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

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1 assessment of search strategies used by RHAS
 2 between 2005 and 2008" and again this is a
 3 copied paragraph.

4 MR. THOMPSON:

5 A. Um-hm.

6 COFFEY, Q.C.:

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

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

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

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

9 MR. THOMPSON:

10 A. Yes.

11 COFFEY, Q.C.:

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

17 MR. THOMPSON:

18 A. Right.

19 COFFEY, Q.C.:

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

22 MR. THOMPSON:

23 A. Correct.

24 COFFEY, Q.C.:

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

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1 below that there's an e-mail from Joyce Penney
 2 at Eastern Health, October 21st, 2008 to
 3 yourself and others. And the text reads
 4 forwarded on behalf of Louise Jones, "Good
 5 morning, Mr. Thompson. Attached please find
 6 Eastern Health's response to your request
 7 directing Eastern Health to conduct an
 8 electronic ER/PR search of pathology reports
 9 for the St. John's sites. Original to follow
 10 via Canada Post". If we go then to this.
 11 This, I take it, is the letter of October 20
 12 which is Ms. Jones' response?
 13 MR. THOMPSON:
 14 A. Correct.
 15 COFFEY, Q.C.:
 16 Q. And to help the Commissioner put this in
 17 context, she writes and I'll read it out and
 18 then ask you some questions about it. "This
 19 is written as a follow-up to your request
 20 received in my office at 1200 hours on October
 21 17th, 2008 directing Eastern Health to conduct
 22 electronic ER/PR search of pathology reports
 23 for the St. John's sites". And I'm just going
 24 to stop there at this point because your e-
 25 mail did indicate that you're directing on

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1 behalf on the minister, is that what your e-
 2 mail said?
 3 MR. THOMPSON:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. So, this is, in effect, under the legislation,
 7 your e-mail was a directive.
 8 MR. THOMPSON:
 9 A. Well, that's a question mark. Although it's
 10 clear that we wanted to indicate that the
 11 Minister was approving of and wanted to see
 12 this done. But what exactly constitutes a
 13 ministerial directive under the act is we just
 14 didn't go there, didn't address that question.
 15 COFFEY, Q.C.:
 16 Q. Okay. So, talking about this now is, is that
 17 back in the Spring you had, as you pointed,
 18 strongly suggested that it might be a good
 19 idea to do this, in effect, conduct, in
 20 effect, the same search.
 21 MR. THOMPSON:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. That you're now going to go to detail.
 25 MR. THOMPSON:

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1 A. That's correct.
 2 COFFEY, Q.C.:
 3 Q. Or you have detailed on the 17th of October.
 4 At that time, you eventually learned that Ms.
 5 Jones, on behalf of Eastern Health, was
 6 declining for the reasons you've indicated.
 7 MR. THOMPSON:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Now, October 17, the language used there is
 11 more direct -
 12 MR. THOMPSON:
 13 A. Correct.
 14 COFFEY, Q.C.:
 15 Q. - in the sense of on behalf of the Minister
 16 directing this.
 17 MR. THOMPSON:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. So, I take it then that as of this month, what
 21 had originally, perhaps five months ago, four
 22 or five months ago being a strong suggestion
 23 has now come to the point where without
 24 determining legally whether or who within the
 25 legislation or not -

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1 MR. THOMPSON:
 2 A. Right.
 3 COFFEY, Q.C.:
 4 Q. - the Minister wants you to do this.
 5 MR. THOMPSON:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. It goes on to say, "the letter indicates that
 9 this search should be conducted using the
 10 search term "breast" and then performing a
 11 manual review of the files to determine if
 12 there are any additional cases not previously
 13 identified. The request also indicated that
 14 this work should be completed within four
 15 weeks from the start date and if this is not
 16 possible, to notify you of your (sic.)
 17 anticipated time frame"--sorry--"of our
 18 anticipated time frame. And then your letter
 19 indicates that this search should be conducted
 20 in the broadest word search utilizing the word
 21 breast. Since we have received your request,
 22 we've had discussions with Mr. MacDonald and
 23 Dr. Reza of NLCHI, this discussion revealed
 24 that using the search methodology that
 25 approximately 1000 pathology reports per year

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

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

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

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1 A. I haven't responded to it.
 2 COFFEY, Q.C.:
 3 Q. Okay. What are your thoughts on it?
 4 MR. THOMPSON:
 5 A. Substantively it responds appropriately to the
 6 St. John's based request. It provides method
 7 of doing the work, it outlines a time line,
 8 indicates a willingness to do it. So, it
 9 meets our satisfaction in terms of carrying
 10 out the work.
 11 COFFEY, Q.C.:
 12 Q. And what then--what's the current status of
 13 it?
 14 MR. THOMPSON:
 15 A. Well, I know really nothing more than what's
 16 in the letter, that they've engaged NLCHI to
 17 provide this leadership or project leadership
 18 role, that that's a good thing from our point
 19 of view. So, I'd just check for updates on a
 20 periodic basis.
 21 COFFEY, Q.C.:
 22 Q. So, in whose hands is it right now?
 23 MR. THOMPSON:
 24 A. Eastern Health's.
 25 COFFEY, Q.C.:

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1 Q. Eastern Health's?
 2 MR. THOMPSON:
 3 A. Oh yes.
 4 COFFEY, Q.C.:
 5 Q. And whomever from NLCHI is -
 6 MR. THOMPSON:
 7 A. Correct, yes.
 8 COFFEY, Q.C.:
 9 Q. - tasked with being the project leader.
 10 MR. THOMPSON:
 11 A. That's right.
 12 THE COMMISSIONER:
 13 Q. Mr. Coffey, it's near the lunch hour. So,
 14 wherever you can find a spot to take a break.
 15 COFFEY, Q.C.:
 16 Q. Yes. There's a reference here to, "will again
 17 delay Eastern Health's analysis related to
 18 ER/PR issues", do you see that?
 19 MR. THOMPSON:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Have you been told what analysis is going on.
 23 MR. THOMPSON:
 24 A. Well, I haven't asked the question, but I've
 25 drawn some assumptions because I've heard from

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

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1 (BREAK FOR LUNCH)
 2 THE COMMISSIONER:
 3 Q. Mr. Coffey.
 4 COFFEY, Q.C.:
 5 Q. Yes. I wanted to ask Mr. Thompson about a
 6 particular briefing note, Commissioner, just
 7 one moment please. If you could bring up,
 8 please, and I believe this is the final
 9 version and I stand to be corrected, but I
 10 believe this probably is, it's Exhibit P-3544.
 11 And this is a series of e-mail exchanges here,
 12 Mr. Thompson, but this is an e-mail of August
 13 18, 2008, you'll see at the top of the page
 14 there addressed to Ms. Chaytor, copied to
 15 myself. The database note, the database
 16 update. "See the attached which addresses
 17 Sandy's inquiries". And look at page three,
 18 it's a status report on ER/PR database.
 19 MR. THOMPSON:
 20 A. I don't think this is the final version.
 21 COFFEY, Q.C.:
 22 Q. Not the final version.
 23 CHAYTOR, Q.C.:
 24 Q. (Inaudible).
 25 BRAZIL, Q.C.:

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

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1 Q. - minute, at least, that this was drafted.
 2 And here, sir, it's a briefing note, noted to
 3 be revised, status report on ER/PR database.
 4 The issue is the ER/PR database will continue
 5 to be updated as necessary by NLCHI, based on
 6 data transfer from regional health
 7 authorities, including newly identified
 8 patients. The background is set out here as
 9 to "the ER/PR database was initiated in June
 10 2007 by the Department with the Office of the
 11 Secretary to Cabinet, Health Issues" which is
 12 yourself, you head the office, "being the
 13 primary client. Construction and maintenance
 14 of the database was performed by NLCHI and
 15 data is provided by the four regional health
 16 authorities. On May"--I'm sorry, "April 14th,
 17 2008, the OSC provided the second of two
 18 summary reports to the co-counsel for the
 19 Commission of Inquiry on the database results.
 20 The report stated there were 1,013 patients
 21 who met the core criteria for inclusion in the
 22 database. The core criteria were that the
 23 original ER/PR test was done between 1997 and
 24 2005, the test result was negative and a
 25 retest was performed at Mount Sinai. After

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1 this report, the OSC, which is the same group
 2 that performs the work of the Task Force on
 3 Adverse Health Events, refocused its work on
 4 its adverse health event mandate and asked
 5 NLCHI to continue to provide updates to the
 6 database to the Commission based on any new
 7 data that may become available from Eastern
 8 Health." I take it that was the state of
 9 affairs at the time?
 10 MR. THOMPSON:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. In April, which you described to the
 14 Commissioner earlier this morning. Then newly
 15 identified patients, you've written "the April
 16 14th, 2008 report noted that one patient who
 17 should have been retested had recently self-
 18 identified. This person had not been
 19 identified in the Meditech system in 2005
 20 because of the order entry field"--I'm sorry,
 21 "because the order entry field had not been
 22 completed at the time of the original test.
 23 It is noteworthy that the 2008 retest of this
 24 patient was not added to the database
 25 immediately because she was retested on

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1 Ventana at Eastern Health, not at Mount Sinai.
 2 Nevertheless, the case is an indicator that
 3 other patients who should be retested may not
 4 yet have been identified, despite the
 5 considerable searching and publicity around
 6 the issue. The report stated that 'these
 7 points have caused Eastern Health to examine
 8 options for alternate search strategies within
 9 Meditech to identify any possible remaining
 10 negative ER/PR patients.' Eastern Health
 11 subsequently examined these options and
 12 decided against a review exercise because it
 13 was uncertain that any of the search
 14 strategies would result in the identification
 15 of previously unidentified patients.
 16 As of August 12th, the total number of
 17 newly identified patients that were not in the
 18 database on April 14th has grown to ten.
 19 Therefore, instead of 1,013 patients who were
 20 original ER negatives between 1997 and 2005,
 21 the new total is 1,023." And then another
 22 bullet says "discovery of these new patients
 23 occurred in the following ways: a patient
 24 called, three; daughter or son called, four;
 25 further regional health authority checking of

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1 pathology reports, three. Six of the ten
 2 patients are deceased. All four living
 3 patients have been informed of their retest
 4 results." Another bullet, "all of the
 5 deceased patients have been retested. NLCHI
 6 is continuing to update the database for these
 7 newly identified cases and also for several
 8 other purposes, i.e. confirmations that
 9 patients who were the subject of letters to
 10 physicians were actually contacted by
 11 physicians, completion of contact for patients
 12 with DCIS and no tumor, and any new contacts
 13 with people who could not be previously
 14 contacted."
 15 Now it goes on about the time line, and
 16 I'll come back to this, but on this--while
 17 we're going through this, Mr. Thompson, the
 18 DCIS and no tumor, how had that--do you recall
 19 how that unfolded then in 2008?
 20 MR. THOMPSON:
 21 A. Well, we weren't -
 22 COFFEY, Q.C.:
 23 Q. From your perspective, in terms of your
 24 involvement.
 25 MR. THOMPSON:

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

13 COFFEY, Q.C.:

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

17 MR. THOMPSON:

18 A. Right.

19 COFFEY, Q.C.:

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

23 MR. THOMPSON:

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

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1 COFFEY, Q.C.:

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

4 MR. THOMPSON:

5 A. Correct.

6 COFFEY, Q.C.:

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

9 MR. THOMPSON:

10 A. Right.

11 COFFEY, Q.C.:

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

17 MR. THOMPSON:

18 A. Correct.

19 COFFEY, Q.C.:

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

24 MR. THOMPSON:

25 A. Right.

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1 COFFEY, Q.C.:

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

6 MR. THOMPSON:

7 A. Um-hm.

8 COFFEY, Q.C.:

9 Q. What was that about?

10 MR. THOMPSON:

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

23 COFFEY, Q.C.:

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

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1 MR. THOMPSON:

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

3 COFFEY, Q.C.:

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

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

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

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

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

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

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

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1 A. I reviewed it a few times in draft form, yes.
 2 COFFEY, Q.C.:
 3 Q. And I take it then that this is as an accurate
 4 account as was available at the time?
 5 MR. THOMPSON:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Bearing in mind at this point.
 9 MR. THOMPSON:
 10 A. Yes, I think so, I think it's--my sense is
 11 it's a comprehensive document.
 12 COFFEY, Q.C.:
 13 Q. And much of it, in fact, is the details of
 14 what you've generally covered for the
 15 Commissioner today?
 16 MR. THOMPSON:
 17 A. Correct.
 18 COFFEY, Q.C.:
 19 Q. Mr. Thompson, is there anything else that you
 20 think, in terms of, bearing in mind this
 21 occurred since you last were here testifying
 22 in May, that should be brought to the
 23 Commissioner's attention?
 24 MR. THOMPSON:
 25 A. No, I don't have anything else.

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1 COFFEY, Q.C.:
 2 Q. Thank you.
 3 COFFEY, Q.C.:
 4 Q. Mr. Simmons?
 5 MR. SIMMONS:
 6 Q. Thank you, Commissioner, I don't have any
 7 questions for Mr. Thompson.
 8 THE COMMISSIONER:
 9 Q. Mr. Browne?
 10 BROWNE, Q.C.:
 11 Q. Thank you, Commissioner. I have no questions
 12 for Mr. Thompson, thank you.
 13 THE COMMISSIONER:
 14 Q. Ms. Newbury?
 15 MS. NEWBURY:
 16 Q. Good afternoon, Mr. Thompson. Jennifer
 17 Newbury, I represent the Newfoundland and
 18 Labrador division of the Canadian Cancer
 19 Society, and I wanted to ask you first of all
 20 about your familiarity with the Cancer
 21 registry and any potential problems or
 22 deficiencies in the registry system. Can you
 23 speak to that generally or should I point you
 24 to -
 25 MR. THOMPSON:

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

6 MR. NEWBURY:
 7 Q. Okay, there's one particular concern and that
 8 relates to cancer statistics pertaining to
 9 death registrations for, I guess related to
 10 tumour reports that have already been filed
 11 with the Cancer Registry and we've had some
 12 evidence from the various regions in the
 13 province and it seems that while several
 14 regions do provide reports there--actually I'm
 15 mixing up two different concepts here, the
 16 first one deals with cancer--the main one I
 17 want to ask you about is the cancer
 18 registrations from the various regions and
 19 whether or not there is legislation that
 20 supports that. And we've actually had some
 21 evidence from pathologists around the
 22 province, not each and every hospital, but
 23 we've had them from several hospitals and one
 24 pathologist, Dr. Dankwa who is with the
 25 Charles Curtis Memorial Hospital in St.

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

14 MR. THOMPSON:
 15 A. Uh-hm.

16 MR. NEWBURY:
 17 Q. And Dr. Dankwa had indicated that he tried to
 18 pursue this to see if there was some way to
 19 overcome that perceived impediment and he was
 20 not able to resolve that. So for a number of
 21 years, Dr. Dankwa has not been filing those
 22 reports.

23 MR. THOMPSON:
 24 A. Right.

25 MR. NEWBURY:

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

6 MR. THOMPSON:
 7 A. No, I've never had any information on that.

8 MR. NEWBURY:
 9 Q. Okay. And is that a concern to you if there
 10 is such a deficiency in -

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

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

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1 on that.

2 MR. THOMPSON:
 3 A. Okay, thanks.

4 MR. NEWBURY:
 5 Q. And you're not able to comment then on the
 6 other issue which is the perceived inadequacy
 7 of data and the collection of death reports to
 8 the Cancer Registry, you're not aware of any
 9 of that?

10 MR. THOMPSON:
 11 A. No. This is not the same issue, is it, as the
 12 problem that Eastern Health may have had with
 13 identifying which of their ER/PR patients had
 14 deceased, is that the same issue?

15 MR. NEWBURY:
 16 Q. There are similar issues, for sure.

17 MR. THOMPSON:
 18 A. Okay.

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

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1 secondly, to find out what the results of the
 2 rest are so that she could identify the
 3 negative ER patients and also to find out
 4 their status of whether they were living or
 5 deceased.
 6 MR. THOMPSON:
 7 A. Right.
 8 MR. NEWBURY:
 9 Q. And in all three respects, as I understand it,
 10 the data was deficient.
 11 MR. THOMPSON:
 12 A. Right.
 13 MR. NEWBURY:
 14 Q. And it has also been apparent that there's a
 15 broader problem with the Cancer Registry
 16 capturing deaths and that has been highlighted
 17 and perhaps I can show you just for your
 18 benefit, if I could bring up Exhibit P-0789
 19 please? This is Canadian Cancer Statistics
 20 and it shows that there's not just with the
 21 ER/PR breast cancer patients, which is all
 22 Heather Predham could possibly speak to at
 23 this particular point, but a broader concern
 24 about that which may have certainly explained
 25 why she was having some difficulties and this

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1 is the Canadian Cancer statistics and they are
 2 produced annually and you can see there are a
 3 number of agencies that are involved in
 4 producing these reports. And on page 16 of
 5 the exhibit, please, I wonder if you could go
 6 to page 87, this might -
 7 REGISTRAR:
 8 Q. Page 87?
 9 MR. NEWBURY:
 10 Q. 87, please. This is one reference here, there
 11 is a second reference and I can locate it
 12 right now. At the bottom of the page and I'll
 13 just read it out, "For all cancers, even those
 14 with poor survival, such as pancreas and lung,
 15 the annual number of incident cases is
 16 expected to be similar to or larger than the
 17 number of deaths. However, there are
 18 situations in which the number of deaths,
 19 either observed or projected, is larger than
 20 the corresponding number of new cases. In
 21 case of Newfoundland and Labrador, this is
 22 caused by the Registry not receiving
 23 information on death certificates that mention
 24 cancer. The limitation of not having access
 25 to death certificates is greater for cancers

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1 with poor prognosis." And it goes on to say
 2 that this results in an underestimate of the
 3 deaths. And perhaps I can bring up another
 4 exhibit because this has been a repetitive
 5 problem over a number of years, P-0786 please,
 6 page 24. And here's another reference and
 7 this is for, cancer statistics for 2005.
 8 MR. THOMPSON:
 9 A. Uh-hm.
 10 MR. NEWBURY:
 11 Q. And it says, "Finally there are differences in
 12 the reporting procedures used in cancer
 13 registration, example registration of
 14 secondary primary cancers and the use of death
 15 certificates. See appendix 2 regarding cancer
 16 registry methodology. For example, death
 17 certificate information has not been available
 18 for registry purposes in Newfoundland until
 19 now and this falsely lowers the number of
 20 incident cases with short life expectancies
 21 such as cases of lung and pancreatic cancer."
 22 So this has been a common theme in the last,
 23 2004 up through 2008.
 24 MR. THOMPSON:
 25 A. I should note that now that I have seen this

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1 report, I do recall actually looking at this,
 2 whether it was 2008 or a prior year, I'm not
 3 sure.
 4 MR. NEWBURY:
 5 Q. Sure.
 6 MR. THOMPSON:
 7 A. And being struck by the fact that Newfoundland
 8 data was so substandard compared to other
 9 provinces. What we were trying to do at the
 10 time was to look at the incidents of breast
 11 cancer or deaths from breast cancer to see if
 12 in some crude way there was a relationship by
 13 year there, with some of the data we were
 14 seeing from the database by year and it was
 15 impossible to draw any conclusion from that,
 16 but that's when it was that we saw that the
 17 Newfoundland and Labrador data in this report
 18 was very--it was below par.
 19 MR. NEWBURY:
 20 Q. Okay, and that's not something that you've
 21 been engaged in as part of this particular
 22 process here.
 23 MR. THOMPSON:
 24 A. No, no.
 25 MR. NEWBURY:

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1 Q. And again, I understand that we'll have some
 2 evidence from Ms. Smith who might speak to
 3 that and efforts to try and resolve these
 4 problems. Mr. Thompson, I wanted to ask you
 5 about the concept of retro conversions and
 6 starting, first of all, with your familiarity
 7 with that particular notion. Is that
 8 something that you have encountered throughout
 9 your involvement?
 10 MR. THOMPSON:
 11 A. Yeah, I've heard the term and I understand it
 12 to be a test that upon retest will go from
 13 positive to negative.
 14 MR. NEWBURY:
 15 Q. And have you had any role beyond sort of
 16 learning generally what it's about, in
 17 assessing whether this is an issue or forming
 18 any conclusions as to whether this is an issue
 19 that warrants further investigation by Eastern
 20 Health?
 21 MR. THOMPSON:
 22 A. No, I've not had a role in assessing, the
 23 question and we hadn't taken it up in our
 24 office as a question for analysis, but one
 25 wonders more generally whether there is any--

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1 if there is an error rate as well among
 2 positives and whether it's a clinically issue
 3 to examine further. So I don't have an
 4 opinion on it, it just emerges as an obvious
 5 question.
 6 MR. NEWBURY:
 7 Q. And have you participated in any sort of
 8 informal discussions on that, not so much to
 9 the point that you may not have reached a
 10 conclusion, but are you aware of the types of
 11 information that might be out there and the
 12 types of information that's not out there that
 13 could help lead you one way or the other?
 14 MR. THOMPSON:
 15 A. No, no.
 16 MR. NEWBURY:
 17 Q. Have you ever become aware, through perhaps
 18 observing proceedings or attending meetings or
 19 what have you, the fact that there were a
 20 number of conversions in the database from an
 21 ER negative result, PR positive result to an
 22 ER and PR negative result?
 23 MR. THOMPSON:
 24 A. I'm not certain I can recall that. It
 25 wouldn't surprise me if there were some

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1 results like that, but I can't recall in
 2 particular how many and if there were.
 3 MR. NEWBURY:
 4 Q. Okay, and I understand from the initial
 5 discussions about the mandate of the Centre
 6 for Health Information that there was an
 7 effort to ascertain what would be included in
 8 the database.
 9 MR. THOMPSON:
 10 A. Uh-hm.
 11 MR. NEWBURY:
 12 Q. And because the focus of the retesting had
 13 been upon ER results and not the ER positive--
 14 ER negative results as opposed to ER positive
 15 results -
 16 MR. THOMPSON:
 17 A. Right.
 18 MR. NEWBURY:
 19 Q. That there were a few results, 18, I believe,
 20 ER positive results that had been done but
 21 were not initially intended to be included in
 22 the database that NLCHI was preparing.
 23 MR. THOMPSON:
 24 A. Yeah. But just to clarify that point is that
 25 the objective was to include all the activity

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1 that Eastern Health had actually engaged in,
 2 in terms of all the retests that they did. So
 3 that's why we included the few positives that
 4 were done as well.
 5 MR. NEWBURY:
 6 Q. Okay.
 7 MR. THOMPSON:
 8 A. So to include that, if Eastern Health had
 9 chosen to do all of the positives, they would
 10 have been in the database as well.
 11 MR. NEWBURY:
 12 Q. Right.
 13 MR. THOMPSON:
 14 A. And so the only reason I focus on it is
 15 because I think there's a sense that there's
 16 somehow a shortcoming in the database because
 17 positives aren't in it. Well that may be a
 18 clinical issue here, but from the point of
 19 view of the database itself, that's not a
 20 shortcoming of the database. If the database
 21 was meant to focus on negatives in the main,
 22 it did and so conclusions that can be reached
 23 based on that feature can indeed be reached
 24 with confidence. So, yeah, that's the point.
 25 MR. NEWBURY:

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1 Q. So the data has been collected and put in a
 2 database, but not the main cohort, is that how
 3 it was done?
 4 MR. THOMPSON:
 5 A. Well when we--within the 1023, there are 18
 6 positive--original positive results, including
 7 their retest results. If more positive cases
 8 had been retested up to the point when the
 9 database project started, okay, then we would
 10 have included them, but we didn't include
 11 anyone's after that because it wasn't the
 12 original intent of Eastern Health to retest
 13 that group.
 14 MR. NEWBURY:
 15 Q. So the database exercise didn't define what
 16 was going to be retested -
 17 MR. THOMPSON:
 18 A. Correct.
 19 MR. NEWBURY:
 20 Q. - they just captured what was being retested.
 21 MR. THOMPSON:
 22 A. Correct, exactly.
 23 MR. NEWBURY:
 24 Q. And as part of that discussion as to how to
 25 deal with those 18 other cases, you, of

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1 course, became aware that there were 18
 2 positive, ER positive cases that were
 3 retested.
 4 MR. THOMPSON:
 5 A. Yes.
 6 MR. NEWBURY:
 7 Q. And did you become aware that four of those
 8 were categorized by Eastern Health as retro
 9 conversions?
 10 MR. THOMPSON:
 11 A. Yes, I saw that from the disclosure records.
 12 MR. NEWBURY:
 13 Q. Okay, and has it ever been brought to your
 14 attention how those retro conversions were
 15 defined, for example, whether or not retro
 16 conversions would have included a result going
 17 from ER positive to ER negative, but the
 18 patient was deceased, whether or not such a
 19 result would be categorized as a retro
 20 conversion?
 21 MR. THOMPSON:
 22 A. Well I only understand it to the extent that
 23 if there was a positive and upon retesting it
 24 was negative, then that defined retro
 25 conversion. If there were other criteria as

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1 well, I'm not aware of -
 2 MR. NEWBURY:
 3 Q. That wasn't part of any of the discussions
 4 that you had?
 5 MR. THOMPSON:
 6 A. No.
 7 MR. NEWBURY:
 8 Q. And whether or not in sort of selecting which
 9 of those 18, we'll call a retro conversion,
 10 whether or not they considered treatment,
 11 types of treatment, whether the change of
 12 treatment occurred or not?
 13 MR. THOMPSON:
 14 A. Well those weren't issues for the database.
 15 We read about those four cases in the
 16 disclosure documents from Eastern Health, but
 17 they weren't issues in how they were
 18 characterized within the database itself, it's
 19 just the straight results were captured.
 20 MR. NEWBURY:
 21 Q. And there's been no discussion about that?
 22 MR. THOMPSON:
 23 A. No.
 24 MR. NEWBURY:
 25 Q. And you're not aware of any final tally or

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1 list of all of the retro conversions -
 2 MR. THOMPSON:
 3 A. No, not beyond those four, if I was asked how
 4 many were there, I would say four based on
 5 what I read in the disclosure documents.
 6 MR. NEWBURY:
 7 Q. Okay. And you're aware that external review
 8 reports have identified problems with the test
 9 procedures used for ER/PR testing.
 10 MR. THOMPSON:
 11 A. Yes.
 12 MR. NEWBURY:
 13 Q. And you're aware generally that some of the
 14 deficiencies would relate to quality control,
 15 absence of expected documentation surrounding
 16 standard operating procedures -
 17 MR. THOMPSON:
 18 A. Yes.
 19 MR. NEWBURY:
 20 Q. Are you aware that there was a concern about
 21 the failure to use negative controls?
 22 MR. THOMPSON:
 23 A. I read that in the reports, yes.
 24 MR. NEWBURY:
 25 Q. And that negative controls would help to

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1 detect false positives?
 2 MR. THOMPSON:
 3 A. Uh-hm.
 4 MR. NEWBURY:
 5 Q. And also that there have been deficiencies
 6 identified in quality assurance and in
 7 particular, the lack of an external
 8 proficiency testing program?
 9 MR. THOMPSON:
 10 A. Right.
 11 MR. NEWBURY:
 12 Q. And in these circumstances, would you have
 13 expected a further review by Eastern Health of
 14 the issue of the positives and the potential
 15 for false positives based on that type of
 16 information being available, I guess, to
 17 Eastern Health?
 18 MR. THOMPSON:
 19 A. I don't think I have the expertise to render
 20 an opinion on it, it may well be that there
 21 are additional factors or factors inherent in
 22 the test itself that might be factors in
 23 making such a decision. So I really can't add
 24 to it or advance an opinion.
 25 MR. NEWBURY:

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

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

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

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

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

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

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1 A. Yeah.
 2 MS. NEWBURY:
 3 Q. And Dr. Denic did say that if they had to
 4 retest all the positives, it would cause the
 5 lab to shut down now. So certainly that would
 6 be a -
 7 MR. THOMPSON:
 8 A. Okay.
 9 MS. NEWBURY:
 10 Q. A human resource type issue.
 11 MR. THOMPSON:
 12 A. And I don't mean to diminish that. That would
 13 be considerations other than what I can speak
 14 to.
 15 MS. NEWBURY:
 16 Q. And is it fair to say that if a decision were
 17 made that this would be a valuable exercise,
 18 and perhaps not, you know, retesting of all
 19 the positives is not the only option, there
 20 might be a decision to perhaps do a review of
 21 slides just to verify whether or not the
 22 interpretation of the slides was correct as
 23 opposed to the underlying technical test, or
 24 perhaps a random sample -
 25 MR. THOMPSON:

1 A. Uh-hm.
 2 MS. NEWBURY:
 3 Q. In the lines of what Dr. MacDonald had thought
 4 might be appropriate to come up with some
 5 statistically significant conclusions, but
 6 whatever Eastern Health decided to do, if
 7 there were a resource issue, do you expect it
 8 would have the support of the Department of
 9 Health?

10 MR. THOMPSON:
 11 A. I suspect that it would, given the
 12 circumstances here and the importance of
 13 pursuing all of these important questions.

14 MS. NEWBURY:
 15 Q. Okay, thank you very much, Mr. Thompson.
 16 Those are my questions.

17 THE COMMISSIONER:
 18 Q. Thank you. Mr. Crosbie.

19 MR. ROBERT THOMPSON - EXAMINATION BY CHESLEY CROSBIE,
 20 Q.C.

21 CROSBIE, Q.C.:
 22 Q. Good afternoon, Mr. Thompson. I wonder if you
 23 could just recap and tell us what you expect
 24 to be the agenda for the task force and when
 25 it will wind up, who it's going to report to,

1 cut of that analysis that we're doing.
 2 Attached to it the compendium of tables, so
 3 that further analysis could be done. We've
 4 provided the database itself, of course, to
 5 the Commission so that - and its scientific
 6 advisors could do further analysis should they
 7 wish. So that's all the work that we'll be
 8 doing on that.

9 CROSBIE, Q.C.:
 10 Q. And my other topic is - could we see Document
 11 P-0287, please.

12 REGISTRAR:
 13 Q. What was that number, Mr. Crosbie?

14 CROSBIE, Q.C.:
 15 Q. 287. As you can see there, Mr. Thompson, this
 16 is minutes of executive management meeting,
 17 June 13, 2007, St. John's. Mr. Tilley, as
 18 chief executive officer, and others you can
 19 see being present there, and if we can go to
 20 page two, Item 1.6. It's under the title,
 21 "CEO meeting with Minister and Deputy
 22 Minister", and it goes on to say how the CEO
 23 is scheduled to have a meeting, and there are
 24 some bullet items there; education to
 25 distinguish between errors versus variation in

1 and what mechanism will there be for releasing
 2 the information more broadly to the public?

3 MR. THOMPSON:
 4 A. Okay, just to remind, the task force proper,
 5 its mandate deals with adverse event
 6 management and not with the data that we've
 7 looked at. I just want to make that
 8 distinction. The - our report on adverse
 9 management, we expect will be concluded in
 10 November, and will be made available soon
 11 thereafter to the public. So it will be
 12 available for anyone to look at and review,
 13 and I report to - I'm appointed by the
 14 Cabinet, so I report - I'll provide my report
 15 both to the Premier and the Minister of
 16 Health.

17 CROSBIE, Q.C.:
 18 Q. What about specifically related to clarifying
 19 the facts and statistics surrounding the ER/PR
 20 event?

21 MR. THOMPSON:
 22 A. We won't be doing any more reporting or
 23 analysis on that. The document that we
 24 provided in March to the Commission is the -
 25 while it says "draft" on it, it's the final

1 medical treatment, move to a just culture, and
 2 the fourth item, HIROC's concern with full
 3 disclosure and the impact on insurability.
 4 That last item, in particular, caught my eye.
 5 Can you tell us whether such a meeting did
 6 occur, do you have any knowledge about that?

7 MR. THOMPSON:
 8 A. Well, I met with Mr. Tilley several times in
 9 June, so - but I can't remember if this
 10 specific meeting occurred on that date, but
 11 likely it did. I'd have to look at my
 12 calendar to verify it.

13 CROSBIE, Q.C.:
 14 Q. As to HIROC's concern with full disclosure and
 15 impact on insurability, what can you tell us
 16 about that, is there an issue with coverage
 17 from HIROC?

18 MR. THOMPSON:
 19 A. I can't recall that being discussed. I don't
 20 know whether Mr. Tilley raised it with me or
 21 not.

22 CROSBIE, Q.C.:
 23 Q. There is no issue about insurability raised
 24 with you?

25 MR. THOMPSON:

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

13 CROSBIE, Q.C.:

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

19 MR. THOMPSON:

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

21 CROSBIE, Q.C.:

22 Q. Thank you, sir.

23 THE COMMISSIONER:

24 Q. Ms. Brazil.

25 BRAZIL, Q.C.:

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

3 EXAMINATION BY MADAM COMMISSIONER

4 THE COMMISSIONER:

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

7 MR. THOMPSON:

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

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

7 THE COMMISSIONER:

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

10 MR. THOMPSON:

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

14 THE COMMISSIONER:

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

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1 -

2 MR. THOMPSON:

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

5 THE COMMISSIONER:

6 Q. Yes.

7 MR. THOMPSON:

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

16 THE COMMISSIONER:

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

19 MR. THOMPSON:

20 A. Um-hm.

21 THE COMMISSIONER:

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

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1 Federal/Provincial roles in health -
 2 MR. THOMPSON:
 3 A. Um-hm.
 4 THE COMMISSIONER:
 5 Q. - and one of the things that you're no doubt
 6 aware that has been raised fairly often is,
 7 for example, the lack of standards in
 8 pathology for certain tests or certain aspects
 9 of tests.
 10 MR. THOMPSON:
 11 A. Right.
 12 THE COMMISSIONER:
 13 Q. And it seems to me that it would be silly of
 14 me to think that within a province in this
 15 country someone would either have the
 16 resources or necessarily the easy access to
 17 the expertise to be involved in that kind of
 18 an activity. That would have to be a national
 19 level activity, but all these things cost
 20 money and it means either the cooperation of a
 21 number of different governments or the taking
 22 on of a role by one government that maybe has
 23 more resources than the others.
 24 MR. THOMPSON:
 25 A. Right.

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1 THE COMMISSIONER:
 2 Q. And are you able to tell me whether or not
 3 there is presently existing any kind of a body
 4 involving governments which will tackle that
 5 kind of question which is larger than one of
 6 the groups involved may be able to tackle
 7 reasonably themselves, and might involve, in
 8 fact, cooperation with those outside of the
 9 groups?
 10 MR. THOMPSON:
 11 A. Sure. Well, the standard way for
 12 interprovincial health matters to be tackled
 13 like that is through the Council of Ministers
 14 of Health and their mirror committees from
 15 deputy ministers and other officials. They
 16 meet regularly. They have a very substantive
 17 agenda on specific health matters to help
 18 improve coordination across the country.
 19 Sometimes they deal with reciprocal billing
 20 issues. Somebody from Alberta gets treated
 21 here in a hospital, there's a billing process,
 22 and so that would be one part of their agenda,
 23 and there are lots of other administrative
 24 components of their agenda. But often there
 25 are specific health treatment diagnosis,

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1 health services issues that they discuss, and
 2 quite often actually, there are issues where
 3 it's clear that interprovincial and
 4 territorial coordination would be beneficial
 5 because the group acting together would be
 6 more effective than everybody acting
 7 separately.
 8 So one example is the establishment of
 9 the Canadian Patient Safety Institute. In
 10 that case, the Federal Government played a
 11 major role because they actually injected the
 12 financing into the idea. But nonetheless, it
 13 exists through cooperation. Health Council of
 14 Canada actually is another example. Again,
 15 the injection of Federal money was an
 16 important way to facilitate it.
 17 But in other circumstances, provinces and
 18 territories act alone and with their own
 19 money, and with their own initiative. The
 20 Canadian Blood Services is an example of that.
 21 Canadian Council on Organ Donation and
 22 Transplantation, although I'm not sure if that
 23 actually still exists today. There was some
 24 uncertainty about its continuation. But there
 25 are examples of provincial, interprovincial

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1 cooperation on issues. Now those are major
 2 issues where you're creating new institutions
 3 and injecting funding.
 4 There are other more transitory issues
 5 where if a set of standards needs to be
 6 developed, they can strike special purpose
 7 committees. They can engage not just people
 8 within their departments, but experts from
 9 their departments or from their health
 10 systems, and this is done regularly to reach a
 11 consensus on a matter, and then if that
 12 consensus needs some kind of official
 13 blessing, it can be brought back to the
 14 Council of Ministers for adoption.
 15 So that forum actually is a very
 16 productive way, has been in my experience, at
 17 any rate, a very productive way to process
 18 some of those issues. But it won't necessarily
 19 be the best forum for every issue. I don't
 20 know if, for example, IHC standards for
 21 pathology labs is the right issue. I'd have
 22 to think about that a bit more. But if there
 23 was a -
 24 THE COMMISSIONER:
 25 Q. Frankly, I'm not sure that that's the right

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

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1 important throughout, the other--because this
 2 group has a limited budget as well to act on
 3 these things. They may say no, if that's of
 4 interest to you and maybe two others, well, go
 5 and just two or three of you sort it out. We
 6 don't want it to be--have a place on the
 7 national agenda. So not all issues will have
 8 the momentum to get to that level.
 9 Just one other comment. Often the
 10 Federal Government is not a player in these
 11 issues because--well, the Federal Government,
 12 interestingly, has an important role in the
 13 territorial health systems but the provincial
 14 governments generally regard issues like I've
 15 talked about, like blood service and organ
 16 transplantation, as health operational issues
 17 within provincial jurisdiction, and they like
 18 to talk to each other, and then if they have--
 19 if they reach priorities, they'll deal with
 20 each other on it, without there being a
 21 Federal role. But sometimes the Federal
 22 Government will come to the table and sit
 23 independently and say "we share a concern in
 24 an area, like patient safety, and we're
 25 willing to inject some funding into this, if

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

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

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