

<p>COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p>BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p>October 3, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Jackie Brazil Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Laura Brocklehurst. Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike NL Medical Association</p> <p>Jennifer Newbury Canadian Cancer Society (NL Division)</p> <p>Blair Pritchett. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p>THIS PAGE ONLY REVISED NOVEMBER 18, 2008</p> <p>LIST OF EXHIBITS</p> <p>EXHIBIT P-2885 to EXHIBIT P-2889 Pg. 5</p> <p>EXHIBITS P-2933 TO P-2938, INCLUSIVE. Pg. 5</p> <p>EXHIBITS P-2945 TO P-2947, INCLUSIVE. Pg. 5</p> <p>EXHIBIT P-2950. Pg. 5</p> <p>EXHIBIT P-3004. Pg. 5</p> <p>EXHIBIT P-3090. Pg. 5</p> <p>EXHIBIT P-3091. Pg. 5</p> <p>EXHIBITS P-3093 TO P-3097, INCLUSIVE. Pg. 5</p> <p>EXHIBIT P-3099. Pg. 5</p> <p>EXHIBITS P-3101 TO P-3104, INCLUSIVE. Pg. 5</p> <p>EXHIBITS P-3106 TO P-3110, INCLUSIVE. Pg. 5</p> <p>EXHIBIT P-3112. Pg. 5</p>
<p>TABLE OF CONTENTS</p> <p>MR. TERRY GULLIVER - SWORN</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 4 - 354</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER:</p> <p>2 Q. Please be seated. Ms. Chaytor.</p> <p>3 MR. TERRY GULLIVER (SWORN) EXAMINATION BY SANDRA CHAYTOR,</p> <p>4 Q.C.</p> <p>5 REGISTRAR:</p> <p>6 Q. Would you please state and spell your complete</p> <p>7 name for the Commission?</p> <p>8 MR. GULLIVER:</p> <p>9 A. Terry Gulliver, T-E-R-R-Y, G-U-L-L-I-V-E-R.</p> <p>10 REGISTRAR:</p> <p>11 Q. Thank you.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. Good morning, Mr. Gulliver. Commissioner,</p> <p>14 there are a number of exhibits that I would</p> <p>15 ask, please, to have entered this morning.</p> <p>16 And they are P-2885 to P-2889, P-2933 to P-</p> <p>17 2938, P-2945 to P-2947, P-2950, P-3004, P-</p> <p>18 3090, P-3093 to P-3097, P-3099, P-3101 to P-</p> <p>19 3104, P-3106 to P-3110 and P-3112.</p> <p>20 REGISTRAR:</p> <p>21 Q. Thank you, Ms. Chaytor. (Inaudible).</p> <p>22 THE COMMISSIONER:</p> <p>23 Q. It's on my list, as well, is that one you want</p> <p>24 entered?</p> <p>25 CHAYTOR, Q.C.:</p>

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1 Q. Okay, thank you very much -
 2 THE COMMISSIONER:
 3 Q. 3091.
 4 CHAYTOR, Q.C.:
 5 Q. - not on my list. So P-3 -
 6 THE COMMISSIONER:
 7 Q. 091.
 8 CHAYTOR, Q.C.:
 9 Q. - 091, thank you.
 10 THE COMMISSIONER:
 11 Q. Entered.
 12 EXHIBIT ENTERED AND MARKED P-2885.
 13 EXHIBIT ENTERED AND MARKED P-2889.
 14 EXHIBITS ENTERED AND MARKED P-2933 TO P-2938, INCLUSIVE.
 15 EXHIBITS ENTERED AND MARKED P-2945 TO P-2947, INCLUSIVE.
 16 EXHIBIT ENTERED AND MARKED P-2950.
 17 EXHIBIT ENTERED AND MARKED P-3004.
 18 EXHIBIT ENTERED AND MARKED P-3090.
 19 EXHIBIT ENTERED AND MARKED P-3091.
 20 EXHIBITS ENTERED AND MARKED P-3093 TO P-3097, INCLUSIVE.
 21 EXHIBIT ENTERED AND MARKED P-3099.
 22 EXHIBITS ENTERED AND MARKED P-3101 TO P-3104, INCLUSIVE.
 23 EXHIBITS ENTERED AND MARKED P-3106 TO P-3110, INCLUSIVE.
 24 EXHIBIT ENTERED AND MARKED P-3112.
 25 CHAYTOR, Q.C.:

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1 Q. Mr. Gulliver, perhaps we could begin, please,
 2 if you could take us through your educational
 3 background and your work experience up to your
 4 current position at Eastern Health?
 5 MR. GULLIVER:
 6 A. Well, before my formal education in colleague,
 7 I was a graduate of St. Bon's School, I went
 8 to Gonzaga High School. From there I directly
 9 proceeded to the College of Trades and
 10 Technology, as it was called then, completed
 11 my three year diploma in medical laboratory
 12 technology, finished in June of 1979. My
 13 first job as a medical lab technologist, I
 14 went to work in St. Anthony for the
 15 International Grenfell Association. I stayed
 16 there less than a year. Then I came back home
 17 to St. John's and I went to work at the Health
 18 Sciences in the pathology laboratory. That
 19 was 1980.
 20 CHAYTOR, Q.C.:
 21 Q. And when you graduated then in 1979 with your-
 22 -with the medical laboratory program, from
 23 that, what did that entitle you to able to do
 24 at that point?
 25 MR. GULLIVER:

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1 A. Well, any student that comes from the training
 2 program anywhere in Canada you are certified
 3 as a general registered technologist. That
 4 means pretty well during your training
 5 program, your study, you're covering off five
 6 of the major disciplines within laboratories,
 7 which would be, I'm sure you've heard before,
 8 hematology, biochemistry, blood bank,
 9 pathology and microbiology. Upon graduation
 10 from your training program, whether it's in
 11 St. John's or BC or Ontario, all students are
 12 required to write a national certification
 13 examination in each of those subjects and you
 14 graduate and then you are certified to
 15 practice as a medical lab technologist in
 16 Canada.
 17 CHAYTOR, Q.C.:
 18 Q. Okay, and in St. Anthony would you have been
 19 doing a little bit of everything within those
 20 five disciplines?
 21 MR. GULLIVER:
 22 A. Except for pathology, actually. Yeah, in St.
 23 Anthony, you know, it's a small hospital
 24 laboratory. Up there we were required to
 25 rotate and do duties, I worked in chemistry, I

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1 worked in hematology, blood bank, microbiology
 2 and did blood collection, phlebotomy, the
 3 front end piece. However, you know, the--
 4 like, their test menu, what's available on
 5 site at the hospital in St. Anthony wouldn't
 6 be as extensive as the Health Sciences, so it
 7 was generally a general laboratory.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. And when you came then to St. John's to
 10 the general laboratory, I guess that would
 11 have been 1980 then?
 12 MR. GULLIVER:
 13 A. Yeah.
 14 CHAYTOR, Q.C.:
 15 Q. And you were assigned to the pathology lab?
 16 MR. GULLIVER:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. And what were your duties at that point in
 20 time?
 21 MR. GULLIVER:
 22 A. Well, initially, you know, as a--it was entry
 23 level as a medical laboratory technologist.
 24 At that time I think we had six technical
 25 staff in the laboratory. And we were required

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1 to perform all the general functions you'd
 2 expect in a pathology lab. It would be
 3 assisting the pathologist at the gross bench,
 4 it would be doing a basic embedding, cutting
 5 of blocks and slides and then performing
 6 stains, various stains on the slides for the
 7 pathologist, and then the sort of your kind of
 8 post-analytical work, filing of blocks, filing
 9 of slides, just basically your general lab
 10 technologist duties.
 11 CHAYTOR, Q.C.:
 12 Q. And when were you first introduced to
 13 immunohistochemistry or what ultimately would
 14 become the beginnings of immunohistochemistry
 15 at the General Hospital?
 16 MR. GULLIVER:
 17 A. Early on, maybe after a couple of years there
 18 in the lab as a technologist at the time our
 19 chief or our university chair was Dr. Wang and
 20 he obviously expressed an interest in this new
 21 kind of testing that was being introduced to
 22 the laboratory and it was immunoflorescent
 23 staining, which is really the precursor to
 24 immunohistochemistry staining. The major
 25 differences are that immunoflorescent

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1 staining, the antibodies that were used were
 2 only applied on fresh frozen tissue, so your
 3 tissue before it even got into formaldehyde,
 4 as you heard, or formalin, to be fixed, you
 5 took fresh tissue, you snapped for--you froze
 6 it, you cut it and then you applied the
 7 antibody stains to those slides. It was
 8 generally only used, Ms. Chaytor, for, mostly
 9 for kidney biopsies, patients who are post
 10 transplant, physicians were looking to see if
 11 the transplant was rejecting or being fine.
 12 And then we started using it later on also for
 13 skin biopsies.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And how were you trained at that point
 16 in time to do the immunoflorescent staining?
 17 MR. GULLIVER:
 18 A. Well, I guess I should back up a little bit.
 19 The training that we took place then, well,
 20 basically Dr. Wang, you know, I spent time
 21 with him and he walked me through the
 22 procedure multiple times and I performed them
 23 and cut the slides and performed them. You
 24 know, he would interpret them and read them
 25 and come back and tell me, yes, they're good

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1 or they're not good. But even before that,
 2 you know, in our general training program
 3 while we're not taught immunohistochemistry
 4 staining and all the, everything that
 5 surrounds that, you are taught the basic
 6 principles of antigen antibody, interactions
 7 and reactions, so I did have that basic level
 8 of knowledge.
 9 CHAYTOR, Q.C.:
 10 Q. From your schooling?
 11 MR. GULLIVER:
 12 A. From my training program. And along with the
 13 side-by-side demonstrations from Dr. Wang, you
 14 know, he had a couple of textbooks. I
 15 remember one in particular, I think it was
 16 called Reid Sternberger, was at the time an
 17 early book, textbook about immunoflorescent
 18 staining that we had, you know, that we read
 19 and went through.
 20 CHAYTOR, Q.C.:
 21 Q. And was it just you or were there other
 22 technologists involved in this?
 23 MR. GULLIVER:
 24 A. At the time it was just me.
 25 CHAYTOR, Q.C.:

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1 Q. And how did that come to be, why were you
 2 chosen?
 3 MR. GULLIVER:
 4 A. I wasn't chosen at all, really. It was there
 5 were about five or six technologists at the
 6 time working in the laboratory. It was
 7 something new. And Dr. Wang just came out and
 8 spoke to all the staff and said there's, you
 9 know, there's a new procedure I'd like to
 10 develop and put in place and do I have a
 11 volunteer who would like to be the one to
 12 learn that. I guess I -
 13 CHAYTOR, Q.C.:
 14 Q. So you volunteered?
 15 MR. GULLIVER:
 16 A. I guess I was the one that volunteered, yeah.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And so then did that progress and did
 19 you eventually also take part in IHC in
 20 paraffin embedded tissue?
 21 MR. GULLIVER:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. And so how long did you then do that procedure
 25 and what training did you receive into that?

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1 MR. GULLIVER:
 2 A. Yes, so I mean, this procedure, and this
 3 procedure what we just talked about started in
 4 the early '80s. It's actually still performed
 5 today. We still do, the technologists in our
 6 pathology lab, immunoflorescent staining is
 7 still performed on fresh frozen tissue, it's
 8 still being used for, mostly for kidney
 9 biopsies. But just, I mean, that really was
 10 the introduction of the beginnings of
 11 immunohistochemical staining. And then maybe
 12 within two or three years after were doing
 13 that procedure, vendors and companies were
 14 coming out and research companies were coming
 15 out with antibodies that could be applied to,
 16 you know, paraffin embedded blocks, which
 17 meant that tissue would have gone through the
 18 fixation process and processing. And the
 19 advantage of being an applied--this principle
 20 to paraffin embedded blocks was that once you
 21 did the immunoflorescent staining on the fresh
 22 frozen tissue, after a period of number of
 23 days, maybe weeks, the slides then were no
 24 longer any good because the staining intensity
 25 just disappeared, because you're looking for

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1 florescence in the cells. With the paraffin
 2 embedded, you now could take slides and
 3 perform the procedure and then you had a
 4 permanent stain. So you could file that and
 5 you can keep it for, we keep them for 20
 6 years. There is also an advantage that if in
 7 two or three years time the same patient
 8 returned back to the pathology lab for various
 9 reasons, you could actually go back and pull
 10 their former slides and the pathologist then
 11 could review then the former case and the
 12 former slides. So it was huge, huge
 13 advancement in pathology, in general. And -
 14 CHAYTOR, Q.C.:
 15 Q. So that would take you up to around the mid
 16 1980s then?
 17 MR. GULLIVER:
 18 A. That would be about the mid '80s to the late
 19 '80s.
 20 CHAYTOR, Q.C.:
 21 Q. And how many stains would you or how many
 22 antibodies would you be working with then in
 23 the immunohistochemical lab?
 24 MR. GULLIVER:
 25 A. In the very beginning it was very few, very

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1 crude, I mean, because that's all was
 2 available to the marketplace.
 3 CHAYTOR, Q.C.:
 4 Q. And who taught you how to do that, who taught
 5 -
 6 MR. GULLIVER:
 7 A. Well, again, just with Dr. Wang. We also had
 8 another pathologist on staff at the Health
 9 Sciences, Dr. Chittal. He also had a great
 10 interest in IHC in general, a lot from the
 11 research side. Because, I mean, back in the--
 12 by the mid '80s, late '80s a lot of research
 13 was taking place across the world into this
 14 whole new science that was being applied in
 15 pathology. Because pathology labs had been,
 16 you know, been around since the '30s and '40s
 17 and doing, you know, tissue fixation, paraffin
 18 embedding, your H & E slides. And then the
 19 histochemical stains that were well developed
 20 in the lab, immunohistochemical staining was
 21 something very, very new and the mid '80s and
 22 late '80s and early '90s and even today,
 23 there's still a fair amount of research work
 24 that's being applied to that science piece in
 25 pathology.

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1 CHAYTOR, Q.C.:
 2 Q. So Dr. Wang worked with you and to a lesser
 3 degree, Dr. Chittal?
 4 MR. GULLIVER:
 5 A. And Dr. Chittal became involved also, yes.
 6 CHAYTOR, Q.C.:
 7 Q. And what about from the technical side, was
 8 there anyone who offered you any assistance
 9 from that perspective?
 10 MR. GULLIVER:
 11 A. No, not really. There was, I was the only
 12 technologist who was performing the procedure.
 13 And again -
 14 CHAYTOR, Q.C.:
 15 Q. And you continued for some time to be the only
 16 technologist, I take it?
 17 MR. GULLIVER:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And by this point in time it's not being done
 21 by any machinery, this is all -
 22 MR. GULLIVER:
 23 A. And I guess I should, maybe I should give you
 24 some explanation there, also. At this time,
 25 and I know through all the testimony you've

Page 17

1 seen here, you've talked about the DAKO
 2 autostainer and then to our newer Ventana
 3 system. You know, pre DAKO how these
 4 procedures were performed were very similar
 5 but the steps you had to take was that every--
 6 one of the critical pieces of doing this
 7 procedure was that the slide, and you've seen
 8 glass slides, it's important that the slide
 9 not dry out, that the tissue not dry out. So
 10 when I was doing this procedure in the mid
 11 '80s, if I was doing a run of 20 or 30 slides,
 12 which would be a common thing to do, because
 13 you may have three or four patient cases, each
 14 may have four or five or six slides or
 15 antibodies, so I would have as many as 24 or
 16 30 petri dishes. And a petri dish, as you
 17 may, some of the people may know, are just a
 18 small round plastic dish with a cover on it.
 19 And in that dish I would place paper towel in
 20 the base of it and I would wet the paper towel
 21 to keep it moist and you put each individual
 22 slide into an individual petri dish and keep
 23 it covered. So when you're doing your
 24 procedure and you're incubating your antibody
 25 for 30 minutes, for example, each one was done

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1 individually and it was covered, so you
 2 provided this humid kind of chamber for each
 3 individual slide. And that's what we did for
 4 many, many, many years until DAKO, as you
 5 know, was the vendor we were using for the
 6 vast majority of our antibodies and secondary
 7 reagents, when, you know, they came out and
 8 developed what we call the DAKO autostainer
 9 and, you know, and I think some people think
 10 that it became automated, really, the
 11 procedure was not automated at all.
 12 CHAYTOR, Q.C.:
 13 Q. And I'll take you to that and get you to
 14 explain about the procedure at that point in
 15 time. Back then when you first started doing
 16 this procedure and it was done in the manual
 17 way that you've described, there were very few
 18 antibodies and did any of those -
 19 MR. GULLIVER:
 20 A. We may have had maybe ten and then a couple
 21 may get added, but it -
 22 CHAYTOR, Q.C.:
 23 Q. Did any of them require antigen retrieval?
 24 MR. GULLIVER:
 25 A. No, no.

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1 CHAYTOR, Q.C.:
 2 Q. And you continued to -
 3 MR. GULLIVER:
 4 A. There were no prognostic markers being done
 5 then.
 6 CHAYTOR, Q.C.:
 7 Q. And you continued then to be the only
 8 technologist. And just take us through then
 9 your progression then in terms of your career
 10 path?
 11 MR. GULLIVER:
 12 A. Then in 1986 at the time our pathology
 13 supervisor, he wasn't well, he went off work
 14 and he was away for over a year. And during
 15 that year period at the time the lab manager
 16 for the Health Sciences laboratory, Max
 17 Thornhill, he would come to me for any issues
 18 within pathology. And then in 1987 Mr.
 19 Pittman formally retired, the position was
 20 advertised, I went through the whole
 21 recruitment interview process and, you know, I
 22 was selected as the new pathology supervisor,
 23 and that was in 1987.
 24 CHAYTOR, Q.C.:
 25 Q. What did it mean to be the pathology

Page 20

1 supervisor, is that the equivalent of the
 2 pathology manager position?
 3 MR. GULLIVER:
 4 A. It would be today, yes. But I mean, in this -
 5 CHAYTOR, Q.C.:
 6 Q. But this was just for the General Hospital?
 7 MR. GULLIVER:
 8 A. Right. In those days we weren't called
 9 managers, we were just called, we were called
 10 supervisors.
 11 CHAYTOR, Q.C.:
 12 Q. Okay.
 13 MR. GULLIVER:
 14 A. So when that happened, and of course, you
 15 know, going into management, we'd say, it
 16 meant that within our union contracts
 17 management staff are not to do technical bench
 18 work. I mean, that is the bargaining unit
 19 staff -
 20 CHAYTOR, Q.C.:
 21 Q. So this is 1987?
 22 MR. GULLIVER:
 23 A. 1987.
 24 CHAYTOR, Q.C.:
 25 Q. So you came off the bench in 1987?

Page 21

1 MR. GULLIVER:
 2 A. So I went through a period where I came off
 3 the bench and then that's when two--the other
 4 technologists in laboratory, Mary Butler and
 5 Peggy Welsh, and actually before I even became
 6 supervisor, I mean, Peggy and Mary were
 7 getting involved in immunoflorescent staining.
 8 By that time they had already been trained in
 9 doing like the kidney biopsies, going up and
 10 collecting the specimen and do the frozen
 11 sections and doing the staining,
 12 immunoflorescence. Because, you know, we
 13 just--we reaches a point where we couldn't
 14 rely just on one technologist to perform these
 15 procedures because if I'm, you know, if I was
 16 taken off on vacation or if I was going to be
 17 away, you always needed that backup person
 18 there.
 19 CHAYTOR, Q.C.:
 20 Q. So Mary Butler and Peggy Welsh at some point
 21 started to do a little bit of the work that
 22 you were doing. And then when you became
 23 supervisor, they took it over?
 24 MR. GULLIVER:
 25 A. And they pretty well then took it over, over a

Page 22

1 period of time, yeah.
 2 CHAYTOR, Q.C.:
 3 Q. And how were they chosen to be the ones to do
 4 this?
 5 MR. GULLIVER:
 6 A. At the time they were the two senior
 7 technologists who--of the staff pool that
 8 existed at the Health Sciences pathology lab.
 9 They were the two senior technologists in
 10 pathology lab, you know, as opposed to the
 11 other three or four staff who were there. And
 12 -
 13 CHAYTOR, Q.C.:
 14 Q. And what does it mean, like, senior, does it
 15 matter -
 16 MR. GULLIVER:
 17 A. Longest serving.
 18 CHAYTOR, Q.C.:
 19 Q. Longest serving, right, okay. Doesn't matter
 20 if you're longest serving in a particular area
 21 or not or -
 22 MR. GULLIVER:
 23 A. Oh, in pathology -
 24 CHAYTOR, Q.C.:
 25 Q. - have a certain aptitude or interest in a

Page 23

1 particular area?
 2 MR. GULLIVER:
 3 A. Well, they're the longest serving in
 4 pathology. You know, we wouldn't have taken
 5 technologists from biochemistry and bring them
 6 over to pathology to start learning these new
 7 techniques. You really need to have a good
 8 pathology background, you know, to begin with.
 9 CHAYTOR, Q.C.:
 10 Q. And who trained Mary and Peggy?
 11 MR. GULLIVER:
 12 A. I guess it's a combination that, you know, for
 13 the knowledge I had gained over the prior
 14 three or four years with Dr. Wang. And, of
 15 course, Dr. Wang had left in the mid '80s.
 16 But Dr. Chittal, who was one of our staff
 17 pathologists, he really--by this time he has
 18 a great interest in IHC and he provided a lot of
 19 material and a lot of guidance to the staff as
 20 new antibodies came on, and I would say for
 21 many years he was our key person that we went
 22 to.
 23 CHAYTOR, Q.C.:
 24 Q. Dr. Chittal?
 25 MR. GULLIVER:

Page 24

1 A. Yeah.
 2 CHAYTOR, Q.C.:
 3 Q. And you yourself then moved on into this
 4 management position. And -
 5 MR. GULLIVER:
 6 A. '87, yes.
 7 CHAYTOR, Q.C.:
 8 Q. 1987. so I take it you're still fairly junior
 9 yourself at that point in time.
 10 MR. GULLIVER:
 11 A. Actually, I was, I think I was the most junior
 12 lab tech when I started pathology in seniority
 13 wise.
 14 CHAYTOR, Q.C.:
 15 Q. Yes. And so did you have any concerns in 1987
 16 in terms of taking on the management position,
 17 in terms of your own level of experience?
 18 MR. GULLIVER:
 19 A. I can't say yes and I can't say no. You know,
 20 by 1987, you know, I've got seven years of lab
 21 experience. I guess maybe I should also
 22 mention that, you know, you still have your
 23 work life and then in sort of side by side
 24 with my work life, with my profession, medical
 25 laboratory profession, you know, I have

1 volunteered pretty well my whole career for
 2 various positions with our Newfoundland and
 3 Labrador Society of Medical Lab Technologists.
 4 I served for eight years as president of our
 5 provincial association. You know, in the mid
 6 '90s I was the first Newfoundlander who was
 7 elected as president of our Canadian
 8 Association, the CSMLS. I served four years
 9 on the Board of Directors there, but I guess,
 10 you know, side by side, your work life and
 11 your professional life, I gained an awful lot
 12 of experience that you can apply from your
 13 professional side to your work side and vice
 14 versa. But by 19 -

15 CHAYTOR, Q.C.:

16 Q. In terms of management experience, had you had
 17 any management experience?

18 MR. GULLIVER:

19 A. No, no direct management experience, but when
 20 I was first appointed supervisor, I--actually,
 21 maybe I should say this, you know, when that
 22 position was opened and I applied for it, I
 23 remember I was probably the junior applicant
 24 and I think that -

25 COFFEY, Q.C.:

1 MR. GULLIVER:

2 A. I would have to say amongst the technical
 3 staff, I don't think there was any concern.
 4 You know, we had a small group. I mean, at
 5 the time now, the pathology lab at the Health
 6 Sciences was not as large and complex as it is
 7 today. At the time, I think the technical
 8 staff, there was no issue. The pathologists
 9 staff, I think that we had a really good crew
 10 at the Health Sciences at the time in
 11 pathology. I had been there for seven years.
 12 Most of the pathologists who were there when I
 13 became the supervisor were still there, and
 14 actually a couple of them were kind of--were
 15 more joke around with me, you know, to say
 16 like the young guy type of thing being
 17 promoted to supervisor, but I never
 18 encountered any animosity whatsoever.

19 CHAYTOR, Q.C.:

20 Q. And how about amongst the other lab
 21 supervisors?

22 MR. GULLIVER:

23 A. At that particular time, I don't--not really,
 24 but over time, there was a little bit, I have
 25 to admit that, and I guess maybe we should

1 Q. So a lot more experienced people had applied
 2 as well?

3 MR. GULLIVER:

4 A. Um-hm. There were--I know there were 10, 12,
 5 13 other people applied, not just within the
 6 Health Sciences, but from across the province
 7 it was advertised, and I have to say that I
 8 can clearly remember the day that Mr.
 9 Thornhill, who was our lab manager, he called
 10 me up to his office and, you know, he pretty
 11 well said to me that "we're going to offer you
 12 this position" and I asked him why.

13 CHAYTOR, Q.C.:

14 Q. And what was his answer?

15 MR. GULLIVER:

16 A. And he said that "because I see the most
 17 potential in you of all the candidates that we
 18 interviewed."

19 CHAYTOR, Q.C.:

20 Q. And did anyone else then, did it cause any
 21 kind of concern or discussion amongst anyone
 22 else in terms of the fact that you had less
 23 experience than others? Was it of any
 24 concern, for example, to pathologists at that
 25 point in time or over time?

1 continue and progress through.

2 CHAYTOR, Q.C.:

3 Q. Sure.

4 MR. GULLIVER:

5 A. Because I didn't just--it didn't just end in
 6 1987 when I was appointed the pathology
 7 supervisor. About a year into the pathology
 8 position, Mr. Thornhill spoke to me and, you
 9 know, he said that I was doing a great job in
 10 pathology. He was really impressed at, you
 11 know, how I've handled myself and all those
 12 kinds of things, and I don't know if he was
 13 kind of buttering me up for what he was going
 14 to ask me to do, but then he asked would I be
 15 willing to take over the blood collection
 16 services for the Health Sciences. At that
 17 time, what we call--now we call it the pre-
 18 analytical or client services, but there was a
 19 blood collection team at the Health Sciences
 20 that worked in the laboratory. They did the
 21 outpatient blood collections and we also had
 22 an in-house team that would go to the in-
 23 patients early in the mornings and do the
 24 blood collections, and that part of the
 25 laboratory is traditionally--has nothing to do

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1 with the pathology part of the laboratory.
 2 It's more aligned with the biochemistry,
 3 hematology, coagulation, blood bank part.
 4 CHAYTOR, Q.C.:
 5 Q. So why would you be asked to take that on?
 6 MR. GULLIVER:
 7 A. I have no idea, but he did ask.
 8 CHAYTOR, Q.C.:
 9 Q. So in addition to being the supervisor then of
 10 pathology, you also took on the blood
 11 collection?
 12 MR. GULLIVER:
 13 A. Right, so a the time, I think it was Vern
 14 Whelan, who was the biochemistry manager, and
 15 he was the chemistry manager and he was
 16 managing blood collection services, and I
 17 think he had become a bit frustrated with it
 18 and Mr. Thornhill asked if I would take it
 19 over, and I told him I will give it a try for
 20 six months, with the proviso that if I felt it
 21 was too much or I felt that I couldn't handle
 22 it, that I'd have to go to him and say "look,
 23 you know, I really can't continue on with
 24 this" and that happened probably around 1988,
 25 and obviously turned -

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1 CHAYTOR, Q.C.:
 2 Q. I'm sorry, 19?
 3 MR. GULLIVER:
 4 A. Around 1988 this happened.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, yes.
 7 MR. GULLIVER:
 8 A. And I did keep blood collection services and
 9 for a number of years. Up until 1996, blood
 10 collection services for the Health Sciences
 11 remained with me and I have to say that I
 12 think that I did a lot of good things in that
 13 part of our lab services. We really
 14 developed, at that point in time, a full pre-
 15 analytical team staff with trained lab
 16 assistants who were taking over the blood
 17 collection services. We added new duties to
 18 that staff where they were assisting the
 19 technologists in doing specimen preparations
 20 for chemistry, hematology. They were doing
 21 the centrifuging, the pipetting and like, you
 22 know, making sub samples and all that kind of
 23 stuff, got developed under my, I guess,
 24 direction or being the manager.
 25 CHAYTOR, Q.C.:

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1 Q. And I appreciate Mr. Thornhill's sentiment and
 2 saw the most potential in you when he chose
 3 you as the supervisor. Did anyone, at that
 4 point in time, did Mr. Thornhill or anyone
 5 else provide you with any additional training
 6 in terms of managerial skills?
 7 MR. GULLIVER:
 8 A. Yes. I mean, when I became the--when I first
 9 became--I should go back, yes, Ms. Chaytor.
 10 When I first became the supervisor of General
 11 Hospital, the General Hospital actually had
 12 sort of an eight-week training program for new
 13 supervisors, new managers, and we spent one
 14 day a week pretty well for eight consecutive--
 15 I think it was eight weeks or it could be ten
 16 weeks--where, for example, out in--first, one
 17 Wednesday, you would do all day, you would
 18 talk about human resources and staff relations
 19 and union contracts and interactions like
 20 those kinds of things. Another week, we would
 21 spend a full day talking about, you know,
 22 budgeting, financial, and so, yeah, we did
 23 have an eight-week entry level program for new
 24 managers.
 25 CHAYTOR, Q.C.:

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1 Q. One day a week for eight weeks?
 2 MR. GULLIVER:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, and in addition then to taking on that
 6 and the blood service collection, were you
 7 assigned any other major projects when you
 8 became supervisor of the pathology lab?
 9 MR. GULLIVER:
 10 A. Well, it coincided, when I was appointed
 11 supervisor, it coincided with the Health
 12 Sciences General Hospital making a decision
 13 that we're going to implement the Meditech
 14 hospital information system, and in that that
 15 parcel was the laboratory information system
 16 piece of Meditech.
 17 CHAYTOR, Q.C.:
 18 Q. Okay, and what was your involvement then in
 19 that?
 20 MR. GULLIVER:
 21 A. Well, I pretty well had to play the lead role
 22 as the pathology supervisor, along with the
 23 other managers or supervisors, like for
 24 chemistry, hematology and blood bank, all of
 25 us played a very active role in actually

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1 travelling to Boston where Meditech
 2 headquarters is located. We went down there
 3 for a week of training and really the week of
 4 training wasn't training on how to use the
 5 system, it was a week of training of how to
 6 read the thousands of pages of material that
 7 we had to go through and to be able to put us
 8 through step by step of how to sort of apply
 9 the Meditech system to the Health Sciences.

10 CHAYTOR, Q.C.:
 11 Q. And what training or what experience would you
 12 have had in that kind of electronic or IT up
 13 to that point in time?

14 MR. GULLIVER:
 15 A. In 1987?

16 CHAYTOR, Q.C.:
 17 Q. Yes.

18 MR. GULLIVER:
 19 A. Very little, as most other people.

20 CHAYTOR, Q.C.:
 21 Q. Yes.

22 MR. GULLIVER:
 23 A. I mean, even computer technology was not
 24 something that was--we thought this was a
 25 huge, major thing, just for the whole hospital

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1 that we're going to be able to start moving
 2 away from paper requisitions and paper reports
 3 going out, you know, by the hundreds every
 4 day. You know, in my training at the college,
 5 you know, we never had computers in the late
 6 '70s to work with. However, before I did--
 7 well, maybe when I was supervisor, the college
 8 actually did have a computer programming
 9 course that was offered in the night time that
 10 I did go do on my own.

11 CHAYTOR, Q.C.:
 12 Q. Was that before you got involved with
 13 implementing the Meditech?

14 MR. GULLIVER:
 15 A. I don't even think I was supervisor then, it
 16 was just something that the college offered
 17 and I was interested in, and when you talk
 18 about computer training, it's nothing like if
 19 you went today for a week training at
 20 Microsoft. This was talking about your bits
 21 and bytes and very basic computer language
 22 really.

23 CHAYTOR, Q.C.:
 24 Q. So what did you have to do then in terms of
 25 where the laboratory medicine program, it's

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1 known now to be the laboratory medicine
 2 program, what did you have to do to bring the
 3 Meditech system online for the lab? Like what
 4 actually was--what did that entail? What did
 5 you have to do? Were you setting up
 6 dictionaries? What were you doing?

7 MR. GULLIVER:
 8 A. Well, I mean, I guess and it wasn't just
 9 myself, I mean, obviously within each of the
 10 modules, lab module, pathology module, blood
 11 bank module, micro module, we had other staff
 12 involved. I mean, I had staff involved with
 13 me.

14 CHAYTOR, Q.C.:
 15 Q. So you did the pathology end?

16 MR. GULLIVER:
 17 A. I did the pathology end, yes, and then there's
 18 one module that's called LIS shared. It's the
 19 lab information systems shared dictionaries
 20 where there are commonalities amongst all the
 21 modules and all the managers at the time, we
 22 all worked together on the LI shared
 23 dictionaries, but for the pathology module,
 24 yes, it was pretty well my responsibility to
 25 ensure that we have, for example, all the

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1 different kinds of procedures and tests that
 2 go into the Meditech system. Working with the
 3 pathologists and looking at here's how a
 4 report will print from the computer, as
 5 opposed to how the secretaries type it up on a
 6 typewriter. I mean, it was just an enormous
 7 change for the whole organization.

8 CHAYTOR, Q.C.:
 9 Q. And you would--as time went on, obviously new
 10 tests come along, even within IHC, new
 11 antibodies come along and quite some volume as
 12 time progresses. Who was then responsible for
 13 updating the system or keeping it current with
 14 new things that were coming on in the
 15 pathology lab?

16 MR. GULLIVER:
 17 A. Well, you've asked me--you're making two
 18 points there. Updating the system would come
 19 from Meditech, maybe every couple of years,
 20 like most computers now today it's almost
 21 every two weeks you're getting a computer
 22 update, but back then, every couple of years,
 23 Meditech would inform us in advance that they
 24 have a new version of the system coming out.
 25 They would pre-send you all of the different

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1 new capabilities of the system that we would
 2 go into the test system and we would make sure
 3 everything works before it was transferred
 4 over to live.
 5 On an ongoing basis, if there was a new
 6 procedure or a new work code that needed to go
 7 into the system, I mean, obviously early on, I
 8 mean, I would be the point person and would do
 9 that, and I don't know exactly at what time
 10 frame, Ms. Chaytor, but for example Peggy
 11 Welsh, who you've heard here testify, who was
 12 one of our senior techs, she also, I guess,
 13 she could log into the computer system and
 14 Peggy helped me an awful lot if there were new
 15 procedures to put in and capturing the work
 16 load and those kinds of things.
 17 CHAYTOR, Q.C.:
 18 Q. And in implementing then Meditech for the
 19 pathology lab, did you run into any particular
 20 challenges?
 21 MR. GULLIVER:
 22 A. Certainly. I think the biggest challenge was
 23 just understanding what this whole computer
 24 system is, you know, we're talking about 1987.
 25 It was huge venture for the whole hospital,

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1 not just for the laboratory. It took an awful
 2 lot of interaction with other parts of the
 3 health care system and coordinating test menus
 4 and order entries with nursing staff, for the
 5 lab staff. It was also--I won't say it was--I
 6 don't know if it was a significant challenge.
 7 I have to say, as a group, the technologists
 8 and the staff who would mostly use the system
 9 were more inclined to learn the system as
 10 opposed to the physicians. So the
 11 pathologists group were not difficult, but it
 12 was much more difficult to get the
 13 pathologists to really start using this new
 14 computer system. You know, I can remember one
 15 of our pathologists and she recently retired,
 16 just sitting down with her to show her how to
 17 use like the e-mail system on the computer.
 18 You know, she didn't even want to touch a
 19 button. But I mean, we're talking about, you
 20 know, like 1987, 1988 where this is not a part
 21 of everyone's work day type of thing.
 22 CHAYTOR, Q.C.:
 23 Q. And still dealing, I guess, in that time frame
 24 then, we're into the late 1980s, up to that
 25 point in time, where was the immunology lab

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1 for the province located? Was that part of
 2 the General Hospital?
 3 MR. GULLIVER:
 4 A. No. That comes later. That comes a bit
 5 later.
 6 CHAYTOR, Q.C.:
 7 Q. Okay.
 8 MR. GULLIVER:
 9 A. Yeah, I guess so -
 10 CHAYTOR, Q.C.:
 11 Q. And this is going on then into the 1990s?
 12 MR. GULLIVER:
 13 A. No, in 19--so in '87, I'm pathology
 14 supervisor. '88, they ask would I take over
 15 the blood collection services for the General
 16 Hospital, which I agreed to do, and -
 17 CHAYTOR, Q.C.:
 18 Q. And during that time period then, you're
 19 involved in implementing Meditech?
 20 MR. GULLIVER:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. Yes, okay.
 24 MR. GULLIVER:
 25 A. Then in 1993, in the building, the Health

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1 Sciences, you know, there's a university side
 2 and there's a hospital side, on the university
 3 side, on the first floor not too far away from
 4 the pathology lab, there was an immunology lab
 5 that was run by the university, and in that
 6 part of immunology, we would have testing for
 7 what's called flow cytometry testing. The
 8 Health Sciences didn't offer flow cytometry
 9 testing. We didn't have the technology, we
 10 didn't have the staff that were trained for
 11 it, and we would send samples over to the MUN
 12 side to do flow cytometry testing. We also
 13 sent samples over there, those were the staff
 14 that did tissue typing. So patients who were
 15 needing of a kidney transplant or a bone
 16 marrow transplant, that part of the lab was
 17 doing that testing. And at some point between
 18 the--and we paid for that service, and
 19 actually the whole province paid MUN for that
 20 service.
 21 At some point, the University, I mean,
 22 above my level, Ms. Chaytor, at some point,
 23 the University decided that really almost all
 24 the work that was taking place in their
 25 immunology lab was clinical work. They were

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1 doing it for the Health Sciences, for St.
 2 Clare's, the Grace, Corner Brook, Gander,
 3 Grand Falls, and their focus should be
 4 research work. So there was a decision made
 5 amongst the General Hospital and the
 6 University that the General Hospital really
 7 should be administering and managing and
 8 offering those clinical services as a part of
 9 the laboratory. After that decision was made,
 10 Mr. Thornhill, who was still the lab manager,
 11 came back to me again.

12 CHAYTOR, Q.C.:
 13 Q. Buttered you up some more.

14 MR. GULLIVER:
 15 A. And asked, you know, you're doing a great job
 16 with blood collection in the last four or five
 17 years. Things are running smoothly and we
 18 need--and we needed to physically get space at
 19 the Health Sciences side, lab side, and
 20 physically move the immunology service and go
 21 through staff recruitment and all the whole
 22 piece and actually set up an immunology lab on
 23 the hospital side of the physical plant, and
 24 he asked would I do it, and I actually didn't
 25 initially say yes. I said "I'm really busy

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1 right now. Could you go ask one of the other
 2 managers to do it?" And he told me he didn't
 3 want to. So he was my manager, so I wasn't
 4 going to say no to him.

5 CHAYTOR, Q.C.:
 6 Q. And when was this, what time period?

7 MR. GULLIVER:
 8 A. This was 1993.

9 CHAYTOR, Q.C.:
 10 Q. Okay. So you took that on then in addition to
 11 whatever else you had on your plate?

12 MR. GULLIVER:
 13 A. Yes.

14 CHAYTOR, Q.C.:
 15 Q. As time went on then, into the mid 1990s and
 16 coming up, I guess, into 1996 when the Health
 17 Care Corporation came on board, what changes
 18 took place then in your position and overall
 19 in the management level with the Health Care
 20 Corporation being created?

21 MR. GULLIVER:
 22 A. Obviously it was a significant event. You
 23 know, when it was announced that the City
 24 hospitals would be formed into one board, you
 25 know, you know that most--the unionized staff

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1 were also very worried. However, I know
 2 management staff were also very worried. You
 3 know, prior to the Health Care Corporation
 4 coming into being, the General Hospital, the
 5 Grace, the Janeway, St. Clare's, all four had
 6 well established laboratory services on site.
 7 All four had laboratory managers at the time.
 8 So there's what we call director today, that
 9 was the lab manager and then we had
 10 supervisors. All four had a lab manager. All
 11 four, to varying degrees, had supervisors, not
 12 in all disciplines. The Health Sciences, we
 13 had a supervisor in chemistry, hematology,
 14 pathology, micro, because we covered--it was
 15 the referral centre for the province. For
 16 example, the Grace Hospital, I think, had
 17 three supervisors, in addition to the manager.
 18 The Janeway, I think, had three supervisors,
 19 plus the manager, and I think St. Clare's had
 20 four supervisors, Ms. Chaytor, in addition to
 21 the manager. So when the Health Care
 22 Corporation was formed and when it came to the
 23 laboratory side of the restructuring, they
 24 took the four managers' positions and made one
 25 director for the City of St. John's.

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1 CHAYTOR, Q.C.:
 2 Q. And then that director had -

3 MR. GULLIVER:
 4 A. Was Mr. Vern Whelan from the Health Sciences.

5 CHAYTOR, Q.C.:
 6 Q. And had responsibility over the Grace, St.
 7 Clare's, Health Sciences and the Janeway?

8 MR. GULLIVER:
 9 A. And the Waterford.

10 CHAYTOR, Q.C.:
 11 Q. And the Waterford?

12 MR. GULLIVER:
 13 A. Yeah.

14 CHAYTOR, Q.C.:
 15 Q. So five sites.

16 MR. GULLIVER:
 17 A. And to a certain extent, Bell Island, because
 18 there's a small lab on Bell Island.

19 CHAYTOR, Q.C.:
 20 Q. Okay. So you're down from your four lab
 21 managers -

22 MR. GULLIVER:
 23 A. To one director.

24 CHAYTOR, Q.C.:
 25 Q. - to one director, and how about in terms of

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1 your level, the pathology--the supervisors?
 2 MR. GULLIVER:
 3 A. At the time, at my level, right, at my level,
 4 the supervisors, we then became division
 5 managers. So we got realigned into program
 6 based management. That was Sister Davis' and
 7 the new Board's decision. So we're all
 8 getting realigned, you know, through your
 9 program. Within the programs, we became
 10 divisional. So there was a division of
 11 biochemistry, division of hematology for the
 12 City of St. John's, a division of pathology
 13 for the City of St. John's, division of
 14 cytology for St. John's. So we made--there
 15 were seven major divisions within laboratory
 16 medicine, and I can't give you the exact
 17 numbers, Ms. Chaytor, but to my recollection,
 18 I think there had been out of 21 or 23 sort of
 19 management staff, we'd say, in laboratory
 20 service for the City and we went down to 11.
 21 CHAYTOR, Q.C.:
 22 Q. So you're cut in half?
 23 MR. GULLIVER:
 24 A. Pretty well cut in half or a bit less than
 25 half, yeah.

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1 CHAYTOR, Q.C.:
 2 Q. And what position did you maintain through
 3 that change?
 4 MR. GULLIVER:
 5 A. Well, the ten managers' positions were
 6 advertised. So you pretty well had to reapply
 7 for a position, and you know, I could have
 8 applied for all ten, but what was decided was
 9 Mr. Vern Whelan who was the lab--the new lab
 10 director, and you've heard Dr. David Haegert
 11 here who was our clinical chief testify, and
 12 he was the clinical chief, I guess they, at
 13 their level, made the decision of if we have
 14 these number of managers and we have these
 15 four hospitals to cover with on site
 16 laboratories in them and we have these numbers
 17 of divisions, you know, realistically, how are
 18 we going to effectively manage all of this
 19 with ten people. So they advertised positions
 20 and what they decided to do at the time--I was
 21 managing pathology and blood collection and
 22 immunology at the Health Sciences site--and by
 23 this time, Ms. Chaytor, blood collection, when
 24 I first took over blood collection in '87, I
 25 think we had six positions, and we may have

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1 had 20 by this time, because we're actually
 2 changing how we practice with the new staff I
 3 was putting in place in blood collection. We
 4 were taking duties from lab technologists that
 5 were really pre-analytical functions like
 6 centrifuging and alliquoting and labelling
 7 tubes and blood collection and passing that on
 8 to the medical lab assistants. So by this
 9 time, I mean, I had a fair number of staff
 10 over three different labs. So what was
 11 decided, they had pathology and immunology
 12 advertised as a divisional manager, and we
 13 took away blood collection from the Health
 14 Sciences and added blood collection to the
 15 other three facilities, and made a corporate
 16 wide person for client services, which looked
 17 after all the pre-analytical functions of lab,
 18 which included blood collection, data entry
 19 and registration, those kinds of functions,
 20 but then I didn't just have pathology and
 21 immunology. So what happened, I guess, to
 22 make a long story short, I became the
 23 pathology manager at the Health Sciences, as I
 24 always was. I kept immunology at the Health
 25 Sciences which I had for several years. Then

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1 I became the manager for pathology at the
 2 Janeway. The Janeway had a small immunology
 3 lab that did allergy testing for the province,
 4 that was added to my responsibilities, and
 5 then Dr. Haegert and Mr. Whelan, because Mr.
 6 Thornhill had retired a couple of years
 7 before, they sat down and spoke to me and they
 8 said that genetics is a new up and coming
 9 laboratory at the Janeway, you know, the
 10 province--our province is really lacking in
 11 DNA testing and the whole--at this time, mid
 12 90s, genetics is coming on stream, and they
 13 asked me--they said you've done a great job
 14 with immunology, do you think you will take
 15 over the molecular and cytogenetic services
 16 and really put a detailed plan in place to be
 17 able to grow that service for the province?
 18 That's what I ended up with.
 19 CHAYTOR, Q.C.:
 20 Q. So did you do that, did you get a plan put in
 21 place for the genetic service?
 22 MR. GULLIVER:
 23 A. Yes, yeah.
 24 CHAYTOR, Q.C.:
 25 Q. And was that -

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1 MR. GULLIVER:
 2 A. We had three staff in genetics at the time who
 3 worked at the Janeway; mostly just doing in
 4 cytogenetics. Most of the work we do, like,
 5 amino fluids, that's the lab it will go to
 6 looking for abnormalities, you know, and birth
 7 defects.
 8 CHAYTOR, Q.C.:
 9 Q. And those people would report to you too?
 10 MR. GULLIVER:
 11 A. Yes, and then - and today I think we have
 12 maybe 18 staff in our genetics service.
 13 CHAYTOR, Q.C.:
 14 Q. So that component has grown substantially?
 15 MR. GULLIVER:
 16 A. Yeah.
 17 CHAYTOR, Q.C.:
 18 Q. And in terms then of your division of
 19 responsibilities, you're now responsible for
 20 the Janeway, and I take it the --
 21 MR. GULLIVER:
 22 A. And Health Sciences.
 23 CHAYTOR, Q.C.:
 24 Q. The Janeway in 1996 was still down in its old
 25 site?

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1 MR. GULLIVER:
 2 A. Still physically there, yes.
 3 CHAYTOR, Q.C.:
 4 Q. And the Health Science. So how did you divide
 5 your time between the two sites?
 6 MR. GULLIVER:
 7 A. It was just had to spend time at both. So I
 8 think I would spend - like, try to spend
 9 Mondays and Thursdays at the Janeway, and then
 10 the other days at the Health Sciences, and
 11 that always didn't - never worked out all the
 12 time, but certainly, I mean - and I think
 13 there was a week that went by that I wasn't at
 14 both sites during the week. There were many
 15 days that went by where I was at both sites on
 16 the same day.
 17 CHAYTOR, Q.C.:
 18 Q. And so in 1996 when the Health Care
 19 Corporation came into being, I just want to
 20 get some sense then of what you ended up with
 21 on your plate, and is it fair to say then that
 22 your workload increased substantially at that
 23 point in time? Was there anything - I'm
 24 hearing the blood collection stayed with you
 25 throughout, genetics added.

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1 MR. GULLIVER:
 2 A. No, by '96 blood collection is taken away from
 3 me.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, it's taken away.
 6 MR. GULLIVER:
 7 A. Right, but in place of -
 8 CHAYTOR, Q.C.:
 9 Q. Immunology stays with you?
 10 MR. GULLIVER:
 11 A. Stays with me.
 12 CHAYTOR, Q.C.:
 13 Q. Genetics is added.
 14 MR. GULLIVER:
 15 A. So what's added - so we take away blood
 16 collection at the Health Sciences on this
 17 side. On the other side, we're moving
 18 immunology from the Janeway, pathology from
 19 the Janeway, molecular genetic and cytogenics,
 20 along with my pathology and immunology at the
 21 Health Sciences, and with a view that we knew
 22 then in three or four years that the Janeway
 23 would physically close and move into a brand
 24 new building, we knew the Grace was going to
 25 close, so during that time frame, you know, we

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1 were planning for those physical plant
 2 closures and we knew at some point most of the
 3 services I was responsible for would be
 4 physically located or relocated under one
 5 roof, but, I mean, it took three or four years
 6 to get there.
 7 CHAYTOR, Q.C.:
 8 Q. And you were involved, I take it, in those
 9 changeovers as well?
 10 MR. GULLIVER:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. In terms of the physical move of the other
 14 laboratories?
 15 MR. GULLIVER:
 16 A. Oh, yes.
 17 CHAYTOR, Q.C.:
 18 Q. Mr. Gulliver, then in terms of your workload,
 19 did you perceive in 1996 with the creation of
 20 the Health Care Corporation that your workload
 21 increased?
 22 MR. GULLIVER:
 23 A. It certainly did.
 24 CHAYTOR, Q.C.:
 25 Q. And was there anything done to offset that?

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1 For example, were there people appointed or
 2 did you put in place other people at the next
 3 tier below you to help you manage?
 4 MR. GULLIVER:
 5 A. Yes. Every lab had senior staff, and I think
 6 every supervisor and manager has their own
 7 style of how they interact with staff and how
 8 you work with your people. For example, in
 9 immunology - I go with immunology to give you
 10 a good example. That was an area of lab
 11 medicine that really was not a part of our
 12 initial training program. You touched upon
 13 some of the theory, but in practice it's a
 14 very highly specialised dedicated part of lab
 15 medicine. Today we have two technologists who
 16 work in flow cytometry, and they're the only
 17 two in Newfoundland. We have three
 18 technologists who work in H & A tissue typing
 19 for bone marrow transplants and kidney
 20 transplants and they're the only three
 21 technologists in Newfoundland. So when I took
 22 over that service, I have to admit, I mean,
 23 I'm not a technical expert or background in
 24 that part of lab medicine, so at the time our
 25 senior technologist, Mr. Ernie Stapleton, you

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1 know, I relied upon him heavily to ensure that
 2 the day to day operations of the laboratory
 3 were running smoothly. He was the senior
 4 technologist there. They all certainly seemed
 5 to know their jobs and what they were doing,
 6 and I really provided more of an
 7 administrative manager or support role to the
 8 immunology lab. I viewed them as "my job is
 9 to ensure that you have what you need to do
 10 your job as best you can", not "my job is to
 11 tell you what you should do". I functioned
 12 that way in pathology also. At the Janeway
 13 site, and you've heard Mr. Dyer who is the
 14 current manager, when I went to the Janeway -
 15 I had met Barry during his training program,
 16 as he graduated several years after I did.
 17 Barry and Dr. Pushpanathan were at the Janeway
 18 in pathology, and Dr. Pushpanathan, she was at
 19 the Health Sciences doing her residency
 20 training program as I was the medical lab
 21 technologist there, and became supervisor
 22 there, so I knew her quite well. You know,
 23 they had well established practices in
 24 pathology at the Janeway. It was a very small
 25 lab, mind you, there was two technologists and

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1 one pathologist, but again, you know, I mean,
 2 I relied upon them. Barry was a senior tech,
 3 had a lot of experience and enthusiasm, and he
 4 pretty well was my right arm for pathology at
 5 the Janeway. Again now moving to genetics,
 6 you know, cytogenetics staff, there were three
 7 staff at the Janeway. Cytogenetics was
 8 something that's not my technical background,
 9 and again it's a very highly specialised piece
 10 of lab medicine. Molecular genetics was
 11 really non-existent, and that was the piece
 12 that we had to develop for the lab and for the
 13 province, but again, you know, there were
 14 three technologists in cytogenetics at the
 15 Janeway. Olga French was there. She had been
 16 there for, I guess, at that time, I would
 17 think over 20 years, working in that piece of
 18 lab medicine, and she was a senior technology.
 19 I mean, they pretty - I relied upon them.
 20 They ran the day to day operations. They're
 21 the ones doing the work, they're the ones who
 22 know how to best perform the work, and any
 23 issues they had or support they needed from me
 24 from a manager's level, I mean, that really
 25 was my role with them also.

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1 CHAYTOR, Q.C.:
 2 Q. And you, yourself, in terms of any technical
 3 work up to this point in time then, it would
 4 have been ten years since you had performed
 5 work yourself in any area?
 6 MR. GULLIVER:
 7 A. By '96?
 8 CHAYTOR, Q.C.:
 9 Q. By '96, '97.
 10 MR. GULLIVER:
 11 A. That's sort of half true.
 12 CHAYTOR, Q.C.:
 13 Q. Okay, so what experience did you have in that
 14 ten year period?
 15 MR. GULLIVER:
 16 A. Well, we've always had these occasions where
 17 the unionized staff have withdrawn their
 18 services, i.e. there's been a strike.
 19 CHAYTOR, Q.C.:
 20 Q. Yes.
 21 MR. GULLIVER:
 22 A. And when that happens, the manager is expected
 23 to be able to go back on the bench and at
 24 least perform to a certain level - well,
 25 provide sort of emergency stat services for

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1 the pathologist and pathology, or overall to
 2 any physician in the hospital. So even though
 3 by 1986, I've been in management for nine or
 4 ten years at this time, '97 - yes, I wouldn't
 5 say my technical skills were equal to the
 6 techs, but there were many occasions where I
 7 would have had to go back on the bench and do
 8 some of those things.
 9 CHAYTOR, Q.C.:
 10 Q. Whenever there was job interruption?
 11 MR. GULLIVER:
 12 A. Yeah.
 13 CHAYTOR, Q.C.:
 14 Q. And -
 15 MR. GULLIVER:
 16 A. I would say, though, Ms. Chaytor, I mean, from
 17 that point onwards, if there was something
 18 like that, I really didn't have the technical
 19 skill to go back on the bench and do IHC
 20 testing, for example, in pathology.
 21 CHAYTOR, Q.C.:
 22 Q. Yes, right.
 23 MR. GULLIVER:
 24 A. But I could certainly do your basic embedding,
 25 your basic cutting, H & E's, and other things.

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1 I mean, some of those things are like riding a
 2 bike, once you learn it, you learn it, and you
 3 kind of don't forget it.
 4 CHAYTOR, Q.C.:
 5 Q. At the time you were appointed then pathology
 6 manager in 1996 for the Health Science and the
 7 Janeway -
 8 MR. GULLIVER:
 9 A. The corporation, yeah.
 10 CHAYTOR, Q.C.:
 11 Q. Right, the Health Care Corporation. So you
 12 have two sites, the Health Science and the
 13 Janeway. Who is appointed your equivalent for
 14 the Grace and St. Clare's?
 15 MR. GULLIVER:
 16 A. There was a - I guess the way things worked
 17 out, there were ten positions approved at the
 18 management level for labs for the City of St.
 19 John's, and again I think there was 21 in the
 20 city existing. However, one of our managers
 21 decided to leave and took another position
 22 over at Canadian Blood Services, and the vast
 23 majority of others were pretty well close to
 24 or at retirement age. So no one really got
 25 downsized and cut, but pretty well most of the

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1 senior managers then at the time were offered,
 2 I guess, some kind of incentive or package,
 3 they called it, to either take early
 4 retirement or they were at retirement. So
 5 there were ten of us left and there were ten
 6 slots to fill. We applied for positions. You
 7 know, there were two positions for pathology
 8 for the city, there were two hematology
 9 managers for the city, there were two
 10 chemistry managers for the city, and two micro
 11 managers for the city, and some managers
 12 applied for four or five different jobs, you
 13 know, just to make sure they had a foot in one
 14 or the other. So how it ended up was there
 15 were three - at the time there were three
 16 managers in hematology left in the system of
 17 the ten, and two of the hematology managers
 18 were given the new positions, and the third
 19 person that was sort of left out of the
 20 hematology side, Mr. John Murphy, at St.
 21 Clare's, and he had been working in hematology
 22 blood bank for a number of years, he was
 23 offered the position of pathology manager for
 24 St. Clare's and the Grace.
 25 CHAYTOR, Q.C.:

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1 Q. And did he have any background in pathology?
 2 MR. GULLIVER:
 3 A. Not to my knowledge, no.
 4 CHAYTOR, Q.C.:
 5 Q. Were you asked to do anything then to assist
 6 Mr. Murphy in his -
 7 MR. GULLIVER:
 8 A. I wasn't formally asked in sort of a formal
 9 written way. You know, at the time, I guess
 10 Mr. Whelan and Dr. Haegert had a decision to
 11 make. If they felt Mr. Murphy was not the
 12 best candidate for that pathology position,
 13 they would have to re-advertise and they
 14 pretty well would have to look at him, you
 15 know, here was a man with 30 years service,
 16 you know, wasn't close enough to retirement
 17 age to avail of any kind of incentive, and do
 18 you just cut him loose and lay him off. So
 19 Mr. Whelan and Dr. Haegert spoke to me and
 20 they said, you know, Terry, you know the Grace
 21 is going to close at some point for pathology,
 22 but, you know, would you sort of keep an eye
 23 out for John Murphy over at St. Clare's and
 24 Grace, and I said I would. What they meant
 25 was keep an eye out so, like, when John first

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1 became manager, I sat down and spoke to him.
 2 I actually brought him over to the Health
 3 Sciences with us for I think maybe a couple of
 4 weeks and just went through all your basic
 5 pathology practises and talked about how we
 6 had organized our work flow over the years,
 7 different changes that came into pathology,
 8 and, you know, certainly extended to him,
 9 look, if you have any concern, any issue, I
 10 don't mind you calling me up and asking for
 11 advice or help. Again laboratories are a very
 12 small community, Ms. Chaytor. You know, at
 13 the time there might be a couple of hundred
 14 lab staff in the city, and I would say 90
 15 percent of them I would know on a first name
 16 basis. So the senior staff at the Grace and
 17 St. Clare's, we have known each other for a
 18 long time. The Grace Hospital, for example,
 19 during my three year training program, I did
 20 my clinical training at the Grace Hospital.
 21 I'm looking at the back of the room there, my
 22 current hematology manager, when I was a
 23 student, she was teaching me hematology on the
 24 bench at the Grace back 30 years ago. So we
 25 kind of all know each other. So some of the

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1 senior staff at the Grace and St. Clare's,
 2 they had no problem picking up the phone and
 3 calling me up and asking, Terry, listen, we
 4 have an issue over here, or we need this and
 5 we need that.
 6 CHAYTOR, Q.C.:
 7 Q. And that happened from time to take, I take
 8 it?
 9 MR. GULLIVER:
 10 A. That happened fairly frequently.
 11 CHAYTOR, Q.C.:
 12 Q. So you were keeping an eye out, so to speak,
 13 on what's going on at the Grace?
 14 MR. GULLIVER:
 15 A. And we did set up - I guess, another big piece
 16 of the restructuring that I think was an
 17 important piece - we're talking now solely
 18 administrative side of the lab, the new
 19 program structure. On the clinical side of
 20 the program, there was also a huge change,
 21 that each site had -
 22 CHAYTOR, Q.C.:
 23 Q. I'll get to that. I just want -
 24 MR. GULLIVER:
 25 A. Oh, okay.

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1 CHAYTOR, Q.C.:
 2 Q. Before we leave, though, the issue of the
 3 management of the pathology lab at St. Clare's
 4 and the Grace.
 5 MR. GULLIVER:
 6 A. Yeah.
 7 CHAYTOR, Q.C.:
 8 Q. So you offered up to Mr. Murphy any assistance
 9 that you could render from time to time.
 10 Frequently you say that the staff there knew
 11 you and they would contact you and ask for
 12 advice or input. How about Mr. Murphy,
 13 himself, did he have occasion to continue or
 14 to avail of your services and take you up on
 15 your offer?
 16 MR. GULLIVER:
 17 A. Oh, yes. I mean, John called me on a regular
 18 basis, and we actually met - we tried to meet
 19 on sort of a monthly basis, or a bi-monthly
 20 basis, myself and him, and at the time whoever
 21 our site chiefs were on the clinical side of
 22 pathology. We did meet regularly, you know,
 23 formally meet, and talk about common issues
 24 amongst pathology at the Grace and at the time
 25 St. Clare's, Health Sciences, Janeway, and

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1 talking about bigger issues, like, well, the
 2 Janeway is going to close, the Grace is going
 3 to close, and getting our heads around the
 4 long term of what is pathology going to look
 5 like at some point in the future.
 6 CHAYTOR, Q.C.:
 7 Q. So it was acknowledged by the clinical chief
 8 of the day and Mr. Whelan, who would have been
 9 your direct supervisor, and that of Mr.
 10 Murphy, that he lacked experience in the
 11 pathology side of the lab. Was there
 12 anything, do you know, in addition to you
 13 keeping an eye out and answering any queries
 14 that may come your way, was there anything
 15 additional done for Mr. Murphy to enable him
 16 to take on the position of the pathology
 17 manager at St. Clare's and the Grace?
 18 MR. GULLIVER:
 19 A. I don't believe there was, no.
 20 CHAYTOR, Q.C.:
 21 Q. And what kinds of questions or issues would
 22 arise that your assistance would have been
 23 sought from those two sites over that period
 24 of time?
 25 MR. GULLIVER:

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1 A. I really can't give you a whole list of
 2 specific things, but it could be anything. It
 3 could be anything from any piece of pathology.
 4 It may be staffing issues, it may be budgeting
 5 issues.
 6 CHAYTOR, Q.C.:
 7 Q. I guess staffing and budgeting, though, he
 8 would have had experience in how to do that?
 9 He was hematology manager for years.
 10 MR. GULLIVER:
 11 A. I would have assumed -
 12 CHAYTOR, Q.C.:
 13 Q. Yes.
 14 MR. GULLIVER:
 15 A. Other issues, he really didn't understand
 16 Meditech, the computer system from the
 17 pathology side could be issues. He would -
 18 and sometimes it would be very basic things,
 19 you know, basic technical questions in
 20 pathology. A lot of them, though, were more
 21 focused on processes, systems kind of things,
 22 and processes kinds of things.
 23 CHAYTOR, Q.C.:
 24 Q. And how long did Mr. Murphy remain in that
 25 position?

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1 MR. GULLIVER:
 2 A. John stayed in that position, actually, until
 3 late 2001, early 2002.
 4 CHAYTOR, Q.C.:
 5 Q. You were going to say there was also changes
 6 with the Health Care Corporation in terms of
 7 the clinical side of the laboratory?
 8 MR. GULLIVER:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. So perhaps you could tell us about that?
 12 MR. GULLIVER:
 13 A. Again prior to the Health Care Corporation,
 14 all four of the major hospitals in the city,
 15 they had a lab manager, and some of them had a
 16 - I think all of them did, then had a clinical
 17 side, a pathologist, who was - they had
 18 different names. At the Health Sciences, our
 19 clinical chief was also university chair. St.
 20 Clare's, for example, their pathologist, I
 21 think, was also called laboratory director,
 22 and I think the manager was called laboratory
 23 manager, and I think that's the way it
 24 operated at the Grace also where the clinical
 25 person was called the lab director, and the

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1 administrative person, like myself, and was
 2 called the lab manager. At the Health
 3 Sciences, it was laboratory manager and it was
 4 the clinical chief, I guess, because it was a
 5 much more extensive service. So during that
 6 restructuring - and then the other hospitals,
 7 Ms. Chaytor, didn't have clinical people like
 8 in hematology, microbiology, and chemistry, as
 9 the Health Sciences did. We were the tertiary
 10 care reference centre for the province. We
 11 had that level of expertise also available to
 12 us. So in the clinical side of restructuring
 13 there was a division manager for hematology,
 14 and then there was a division chief appointed
 15 for hematology for the city of St. John's. At
 16 the time that was Dr. Cindy Whitman, who is
 17 still with us.
 18 CHAYTOR, Q.C.:
 19 Q. And she would be in that position for all four
 20 sites?
 21 MR. GULLIVER:
 22 A. Yes, on a clinical side.
 23 CHAYTOR, Q.C.:
 24 Q. Yes.
 25 MR. GULLIVER:

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1 A. We appointed at the time Dr. Prabhakaran. He
 2 was the chief biochemist at the Health
 3 Sciences and he became the chief biochemist
 4 for the city of St. John's, and Dr. Randell,
 5 who at the time was the biochemist at the
 6 Janeway, still remained in that role on the
 7 pediatric side of biochemistry. Dr. Jim
 8 Hutchinson was the chief at Health Sciences
 9 and he assumed the greater role to become the
 10 division chief, microbiology for the city of
 11 St. John's. At the time in cytology in '96, I
 12 don't remember who was our division chief
 13 there.
 14 CHAYTOR, Q.C.:
 15 Q. But there was one, I take it for the entire
 16 city.
 17 MR. GULLIVER:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And what happened with pathology?
 21 MR. GULLIVER:
 22 A. And pathology was different.
 23 CHAYTOR, Q.C.:
 24 Q. Why is that? Tell us about that.
 25 MR. GULLIVER:

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1 A. Pathology, they decided to have four chiefs;
 2 one for each site. So, there was a site--then
 3 they called them site chiefs. So, we had
 4 Division Chief Hematology, Clinical side for
 5 the city of St. John's. We have a Division
 6 Chief Microbiology for the City of St. John's.
 7 But in pathology, there was a Site Chief
 8 Pathology, Health Sciences; Site Chief
 9 Pathology, Janeway; Site Chief Pathology,
 10 Grace; Site Chief Pathology at the St.
 11 Clare's.

12 CHAYTOR, Q.C.:

13 Q. And why was that? Why was it done differently
 14 for pathology?

15 MR. GULLIVER:

16 A. I really don't know. I mean, that decision
 17 was--certainly I was not a part of it and I
 18 think it was decided amongst the new clinical
 19 chief, Dr. Haegert, who was also University
 20 Chair. I guess amongst the pathologists
 21 themselves, they must have decided to put this
 22 structure in place.

23 CHAYTOR, Q.C.:

24 Q. And were you involved in any discussions
 25 around that?

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1 MR. GULLIVER:

2 A. None whatsoever.

3 CHAYTOR, Q.C.:

4 Q. You weren't consulted on that as the pathology
 5 manager for two of the sites.

6 MR. GULLIVER:

7 A. No.

8 CHAYTOR, Q.C.:

9 Q. And did you hear, at the time, as to the
 10 thinking behind that? Was it something that
 11 was deemed to be necessary, that this is the
 12 way we should be doing it. Did you hear any
 13 discussion about that at the time?

14 MR. GULLIVER:

15 A. Nothing in a formal way. I mean, obviously
 16 you hear things in a corridor and you hear
 17 rumours as you would in any workplace, but in
 18 a formal way, I didn't hear anything.

19 CHAYTOR, Q.C.:

20 Q. Okay. So, what did you hear in the corridors?

21 MR. GULLIVER:

22 A. I really don't know if I can say what I heard
 23 in the corridors, but I really couldn't verify
 24 anything. It's people's opinions and people's
 25 rumours. And I don't think that that

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1 warrants, you know, me saying here officially,
 2 this is the kind of this -

3 CHAYTOR, Q.C.:

4 Q. Well, no, perhaps you can tell us then what
 5 you understood. Was this the direction Dr.
 6 Haegert wanted to go? Did he, as clinical
 7 chief, want to keep four site chiefs or was
 8 there some issue amongst the pathologists as
 9 to why they wanted it done that way?

10 MR. GULLIVER:

11 A. I think--this is just my opinion--I think one
 12 of the issues had been that remuneration, when
 13 it comes to salaries. I think that the former
 14 lab directors at, for example, the Grace and
 15 St. Clare's, the Janeway I'm not so sure
 16 about, Ms. Chaytor, they were receiving an
 17 additional salary to perform that role for the
 18 Grace Hospital or for St. Clare's Hospital and
 19 I think the four site chiefs set up, I think,
 20 enabled them to carry on that piece, the
 21 financial piece of the structure.

22 CHAYTOR, Q.C.:

23 Q. So, it may have somehow impacted under salary,
 24 the issues that you heard being raised.

25 MR. GULLIVER:

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1 A. I think so.

2 CHAYTOR, Q.C.:

3 Q. Whether or not that's correct or not, you're
 4 not in a position to verify. Okay. Mr.
 5 Gulliver, from your perspective as pathology
 6 manager, did it make any difference in terms
 7 of maintaining four site chiefs, one person at
 8 each of the hospitals? Would that have been
 9 helpful given for example the situation that
 10 you found yourself in having to take on
 11 additional responsibilities? Would it, I take
 12 it, have been a good thing to have a site
 13 chief at each hospital?

14 MR. GULLIVER:

15 A. I think, in theory, yes. I think that it
 16 would be a good thing to have, you know, a
 17 clinical lead, in particular, in pathology.
 18 As you've probably seen through this Inquiry
 19 that pathology is not the same as chemistry,
 20 hematology and other divisions that we have.
 21 We do we have a large number of clinical staff
 22 in pathology, you know, and those clinical
 23 staff are pretty well independent
 24 practitioners. So, I think for each site to
 25 have a designated clinical lead for the

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1 pathologists to be able to voice their
 2 concerns or opinions too, for pathologists on
 3 those sites to be able to go for advice or for
 4 expertise, I think it's a good thing. I don't
 5 know necessarily if it was the right thing for
 6 the way the Health Care Corporation was being
 7 restructured and if it was the right thing for
 8 program based management. I think that when--
 9 and if you put it in the bigger picture, we
 10 know the Grace is going to close, that the
 11 decision has been made by government. We know
 12 the Janeway is going to move into a new
 13 building. And having four chiefs, I think,
 14 hindered that process to a certain extent.
 15 CHAYTOR, Q.C.:
 16 Q. So, it hindered the consolidation or bringing
 17 together of the program, is that what you're
 18 saying?
 19 MR. GULLIVER:
 20 A. It was my experience. And not for--I think
 21 it's more self preservation kind of mode as
 22 opposed to not agreeing with something or not
 23 wanting to change or do something differently,
 24 you really have to understand that, you know,
 25 when you've got staff or physicians who are

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1 use to their culture and used to their setup,
 2 you know, everyone is different, you know.
 3 You can show through my whole career, I love
 4 change. I embrace change because I don't want
 5 to do what I did yesterday. And maybe I'm on
 6 the other end of the spectrum, but certainly I
 7 have encountered technical staff, management
 8 staff and physician staff who are on the other
 9 side. Their comfort zone is, this is where I
 10 came to work, this is where I like to work,
 11 this is the way I do things, and I really
 12 don't want to change the way I do things. So
 13 having the four site chiefs in place, I think
 14 in theory it was a really good--it was needed
 15 to provide that clinical leadership to the
 16 pathologists on all sites and to really allay
 17 their fears of what's going to happen when the
 18 Grace closed and when the Janeway closed and
 19 where are services going to move to and where
 20 are pathologists going to move to? But I
 21 think over on the big picture schemes of the
 22 organization side, I don't think it helped the
 23 process a lot.
 24 CHAYTOR, Q.C.:
 25 Q. So I guess it made it more difficult to get

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1 consensus on how to move forward with the
 2 program?
 3 MR. GULLIVER:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. Because you have that many more people who
 7 have a say in it. Did it impede in any way
 8 the effect of operation of the Laboratory
 9 Medicine Program?
 10 MR. GULLIVER:
 11 A. You mean laboratory overall in general?
 12 CHAYTOR, Q.C.:
 13 Q. Yeah, the overall--did you see it on a
 14 practical basis that it had any effect?
 15 MR. GULLIVER:
 16 A. I would have to say no because even though the
 17 pathology structure was different than the
 18 other six divisions, the pathologist site
 19 chiefs were pretty well only, really involved
 20 interested in, you know, what their profession
 21 is, as pathology. They didn't really have
 22 much impact or say on how hematology was
 23 restructured or organized or how services were
 24 developed or offered or biochemistry, because
 25 we did have a clinical leadership there along

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1 with our division managers. So really, I mean
 2 the question is outside of pathology had very
 3 little or no effect; within pathology, it's
 4 debateable. I mean, did it have, did it
 5 impeded progress or maybe it slowed down
 6 process and made us think more.
 7 CHAYTOR, Q.C.:
 8 Q. What did -
 9 THE COMMISSIONER:
 10 Q. Excuse me, there's just one small little
 11 detail that I need clarification on. We're
 12 talking about the four site chiefs.
 13 MR. GULLIVER:
 14 A. Site chiefs, yes.
 15 THE COMMISSIONER:
 16 Q. And I'm just a little unclear as to what you
 17 said about the position of clinical chief for
 18 pathology?
 19 MR. GULLIVER:
 20 A. Well there's no clinical chief for pathology.
 21 THE COMMISSIONER:
 22 Q. Well that's my point, is there just four equal
 23 level site chiefs or does one of the site
 24 chiefs also act in another capacity?
 25 MR. GULLIVER:

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1 A. No, there's a clinical chief, Dr. David
 2 Haegert for all laboratory services, including
 3 pathology and microchemistry.
 4 THE COMMISSIONER:
 5 Q. Okay.
 6 MR. GULLIVER:
 7 A. And the next organizational level down, you
 8 have your manager structure and administrative
 9 structure; on the clinical side we have a
 10 similar structure as the managers, on the
 11 clinical side with hematology and chemistry
 12 and microcytology.
 13 THE COMMISSIONER:
 14 Q. Un-hm.
 15 MR. GULLIVER:
 16 A. But on the pathology side then, there were
 17 four other pathologists who had a designated
 18 role as site chief for the four different
 19 individual sites.
 20 THE COMMISSIONER:
 21 Q. Okay, so what was called -
 22 MR. GULLIVER:
 23 A. And they reported up through the clinical
 24 chief.
 25 THE COMMISSIONER:

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1 Q. So that's really what I wanted to make sure
 2 about, what happened is it went from clinical
 3 chief laboratory to, in everything except
 4 pathology, a person who is--was responsible
 5 for their particular special branch of the
 6 service throughout the whole of the city;
 7 whereas on the side of pathology, it branched
 8 into four.
 9 MR. GULLIVER:
 10 A. Right.
 11 THE COMMISSIONER:
 12 Q. So there would be no one person to whom the
 13 clinical chief could say, ask questions or
 14 have a discussion vis-a-vis pathology in its
 15 totality.
 16 MR. GULLIVER:
 17 A. Exactly.
 18 THE COMMISSIONER:
 19 Q. Okay, all right. Thank you.
 20 CHAYTOR, Q.C.:
 21 Q. The clinical chief would have to deal with
 22 four people on that.
 23 MR. GULLIVER:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. And try and reach consensus.
 2 MR. GULLIVER:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. And in terms of then the technical staff and
 6 in terms of looking for any direction from the
 7 clinical side, who would they go to if they
 8 needed direction from the clinical side?
 9 MR. GULLIVER:
 10 A. Are you talking, because my structure is
 11 Health Sciences Janeway.
 12 CHAYTOR, Q.C.:
 13 Q. Yeah, so who would they go--they'd go to
 14 whichever is their site chief at their
 15 particular site, is that how that would work?
 16 MR. GULLIVER:
 17 A. It would all depend on what they're looking
 18 for. If they're looking for--if it's a
 19 budgeting issue or supplies issue or equipment
 20 issue -
 21 CHAYTOR, Q.C.:
 22 Q. No, clinical.
 23 MR. GULLIVER:
 24 A. Oh clinical issue. Oh, clinical you would go
 25 to your site chief. So, for example, I mean

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1 at the Janeway it was very simple because, you
 2 know, you had Mr. Dyer there as the
 3 technologist.
 4 CHAYTOR, Q.C.:
 5 Q. Yes, but St. Clare's would speak to whoever
 6 who the site chief was there -
 7 MR. GULLIVER:
 8 A. Exactly.
 9 CHAYTOR, Q.C.:
 10 Q. Take direction from the clinical side, from
 11 ever who the site chief is there.
 12 MR. GULLIVER:
 13 A. Right.
 14 CHAYTOR, Q.C.:
 15 Q. Health Science would be ever who is there and
 16 Grace, so on.
 17 MR. GULLIVER:
 18 A. Right.
 19 CHAYTOR, Q.C.:
 20 Q. Did the existence of the four site chiefs for
 21 pathology impede in any way Meditech
 22 consolidation across the four sites?
 23 MR. GULLIVER:
 24 A. I guess you're referring to when the Health
 25 Care Corporation decided to go to one computer

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1 system and not have multiple systems in place.
 2 CHAYTOR, Q.C.:
 3 Q. Yes, you had come together in 1996, it's
 4 going--it's one corporation -
 5 MR. GULLIVER:
 6 A. No, but that doesn't happen until--Meditech
 7 consolidation doesn't start until maybe '98 we
 8 started on that project.
 9 CHAYTOR, Q.C.:
 10 Q. And was that at all influenced by the fact
 11 that you had four site chiefs?
 12 MR. GULLIVER:
 13 A. Again, it's a yes and no answer. No, it had
 14 no impact whatsoever on the actual
 15 consolidation of Meditech. And yes, it had
 16 impact on trying to standardize things within
 17 Meditech.
 18 CHAYTOR, Q.C.:
 19 Q. For the pathology lab is what I'm asking
 20 about.
 21 MR. GULLIVER:
 22 A. Yes. So the actual consolidation had no
 23 impact.
 24 CHAYTOR, Q.C.:
 25 Q. Takes place, but how does it affect your

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1 program?
 2 MR. GULLIVER:
 3 A. That was going to happen regardless of who was
 4 for or who was against, but it did have some
 5 impact on the work that was--and I was pretty
 6 well the pathology manager at the Health
 7 Sciences, but I kind of played a lead role in
 8 that whole consolidation piece. What I had--I
 9 had put together, I guess a team of senior
 10 staff that included, I remember Ms. Catherine
 11 Parnell, who came from the Grace side; I think
 12 it was Les Simms from St. Clare's and who
 13 eventually became one of our IHC techs; Barry
 14 Dyer from the Janeway; I think it was Peggy
 15 Welsh and maybe Peggy and Mary from the Health
 16 Sciences, but there were four or five
 17 technology staff and myself and John Murphy
 18 looking at doing this Meditech consolidation
 19 and the kinds of things that we would talk
 20 about, well, we had four distinctive stand-
 21 alone pathology labs for decades, you know,
 22 not for a year, for decades in those sites, so
 23 there were well established practices and well
 24 established protocols and this is how we did
 25 things at the Grace, this is how we do things

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1 at the Health Sciences. So trying to bring
 2 all of those practices together and trying to
 3 do an assessment of, well at the time what's
 4 the best practice? And even simple things
 5 like at the Health Sciences in the computer
 6 system what we called the pneumonic we used
 7 for a PS stain could be different than the
 8 pneumonic that was used at St. Clare's or the
 9 Grace. So, just standardizing all the test
 10 names and procedure names and work load codes
 11 and what prefixes to use, it was just an
 12 enormous amount of work, you know, but however
 13 we figured we're going to do it once and it's
 14 going to be pretty well done, because once the
 15 system is consolidated, we now have this
 16 system we're all using off the same
 17 dictionaries.
 18 CHAYTOR, Q.C.:
 19 Q. And so did that happen? Did you run into any
 20 challenges?
 21 MR. GULLIVER:
 22 A. The challenges were mostly when it involved
 23 any clinical component of the computer system
 24 and understand, you know, I think there were
 25 probably 16, 17, 18 pathologists in the city

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1 at the time on four different sites, so trying
 2 to work within that group to agree upon sort
 3 of a standard report format that, you know,
 4 once we had one computer system, here's what a
 5 pathology report is going to look like. Well,
 6 that might have taken a month to get an
 7 agreement on just that one piece, let alone
 8 what are you going to call each, what we call
 9 data section. Are we going to call a path
 10 report pathological interpretation, are we
 11 going to call it final diagnosis, are we going
 12 to call it diagnosis, will we just call it
 13 interpretation, are we going to have a
 14 preliminary report, provisional report and I
 15 mean, that went on for a significant amount of
 16 time. And it's just everyone had their way of
 17 doing things. Everyone had their own way of
 18 reporting.
 19 CHAYTOR, Q.C.:
 20 Q. And Mr. Gulliver, we know, of course, the
 21 period that the Commissioner is looking at in
 22 this inquiry is from 1997 to 2005 and she'll
 23 hear from you as to your involvement then in
 24 2005 and onwards in trying to access the
 25 system to identify patients who had had ER/PR

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1 testing. Are you able to say that lack of
 2 standardization in terms of test names or
 3 procedures and what you're talking about in
 4 terms of the nitty gritty actual forms and how
 5 the information is to be kept, did that impact
 6 or make your job more difficult in 2005 and
 7 2006 for identifying patients?
 8 MR. GULLIVER:
 9 A. I guess, are you trying to ask me that if we
 10 had to do a better job of consolidation in
 11 '98, would it have been easier to do the
 12 patient searches in 2005?
 13 CHAYTOR, Q.C.:
 14 Q. Sure.
 15 MR. GULLIVER:
 16 A. I don't think so.
 17 CHAYTOR, Q.C.:
 18 Q. And why not?
 19 MR. GULLIVER:
 20 A. Because we all agreed upon the procedure codes
 21 and the pneumonics and test names, I mean, all
 22 that stuff was done and implemented and
 23 finished. I guess if you really wanted to
 24 look at it and I still wouldn't be able to
 25 give you--it's just my best opinion, if you

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1 look back at 1998, the kinds of things that we
 2 were trying to get agreement upon, I mean,
 3 you're probably going to look, think about
 4 standardized reporting formats, I mean, that's
 5 what you're talking about. However, we were
 6 talking about standardized report formats in
 7 this is how the report is going to look, this
 8 is how the report will print and how it will
 9 be laid out, so when a physician or surgeon
 10 receives a path report from any lab in the
 11 city, it will look the same, it will flow the
 12 same and follow the same. We were never
 13 talking about within that report having a
 14 standardized format for how pathologists
 15 interpreted or dictated their reports. That
 16 was never discussed, but to go back to -
 17 CHAYTOR, Q.C.:
 18 Q. So any difficulties -
 19 MR. GULLIVER:
 20 A. - and to answer your question in theory that
 21 in 1998 we had to have sort of every path
 22 report, that if this was a breast cancer
 23 report, in '98 we went through a whole
 24 consolidation and standardization. If we had
 25 to put in a standardized, not just a report

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1 format, but what goes in the report -
 2 CHAYTOR, Q.C.:
 3 Q. The content as well, yes.
 4 MR. GULLIVER:
 5 A. The content in the report, maybe that might
 6 have helped with the searches in 2005 in that
 7 it would have given us a second avenue to
 8 cross-reference the searches that I had done
 9 in 2005 by searching the procedure codes.
 10 CHAYTOR, Q.C.:
 11 Q. Yes.
 12 MR. GULLIVER:
 13 A. But again, it's a stretch to say, you know, I
 14 can't say for sure if it would have really
 15 helped or it would have been any better or
 16 worse.
 17 CHAYTOR, Q.C.:
 18 Q. Do you have any reason to believe that the
 19 difficulties you were having in standardizing
 20 the actual format were any different for the
 21 individuals who were trying to standardize the
 22 content?
 23 MR. GULLIVER:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. You do have reason to believe that it's
 2 different?
 3 MR. GULLIVER:
 4 A. You're saying -
 5 CHAYTOR, Q.C.:
 6 Q. Do you have any reason to believe that if you
 7 encountered difficulties in 1998 and trying to
 8 standardize the format of the form, that
 9 perhaps the individuals who were trying to
 10 standardize the content that went into the
 11 form were also dealing with the same issues
 12 and encountering the same obstacles that you
 13 encountered?
 14 MR. GULLIVER:
 15 A. I would have to say I think so, yes.
 16 THE COMMISSIONER:
 17 Q. Mr. Gulliver, when the consolidation of
 18 Meditech was being or the standardization of
 19 Meditech or however you want to phrase that,
 20 the process of putting the Meditech system -
 21 MR. GULLIVER:
 22 A. Into one.
 23 THE COMMISSIONER:
 24 Q. Into one. What was the level of involvement
 25 of Meditech itself and was there any

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1 consideration at that time about things like
 2 search fields, the kinds of little buzz words
 3 that we now know assist us in trying to
 4 extract information out of your systems.
 5 MR. GULLIVER:
 6 A. There was very little involvement from
 7 Meditech at the lab level. Meditech was
 8 involved at the organizational level in
 9 dealing with IM&T in how this will roll out
 10 and making decisions, okay, once you've
 11 decided upon your St. John's wide menu or
 12 system, how it was going to work by then,
 13 stopping the Grace and then implementing the
 14 new and stopping the Janeway with the new.
 15 But what we used, Justice Cameron, the
 16 pathology module that existed in Meditech at
 17 the Health Sciences, because it was the
 18 largest module and it was the largest
 19 database, pretty well all what we did, we
 20 changed the dictionaries in the Health
 21 Sciences system and incorporated many good
 22 things that were taking place at the Grace and
 23 St. Clare's and Janeway, that their practices
 24 were better than the Health Sciences in some
 25 cases and they were behind Health Sciences in

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1 others. We took the best of all of them and
 2 we put them all into the Health Sciences
 3 system and it was like Meditech then flicked a
 4 switch and said, now, that's the system that
 5 the Grace is now using and that's the system
 6 that the St. Clare's is now using.
 7 THE COMMISSIONER:
 8 Q. So it really wasn't - I'm just trying to get
 9 into my mind the -
 10 MR. GULLIVER:
 11 A. It was not a Meditech upgrade.
 12 THE COMMISSIONER:
 13 Q. The nature of the -
 14 MR. GULLIVER:
 15 A. Exactly.
 16 THE COMMISSIONER:
 17 Q. It was a case of melding, not a case of
 18 saying, okay, what is the best kind of system
 19 now at this stage in our lives?
 20 MR. GULLIVER:
 21 A. No, it was not, no.
 22 THE COMMISSIONER:
 23 Q. And we'll all up this into the best system as
 24 opposed to one that actually gets together?
 25 MR. GULLIVER:

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1 A. Right.
 2 THE COMMISSIONER:
 3 Q. Thank you.
 4 CHAYTOR, Q.C.:
 5 Q. Mr. Gulliver, when was the switch flicked?
 6 MR. GULLIVER:
 7 A. When was the switch flicked? I can't tell you
 8 the exact date.
 9 CHAYTOR, Q.C.:
 10 Q. What year?
 11 MR. GULLIVER:
 12 A. I think in '99, the Grace came on to the
 13 system. Well, St. Clare's did first, then the
 14 Grace, and then the Janeway came on before
 15 2000, and really -
 16 CHAYTOR, Q.C.:
 17 Q. The Janeway would have been moved in '99, is
 18 that right? The Janeway physically moves in
 19 1999?
 20 MR. GULLIVER:
 21 A. Maybe Janeway came on first and then the
 22 Grace, but they came on within fairly close
 23 time frame to each other, and they had to come
 24 on first, you're right, I mean, the physical
 25 plants were closing.

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1 CHAYTOR, Q.C.:
 2 Q. So by 2000, though -
 3 MR. GULLIVER:
 4 A. Yes, certainly by late '99, early 2000, were
 5 all operating - not just pathology, but all
 6 laboratories are all operating under the one
 7 Meditech system for the city of St. John's,
 8 all the nurse order entries operating for the
 9 city of St. John's, so, you know, a nurse at
 10 the Waterford can order a blood test and the
 11 order just goes into the system, and even
 12 though it's getting tested at the Health
 13 Sciences, it can be collected over there, bar
 14 coded and sent over, so all that starts to
 15 take place around 2000.
 16 CHAYTOR, Q.C.:
 17 Q. Mr. Gulliver, I'd like to ask you now some
 18 questions about Dr. Khalifa and your knowledge
 19 of him and what he accomplished while he was
 20 here in St. John's. Did you have, yourself, a
 21 good working relationship with Dr. Khalifa,
 22 and perhaps you can tell the Commissioner what
 23 you actually remember about Dr. Khalifa and
 24 his involvement here?
 25 MR. GULLIVER:

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1 A. Well, Dr. Khalifa was appointed site chief for
 2 the Health Sciences. I loved working with Dr.
 3 Khalifa. I thought he was an excellent
 4 pathologist and I think he exhibited skills
 5 that you rarely find in physicians, and that
 6 would be administrative skills. I think he
 7 was a very good administrator, I think he was
 8 an excellent communicator, and I think the
 9 biggest part he probably played - and that's
 10 at my level, as the manager, and interacting
 11 with Dr. Khalifa and working with him, I think
 12 the biggest role he played for us was pretty
 13 well as a teacher. I think that he taught our
 14 technologists who worked with him directly an
 15 awful lot. I think he instilled confidence in
 16 our staff, and I actually believe that he
 17 taught our pathologists a fair bit.
 18 CHAYTOR, Q.C.:
 19 Q. Okay.
 20 MR. GULLIVER:
 21 A. And not just myself, I think many of us were
 22 so disappointed and sad when he decided to
 23 leave and go - leave Newfoundland.
 24 CHAYTOR, Q.C.:
 25 Q. What do you recall about his role in

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1 initiative ER/PR as IHC tests?
 2 MR. GULLIVER:
 3 A. Obviously, he was the key player, he was the
 4 lead role in implementing and transferring
 5 this science from a biochemical assay
 6 methodology in our chemistry lab, you know,
 7 now to the IHC part of our pathology lab.
 8 CHAYTOR, Q.C.:
 9 Q. So he introduced you to that notion. Were you
 10 even aware that these antibodies, ER and PR,
 11 existed through the IHC method at that point?
 12 MR. GULLIVER:
 13 A. At that point, probably not, Ms. Chaytor. I
 14 certainly did know that estrogen and
 15 progesterone was a methodology that was
 16 performed over in biochemistry.
 17 CHAYTOR, Q.C.:
 18 Q. Yes.
 19 MR. GULLIVER:
 20 A. I knew that much, but certainly to have that
 21 level of knowledge that Dr. Khalifa possessed,
 22 no, I did not.
 23 CHAYTOR, Q.C.:
 24 Q. And this is now, I take it, into the late
 25 1990s?

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1 MR. GULLIVER:
 2 A. I guess, you know -
 3 CHAYTOR, Q.C.:
 4 Q. That time period, '97.
 5 MR. GULLIVER:
 6 A. Late '96, early '97, when he's talking about
 7 this and starting to do - working with Dr.
 8 Prabhakaran and I guess doing correlations and
 9 those things.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and at that point in time then, at the
 12 time that Dr. Khalifa is looking at bringing
 13 on ER/PR, how many other antibodies would it
 14 have been available at the Health Science, how
 15 many IHC antibodies were you using at that
 16 time?
 17 MR. GULLIVER:
 18 A. By '97, I mean, this is just a guesstimate. I
 19 mean, I would assume it could be up in the
 20 40s, 50s, 60s, or 70s. By that time, there
 21 were antibodies for most of your major cancer
 22 sites in the body. There were antibodies in
 23 development and in production and in use
 24 around the world for prostate cancers, lung
 25 cancers, and lymphomas, carcinomas, and brain

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1 cancers. So by that time, IHC testing is
 2 fairly well established within pathology, not
 3 pathology in St. John's, but pathology, in
 4 general, within the country.
 5 CHAYTOR, Q.C.:
 6 Q. And how many antibodies would you have
 7 available here at the Health Science at the
 8 time?
 9 MR. GULLIVER:
 10 A. You mean today or at that time?
 11 CHAYTOR, Q.C.:
 12 Q. At that time.
 13 MR. GULLIVER:
 14 A. I think it was probably in the 40s or 50s.
 15 That's my best estimate.
 16 CHAYTOR, Q.C.:
 17 Q. Are there any records that still exist which
 18 would tell us which antibodies you would have
 19 had in that time period?
 20 MR. GULLIVER:
 21 A. What kind of records would you be looking for?
 22 CHAYTOR, Q.C.:
 23 Q. Well, whatever you have.
 24 MR. GULLIVER:
 25 A. We can give you the actual physical slides.

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1 CHAYTOR, Q.C.:

2 Q. Yes, but in terms of actual documents to say -

3 MR. GULLIVER:

4 A. And to me - to me, the permanent record - in

5 pathology, we always consider your permanent

6 record is the actual -

7 CHAYTOR, Q.C.:

8 Q. So for you to tell me that, you'd have to go

9 to a slide?

10 MR. GULLIVER:

11 A. Is actually the block and the slide. That's

12 our permanent record.

13 CHAYTOR, Q.C.:

14 Q. So for you to tell me or answer at, you'd have

15 to go and actually pull the slides and blocks?

16 MR. GULLIVER:

17 A. No, what I have to do -

18 THE COMMISSIONER:

19 Q. Did a requisition form reflect what it is you

20 were offering at that -

21 MR. GULLIVER:

22 A. Well, we don't keep paper requisitions for ten

23 years. So what I would have to do, I would

24 have to go into the Meditech system and pretty

25 well go and do a search to look for what

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1 antibodies were performed in the year 1997. So

2 whether it was LCA, EMA, you know, all the

3 list, it may be there.

4 CHAYTOR, Q.C.:

5 Q. So the checklist that we see for the

6 requisition that you now have where the

7 pathologists can tick off what they wanted,

8 would there be such a form that would exist at

9 different points in time?

10 MR. GULLIVER:

11 A. Well, Dr. Khalifa, actually, I think, was the

12 one who put all that form together, but I -

13 the actual hard copies of those requisitions

14 are not kept ten years later.

15 CHAYTOR, Q.C.:

16 Q. But the standard form -

17 THE COMMISSIONER:

18 Q. We're just looking for one of them, though, in

19 the sense of do you have some kind of a file

20 which contains not forms from a particular

21 person, but the development - which would

22 demonstrate the development of the form over

23 time, including the addition of various new

24 tests available, you know, in 2000 or - sorry,

25 more in 2002 and 2003, etc?

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1 MR. GULLIVER:

2 A. That generally is practice, Justice Cameron,

3 that if you been using this form for five

4 years and you switch to a newer form -

5 THE COMMISSIONER:

6 Q. Uh-hm.

7 MR. GULLIVER:

8 A. You generally do keep a copy of the old form,

9 and I can't say if we have one or not. I've

10 seen evidence here where you've had copies of

11 those forms.

12 CHAYTOR, Q.C.:

13 Q. Two different forms. Yeah, we've seen at

14 least two different forms.

15 MR. GULLIVER:

16 A. And I don't know if there is, like I said, an

17 older copy of any older forms.

18 CHAYTOR, Q.C.:

19 Q. Okay, well, maybe that's something if you

20 wouldn't mind if you could check for us and

21 see if there are the different forms over

22 time.

23 MR. GULLIVER:

24 A. Yeah.

25 CHAYTOR, Q.C.:

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1 Q. That might be helpful.

2 MR. SIMMONS:

3 Q. If I can help with that, there have been quite

4 a few copies of requisition forms supplied,

5 and I just checked my notes and there are ones

6 from as early as 1996.

7 MR. GULLIVER:

8 A. That's what I thought too.

9 THE COMMISSIONER:

10 Q. It seems to me I remember a witness talking

11 about the changing - the forms reflecting the

12 change because they were adding various

13 things, but I don't remember which form -

14 which witness, sorry.

15 CHAYTOR, Q.C.:

16 Q. What we're looking for is what would have been

17 through the whole course in time, whether or

18 not we have all of them or not, and I don't

19 know that we know that. Mr. Gulliver, how

20 would you, as the manager in that time frame,

21 1997/1998, how would you keep apprised as to

22 the developments in the IHC area?

23 MR. GULLIVER:

24 A. You mean at the technical level?

25 CHAYTOR, Q.C.:

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1 Q. In terms of you to be able to do your job as
 2 manager of the people who are actually
 3 performing the tests, what would you do to
 4 keep apprised as to, well, these are the
 5 number of antibodies they now have, here's
 6 what's happening in the IHC lab, here are
 7 other developments, other things that may be
 8 coming on stream? How did you keep yourself
 9 apprised?
 10 MR. GULLIVER:
 11 A. Well, I guess some of the things - well,
 12 everyone has their own role. At that time,
 13 Dr. Khalifa certainly was our key lead person.
 14 You know, the technical staff relied upon him,
 15 as did I, that if there are new advancements
 16 in IHC - not just Dr. Khalifa, you know, we
 17 had multiple pathologists practising at the
 18 Health Sciences who were ordering and reading
 19 and interpreting IHC tests. We had many
 20 occasions where, Dr. Mathieson who for a long
 21 time was our newer pathologist, and he would
 22 come with information and say that there's a
 23 new antibody coming out that we could use for
 24 newer pathology for certain brain tumours.
 25 You know, we would go to either Khalifa or the

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1 site chief, or the clinical chief, and say,
 2 you know, should we order this here. I mean,
 3 really my role, as the manager, was to
 4 facilitate that process, and being a pathology
 5 technologist, over the years, I mean, I've
 6 attended - I had said to you earlier that on
 7 my professional side of my career in
 8 volunteering, you know, I've served as
 9 president of our Canadian Medical Lab
 10 Sciences, and through various reasons I have
 11 been able to attend a fair number of our of
 12 province conferences within our profession. In
 13 2001, for example, St. John's, we hosted our
 14 annual national conference. I was chairperson
 15 for that conference. We organized full day
 16 workshops in IHC testing, not just for techs,
 17 but for technologists in the country, and
 18 through those conferences - I mean, I have
 19 attended many, many sessions on
 20 immunohistochemistry testing, the theory,
 21 background, new advances and those kinds of
 22 things. So, you know, I wasn't in the Health
 23 Sciences reading a book, however, I've had
 24 many opportunities to kind of keep abreast of
 25 changes, but I would be keeping abreast more

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1 of changes from an administrative side, like,
 2 technology changes, or if there were new
 3 improvements in the kinds of reagents that
 4 we're using and the company is offering us,
 5 look, for an extra ten bucks, you know, a pop,
 6 we can give you new and improved type of
 7 stuff. I mean, those are the things I'd be
 8 more involved in. On the clinical decision
 9 side, that really was left to the
 10 pathologists.
 11 CHAYTOR, Q.C.:
 12 Q. And in terms of your overseeing of the staff
 13 and what the technologists are actually doing
 14 with the staining, what role did you play in
 15 that?
 16 MR. GULLIVER:
 17 A. Do you mean in assessing the quality of the
 18 stain?
 19 CHAYTOR, Q.C.:
 20 Q. In assessing - overseeing their work as their
 21 manager, what role did you play?
 22 MR. GULLIVER:
 23 A. Well, certainly in overseeing their work, I
 24 mean, within the pathology environment, and
 25 it's different than other parts of the lab,

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1 within the pathology environment the technical
 2 staff and myself, as the manager, we certainly
 3 rely upon a lot of feedback from the
 4 pathologists who - you know, as you've heard
 5 here before, every slide that's produced by
 6 the technologist is read and interpreted by a
 7 pathologist. So we rely upon the pathologist
 8 for constructive feedback. If they find that
 9 someone's work isn't up to scratch, they would
 10 certainly come to me and tell me so, and as
 11 the manager, I mean, it was my duty to deal
 12 with that. If no pathologist ever came and
 13 had an issue, I certainly just assumed that
 14 the technical staff, in general, not just IHC
 15 staff, but all the staff, you know, are
 16 performing their work as per protocol.
 17 CHAYTOR, Q.C.:
 18 Q. So no news is good news?
 19 MR. GULLIVER:
 20 A. Not necessarily. You know, I don't think that
 21 within the pathology lab - the work in there
 22 is so technical, it's so hands on, and the
 23 volume of work in there, you know, it would be
 24 impossible to go in the run of a week and not
 25 have a complaint on something. Whether it was

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1 this particular slide, the tissue was folded
 2 over, and had to recut a block to get a better
 3 section, or whether it was, I don't know if
 4 the H & Es are really that crisp today, you
 5 know, go in and troubleshoot and see, maybe
 6 the hematoxin is getting a bit off, and you
 7 need to filter it or replace it. That's the
 8 kind of environment that pathology is whereas
 9 if you looked at the other divisions, if you
 10 looked at in chemistry where a lot of their
 11 work is based upon these million dollar
 12 analyzers, pretty well you're putting blood
 13 specimens in, it's giving you a cholesterol
 14 results or glucose result, and if all those
 15 results fall within this exact parameter and
 16 the controls are working, then there's never
 17 an issue. Pathology is different.
 18 CHAYTOR, Q.C.:
 19 Q. My point being, though, you relied on
 20 pathologists to bring any issues to your
 21 attention and along life's way, complaints did
 22 come forward?
 23 MR. GULLIVER:
 24 A. Yeah.
 25 CHAYTOR, Q.C.:

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1 Q. And you would then deal with your
 2 technologists on it?
 3 MR. GULLIVER:
 4 A. Yeah.
 5 CHAYTOR, Q.C.:
 6 Q. Would it also - you'd have feedback, I take
 7 it, directly from your staff as well?
 8 MR. GULLIVER:
 9 A. Oh, certainly, I mean -
 10 CHAYTOR, Q.C.:
 11 Q. Coming to you and looking for assistance?
 12 MR. GULLIVER:
 13 A. Obviously, all the time, and I'm not saying
 14 that I did this all the time, I was certainly
 15 a manager who felt very close to the staff and
 16 worked very well with all the staff, and, you
 17 know, I have an open door policy, you can come
 18 and speak to me about anything, and they did
 19 come and speak about anything, and I also felt
 20 it was important to have feedback from my
 21 viewpoint to the staff, I also felt it was
 22 really critical to have staff give feedback to
 23 me of how they felt my performance was. So -
 24 and as you can - you've heard through all the
 25 testimony about the workloads and all those

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1 things. I did make a concerted effort to meet
 2 on a fairly regular basis with staff
 3 individually and just talk about, you know,
 4 how do you feel here? Do you think you're
 5 doing good work? Do you feel I'm supporting
 6 you? Do you feel there's something else I can
 7 do? And if I had issues with the staff,
 8 that's the time where we would talk about it.
 9 CHAYTOR, Q.C.:
 10 Q. And you've spoken a bit about how you keep
 11 apprised and you're not sitting in your
 12 office, I'm hearing you, reading a book, but
 13 you're out and about and you're going to
 14 conferences and you're involved in your
 15 voluntary efforts. What about the
 16 technologists who are actually doing the
 17 staining and doing the work, what
 18 opportunities were made available to them to
 19 attend conferences where they could learn?
 20 MR. GULLIVER:
 21 A. I would have to say, I mean, you know,
 22 certainly the Health Care Corporation, through
 23 all the--through whatever, you know, we didn't
 24 have millions of dollars lying around for
 25 education budgets that we could send staff off

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1 to annual conferences or to get--to keep
 2 apprised of things. A lot of it, you know, a
 3 part of our profession is that we--you kind of
 4 expect that med-lab science is med-lab
 5 science. It's an evolving science every day.
 6 We couldn't do HIV testing 15 years ago as we
 7 can do today. I mean, everything advances. A
 8 part of our life-long career is to self learn
 9 and to keep up with the new advances and new
 10 technology. But Mary and Peggy, who were the
 11 two techs primarily doing the testing, you
 12 know, for most of the years, they attended
 13 many of the conferences I did. I sat in
 14 lecture rooms, similar to this room, with
 15 myself and Mary and Peggy, listening to a
 16 lecture from a doctor or pathologist or
 17 another technologist, some -
 18 CHAYTOR, Q.C.:
 19 Q. Where IHC was discussed?
 20 MR. GULLIVER:
 21 A. Yes, sometimes -
 22 CHAYTOR, Q.C.:
 23 Q. Okay, here in the City?
 24 MR. GULLIVER:
 25 A. Yeah.

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1 CHAYTOR, Q.C.:

2 Q. Okay, and who would have been giving the

3 lectures at that point in time in IHC?

4 MR. GULLIVER:

5 A. My gosh, I can't tell you all the many of them

6 over the years that I've attended.

7 CHAYTOR, Q.C.:

8 Q. Who would have been -

9 MR. GULLIVER:

10 A. For example, Brian Hewlett, who's been called

11 here now, be testifying next week. I mean,

12 Brian has been in St. John's and given a

13 workshop in IHC that our techs participated

14 years--this is many, this is going back 15-20

15 years. Through our national professional

16 conferences, which I know Mary and Peggy has

17 attended a fair number of them, they would

18 make a point of if there was a lecture on IHC

19 testing or pathology in general, they would

20 make a point to attend them and any new

21 information, they would bring it back to the

22 lab.

23 Our annual provincial lab conference in

24 Newfoundland, I myself have given some

25 lectures back in the early days in IHC testing

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1 and pathology in general. Peggy has given

2 them. Pathologists have given them. So I

3 mean, there's been numerous occasions where

4 we've been able to, you know, attend lectures

5 in IHC. However, I don't--I mean, even--that

6 just keeps us in the periphery, you know. It

7 doesn't mean that they've been off to do sort

8 of a really in-depth two week, you know,

9 training in troubleshooting or interpretation

10 or those things, which we've heard from, you

11 know, from Trish Wegrynowski in Mount Sinai.

12 You know, we have to realize, we've practised

13 down here in St. John's, you know. We're on

14 the far reaches of the country and you know,

15 we're not in the mainstream.

16 CHAYTOR, Q.C.:

17 Q. No, but you're a tertiary care centre offering

18 the same service that Trish Wegrynowski is

19 offering. So are you saying that -

20 MR. GULLIVER:

21 A. No.

22 CHAYTOR, Q.C.:

23 Q. - the training of your staff would be any less

24 than what they would be for her staff?

25 MR. GULLIVER:

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1 A. No. I don't think that we're offering the

2 same service either.

3 CHAYTOR, Q.C.:

4 Q. Well, you're offering--well, in terms of what

5 we're dealing with here.

6 MR. GULLIVER:

7 A. I think Mount Sinai--we offer a similar

8 service, but I think Mount Sinai sort of

9 offers, also offers service where you can -

10 CHAYTOR, Q.C.:

11 Q. But in terms of the ER/PR tests.

12 MR. GULLIVER:

13 A. - but you can send and get expert

14 interpretation and opinions and you can, as

15 consult and those things. We never offered

16 that level of service to say that we can--

17 "send us your work and we'll do a consult for

18 you." I'm just saying in the environment in

19 Toronto, for example, where Trish--at Mount

20 Sinai and other techs who I know, you know,

21 they have a networking process within Toronto,

22 within Greater Toronto, within Hamilton,

23 McMaster, London University Health Network,

24 you know, there's greater opportunities there

25 to stay in tune with your coworkers in IHC or

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1 your pathologists that we don't have that

2 luxury here, never did.

3 CHAYTOR, Q.C.:

4 Q. So at the time that the ER and PR is

5 introduced then through the IHC method by Dr.

6 Khalifa, did you understand that there was

7 anything peculiar about ER and PR as opposed

8 to the other antibodies that were being

9 offered at the time?

10 MR. GULLIVER:

11 A. I certainly knew through Dr. Khalifa and

12 through, I think it was Mary, I think Mary did

13 most of the work with Dr. Khalifa in doing the

14 correlations and I'd say Peggy probably had a

15 hand in it also, but yes, I certainly was

16 aware that there was a new step being added

17 for the antigen retrieval process, that these

18 two markers were prognostic and they were very

19 difficult antibodies that I knew that there

20 could be lots of things could go wrong with it

21 in the antigen retrieval and this was--that

22 was a new step being added to our IHC

23 methodology.

24 CHAYTOR, Q.C.:

25 Q. And would this have been the first time that

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1 the staff would have to do antigen retrieval?
 2 MR. GULLIVER:
 3 A. Yes, certainly.
 4 CHAYTOR, Q.C.:
 5 Q. And what were they--what instruction were they
 6 given then to how to carry out the procedure?
 7 MR. GULLIVER:
 8 A. Again, I mean, Dr. Khalifa--I mean, I
 9 certainly didn't instruct them.
 10 CHAYTOR, Q.C.:
 11 Q. And Dr. Khalifa would instruct them from a
 12 technical point of view?
 13 MR. GULLIVER:
 14 A. Dr. Khalifa, certainly, and the main
 15 instruction though came from, Ms. Chaytor,
 16 DAKO. As you are aware, were--that's where we
 17 were purchasing most of our antibodies and
 18 reagents and subsequently reagents and
 19 detection kits, you know, they provided to the
 20 lab here, I mean, and before all this stuff
 21 comes to the marketplace, I mean, there are
 22 years of research put into this by companies,
 23 you know, and they recommended to their
 24 customers that if you're going to do ER/PR,
 25 here is the antigen retrieval process that

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1 must be done. Before you actually do your
 2 peroxidase procedure, you must do this step
 3 first, and pretty well, it was DAKO who
 4 recommended "here's our recommended protocol
 5 for doing the antigen retrieval." It would
 6 have been done multiple times by Mary and/or
 7 Peggy and Dr. Khalifa would have been the one
 8 who then would have said yea or nay, but I
 9 certainly had no active role in that whole
 10 technical piece.
 11 CHAYTOR, Q.C.:
 12 Q. And you would have been their manager at the
 13 time, so in essence, your role would have been
 14 what Barry Dyer's role is now? He's now the
 15 quality manager.
 16 MR. GULLIVER:
 17 A. Pretty well, yeah.
 18 CHAYTOR, Q.C.:
 19 Q. Except he has the two additional -
 20 MR. GULLIVER:
 21 A. Although Barry probably has a bit more
 22 technical knowledge than I do.
 23 CHAYTOR, Q.C.:
 24 Q. All right.
 25 THE COMMISSIONER:

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1 Q. Ms. Chaytor, wherever you can find an
 2 appropriate spot, we'll take the morning
 3 break.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. Actually, this is a good spot, please,
 6 Commissioner.
 7 THE COMMISSIONER:
 8 Q. All right. We'll take 15 minutes.
 9 (BREAK)
 10 THE COMMISSIONER:
 11 Q. Ms. Chaytor.
 12 CHAYTOR, Q.C.:
 13 Q. Thank you, Commissioner.
 14 CHAYTOR, Q.C.:
 15 Q. Mr. Gulliver, I'd like to just canvas a little
 16 bit more about the training of the staff in
 17 the IHC area. And Registrar, if we could
 18 please the transcript of Trish Wegrynowski,
 19 June 25, 2008? I'm at page 33, please,
 20 Registrar. Mr. Gulliver, I'm not sure,
 21 perhaps you were here when Ms. Wegrynowski was
 22 giving her evidence or -
 23 MR. GULLIVER:
 24 A. I was not, no.
 25 CHAYTOR, Q.C.:

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1 Q. - had an opportunity to hear some of what she
 2 had to say?
 3 MR. GULLIVER:
 4 A. I did not, no.
 5 CHAYTOR, Q.C.:
 6 Q. You didn't follow what she had to say? Okay.
 7 So at this point, on page 33, I'm asking "I'd
 8 just like to explore with you a little bit
 9 about the training of the technologists for
 10 IHC and you indicated that when you were
 11 trained, that it was not part of the--the
 12 actual IHC was not part of your training at
 13 that point in time, and is it currently part
 14 of the curriculum for technologists?" and she
 15 responds "no, it is not, unfortunately."
 16 "Okay, and so then bringing your technologists
 17 into your IHC lab at Mount Sinai, how is that
 18 person trained to do their job?" and she says
 19 "we start off at the ground. The microtomy
 20 that is used in IHC is very different than
 21 what you would use in the routine histology
 22 lab. One of the reasons are that the block
 23 has already been given an H & E so you want to
 24 ensure that the tissue is never removed" and
 25 she goes on and says "going forward from that,

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1 the way we handle our slides are different.
 2 Some slides are heated. Some are kept cold
 3 and so there's different parameters" and she
 4 continues with "once the technologist is
 5 comfortable with the microtomy, and it's not
 6 just the microtomy they're learning, and
 7 they're understanding it's a different
 8 nomenclature," is that--not sure, "the names
 9 that I use today probably don't make much
 10 sense to many people. If you can imagine, we
 11 have over 300--if you have 300 different
 12 antibodies that they sound so alien, so it's
 13 an opportunity for technologists to start
 14 understanding the verbiage that we use and how
 15 we handle them. There are many different
 16 pretreatments associated with the antibodies
 17 and that comes all marked on the slides for
 18 them. So they start understanding a little
 19 bit about the work flow. They are always
 20 given the opportunity to review the antibody
 21 specification sheet and all the validation
 22 slides that are held with them. All the slides
 23 that we are presently using now for validation
 24 are all marked with the validation date and
 25 the lot number down the slide, and they are

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1 always kept by our microscope."
 2 She goes on to say "and so that's just
 3 part, just of that portion, and then the
 4 technologist would start moving on to what we
 5 call the sort and handling desk which is where
 6 if you have 400 slides looking at you, you
 7 have to find a way to put them in some
 8 semblance of order," and then she continues on
 9 the next page with "many of them will start
 10 with very simple techniques, which is a kidney
 11 biopsy. If it comes in cut on a microtome,"
 12 and she goes on to talk about "and from there,
 13 in a very slow organized fashion, they move on
 14 to being able to work on the equipment,
 15 understanding the equipment, what the alarms
 16 mean, if there is a problem with set up, how
 17 do we change drops and that is gone over in a
 18 very slow fashion. From there, we'll start
 19 working on getting the slides out and then
 20 sitting down together and finally reading the
 21 controls together."
 22 And so then I asked her "how long does
 23 all that--how long does it all take? How long
 24 a process is it before the technologist is
 25 then actually left on their own to do their

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1 job in the IHC lab?" and she responded "about
 2 a year. About a year before they're left to do
 3 their job on their own, depending on what part
 4 it is. Some parts, you're certainly
 5 comfortable with in six months, but we're
 6 talking the full gamut. I would say easily a
 7 year and then it's not unusual to come"--oh,
 8 sorry, I missed a page, sorry, "and then
 9 it's"--no, that's right. "not unusual to come
 10 in in the morning and say 'I didn't hand this
 11 out because I'm not quite sure"--it seems to
 12 be something missing. Sorry, "and if that, if
 13 it's a technologist who otherwise had years of
 14 training in other parts of the pathology lab,
 15 would that time period be abbreviated?" "Yes,
 16 it would be because my expectations are at
 17 that point that they understand microtomy.
 18 They would understand the issues with that.
 19 They would still certainly have to spend time
 20 on that bench understanding the differences
 21 between the different antibodies and how the
 22 slides have to be handled. It would be an
 23 abbreviated version, but it still wouldn't be--
 24 it would be still about six to nine months.
 25 It's not routine histology. It's very, very

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1 different, so we spend a lot of time going
 2 over troubleshooting issues."
 3 So I just wanted to show that to you and
 4 then, please, Registrar, if we could have July
 5 15th, 2008, and this is an excerpt from Mr.
 6 Simms' testimony here at the Commission, Les
 7 Simms, and it's page 305, please. And you'll
 8 see here, I asked Mr. Simms "when did you
 9 actually start? What was your start date at
 10 the Health Sciences?" and he said "March 18th,
 11 2003." "And so, when you went there, what
 12 training did you then receive in IHC?" "My
 13 training then was Peggy was the lead tech
 14 there, that was my understanding from when I
 15 was moved in, and I was--the first week I was
 16 there, I don't think I was on IHC the first
 17 week. I think it was the second week, and I
 18 followed Peggy around while she actually did
 19 the stains. I made my own notes and followed
 20 there and for that week and the following
 21 week, if I remember correctly, then I did them
 22 and Peggy kept an eye on what I was doing."
 23 "So for the first week, you think you were not
 24 doing--you were doing something other than
 25 IHC?" "Probably just getting orientated into

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1 the laboratory." "And the second week then,
 2 you job shadowed, for the lack of a better
 3 term, you job shadowed Peggy Welsh during the
 4 IHC procedures?" "That's right." "And then
 5 the week after that, you went back to the IHC
 6 portion of the lab and then she observed while
 7 you did the procedures?" "That's what I
 8 recall." "That's what you recall, okay, and
 9 how long was it then before you were left on
 10 your own then to do--when were you next back
 11 into the IHC portion of the lab, and were you
 12 then on your own doing the tests?" "I could
 13 only assume that it was, you know, then after
 14 Mary did the third week after, I would assume
 15 that then I did it on my own. But at that
 16 point in time, I was completely new at it, so
 17 I was never on my own, even if, you know, if I
 18 was setting up a machine or on whatever, I
 19 would sometimes ask Ken to check it or Mary,
 20 whoever was around, just to make sure, just to
 21 double check and triple check because
 22 unfortunately or fortunately, I am a
 23 perfectionist and sometimes that's detrimental
 24 because you just check, recheck, check again,
 25 but I would, if I had any problems or wasn't

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1 absolutely sure, I would ask Ken or Mary."
 2 "Okay, and so they were nearby?" "Yes. Even
 3 though they weren't in the rotation, you were
 4 in there by yourself, you could check with
 5 them. They were in shouting distance."
 6 And then if we go on to the next page,
 7 309, "Okay, and Peggy taught you to use that?"
 8 and you'll see we're talking about the DAKO
 9 machine. "Okay, and other than actually using
 10 the machine, what else were you--what other
 11 instruction, in terms of IHC were you given or
 12 was the focus mostly on the operation of the
 13 machine or were you given anything in terms of
 14 the theory, for example, of IHC?" "The focus
 15 was mainly on the machine, the operation of
 16 the machine. It was my own, my own
 17 responsibility to find textbooks and so on and
 18 the theory, if I was so interested, you know,
 19 in the theory at the time. I would focus, it
 20 was my responsibility to go find textbooks and
 21 journals and whatever else." "And did you do
 22 that?" "Yes, I did." "So you sought out
 23 extra information?" "I sought out extra
 24 reading material, yes." "And when you began
 25 in March of 2003, how many antibodies were

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1 there, approximately?" and he says "between 70
 2 and 80."
 3 And then, Registrar, if we could have,
 4 please, July 8th, 2008, and this is Peggy
 5 Welsh's portion of her evidence about how she
 6 was trained, and she indicates, Mr. Gulliver,
 7 that it would have been you that trained her,
 8 and it's page, please, 115.
 9 So I ask "okay, and who then taught you
 10 about IHC? You haven't learned it in your
 11 schooling, and so how were you taught or
 12 trained to do IHC procedures?" "Dr. Wong," I
 13 guess that should be Dr. Wang, is that right?
 14 "showed Terry how to do them and Terry showed
 15 me." "Okay, and what exactly did Mr. Gulliver
 16 show you?" "We just learned the basic
 17 procedure, how to--exactly what you did. We
 18 had a procedure that we followed just to make
 19 up the antibodies, put them on the slides,
 20 incubate the slides. We didn't have very
 21 much, other than just hands on training from
 22 the person who was doing it." "So whatever you
 23 learned it was through Mr. Gulliver?" "Um-hm."
 24 "And then, you said there was a procedure that
 25 you followed. So was there a written

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1 procedure?" "I don't recall if it was a
 2 written procedure or not. I probably made
 3 notes when he was teaching me, but I don't
 4 recall if there was ever a written procedure.
 5 I think there probably would have been, but I
 6 just don't remember that." "Okay, and do you
 7 recall were you provided any textbooks?" "No,
 8 we had no textbooks." "Were you provided
 9 anything in the way of seminar or conference
 10 that you could attend where you could learn
 11 from it?" "No."
 12 And then if we could have, please, page
 13 269 of the same transcript?
 14 MR. GULLIVER:
 15 A. If you--can you just go back a page, that same
 16 page?
 17 CHAYTOR, Q.C.:
 18 Q. Back a page before?
 19 MR. GULLIVER:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. Okay.
 23 THE COMMISSIONER:
 24 Q. The page before or the one we were looking at
 25 before?

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1 MR. GULLIVER:
 2 A. The one, I guess, that -
 3 CHAYTOR, Q.C.:
 4 Q. Right here, this one?
 5 MR. GULLIVER:
 6 A. Yeah, where it said, she said "no."
 7 CHAYTOR, Q.C.:
 8 Q. Okay, after that, okay.
 9 MR. GULLIVER:
 10 A. About courses or something.
 11 CHAYTOR, Q.C.:
 12 Q. Okay, let's go back to page 117. "No." "And
 13 throughout your time, actually up until you
 14 left in April 2003, had you ever attended a
 15 conference or seminar on IHC?" "No, not
 16 specifically." "Did you say not
 17 specifically?" the Commissioner asked. "Not
 18 specifically. I attended conferences, though,
 19 our professional society, and there would have
 20 been maybe one or two lectures from a
 21 p a t h o l o g i s t s o r i m m u n o - - o n
 22 immunohistochemistry, but no specific training
 23 for IHC." Is that the part?
 24 MR. GULLIVER:
 25 A. Yeah, and there's a couple of more, she

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1 continues on over here.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. "No, they would have been in various
 4 places around the province", where she
 5 attended the seminars, I think.
 6 MR. GULLIVER:
 7 A. Yeah, she's talking about Dr. Paul Neil who as
 8 giving one in Corner Brook.
 9 CHAYTOR, Q.C.:
 10 Q. Yes. "So Dr. Paul Neil gave one in Corner
 11 Brook. I don't recall when that was, probably
 12 early 1990s, but I can't recall exactly who
 13 would have given the lectures. That would
 14 have been an hour long sort of information
 15 session. And was there any concentration on
 16 the actual technical aspect of conducting IHC?
 17 No. So in terms of any training that you
 18 received from a technical point of view did
 19 you attend any seminars or have any courses in
 20 that? No. I attended one conference in
 21 Montreal and I don't remember the year, maybe
 22 early 1990s, and one of the days was spent as
 23 a workshop in IHC, but it was basically on a
 24 particular instrument that somebody was trying
 25 to sell across the country and so we did a

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1 seminar on how to actually use that instrument
 2 but we never bought that instrument or
 3 anything." Is that it?
 4 MR. GULLIVER:
 5 A. Yeah.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. Page 269, please? And Ms. Welsh says
 8 here in her evidence, "I've learned a lot in
 9 the last month that I had never heard in all
 10 the time I was doing the work. And, Ms.
 11 Welsh, where in particular have you learned
 12 that, is it through anybody's evidence in
 13 particular that you've listened to? Probably
 14 the woman from Mount Sinai. Trish Wegrynowski?
 15 Yeah, things that she had talked about I had
 16 never heard about before." So, Mr. Gulliver,
 17 I just wanted to take you through that to get
 18 some sense of what your technologists have
 19 said in their evidence before the Commissioner
 20 and how that compares to what Ms. Wegrynowski
 21 laid out in her evidence as to the training
 22 that a technologist would receive at her
 23 institution. And is it your position that the
 24 technologists here in St. John's were well
 25 trained in IHC?

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1 MR. GULLIVER:
 2 A. Well, I think all of what you just flipped
 3 through, Ms. Chaytor, if you look at Trish's
 4 document there, it looks like she's talking
 5 about training two different types of
 6 technologists. And looks like one could be a
 7 new technologist in pathology where they
 8 certainly would have to go through many, many
 9 months of learning the basics of pathology
 10 before they would start being taught to
 11 perform procedures in the IHC lab. When you
 12 look at the technologists who did this
 13 procedure with us, mostly Mary and Peggy, and
 14 after Peggy retired or left then Les Simms,
 15 you know, you're talking about technologists,
 16 by the time they started learning IHC testing,
 17 the basic principles, these techs have 100
 18 years in pathology behind them in total, so
 19 basic things like microtomy and all those
 20 things, I mean, they've already been skilled
 21 in that and doing that function for many,
 22 many, many years.
 23 CHAYTOR, Q.C.:
 24 Q. Yes, that's why I also brought Ms. Wegrynowski
 25 back to the point of, say, technologists who

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1 would already have that training.
 2 MR. GULLIVER:
 3 A. Right, yeah.
 4 CHAYTOR, Q.C.:
 5 Q. And she said then it would be a six to nine
 6 month, so it would abbreviate the time period
 7 somewhat, but from the year.
 8 MR. GULLIVER:
 9 A. So, I mean, the technologists in the past, who
 10 you're talking about, Mary and Peggy, you
 11 know, again, you know, they had the same
 12 professional background as any other
 13 technologist in Canada. They have their RT.
 14 They had many, many years experience in
 15 pathology. And performing this procedure,
 16 it's very similar to performing dozens of
 17 other procedures in the pathology lab, that
 18 you have a step-by-step process that you must
 19 follow.
 20 CHAYTOR, Q.C.:
 21 Q. So you didn't see this as being anything
 22 different or more complicated than anything
 23 else they were doing in the pathology lab?
 24 MR. GULLIVER:
 25 A. The difference was when the ER/PR test came

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1 in, by that time Mary and Peggy were doing IHC
 2 testing for ten years, you know, where every
 3 slide they produced was being read,
 4 interpreted by a pathologist. Certainly there
 5 had to be times where we had to troubleshoot,
 6 but by this time they are ten years, you know,
 7 cutting blocks and slides for IHC, they know
 8 the antibody names and all that kind of stuff.
 9 The big difference for ER/PR was the antigen
 10 retrieval process that was put in place prior
 11 to doing your peroxidase staining. And just
 12 to go through some of your stuff where Ms.
 13 Welsh said that she can't remember having a
 14 procedure, but, you know, we had a written
 15 procedure right from the start for the, you
 16 know, the peroxidase and the peroxidase stain,
 17 which is the very principle behind IHC testing
 18 for all the antibodies. And I know I've
 19 submitted that document to you, I think it was
 20 dated 1985 or '86 where there was a written
 21 protocol procedure that we followed for IHC.
 22 I guess Peggy just didn't remember that day on
 23 the stand. But again, I mean, the pool of
 24 technologists that we're talking about doing
 25 this training in our lab were well seasoned,

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1 well experienced technologists who were
 2 certified as technologists. Again -
 3 CHAYTOR, Q.C.:
 4 Q. But it's a new procedure for them, IHC, when
 5 they were first introduced. And so you've
 6 saying that Peggy and Mary, by the time that
 7 ER/PR is introduced, they've had almost ten
 8 years in IHC at that point in time. And did
 9 you--are you of the understanding that they
 10 understood the theory of IHC?
 11 MR. GULLIVER:
 12 A. To the best--well, you'd have to ask them
 13 that. But to the best of my knowledge, and
 14 knowing the quite well and knowing, you know,
 15 their level and quality of their work, that,
 16 yeah, that they had a good understanding of
 17 how to perform the procedures. They had a
 18 good understanding in knowing to follow the
 19 protocols that whatever antibodies had to be
 20 diluted at a certain dilutions that were
 21 recommended. They had good knowledge in
 22 control slides in routine pathology because
 23 they've done it for years. However, the
 24 control slides for IHC were, you know, had to
 25 go to pathologists. But certainly, Mary and

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1 Peggy and I have witnessed them on numerous
 2 occasions, when they finished running IHC
 3 testing, whether it was ER/PR or other
 4 antibodies, you know, they would make a point
 5 of, look, have a quick look under the
 6 microscope to makes sure they can look for
 7 positive staining whatever antibody may be,
 8 whether it was an ER/PR or an NCEMA or various
 9 antibodies, to make sure the procedure worked
 10 according--the technologist is, is the
 11 positive control, external control positive.
 12 If that was the case, the slides then went to
 13 the pathologist for the interpretation.
 14 CHAYTOR, Q.C.:
 15 Q. Mr. Gulliver, and I'll take you to it later
 16 today, if not today, next time you're here,
 17 but you were involved, of course, in Trish
 18 Wegrynowski coming to St. John's to do her
 19 review and you were provided a copy of her
 20 reports at the time. And so, and I would take
 21 it that then you're well aware that she felt
 22 your technologists had a lot to learn in terms
 23 of the theory of IHC and you would have known
 24 that back in 2005 when she completed her
 25 assessment?

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1 MR. GULLIVER:
 2 A. When I read her report -
 3 CHAYTOR, Q.C.:
 4 Q. Do you disagree with that? Do you disagree
 5 with that?
 6 MR. GULLIVER:
 7 A. Disagree with what?
 8 CHAYTOR, Q.C.:
 9 Q. That Trish Wegrynowski found that your
 10 technologists had a lot to learn in terms of
 11 the theory, this is in 2005 that she felt that
 12 the technologists had a lot to learn in terms
 13 of the theory of IHC?
 14 MR. GULLIVER:
 15 A. Well, see, in 2005, and certainly I can't
 16 disagree with her opinion. I mean, if that's
 17 Trish's opinion, I mean, I can't disagree with
 18 it -
 19 CHAYTOR, Q.C.:
 20 Q. Yes, and I'm wondering what your opinion is as
 21 their manager?
 22 MR. GULLIVER:
 23 A. Well, my opinion in 2005 I wasn't the manager.
 24 I had not been the manager in pathology since
 25 2001.

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1 CHAYTOR, Q.C.:
 2 Q. Well, you're the director of the program, a
 3 step above at that point?
 4 MR. GULLIVER:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. And responsible for, and their manager would
 8 be reporting to you?
 9 MR. GULLIVER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So what was your -
 13 MR. GULLIVER:
 14 A. I know, and I'm responsible for 250 other
 15 technologists in every other lab.
 16 CHAYTOR, Q.C.:
 17 Q. Okay.
 18 MR. GULLIVER:
 19 A. So I can't be on the bench with every
 20 technologist ensuring that they know exactly,
 21 that exactly what they're doing and they can
 22 troubleshoot. I think Trish's point is that
 23 when she came in 2005, you know, Mary Butler
 24 was still there, who had been there a long
 25 time, and Peggy was there since 1985, that,

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1 you know, at that time Les Simms was fairly
 2 new to the IHC lab, you know, through Peggy
 3 retiring and Les coming in, Ken Green moved
 4 over St. Clare's -
 5 CHAYTOR, Q.C.:
 6 Q. But he was a very senior technologist?
 7 MR. GULLIVER:
 8 A. In pathology, yes.
 9 CHAYTOR, Q.C.:
 10 Q. Right.
 11 MR. GULLIVER:
 12 A. But Les then was working in IHC, he had less
 13 than two years experience in IHC lab when
 14 Trish came in. And Ken had less than three
 15 years experience, maybe less, he had less than
 16 three years experience.
 17 CHAYTOR, Q.C.:
 18 Q. So that does make a difference. I just want
 19 to be clear. So that makes a difference, that
 20 they have little experience in IHC regardless
 21 of how many years you have in pathology?
 22 MR. GULLIVER:
 23 A. I have to agree with that, yes. Because as
 24 Trish states, I mean, IHC testing, and it's
 25 not that it's different, Ms. Chaytor, in being

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1 able to follow a procedure and being able to
 2 follow a protocol, I mean, IHC testing, it's
 3 used for many purposes by the pathologist. I
 4 think the key thing in IHC testing is being
 5 able to recognize when something is not
 6 working properly or when something is not
 7 optimal. And whether the technologist must
 8 recognize it or whether the pathologist must
 9 recognize it, you know, is a different issue.
 10 And I can't disagree with Trish. That the
 11 point is when she did come in, our three techs
 12 at the time, two of them had about
 13 approximately two years experience in IHC
 14 testing. And it wouldn't surprise me if Trish
 15 said that, you know, our techs don't have a
 16 lot of theory in, and background theory in IHC
 17 testing at that point in time.
 18 CHAYTOR, Q.C.:
 19 Q. And your own technologist, Peggy Welsh, saying
 20 that she learned a lot through just hearing
 21 Trish Wegrynowski's evidence through the
 22 Commission, she seems to have been
 23 acknowledging that she herself didn't have
 24 that solid base, that she learned, actually,
 25 from hearing Trish -

1 MR. GULLIVER:

2 A. I don't know. I think when--you know, and I
3 did hear a fair bit of Peggy's testimony. I
4 think Peggy's statement overall was that she
5 learned a lot from Trish's report in things
6 that Trish recommended in having standard
7 operating procedures and policies and
8 documentation and the level of documentation
9 that Mount Sinai performs that she would have
10 expected us to be performing here. I don't
11 know if it was Peggy's intent she learned a
12 lot of knowledge of IHC testing and the
13 theory. I think she learned a lot of what
14 came out of Trish's recommendations.

15 CHAYTOR, Q.C.:

16 Q. She certainly talked about it as being Ms.
17 Wegrynowski's evidence. There was a reference
18 to her report or whether or not she'd actually
19 read the report when I asked it her that, it
20 was, she said, "I've learned a lot in the past
21 month that I had never heard in all the time I
22 was doing the work." And I asked her who it
23 was that she'd learned that from and she
24 indicated the woman from Mount Sinai. "Yeah,
25 things that she talked about, I had never

1 CHAYTOR, Q.C.:

2 Q. Why is it that over the years there wasn't
3 more done in terms of bringing on something
4 like IHC, why weren't there more opportunities
5 for them to have more formal training as to
6 how to do the procedure or to be educated in
7 the theory?

8 MR. GULLIVER:

9 A. Well, I guess--do you mean why there wasn't
10 more opportunity created by us in the
11 workplace, by the Health Care Corporation or
12 do you mean in general?

13 CHAYTOR, Q.C.:

14 Q. Yeah, I'm just wondering, like, someone comes
15 in to the program and why isn't there a more
16 formal--like, we've heard Mr. Simms say, well,
17 you know, I job shadowed, I job shadowed for -

18 MR. GULLIVER:

19 A. I know. Well -

20 CHAYTOR, Q.C.:

21 Q. - a week or two. You know, why -

22 MR. GULLIVER:

23 A. I guess, I mean, and it's like many parts of
24 the laboratory, you know, as I mentioned in my
25 opening testimony that, you know, we're

1 heard before."

2 MR. GULLIVER:

3 A. And again, I can't speak for Peggy. Whether
4 she never heard about internal controls or
5 whether she never heard about fixation issues
6 or whether she never heard there were problems
7 with the procedures, I can't say -

8 CHAYTOR, Q.C.:

9 Q. So I just want to be clear that you as the
10 manager of the pathology lab until 2001 when
11 you became the director of the overall program
12 and continued on in that position until today,
13 you feel that your technologists were well
14 trained, well informed and capable of doing
15 the job?

16 MR. GULLIVER:

17 A. I have to say yes.

18 CHAYTOR, Q.C.:

19 Q. And you have no concerns as to even with
20 everything that you've heard, any concerns
21 that they were other than well trained, well
22 informed and knew how to do their job and did
23 their job properly?

24 MR. GULLIVER:

25 A. I would have to say yes.

1 trained as general medical lab technologists
2 where you receive the basic knowledge and
3 training and the foundation, really, to build
4 upon that in the workplace. Within the lab
5 environment we have, you know, four or five
6 hundred staff that work at Eastern Health
7 laboratories and they're at various stages.
8 You have entry level technologists, which
9 would make up a portion of your workforce, you
10 have then the next level, technologist twos,
11 technologist threes, technologists fours. So
12 depending upon the experience they've gained
13 and depending upon the expertise they've
14 acquired or the knowledge they've gained and
15 being specialized, in those specialized parts
16 of the lab, there really is very few formal
17 training programs where you can actually go
18 and say, okay, I'm now a certified IHC
19 technologist. It doesn't exist.

20 CHAYTOR, Q.C.:

21 Q. Well how about something within, though,
22 within your program itself so that someone
23 comes in and it's not one or two or three
24 weeks job shadowing with somebody, it's, you
25 know, here's what we're going to do. There's

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1 going to be a classroom component for two or
 2 three, we're going to have, you know, people
 3 work with you in that regard and then your
 4 period of job shadowing is going to be much
 5 more extensive. I mean, now they're up to
 6 over 100 stains, for example?
 7 MR. GULLIVER:
 8 A. Yeah. Well, I'm thinking, you know, for
 9 there's a--if there's a classroom time -
 10 CHAYTOR, Q.C.:
 11 Q. No, I mean, that's just an example.
 12 MR. GULLIVER:
 13 A. I know. Well, obviously for classroom time,
 14 you'd need someone to teach it.
 15 CHAYTOR, Q.C.:
 16 Q. Yes. And so you don't have clinical educators
 17 that we've heard other programs would have?
 18 MR. GULLIVER:
 19 A. Right. And we don't, so we don't have someone
 20 to teach in the classroom.
 21 CHAYTOR, Q.C.:
 22 Q. Why would that be, why isn't there any
 23 clinical educator component for the laboratory
 24 medicine program?
 25 MR. GULLIVER:

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1 A. It's not something that we've ever had.
 2 CHAYTOR, Q.C.:
 3 Q. Is it something you ever sought?
 4 MR. GULLIVER:
 5 A. I personally, I have never asked for a
 6 clinical educator. What we have within the
 7 lab environment, we have senior technologists
 8 in all our divisions when our students in
 9 training at CONA, when they come into the
 10 workplace to spend their clinical component,
 11 we have senior technologists in all divisions
 12 who work with those students in helping them
 13 go through their competency profiles and what
 14 they must learn to become an entry level
 15 medical lab technologist. What we don't have
 16 within the programs are senior technologists
 17 who have expertise that can actually transfer
 18 that expertise to the person replacing their
 19 job. For example, and a good point is here,
 20 you know, Peggy Welsh, who in my opinion was
 21 well qualified to work in our IHC lab and
 22 pathology lab, as Mary Butler was, when Peggy
 23 decided that she was going to leave our lab
 24 after many, many, many years, her replacement
 25 was Les Simms and we didn't have--we don't

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1 have those opportunities, Ms. Chaytor, where
 2 Peggy gives us 30 days notice that I'm
 3 leaving. So we took the next senior
 4 technologist who has the most experience in
 5 pathology in the city, who happened to be Les
 6 Simms, and as best we could Les spent as much
 7 time with Peggy trying to absorb her knowledge
 8 before she left the organization. And I would
 9 say to you in most workplaces that's the way
 10 it is. Once you learn your basic level of
 11 medical lab technology, a lot of it's
 12 continued learning. You continue to learn on
 13 the job. But then again, we have other parts
 14 of the program where, you know, several years
 15 ago working with our fertility physicians,
 16 they wanted to put new testing in place to do
 17 inseminations and there is a lab component to
 18 that. And, you know, we took one of our
 19 senior technologists in biochemistry who got
 20 some experience in this testing and we sent
 21 her to McGill University for a week to learn
 22 some more in depth training. But IHC testing
 23 is even more encompassing than just going to
 24 learn to do procedures for fertility testing
 25 and there is no formalized training for IHC

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1 testing. I would submit that if you really
 2 wanted to have technologists who were experts
 3 in IHC testing, you would need to probably
 4 have another six months post RT training and
 5 maybe ten years pathology experience first and
 6 then do a dedicated training or formal
 7 training in IHC testing.
 8 CHAYTOR, Q.C.:
 9 Q. Registrar, if you could bring up, please,
 10 September 30th, 2008? This is the transcript
 11 of Maria Tracey. And in answering a question
 12 put to her by Mr. Simms about the type of
 13 training that happens, it's at page 27,
 14 please, the type of happens for a new nurse
 15 starting in the perioperative program within
 16 Eastern Health. Mr. Simmons says, "Mr. Coffey
 17 asked you a moment ago about communicating
 18 policies and procedures to new staff who join
 19 the perioperative service. Can you explain a
 20 bit about the process of orienting new nursing
 21 staff to the operating room, how long it
 22 takes, what sort of things are involved and
 23 what the process is, please? The actual
 24 orientation to the operating room is the most
 25 extensive orientation provided to any service

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1 because of the complexity of the area. The
 2 orientation ranges from 16 weeks at St.
 3 Clare's site, a minimum of 16 weeks to
 4 actually almost six months at the General site
 5 because there are more services for a staff
 6 member to become familiar with at the General
 7 site. There's a classroom component first
 8 which is three to four weeks and following
 9 that the staff are orientated for two weeks in
 10 each service. They are mentored by the nurse
 11 II in the service. After the first six weeks
 12 orientation is complete, there is an
 13 examination, preliminary examination to make
 14 sure the staff member has the initial skills
 15 of an operating room nurse. Towards the end
 16 of their orientation the clinical educators
 17 review their clinical skills and make sure
 18 they're at a level they should be, but there's
 19 ongoing monitoring by the clinical educators
 20 of all new staff members at each service and
 21 they get continuous feedback from the nurse II
 22 and they actually spend time in the operating
 23 room observing the progress and progression of
 24 the skills of the person. The operating room
 25 is a very complex area. The policies and

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1 procedures are very rigid. Staff have to be
 2 familiar with all of them and they have to
 3 follow the practice, is very much delineated
 4 and there cannot be any deviation. So that's
 5 the way we ensure that all our patients
 6 receive safe care that we always have the
 7 right patient getting the right surgery." So,
 8 Mr. Gulliver, I'm just thinking about this as
 9 an analogy for what goes on in the IHC lab.
 10 Why couldn't a similar type of orientation
 11 take place in the lab?
 12 MR. GULLIVER:
 13 A. Well, you're talking about the IHC lab, Ms.
 14 Chaytor, and IHC lab is one piece of a
 15 pathology lab. Before technologists even get
 16 to the IHC lab, they've probably already had
 17 many, many years experience in our pathology
 18 department, so they're only building up what
 19 they've already learned in pathology for many
 20 years. If you want me to compare lab training
 21 to nursing training, it's very difficult. But
 22 if I look across the lab program, for example,
 23 if we have a new technologist, even if they've
 24 got many years experience in, say,
 25 biochemistry, and it happens quite frequently,

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1 if a new technologist goes to our microbiology
 2 laboratory, our microbiology lab looks at that
 3 person as a new technologist, they don't have
 4 technical training in micro. And sometimes it
 5 takes up to a year before that new
 6 technologist is actually doing any back end
 7 work in microbiology, because they're
 8 introduced to a whole new field within lab
 9 medicine. So the IHC piece is a very--you
 10 know, it's one component of our pathology
 11 training. IHC lab is one, there's one in
 12 Newfoundland, only one. There's an operating
 13 room in every hospital in Newfoundland. So
 14 you're probably pooling from a pool of nurses
 15 that has probably got other experience in
 16 somewhere else that are being introduced now
 17 to the operating procedures at the Health
 18 Sciences or St. Clare's. So I really don't
 19 think we're comparing apples to apples.
 20 CHAYTOR, Q.C.:
 21 Q. Okay.
 22 MR. GULLIVER:
 23 A. But to go to read--to look at the resources
 24 that our nursing profession can avail of, that
 25 when they have a new nurse go to the OR, that

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1 they can actually take that nurse and spend
 2 four months to go through a classroom section
 3 and ensure that nurse is up to scratch before
 4 they go into the operating room, I'd love to
 5 have that kind of resources for the lab
 6 medicine program.
 7 CHAYTOR, Q.C.:
 8 Q. Yes. Well, and did you ever look for those
 9 kinds of resources?
 10 MR. GULLIVER:
 11 A. I have to say no. But, I mean, these
 12 resources, this is not just resources, this is
 13 cultural.
 14 CHAYTOR, Q.C.:
 15 Q. So explain that, what does that mean?
 16 MR. GULLIVER:
 17 A. You're getting into an issue that's cultural.
 18 Culturally within the health care system I
 19 believe physicians and nurses are granted a
 20 lot more recognition and a lot more resources
 21 than other parts of the health care system,
 22 not just medical laboratories. This is
 23 something that's been in place, I would say,
 24 for decades. This didn't come in because of
 25 the Health Care Corporation. This didn't come

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1 in because it was practised at the Health
 2 Sciences and carried over to other hospitals.
 3 This has been nursing practice and it's been
 4 hospitals practice for many, many decades.
 5 You know, to ask for this level of being able
 6 to train and orientate our new staff, it would
 7 be excellent for--and I would give an example
 8 just this week. Just this past summer in our
 9 microbiology lab, which is a very highly
 10 specialized part of lab medicine, our
 11 technical staff there, you know, they're all
 12 getting older and retiring, we brought back
 13 one of our retirees who does hold a lot of
 14 technical knowledge and we've now asked her to
 15 stay on until Christmas because we have some
 16 new junior staff over there and her fulltime
 17 role is going to be to get those technologists
 18 who got many years experience in other parts
 19 of the lab, but not micro, but to get those
 20 technologists up to a certain level of
 21 training in microbiology. So it's things that
 22 we've done, we kind of have to do ourselves,
 23 Ms. Chaytor. We don't have a formal organized
 24 program with clinical educators across all of
 25 our labs.

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1 CHAYTOR, Q.C.:
 2 Q. And that's, I guess that's my question in
 3 terms of it's obvious and I know you didn't
 4 have that in past, but on a go-forward basis,
 5 can you see a formal protocol similar to what
 6 Ms. Tracey has articulated exists for the
 7 perioperative program might be of some
 8 assistance to the laboratory medicine program?
 9 MR. GULLIVER:
 10 A. I think in certain parts certainly could be.
 11 Now, if we flip forward to today, you know,
 12 I'm talking about retirements, you've had--
 13 we've had two of our former technologists
 14 here, Ms. Butler and Mr. Simms who have
 15 testified and since they've testified they've
 16 both retired in our IHC lab. And here we are
 17 faced again with staff turnover and in a very
 18 highly specialized part of our pathology lab.
 19 And you know, almost a year ago in
 20 anticipation of this and I would say it's only
 21 because of who Mary and Les are that they gave
 22 us a much, much notice of their intent to
 23 retire and we did recruit and replace Mary and
 24 Les six months before their proposed
 25 retirement date so we could actually have

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1 those staff in the lab with our current three
 2 IHC techs and the new staff are undergoing, I
 3 would submit to you a training program very
 4 similar to what Ms. Wegrynowski recommends in
 5 her report. We have much more pathologists
 6 involvement, we do have a theory lecture
 7 component of the training, we've added, as you
 8 know, a new PhD level to that part of the lab
 9 to look after the quality control and quality
 10 assurance, and that's only happened because we
 11 have resources to do it now. It's not--I have
 12 to say, it's not because the wish was never
 13 there to do it before. We have not had the
 14 dedicated staff or resources or the time or
 15 additional time to free up staff time to do
 16 that level of in-house training.
 17 CHAYTOR, Q.C.:
 18 Q. And it's not something, though, over the
 19 years, either, that you went looking for?
 20 MR. GULLIVER:
 21 A. It's not, no, I didn't look for, like,
 22 clinical educators, I have to say that.
 23 CHAYTOR, Q.C.:
 24 Q. No, but even the measures that you've now
 25 indicated that are put in place, those weren't

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1 things which were included in your budget
 2 submissions over the years?
 3 MR. GULLIVER:
 4 A. No. I think before you can even get to this
 5 level of an organized training, in-house
 6 training programs with different parts of
 7 your--of laboratories as they do for nursing,
 8 I think we have to put the foundation in first
 9 to be able to do that.
 10 CHAYTOR, Q.C.:
 11 Q. Um-hm.
 12 MR. GULLIVER:
 13 A. And if that's--I think that's the piece where
 14 we're to right now is putting the foundation
 15 in place and being able to identify staff
 16 within the program who could provide this
 17 level of training to our new staff.
 18 CHAYTOR, Q.C.:
 19 Q. Your new IHC technologists, how close are they
 20 to retirement?
 21 MR. GULLIVER:
 22 A. They're a lot further away than I am. I would
 23 say maybe 15, 20 years, so they're--and, you
 24 know, we have to follow, we have to follow
 25 human resources guidelines and union

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1 guidelines.
 2 CHAYTOR, Q.C.:
 3 Q. So what criteria was used to choose them?
 4 MR. GULLIVER:
 5 A. Pretty well we asked for, well, obviously a
 6 general registered technologist, that you've
 7 got your basic medical lab science behind you.
 8 And we asked for a certain number of years
 9 experience in the pathology lab so they've got
 10 all the building blocks and the foundation
 11 already settled so they can start learning
 12 this part of pathology. And luckily, we do
 13 have two candidates who, if they stay with us,
 14 will be in our lab for a good many years.
 15 CHAYTOR, Q.C.:
 16 Q. And you say, of course, you have to follow
 17 your human resources and union guidelines.
 18 Have you, over the years, been restricted in
 19 your ability to choose the most appropriate
 20 candidate because of those guidelines?
 21 MR. GULLIVER:
 22 A. Not because of human resources guidelines, but
 23 certainly with union guidelines, yes.
 24 CHAYTOR, Q.C.:
 25 Q. So ultimately then how would the union

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1 guidelines have restricted you?
 2 MR. GULLIVER:
 3 A. Well, I mean, as at every--as I think health
 4 care is probably the most unionized sector
 5 within the workforce. You know, our medical
 6 lab technologists belong to NAPE. NAPE is
 7 their bargaining agent. There is a signed
 8 agreement between management and the union of
 9 how staff are utilized, treated. There's many
 10 components in there besides just salaries.
 11 And under one of the segments there, under job
 12 promotions, the union recognizes seniority as
 13 being sort of their number one factor in
 14 someone receiving a promotion, because most of
 15 these jobs in--whether it's IHC or senior tech
 16 in biochemistry, whether it's fertility
 17 testing or HLA testing, in the specialized
 18 parts of all the labs, are generally more
 19 senior held positions and they're a promotion
 20 for most staff. So certainly there are
 21 guidelines in the union contract that we're
 22 obliged to follow where it's outlined in how
 23 you would select a candidate for a promotion.
 24 CHAYTOR, Q.C.:
 25 Q. The two new hires, were they--was the ultimate

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1 choice then based on seniority?
 2 MR. GULLIVER:
 3 A. No. Luckily, the two candidates that we had
 4 apply for the positions were--they had the
 5 necessary qualifications that we required with
 6 their general RT. They had experience already
 7 in pathology lab for a number of years and
 8 they happened to be the two senior candidates
 9 for the position. So it worked out pretty
 10 good.
 11 CHAYTOR, Q.C.:
 12 Q. And what if they hadn't been the most senior?
 13 MR. GULLIVER:
 14 A. If they had not been the most senior?
 15 CHAYTOR, Q.C.:
 16 Q. Yes.
 17 MR. GULLIVER:
 18 A. It's--and every job posting for a promotion,
 19 some are straightforward and some, you do have
 20 to go back and talk to Human Resources and
 21 talk to the union. If you feel that the
 22 senior candidate really is not qualified for
 23 the job--and see, there's a difference between
 24 who is best qualified and who is qualified.
 25 We may think this number five candidate is the

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1 best qualified. However, the senior candidate
 2 does meet the qualifications of the job
 3 posting. Then you have to go through a
 4 process where you must, by the contract, offer
 5 that position to that senior candidate. If
 6 they accept it, there's now another piece of
 7 the union contract where you would give them a
 8 60-day trial period, and after 60 days, you
 9 assess their ability to be able to master that
 10 job. Not that they can perform the job in 60
 11 days, but do you think they've got the
 12 ability, over a period of time, to be able to
 13 perform in that position. If you feel they
 14 don't, you can do two. You can take them out
 15 of the job and then deal with a union
 16 grievance maybe or you work with the union and
 17 HR and you may extend their training period or
 18 trial period to an additional length of time.
 19 For example, we did that with the four
 20 PAs. Our internal candidates, one of the
 21 senior applicants who had 16 years in
 22 pathology, but had not been in pathology more
 23 recently, you know, we put her into that
 24 position and after two months, you go through
 25 an assessment and you make an assessment, do

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1 you think this person is going to be able to
 2 complete the process. So it's -
 3 CHAYTOR, Q.C.:
 4 Q. Yes, and we've heard one of your candidates
 5 was removed or didn't complete the process, so
 6 that was based on that assessment?
 7 MR. GULLIVER:
 8 A. Exactly, yes.
 9 CHAYTOR, Q.C.:
 10 Q. And I'm going to talk to you a little bit
 11 about the PAs later on, in terms of utilizing
 12 technologists as opposed to people who may
 13 have a different background, because I think
 14 there's some debate on that as well, as to is
 15 it a technologist or a Bachelor of Science
 16 person, but we'll come to that, or other
 17 training.
 18 MR. GULLIVER:
 19 A. Bachelor of Science person will still be a
 20 technologist.
 21 CHAYTOR, Q.C.:
 22 Q. Yes, but whether or not they need that on top
 23 of.
 24 MR. GULLIVER:
 25 A. Right.

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1 CHAYTOR, Q.C.:
 2 Q. Yes.
 3 THE COMMISSIONER:
 4 Q. Excuse me, just on that latter point, Mr.
 5 Gulliver. When one is filling a position, I'm
 6 thinking particularly going into these
 7 specialist areas of a lab, it seems to me that
 8 even there is a question about the very issue
 9 you raised, and that is the retirement of your
 10 staff, because if there is a education
 11 component, are you potentially educating
 12 people who as soon as they're trained are
 13 going to walk out the door because they're
 14 ready to retire, and that would seem to be
 15 using resources which are not going to be of
 16 benefit to you down the road.
 17 MR. GULLIVER:
 18 A. And you know, when I answered Ms. Chaytor
 19 about the two new techs in IHC, you know, "how
 20 many years do they have left?" I said we're
 21 kind of lucky that the two senior applicants
 22 who met the qualifications do have a fair
 23 number of years left, so the amount of
 24 investment that we will make into those two
 25 technologists is for the long term. But

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1 you're right, we do have cases where a
 2 retiree, after 35 years retires, they've been
 3 doing this senior level job for maybe the last
 4 ten years. So no one else has had the
 5 opportunity to get into that position and the
 6 next person in the position got two years left
 7 to retire, and that's what the labs are
 8 facing, and it's all across all of our
 9 laboratories, and it is an issue. For
 10 example, I just said, in microbiology, we
 11 brought back one of our retirees last year,
 12 who does have a wealth of knowledge, to help
 13 with our newer staff.
 14 THE COMMISSIONER:
 15 Q. So is demographics a problem in labs as well?
 16 MR. GULLIVER:
 17 A. Huge. It's--and you talk about nursing, it's
 18 probably worse than nursing.
 19 THE COMMISSIONER:
 20 Q. All right.
 21 CHAYTOR, Q.C.:
 22 Q. I want to take you back now then and go back
 23 to Dr. Khalifa's days, and Dr. Khalifa
 24 bringing in ER/PR and you've touched on that
 25 earlier in your evidence, and I understood

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1 from what you said that basically Dr. Khalifa
 2 worked with the technologists at the time,
 3 Mary and Peggy, and you didn't have, yourself,
 4 much involvement in the process in introducing
 5 ER/PR to the IHC?
 6 MR. GULLIVER:
 7 A. Not, nothing from a technical level or
 8 clinical level, nothing like that.
 9 CHAYTOR, Q.C.:
 10 Q. Okay.
 11 MR. GULLIVER:
 12 A. I certainly was well aware of it, you know,
 13 that it was taking place.
 14 CHAYTOR, Q.C.:
 15 Q. If we could look, please, at P-1889? This is
 16 a letter written to yourself from Dr. Khalifa
 17 and it's copied to Dr. Haegert and Mr. Whelan,
 18 Dr. Haegert being the clinical chief and I
 19 take it, Mr. Whelan would have been your
 20 immediate supervisor?
 21 MR. GULLIVER:
 22 A. Yeah.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and it's two different dates, March 12th
 25 1997 and February 27th 1997. Do you recall,

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1 Mr. Gulliver, did you receive this letter at
 2 that time?
 3 MR. GULLIVER:
 4 A. I know in preparation for the Inquiry, back
 5 months and months ago when we were supplying
 6 documents, I was shown this by my counsel and
 7 asked, you know, the same question, like "what
 8 do you remember of it?" and I had to say that
 9 I don't ever--didn't ever remember seeing it
 10 or receiving it. I can't say that I did not.
 11 I can't say that I did.
 12 CHAYTOR, Q.C.:
 13 Q. Well, I'm just going to take you through a bit
 14 of it, but--and I know you've been through -
 15 MR. GULLIVER:
 16 A. But I've certainly read it -
 17 CHAYTOR, Q.C.:
 18 Q. - it before, yes.
 19 MR. GULLIVER:
 20 A. - I've certainly read it since.
 21 CHAYTOR, Q.C.:
 22 Q. Yes, you've been through it since.
 23 MR. GULLIVER:
 24 A. Yeah.
 25 CHAYTOR, Q.C.:

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1 Q. And it's somewhat critical of you, so I'm
 2 wondering had you received this, do you think
 3 that's something you would remember, something
 4 that would stick in your mind?
 5 MR. GULLIVER:
 6 A. I know, and that's--at the time when I was
 7 shown this, you know, I think it was back in
 8 December some time, you know, and my point was
 9 what you just said, that you know, if I had--I
 10 don't remember it, and you know, I generally
 11 remember most stuff, and knowing that the
 12 second paragraph, Dr. Khalifa is kind of mad
 13 with me there that one of the kits ran out and
 14 it hasn't been, you know, replenished in a
 15 timely manner.
 16 CHAYTOR, Q.C.:
 17 Q. Yes.
 18 MR. GULLIVER:
 19 A. And he couldn't locate me, that would have
 20 jogged my memory to say "oh yeah, I remember
 21 exactly that." But I really don't.
 22 CHAYTOR, Q.C.:
 23 Q. So what about then, the subject matter, and
 24 again, I'll take you through it in a little
 25 bit of detail, but what about then the subject

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1 matter of that? Do you recall, regardless of
 2 whether you received the letter or not, do you
 3 recall Dr. Khalifa coming to you and raising
 4 these concerns that it's difficult for him to
 5 get in touch with you, that he's trying to
 6 validate this test and his kit has run out.
 7 Do you recall that being the subject of
 8 discussion with you?
 9 MR. GULLIVER:
 10 A. I don't know, at this particular time, Ms.
 11 Chaytor, but I--and I do--and I kind of look
 12 back and at this particular time, in 1997 is
 13 when--and I had received permission from our
 14 CEO at the time, I had put my name forward to
 15 be--to run for president of our national
 16 professional association, CSMLS. Well, at the
 17 time, it was CSLT, Canadian Society of
 18 Laboratory Technologists. And you know, I was
 19 voted in by the members across the country and
 20 this particular year was the year I was
 21 serving as president, and pretty well almost
 22 once a month, usually on a like Thursday,
 23 Friday, Saturday, Sunday, I would be out of
 24 the province attending board meetings for our
 25 professional association or doing matters like

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1 that. I think this particular week -
 2 CHAYTOR, Q.C.:
 3 Q. So that's a volunteer position that you took
 4 on?
 5 MR. GULLIVER:
 6 A. Yes, yeah, but I had to seek permission from
 7 our CEO to put my name forward. If I was
 8 elected president, it involved some time away
 9 from work to deal with those issues.
 10 CHAYTOR, Q.C.:
 11 Q. And that would have been right after Health
 12 Care Corporation came together -
 13 MR. GULLIVER:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. - in 1996, that you took that on?
 17 MR. GULLIVER:
 18 A. Yeah.
 19 CHAYTOR, Q.C.:
 20 Q. And you took on the responsibilities for the
 21 Janeway site?
 22 MR. GULLIVER:
 23 A. Yeah.
 24 CHAYTOR, Q.C.:
 25 Q. Okay.

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1 MR. GULLIVER:
 2 A. But I think this particular week though, I was
 3 at the Banff School of Management for
 4 leadership training.
 5 CHAYTOR, Q.C.:
 6 Q. Yes, okay, so I'll just take you through a bit
 7 of this. He writes "Dear Mr. Gulliver, the
 8 estrogen progesterone, ER/PR kit that we have
 9 tried and which offered us very good and
 10 reliable results has been totally consumed by
 11 late last week. You knew this and you were
 12 trying to use a new detection system in
 13 combination with an old primary antibody that
 14 the laboratory had for some time. This
 15 combination did not work. I called you on
 16 Monday morning at the Janeway Hospital site
 17 and told you that we were having an emergency
 18 situation. Any trial of a new technique need
 19 to be done in parallel with a well established
 20 one before a switch could be safely made. I
 21 thought I conveyed to you this message clearly
 22 and asked you to replace the ER/PR kit as soon
 23 as possible."
 24 The idea here--I just want to just stop
 25 there for a second. The idea that you tried

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1 to use a new detection system in combination
 2 with an old primary antibody, did you
 3 understand the significance in doing that at
 4 the time?
 5 MR. GULLIVER:
 6 A. Well, I don't remember doing it at the time,
 7 let alone the significance of doing it at the
 8 time. The only thing, when I read this here
 9 several times since it's been shown to me, the
 10 only thing that I could even surmise was that,
 11 as I mentioned to you earlier, Dr. Chittal,
 12 who was one of our long standing pathologists,
 13 he was very interested in IHC and he would
 14 bring back primary antibodies to the staff to
 15 try out in the lab and try and use, and I
 16 don't know if this is an instance where maybe
 17 Dr. Chittal had brought something back to the
 18 lab. He used to go to France and he had
 19 contacts over there with new antibodies and
 20 new clones. I really can't answer your
 21 question fully to what you're looking for.
 22 CHAYTOR, Q.C.:
 23 Q. But would Dr. Chittal have been doing anything
 24 with the--this wouldn't have been the ER/PR
 25 antibodies that Dr. -

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1 MR. GULLIVER:
 2 A. But he may have brought back some kind of
 3 primary antibody that was being researched or
 4 tried out somewhere else.
 5 CHAYTOR, Q.C.:
 6 Q. ER/PR?
 7 MR. GULLIVER:
 8 A. He could have, yeah.
 9 CHAYTOR, Q.C.:
 10 Q. At the same time that Dr. Khalifa is trying to
 11 validate and introduce this?
 12 MR. GULLIVER:
 13 A. I'm not sure, but I'm saying that's my only--
 14 my best guess, if there's something else here
 15 that Dr. Khalifa is saying.
 16 CHAYTOR, Q.C.:
 17 Q. So do you have any recollection that that in
 18 fact was the case -
 19 MR. GULLIVER:
 20 A. No, I don't.
 21 CHAYTOR, Q.C.:
 22 Q. - that Dr. Chittal was involved in this?
 23 MR. GULLIVER:
 24 A. Oh, Chittal was not involved with the ER/PR,
 25 no, no, and I don't know if you asked Dr.

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1 Khalifa when he was testifying about this
 2 letter or not. I don't know what he said.
 3 CHAYTOR, Q.C.:
 4 Q. And the idea that he's trying to optimize the
 5 test and he says to you "any trial of a new
 6 technique need to be done in parallel with a
 7 well established one before the switch can be
 8 safely made," at the time in 1997 that he's
 9 stating this, would you know that? Would that
 10 be something that you would be well familiar
 11 with?
 12 MR. GULLIVER:
 13 A. Well, the new technique he's talking about
 14 switching is from the biochemical assay
 15 technique -
 16 CHAYTOR, Q.C.:
 17 Q. Yes.
 18 MR. GULLIVER:
 19 A. - to the IHC lab. It's not switching--trying
 20 a new procedure in pathology, an old pathology
 21 procedure versus a new pathology procedure.
 22 It's a whole new methodology he's talking
 23 about.
 24 CHAYTOR, Q.C.:
 25 Q. Yes, and the idea of doing that and the

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1 correlation -
 2 MR. GULLIVER:
 3 A. Side by side, yes.
 4 CHAYTOR, Q.C.:
 5 Q. - that he's trying to do -
 6 MR. GULLIVER:
 7 A. I was aware of that, yeah.
 8 CHAYTOR, Q.C.:
 9 Q. Okay, and he goes on to say that "it's an
 10 emergency situation because at that time, we
 11 had two cases referred from Corner Brook and
 12 one in-house case from 1996 which were waiting
 13 for the tests to be reliably performed. As of
 14 now, the kit has not arrived and I was told
 15 that you are out of town. Ordering such kit
 16 in a timely fashion was vital and a follow up
 17 on the order was even more crucial. Mr.
 18 Gulliver, I do not think you fully appreciate
 19 the delicacy of this test, its clinical
 20 consequences and the overall emotional charge
 21 in the public regarding this sensitive
 22 procedure."
 23 So Mr. Gulliver, if you think back into
 24 these early days of ER/PR, did you fully
 25 appreciate the delicacy of the test, its

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1 clinical consequences?
 2 MR. GULLIVER:
 3 A. I have to say he's right.
 4 CHAYTOR, Q.C.:
 5 Q. He's right, you wouldn't have understood that
 6 at the time?
 7 MR. GULLIVER:
 8 A. No.
 9 CHAYTOR, Q.C.:
 10 Q. Okay.
 11 MR. GULLIVER:
 12 A. I mean, it was a new test coming into our
 13 pathology lab. I mean, certainly Dr. Khalifa
 14 and I would assumed other pathologists and Dr.
 15 Prabhakaran in chemistry, I mean, they would
 16 appreciate more than I would, you know, the
 17 clinical implications of this particular test.
 18 It was brand new to the lab. Certainly if you
 19 ask me today, I'll give you a different
 20 answer.
 21 CHAYTOR, Q.C.:
 22 Q. Yes.
 23 MR. GULLIVER:
 24 A. But back -
 25 CHAYTOR, Q.C.:

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1 Q. So in 1997, you wouldn't have appreciated it.
 2 MR. GULLIVER:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. So this would have been a fair statement he's
 6 making?
 7 MR. GULLIVER:
 8 A. Yeah.
 9 CHAYTOR, Q.C.:
 10 Q. Would your technologists have fully
 11 appreciated the delicacy and sensitivity of
 12 the test and its clinical consequences?
 13 MR. GULLIVER:
 14 A. Did you ask them?
 15 CHAYTOR, Q.C.:
 16 Q. What's your knowledge of what they knew or
 17 understood?
 18 MR. GULLIVER:
 19 A. Well, speaking for them, I would think that
 20 they would have understood that the actual
 21 procedure itself in introducing the new
 22 antigen retrieval process that we had not done
 23 before with the other IHC tests, I think
 24 they'd understand that yes, that is a delicacy
 25 there in performing the test. I don't think

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1 that they would understand the clinical
 2 implications of how the results of this test
 3 is applied by the oncologists or applied to
 4 the patient.
 5 CHAYTOR, Q.C.:
 6 Q. Mr. Gulliver, what point--obviously your--as
 7 you say, you know now and you'd give me a
 8 different answer in 2008, but at what point
 9 was this driven home to you and you did fully
 10 appreciate the sensitivity and the delicacy of
 11 the test?
 12 MR. GULLIVER:
 13 A. That's a tough one to answer. A few years
 14 after we started doing ER/PR testing, another
 15 new prognostic marker was coming out,
 16 HER2/neu, which you've heard lots about here
 17 at the Inquiry.
 18 CHAYTOR, Q.C.:
 19 Q. Yes.
 20 MR. GULLIVER:
 21 A. And the HER2/neu was a new test being
 22 developed to be able to offer breast cancer
 23 patients with Herceptin therapy. It was
 24 around that time when I started to understand
 25 about Herceptin therapy was a hormonal therapy

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1 and the reason why I got involved with it,
 2 because I was told that test is going to cost
 3 a hundred dollars a patient, very expensive to
 4 do it. However, it was like \$35,000 for one
 5 patient to go on this Herceptin therapy. But
 6 it was around that time where I got more
 7 understanding about the ER/PR and the hormonal
 8 therapy piece of the treatment side of this
 9 test.
 10 CHAYTOR, Q.C.:
 11 Q. Okay.
 12 MR. GULLIVER:
 13 A. And that may have been 2000 or 2001, you know.
 14 It's not 2005. I mean, it certainly--it was
 15 after this here, but -
 16 CHAYTOR, Q.C.:
 17 Q. So it's three or four years into doing ER/PR?
 18 MR. GULLIVER:
 19 A. That's my best guess.
 20 CHAYTOR, Q.C.:
 21 Q. Yes.
 22 MR. GULLIVER:
 23 A. Yeah, and I was certainly still pathology
 24 manager, so I became program director in -
 25 CHAYTOR, Q.C.:

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1 Q. In 2001.
 2 MR. GULLIVER:
 3 A. - late 2001, so you know, it's got to be
 4 somewhere in that time frame.
 5 CHAYTOR, Q.C.:
 6 Q. So some period up before you became director
 7 of the program?
 8 MR. GULLIVER:
 9 A. Yeah, yeah.
 10 CHAYTOR, Q.C.:
 11 Q. Okay. He goes on to say "I am also uncertain
 12 whether our service is being run as smoothly
 13 as it should. The medical legal implications
 14 of delaying this test are huge, and I want to
 15 clearly document my concerns at this time.
 16 You willingly have put me in a situation
 17 where I have to explain to other physicians
 18 why our results are being delayed. I do not
 19 want to be responsible for this. I am also
 20 having a very difficult time communicating
 21 with you basically because you are either out
 22 of town, on another site, or extremely busy
 23 within this site. I would have expected you
 24 to approach this issue with more precision
 25 since Monday morning, as you had told me, and

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1 even more not to have allowed the first kit to
 2 be consumed without obtaining a replacement in
 3 a timely manner."
 4 So his assertion that he has "concerns
 5 about our service being run as smoothly as it
 6 should," was that discussed with you then, Mr.
 7 Gulliver, at this time?
 8 MR. GULLIVER:
 9 A. Dr. Khalifa, and I'm wondering through his
 10 testimony, have you seen any other
 11 documentation where Dr. Khalifa has an issue
 12 with the service or an issue with me as the
 13 manager at the time? Again, when I read this
 14 here, I was surprised. I still don't know if
 15 I ever--I don't remember reading it ten years
 16 ago. I would just have to say that my
 17 relationship and working relationship with Dr.
 18 Khalifa, for all the years he was there, was
 19 fantastic, and you know, I would have assumed
 20 if I got this, I would have explained to him
 21 why I was away. I do know, at some point,
 22 with DAKO, you know, the way things process
 23 works, you know, the manager is responsible
 24 for ordering supplies and you need to have a
 25 manager's signature to get things authorized

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1 within the system. I know I did put a process
 2 in place with DAKO for Mary and Peggy. We did
 3 sort of a standard, a standing PO, purchase
 4 order number where Mary and Peggy could just
 5 call DAKO immediately and say "PO number
 6 123456, we need this, this, this and this"
 7 without having to go through paper
 8 requisitions and going to purchasing and get
 9 purchasing to call. So we kind of sped the
 10 process up. But that probably happened in
 11 '98, I think.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. In terms of though the idea that the
 14 service not being run as smoothly as it should
 15 and your--it appears he has issues with your
 16 availability and being able to be available at
 17 a timely fashion. He speaks about you being
 18 out of town and being busy at another site
 19 from time to time, and I take it that would
 20 mean the Janeway site at this point in time?
 21 MR. GULLIVER:
 22 A. Yeah.
 23 CHAYTOR, Q.C.:
 24 Q. You don't recall that issue being discussed
 25 with you by Dr. Khalifa?

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1 MR. GULLIVER:
 2 A. Again I can't say that it was not, but I can't
 3 say it was at this particular time either.
 4 CHAYTOR, Q.C.:
 5 Q. But is it a fair - well, is it a fair
 6 criticism, do you think, for that point in
 7 time in terms of the workload that you were
 8 carrying and your additional duties that you
 9 took on with your volunteer efforts?
 10 MR. GULLIVER:
 11 A. Well, obviously, he felt strong enough to put
 12 it in writing. I guess maybe for that
 13 particular week it might have been - it may
 14 have been, but again I will go to say, I mean,
 15 I did - I spent my time at the Health Sciences
 16 and Janeway, going back and forth between both
 17 sites, I made myself available to staff any
 18 time of day. I pretty well worked almost
 19 every single weekend, you know, that doesn't
 20 bother me, just working extra time.
 21 CHAYTOR, Q.C.:
 22 Q. So you, yourself, weren't finding that there
 23 was any difficulties with you coping with your
 24 workload and you didn't perceive that your
 25 service wasn't being run smoothly or as

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1 smoothly as it should be?
 2 MR. GULLIVER:
 3 A. I didn't feel that way because I felt very
 4 comfortable in the fact that in the services
 5 that I was managing, I had senior
 6 technologists who, you know, looked after day
 7 to day operations. Whether it was Barry at
 8 the Janeway, whether it was Ernie in
 9 immunology, whether it was Greg in the allergy
 10 immunology testing, or Olga in cytogenetics,
 11 whether it was Mary and Peggy in the pathology
 12 lab at the Health Sciences, and, I mean,
 13 that's a part of their role and function is to
 14 be able to play that lead role if the manager
 15 isn't around. I mean, things can't stop
 16 because the manager isn't on site today. You
 17 know, that's the way all the labs operate
 18 CHAYTOR, Q.C.:
 19 Q. So you felt comfortable in the delegation of
 20 some of the duties to the lead techs?
 21 MR. GULLIVER:
 22 A. Certainly did, yes, yeah.
 23 CHAYTOR, Q.C.:
 24 Q. So you said if you had received this, you
 25 likely would have spoken to Dr. Khalifa about

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1 it. He felt, as he says here, important to
 2 document his concerns. Would you have felt it
 3 important to document your response?
 4 MR. GULLIVER:
 5 A. No. The way I operate, if Dr. Khalifa - if I
 6 had seen this here and Khalifa sent it to me,
 7 I would have went over to his office and sat
 8 down, chatted and spoke about it. We're
 9 together on the same site.
 10 CHAYTOR, Q.C.:
 11 Q. Could we have, please, P -
 12 MR. GULLIVER:
 13 A. Can I ask you a question?
 14 CHAYTOR, Q.C.:
 15 Q. Sure.
 16 MR. GULLIVER:
 17 A. Have you ever received documentation that I
 18 actually received this, this letter, or memo?
 19 CHAYTOR, Q.C.:
 20 Q. Well, you certainly didn't provide us with
 21 your copy of the letter.
 22 MR. GULLIVER:
 23 A. I know.
 24 CHAYTOR, Q.C.:
 25 Q. That's the best I can tell you about that, not

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1 to my knowledge, that we've seen a copy that
 2 you received. So what you're saying then to
 3 the Commissioner is that you don't recall
 4 having received it, nor do you recall any
 5 discussion with Dr. Khalifa around the subject
 6 matter?
 7 MR. GULLIVER:
 8 A. Not at that particular time, no.
 9 CHAYTOR, Q.C.:
 10 Q. Well, at any particular - at any time?
 11 MR. GULLIVER:
 12 A. My point is, Commissioner, I can't verify that
 13 I received it or didn't receive it. When I
 14 read this last year when Dan showed it to me,
 15 my first statement was, you know, I'm reading
 16 this for the first time. That's how I felt.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. If we could have, please, P-2531. Mr.
 19 Gulliver, on that point, though, in terms of
 20 you not having a copy of the letter to produce
 21 to the Commission, can we read anything into
 22 that in terms of what's your habit, anyhow, in
 23 terms of keeping things or discarding things?
 24 MR. GULLIVER:
 25 A. Say that again?

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1 CHAYTOR, Q.C.:

2 Q. We don't have, to our knowledge, your copy of

3 this letter.

4 MR. GULLIVER:

5 A. Yeah.

6 CHAYTOR, Q.C.:

7 Q. But can we read anything into that, are you

8 someone who tends to keep things or do you

9 tend to be more of the type of person after a

10 period of time to -

11 MR. GULLIVER:

12 A. I clean up. I clean house.

13 CHAYTOR, Q.C.:

14 Q. Yes. So if you did receive it, it could also

15 be just as likely that it got thrown out along

16 life's way?

17 MR. GULLIVER:

18 A. It's a possibility, yes.

19 CHAYTOR, Q.C.:

20 Q. This is a minute of anatomic pathology site

21 chiefs and divisional managers, May 13th,

22 1997, and it takes place at St. Clare's

23 Hospital and you'll see that Dr. Khalifa,

24 yourself, Dr. Cook, Drs. Parai, Pushpanathan,

25 yourself, and Mr. John Murphy are in

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1 attendance, and Dr. Haegert is not there. If

2 we look at page three of the exhibit, scroll

3 down here, we'll see under new business, ER/PR

4 immunoperoxidase receptors, "Dr. Khalifa

5 reported to the committee that there is a good

6 correlation between the biochemical assay and

7 immunoperoxidase staining for breast

8 receptors. It appears that the time may be

9 right to implement the immunoperoxidase breast

10 receptors corporate-wide. Dr. Cook stated

11 that there is a concern amongst pathologists

12 at St. Clare's that they should be the ones

13 reporting the breast receptors. Discussion

14 then arose that if individual pathologists are

15 reporting these receptors, then there is a

16 need for standardized criteria to determine

17 what is regarded as receptor positive and

18 negative. There was also discussion as to how

19 the Mayo Clinic reports its receptors. It was

20 decided that this issue should be brought to a

21 discipline meeting to get a consensus amongst

22 pathologists. Hopefully, such a meeting will

23 be held in June. Until then, it was agreed to

24 maintain the status quo. Dr. Cook also

25 recognized the amount of hard work Dr. Khalifa

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1 had given the project". So Dr. Khalifa is

2 reporting basically that he has had good

3 correlation between the two methods, and it's

4 now time to go with the service corporate-wide

5 and I take it that meant across the -

6 MR. GULLIVER:

7 A. City.

8 CHAYTOR, Q.C.:

9 Q. Across the city. What do you recall about

10 this discussion around the pathologists at St.

11 Clare's being concerned about reporting their

12 own cases?

13 MR. GULLIVER:

14 A. I can't - I really can't give you a lot more

15 information than what's already there, you

16 know, in the minutes. You know, I just

17 remember that when it was started, Dr.

18 Khalifa, to my understanding, had had

19 experience in breast pathology, that he was

20 comfortable in doing the ER/PR

21 interpretations, and I think it was his

22 viewpoint that he would continue on doing the

23 interpretations for all the ER/PRs, and do

24 them as consults from across the province. I

25 don't remember any real discussion at this

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1 particular meeting, except for what's there in

2 the meetings - what's there in the minutes,

3 sorry. I would - I think Dr. Cook's concern

4 would be, you know, if Dr. Khalifa left -

5 again even going back to, like, I mentioned

6 earlier, our technologists level. You got

7 senior technologists who got expertise. You

8 know, when they leave, that knowledge goes

9 with them. I don't know if it was Dr. Cook's

10 concern here, you know, if we put all of our

11 eggs in the one basket, and that person

12 leaves, you know, we now have no pathologist

13 who got this skill to interpret ER/PR.

14 CHAYTOR, Q.C.:

15 Q. Mr. Gulliver, from the technologists point of

16 view then, this service is about to be

17 transferred from the biochemical to -

18 MR. GULLIVER:

19 A. I think it was ongoing for a good while, Ms.

20 Chaytor.

21 CHAYTOR, Q.C.:

22 Q. At this point in time, yes, but at the time

23 that the transfer is made that Dr. Khalifa

24 feels that it's now good correlation. So at

25 the time that it's taken over by pathology,

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1 was that an increase then in the workload for
 2 the technologists?
 3 MR. GULLIVER:
 4 A. For the techs in IHC?
 5 CHAYTOR, Q.C.:
 6 Q. Uh-hm.
 7 MR. GULLIVER:
 8 A. It was, but at this time, you know, the
 9 overall volume in the IHC part of pathology,
 10 while we did have Mary and Peggy both trained
 11 and you do - you kind of have backup in case
 12 one person is off for a month, you got to keep
 13 the service going. They - it wasn't enough
 14 work to have two full time techs on the bench
 15 every day doing the procedures, so they shared
 16 the duties, they shared the workload, but
 17 certainly, I mean, adding the ER/PR workload
 18 to the lab was additional workload, but then
 19 what was done - and to do the ER/PR procedure
 20 with the front end antigen retrieval piece, it
 21 was almost a full day from start to finish for
 22 the lab -
 23 CHAYTOR, Q.C.:
 24 Q. To do the ER/PR's?
 25 MR. GULLIVER:

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1 A. Yes, for a lab technologist to do a batch, it
 2 was almost a full day's work. So we batched
 3 them. So as requests came in, you get on
 4 Monday, a couple on Tuesday, maybe got one
 5 Thursday, so generally the practice was on a
 6 Friday was the ER/PR day. So Mary or Peggy,
 7 whoever was assigned, on Fridays they would do
 8 the ER/PR procedure.
 9 CHAYTOR, Q.C.:
 10 Q. So it was a full day procedure, you say?
 11 MR. GULLIVER:
 12 A. Pretty well a full day, yeah.
 13 CHAYTOR, Q.C.:
 14 Q. So in terms of that adding to their workload,
 15 and that would be, I take it, they're still
 16 rotating, alternating, so one week it's a day
 17 out of Mary's five day week, and the next week
 18 it's a day out of Peggy's five day week?
 19 MR. GULLIVER:
 20 A. Well - Mary could be on IHC all this week -
 21 all week long.
 22 CHAYTOR, Q.C.:
 23 Q. Yes.
 24 MR. GULLIVER:
 25 A. But on Friday, they did ER/PRs.

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1 CHAYTOR, Q.C.:
 2 Q. So one of her days then -
 3 MR. GULLIVER:
 4 A. Right.
 5 CHAYTOR, Q.C.:
 6 Q. Is devoted to just ER/PR once it comes over
 7 from biochemical?
 8 MR. GULLIVER:
 9 A. Yeah.
 10 CHAYTOR, Q.C.:
 11 Q. Biochemistry portion of the lab. So what in
 12 terms of then additional resources were
 13 offered to the pathology lab to compensate for
 14 that increase in workload?
 15 MR. GULLIVER:
 16 A. There was no additional staffing resources
 17 added to the lab. By this time, I think too -
 18 this is maybe '97, '98, here, Ms. Chaytor?
 19 CHAYTOR, Q.C.:
 20 Q. This particular - what is happening here in
 21 these minutes is 1997.
 22 MR. GULLIVER:
 23 A. '97.
 24 CHAYTOR, Q.C.:
 25 Q. March - May of 1997.

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1 MR. GULLIVER:
 2 A. I'm trying to think too - around that time,
 3 like, you know, pathology is a very tedious
 4 manual work for laboratories. Other labs,
 5 like chemistry, you've seen the high analyzers
 6 where you put a blood specimen in and it spits
 7 out 20 results in ten minutes. Pathology is
 8 completely different. By this time, though,
 9 we've introduced some new equipment to the lab
 10 where we have automatic stainers for H & E
 11 staining, we have automated cover slippers for
 12 doing the slides. So if you picture this
 13 here, lab technologists, part of their day in
 14 pathology, if you did 400 H & E slides, you
 15 had to do them manually on a bench and bring
 16 them along every step of the procedure. Now
 17 we can put them on an instrument and the
 18 instrument carried the batches through all the
 19 stains and solutions. That saved the
 20 technologists time, and then when the slides
 21 are all finished, you had to take each
 22 individual slide and put a glass cover slip on
 23 400 slides every day, and we bought a machine
 24 that could do the cover slip, so that freed up
 25 a lot of our technologists time that were

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1 really doing non-technologist work. I think
 2 through those other innovations we're able to
 3 be able to take on some extra volume and
 4 workload.
 5 CHAYTOR, Q.C.:
 6 Q. So once the ER/PR came on, the person who,
 7 whether it's Mary or Peggy for that week
 8 assigned to the IHC, and I would take it they
 9 must have had a five day - enough work to fill
 10 five days before. You're saying that to
 11 compensate for now we've got another full day
 12 of work to do with these ER/PRs because you
 13 now have to go through your antigen retrieval,
 14 and all that -
 15 MR. GULLIVER:
 16 A. Well -
 17 CHAYTOR, Q.C.:
 18 Q. You're saying there was new technology offered
 19 to them to make their jobs easier?
 20 MR. GULLIVER:
 21 A. No, no, no, in the general pathology
 22 laboratory, when Mary and Peggy were doing -
 23 primarily they were doing - they weren't doing
 24 primarily IHC testing all day long both of
 25 them. They were our two technologists who

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1 were primarily designated as the two techs for
 2 IHC testing when the IHC tests needed to be
 3 done. So if you don't have enough work to
 4 fill your day - I mean, Mary and Peggy were
 5 very skilled technologists in doing routine
 6 cutting, or routine embedding, or routine
 7 staining. So there were days when Mary and
 8 Peggy still cut blocks every single day for
 9 their routine pathology lab, but as more work
 10 became in IHC, we took away those duties from
 11 Mary and Peggy, but most of those duties were
 12 replaced by technology.
 13 CHAYTOR, Q.C.:
 14 Q. So when they're doing - even though they're
 15 assigned that week to IHC, they may not, in
 16 fact, be in the IHC portion of what was then a
 17 portion of the lab?
 18 MR. GULLIVER:
 19 A. It's the back bench of the lab, yeah.
 20 CHAYTOR, Q.C.:
 21 Q. So they may not, in fact, be there assigned
 22 strictly to just doing those tests?
 23 MR. GULLIVER:
 24 A. If there were no tests to perform, there's
 25 nothing to do down there, so -

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1 CHAYTOR, Q.C.:
 2 Q. And was that the situation that there were -
 3 MR. GULLIVER:
 4 A. You know, there's lots of days they might have
 5 only had two slides to do, or five slides to
 6 do. I mean, that's not going to take them a
 7 full day's work, so they're skilled as general
 8 technologists in pathology, so if you come in
 9 today and there's no orders for IHC, well, you
 10 go and do - you cut blocks or you stain
 11 slides, or you do other skills that you've
 12 gained in pathology.
 13 CHAYTOR, Q.C.:
 14 Q. So as their manager at the time, what
 15 inquiries did you make of them - once ER/PR
 16 was introduced, what inquiries did you make of
 17 them as to what their workload was and whether
 18 or not they needed to have any additional
 19 resources assigned to them to be able to cope
 20 with the additional work?
 21 MR. GULLIVER:
 22 A. Well, neither one of them said it was an issue
 23 or a problem.
 24 THE COMMISSIONER:
 25 Q. Ms. Chaytor, we're going to break in a minute.

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1 CHAYTOR, Q.C.:
 2 Q. Mr. Gulliver, the idea that in running the
 3 tests then at this point in time when it
 4 started up, we understand it wasn't - the DAKO
 5 machine wasn't in place first when the tests -
 6 MR. GULLIVER:
 7 A. That comes a year later.
 8 CHAYTOR, Q.C.:
 9 Q. Yes, a year later. So for this period of time
 10 in doing the tests, in doing the antigen
 11 retrieval, that would be Mary and Peggy
 12 performing those tests and just Mary and
 13 Peggy?
 14 MR. GULLIVER:
 15 A. Yeah.
 16 CHAYTOR, Q.C.:
 17 Q. And at that point in time, were they also
 18 pooling the tests and doing it on Friday?
 19 MR. GULLIVER:
 20 A. To my knowledge, yeah, my recollection when we
 21 were doing ER/PRs, and for a long time, I
 22 think Friday was batch day for ER/PRs. I
 23 think we reached some point too where
 24 sometimes they might have done two batches in
 25 one week, depending on the number of requests

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1 that were coming in, how frequently they were
 2 coming in.
 3 CHAYTOR, Q.C.:
 4 Q. Okay, and we spoke in the last letter that I
 5 showed you from Khalifa about when you became
 6 aware of the different sensitivities of the
 7 ER/PR antibodies and the importance of the
 8 test. The significance of percentages in
 9 positivity for ER and PR, were you aware of
 10 that at the time?
 11 MR. GULLIVER:
 12 A. No.
 13 CHAYTOR, Q.C.:
 14 Q. When did you first become aware that there may
 15 be any significance to percentage of
 16 positivity?
 17 MR. GULLIVER:
 18 A. In the summer of 2005.
 19 CHAYTOR, Q.C.:
 20 Q. So that's after the issue -
 21 MR. GULLIVER:
 22 A. Once we started dealing with, you know, the
 23 index case and started down this route, that's
 24 pretty well where I think for a lot of people
 25 from the lab side, that there was a

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1 significance in the percent of positivity. I
 2 mean, I work in a lab environment, something
 3 is positive or something is negative. You
 4 know, hearing someone say, well, it was only
 5 30 percent positive, that's foreign to me. It
 6 was until '05 before I really understood the
 7 significance of the application of the test
 8 and the positivity rates.
 9 CHAYTOR, Q.C.:
 10 Q. And do you think that the technologists would
 11 have had that understanding?
 12 MR. GULLIVER:
 13 A. I don't think so, no.
 14 CHAYTOR, Q.C.:
 15 Q. Thank you, Commissioner, this is a good place.
 16 THE COMMISSIONER:
 17 Q. All right, we'll meet at ten after two. Thank
 18 you.
 19 (BREAK)
 20 THE COMMISSIONER:
 21 Q. Ms. Chaytor.
 22 CHAYTOR, Q.C.:
 23 Q. Good afternoon, Commissioner. Good afternoon,
 24 Mr. Gulliver.
 25 MR. GULLIVER:

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1 A. Good afternoon, Ms. Chaytor.
 2 CHAYTOR, Q.C.:
 3 Q. Registrar, if we could have, please, P-2935.
 4 Mr. Gulliver, this is a letter that you wrote
 5 to Ms. Bertha Paulse at the Newfoundland
 6 Cancer Treatment and Research Foundation on
 7 November 17th, 1998, and it's a two page
 8 letter, and you start off by saying, "Dear Ms.
 9 Paulse, I am writing this letter in regard to
 10 requests from your centre for pathology
 11 consultations. I have received two types of
 12 consults, and I will address each type
 13 individually", and the first one is concerning
 14 routine pathology consultations, and you point
 15 out to her that your staff spend a great deal
 16 of time trying to determine where to request
 17 the pathology slides and blocks in order that
 18 our pathologists can review them for your
 19 physicians. In future, would you please
 20 inform your staff that they must include where
 21 the patient had their surgery and pathology
 22 work performed. If the information is not
 23 provided, then I have instructed my staff to
 24 simply return the consultation request form to
 25 the centre as not providing the proper

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1 information. Then the second issues concerns
 2 consultation requests for estrogen and
 3 progesterone receptors, HER2/neu, and perhaps
 4 you can just tell us what do you recall about
 5 this, why you wrote this letter to Ms. Paulse?
 6 MR. GULLIVER:
 7 A. It was really talking about the process, Ms.
 8 Chaytor. Where the pathology lab at the
 9 Health Sciences was the reference centre for
 10 the province, and as many other parts of the
 11 lab, routinely other pathology labs across the
 12 province, if patients were seen - referred in
 13 to the Cancer Centre, the physicians in the
 14 Cancer Centre would then reflex a request to
 15 get either patient information or lab
 16 information or have additional testing done on
 17 those patients, and what the process that used
 18 to happen would be the patient would go to the
 19 Cancer Clinic, the Cancer Clinic would go back
 20 to the original site - just say, for example,
 21 it was Western Memorial, it could be anywhere,
 22 they would request Western Memorial, we need
 23 to get blocks on patient "A". They would send
 24 the blocks in to our pathology lab, sometimes
 25 the right information didn't come in. We

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1 would do the ER/PR, and then - so the whole
 2 process was time consuming, and this was
 3 really something recommending that if we could
 4 speed the process up, the delay in getting the
 5 testing done, so if we had more information up
 6 front, we'd be able to do the ER/PRs in a much
 7 more timely fashion.

8 CHAYTOR, Q.C.:
 9 Q. Okay. So you write, "As you are probably
 10 aware, since the spring of this year", so that
 11 would be the spring of 1998?

12 MR. GULLIVER:
 13 A. That's when they were fully - Dr. Khalifa kind
 14 of fully put them in place for, I think, the
 15 whole province.

16 CHAYTOR, Q.C.:
 17 Q. Okay, "ER and PRs are now performed by
 18 immunohistochemical assay in pathology, and
 19 not by biochemical assay in chemistry". So
 20 that would be for the entire province is what
 21 you're referring to there, it's starting up in
 22 the spring of 1998, because it was well
 23 underway in 1997, I take it, ER and PR, in and
 24 of itself, is that correct?

25 MR. GULLIVER:

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1 A. Yeah.

2 CHAYTOR, Q.C.:
 3 Q. By the IHC method, yes, okay, and then you go
 4 on to say, "The decision has greatly improved
 5 this portion of the laboratory service to the
 6 province, however, it has greatly increased
 7 our workload in pathology", and, Mr. Gulliver,
 8 how so, how did it increase - greatly increase
 9 your workload in pathology because this
 10 morning I thought I had understood that it
 11 hadn't had that kind of an impact?

12 MR. GULLIVER:
 13 A. Well, I think it's a combination here. When I
 14 refer to pathology, it's not just necessarily
 15 the pathology technical side. It's also
 16 increased the workload for our pathologists,
 17 and, I mean, the whole point of this letter
 18 was to kind of streamline the process, while
 19 we've taken on this new procedure, new duties,
 20 both technically and clinically, and the
 21 pathologists workload, you wouldn't believe
 22 how much time the technologists spent and
 23 wasted trying to figure out, I have a block
 24 here, we don't know where the block is from,
 25 is it from Western, what's the original

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1 numbers, where does the slides go back to, and
 2 sometimes that could take someone an hour or
 3 two in the run of a day just figuring out,
 4 like, you know, the processes of it. So when
 5 I say workload there, I'm assuming I'm meaning
 6 there just overall workload in pathology,
 7 pathologists included.

8 CHAYTOR, Q.C.:
 9 Q. Okay, and you go on to talk about received
 10 requests across the province for this service.
 11 Was Health Care Corporation able to then bill
 12 the other areas in the province for providing
 13 the ER/PR service?

14 MR. GULLIVER:
 15 A. We billed for IHC testing.

16 CHAYTOR, Q.C.:
 17 Q. Which included ER/PR?

18 MR. GULLIVER:
 19 A. Which included ER/PR. So the technical
 20 component on basically a quarterly basis, if
 21 we had IHC tests referred in from outside St.
 22 John's, on a quarterly basis we would run off
 23 the tests performed, the workload, and then
 24 bill out and charge for the value of that
 25 service. On the clinical side, I'm not 100

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1 percent sure if the pathologists were
 2 receiving additional remuneration for consults
 3 for these kinds of cases.

4 CHAYTOR, Q.C.:
 5 Q. So in terms of greatly increasing your
 6 workload in pathology, you're not - you're
 7 talking about the logistics of having the
 8 block there, having the block identified from
 9 a technical point of view?

10 MR. GULLIVER:
 11 A. That's part of it.

12 CHAYTOR, Q.C.:
 13 Q. But no major increase in the workload of the
 14 technologists who are offering this service
 15 throughout the -

16 MR. GULLIVER:
 17 A. Not really in your day to day, week to week
 18 workload, and again, as I said, on the other
 19 side of this here, we were continuously making
 20 other advancements in the lab from a
 21 technology perspective where we did bring in
 22 automated stainers, we brought in automated
 23 cover slippers, and we're pretty well now at
 24 this point have got the DAKO autostainer which
 25 really freed up a fair bit of staff technical

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1 time in the steps of adding solutions to every
 2 single slide and doing all the washings in
 3 between each step. I mean, that was really
 4 the time consuming piece of doing the IHC
 5 testing. By this time, DAKO is already in
 6 operating.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, and you go on in your letter then to Ms.
 9 Paulse to say, "All of the requests from the
 10 Cancer Clinic are coming directly to our
 11 laboratory, even though the majority of the
 12 patients being seen by your physicians have
 13 been referred from hospitals across the
 14 province. As you can see, this means that my
 15 staff are spending a great deal of time in
 16 ascertaining (a) where the patient originated
 17 from, and (b) did they already have ER/PR
 18 performed. The only consultation forms for
 19 ER/PRs", and then somebody has handwritten in,
 20 HER2/neu. Is that your handwriting?
 21 MR. GULLIVER:
 22 A. It's not mine, no.
 23 CHAYTOR, Q.C.:
 24 Q. So you didn't make that change to the letter?
 25 MR. GULLIVER:

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1 A. No.
 2 CHAYTOR, Q.C.:
 3 Q. "That we need to see from your centre are for
 4 those patients that originated from within the
 5 General Hospital. On those cases we will
 6 perform the ER/PRs, and one of the
 7 pathologists will provide the interpretation.
 8 For all other patients that have been referred
 9 to your centre from across the province who
 10 require ER/PRs, the consultation requests by
 11 your physicians should be completed and sent
 12 to the pathology lab at the site where the
 13 patient had surgery. It will then be up to
 14 the pathologists at that site to request our
 15 laboratory to perform ER/PRs if they haven't
 16 already been performed. The originating site
 17 will then send us the pathology blocks on the
 18 patient and we will fulfil the request and
 19 send the slides to the requesting
 20 pathologist". So what happened after that, Mr.
 21 Gulliver? Is your suggestion as you put
 22 forward here, is that what then started to
 23 happen?
 24 MR. GULLIVER:
 25 A. Yes. I mean, I'm not sure of the timelines,

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1 Ms. Chaytor, but at this point too, as you're
 2 well aware, up until the very beginning of
 3 performing this test, we had, you know,
 4 dedicated pathologists, mostly Dr. Khalifa,
 5 who was doing the interpretations for all the
 6 labs in the province, and then at some point
 7 we reached a decision where all pathologists
 8 in the province will be interpreting their own
 9 ER/PRs. So again it meant a different way in
 10 the processes of setting it up and slides
 11 going back, and there were - you know, we had
 12 cases in from outside St. John's, and the
 13 testing was performed, the slides went back to
 14 that pathologists, we had no record in St.
 15 John's of the interpretation or the results of
 16 those.
 17 CHAYTOR, Q.C.:
 18 Q. Okay, and then - so in terms of what you're
 19 suggesting to help alleviate the burden on
 20 your staff in having to coordinate this, so
 21 from this point onwards, or sometime shortly
 22 after you wrote in November, 1998, if the
 23 patient originated from outside the Health
 24 Care Corporation area, then that person would
 25 be referred in by the pathologist from out in

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1 the outlying regions?
 2 MR. GULLIVER:
 3 A. Right.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. If we could have, please, P-1893. This
 6 is the contract, I understand, for the DAKO
 7 machine, the acquisition of the DAKO machine,
 8 and it's dated May 27th, 1998, and it's signed
 9 by yourself as well as Susan Tanguay of DAKO
 10 Diagnostics. I just want to take you through
 11 a bit of this. Is this, in fact - this is the
 12 DAKO autostainer we've heard about in this
 13 inquiry, I take it, is it, Mr. Gulliver?
 14 MR. GULLIVER:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, and it says, "Pursuant to a tender
 18 number, and in compliance with the conditions
 19 outlined therein, we submit the following
 20 proposal for blanket purchase order number
 21 covering the purchase of both the DAKO
 22 autostainer and DAKO reagents. The price of
 23 the autostainer is quoted in the tender as
 24 \$54,000.00, plus HST, for a total of
 25 \$62,675.00. On a monthly basis, and for a

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1 period of 60 months, Health Care Corporation
 2 of St. John's will be invoiced an amount of
 3 \$3,750.00 under blanket purchase order number
 4 for an annual total cost of \$45,000.00. A
 5 minimum of \$10,000.00 from these funds must be
 6 allocated towards the overall purchase price
 7 of \$62,675.00, and at the end of March of each
 8 year, a detailed purchase analysis will be
 9 supplied by DAKO with an adjustment of a
 10 credit note or invoice reconciling the reagent
 11 usage. Health Care Corporation of St. John's
 12 will also at this time be invoiced in the
 13 amount of \$5,000.00 to cover the service
 14 contract for each year". That's signed on May
 15 27th, 1998. Mr. Gulliver, was the DAKO
 16 machine, in fact, in usage prior to this
 17 contract being signed?
 18 MR. GULLIVER:
 19 A. I'm not 100 percent sure. It might have been
 20 in within a few weeks, but usually the machine
 21 would come in, their technical support would
 22 come in and set it up, and while that's
 23 ongoing, the final details of the contract
 24 could be worked out, but I think it was in May
 25 where their technical guy, Dan Bolechowski

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1 actually physically came into St. John's, and
 2 I think he spent three, four, or five days in
 3 the lab setting it up, and training Mary and
 4 Peggy on the actual instrument.
 5 CHAYTOR, Q.C.:
 6 Q. So sometime around May of 1998 is your best
 7 recollection of when the machine actually got
 8 up and running?
 9 MR. GULLIVER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. And prior to that, the test being done by IHC
 13 method was being done through the kits and not
 14 through -
 15 MR. GULLIVER:
 16 A. On the bench.
 17 CHAYTOR, Q.C.:
 18 Q. On the bench, the manual -
 19 MR. GULLIVER:
 20 A. Using petri dishes.
 21 CHAYTOR, Q.C.:
 22 Q. Yes, the petri dishes that you described for
 23 us earlier.
 24 MR. GULLIVER:
 25 A. Yeah.

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1 CHAYTOR, Q.C.:
 2 Q. So in entering into this kind of a contract
 3 then, do I understand that the total cost of
 4 the machine and the reagents was to be
 5 \$62,675.00 inclusive of the -
 6 MR. GULLIVER:
 7 A. That's the price of the machine itself.
 8 CHAYTOR, Q.C.:
 9 Q. That's the machine itself, okay.
 10 MR. GULLIVER:
 11 A. But before this for many, many years, we were
 12 already spending a fair amount of dollars per
 13 year. In purchasing DAKO, you know, their
 14 primary antibodies, linking reagents, and
 15 different things from the company, so we're a
 16 high volume spender with DAKO before we do
 17 this contract.
 18 CHAYTOR, Q.C.:
 19 Q. And then you're going to purchase a certain
 20 volume of reagents from DAKO and that's going
 21 to be applied against the purchase price, is
 22 that correct?
 23 MR. GULLIVER:
 24 A. A portion of it, yes. This is like a
 25 standard, what we call a reagent lease within

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1 the lab. We have some of them as high as
 2 three million dollars a year. It's a
 3 combination of we provide the equipment, you
 4 commit over a period of time to use our
 5 reagents, they provide the maintenance support
 6 and service, and you agree upon doing a five
 7 year agreement. It's not much different than
 8 leasing a car, a fairly similar thing.
 9 CHAYTOR, Q.C.:
 10 Q. So the value - the cost of the machine at the
 11 time it was acquired in May of 1998 was over
 12 \$62,000.00?
 13 MR. GULLIVER:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. If we could have then, please, P-2889. This
 17 document, Mr. Gulliver, says that it's sales,
 18 January 1st, 1997, to December 31st, 2004, and
 19 over on the - there's handwriting over on the
 20 side here which says DAKO sales record.
 21 MR. GULLIVER:
 22 A. That's my writing.
 23 CHAYTOR, Q.C.:
 24 Q. Are you able to tell us what these documents
 25 are?

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1 MR. GULLIVER:
 2 A. I was asked actually to gather - if I could
 3 gather, and I called DAKO - and actually I
 4 think it was Mr. Dyer who called DAKO. I had
 5 a request come from a different group of
 6 lawyers in a different process asking could we
 7 have a list of all the reagents we have
 8 purchased from DAKO over the years, and this
 9 is what DAKO supplied to us.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and when did you make that request?
 12 MR. GULLIVER:
 13 A. I made this request in, I think, maybe 2006.
 14 I made the request - this is for the class
 15 action lawsuit.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, and so what was your purpose then in
 18 making the request at that time, what is it
 19 that you were trying to show?
 20 THE COMMISSIONER:
 21 Q. I think you said all the reagents purchased
 22 over the years.
 23 MR. GULLIVER:
 24 A. Right.
 25 CHAYTOR, Q.C.:

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1 Q. In that time period?
 2 MR. GULLIVER:
 3 A. Yeah.
 4 CHAYTOR, Q.C.:
 5 Q. Was there anything in particular, though, to
 6 the ER/PR issue?
 7 MR. GULLIVER:
 8 A. For this here, in particular?
 9 CHAYTOR, Q.C.:
 10 Q. Yes.
 11 MR. GULLIVER:
 12 A. No, it was - I was asked to provide a list of
 13 all the reagents that we used from DAKO, and
 14 also to look to see if at some points during
 15 this procedure, because we're seven or eight
 16 years with DAKO, and you can see when maybe
 17 DAKO came out with a different block,
 18 different reagent, or a new and improved -
 19 CHAYTOR, Q.C.:
 20 Q. For the ER and PR antibody?
 21 MR. GULLIVER:
 22 A. Well, for IHC, in general.
 23 CHAYTOR, Q.C.:
 24 Q. Mr. Gulliver, whose decision was it to obtain
 25 the DAKO autostainer?

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1 MR. GULLIVER:
 2 A. Well I was the manager, I would be a key
 3 player in it. It was the first time we had
 4 seen any kind of--any kind of automation, you
 5 know, sort of as crude as it was, it was still
 6 a big help with the, sort of the mundane tasks
 7 of having to have a technologist constantly
 8 standing above the bench, constantly watching
 9 from slide to slide, from slide to slide, to
 10 slide. At the time, I would think it's myself
 11 and Dr. Khalifa would be the main two who
 12 would be involved in it.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, and do you recall that? Did you consult
 15 with Dr. Khalifa on -
 16 MR. GULLIVER:
 17 A. To the best of my knowledge, yes, yeah.
 18 CHAYTOR, Q.C.:
 19 Q. And why, why was it the DAKO autostainer that
 20 you went with, as opposed to any other that
 21 may have been in the market at that time?
 22 MR. GULLIVER:
 23 A. Well I guess at the time we had been using
 24 DAKO reagents for almost ten years and we went
 25 through the public tendering process and we

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1 put a proposal out to the marketplace where
 2 vendors or possible vendors or suppliers, you
 3 know, they had the opportunity to say, yeah,
 4 we're looking for equipment, we're looking for
 5 a commitment for reagents, some service, all
 6 inclusive package and you'd get proposals back
 7 from various vendors and then you go through
 8 our process. I think back then DAKO might
 9 have been the only one.
 10 CHAYTOR, Q.C.:
 11 Q. Was Dr. Haegert, as he was clinical chief at
 12 the time, do you recall--did you consult with
 13 him on the decision to acquire the DAKO
 14 machine?
 15 MR. GULLIVER:
 16 A. I don't know if I consulted with him directly,
 17 but certainly he would have been well aware
 18 that we're hoping to obtain, you know, this
 19 level of technology in the lab and certainly
 20 Mr. Whelan who was my direct-line manager
 21 would be well aware.
 22 CHAYTOR, Q.C.:
 23 Q. And in terms of Dr. Haegert, though, being
 24 aware of the particular type of machine that
 25 you were looking at acquiring, would he have

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1 that kind of a detail or would he have
 2 consulted?
 3 MR. GULLIVER:
 4 A. I don't think so, no.
 5 CHAYTOR, Q.C.:
 6 Q. He's, in fact, I think said that he didn't
 7 realize that it was--that the DAKO machine had
 8 been acquired until after the fact and he's
 9 told that to the Commissioner, he was walking
 10 down the corridor one day shortly after it had
 11 arrived and he recalled a conversation, I
 12 believe, that you were having with a couple of
 13 technologists about some difficulties with the
 14 DAKO autostainer and that's when he first
 15 became aware. Do you recall that? Do you
 16 recall him approaching you then and telling
 17 you any concern he had about the DAKO
 18 autostainer?
 19 MR. GULLIVER:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. I believe he said that he explained that when
 23 he was at Montreal General, there had been
 24 some problems with the antibody staying on the
 25 slides or something along those lines, do you

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1 recall any discussion with Dr. Haegert about
 2 that?
 3 MR. GULLIVER:
 4 A. No.
 5 CHAYTOR, Q.C.:
 6 Q. And do you recall shortly after the machine
 7 was acquired any problems that you were
 8 having?
 9 MR. GULLIVER:
 10 A. Not that I--now, I mean, again, Peggy and Mary
 11 were the two technologists who were directly
 12 using the equipment. I don't recollect, you
 13 know, anything major happening shortly after
 14 acquiring it. I do remember the guy Dan who
 15 came in and did the set up and showed Peggy
 16 and Mary how to operate it. You know, with
 17 any new piece of equipment, if there was a
 18 software computer came with the system, sort
 19 of an operational software package, you know,
 20 I'm sure they had probably ongoing questions
 21 or something once Dan went back to Ontario and
 22 there was, you know, a phone number and a
 23 phone line to call with any concerns or
 24 questions that they would help you over the
 25 phone.

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1 CHAYTOR, Q.C.:
 2 Q. Okay, so nothing sticks out in your mind as to
 3 shortly after it's acquired having any
 4 particular type of problem?
 5 MR. GULLIVER:
 6 A. Not that I know, no.
 7 CHAYTOR, Q.C.:
 8 Q. And in terms of the actual involvement of the
 9 clinical chief in that kind of a discussion
 10 that we're now going to go this automated
 11 route and here's the machine we're looking at
 12 acquiring, that wouldn't have happened at that
 13 level, I take it?
 14 MR. GULLIVER:
 15 A. I can't remember. I mean, this--the clinical
 16 chief is, you know, is the chief of all
 17 laboratories, you know, you have site chiefs
 18 and divisional chiefs and divisional managers,
 19 I mean, this is operational stuff at the
 20 divisional level. So generally it would be
 21 your site chief and the techs who using it and
 22 the manager who would be doing the assessment.
 23 Obviously when any new piece of equipment come
 24 in, you'd go through sort of an assessment
 25 period to make sure it meets all your needs,

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1 to make sure it meets the tender specs. And
 2 remember, though, it's not--this is not
 3 automating the procedure. This is just simply
 4 a robotic arm that's dispensing liquids on the
 5 slides at a certain time period, as opposed to
 6 a technologist doing that, that function.
 7 CHAYTOR, Q.C.:
 8 Q. So that type of a decision, you wouldn't see
 9 any need to consult with the clinical chief?
 10 MR. GULLIVER:
 11 A. I don't remember if I consulted with them or
 12 not. And I don't know if Dr. Khalifa did, I
 13 mean, Dr. Khalifa was certainly the site chief
 14 and he would be involved.
 15 CHAYTOR, Q.C.:
 16 Q. The autostainer itself, the machine, did it
 17 come with the computer on board, the computer
 18 is included with it?
 19 MR. GULLIVER:
 20 A. The computer came with it, but it was, you
 21 know, a separate computer plugged into the
 22 machine.
 23 CHAYTOR, Q.C.:
 24 Q. And would--is it anything special about that
 25 computer or would any computer be able to

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1 operate with the machine?
 2 MR. GULLIVER:
 3 A. I don't know if there's anything special about
 4 the computer. I just think maybe any computer
 5 could be--it's their software was really the
 6 key thing that came with the instrument, but
 7 you know, in the price of the instrument, the
 8 computer came with it.
 9 CHAYTOR, Q.C.:
 10 Q. Included the computer for the \$62,000, that
 11 included the computer.
 12 MR. GULLIVER:
 13 A. Yeah.
 14 CHAYTOR, Q.C.:
 15 Q. And whether or not it was anything--any
 16 particular type of computer that was required
 17 to run the machine?
 18 MR. GULLIVER:
 19 A. I don't think there was any kind of
 20 specialized computer. Understand in the
 21 laboratory at this time, as most parts of the
 22 system, where our computerized system is sort
 23 of a hard drive Meditech system, we don't have
 24 a lot of PCs around the system at that point.
 25 CHAYTOR, Q.C.:

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1 Q. And the software came as well with it.
 2 MR. GULLIVER:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. Included in the price.
 6 MR. GULLIVER:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. If we could have, please, P-2536? And this is
 10 the annual report for the Laboratory Medicine
 11 Program from 1997 to 1998 and it's dated
 12 February 28th, 1999. And would you have been
 13 involved in any preparation of this?
 14 MR. GULLIVER:
 15 A. I think I provided this to you, this is
 16 something that would have been prepared by,
 17 you know, Vern Whelan, the former director and
 18 Dr. Haegert. I think the involvement here,
 19 you would go to your divisions and ask, Vern
 20 would ask do you have anything to include in
 21 our annual report type of thing.
 22 CHAYTOR, Q.C.:
 23 Q. So for example, when the division of
 24 anatomical pathology, you would have been--you
 25 would have provided information.

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1 MR. GULLIVER:
 2 A. Oh I would have been asked to provide it,
 3 yeah.
 4 CHAYTOR, Q.C.:
 5 Q. Yes, okay. And on page 3 and I realize this
 6 refers to the entire program, the overview,
 7 "This past year many changes were attempted in
 8 the laboratory program. Many have done quite
 9 well and others have been significant learning
 10 experiences. There still exist barriers,
 11 people have comfort zones, strong cultural
 12 ties and resist change, but overall,
 13 significant changes have occurred for the
 14 better." And Mr. Gulliver, is that the type
 15 of thing you were referring to earlier today
 16 in your evidence, in terms of the cultural
 17 ties -
 18 MR. GULLIVER:
 19 A. I would say, yeah.
 20 CHAYTOR, Q.C.:
 21 Q. - and the resistance to change?
 22 MR. GULLIVER:
 23 A. And I mean, to put this in perspective is the
 24 timeframe of '98, we know the decision is
 25 made, the Grace is going to close, the Janeway

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1 is going to close, where our service is going
 2 to be moving to, either to St. Clare's or to
 3 the Health Sciences and I think that's exactly
 4 what Vern would have been referring to here.
 5 CHAYTOR, Q.C.:
 6 Q. And it goes on to state, "These changes were
 7 the result of restructuring and consolidation.
 8 Each division implemented procedures that were
 9 required to achieve an overall budget
 10 reduction of \$700,000 from the previous year.
 11 For the year ending March 31st, 1998, this
 12 target was not only achieved, but passed by
 13 \$205,000. In addition, revenue was increased
 14 by \$109,000." So I take it overall that
 15 there's been a significant cost reduction in
 16 the program.
 17 MR. GULLIVER:
 18 A. Downsizing.
 19 CHAYTOR, Q.C.:
 20 Q. "The measures resulted in some limiting of new
 21 resources, reduced educational activities, but
 22 overall the benefits are many with significant
 23 potential." And then examples of these
 24 benefits are improving outcomes through
 25 standardization of tests, improve reporting

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1 system, improve working schedules. And I
 2 realize again this is for the entire program,
 3 but would that be accurate in terms of your
 4 portion of the program, the pathology portion,
 5 that there was cost reductions which were met
 6 and that there were some measures, those
 7 measures ended up limiting things such as
 8 educational activities?
 9 MR. GULLIVER:
 10 A. I think that's a fair assessment, it applied
 11 to the whole laboratory program and you will
 12 probably see many documents, this is one, but
 13 of many years like this.
 14 CHAYTOR, Q.C.:
 15 Q. Yes, now I don't know that I see too many
 16 afterwards, though, where they actually happen
 17 to make your reductions and achieve that by
 18 another \$200,000?
 19 MR. GULLIVER:
 20 A. I know, I'm six years as director, I haven't
 21 balanced a budget yet.
 22 CHAYTOR, Q.C.:
 23 Q. And we'll talk a bit about that. If we look
 24 at page 6 of this document, there's laboratory
 25 strategic directions for 1998 through to 2001.

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1 And the directions will be along the following
 2 guidelines, "providing the highest quality
 3 service possible within available resources,
 4 constantly seeking ways to be more efficient,
 5 reduce costs and above all, improve quality"
 6 and Mr. Gulliver and we will look at some of
 7 the further annual reports when you take over
 8 in 2001 for, as the director, but I'm just
 9 wondering what your opinion is on the ability
 10 to provide the highest quality service
 11 possible while at the same time seeking ways
 12 to be more efficient, reducing costs. How do
 13 you improve quality while you reduce costs and
 14 become more efficient?
 15 MR. GULLIVER:
 16 A. Well obviously it's much more difficult. It
 17 all depends what your main outcome is and what
 18 your main focus is. If your main focus is to,
 19 you know, to continuously improve quality, you
 20 know, having an environment of constraint
 21 reduced costs and budget constraints and staff
 22 reductions really is not conducive to
 23 improving quality, it's more conducive to
 24 improving productivity and improving
 25 efficiencies. It doesn't mean to say that

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1 through these years that lab services in
 2 general, and this is Vern's report, I mean,
 3 it's not my report, that lab services in
 4 general have not improved overall quality
 5 either in parts of the, could be in chemistry
 6 division or other divisions, but again, yes, I
 7 mean, it is very difficult.
 8 CHAYTOR, Q.C.:
 9 Q. And if we could have, please, P-2150? And
 10 this document you are the source of and it's
 11 entitled "IHC Timelines" and then there's a
 12 number of items, the first being technology
 13 and equipment, then antibodies used. Number
 14 three is your reagents, solutions and other;
 15 number four is staffing; and then number five
 16 is space and physical environment. Did you
 17 create this document, Mr. Gulliver?
 18 MR. GULLIVER:
 19 A. Yes, I did.
 20 CHAYTOR, Q.C.:
 21 Q. And what was your purpose for creating this?
 22 MR. GULLIVER:
 23 A. I was asked for this information for the class
 24 action lawsuit.
 25 CHAYTOR, Q.C.:

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1 Q. And so when would this have been created?
 2 MR. GULLIVER:
 3 A. I'm thinking maybe 2006.
 4 CHAYTOR, Q.C.:
 5 Q. And here it indicates again, the 1980's
 6 through early 1998. It's May 1998 that the
 7 DAKO autostainer was installed and the DAKO
 8 water bath for antigen retrieval, October,
 9 1999, what does that refer to?
 10 MR. GULLIVER:
 11 A. Oh, I mean, these are showing some of the
 12 things, Ms. Chaytor, when--you know, we've
 13 been following pretty well the same procedure
 14 and the same protocols for years, but DAKO, as
 15 our main vendor, if they came out with
 16 improvements, we certainly would like to
 17 switch to those improvements. So prior to
 18 this here when Mary and Peggy were doing the
 19 antigen retrieval piece for ER/PR and you've
 20 heard them testify it's pretty well, you have
 21 a hot plate, you put your--on the hot plate,
 22 you boil the slides. This here was just a
 23 small piece--like a water bath that you could
 24 use as you're boiling your substrate solution.
 25 CHAYTOR, Q.C.:

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1 Q. Yes, and then it goes on with some detail with
 2 other dates and then antibodies used, your
 3 clones. For example, ER ID5, 1997 through
 4 April, 2004. You give a history of ER/PR kit
 5 system, then Ventana clones and then the
 6 reagent solutions, the staffing, as I said,
 7 and then the physical space. And I'm
 8 wondering what did you have of assistance to
 9 you when you prepared this for the class
 10 action to be able to fill in all this detail
 11 on these dates as to when certain clones were
 12 used and when certain techniques were used.
 13 What documentation was available to you?
 14 MR. GULLIVER:
 15 A. It was certainly a combination of multiple
 16 sources, I mean, it was going directly to the
 17 technologists in the lab to see what
 18 documentation either Mary, Peggy and Barry
 19 had, you see the list of all the reagents,
 20 that's what I asked DAKO could they supply me,
 21 you know, on their records, could they supply
 22 me with a list of the reagents that we had
 23 used over the years from DAKO and when you see
 24 the purchase orders, you can kind of see the
 25 dates -

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1 CHAYTOR, Q.C.:
 2 Q. So this information would come from the
 3 exhibit I showed you, P-2889?
 4 MR. GULLIVER:
 5 A. Yes, pretty well, a lot of that would, yes.
 6 CHAYTOR, Q.C.:
 7 Q. And you piece together from that exhibit, that
 8 document.
 9 MR. GULLIVER:
 10 A. Exactly, yes.
 11 CHAYTOR, Q.C.:
 12 Q. So in terms of documentation, you would have
 13 had DAKO's sales record for number three,
 14 reagent solutions.
 15 MR. GULLIVER:
 16 A. For that there and I mean, there were still a
 17 fair bit of, you know, over the lab, there
 18 were still some documentation there that, you
 19 know, in a binder where there were sheets here
 20 and Mary had written dates down when they came
 21 in and when they used them and it certainly
 22 wasn't complete records. By this time, as
 23 you're aware in 2004, that part of our lab
 24 underwent a severe flood and a lot of the
 25 paper stuff was--had to be discarded from

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1 asbestos contamination, but yeah, most of the
 2 stuff here, I took out of the DAKO information
 3 they sent me.
 4 CHAYTOR, Q.C.:
 5 Q. And so the ER/PR pre-diluted antibodies from
 6 October, 1997 through to April, 1998, that
 7 time period, how would you figure that out,
 8 that that's when you used your pre-diluted -
 9 MR. GULLIVER:
 10 A. I think that came off the DAKO sheets that
 11 early on DAKO had pre-diluted ER/PR's that
 12 came in and then at some point, you know, they
 13 switched over, they came up with a primary
 14 ER/PR antibody where you did your own
 15 dilutions. And this here, pretty well, Ms.
 16 Chaytor, this is just my--just from my memory,
 17 the timelines is -
 18 CHAYTOR, Q.C.:
 19 Q. This is, the technologist -
 20 MR. GULLIVER:
 21 A. The timelines of when I was the bench
 22 technologist and then Mary and Peggy, when Ken
 23 transferred up to St. Clare's, Peggy resigned,
 24 Les comes from St. Clare's and then again, to
 25 present, as you can see now, Mary and Les are

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1 both retired.
 2 CHAYTOR, Q.C.:
 3 Q. Yes. This wasn't necessarily done consulting
 4 any personnel records, this was just based on
 5 your own recollection of when -
 6 MR. GULLIVER:
 7 A. Oh, and asking Ken, exactly, Ken, when did you
 8 move over to Health Sciences.
 9 CHAYTOR, Q.C.:
 10 Q. Yes.
 11 MR. GULLIVER:
 12 A. Which was, I think he said St. Patrick's day
 13 in March, 2002.
 14 CHAYTOR, Q.C.:
 15 Q. And how about the date in which Peggy finished
 16 up?
 17 MR. GULLIVER:
 18 A. Well, I knew that Peggy had resigned at that
 19 time, that's when she left. We had her
 20 resignation letter.
 21 CHAYTOR, Q.C.:
 22 Q. In March of 2003?
 23 MR. GULLIVER:
 24 A. That's right.
 25 CHAYTOR, Q.C.:

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1 Q. Her resignation letter or her date of actually
 2 finishing up?
 3 MR. GULLIVER:
 4 A. I think her resignation letter. I'm not sure.
 5 CHAYTOR, Q.C.:
 6 Q. And then under number five, "Space. Physical
 7 environment," it's indicated that "The IHC
 8 testing, both manual and semi-manual with the
 9 DAKO autostainer performed in the main
 10 pathology laboratory staff."
 11 MR. GULLIVER:
 12 A. "Space."
 13 CHAYTOR, Q.C.:
 14 Q. Sorry, "space," sorry.
 15 MR. GULLIVER:
 16 A. "Space."
 17 CHAYTOR, Q.C.:
 18 Q. "Space." "December 2003 with the installation
 19 of the new Ventana system the process was
 20 started to move all IHC testing reagents,
 21 equipment to separate space from the main
 22 lab." So it was in December of '03 before the
 23 Ventana system came in that everything started
 24 to move, all the IHC started--I'm sorry,
 25 before the Ventana came in, the IHC was moved

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1 into its own separate space or that process
 2 began?
 3 MR. GULLIVER:
 4 A. Yeah.
 5 CHAYTOR, Q.C.:
 6 Q. Okay. And that was being done in, at that
 7 point in time, for what purpose?
 8 MR. GULLIVER:
 9 A. Well, through the whole Janeway closing and
 10 the Grace closing, having to amalgamate
 11 services, from a laboratory perspective, if
 12 you look at the old Janeway and Grace, the
 13 laboratories in general in the St. John's, not
 14 only did we suffer major downsizing in our
 15 staffing, we lost a significant amount of
 16 floor space. And we pretty well had to
 17 squeeze staff and equipment into existing
 18 space at the Health Sciences or existing space
 19 at St. Clare's because in the new Janeway
 20 extension, we had only a small bit of new
 21 space built on for a genetic laboratory and
 22 biochemical genetics. In that whole
 23 reorganization we were looking at a part of
 24 chemistry at the time was hormone assay
 25 chemistry, there were several staff, the lab

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1 that you visited, the IHC lab today, used to
 2 be occupied by those staff. Before then it
 3 was occupied by Dr. Wang back in the early
 4 '80s and myself doing some of this IHC testing
 5 back even before that time frame. So the plan
 6 was all during the consolidation and
 7 renovations that when the hormone assay staff
 8 would move to chemistry where they belonged,
 9 that that floor space would go to pathology
 10 and we would have our own dedicated IHC space
 11 for pathology. And it, you know, kind of
 12 happened around, it coincided at around a
 13 similar time. So when we had the Ventana
 14 system come in, we're still operating the DAKO
 15 system, you know, so we've got to put Ventana
 16 in a different space because you can't be
 17 operating in two--you don't have the space for
 18 two different system. So that's when we
 19 started to move to set up a separate lab for
 20 IHC.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. And so that was the incentive for doing
 23 that at that point in time, you're bringing in
 24 your new system and you needed additional
 25 space for that?

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1 MR. GULLIVER:
 2 A. The incentive all--the plan all along was for
 3 years -
 4 CHAYTOR, Q.C.:
 5 Q. To be able to get that?
 6 MR. GULLIVER:
 7 A. To have a separate IHC lab.
 8 CHAYTOR, Q.C.:
 9 Q. Why was that important, why would you need a
 10 separate IHC lab?
 11 MR. GULLIVER:
 12 A. Well, the IHC part of pathology started off at
 13 the back of a bench. You know, I was the
 14 first one to start it and I had a square space
 15 about as big as this desk. And, you know, by
 16 this time frame you're talking about now the
 17 Ventana system were two large systems, we
 18 needed more space for storage, for
 19 refrigeration storage, for antibodies and
 20 reagents. We needed more space for we wanted
 21 to have a separate space for, you know,
 22 cutting, the staff cut their own blocks with a
 23 microtome and a water bath. So it really was
 24 evolving into having its own separate space
 25 and own separate lab long before this, the

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1 Ventana instrument.
 2 CHAYTOR, Q.C.:
 3 Q. And if we could look, please, at P-2936,
 4 Registrar? This document, Mr. Gulliver, is
 5 dated 1998 and it's not pathology, it's
 6 hematology. And it's College of American
 7 Pathologists. And it appears to be referring
 8 to proficiency testing. Perhaps you can tell
 9 us what this is?
 10 MR. GULLIVER:
 11 A. This is, again, I think I supplied this to the
 12 class action lawsuit -
 13 CHAYTOR, Q.C.:
 14 Q. Well, you supplied it to us, anyhow.
 15 MR. GULLIVER:
 16 A. documentation. What?
 17 CHAYTOR, Q.C.:
 18 Q. You supplied it to us. You're indicated to be
 19 the source on our records.
 20 MR. GULLIVER:
 21 A. I think whatever I gave them, I supplied to
 22 the Commission, also. This was to show some
 23 records about laboratories in general. This
 24 was copies that I found in old filing cabinets
 25 belonging to my former director showing the,

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1 some of the CAP surveys, this is external
 2 proficiency testing.
 3 CHAYTOR, Q.C.:
 4 Q. Yes.
 5 MR. GULLIVER:
 6 A. That, you know, back in 1998 here are some of
 7 the things that the hematology division
 8 participated in from an external proficiency
 9 testing perspective.
 10 CHAYTOR, Q.C.:
 11 Q. And were there--and this was done for
 12 hematology and, I take it, for a number of
 13 other divisions -
 14 MR. GULLIVER:
 15 A. And there'd be chemistry, immunology and other
 16 divisions, also, yes. We've just seen some
 17 more went past. HLA, tissue typing.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, when we go through the documents. None
 20 for pathology. And I'm just wondering why
 21 there wasn't external proficiency testing, as
 22 well, for the pathology division?
 23 MR. GULLIVER:
 24 A. Well, at the time the external proficiency
 25 testing that the pathologists, I mean, it was

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1 their decision to participate in whatever they
 2 wanted to participate in. They participated
 3 in ASCP, that there were CAP checks, where it
 4 was more of a pathologist proficiency testing
 5 but just there was nothing in place for the
 6 technical side of proficiency testing in
 7 pathology.
 8 CHAYTOR, Q.C.:
 9 Q. For the--yeah, for a review of producing
 10 slides and the quality of the slides -
 11 MR. GULLIVER:
 12 A. Right. Now, back in '98 I don't even know if
 13 I'm aware of even if CAP offered any kind of
 14 technical external proficiency testing, in
 15 particular, for IHC.
 16 CHAYTOR, Q.C.:
 17 Q. Did you ever inquire?
 18 MR. GULLIVER:
 19 A. Not to my knowledge, no.
 20 CHAYTOR, Q.C.:
 21 Q. And what about 1999, 2000, through to 2005,
 22 did you ever make any inquiry as to whether or
 23 not there would be such proficiency testing
 24 available?
 25 MR. GULLIVER:

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1 A. No.
 2 CHAYTOR, Q.C.:
 3 Q. And why not?
 4 MR. GULLIVER:
 5 A. Because it's--the proficiency testing in
 6 pathology, we left it to the pathologists. I
 7 mean, if a pathologist came and said, oh,
 8 there's a new program for IHC and it's from
 9 anywhere, my job was to facilitate that
 10 process, do the paperwork, the documentation
 11 and get the funding or resources to put that
 12 in place. It wasn't my role to decide this is
 13 the proficiency testing pathologists should
 14 participate in.
 15 CHAYTOR, Q.C.:
 16 Q. What about the proficiency testing, though,
 17 which would measure the quality of what your
 18 technologists are producing?
 19 MR. GULLIVER:
 20 A. And again, at that point in time I don't know
 21 if anything existed for that.
 22 CHAYTOR, Q.C.:
 23 Q. And my question is did you make any inquiries,
 24 right up and through until 2005 did you make
 25 any inquires as to what may exist?

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1 MR. GULLIVER:
 2 A. For external--for pathology?
 3 CHAYTOR, Q.C.:
 4 Q. Yes.
 5 MR. GULLIVER:
 6 A. Well, in 2001 I'm not the manager, so up to
 7 2001 when I was the manager of pathology -
 8 CHAYTOR, Q.C.:
 9 Q. 2001 to 2005 you're the director.
 10 MR. GULLIVER:
 11 A. Program director.
 12 CHAYTOR, Q.C.:
 13 Q. Yes. Did you ever make any inquiries as to
 14 what may exist in terms of proficiency
 15 testing?
 16 MR. GULLIVER:
 17 A. No, because as I said, I mean, that was always
 18 the domain of the pathologists to decide.
 19 CHAYTOR, Q.C.:
 20 Q. Including anything that would assess or
 21 evaluate the quality of the product that your
 22 technologists are performing?
 23 MR. GULLIVER:
 24 A. Right, because it's still a pathologist who's
 25 reading and assessing the quality.

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1 CHAYTOR, Q.C.:
 2 Q. And don't you talk to each other and find out,
 3 well, look, we're doing this for every other
 4 area, why isn't it happening for pathology or
 5 for IHC, why wouldn't that discussion take
 6 place?
 7 MR. GULLIVER:
 8 A. Well, if you look at '98, hematology has been
 9 a well established lab practice for decades by
 10 this time. IHC testing in 1998 was still a
 11 growing science and I don't think that there
 12 were programs out there that were available.
 13 CHAYTOR, Q.C.:
 14 Q. And what about -
 15 MR. GULLIVER:
 16 A. If there were -
 17 CHAYTOR, Q.C.:
 18 Q. - 2001 and 2005, up to that point in time?
 19 MR. GULLIVER:
 20 A. In 2001, my last year as manager, I still
 21 don't know if there were external proficiency
 22 testing from CAP for IHC testing. And I would
 23 not inquire if there was because that, to me,
 24 was the position of the clinical side of our
 25 program, the pathologists or site chiefs or

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1 clinical chiefs. They were participating in
 2 CAP for their--samples would come in for
 3 checking pathologist's interpretation. The
 4 pathologists and site chiefs well knew that
 5 all parts of our program were participating in
 6 external proficiency testing for hematology,
 7 chemistry, tissue typing. For example, you
 8 asked earlier I was the division manager for
 9 immunology, and I was well aware that we had
 10 proficiency testing for immunology for H & A
 11 tissue typing, for bone marrow and kidney
 12 transplants, and for flow cytometry. I'm the
 13 manager for pathology, but in pathology it's
 14 the pathologists' decision to decide what
 15 quality control for proficiency testing
 16 they're going to take place in.
 17 CHAYTOR, Q.C.:
 18 Q. And so were you aware that there wasn't any
 19 for the pathology side?
 20 MR. GULLIVER:
 21 A. I wasn't aware at the time, no.
 22 CHAYTOR, Q.C.:
 23 Q. You weren't. And these documents that you've
 24 given us here came from your predecessor, from
 25 Vern Whelan?

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1 MR. GULLIVER:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. In 19 -
 5 MR. GULLIVER:
 6 A. And we have those up to current.
 7 CHAYTOR, Q.C.:
 8 Q. Right. And he had this in his possession in
 9 1998 as the director of the program?
 10 MR. GULLIVER:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. Mr. Gulliver, in terms of--and I just
 14 want to understand that because what you're
 15 telling us is that you didn't make any
 16 inquiries and nor was it--did it become the
 17 subject of discussion with the clinical side,
 18 so there was no discussion as to, well, we
 19 might have a gap here, is there some way we
 20 can fill this gap. So you didn't make any
 21 inquiries about it, you thought it was more
 22 the domain of the clinical side of the program
 23 to do that, and there was no discussion
 24 between you or the clinical side about the
 25 absence of this?

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1 MR. GULLIVER:
 2 A. And I don't remember having discussion about
 3 proficiency testing for IHC testing, it never
 4 happened. But our pathologists, I've had
 5 discussions with our pathologists and site
 6 chiefs when I was the pathology manager in
 7 the CAP surveys and the ASCP checks that they
 8 were participating in where they would come
 9 and give me the forms to make sure I had them
 10 filled out and get the purchasing stuff done
 11 and then renew them from year after year.
 12 CHAYTOR, Q.C.:
 13 Q. And it was a new service in terms of when it
 14 came on in terms of the technologists doing
 15 this and as it continued to grow and many
 16 stains got added to it, but it wasn't
 17 something that ever came up then for
 18 discussion as to, well, is there some way that
 19 we can monitor the product that we're
 20 producing, that didn't come up for discussion?
 21 MR. GULLIVER:
 22 A. No, it never did come up, Ms. Chaytor, not
 23 until, I guess it was Dr. Ejeckam in, you
 24 know, summer of '05 when we started all this
 25 here, Dr. Ejeckam came with some information

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1 with external proficiency testing for IHC that
 2 included the technical component and not just
 3 the clinical component.
 4 CHAYTOR, Q.C.:
 5 Q. And that would be the first time, then, you
 6 became aware of that such testing was
 7 available and that you could avail of it?
 8 MR. GULLIVER:
 9 A. Certainly.
 10 CHAYTOR, Q.C.:
 11 Q. When ER/PR came on through IHC, when it was
 12 first introduced through the IHC method, Dr.
 13 Khalifa was going to be doing all the
 14 reporting we've heard, so there'd be
 15 centralized reporting by him. Eventually that
 16 changed and we've seen some documents on that,
 17 and pathologists throughout the province then
 18 started reporting their own. And there's some
 19 discussion of that, I believe, in the minutes
 20 that I brought you to earlier today. Do you
 21 recall anything about that, were you involved-
 22 -I understand you're not involved in the
 23 decision to, for pathologist to then report
 24 their own cases. But do you recall any
 25 involvement that you would have had in the

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1 fall out of that decision?
 2 MR. GULLIVER:
 3 A. I'm not sure at what level -
 4 CHAYTOR, Q.C.:
 5 Q. I'm just thinking in terms -
 6 MR. GULLIVER:
 7 A. - from the fall out.
 8 CHAYTOR, Q.C.:
 9 Q. In terms of then if every pathologist across
 10 the island is going to then report their own
 11 cases, did that have any impact on the
 12 technical side, the people who are running the
 13 test, your management of -
 14 MR. GULLIVER:
 15 A. Certainly, yes.
 16 CHAYTOR, Q.C.:
 17 Q. - what they're doing -
 18 MR. GULLIVER:
 19 A. Well, I mean, when this new testing went in
 20 place for IHC, you know, with Dr. Khalifa and
 21 Mary and Peggy, the two techs who were
 22 performing the procedure was pretty well under
 23 his guidance. And as you know, he pretty well
 24 did almost all the interpretations, he read
 25 all the controls and he signed the cases out.

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1 I think it was only in his absence that
 2 another pathologist at the Health Sciences
 3 actually fill in for him and do these cases if
 4 he was away.
 5 CHAYTOR, Q.C.:
 6 Q. And who was that?
 7 MR. GULLIVER:
 8 A. I think it was mostly Dr. Lynn Morris-Larkin
 9 and Dr. Fernandez strikes, strikes a tone with
 10 me.
 11 CHAYTOR, Q.C.:
 12 Q. So not Dr. Chittal?
 13 MR. GULLIVER:
 14 A. And I think maybe Chittal might have done
 15 some, too. But I don't think you'll see many
 16 cases--when Khalifa was reading them, the vast
 17 majority were done by him. Obviously when he-
 18 -when the decision was made that he wouldn't
 19 be doing all the interpretations for ER/PRS,
 20 that meant that the technologists had to
 21 change their practice. It meant then when
 22 you're running your batch on Fridays, there
 23 were times when they had to run multiple
 24 controls in the same batch, depending on how
 25 many pathologists and how many cases were

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1 being done, running that batch. So if you had
 2 a pathologist in Corner Brook and a
 3 pathologist at St. Clare's and a pathologist
 4 in the Health Sciences and one at Grand Falls,
 5 sometimes as many as four controls, ER and PR
 6 controls were run by the techs to send a
 7 control slide back with the pathologist. And,
 8 you know, and I can't tell you all the time
 9 frames, Ms. Chaytor, but and even that changed
 10 during a period of time. At this time we're
 11 getting close to Dr. Khalifa, he stops
 12 interpretation. He stays on board as site
 13 chief. He's then leaving. We have a new site
 14 chief coming in. The Grace is about to close.
 15 And during that time frame there was a time
 16 where Dr. Khalifa still read controls, but he
 17 wasn't interpreting the cases. And then there
 18 was a time where controls went to all the
 19 pathologists, multiple pathologists. And then
 20 when Dr. Sushil Parai came from the Grace as
 21 the new site chief, he was then started--he
 22 was reading the controls for IHC before they
 23 went out to pathologists. So--and I can't
 24 give you an exact, you know, this week, this
 25 month, you know, ten years ago, but that was

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1 sort of the--but there is the fall out, when
 2 you're saying what's the fallout from Dr.
 3 Khalifa stopped interpretation.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. And so--sorry, go ahead.
 6 MR. GULLIVER:
 7 A. And, you know, we're talking about two--I
 8 mean, almost leading into two things. So when
 9 Dr. Khalifa stopped the interpretations, it
 10 meant the practice would change for the techs
 11 in the numbers of controls and who's going to
 12 be reading cases. And, but he was still there
 13 to provide guidance and he was still there for
 14 the technologists to go to if they had any
 15 issues or concerns.
 16 CHAYTOR, Q.C.:
 17 Q. Did you ever raise any concern about the
 18 number of controls that were having to be run?
 19 MR. GULLIVER:
 20 A. Certainly did, yes.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. And who did you raise that with and
 23 what was the source of your concern?
 24 MR. GULLIVER:
 25 A. I generally raised it through our monthly site

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1 chiefs meetings with, you know, the various
 2 site chiefs in pathology and myself and Mr.
 3 Murphy, the other pathology manager. And I
 4 raised it for a couple of issues. It was one,
 5 who's going to read the controls and document
 6 reading controls. And number two, as you've
 7 seen, you know, back in those days it was a
 8 fairly expensive--in pathology this is the
 9 most expensive technical side of pathology to
 10 run, and for every slide you run you're paying
 11 for it, so--and I had an issue with why are we
 12 running four and five controls of the same
 13 control in the same batch, it's costing four
 14 and five times the amount, the cost.
 15 CHAYTOR, Q.C.:
 16 Q. And so you were proposing that one control be
 17 run and that there'd be a pathologist in
 18 charge for, or responsible for reading that
 19 control?
 20 MR. GULLIVER:
 21 A. I guess so, because that's what we had been--
 22 we set this service up in that fashion and
 23 that's what I would liked to have continued
 24 that way.
 25 CHAYTOR, Q.C.:

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1 Q. Was there ever any agreement reached amongst
 2 at least the hospitals within the city that
 3 that could happen, that one of them would be
 4 responsible -
 5 MR. GULLIVER:
 6 A. It did. You know, after talking through
 7 multiple meetings about this and it could have
 8 went on for months and months, there was
 9 another process in place where if there were
 10 multiple patients from the city hospitals
 11 looking for the same antibody, that we would
 12 run one control and then a pathologist at
 13 Health Sciences would read the control, verify
 14 it was positive and then would send the slides
 15 to the pathologist.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, so -
 18 MR. GULLIVER:
 19 A. And that happened for awhile, it didn't happen
 20 for all the time.
 21 CHAYTOR, Q.C.:
 22 Q. So what was the problem, why didn't that
 23 agreement last?
 24 MR. GULLIVER:
 25 A. I can't tell you exactly why it didn't last.

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1 It started off at the Health Sciences where--
 2 and I think Mary did up, and I can remember
 3 asking her, did up like this here, got a
 4 logbook and drew the lines and paper and put
 5 it in a reporting room for the pathologist for
 6 this was to document that I'm the pathologist
 7 on today and I'm going to read the IHC
 8 controls and verify them, then the slides go
 9 out. That lasted for awhile. And it was just
 10 like they just didn't fill it out any more.
 11 CHAYTOR, Q.C.:
 12 Q. And so was this for all the IHC controls or is
 13 this just ER and PR that this -
 14 MR. GULLIVER:
 15 A. No, for all controls.
 16 CHAYTOR, Q.C.:
 17 Q. This was for all IHC controls?
 18 MR. GULLIVER:
 19 A. For my knowledge, yes, all controls.
 20 CHAYTOR, Q.C.:
 21 Q. So not only ER/PR, any antibody that was
 22 requested, they wanted a separate -
 23 MR. GULLIVER:
 24 A. From the IHC lab, yeah.
 25 CHAYTOR, Q.C.:

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1 Q. For anything from the IHC lab, they wanted a
 2 separate control. So it wasn't anything
 3 unique to ER/PR?
 4 MR. GULLIVER:
 5 A. No, no, no. If we had five antibodies
 6 requested on a patient case from St. Clare's
 7 and the same five from the Grace and the same
 8 five from Health Sciences, you're talking
 9 about running 15 controls and 15 patient
 10 slides. You know what I mean, it was some
 11 days you probably ran as many controls or more
 12 than you did patient slides, because of
 13 multiple pathologists requesting the same, the
 14 same antibody.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. And in terms of you said there were a
 17 couple of things, cost was one concern in your
 18 mind, but the other thing being, you know,
 19 who's going to be responsible and document
 20 that the controls were, in fact, run and read,
 21 and were appropriate. I take it you were
 22 expecting that the pathologist assigned
 23 responsibility would, in fact, document that,
 24 would -
 25 MR. GULLIVER:

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1 A. I would assume, yes.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. And what you had in mind in terms of
 4 documentation was this logbook that you asked
 5 Ms. Butler to create?
 6 MR. GULLIVER:
 7 A. (No audible response).
 8 CHAYTOR, Q.C.:
 9 Q. Okay. Would there be any kind of electronic
 10 recording of the fact that controls have been
 11 read, ran, read, and appropriate?
 12 MR. GULLIVER:
 13 A. No electronic documentation of the control,
 14 that they read a control. From a lab
 15 perspective, though, when a procedure was
 16 requested by the pathologist a lot of our
 17 procedures in the routine pathology lab,
 18 histochemical staining and then the
 19 immunohistochemical staining had control
 20 slides. And I guess, you know, I've said
 21 earlier, in pathology what we call our record
 22 is the hard copy. You know, we keep the
 23 slides, we keep the blocks, and we keep them
 24 for 20 years. The electronic side of it, in
 25 Meditech when a procedure was ordered, if that

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1 procedure required a external positive
 2 control, the technologist would order a
 3 control and when it was completed, they would
 4 go into Meditech and they would go in and
 5 capture, really it was being done from a
 6 workload perspective. They would go into the
 7 Meditech system and they would say that today
 8 in our pathology lab we did an auramine
 9 control, a masdon control (phonetic) and we
 10 did ten peroxidase controls. And it was more
 11 documenting that we did them and captured the
 12 workload measurement for it, really, as
 13 opposed to documenting that we did this
 14 control today for this patient.
 15 CHAYTOR, Q.C.:
 16 Q. Yes. And, Mr. Gulliver, I think there was a
 17 volume of documents that we received this week
 18 when we -
 19 MR. GULLIVER:
 20 A. Just Tuesday, yeah.
 21 CHAYTOR, Q.C.:
 22 Q. That's just in the last couple of days on
 23 that.
 24 MR. GULLIVER:
 25 A. Yeah.

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1 CHAYTOR, Q.C.:

2 Q. And I must confess, I haven't looked at all, I

3 don't know, 200 pages or whatever is there,

4 but what I did go through, there wasn't really

5 any record kept. There was one I found where

6 it said that there was a control run, but

7 there was no consistent reference to whether

8 or not there's controls or not. Like, that,

9 am I wrong in saying that, have you had a

10 chance to look through it in any greater

11 detail and satisfy yourself that that is, in

12 fact, the electronic record of controls that

13 were run?

14 MR. GULLIVER:

15 A. On those sheets that you see, everything you

16 see there is actual controls that were run and

17 completed.

18 CHAYTOR, Q.C.:

19 Q. Yes.

20 MR. GULLIVER:

21 A. What's not on those sheets that we didn't put

22 in there was saying the control was verified

23 that it worked.

24 CHAYTOR, Q.C.:

25 Q. Yes.

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1 MR. GULLIVER:

2 A. You know, that's the next level of

3 documentation.

4 CHAYTOR, Q.C.:

5 Q. And does it tell you controls for what?

6 MR. GULLIVER:

7 A. The test procedure names are there.

8 CHAYTOR, Q.C.:

9 Q. Yes.

10 MR. GULLIVER:

11 A. You mean for IHC or for pathology in general?

12 CHAYTOR, Q.C.:

13 Q. Yeah, well, when I was looking at it, I mean,

14 you tell me what you saw in it because when

15 I'm looking at it -

16 MR. GULLIVER:

17 A. Okay, so -

18 CHAYTOR, Q.C.:

19 Q. - it'll say immunoperoxidase test.

20 MR. GULLIVER:

21 A. Exactly, okay.

22 CHAYTOR, Q.C.:

23 Q. Right.

24 MR. GULLIVER:

25 A. So in pathology when the pathology Meditech

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1 system came in in 1987, by that time there

2 were many, many, many standard procedures that

3 had been well established in pathology. All

4 those procedures were put into the computer

5 system and each of them that required a known

6 positive external control to be run, we also

7 put in a procedure code for quality control

8 slide that was run. Now, IHC testing had

9 started to come on stream in the late '80s.

10 For IHC testing on the Meditech side you could

11 order an ER, a PR, an LCA, and EMA, most of

12 the antibodies we had a separate procedure

13 code for each individual antibody or a stain

14 that was run on a daily basis. On the quality

15 control side of the Meditech we just had a

16 basic QC and procedure code for IHC testing.

17 And you will see quality control, peroxidase

18 or quality control, immuno. And you may see

19 QC 15, QC 2 or QC 35. That doesn't tell you

20 the exact quality control slide that was run,

21 whether it was ER/PR or LCA, EMA or CD30 or

22 whatever it may be. On the histochemical

23 side, you will see a QC auramine QC gram, QC

24 GMS. Those procedures had a direct procedure

25 code and a direct QC procedure code. But I

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1 have to confess to you, we did all that work

2 and the technologists did it, they put all

3 that into the computer system, it really was

4 not done to document that we ran controls.

5 CHAYTOR, Q.C.:

6 Q. It was documented for their workload?

7 MR. GULLIVER:

8 A. It was done to document for the workload. You

9 know, I can't say--I can't sit here and say,

10 oh, yes, we documented those all those years,

11 but it is a certain level of documentation but

12 it certainly doesn't meet today's criteria.

13 CHAYTOR, Q.C.:

14 Q. And you can't look through that and tell us

15 what controls were run for which antibodies,

16 like, that's not a electronic or -

17 MR. GULLIVER:

18 A. No.

19 CHAYTOR, Q.C.:

20 Q. - any kind of documentation that would be able

21 to tell this Commission that controls were run

22 for ER/PR tests on the following days?

23 MR. GULLIVER:

24 A. Right.

25 CHAYTOR, Q.C.:

1 Q. You can't tell that?
 2 MR. GULLIVER:
 3 A. I can't tell you that except for if we pull
 4 the patients slides and the control slides
 5 that are filed, then we can actually produce
 6 the hard control slide.
 7 CHAYTOR, Q.C.:
 8 Q. So I just want to be clear. In terms of what
 9 that does show us or what you're saying that
 10 would show is that this was a record for
 11 documenting for workload purposes for the
 12 technologists, controls that they were running
 13 for whatever was being run on that particular
 14 day?
 15 MR. GULLIVER:
 16 A. Exactly.
 17 CHAYTOR, Q.C.:
 18 Q. And whatever was on that particular day, it's
 19 not a record of that in terms of what types of
 20 antibodies?
 21 MR. GULLIVER:
 22 A. No.
 23 CHAYTOR, Q.C.:
 24 Q. All right.
 25 THE COMMISSIONER:

1 A. Pretty well it, yeah.
 2 THE COMMISSIONER:
 3 Q. Okay. So we don't know whether that control
 4 might have related to which particular test
 5 you were running on that day, if there were--
 6 unless you knew that it happened to be a day
 7 in which you ran only one kind of test?
 8 MR. GULLIVER:
 9 A. Right, yeah.
 10 THE COMMISSIONER:
 11 Q. Then you could be reasonably assured that
 12 that's -
 13 MR. GULLIVER:
 14 A. That that control was with that test -
 15 THE COMMISSIONER:
 16 Q. - that's the control for that?
 17 MR. GULLIVER:
 18 A. Yeah.
 19 THE COMMISSIONER:
 20 Q. But otherwise you can't make that match?
 21 MR. GULLIVER:
 22 A. Not electronically, no.
 23 THE COMMISSIONER:
 24 Q. Other than going back into all of the files -
 25 MR. GULLIVER:

1 Q. So do I take from that that even on a
 2 particular run there might have been a number
 3 of--I mean, as I understand it, at least more
 4 recently you can run all kinds of different
 5 tests on the one machine as long as your
 6 machine knows what--on the one run of the
 7 machine as long as -
 8 MR. GULLIVER:
 9 A. Right, antibodies.
 10 THE COMMISSIONER:
 11 Q. - the machine is programmed to know precisely
 12 what it is it's required to do. So it's not
 13 like you've got to save up all your ER/PRs and
 14 only put ER/PR on the particular -
 15 MR. GULLIVER:
 16 A. Correct.
 17 THE COMMISSIONER:
 18 Q. - run on that particular day?
 19 MR. GULLIVER:
 20 A. Yeah.
 21 THE COMMISSIONER:
 22 Q. So do I take it that all we can learn from the
 23 material which has been provided is that there
 24 was a control on a particular day?
 25 MR. GULLIVER:

1 A. Exactly.
 2 THE COMMISSIONER:
 3 Q. - and seeing if you can find that elusive
 4 control slide which if more than one were done
 5 on the one day, I understand, might be filed
 6 with any one of the tests that were run on
 7 that one day?
 8 MR. GULLIVER:
 9 A. Exactly.
 10 THE COMMISSIONER:
 11 Q. Okay. Thank you.
 12 CHAYTOR, Q.C.:
 13 Q. And you had said earlier that ER/PRs were
 14 saved up and ran on Fridays?
 15 MR. GULLIVER:
 16 A. They were mostly done in batches, and mostly
 17 Fridays.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. So would most of the Fridays in that
 20 batch you would expect to be ER/PR tests? In
 21 that batch of documents, I mean, now.
 22 MR. GULLIVER:
 23 A. No, not necessarily.
 24 CHAYTOR, Q.C.:
 25 Q. Could be anything?

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1 MR. GULLIVER:
 2 A. Yeah. I mean, it could be other IHC tests
 3 that day too.
 4 CHAYTOR, Q.C.:
 5 Q. Yes. The logbook that at one point in time
 6 Ms. Butler kept -
 7 MR. GULLIVER:
 8 A. I think it was Mary who did it up, yeah.
 9 CHAYTOR, Q.C.:
 10 Q. Or whoever, and it was only for a brief period
 11 of time. Do you know if - when did you learn
 12 that that was no longer being kept?
 13 MR. GULLIVER:
 14 A. I don't know. I mean, I just know at some
 15 point we tried to facilitate for the
 16 pathologists to put sort of a paper record in
 17 place, that originally it was Dr. Sushil Parai
 18 who, I think, was going to read all the
 19 controls, I think he started that for a period
 20 of time, not long, not years, but maybe weeks
 21 or months, and then it was decided that the
 22 pathologist who was on surgicals assigned for
 23 that day in the reporting room, that they
 24 would read the controls. That happened for a
 25 while, and then it just stopped.

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1 CHAYTOR, Q.C.:
 2 Q. So were you concerned then when that happened,
 3 when you realized that there was no longer any
 4 real documentation of controls taking place?
 5 MR. GULLIVER:
 6 A. I can't say that I was overly concerned. I
 7 would be concerned if no one was reading the
 8 controls.
 9 CHAYTOR, Q.C.:
 10 Q. And what documentation did you have then to
 11 tell you that they were reading them?
 12 MR. GULLIVER:
 13 A. I guess the documentation is that they read
 14 the case, they interpreted it, and they signed
 15 the case out.
 16 CHAYTOR, Q.C.:
 17 Q. And was it the norm then that it would be
 18 referred to on the pathology report that, in
 19 fact, controls had been read?
 20 MR. GULLIVER:
 21 A. I don't know.
 22 CHAYTOR, Q.C.:
 23 Q. You went through all of those pathology
 24 reports at the end of the day -
 25 MR. GULLIVER:

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1 A. Oh, you're talking about ER/PR. I'm talking
 2 about every control that a pathologist has to
 3 read. It could be multiple controls.
 4 CHAYTOR, Q.C.:
 5 Q. Well, would you have any reason to believe
 6 that it would be any different for ER/PR than
 7 anything else?
 8 MR. GULLIVER:
 9 A. I'm not a pathologist, so I don't know how
 10 they would decide to document what they read
 11 on the slides.
 12 CHAYTOR, Q.C.:
 13 Q. You brought up in the meeting that you were
 14 concerned, or at some point during the
 15 discussion, of all the controls, and your main
 16 concern being two-fold; cost, and also that
 17 there be documented record of controls. So
 18 when you learned that there was no longer a
 19 documented record of controls, are you
 20 concerned, and did you talk about, well, what
 21 else can we do to make sure this is happening?
 22 MR. GULLIVER:
 23 A. You mean back in early 2000, or whenever they
 24 stopped documenting the controls?
 25 CHAYTOR, Q.C.:

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1 Q. Is that when it was?
 2 MR. GULLIVER:
 3 A. Yeah, I mean, it's - well, I was the pathology
 4 manager in 2001, and I clearly remember, you
 5 know, when I was still manager there, you
 6 know, talking about controls, talking to
 7 pathologists and site chiefs about, well, who
 8 is going to read the IHC controls. We tried
 9 the logbook, and I know I brought it back to
 10 people's attention that no one is filling the
 11 logbook out, and I think that's as much as I
 12 could do. You know, it's not - I'm not the
 13 one who's interpreting the slide, I'm not the
 14 one who's doing a report, I'm not the one
 15 who's signing my name to a report. So if you
 16 feel comfortable enough to read a control and
 17 know in your mind as pathologist that the
 18 control worked, and I'm going to read my
 19 patients, without writing it down, well,
 20 that's their decision to make.
 21 CHAYTOR, Q.C.:
 22 Q. So you didn't raise any concern after that in
 23 terms of the logbook not -
 24 MR. GULLIVER:
 25 A. Not that I remember, no.

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1 CHAYTOR, Q.C.:

2 Q. And suggest, well, maybe there's some other

3 way we can be doing this, or perhaps you need

4 to be making sure that you recorded somewhere,

5 pathologists, that these controls, in fact,

6 have been read?

7 MR. GULLIVER:

8 A. Not that I remember, no.

9 CHAYTOR, Q.C.:

10 Q. And now, Mr. Gulliver, you did go, and we'll

11 talk in some detail at some point about what

12 you did in reviewing all the pathology reports

13 for ER/PR in 2005 and beyond that time period,

14 but mostly 2005. So you would have read

15 through all of the pathology repots for ER and

16 PR, or certainly a significant number of them.

17 What did you see in terms of the trend for

18 pathologists recording controls, whether it's

19 external controls, internal controls? Did

20 most of the pathologists in your review refer

21 to controls in their pathology reports?

22 MR. GULLIVER:

23 A. Well, we're talking about approximately 3,000

24 reports, and, yes, I have - the amount of time

25 it took to read those and sort them, but to

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1 answer your question as best I can, I would

2 have to say that if I took the reports from

3 1997 when Dr. Khalifa and we had one person

4 interpreting and documenting, I think his

5 repots were excellent. You will find, and I

6 can't say in all the cases, you will find in

7 the vast majority of his reports that he

8 documents in the patient's report that the

9 positive control was positive, which is the

10 external technical control which we talked

11 about, and you will find many cases where he

12 says, "and the internal control worked fine".

13 CHAYTOR, Q.C.:

14 Q. Yes, and what about the other pathologists?

15 Dr. Khalifa, you happened to note, would have

16 referred to his controls?

17 MR. GULLIVER:

18 A. Yeah.

19 CHAYTOR, Q.C.:

20 Q. External and internal.

21 MR. GULLIVER:

22 A. I certainly seen - I certainly seen that level

23 of documentation on some reports. I would say

24 that it's probably not until maybe 2003 or

25 2004 that you kind of start to see that's the

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1 - like, if you read all of '97, you can see

2 the major trend is sort of a standard format

3 Dr. Khalifa used, you can see pretty well most

4 of the time mentioned the positive external

5 control and most of the time he mentions the

6 internal control for the patient, and if you

7 went through every year like that, I don't

8 think you'll find another year as sort of

9 standard as that until maybe 2004.

10 CHAYTOR, Q.C.:

11 Q. After Dr. Ejeckam -

12 MR. GULLIVER:

13 A. And I have to say it's probably after -

14 CHAYTOR, Q.C.:

15 Q. And after Dr. Ejeckam's memo?

16 MR. GULLIVER:

17 A. Yeah.

18 CHAYTOR, Q.C.:

19 Q. And then you start seeing more regularly

20 reference to controls in the pathology

21 reports?

22 MR. GULLIVER:

23 A. Yeah, you do.

24 CHAYTOR, Q.C.:

25 Q. And the interim period after Dr. Khalifa stops

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1 doing the centralized reporting for those

2 tests, until that period of time in 2004, most

3 of the reports would not refer to controls, is

4 that fair?

5 MR. GULLIVER:

6 A. No, I can't say most, Ms. Chaytor. I would

7 certainly - I would feel comfortable in saying

8 in that time frame if there were, I don't know

9 how many, I would say there's a fair number

10 where there is documentation in the patient's

11 report of the external control, even lesser

12 for internal control, and maybe 25 percent

13 would be my estimate of, you know, that time

14 frame, or less than 25 percent.

15 CHAYTOR, Q.C.:

16 Q. Referring to controls?

17 MR. GULLIVER:

18 A. Where it's documented in the patient's

19 reports, yes.

20 CHAYTOR, Q.C.:

21 Q. So less than 25 percent referring to controls

22 in the patient's report?

23 MR. GULLIVER:

24 A. That would be a good estimate, I think.

25 CHAYTOR, Q.C.:

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1 Q. So when I said "most" didn't refer to controls
 2 -
 3 MR. GULLIVER:
 4 A. Yeah, you said most -
 5 CHAYTOR, Q.C.:
 6 Q. Seventy-five percent is most -
 7 MR. GULLIVER:
 8 A. Yeah, and again I could not be 100 percent
 9 correct. I could be 50/50, but you're right,
 10 there was a significant number that doesn't
 11 mention either internal controls or external
 12 controls.
 13 CHAYTOR, Q.C.:
 14 Q. If we could then, please, have P-1874. This
 15 is another meeting of the Division of
 16 Anatomical Pathology, site chiefs and
 17 divisional managers, of the Health Care
 18 Corporation, February 22nd, 2001, and Dr.
 19 Parai is the chair, Dr. Haegert, Dr. Cook,
 20 yourself, and Mr. Murphy, and if we look at
 21 page three under 4.2, "Quality control of
 22 immunoperoxidase staining. There has been a
 23 study going on. The quality of the
 24 immunoperoxidase staining for both sites, it
 25 is agreed that controls for immunoperoxidase

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1 staining be run for every batch. The
 2 pathologist will check the control slide
 3 before sending the slide to the other site.
 4 Dr. S. Parai has agreed to do this. In case
 5 he is not available, another pathologist will
 6 be looking at the controls". What was the
 7 study going as to the quality of the
 8 immunoperoxidase staining for the two sites?
 9 MR. GULLIVER:
 10 A. I really do believe whoever typed the minutes
 11 for this meeting - that certainly is not what
 12 was discussed. I think at most of these
 13 meetings that I was involved with - because
 14 this was our site chiefs meeting, it wasn't
 15 just the pathologists only meeting. Most of
 16 this here had to do with the pathologists at
 17 St. Clare's expressing concern over the
 18 turnaround times, and sometimes the delays in
 19 getting slides back from the Health Sciences
 20 for IHC testing, and there was never any
 21 study, to my knowledge, of the quality of the
 22 IHC stains, it was all about the timing and
 23 how long it took sometimes to get slides back.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. Now, Mr. Gulliver, at this point in

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1 time, you still haven't taken over your
 2 position as director. That happens later in
 3 2001, I understand?
 4 MR. GULLIVER:
 5 A. That happens later, yes.
 6 CHAYTOR, Q.C.:
 7 Q. So you're still the manager for pathology for
 8 the two sites, the Janeway and the Health
 9 Science. Well, I guess it's all into the one
 10 lab at that point in time.
 11 MR. GULLIVER:
 12 A. Yeah, by this time it's only St. Clare's,
 13 Health Sciences operating with pathology labs
 14 now.
 15 CHAYTOR, Q.C.:
 16 Q. So the Grace is also closed at this point in
 17 time?
 18 MR. GULLIVER:
 19 A. Yes, yeah.
 20 CHAYTOR, Q.C.:
 21 Q. And Dr. Parai has taken over - he's chairman,
 22 so he is now, I take it -
 23 MR. GULLIVER:
 24 A. No, he's site chief.
 25 CHAYTOR, Q.C.:

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1 Q. He's site chief at the Health Sciences.
 2 MR. GULLIVER:
 3 A. For Health Sciences. This is just chair of
 4 this group, the committee, of the meeting.
 5 This is not chairman of the - Dr. Haegert is
 6 the chairman, clinical chief.
 7 CHAYTOR, Q.C.:
 8 Q. So Dr. Khalifa has moved on at this point in
 9 time?
 10 MR. GULLIVER:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. And what effect did that have on the IHC
 14 service, of Dr. Khalifa leaving?
 15 MR. GULLIVER:
 16 A. Well, I think that everyone who worked with
 17 Dr. Khalifa certainly respected his knowledge.
 18 I think everyone really appreciated the time
 19 he took to help our technologist staff, and I
 20 really believe our pathologist staff also. I
 21 think Dr. Khalifa leaving - I was very upset.
 22 I mean, he was - I always thought he was
 23 excellent to deal with, we had a good
 24 relationship, and I always thought he was
 25 going to stay in St. John's and become our

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1 clinical chief some day. I think Dr. Khalifa
 2 leaving really did leave a vacuum in the
 3 laboratory, and, you know, I think it did have
 4 a fairly significant impact on our pathology
 5 lab.
 6 CHAYTOR, Q.C.:
 7 Q. And in terms of the role that he filled that
 8 you described earlier today in terms of his
 9 interaction with technologists, did anyone
 10 else take up that role and provide that kind
 11 of guidance to the technologists doing IHC?
 12 MR. GULLIVER:
 13 A. Well, I mentioned earlier, when we started
 14 earlier, I mean, ten years before this,
 15 fifteen years by this time, Dr. Chittal, which
 16 was a staff pathologist, you know, we all got
 17 along famously with Dr. Chittal, he was an
 18 excellent person to deal with. He had
 19 expressed interest in IHC over the years, but
 20 again even Dr. Chittal, himself, you know, he
 21 would go on extended sabbaticals to France for
 22 a year and he wouldn't be available in the
 23 lab, and when he'd come back, he'd be doing
 24 research work, so it's - if he was around, the
 25 staff would still go to him, but he was not

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1 around also to be there as a constant source
 2 of guidance or a constant source of
 3 information.
 4 CHAYTOR, Q.C.:
 5 Q. So it's fair to say the vacuum that you're
 6 talking about included the loss of that kind
 7 of constant resource to the technologists?
 8 MR. GULLIVER:
 9 A. I feel so, yes.
 10 CHAYTOR, Q.C.:
 11 Q. And when, if ever, is that filled again?
 12 MR. GULLIVER:
 13 A. You mean for IHC, in particular?
 14 CHAYTOR, Q.C.:
 15 Q. Yes.
 16 MR. GULLIVER:
 17 A. I have to be honest, I don't think we've seen
 18 another pathologist who expressed, you know,
 19 that level of interest until Dr. Ejeckam comes
 20 back to work in St. John's at the Health
 21 Sciences, and after - I think maybe after
 22 three or four months where he's back on staff
 23 - well, he was at the Grace before - before
 24 the Grace closed. I have to say, I mean, that
 25 was the next significant time where we had a

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1 pathologist who had the interest in IHC and
 2 wanted to spend the time in the lab and look
 3 at things.
 4 CHAYTOR, Q.C.:
 5 Q. And that's 2002, I take it?
 6 MR. GULLIVER:
 7 A. I have to say it was probably not until 2003.
 8 He was back at work, and he didn't immediately
 9 jump in and say I want to get into the IHC
 10 lab, but -
 11 CHAYTOR, Q.C.:
 12 Q. So it's the spring of 2003 then, in that time
 13 period?
 14 MR. GULLIVER:
 15 A. Or maybe the winter, you know, something like
 16 that.
 17 CHAYTOR, Q.C.:
 18 Q. Where we see his memos coming in April?
 19 MR. GULLIVER:
 20 A. Yeah, yeah.
 21 THE COMMISSIONER:
 22 Q. Ms. Chaytor, wherever you can find a spot for
 23 the afternoon break?
 24 CHAYTOR, Q.C.:
 25 Q. Okay, so in the interim then from when Dr.

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1 Khalifa left in 1999, I understand, until then
 2 the winter of 2003 when Dr. Ejeckam gets
 3 involved, who would the technologist--who
 4 would assist the technologist, for example in
 5 choosing appropriate specimens to use as
 6 external controls?
 7 MR. GULLIVER:
 8 A. It could be a multiple of pathologists, you
 9 know, and I have to say this too, I mean,
 10 you're alluding that when Dr. Khalifa left, I
 11 think he left a vacuum on both sides of our
 12 laboratory, both the technical side and our
 13 clinical side. And I think during that
 14 timeframe, whoever Mary and Peggy could go
 15 speak to and say we need to verify this
 16 control, they would have run some samples and
 17 they'd bring it to a pathologist and say,
 18 look, how does this control look like compared
 19 to the last one? I mean, that's the way
 20 things went on during that timeframe.
 21 CHAYTOR, Q.C.:
 22 Q. And what if they need to validate a new lot
 23 number of an antibody or a brand new antibody?
 24 MR. GULLIVER:
 25 A. I think they would do the same process. The

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1 brand new antibodies was also something that
 2 it was really, it was by pathologists, you
 3 know, if our neuro pathologist came across a
 4 new antibody that could be used for some kind
 5 of neuro pathology investigation, they would
 6 come and ask can we buy it and we'd buy it, if
 7 it was available from DAKO we'd get it and
 8 purchase it and they would ask the staff to do
 9 a few controls or a few runs or they'd supply
 10 the control and the staff person would go back
 11 to that particular pathologist and get their
 12 opinion. If they said it was okay, well
 13 that's what they did. And it could be a
 14 different pathologist who brought a different
 15 antibody in maybe for skin lesions. It could
 16 have been a different pathologist who came in
 17 for something for gastric or for lung cancers.

18 CHAYTOR, Q.C.:

19 Q. So in terms of, and I hear what you're saying
 20 about on the clinical side as well, and maybe
 21 I'll take that up with you later, but in terms
 22 of for the technologists, the void that was
 23 left with Dr. Khalifa leaving, in terms of the
 24 go-to person who could give them that kind of
 25 assistance or guidance in looking at those

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1 things, did you take that up with anyone else?
 2 Did you go to the clinical chief or anyone
 3 else and raise the fact that you thought it
 4 would be prudent to have a pathologist
 5 assigned to that role to give guidance and
 6 direction to the technologists?

7 MR. GULLIVER:

8 A. I don't think I ever did because, I mean, our
 9 clinical chief knew the role Dr. Khalifa had
 10 played, our site chiefs knew the role Dr.
 11 Khalifa had played and he just left. And
 12 there was no discussion or meeting where who
 13 is going to replace Dr. Khalifa? We replaced
 14 Dr. Khalifa with a site chief, but there was
 15 no discussion of who is going to perform the
 16 duties that Dr. Khalifa was performing?

17 CHAYTOR, Q.C.:

18 Q. And even though as we see here on Exhibit P-
 19 1874, you meet on a regular basis.

20 MR. GULLIVER:

21 A. We tried to.

22 CHAYTOR, Q.C.:

23 Q. But that never came up?

24 MR. GULLIVER:

25 A. That specific question that you're asking -

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1 CHAYTOR, Q.C.:

2 Q. Who is going to provide guidance or direction
 3 on IHC which is expanding at a fairly rapid
 4 pace, who is going to provide that guidance?

5 MR. GULLIVER:

6 A. I don't remember having a discussion with this
 7 group, with Dr. Haegert or Dr. Parai, Dr. Cook
 8 about that. I mean, that was really at the
 9 clinical level.

10 CHAYTOR, Q.C.:

11 Q. Thank you, Commissioner, this is a good place.

12 THE COMMISSIONER:

13 Q. All right, we'll take the afternoon break.

14 (RECESS)

15 THE COMMISSIONER:

16 Q. Please be seated. Ms. Chaytor.

17 CHAYTOR, Q.C.:

18 Q. Thank you, Commissioner. Okay, Mr. Gulliver,
 19 perhaps then we can pick up with Dr. Ejeckam
 20 arriving into the winter of 2003 and he takes
 21 an interest in the IHC components of the lab.
 22 By that time, of course, you would have been
 23 in your director's position for -

24 MR. GULLIVER:

25 A. About two years.

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1 CHAYTOR, Q.C.:

2 Q. A couple of years, okay. And if we could just
 3 look at, please, P-0900? And this document is
 4 a document to "All staff, physicians and
 5 volunteers" from George Tilley, executive
 6 director, officer, appointment of director of
 7 Laboratory Medicine Program, Wednesday,
 8 October 10th, 2001. "I am pleased to advise
 9 you that Terry Gulliver has been appointed as
 10 program director of Laboratory Medicine.
 11 Terry has over 20 years experience within the
 12 Health Care Corporation and has served in
 13 management positions over the last 15 years."
 14 And it indicates that you're replacing Mr.
 15 Whelan. So I take it that as of October 10th,
 16 2001, you are officially in your position.
 17 And that continued on then, you continued to
 18 be the director into Eastern Health time
 19 period as well, and we'll get to that later.
 20 But as of this point in time then, you are now
 21 the director and is that for, that's then, I
 22 take it, for all of the Health Care
 23 Corporation, all the hospitals within the
 24 Health Care Corporation?

25 MR. GULLIVER:

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1 A. All the laboratories, yes.
 2 CHAYTOR, Q.C.:
 3 Q. All the laboratories, yes. And after Dr.
 4 Ejeckam arrived and took an interest in IHC,
 5 was that something that Dr. Ejeckam approached
 6 you about as the program director or discussed
 7 with you?
 8 MR. GULLIVER:
 9 A. No.
 10 CHAYTOR, Q.C.:
 11 Q. And how did you then become aware that he had
 12 a particular interest?
 13 MR. GULLIVER:
 14 A. I'm pretty sure it was through--I'm in the
 15 same building as Dr. Ejeckam, you know, my
 16 pathology manger is there and the staff, Dr.
 17 Cook. I just think through general consensus,
 18 I think people sensed that he was interested
 19 in IHC, but I think it was pretty well Dr.
 20 Cook who more or less said to me that Dr.
 21 Ejeckam is interested in the IHC part of the
 22 pathology lab.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and by that point in time then, Dr. Cook
 25 would have been the clinical chief?

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1 MR. GULLIVER:
 2 A. He's clinical chief, yes.
 3 CHAYTOR, Q.C.:
 4 Q. And after he arrived, after Dr. Ejeckam has
 5 taken on that interest, did you hear any
 6 complaints from the technologists in terms of
 7 any conflicting instructions they were
 8 continuing to receive with respect to IHC?
 9 MR. GULLIVER:
 10 A. Well see when Dr. Ejeckam arrived and I'm sure
 11 that we're going to see his memos of '03 and
 12 stuff, it's certainly after that before Dr.
 13 Ejeckam is officially appointed as director of
 14 IHC lab.
 15 CHAYTOR, Q.C.:
 16 Q. I think that doesn't happen until in fact
 17 after the 2005 incident that there's anything
 18 official.
 19 MR. GULLIVER:
 20 A. Yeah, I'm saying yeah, it goes on for a period
 21 of time. See, even though--I don't know the
 22 word I'm looking for, even though we all kind
 23 of know Dr. Ejeckam is the one that's sort of
 24 dealing with any issues in IHC and is doing
 25 that work, it has not been made official and I

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1 still think there were still, you know, a
 2 significant amount of times where--and it
 3 wouldn't be the technologist staff come to me
 4 directly, Ms. Chaytor, would be coming up
 5 through, you know, their line manager, you
 6 know, I've got all the divisions and division
 7 managers and chiefs who I am working with, but
 8 I still know there were significant amounts of
 9 times where they were still, you know,
 10 pathologist "A" was going directly to the
 11 staff and saying I'd like to have this new
 12 antibody in place, could you do this. Someone
 13 else was coming over and say, well, I'd like
 14 to get this done and this protocol done. Even
 15 though Dr. Ejeckam was there, there still was
 16 no real firm directive or co-ordination that
 17 any issues, concerns that pathologists had or
 18 technologists had, that he really was the
 19 point person that should deal with those.
 20 CHAYTOR, Q.C.:
 21 Q. And you think that's because there was
 22 nothing--he wasn't formally appointed or no
 23 memo went out as we see in 2005 advising the
 24 other pathologists of Dr. Ejeckam's role?
 25 MR. GULLIVER:

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1 A. That's my belief, yes.
 2 CHAYTOR, Q.C.:
 3 Q. Did you take that up with anyone? Did you go
 4 to Dr. Cook and say, you know, that this is
 5 happening and different pathologists are still
 6 coming at the technologists from different
 7 angles and with different requests?
 8 MR. GULLIVER:
 9 A. I didn't personally, no, but I'm well aware
 10 that the manager would have done that.
 11 CHAYTOR, Q.C.:
 12 Q. Do you recall were there any meetings or
 13 discussions to try and standardize grossing
 14 techniques and the reporting and in particular
 15 with respect to anything to do with IHC?
 16 MR. GULLIVER:
 17 A. Yes, there were discussions ongoing, you know,
 18 probably around this timeframe where, I know
 19 that manager Barry Dyer, one of his goals was
 20 to try to standardize the grossing practices
 21 and in particular, standardize the descriptive
 22 part of grossing, sort of like a canned text
 23 where you could actually put that stuff into
 24 the Meditech system so it would make it more
 25 efficient, make it easier on the secretaries

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1 and stenosis who are typing a dictation on all
 2 this gross description, but there was
 3 discussions by this time talking about
 4 standardizing grossing practices.
 5 CHAYTOR, Q.C.:
 6 Q. And what happened with that? Were any
 7 decisions made around that?
 8 MR. GULLIVER:
 9 A. I'm aware that Barry and I thought he was
 10 working with one of the pathologists, Mira
 11 Parai, looking at doing some of the
 12 standardized canned text for grossing. I do
 13 recall, though, that Dr. Cook asked--our
 14 pathologists would meet on a fairly regular
 15 basis, not every month. I remember at one
 16 pathologist meeting that he was having at the
 17 Health Sciences, he invited myself and Barry
 18 to attend that meeting and it was talking
 19 about standardizing some grossing practices
 20 and techniques. I'm not sure of the
 21 timeframe, Ms. Chaytor, I mean, it might have
 22 been 2004, it could have been late 2003.
 23 CHAYTOR, Q.C.:
 24 Q. And if we could have then, please, P-2539?
 25 And this is another meeting of a division of

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1 the anatomical pathology, this one is
 2 pathologists' meeting at the General Hospital
 3 site, April 24th, 2001. And if we look at
 4 page 3 of this document, under business
 5 arising, item 3.8 "Pathologist Assistants".
 6 There has been much discussion on this issue;
 7 however, Dr. Haegert will discuss with Dr.
 8 Williams in future; however, there is no money
 9 in the budget to fund this position. Dr. S.
 10 Parai will talk to Terry Gulliver exploring
 11 the possibility of training two senior
 12 technologists for doing additional grossing."
 13 What do you recall in this time period, Mr.
 14 Gulliver, about discussions regarding having
 15 senior technologists doing additional
 16 grossing?
 17 MR. GULLIVER:
 18 A. Well certainly I was the manager and I
 19 remember this very clearly, that our
 20 pathologists, at the time both sites were
 21 talking about their workloads. We have heard
 22 that well documented through this inquiry.
 23 We've had a huge turnover in our pathologist
 24 staff over the years and there were times
 25 where we didn't even have one resident in

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1 training for to become a pathologist. And as
 2 a pathologist, a practising pathologist, one
 3 of your functions is to do the front-end part
 4 of tissue fixation and grossing. It's a very
 5 time consuming part of their job; however,
 6 it's a very critical part of their job. And
 7 pathology residents, that would be one of the
 8 functions that they will be trained to do to
 9 assist the pathologists with their workload,
 10 along with training for autopsy work. And
 11 during this time period, we had some
 12 discussions about if we could take a part of
 13 the grossing function and take it away from
 14 the pathologist and help with their workload,
 15 at times we had no residents and to see if we
 16 could actually assign that function to some of
 17 our senior technologists in the laboratory.
 18 By senior, I mean someone who has got a lot of
 19 pathology experience, not necessarily
 20 seniority as in a union perspective, but
 21 pathology experience. But the grossing we're
 22 talking about here, Ms. Chaytor, is not
 23 actually grossing and dissecting and cutting
 24 any large specimens or cancer specimens. In a
 25 run of a day in our pathology lab, you know,

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1 sometimes 30, 40, 50 percent of the specimens
 2 do not require an actual surgical dissection.
 3 It's more the specimen comes in from the
 4 operating room or from daycare somewhere, has
 5 more of actually taking the specimen from the
 6 bottle and dictating to a microphone and a
 7 tape that I have a specimen on, you know, Mr.
 8 Terry Gulliver, MCP number, the type of
 9 specimen it is and you open it up, you make a
 10 cassette that you've seen the block or
 11 cassette and you place the tissue directly
 12 into the cassette and there's no more function
 13 than that. And that's time consuming. So it
 14 was more of taking that workload away from the
 15 pathologist and we could give it to our senior
 16 technologists.
 17 CHAYTOR, Q.C.:
 18 Q. And if we could look, please, at P-2540 and
 19 it's page 3 then of this document and you can
 20 see this is another meeting, Division of
 21 Anatomical Pathologist meeting at the General
 22 Hospital site, June 14th, 2001. And at page 3
 23 we see under "business arising" the same
 24 topic, 3.4, "Pathologist Assistant. Much
 25 discussion on this issue. It is unlikely that

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1 the corporation will fund for pathologist
 2 assistant; however, we have three senior
 3 technologists who will be willing to do
 4 additional grossing if their jobs are
 5 reclassified to technologist III level. It is
 6 expected that we will know this information
 7 very soon. There have been some errors
 8 recently in specimen labelling and handling.
 9 Dr. S. Parai will discuss with Terry Gulliver
 10 about this problem." So at this point in them
 11 then, by June of 2001, did that happen, were
 12 these three senior technologists reassigned or
 13 reclassified as being technologists III?
 14 MR. GULLIVER:
 15 A. They weren't reclassified, coincidentally
 16 through all this timeframe and I think it was
 17 October 2000 we had an illegal strike by our
 18 lab and x-ray staff in this province. It was
 19 over an issue of government had offered and
 20 performed an occupation review of other
 21 professions in the health care system and they
 22 did not extend that to the medical lab
 23 technologists or diagnostic imaging
 24 technologists and that caused an illegal
 25 walkout from the staff. Pursuant to that, all

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1 the medical lab staff went under an occupation
 2 review and these staff positions were kind of
 3 classified through that process,
 4 coincidentally. But the actual start of this
 5 function here now, Ms. Chaytor, there's two
 6 differences here because we're talking about
 7 pathology assistants and we're talking about
 8 technologists being skilled up to do the basic
 9 non dissecting specimens. In the advent that
 10 we don't have pathologist assistants and
 11 pathologist assistants, as you know today we
 12 have them, is someone who actually can do
 13 almost all the full grossing function that a
 14 pathologist would normally perform. So since
 15 we didn't have money for, to make new
 16 positions for PAs, the next best scenario was,
 17 well could we at least take some of this
 18 workload away from the pathologists or really
 19 the non-dissecting stuff and give it to our
 20 technologists to do. And that's what we
 21 started to do.
 22 CHAYTOR, Q.C.:
 23 Q. So without creating PA positions at the pay
 24 level, I would take it of a PA, you were able
 25 to move technologists in to take over some of

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1 that workload?
 2 MR. GULLIVER:
 3 A. Right.
 4 CHAYTOR, Q.C.:
 5 Q. And in essence though, would they be
 6 performing the job of PAs?
 7 MR. GULLIVER:
 8 A. Not even close, no.
 9 CHAYTOR, Q.C.:
 10 Q. So they were just doing some of the grossing,
 11 but -
 12 MR. GULLIVER:
 13 A. Dictation really and physically taking a
 14 specimen from the bottle with formalin in it
 15 and just placing that specimen into a cassette
 16 and closing the cover on the cassette. There
 17 was no dissection involved.
 18 CHAYTOR, Q.C.:
 19 Q. Was there any--did anyone go looking for the
 20 funding at this point in time in 2001 for
 21 those positions?
 22 MR. GULLIVER:
 23 A. For pathologist assistants?
 24 CHAYTOR, Q.C.:
 25 Q. Yes.

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1 MR. GULLIVER:
 2 A. That was certainly requested over multiple
 3 years, you know, back in 2000--this is 2001, I
 4 take it, isn't it?
 5 CHAYTOR, Q.C.:
 6 Q. 2001, June of 2001.
 7 MR. GULLIVER:
 8 A. And, you know, certainly in 2000 and this time
 9 2001 through various avenues, this request had
 10 gone up the line, we had the support from Dr.
 11 Robb at the time who was our university chair,
 12 certainly support from me, as the manager, you
 13 know, it was something--and keep in mind this
 14 is through a time period where we've gone
 15 through major downsizing and cutbacks. And,
 16 you know, really still continue to or we
 17 haven't even balanced the budget yet within
 18 the lab program, and I think generally in the
 19 health care system, you know, trying to get
 20 resources for new staff was one of the most
 21 difficult things you could do. I don't think
 22 it was, laboratory was no different than other
 23 parts of the system, in my belief, that all
 24 kinds of parts of the system were crying out
 25 for new staff and additional resources. It

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1 just wasn't forthcoming.

2 CHAYTOR, Q.C.:

3 Q. So this would be put forward in the budget

4 each year, but it would never be approved?

5 MR. GULLIVER:

6 A. It's a combination, sometimes it would go

7 through, you could go through the budget;

8 other times you could do a direct request to

9 your VP and have the VP advocate on your

10 program's behalf to executive and to the

11 finance people.

12 CHAYTOR, Q.C.:

13 Q. And that happened for pathologist assistants?

14 MR. GULLIVER:

15 A. Yes, it did.

16 CHAYTOR, Q.C.:

17 Q. And all of that, whatever was done in terms of

18 requests through whatever mechanism, it was

19 always turned down?

20 MR. GULLIVER:

21 A. I can't say it was turned down, no one ever

22 told me directly you're not getting money for

23 pathology assistants. What came back was

24 here's what funding is approved for and that

25 was not one of them.

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1 CHAYTOR, Q.C.:

2 Q. And so isn't that the same as it -

3 MR. GULLIVER:

4 A. I guess it's the same outcome.

5 CHAYTOR, Q.C.:

6 Q. If it's not on the list of what's approved -

7 MR. GULLIVER:

8 A. It's the same outcome, but no one ever told me

9 directly, no, you can't have money for

10 pathology assistants.

11 CHAYTOR, Q.C.:

12 Q. But you never received it?

13 MR. GULLIVER:

14 A. But never received it, no.

15 CHAYTOR, Q.C.:

16 Q. And who, Mr. Gulliver, made those decisions?

17 Who would send back the list of what had been

18 approved and the list not containing funding

19 for pathologist assistants?

20 MR. GULLIVER:

21 A. I really can't answer that question completely

22 because the budgeting process, I mean -

23 CHAYTOR, Q.C.:

24 Q. Well what would you get back and who would it

25 be communicated to you through?

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1 MR. GULLIVER:

2 A. What we would do, and as a matter of fact,

3 this Sunday I have to work to put my budget in

4 for next year, to start the process. It

5 starts six months ahead, our fiscal year is

6 ending, we're starting our budget process. So

7 the budget process would work, you work within

8 your team, you submit items that you feel are

9 inflationary or unavoidable costs on your

10 budget. You submit items for new tests, new

11 procedures that you have to implement or

12 people are asking to do. You submit requests

13 for service agreements and contracts and

14 equipment that will increase your budget cost.

15 You submit requests for additional or new

16 staff in through that process. You meet with

17 senior finance people in executive within the

18 Health Care Corporation at the time. They

19 then meet with the Department of Health

20 officials to go over the health care

21 submission budget and at some point, six

22 months or eight months later, usually four

23 months after your year begins, you finally

24 hear something back and say, and here's what

25 is approved for your budget submission.

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1 CHAYTOR, Q.C.:

2 Q. Yes, and who do you hear that back from?

3 MR. GULLIVER:

4 A. Well it comes back through our finance

5 department.

6 CHAYTOR, Q.C.:

7 Q. Okay.

8 MR. GULLIVER:

9 A. Through our finance people.

10 CHAYTOR, Q.C.:

11 Q. And where it gets cut along the way -

12 MR. GULLIVER:

13 A. I don't know.

14 CHAYTOR, Q.C.:

15 Q. You don't know. So have you ever asked that?

16 Have you ever asked, well did it ever get put

17 forward and proposed to government, for

18 example?

19 MR. GULLIVER:

20 A. I've never asked that question.

21 CHAYTOR, Q.C.:

22 Q. So you don't know if it was done at senior -

23 MR. GULLIVER:

24 A. But lately, I know this is back in--but now

25 when we do our budget submissions, there's a

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1 point where now the program leadership teams,
 2 we actually meet with, in conjunction with our
 3 finance people, there is a government
 4 representative at the table, so you can kind
 5 of speak directly to government officials.
 6 And this has happened the last couple of years
 7 now.
 8 CHAYTOR, Q.C.:
 9 Q. That's a new process.
 10 MR. GULLIVER:
 11 A. Yeah.
 12 CHAYTOR, Q.C.:
 13 Q. So back in the days when pathologist
 14 assistants--the funding for that is being
 15 requested and turned down, at what level that
 16 decision is made, you don't know.
 17 MR. GULLIVER:
 18 A. I don't know.
 19 CHAYTOR, Q.C.:
 20 Q. The lab program was looking for it and it was
 21 always turned down.
 22 MR. GULLIVER:
 23 A. Yeah.
 24 CHAYTOR, Q.C.:
 25 Q. But who made that decision, whether it was

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1 within your own organization or beyond, you're
 2 not able to say?
 3 MR. GULLIVER:
 4 A. I can't say, no.
 5 CHAYTOR, Q.C.:
 6 Q. And you've never asked that question?
 7 THE COMMISSIONER:
 8 Q. You know, what--as I understand it, there's an
 9 opportunity for the organization seeking
 10 funding to indicate priorities when they're
 11 looking to government for funding. Do you
 12 have any knowledge of what priority, for
 13 example, pathologist assistants might have
 14 been given by your organization?
 15 MR. GULLIVER:
 16 A. At that time, Justice Cameron, the budgeting
 17 process didn't ask to identify priorities
 18 within the program. You know, the
 19 organization may have presented priorities to
 20 government, but right now, for example, as I
 21 said, Sunday we're working we do my budget.
 22 We have, within the programs we're now asked
 23 to identify within your program if these are
 24 your requests, what are the priorities within
 25 your program? Rank them one, two, three,

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1 four, five. That's the process that we do
 2 follow now, but we didn't follow that, like
 3 five, six years ago at that time.
 4 CHAYTOR, Q.C.:
 5 Q. So in the process then, back in those days,
 6 was there ever any opportunity for you to be
 7 able to make a submission and tell people,
 8 well here's what I think the negative effects
 9 will be if you don't approve certain aspects?
 10 MR. GULLIVER:
 11 A. There really wasn't, no.
 12 CHAYTOR, Q.C.:
 13 Q. And is there an opportunity for that kind of
 14 dialogue today?
 15 MR. GULLIVER:
 16 A. It is, I have to say it's much improved today.
 17 Again, having the ability to, once within
 18 Eastern Health, for example, now when we've
 19 kind of finalized our submission for a budget,
 20 we have to submit briefing notes on your
 21 priority request and then at some point we
 22 would get to meet with a government official
 23 from Finance or Department of Health, the
 24 financial side of it, and we can actually make
 25 our pitch directly to that person with our

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1 senior team there.
 2 CHAYTOR, Q.C.:
 3 Q. And did the pitch ever get made in terms of
 4 pathology assistants what they can do in terms
 5 of taking the workload off pathologists and
 6 also lead to the standardization of the
 7 grossing, the benefits to the quality of the
 8 product, plus the alleviation of the workload
 9 issue with the pathologists, did you ever have
 10 an opportunity to make that pitch?
 11 MR. GULLIVER:
 12 A. I certainly did, yes.
 13 CHAYTOR, Q.C.:
 14 Q. And who did you make the pitch to?
 15 MR. GULLIVER:
 16 A. And that pitch was not done really through the
 17 normal budgeting channels. That pitch was
 18 made directly to our VP.
 19 CHAYTOR, Q.C.:
 20 Q. And that would be Dr. Williams, I take it?
 21 MR. GULLIVER:
 22 A. Dr. Williams, yes, at the time. And we made
 23 to Dr. Williams and I know that Dr. Williams
 24 supported it, so I know it's not something
 25 that Dr. Williams did not, you know, bring

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1 forward to his counterparts.
 2 CHAYTOR, Q.C.:
 3 Q. So he took it forward to the best of your
 4 knowledge?
 5 MR. GULLIVER:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. And where it got lost or cut along the way
 9 after that, you're not able to say. Is there
 10 anything--do you keep in writing for now,
 11 today, would there be any written record of
 12 anything that gets put forward, in terms of
 13 warnings to the quality of lab services if
 14 certain items aren't in fact funded?
 15 MR. GULLIVER:
 16 A. It's our process now, when we started this,
 17 maybe one budget cycle or two, that yes, that
 18 in that process when you do your briefing
 19 notes, a part of that, that summary that goes
 20 in there is, for example, if it was the PAS
 21 now, if we're asking now, you know, which we
 22 have them, it would include why do you need
 23 PAS, how does it impact on your efficiencies
 24 in the program, how does it affect patient
 25 care in the program and what would be the sort

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1 of one time cost and ongoing cost to maintain
 2 this? So it is a fairly in-depth submission
 3 now that you go through.
 4 CHAYTOR, Q.C.:
 5 Q. And when was that started? That's the last
 6 couple of years, is it?
 7 MR. GULLIVER:
 8 A. I think this will be my third time, Ms.
 9 Chaytor, preparing, so maybe in the last
 10 couple of years it started. I think the
 11 budgeting process now within, you know, with
 12 this government, I mean and our Eastern
 13 Health, I think it's a much more better
 14 process than we had for years prior.
 15 CHAYTOR, Q.C.:
 16 Q. If we could have please, P-1876? And this is
 17 another meeting of site chiefs and divisional
 18 managers. And it's April 25th, 2001 and you
 19 will see that you are in attendance, along
 20 with Drs. Cook, Parai, Haegert, Mr. Murphy and
 21 perhaps others. And if we look at page three
 22 of this document, no, here it is on the first
 23 page, actually, under business arising,
 24 "Quality control of immunoperoxidase staining.
 25 Generally the immunos appear to be very good,

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1 there appears to be some problems with
 2 estrogen and progesterone receptors. The
 3 positive controls are checked daily by
 4 pathologists; however, these need to be
 5 documented. Dr. Parai will follow up on this.
 6 Note is also made of the heavy utilization of
 7 immunoservices and the high volumes
 8 encountered." Now this is April of '01, so
 9 Mr. Gulliver, you're still the pathology
 10 manager at this point. And what do you recall
 11 being discussed here? There's a couple of
 12 things and the first being the problems with
 13 the estrogen and progesterone receptors, what
 14 do you recall about that?
 15 MR. GULLIVER:
 16 A. I don't remember anything specific, Ms.
 17 Chaytor, into problems with ER/PR receptors,
 18 you know, who was taking the minutes of this
 19 meeting? Was it Dr. Cook? Well whoever was
 20 taking the minutes or writing this down, so
 21 whoever it is, they're saying that generally
 22 the immunos appear to be very good. I don't
 23 remember any discussion over what the problems
 24 were with the ER/PR at that particular
 25 meeting.

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1 CHAYTOR, Q.C.:
 2 Q. And your practice -
 3 MR. GULLIVER:
 4 A. I do remember the utilization piece, though.
 5 CHAYTOR, Q.C.:
 6 Q. Okay. Your practice--just a moment, then.
 7 The practice though in terms of who recorded
 8 the minutes, you don't know who normally would
 9 do that, whether--you don't know who would do
 10 it?
 11 MR. GULLIVER:
 12 A. It was never--it wasn't me that I remember.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. But this is the practice certainly
 15 would be then the minutes of the previous
 16 meeting would then be approved. You can see
 17 here the minutes of the previous meeting you,
 18 in fact, have seconded the approval. So I
 19 take it then that the minutes then get
 20 approved and if there's any error in the
 21 minutes, it would be brought up at the next
 22 meeting?
 23 MR. GULLIVER:
 24 A. Right, you go through that standard meeting
 25 protocol, yeah.

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1 CHAYTOR, Q.C.:

2 Q. Yes, right, okay. So you have no recollection

3 as to what would have been referred to here

4 about the problems with the ER/PR?

5 MR. GULLIVER:

6 A. I don't, I'm sorry, no.

7 CHAYTOR, Q.C.:

8 Q. Receptors?

9 MR. GULLIVER:

10 A. No.

11 CHAYTOR, Q.C.:

12 Q. And but you do recall what's being referred to

13 in terms of the heavy utilization?

14 MR. GULLIVER:

15 A. Utilization. And I recall it as being an

16 issue not specifically on February 22nd, 2001,

17 whatever that day is. Some of the issues we

18 used to talk about the heavy utilization of

19 immuno services was really in the proper

20 utilization of the immuno services. For

21 example, if you had a lymphoma case that

22 needed to be investigated, one pathologist may

23 order 20 antibodies, another one may order

24 three. One pathologist might order 20

25 antibodies and five blocks from the same case

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1 and someone else would have a different one.

2 So there was always the issues talking about

3 that in the over utilization of immuno

4 services. And I remember saying to our

5 pathologists that, you know, why is it that we

6 need to do, you know, 15 antibodies on the

7 same patient of three different blocks and

8 that was certainly recognized as being an

9 issue. And I know amongst the pathologist

10 group, that's something that they discussed.

11 CHAYTOR, Q.C.:

12 Q. Okay. And the issue, and we saw on another

13 meeting around this same time frame about

14 surveying. You don't recall anything about

15 that. So -

16 MR. GULLIVER:

17 A. The quality--yeah, no, nothing.

18 CHAYTOR, Q.C.:

19 Q. On quality of slides or anything like that?

20 MR. GULLIVER:

21 A. No. It was more about turn around, I'm sure

22 it was about turn around times, the length of

23 time it took to get slides back and forth from

24 Health Sciences to St. Clare's.

25 CHAYTOR, Q.C.:

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1 Q. And I may not be recalling this correctly, but

2 I thought that we heard evidence from one of

3 the pathologists, I thought it was Dr. Pari,

4 who discussed receiving feedback from quite a

5 number of pathologists in providing you

6 feedback about issues about the quality of

7 slides. Do you recall anything about that?

8 MR. GULLIVER:

9 A. For the quality of immuno slides, I don't, no.

10 CHAYTOR, Q.C.:

11 Q. Okay. And there's nothing else then, nothing

12 else that you have any recollection about the

13 ER/PR slides or overall in this time period

14 being involved in getting any feedback on

15 quality of immuno slides?

16 MR. GULLIVER:

17 A. I don't, no.

18 CHAYTOR, Q.C.:

19 Q. And if we could have, please, 1877? And this

20 is a meeting then of anatomical pathology, the

21 site chiefs, again, divisional managers.

22 1877. And it's now June 26th, 2001. And

23 present is Dr. Parai, Dr. Cook and Dr.

24 Haegert. You're not in attendance, nor is Mr.

25 Murphy. And it looks like the minutes of the

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1 previous meeting were adopted with some

2 changes in item seven of the new business. So

3 it appears that the minutes were adopted,

4 including the portion that I had brought you

5 to. And under "New Business" "Quality

6 assurance program for anatomical

7 pathology/pathologists review. This meeting

8 is dedicated for the above items" and the

9 following points are discussed. "System

10 review. This system review is not in place.

11 It will be discussed in the next meeting for

12 possible implementation of pathology report

13 review by system by a committee. Turn around

14 times, outstanding reports, canned text.

15 There is partial implementation for canned

16 text at the General Hospital site for ER/PR

17 and HER2/neu expression. It is important to

18 use standard specimen grossing and reporting.

19 Frozen section review, performance improvement

20 program."

21 MR. GULLIVER:

22 A. Do you mind stopping there, Ms. Chaytor?

23 CHAYTOR, Q.C.:

24 Q. Sure.

25 MR. GULLIVER:

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1 A. Again, we've mentioned earlier, this is where
 2 pathologists would talk about proficiency
 3 testing and performance review where the cases
 4 that they are involved in with the CAP and the
 5 ASCP check samples.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. "Quality control rounds.
 8 Intradepartmental round, interhospital rounds,
 9 intradepartmental consultation, external
 10 consultation." And what do you recall--and I
 11 realize you're not at this particular meeting,
 12 but what do you recall around this time period
 13 in terms of a new business being quality
 14 assurance program for anatomical pathology?
 15 MR. GULLIVER:
 16 A. Well, I think what you see there is the list.
 17 I think it was the pathologists as a group
 18 were looking at putting in some kind of
 19 documented quality assurance processes for the
 20 pathologists. Because, I mean, you look at
 21 the list of items they're talking about, the
 22 outstanding reports, the turn around time
 23 reports, their standardized canned text,
 24 frozen sections, the CAP, ASCP checks, I don't
 25 think they're talking about what we would see

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1 today, Ms. Chaytor, as a full quality
 2 assurance program today.
 3 CHAYTOR, Q.C.:
 4 Q. Um-hm.
 5 MR. GULLIVER:
 6 A. I think this is very focused on pathologists.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. And was there ever any discussion with
 9 you then in terms of looking at that fuller
 10 program which would include both sides of the
 11 program?
 12 MR. GULLIVER:
 13 A. Not back in, not back then. I think, you
 14 know, when I move on to the directors role and
 15 the new manager comes in, Mr. Dyer, I know
 16 early into his new position it's something
 17 that he and Dr. Parai were going to work
 18 towards.
 19 CHAYTOR, Q.C.:
 20 Q. Okay. And, Mr. Gulliver, then I'd like to
 21 move on and talk to you a little bit about the
 22 HAY report. And the Commissioner has heard
 23 some things about that. By the time the HAY
 24 report is filed, are you in your director's
 25 position at that point in time?

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1 MR. GULLIVER:
 2 A. Maybe a week. I was--I know I took over the
 3 position of director of the program for Health
 4 Care Corporation and I know I think that was
 5 pretty well my first big thing to hit was that
 6 the corporation was bringing in an external
 7 consultant who were going to review all parts
 8 of the health care system, including the
 9 laboratory. And, you know, that happened
 10 early on into my new position.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. And perhaps then you can tell the
 13 Commissioner whether or not you had any
 14 concerns coming out of the HAY report with
 15 respect to the laboratory medicine program
 16 and, if so, what those concerns were and what
 17 you did to try and have the concerns
 18 addressed?
 19 MR. GULLIVER:
 20 A. Well, the HAY review, actually, before the
 21 report, but the HAY reviewers who came in,
 22 they certainly met with all the directors and
 23 clinical directors and program directors. It
 24 actually had two components for different
 25 programs. If you were strictly an

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1 administrative program only, there was a group
 2 of people who reviewed your services looking
 3 for efficiencies. Within the lab medicine
 4 program we had both, you know, we have--and we
 5 referred to them back then like the bean
 6 counters, the non-lab people came in to assess
 7 your services and operations to see where you
 8 could find money. And then we had a
 9 pathologist who was a part of that group as a
 10 consultant to it, I guess, the HAY Group, who
 11 also came in and reviewed our lab services.
 12 And both of them kind of took--they mirrored
 13 each other but were different. The time I
 14 spent with the non-clinical people was pretty
 15 well focused only on volume and workload and
 16 productivity. And they were going to assess
 17 our numbers of tests, numbers of procedures
 18 and look at our workload measurement and
 19 workload units and to see if we're staffed
 20 appropriately or are we overstaffed in the
 21 program as whole or are we overstaffed in
 22 parts of the program. The time that I had to
 23 spend with Dr. Manley, who was the pathologist
 24 with that group, was actually I seen it as
 25 sort of almost like an opportunity, whether it

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1 was because I was a new director and I was
 2 green to it, I don't know, but my time with
 3 him I thought was very productive. He worked
 4 in Kingston, Kingston hospital, Kingston
 5 General, I think it is, and he and I actually
 6 had discussions back and forth and he had
 7 discussions with Dr. Cook about, you know, our
 8 current laboratory environment. And we talked
 9 to him more about things that we needed in the
 10 lab as opposed to things that we needed to cut
 11 out of the lab, you know, so it was two
 12 different focuses.

13 CHAYTOR, Q.C.:

14 Q. And what were some of those things that you
 15 discussed with Dr. Manley that you felt you -

16 MR. GULLIVER:

17 A. Well, one of my top things, and you know, and
 18 just coming from pathology manager and my
 19 long-term technical background in pathology,
 20 one of the things that we had said to him
 21 that, you know, we have been asking for and
 22 trying to get money for pathologist assistants
 23 and we'd appreciate it if he would include
 24 that in his report and his assessment of our
 25 lab services. Of course, we talked about

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1 efficiencies with Dr. Manley also. We were
 2 asking him at the time in your--what you seen
 3 across the country, do you have a core lab set
 4 up, for example, rapid response labs, do you
 5 have sort of separate dedicated labs, and
 6 that's more of our context and discussions
 7 with Dr. Manley. The other people were
 8 strictly numbers, that pretty well was it.

9 CHAYTOR, Q.C.:

10 Q. So did Dr. Manley do a review of all of your
 11 services?

12 MR. GULLIVER:

13 A. He pretty well reviewed most of--most aspects
 14 of our lab services.

15 CHAYTOR, Q.C.:

16 Q. Okay. And did he offer any suggestions of
 17 what you could be--anything that he saw that
 18 may have been lacking in your services or
 19 other things that you could be doing
 20 differently?

21 MR. GULLIVER:

22 A. No, he didn't, he didn't--there was nothing
 23 that he came and said, oh, you should be doing
 24 this, doing this, doing this on an operational
 25 perspective. What you will see in the report,

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1 and I'm assuming it came from him, when you
 2 see that the recommendation of, you know, we
 3 should have pathologist assistants to help
 4 with our pathologists', you know, workload and
 5 grossing functions, I don't think the
 6 administrative--the bean counters really had
 7 any idea about that. That must have been
 8 coming from Dr. Manley's assessment.

9 CHAYTOR, Q.C.:

10 Q. And how long did Dr. Manley spend assessing--
 11 this would have been your entire program?

12 MR. GULLIVER:

13 A. Yeah. Well, he spent about a full day.

14 CHAYTOR, Q.C.:

15 Q. About a day.

16 MR. GULLIVER:

17 A. I remember he spent a full day with myself.
 18 We went to St. Clare's, I took him to the
 19 Waterford. We spent most of the time in the
 20 Health Sciences, obviously. He went through
 21 all the labs and we had a lot of discussion.
 22 He asked a lot of questions about our, you
 23 know, what we're doing in all of our labs and
 24 how we're set up and what equipment do we have
 25 and what pressures do we have.

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1 CHAYTOR, Q.C.:

2 Q. And that would be all of, all components of
 3 the lab?

4 MR. GULLIVER:

5 A. For all the lab, yes.

6 CHAYTOR, Q.C.:

7 Q. Hematology, the whole thing?

8 MR. GULLIVER:

9 A. Yes, yes.

10 CHAYTOR, Q.C.:

11 Q. And what do you mean when you say you also
 12 discussed with him efficiencies, what's meant
 13 by efficiency?

14 MR. GULLIVER:

15 A. For example, at that time, you know, when I
 16 just took over, we had at the Waterford site,
 17 and we still do today, we have a walk-in blood
 18 collection centre. You know, we see two or
 19 three hundred patients a day go there for a
 20 blood test and their sample has to be tested
 21 and processed. Back before this time those
 22 samples were first transported every hour,
 23 they were sent to St. Clare's lab. And the
 24 St. Clare's lab, which had a hematology,
 25 chemistry, blood bank, coag and pathology lab

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1 at the time, they would do the testing on the
 2 specimen that they could perform, subsequently
 3 if there was any specialized testing, they
 4 were repacked up and reshipped to the Health
 5 Sciences because the Health Sciences was the
 6 only lab in the province that was able to
 7 perform almost all laboratory testing. We
 8 received samples and tests from Corner Brook,
 9 Lab City, Carbonear every day looking for
 10 specialized testing. So one of the things
 11 from that outcome was, you know, Dr. Manley
 12 agreed and said, you know, you should send
 13 your specimens directly from Waterford
 14 directly to Health Sciences where there's no
 15 further delays, all the testing can be done on
 16 one site and done on the same day, type of
 17 thing.
 18 CHAYTOR, Q.C.:
 19 Q. And did any of that discussion involve
 20 anything to do with the IHC lab?
 21 MR. GULLIVER:
 22 A. No, it didn't, no.
 23 CHAYTOR, Q.C.:
 24 Q. The idea of a core lab, you said core lab set
 25 up, what does that mean, a core lab?

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1 MR. GULLIVER:
 2 A. Core lab is if you look at traditionally most
 3 labs, they have a hematology lab, a chemistry
 4 lab, coagulation lab, blood bank lab,
 5 pathology, micro, the divisions. Generally if
 6 you went to an outpatient department and had
 7 your blood collected, you'd see multiple
 8 coloured tubes. There could be a purple tube
 9 and a red stopper tube and those things.
 10 Those samples go to those various labs. And
 11 we refer to those as the core services for
 12 laboratory. They're really the rapid
 13 response, the high turnaround time labs that
 14 are highly automated. And, you know, back
 15 maybe ten years ago most major labs in the
 16 country were moving to sort of taking the
 17 walls down out of those labs, instead of
 18 having a room like this with every separate
 19 lab, having one large room where all of your
 20 automation is in one room and instead of
 21 having your technologist just working in
 22 chemistry, they would be cross trained to work
 23 in hematology, chemistry, blood bank, coag, so
 24 you're utilizing your services in a much more
 25 efficient manner. In particular, it's

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1 important now that like the night shifts and
 2 the evening and weekend shifts, so in those
 3 cases instead of having four staff on a shift
 4 per weekend, a hematology tech, a chemistry
 5 tech, a coag tech, a blood bank tech, you
 6 could utilize your staff maybe have two staff
 7 on because the volume wouldn't be there to
 8 warrant four, so if you had them all together
 9 working under the same roof. And that's a
 10 core lab kind of concept.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. And so you meet with the reviewers, you
 13 go through the whole process and then the
 14 report is forthcoming. And when you get--when
 15 you received the report, did you have any
 16 concerns and, if so, what -
 17 MR. GULLIVER:
 18 A. Oh, I was shocked.
 19 CHAYTOR, Q.C.:
 20 Q. You were shocked. And perhaps you can tell
 21 the Commissioner then about that?
 22 MR. GULLIVER:
 23 A. Well, when I was reading through the report
 24 and after, you know, spending time--and I
 25 guess maybe again I could have been naive,

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1 after spending most of my time talking to Dr.
 2 Manley, and seeing this more of an opportunity
 3 for the laboratory, I really was shocked to
 4 read the report and see, you know,
 5 recommendations there where I think overall
 6 they were saying we should reduce our staffing
 7 in St. John's by 29 or 30 staff. After going
 8 through a major downsizing two years prior
 9 with the Grace and Janeway closing, after
 10 going through major cutbacks in '96 with the
 11 Health Care Corporation coming to being, you
 12 know, we're at a point in our life where we
 13 should be adding staff to our program and in
 14 various parts of our program and not taking
 15 another 29 staff out. So I vehemently fought,
 16 I guess, the report. I disputed the, you
 17 know, the administrative people, I disputed
 18 their assessment of our volumes and our
 19 workload. I did much work to provide to them
 20 factual figures of our actual patient volumes,
 21 our test volumes, our workload units. And I
 22 think I was one of the very, very few programs
 23 in the whole corporation where the HAY
 24 reviewers actually almost acknowledged receipt
 25 of my assessment and I think they put

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1 something, there's sort of an overrider in
 2 their report that they could not dispute what
 3 I said, nor could they verify, so based upon
 4 that, they would amend their amount of
 5 cutbacks and stuff for the laboratory.
 6 CHAYTOR, Q.C.:
 7 Q. And what was the outcome at the end of the
 8 day?
 9 MR. GULLIVER:
 10 A. At the end of the day, we sort of did a
 11 division by division review of what
 12 operational savings we could achieve, and at
 13 the end of the day, I think we agreed upon a
 14 consensus of, I think, nine or maybe ten FTE's
 15 that will be achieved through attrition or
 16 various means, no layoffs being issued, but
 17 even that nine or ten, you know, while I had
 18 to achieve that, I can't say it was something
 19 that was done -
 20 CHAYTOR, Q.C.:
 21 Q. I'm sorry, you can't say?
 22 MR. GULLIVER:
 23 A. I can't say that I enjoyed doing it, you know,
 24 I don't think I still fully agreed with even
 25 losing that number of staff.

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1 CHAYTOR, Q.C.:
 2 Q. And in terms of - that would have been for
 3 your overall program, nine or ten positions.
 4 How many, if any, were part of the pathology
 5 lab?
 6 MR. GULLIVER:
 7 A. Oh, let me think. I think - see in the
 8 recommendations, and, I guess, I took it to be
 9 that the people who are writing the report,
 10 they probably got input from Dr. Manley,
 11 combined his assessment recommendations with
 12 the administrative side of this review, and
 13 came up with these list of recommendations for
 14 the laboratory. In there, there was sort of -
 15 it wasn't really quite clear. They were
 16 saying about we should reduce one technologist
 17 in pathology, and we should reduce two
 18 technologists in cytology, and then train them
 19 as PA's, and when we reviewed it, it was,
 20 like, well, our cytology technologists who
 21 read all the pap smears for the province, you
 22 know, those staff have an additional two years
 23 training after they finish our RT program, and
 24 we don't have a training school in
 25 Newfoundland, and it was, like, well, we

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1 certainly ain't going to get rid of two of our
 2 cyto technologists, that's a skill mix that we
 3 don't have and we can't place, and we
 4 certainly didn't agree with losing one of our
 5 technologists in pathology because of our
 6 workload and volumes. While we agreed with
 7 having positions of PAs, we did not agree to
 8 trade of two cyto technologists and a
 9 pathology technologist for the creation of
 10 PA's.
 11 CHAYTOR, Q.C.:
 12 Q. Perhaps I'll take you then to P-0901. I
 13 understand this document to be your response
 14 to the HAY operational review. It's dated
 15 March 3rd, 2002. It's written to Dr.
 16 Williams, VP Medical Services, by yourself as
 17 the Program Director, and it appears you've
 18 met with Dr. Williams, "Further to our meeting
 19 of February 22nd, 2002, the following is a
 20 more detailed response to the HAY operational
 21 review report, based upon the revised
 22 statistics as provided by Ms. Sharon Lehr,
 23 Director of Budgeting". So I take it before
 24 you would come up with this written response,
 25 you've had discussions with and meetings with

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1 Dr. Williams about your opposition to this
 2 report?
 3 MR. GULLIVER:
 4 A. Oh, certainly, oh, yes.
 5 CHAYTOR, Q.C.:
 6 Q. And the -
 7 MR. GULLIVER:
 8 A. I wouldn't have done this here without Dr.
 9 Williams support to say, go ahead, get me
 10 documentation, get me figures, so we can
 11 verify what I have been saying.
 12 CHAYTOR, Q.C.:
 13 Q. Okay, and the first part here is a table which
 14 is indicated to be Exhibit 5.29, laboratory
 15 workload on FTEs [revised]. For anatomical
 16 pathology, there's asterisk which says that -
 17 I saw the asterisk down here, "includes
 18 anatomical pathology, surgical pathology,
 19 autopsy and diagnostic cytology".
 20 MR. GULLIVER:
 21 A. That's how the HAY -
 22 CHAYTOR, Q.C.:
 23 Q. Grouped it?
 24 MR. GULLIVER:
 25 A. Grouped people together.

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1 CHAYTOR, Q.C.:

2 Q. For anatomical pathology.

3 MR. GULLIVER:

4 A. Yeah.

5 CHAYTOR, Q.C.:

6 Q. So this chart here is taken - is this directly

7 from the HAY report?

8 MR. GULLIVER:

9 A. No, this is my report.

10 CHAYTOR, Q.C.:

11 Q. This is your assessment.

12 MR. GULLIVER:

13 A. This is my response to say to the HAY people,

14 here's the actual workload within these

15 categories, here are the number of FTEs that

16 we were working with over this time frame,

17 here are the number of FTEs that we currently

18 have, and you're telling me we have to go even

19 further - down further now.

20 CHAYTOR, Q.C.:

21 Q. Okay, so what you've done here then, you have

22 patient care workload units, and it's broken

23 down, 1999 -

24 MR. GULLIVER:

25 A. And remember we talked about the quality

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1 control about taking workload units -

2 CHAYTOR, Q.C.:

3 Q. Yes.

4 MR. GULLIVER:

5 A. Staff are trained for all the tests we perform

6 and procedures to take your workload units

7 because we always - we base our staffing

8 levels on the workload units produced by the

9 laboratory staff.

10 CHAYTOR, Q.C.:

11 Q. Yes. So Mr. Gulliver, what does it tell us?

12 From 1999 to 2000, you have indicated there to

13 be over 3,221,198 workload units.

14 MR. GULLIVER:

15 A. In that category.

16 CHAYTOR, Q.C.:

17 Q. Patient care, right.

18 MR. GULLIVER:

19 A. Yeah.

20 CHAYTOR, Q.C.:

21 Q. And then continuing on then, the following

22 year that's reduced down to 3,050,000, and

23 then 2001/2002, it's at 3,147,000 thereabouts.

24 So for overall percentage change, you've

25 indicated to be down by 2.3 percent.

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1 MR. GULLIVER:

2 A. Yeah, and -

3 CHAYTOR, Q.C.:

4 Q. And then -

5 MR. GULLIVER:

6 A. And workload units, they're updated every year

7 through CIHI, and sometimes workload units

8 changed, the values decreased for procedures

9 and tests. So when you change that value, you

10 may see a decrease in your workload units, but

11 then you may see an increase in your overall

12 number of tests and procedures performed, and

13 remember too in this fiscal year, we had an

14 illegal strike. So during that time frame

15 there's no work getting done.

16 CHAYTOR, Q.C.:

17 Q. So that's in the '01 -

18 MR. GULLIVER:

19 A. That'll reduce your workload also.

20 CHAYTOR, Q.C.:

21 Q. So that would account for the 2000/2001

22 decrease, is that correct?

23 MR. GULLIVER:

24 A. I would say that's a portion of it, yeah.

25 CHAYTOR, Q.C.:

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1 Q. Yes.

2 MR. GULLIVER:

3 A. But this is showing overall, Ms. Chaytor, for

4 the laboratory for St. John's.

5 CHAYTOR, Q.C.:

6 Q. Yes.

7 MR. GULLIVER:

8 A. In '99, you can see we had full time

9 equivalent staff, and now -- two years later

10 we're down to 240. So there's a five percent

11 reduction in our FTE equivalents, but yet

12 there's an increase, 4 percent increase in our

13 workload.

14 CHAYTOR, Q.C.:

15 Q. Right, so that's overall for your -

16 MR. GULLIVER:

17 A. So our work is going up, staff is going down.

18 CHAYTOR, Q.C.:

19 Q. That's overall for your entire program?

20 MR. GULLIVER:

21 A. Yeah.

22 CHAYTOR, Q.C.:

23 Q. And I was just looking at, though, your

24 anatomical pathology which would be the area,

25 am I right, that we're dealing with?

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1 MR. GULLIVER:
 2 A. Yeah.
 3 CHAYTOR, Q.C.:
 4 Q. And so your workload - patient care workload
 5 units are down in that time period, but your
 6 FTEs are also down, is this what this is
 7 saying?
 8 MR. GULLIVER:
 9 A. Yeah.
 10 CHAYTOR, Q.C.:
 11 Q. And they're down by -
 12 MR. GULLIVER:
 13 A. 3 percent.
 14 CHAYTOR, Q.C.:
 15 Q. 3.18 percent.
 16 MR. GULLIVER:
 17 A. Yeah.
 18 CHAYTOR, Q.C.:
 19 Q. Whereas your workload units are down. Why
 20 would it be that - I just want to understand,
 21 based on what we've talked about here today in
 22 terms of - I was having the impression that
 23 your workload was continuing to increase over
 24 that time period. So why would your patient
 25 care workload units be shown to be down?

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1 MR. GULLIVER:
 2 A. Again you see in 1999/2000 - you're really
 3 into real operational issues here. The
 4 workload measurement system switched to - we
 5 used to capture all of our workload. Then
 6 CIHI for the country was looking at
 7 standardizing workload capture so you could
 8 compare one system to another, and we moved to
 9 a system of patient care workload, non-patient
 10 care workload, and then we have quality
 11 control workload, we have other workload,
 12 referred in, referred out, there's a whole
 13 bunch of categories that are rolled up into
 14 here, and at some point in here, Ms. Chaytor,
 15 documenting your patient care workload,
 16 separating out what's patient care versus non-
 17 patient care, there's a changeover here.
 18 Again workload unit values change, and
 19 sometimes it decreased, and overall for the
 20 program you can see that year our workload has
 21 been up 4 percent in that two year time frame,
 22 and I will tell you today that since '01, '02,
 23 our workload is probably up 20 percent more
 24 since this time frame.
 25 CHAYTOR, Q.C.:

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1 Q. So at this point in time, even though these
 2 numbers are saying that your workload is down
 3 by a little over 2 percent -
 4 MR. GULLIVER:
 5 A. That's pathology.
 6 CHAYTOR, Q.C.:
 7 Q. Yeah, in the pathology lab. Would that be
 8 accurate?
 9 MR. GULLIVER:
 10 A. Workload units.
 11 CHAYTOR, Q.C.:
 12 Q. Yes, would that be accurate?
 13 MR. GULLIVER:
 14 A. No.
 15 CHAYTOR, Q.C.:
 16 Q. This is -
 17 MR. GULLIVER:
 18 A. This is saying workload units.
 19 CHAYTOR, Q.C.:
 20 Q. Yes.
 21 MR. GULLIVER:
 22 A. Workload units is a capture of the value
 23 attached to every test procedure you perform.
 24 It doesn't necessarily mean that the volume of
 25 work is decreased. So you may have 100 tests

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1 this year and each test is valued at 10
 2 workload units to give you 1000 units. This
 3 year the workload unit drops to 8, but you do
 4 120 tests, so showing your workload units are
 5 pretty well the same, but your volume of work
 6 has gone up.
 7 CHAYTOR, Q.C.:
 8 Q. Right.
 9 MR. GULLIVER:
 10 A. What you're not seeing here in this submission
 11 is the number of tests performed in each of
 12 those categories because the HAY group were
 13 only focused on the workload units.
 14 CHAYTOR, Q.C.:
 15 Q. So in terms of you putting this forward,
 16 though, as the analysis, what you're saying is
 17 that this is how they decided to do the
 18 analysis?
 19 MR. GULLIVER:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. But there's a piece of the puzzle missing
 23 here?
 24 MR. GULLIVER:
 25 A. Exactly.

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1 CHAYTOR, Q.C.:

2 Q. But in your response going back, you don't

3 address that?

4 MR. GULLIVER:

5 A. No, because I had - I had to respond to how

6 they're doing their assessment, and even in

7 this assessment, they had underestimated our

8 workload, I think - I can't remember offhand,

9 Ms. Chaytor, but it was like significant, it

10 was like two or three million workload units

11 that they were not acknowledging us for doing.

12 CHAYTOR, Q.C.:

13 Q. Okay. i'm just going to take you then to page

14 five of - this is still your response, the

15 same document, and you write, "The anatomical

16 pathology revised figures were the same as the

17 original figure of 0.0219". I'm sorry, I

18 should give that some context for you because

19 you're now talking about productivity

20 comparisons.

21 MR. GULLIVER:

22 A. For pathology.

23 CHAYTOR, Q.C.:

24 Q. Yes, and this is for pathology, "The

25 anatomical pathology figures are compiled from

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1 our division of cytology and division of

2 surgical and autopsy pathology. The report

3 recommends the reduction of two FTEs in

4 cytology and one in - one full time equivalent

5 in pathology. Upon further review, I

6 separated out statistics for cytology and

7 pathology labs at the General and St. Clare's.

8 The statistics show the following", and then

9 you break down that, "and based upon the

10 statistics, I plan to reduce by a minimum of

11 1.6 FTEs in cytology and one by one full time

12 equivalent in pathology at St. Clare's". So

13 your proposal after doing your analysis is

14 that you -

15 MR. GULLIVER:

16 A. To meet those targets.

17 CHAYTOR, Q.C.:

18 Q. Yes, you can take away -

19 MR. GULLIVER:

20 A. That's what we would have to do to meet their

21 targets, and the cytology reductions took

22 place eventually through accommodation of

23 attrition and we moved our cytology service to

24 what we call liquid-based technology, and

25 that's - this only happened in the last couple

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1 of years. It didn't happen anywhere near

2 close to 2002.

3 CHAYTOR, Q.C.:

4 Q. So the actual reduction by one full time

5 equivalent pathology at St. Clare's, did that

6 happen, did you lose a person out of there?

7 MR. GULLIVER:

8 A. Well, yes and no. At St. Clare's, we had two

9 staff who were funded at half time each, but

10 both of those staff were working full time

11 hours, and what we did, we combined them and

12 made one permanent full time position. So

13 technically on the books from budget size, we

14 reduced our budget expenditure, our worked

15 hours, but we didn't actually reduce a staff

16 person.

17 THE COMMISSIONER:

18 Q. (Inaudible).

19 MR. GULLIVER:

20 A. It's - in our pathology lab at the time at St.

21 Clare's, we had two employees.

22 THE COMMISSIONER:

23 Q. Uh-hm.

24 MR. GULLIVER:

25 A. They both owned a half time job.

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1 THE COMMISSIONER:

2 Q. Uh-hm.

3 MR. GULLIVER:

4 A. We were giving them additional hours, which we

5 really didn't have money for in the budget,

6 because we had closed the Grace and people

7 were getting amalgamated and we were getting

8 used to all this new stuff, and when this came

9 out, what we did, we took two half time jobs

10 and posted one permanent full time job. So

11 there was one full time employee there, and we

12 stopped giving the extra hours in our budget.

13 So our FTEs funded didn't change, but we

14 actually reduced our expenditures because we

15 weren't overspending.

16 THE COMMISSIONER:

17 Q. Sorry, I --

18 MR. GULLIVER:

19 A. We stopped paying overtime, we stopped paying

20 extra hours.

21 THE COMMISSIONER:

22 Q. But if you had one full time position, doesn't

23 that still mean that you now go to one person

24 where you had two?

25 MR. GULLIVER:

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1 A. Instead of two half time people that were
 2 funded, we had one full time person funded.
 3 THE COMMISSIONER:
 4 Q. Yes.
 5 MR. GULLIVER:
 6 A. But those two half times were putting in the
 7 work of two people.
 8 THE COMMISSIONER:
 9 Q. Yes.
 10 MR. GULLIVER:
 11 A. And the additional money - we had no money in
 12 our budget for it. So I was going over budget.
 13 THE COMMISSIONER:
 14 Q. Yes.
 15 MR. GULLIVER:
 16 A. So we kept a full time person, but we stopped
 17 paying extra hours, what we call workload
 18 increase, and we stopped paying overtime to
 19 reduce our budget expenditures.
 20 THE COMMISSIONER:
 21 Q. So you still had to get rid of one person,
 22 though, didn't you?
 23 MR. GULLIVER:
 24 A. Well, we --
 25 THE COMMISSIONER:

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1 Q. Either by attrition or otherwise?
 2 MR. GULLIVER:
 3 A. Yeah, we didn't get - they went to another
 4 part of the program.
 5 CHAYTOR, Q.C.:
 6 Q. The work of that one person stopped being
 7 done?
 8 MR. GULLIVER:
 9 A. Pretty well, yes.
 10 CHAYTOR, Q.C.:
 11 Q. So you reduced by one full time equivalent?
 12 MR. GULLIVER:
 13 A. Yes, pretty well, yes.
 14 CHAYTOR, Q.C.:
 15 Q. Okay.
 16 MR. GULLIVER:
 17 A. But it wasn't a person who left.
 18 THE COMMISSIONER:
 19 Q. A person got transferred to some place else?
 20 MR. GULLIVER:
 21 A. Right, yeah.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. I'm on page six now of the document
 24 because you have a list of recommendations
 25 there, and number -- these come out of the -

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1 MR. GULLIVER:
 2 A. Ms. Chaytor, this is with consultation with
 3 Dr. Cook and our leadership team about our
 4 response to this.
 5 CHAYTOR, Q.C.:
 6 Q. So this is the program management got together
 7 and came up with this?
 8 MR. GULLIVER:
 9 A. Yes, this is what we agree with -
 10 CHAYTOR, Q.C.:
 11 Q. This is just not your -
 12 MR. GULLIVER:
 13 A. This is what we don't agree with.
 14 CHAYTOR, Q.C.:
 15 Q. All right, so you say, "I disagree with having
 16 a single manager for pathology and cytology
 17 for the Health Care Corporation. This means
 18 that one manager would have the responsibility
 19 for almost 70 staff", and then you go on with,
 20 "The laboratory program has recently downsized
 21 from ten division managers to seven".
 22 MR. GULLIVER:
 23 A. Uh-hm.
 24 CHAYTOR, Q.C.:
 25 Q. "This allows for only one manager for each

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1 division corporate-wide. The proposed new
 2 core lab at St. Clare's, which would have
 3 combined hematology and chemistry functions,
 4 would be managed by one of the existing
 5 managers". So what is it that you're
 6 suggesting here, what is the issue?
 7 MR. GULLIVER:
 8 A. Well, the issue was they recommended that we
 9 have--we had one manager for pathology, for
 10 St. John's and one manager for cytology.
 11 They're both completely different divisions.
 12 CHAYTOR, Q.C.:
 13 Q. And they were recommending that there be one
 14 manager for both of those divisions.
 15 MR. GULLIVER:
 16 A. You lay one of the off and you keep one of
 17 them to manager both services. And I was
 18 pointing out here, well, just recently I, as
 19 the new director, we reorganized our ten
 20 managers and we were cut down from ten to
 21 seven, only months before this. So, there was
 22 no way could we support even going down
 23 further again.
 24 CHAYTOR, Q.C.:
 25 Q. And what is that reference to you had just

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1 recently downsized from ten to seven. What
 2 happened around that period of time?
 3 MR. GULLIVER:
 4 A. When I became the program director in October
 5 2001--go back to the Health Corporation days
 6 when we had four facilities operating, there
 7 were two positions for hematology managers for
 8 the city of St. John's. There were two
 9 positions for chemistry; there were two
 10 positions for micro; two positions for
 11 pathology. Each manager had a set--there was
 12 a Health Sciences/Janeway group, a St. Clare's
 13 and Grace group and there was ten positions.
 14 And they had been cut from 21 down to ten at
 15 that time. When I took over, the Grace had
 16 physically closed, the Janeway had physically
 17 closed and I still had ten positions. I had a
 18 couple of managers who were getting close to
 19 retirement and I thought as director of the
 20 program that we should have one division
 21 manager for each service. As we had one
 22 manager for cytology all along. But we had
 23 multiple managers in some divisions. And it
 24 was an opportunity to restructure our
 25 management functions and set up and that was

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1 the outcome from it, that we went down from
 2 ten to seven.
 3 CHAYTOR, Q.C.:
 4 Q. And in going down from ten to seven at that
 5 point in time, did you plan to replace the
 6 three management positions with managers to
 7 fulfil other functions?
 8 MR. GULLIVER:
 9 A. Good question. Yes, I did.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and what was your plan?
 12 MR. GULLIVER:
 13 A. Well, it was--I seen that if we were able to,
 14 you know, make our hematology manager
 15 corporate wide as opposed to having separate
 16 sites, I thought that structure with the
 17 division chief would lend to better decision
 18 making. And you're taking the
 19 responsibilities for decisions into a core
 20 team. And the other positions that we could
 21 have reassigned, a part of this too, Ms.
 22 Chaytor, was to backfill at my position
 23 because I moved up from pathology manager to
 24 program director, but I was pathology manager,
 25 I was genetics manager and I was immunology

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1 manager. So, I recommended that immunology
 2 and genetics and pathology be separated. That
 3 pathology now have one manager for the city,
 4 instead of two like before, myself and Mr.
 5 Murphy. And instead of immunology and
 6 genetics having to share a manger with
 7 pathology, that those divisions had grown so
 8 much by that time, that they warranted to have
 9 a separate division manager with their
 10 division chief.
 11 The vacancies that would occur around
 12 this here, it was my view, at the time, that
 13 we could reassign or reuse that money and have
 14 a manager for utilization of lab services. I
 15 had hope for a manager for the LIS system
 16 which is the Lab Information Systems, to have
 17 a dedicated person in that position and I had
 18 hoped to have a dedicated manager for quality
 19 for laboratory services.
 20 CHAYTOR, Q.C.:
 21 Q. For quality.
 22 MR. GULLIVER:
 23 A. Um-hm.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. And did you make that submission for

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1 utilization manager, for lab information
 2 services manager and quality manager for lab
 3 services, did you make that submission in
 4 writing to anybody?
 5 MR. GULLIVER:
 6 A. I don't know if I made the submission through
 7 the budgeting side. I know I certainly spoke
 8 to Dr. Williams about it and, you know, as my
 9 VP and advocate for laboratory, that he would
 10 speak to executive team. I do remember
 11 getting correspondence from our VP of HR at
 12 the time telling me that the plan to have one
 13 manager for all of our divisions looked fine
 14 to him. I remember having that
 15 correspondence. I don't know if I put a
 16 detailed proposal to executive team. I know I
 17 spoke to Dr. Williams about it. But what, I
 18 guess, the outcome was--the answer was no and
 19 it was \$245,000.00 for the salaries and
 20 benefits for those positions and I just lost
 21 it from the budget.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And that happened, you went ahead and
 24 decreased from your ten to your seven with
 25 your plan being to create these three

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1 managerial positions, one of which would have
 2 included a manager for quality.
 3 MR. GULLIVER:
 4 A. Um-hm.
 5 CHAYTOR, Q.C.:
 6 Q. And in terms of that plan and your plans in
 7 that regard, going forward, you talked to Dr.
 8 Williams about it, whether or not it was
 9 committed to writing or not, you're not sure.
 10 MR. GULLIVER:
 11 A. I can't remember.
 12 CHAYTOR, Q.C.:
 13 Q. But you went ahead and made the reductions in
 14 your managers and that money, in the next
 15 budget, just disappears.
 16 MR. GULLIVER:
 17 A. Yeah.
 18 CHAYTOR, Q.C.:
 19 Q. Was this the first time that you had planned
 20 or proposed to have a manager for quality for
 21 the lab?
 22 MR. GULLIVER:
 23 A. Yeah, this is just--I'm the director of
 24 several months at this point. This is very
 25 new.

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1 CHAYTOR, Q.C.:
 2 Q. And do you know whether or not your
 3 predecessor or anybody else had ever put
 4 forward for a manger for quality?
 5 MR. GULLIVER:
 6 A. I don't remember Mr. Whelan putting something
 7 in. I can't say yes or no, Ms. Chaytor, to
 8 that. I don't remember it.
 9 CHAYTOR, Q.C.:
 10 Q. What niche, at that point in time, did you
 11 think needed to be filled by a manager of
 12 quality?
 13 MR. GULLIVER:
 14 A. Repeat the question.
 15 CHAYTOR, Q.C.:
 16 Q. What niche did you think needed to be filled
 17 by a manager of quality.
 18 MR. GULLIVER:
 19 A. Oh, what niche?
 20 CHAYTOR, Q.C.:
 21 Q. Yes.
 22 MR. GULLIVER:
 23 A. I didn't know what word you said.
 24 CHAYTOR, Q.C.:
 25 Q. I'm sorry.

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1 MR. GULLIVER:
 2 A. I don't know -
 3 CHAYTOR, Q.C.:
 4 Q. Vacuum is your word.
 5 MR. GULLIVER:
 6 A. I know and I don't know if it was a niche that
 7 needed to be filled. I mean, when I was
 8 looking at this, 2001, as documented, you
 9 know, many years of downsizing and cutbacks,
 10 when I looked at, as the director of the
 11 program, I would have to say, I mean, I came
 12 into this position with an extensive amount of
 13 experience in pathology. I also came to the
 14 position, as I mentioned, with an extensive
 15 amount of experience through my volunteer
 16 work, you know, having served for four years
 17 on our national board of directors for our
 18 association and profession, having the
 19 opportunity to meet with counterparts in
 20 Ontario, Alberta, other provinces. I've
 21 certainly had the opportunity to see a lot of
 22 other labs in the country and I felt that our
 23 program could be better served--this is in
 24 2002 now, early, that you know, the future,
 25 where we're going in this province, that

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1 having a dedicated manager for utilization of
 2 lab services will be a good thing. Having a
 3 manager dedicate for quality management to put
 4 a whole program in place for lab services
 5 would be a good thing.
 6 CHAYTOR, Q.C.:
 7 Q. So, that's something based on your liaison
 8 with others across the country and -
 9 MR. GULLIVER:
 10 A. And my -
 11 MR. GULLIVER:
 12 A. - attending conferences was a position that
 13 was available in other centres.
 14 MR. GULLIVER:
 15 A. Certainly so, yes.
 16 CHAYTOR, Q.C.:
 17 Q. And on that note, in your attendance at
 18 conferences and your involvement at the
 19 national level and your volunteer efforts and
 20 visiting other labs across the country, did
 21 you ever make any inquiries about external
 22 proficiency testing and whether or not that
 23 service was available?
 24 MR. GULLIVER:
 25 A. Well, I knew external proficiency testing was

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1 available in most parts of laboratory. We
 2 were participating in them actively in most
 3 parts of the program. What I would be
 4 interested in, Ms. Chaytor, and through--and
 5 it's not through my work environment, but
 6 through my volunteer environment, was
 7 certainly interested in looking at lab
 8 standards and looking at accreditation which
 9 we know that our province has been lacking in.
 10 CHAYTOR, Q.C.:
 11 Q. So, whether or not any of your conferences,
 12 the idea of external proficiency testing for
 13 the--and the technical component.
 14 MR. GULLIVER:
 15 A. That wouldn't even be on the radar; it
 16 wouldn't be on the radar.
 17 CHAYTOR, Q.C.:
 18 Q. And the technical component and whether or not
 19 that was available or being availed of by
 20 others across the country. That didn't come
 21 up in any of your discussion or anything that
 22 you took part in?
 23 MR. GULLIVER:
 24 A. No, and I didn't see it either. The quality
 25 manager position, you said that you discussed

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1 with Dr. Williams your plan that you would do
 2 this management restructuring and reduce down
 3 to seven with the idea that these three other
 4 positions would then be created or you'd have
 5 the funding, over two hundred thousand dollars
 6 to create -
 7 MR. GULLIVER:
 8 A. No, I wasn't asking for funding.
 9 CHAYTOR, Q.C.:
 10 Q. You weren't asking for that. You had it, you
 11 thought, yourself.
 12 MR. GULLIVER:
 13 A. I was saying we have the funding now in our
 14 program, the money is there, instead of
 15 spending it on this position and this position
 16 or this position, we've got it there to spend
 17 and it's got to be used this way.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, but you had that discussion with Dr.
 20 Williams, is that right?
 21 MR. GULLIVER:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. You had that. Whether or not you put anything
 25 in writing to him, you had that discussions.

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1 MR. GULLIVER:
 2 A. I don't know.
 3 CHAYTOR, Q.C.:
 4 Q. Did he agree with your proposal?
 5 MR. GULLIVER:
 6 A. I don't remember him disagreeing and I think
 7 Dr. Williams certainly, I mean, he was someone
 8 who was a greater supporter of laboratory
 9 medicine and I would have thought that Dr.
 10 Williams would have brought that forward to
 11 executive team.
 12 CHAYTOR, Q.C.:
 13 Q. And at the end of the day -
 14 MR. GULLIVER:
 15 A. Understand, we're talking about now early 2002
 16 and the Health Care Corporation has got this
 17 humongous report in their hand from Hey that
 18 says cut, chop, cut, chop and then cut some
 19 more. And I'm assuming executive had looked -
 20 CHAYTOR, Q.C.:
 21 Q. But that happens before, doesn't it, according
 22 to this you're saying that I've already lost
 23 my seven--I'm down to seven managers.
 24 MR. GULLIVER:
 25 A. I know, but we know at this point in time, Hay

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1 has been in for months, we know what's going
 2 to come down the pipeline. And I'm assuming,
 3 I mean, if I'm executive team, they're going
 4 to look at some areas where what is the less
 5 traumatic to the organization? What is the
 6 less traumatic to the staff in the
 7 organization? If we know we have this
 8 millions of dollars to have to come out of the
 9 health care system through -
 10 CHAYTOR, Q.C.:
 11 Q. Did you know that? Did you know that's what
 12 was coming down? I thought you were shocked
 13 by the outcome?
 14 MR. GULLIVER:
 15 A. It was no shock to anybody really that what
 16 the Hay Group were coming in for.
 17 CHAYTOR, Q.C.:
 18 Q. So, Mr. Gulliver -
 19 MR. GULLIVER:
 20 A. I think the shock was when a report finally
 21 came in, the magnitude of what these people
 22 were saying, how we should cut beds and we
 23 should cut medicine beds, we should cut the
 24 laboratory, we should cut surgery, that's all
 25 they talked about.

1 CHAYTOR, Q.C.:

2 Q. Okay. So, the loss to your budget of those

3 three managerial positions, that had happened

4 before the Hay Report comes out?

5 MR. GULLIVER:

6 A. It's around the same time.

7 CHAYTOR, Q.C.:

8 Q. And what you're saying here is that well,

9 we've already lost three managerial positions,

10 so for whatever reason, those positions are

11 already gone before they Hay report comes out.

12 MR. GULLIVER:

13 A. But the Hay people are in months before we get

14 the report. I'm sure people like George

15 Tilley and executive had a fair good idea by

16 the time the Hay people went away to write

17 their reports which came in, you know, later

18 one, what kinds of things were going to be in

19 that report.

20 CHAYTOR, Q.C.:

21 Q. Okay. And this person, the manager, that you

22 proposed to be the quality manager, would you

23 envision--what did you envision in terms of

24 what their role would be? For example, did

25 you envision that they would be responsible

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 3rd 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 3rd day of October, A.D., 2008

13 Judy Moss

1 for assuring that appropriate policies and

2 procedures were in place for the laboratory

3 medicine program?

4 MR. GULLIVER:

5 A. Certainly, not just pathology, but for

6 laboratory medicine program.

7 CHAYTOR, Q.C.:

8 Q. Has that position, Mr. Gulliver, or a position

9 equivalent, similar position ever been

10 approved?

11 MR. GULLIVER:

12 A. We got one last July, July '07.

13 THE COMMISSIONER:

14 Q. Ms. Chaytor, it's getting close to 5, so where

15 you can find a place to break, you can do

16 that.

17 CHAYTOR, Q.C.:

18 Q. Perhaps we can take it up there another day.

19 THE COMMISSIONER:

20 Q. Okay, we'll meet at 9:30 on Monday. Thank

21 you.

22 Upon conclusion.

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