COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

October 3, 2008

Appearances:

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

Jackie Brazil . . . . . Her Majesty in Right of NL

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

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

Laura Brocklehurst. . . . . Members of the Breast Cancer
. . . . . Testing Class Action

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

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LIST OF EXHIBITS

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THE COMMISSIONER:
Q. Please be seated. Ms. Chaytor.
MR. TERRY GULLIVER (SWORN) EXAMINATION BY SANDRA CHAYTOR, Q.C.
REGISTRAR:
Q. Would you please state and spell your complete name for the Commission?
MR. GULLIVER:
A. Terry Gulliver, T-E-R-R-Y, G-U-L-L-I-V-E-R.
REGISTRAR:
Q. Thank you.
CHAYTOR, Q.C.:
Q. Good morning, Mr. Gulliver. Commissioner, there are a number of exhibits that I would ask, please, to have entered this morning. And they are P-2885 to P-2889, P-2933 to P-2938, P-2945 to P-2947, P-2950, P-3004, P-3090, P-3093 to P-3097, P-3099, P-3101 to P-3104, P-3106 to P-3110 and P-3112.
REGISTRAR:
Q. Thank you, Ms. Chaytor. (Inaudible).
THE COMMISSIONER:
Q. It's on my list, as well, is that one you want entered?
CHAYTOR, Q.C.:

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Q. Okay, thank you very much -
THE COMMISSIONER:
Q. 3091.
CHAYTOR, Q.C.:
Q. - not on my list. So P-3 -
THE COMMISSIONER:
Q. 091.
CHAYTOR, Q.C.:
Q. - 091, thank you.
THE COMMISSIONER:
Q. Entered.
EXHIBIT ENTERED AND MARKED P-2885.
EXHIBIT ENTERED AND MARKED P-2889.
EXHIBITS ENTERED AND MARKED P-2933 TO P-2938, INCLUSIVE.
EXHIBITS ENTERED AND MARKED P-2945 TO P-2947, INCLUSIVE.
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EXHIBITS ENTERED AND MARKED P-3093 TO P-3097, INCLUSIVE.
EXHIBIT ENTERED AND MARKED P-3099.
EXHIBITS ENTERED AND MARKED P-3101 TO P-3104, INCLUSIVE.
EXHIBITS ENTERED AND MARKED P-3106 TO P-3110, INCLUSIVE.
EXHIBIT ENTERED AND MARKED P-3112.
CHAYTOR, Q.C.:

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

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

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worked in hematology, blood bank, microbiology and did blood collection, phlebotomy, the front end piece. However, you know, the--like, their test menu, what's available on site at the hospital in St. Anthony wouldn't be as extensive as the Health Sciences, so it was generally a general laboratory.
CHAYTOR, Q.C.:
Q. Okay. And when you came then to St. John's to the general laboratory, I guess that would have been 1980 then?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And you were assigned to the pathology lab?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And what were your duties at that point in time?
MR. GULLIVER:
A. Well, initially, you know, as a--it was entry level as a medical laboratory technologist. At that time I think we had six technical staff in the laboratory. And we were required

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to perform all the general functions you'd expect in a pathology lab. It would be assisting the pathologist at the gross bench, it would be doing a basic embedding, cutting of blocks and slides and then performing stains, various stains on the slides for the pathologist, and then the sort of your kind of post-analytical work, filing of blocks, filing of slides, just basically your general lab technologist duties.

CHAYTOR, Q.C.:

Q. And when were you first introduced to immunohistochemistry or what ultimately would become the beginnings of immunohistochemistry at the General Hospital?

MR. GULLIVER:

A. Early on, maybe after a couple of years there in the lab as a technologist at the time our chief or our university chair was Dr. Wang and he obviously expressed an interest in this new kind of testing that was being introduced to the laboratory and it was immunoflorescent staining, which is really the precursor to immunohistochemistry staining. The major differences are that immunoflorescent

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staining, the antibodies that were used were only applied on fresh frozen tissue, so your tissue before it even got into formaldehyde, as you heard, or formalin, to be fixed, you took fresh tissue, you snapped for--you froze it, you cut it and then you applied the antibody stains to those slides. It was generally only used, Ms. Chaytor, for, mostly for kidney biopsies, patients who are post transplant, physicians were looking to see if the transplant was rejecting or being fine. And then we started using it later on also for skin biopsies.

CHAYTOR, Q.C.:

Q. Okay. And how were you trained at that point in time to do the immunoflorescent staining?

MR. GULLIVER:

A. Well, I guess I should back up a little bit. The training that we took place then, well, basically Dr. Wang, you know, I spent time with him and he walked me through the procedure multiple times and I performed them and cut the slides and performed them. You know, he would interpret them and read them and come back and tell me, yes, they're good

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or they're not good. But even before that, you know, in our general training program while we're not taught immunohistochemistry staining and all the, everything that surrounds that, you are taught the basic principles of antigen antibody, interactions and reactions, so I did have that basic level of knowledge.

CHAYTOR, Q.C.:

Q. From your schooling?

MR. GULLIVER:

A. From my training program. And along with the side-by-side demonstrations from Dr. Wang, you know, he had a couple of textbooks. I remember one in particular, I think it was called Reid Sternberger, was at the time an early book, textbook about immunoflorescent staining that we had, you know, that we read and went through.

CHAYTOR, Q.C.:

Q. And was it just you or were there other technologists involved in this?

MR. GULLIVER:

A. At the time it was just me.

CHAYTOR, Q.C.:

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Q. And how did that come to be, why were you chosen?

MR. GULLIVER:

A. I wasn't chosen at all, really. It was there were about five or six technologists at the time working in the laboratory. It was something new. And Dr. Wang just came out and spoke to all the staff and said there's, you know, there's a new procedure I'd like to develop and put in place and do I have a volunteer who would like to be the one to learn that. I guess I -

CHAYTOR, Q.C.:

Q. So you volunteered?

MR. GULLIVER:

A. I guess I was the one that volunteered, yeah.

CHAYTOR, Q.C.:

Q. Okay. And so then did that progress and did you eventually also take part in IHC in paraffin embedded tissue?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And so how long did you then do that procedure and what training did you receive into that?

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

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florescence in the cells. With the paraffin embedded, you now could take slides and perform the procedure and then you had a permanent stain. So you could file that and you can keep it for, we keep them for 20 years. There is also an advantage that if in two or three years time the same patient returned back to the pathology lab for various reasons, you could actually go back and pull their former slides and the pathologist then could review then the former case and the former slides. So it was huge, huge advancement in pathology, in general. And -
CHAYTOR, Q.C.:
Q. So that would take you up to around the mid 1980s then?
MR. GULLIVER:
A. That would be about the mid ’80s to the late ’80s.
CHAYTOR, Q.C.:
Q. And how many stains would you or how many antibodies would you be working with then in the immunohistochemical lab?
MR. GULLIVER:
A. In the very beginning it was very few, very

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

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CHAYTOR, Q.C.:
Q. So Dr. Wang worked with you and to a lesser degree, Dr. Chittal?
MR. GULLIVER:
A. And Dr. Chittal became involved also, yes.
CHAYTOR, Q.C.:
Q. And what about from the technical side, was there anyone who offered you any assistance from that perspective?
MR. GULLIVER:
A. No, not really. There was, I was the only technologist who was performing the procedure. And again -
CHAYTOR, Q.C.:
Q. And you continued for some time to be the only technologist, I take it?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And by this point in time it’s not being done by any machinery, this is all -
MR. GULLIVER:
A. And I guess I should, maybe I should give you some explanation there, also. At this time, and I know through all the testimony you’ve

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

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individually and it was covered, so you provided this humid kind of chamber for each individual slide. And that's what we did for many, many, many years until DAKO, as you know, was the vendor we were using for the vast majority of our antibodies and secondary reagents, when, you know, they came out and developed what we call the DAKO autostainer and, you know, and I think some people think that it became automated, really, the procedure was not automated at all.

CHAYTOR, Q.C.:

Q. And I'll take you to that and get you to explain about the procedure at that point in time. Back then when you first started doing this procedure and it was done in the manual way that you've described, there were very few antibodies and did any of those -

MR. GULLIVER:

A. We may have had maybe ten and then a couple may get added, but it -

CHAYTOR, Q.C.:

Q. Did any of them require antigen retrieval?

MR. GULLIVER:

A. No, no.

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CHAYTOR, Q.C.:

Q. And you continued to -

MR. GULLIVER:

A. There were no prognostic markers being done then.

CHAYTOR, Q.C.:

Q. And you continued then to be the only technologist. And just take us through then your progression then in terms of your career path?

MR. GULLIVER:

A. Then in 1986 at the time our pathology supervisor, he wasn't well, he went off work and he was away for over a year. And during that year period at the time the lab manager for the Health Sciences laboratory, Max Thornhill, he would come to me for any issues within pathology. And then in 1987 Mr. Pittman formally retired, the position was advertised, I went through the whole recruitment interview process and, you know, I was selected as the new pathology supervisor, and that was in 1987.

CHAYTOR, Q.C.:

Q. What did it mean to be the pathology

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supervisor, is that the equivalent of the pathology manager position?

MR. GULLIVER:

A. It would be today, yes. But I mean, in this -

CHAYTOR, Q.C.:

Q. But this was just for the General Hospital?

MR. GULLIVER:

A. Right. In those days we weren't called managers, we were just called, we were called supervisors.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. So when that happened, and of course, you know, going into management, we'd say, it meant that within our union contracts management staff are not to do technical bench work. I mean, that is the bargaining unit staff -

CHAYTOR, Q.C.:

Q. So this is 1987?

MR. GULLIVER:

A. 1987.

CHAYTOR, Q.C.:

Q. So you came off the bench in 1987?

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

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period of time, yeah.
CHAYTOR, Q.C.:
Q. And how were they chosen to be the ones to do this?
MR. GULLIVER:
A. At the time they were the two senior technologists who--of the staff pool that existed at the Health Sciences pathology lab. They were the two senior technologists in pathology lab, you know, as opposed to the other three or four staff who were there. And -
CHAYTOR, Q.C.:
Q. And what does it mean, like, senior, does it matter -
MR. GULLIVER:
A. Longest serving.
CHAYTOR, Q.C.:
Q. Longest serving, right, okay. Doesn't matter if you're longest serving in a particular area or not or -
MR. GULLIVER:
A. Oh, in pathology -
CHAYTOR, Q.C.:
Q. - have a certain aptitude or interest in a

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

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A. Yeah.
CHAYTOR, Q.C.:
Q. And you yourself then moved on into this management position. And -
MR. GULLIVER:
A. '87, yes.
CHAYTOR, Q.C.:
Q. 1987. so I take it you're still fairly junior yourself at that point in time.
MR. GULLIVER:
A. Actually, I was, I think I was the most junior lab tech when I started pathology in seniority wise.
CHAYTOR, Q.C.:
Q. Yes. And so did you have any concerns in 1987 in terms of taking on the management position, in terms of your own level of experience?
MR. GULLIVER:
A. I can't say yes and I can't say no. You know, by 1987, you know, I've got seven years of lab experience. I guess maybe I should also mention that, you know, you still have your work life and then in sort of side by side with my work life, with my profession, medical laboratory profession, you know, I have

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

COFFEY, Q.C.:

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

Q. And what was his answer?

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

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MR. GULLIVER:

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

CHAYTOR, Q.C.:

Q. And how about amongst the other lab supervisors?

MR. GULLIVER:

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

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continue and progress through.

CHAYTOR, Q.C.:

Q. Sure.

MR. GULLIVER:

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

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with the pathology part of the laboratory. It's more aligned with the biochemistry, hematology, coagulation, blood bank part.

CHAYTOR, Q.C.:

Q. So why would you be asked to take that on?

MR. GULLIVER:

A. I have no idea, but he did ask.

CHAYTOR, Q.C.:

Q. So in addition to being the supervisor then of pathology, you also took on the blood collection?

MR. GULLIVER:

A. Right, so a the time, I think it was Vern Whelan, who was the biochemistry manager, and he was the chemistry manager and he was managing blood collection services, and I think he had become a bit frustrated with it and Mr. Thornhill asked if I would take it over, and I told him I will give it a try for six months, with the proviso that if I felt it was too much or I felt that I couldn't handle it, that I'd have to go to him and say "look, you know, I really can't continue on with this" and that happened probably around 1988, and obviously turned -

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CHAYTOR, Q.C.:

Q. I'm sorry, 19?

MR. GULLIVER:

A. Around 1988 this happened.

CHAYTOR, Q.C.:

Q. Okay, yes.

MR. GULLIVER:

A. And I did keep blood collection services and for a number of years. Up until 1996, blood collection services for the Health Sciences remained with me and I have to say that I think that I did a lot of good things in that part of our lab services. We really developed, at that point in time, a full pre-analytical team staff with trained lab assistants who were taking over the blood collection services. We added new duties to that staff where they were assisting the technologists in doing specimen preparations for chemistry, hematology. They were doing the centrifuging, the pipetting and like, you know, making sub samples and all that kind of stuff, got developed under my, I guess, direction or being the manager.

CHAYTOR, Q.C.:

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Q. And I appreciate Mr. Thornhill's sentiment and saw the most potential in you when he chose you as the supervisor. Did anyone, at that point in time, did Mr. Thornhill or anyone else provide you with any additional training in terms of managerial skills?

MR. GULLIVER:

A. Yes. I mean, when I became the--when I first became--I should go back, yes, Ms. Chaytor. When I first became the supervisor of General Hospital, the General Hospital actually had sort of an eight-week training program for new supervisors, new managers, and we spent one day a week pretty well for eight consecutive--I think it was eight weeks or it could be ten weeks--where, for example, out in--first, one Wednesday, you would do all day, you would talk about human resources and staff relations and union contracts and interactions like those kinds of things. Another week, we would spend a full day talking about, you know, budgeting, financial, and so, yeah, we did have an eight-week entry level program for new managers.

CHAYTOR, Q.C.:

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Q. One day a week for eight weeks?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, and in addition then to taking on that and the blood service collection, were you assigned any other major projects when you became supervisor of the pathology lab?

MR. GULLIVER:

A. Well, it coincided, when I was appointed supervisor, it coincided with the Health Sciences General Hospital making a decision that we're going to implement the Meditech hospital information system, and in that that parcel was the laboratory information system piece of Meditech.

CHAYTOR, Q.C.:

Q. Okay, and what was your involvement then in that?

MR. GULLIVER:

A. Well, I pretty well had to play the lead role as the pathology supervisor, along with the other managers or supervisors, like for chemistry, hematology and blood bank, all of us played a very active role in actually

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

CHAYTOR, Q.C.:

Q. And what training or what experience would you have had in that kind of electronic or IT up to that point in time?

MR. GULLIVER:

A. In 1987?

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Very little, as most other people.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. I mean, even computer technology was not something that was--we thought this was a huge, major thing, just for the whole hospital

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

CHAYTOR, Q.C.:

Q. Was that before you got involved with implementing the Meditech?

MR. GULLIVER:

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

CHAYTOR, Q.C.:

Q. So what did you have to do then in terms of where the laboratory medicine program, it's

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

MR. GULLIVER:

A. Well, I mean, I guess and it wasn't just myself, I mean, obviously within each of the modules, lab module, pathology module, blood bank module, micro module, we had other staff involved. I mean, I had staff involved with me.

CHAYTOR, Q.C.:

Q. So you did the pathology end?

MR. GULLIVER:

A. I did the pathology end, yes, and then there's one module that's called LIS shared. It's the lab information systems shared dictionaries where there are commonalities amongst all the modules and all the managers at the time, we all worked together on the LI shared dictionaries, but for the pathology module, yes, it was pretty well my responsibility to ensure that we have, for example, all the

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

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new capabilities of the system that we would go into the test system and we would make sure everything works before it was transferred over to live.

On an ongoing basis, if there was a new procedure or a new work code that needed to go into the system, I mean, obviously early on, I mean, I would be the point person and would do that, and I don't know exactly at what time frame, Ms. Chaytor, but for example Peggy Welsh, who you've heard here testify, who was one of our senior techs, she also, I guess, she could log into the computer system and Peggy helped me an awful lot if there were new procedures to put in and capturing the work load and those kinds of things.

CHAYTOR, Q.C.:

Q. And in implementing then Meditech for the pathology lab, did you run into any particular challenges?

MR. GULLIVER:

A. Certainly. I think the biggest challenge was just understanding what this whole computer system is, you know, we're talking about 1987. It was huge venture for the whole hospital,

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not just for the laboratory. It took an awful lot of interaction with other parts of the health care system and coordinating test menus and order entries with nursing staff, for the lab staff. It was also--I won't say it was--I don't know if it was a significant challenge. I have to say, as a group, the technologists and the staff who would mostly use the system were more inclined to learn the system as opposed to the physicians. So the pathologists group were not difficult, but it was much more difficult to get the pathologists to really start using this new computer system. You know, I can remember one of our pathologists and she recently retired, just sitting down with her to show her how to use like the e-mail system on the computer. You know, she didn't even want to touch a button. But I mean, we're talking about, you know, like 1987, 1988 where this is not a part of everyone's work day type of thing.

CHAYTOR, Q.C.:

Q. And still dealing, I guess, in that time frame then, we're into the late 1980s, up to that point in time, where was the immunology lab

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for the province located? Was that part of the General Hospital?

MR. GULLIVER:

A. No. That comes later. That comes a bit later.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. Yeah, I guess so -

CHAYTOR, Q.C.:

Q. And this is going on then into the 1990s?

MR. GULLIVER:

A. No, in 19--so in '87, I'm pathology supervisor. '88, they ask would I take over the blood collection services for the General Hospital, which I agreed to do, and -

CHAYTOR, Q.C.:

Q. And during that time period then, you're involved in implementing Meditech?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Yes, okay.

MR. GULLIVER:

A. Then in 1993, in the building, the Health

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Sciences, you know, there's a university side and there's a hospital side, on the university side, on the first floor not too far away from the pathology lab, there was an immunology lab that was run by the university, and in that part of immunology, we would have testing for what's called flow cytometry testing. The Health Sciences didn't offer flow cytometry testing. We didn't have the technology, we didn't have the staff that were trained for it, and we would send samples over to the MUN side to do flow cytometry testing. We also sent samples over there, those were the staff that did tissue typing. So patients who were needing of a kidney transplant or a bone marrow transplant, that part of the lab was doing that testing. And at some point between the--and we paid for that service, and actually the whole province paid MUN for that service.

At some point, the University, I mean, above my level, Ms. Chaytor, at some point, the University decided that really almost all the work that was taking place in their immunology lab was clinical work. They were

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

CHAYTOR, Q.C.:

Q. Buttered you up some more.

MR. GULLIVER:

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

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

CHAYTOR, Q.C.:

Q. And when was this, what time period?

MR. GULLIVER:

A. This was 1993.

CHAYTOR, Q.C.:

Q. Okay. So you took that on then in addition to whatever else you had on your plate?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. As time went on then, into the mid 1990s and coming up, I guess, into 1996 when the Health Care Corporation came on board, what changes took place then in your position and overall in the management level with the Health Care Corporation being created?

MR. GULLIVER:

A. Obviously it was a significant event. You know, when it was announced that the City hospitals would be formed into one board, you know, you know that most--the unionized staff

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were also very worried. However, I know management staff were also very worried. You know, prior to the Health Care Corporation coming into being, the General Hospital, the Grace, the Janeway, St. Clare's, all four had well established laboratory services on site. All four had laboratory managers at the time. So there's what we call director today, that was the lab manager and then we had supervisors. All four had a lab manager. All four, to varying degrees, had supervisors, not in all disciplines. The Health Sciences, we had a supervisor in chemistry, hematology, pathology, micro, because we covered--it was the referral centre for the province. For example, the Grace Hospital, I think, had three supervisors, in addition to the manager. The Janeway, I think, had three supervisors, plus the manager, and I think St. Clare's had four supervisors, Ms. Chaytor, in addition to the manager. So when the Health Care Corporation was formed and when it came to the laboratory side of the restructuring, they took the four managers' positions and made one director for the City of St. John's.

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CHAYTOR, Q.C.:

Q. And then that director had -

MR. GULLIVER:

A. Was Mr. Vern Whelan from the Health Sciences.

CHAYTOR, Q.C.:

Q. And had responsibility over the Grace, St. Clare's, Health Sciences and the Janeway?

MR. GULLIVER:

A. And the Waterford.

CHAYTOR, Q.C.:

Q. And the Waterford?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. So five sites.

MR. GULLIVER:

A. And to a certain extent, Bell Island, because there's a small lab on Bell Island.

CHAYTOR, Q.C.:

Q. Okay. So you're down from your four lab managers -

MR. GULLIVER:

A. To one director.

CHAYTOR, Q.C.:

Q. - to one director, and how about in terms of

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

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

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

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

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MR. GULLIVER:
A. We had three staff in genetics at the time who worked at the Janeway; mostly just doing in cytogenetics. Most of the work we do, like, amino fluids, that's the lab it will go to looking for abnormalities, you know, and birth defects.
CHAYTOR, Q.C.:
Q. And those people would report to you too?
MR. GULLIVER:
A. Yes, and then - and today I think we have maybe 18 staff in our genetics service.
CHAYTOR, Q.C.:
Q. So that component has grown substantially?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And in terms then of your division of responsibilities, you're now responsible for the Janeway, and I take it the --
MR. GULLIVER:
A. And Health Sciences.
CHAYTOR, Q.C.:
Q. The Janeway in 1996 was still down in its old site?

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

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MR. GULLIVER:
A. No, by '96 blood collection is taken away from me.
CHAYTOR, Q.C.:
Q. Okay, it's taken away.
MR. GULLIVER:
A. Right, but in place of -
CHAYTOR, Q.C.:
Q. Immunology stays with you?
MR. GULLIVER:
A. Stays with me.
CHAYTOR, Q.C.:
Q. Genetics is added.
MR. GULLIVER:
A. So what's added - so we take away blood collection at the Health Sciences on this side. On the other side, we're moving immunology from the Janeway, pathology from the Janeway, molecular genetic and cytogenics, along with my pathology and immunology at the Health Sciences, and with a view that we knew then in three or four years that the Janeway would physically close and move into a brand new building, we knew the Grace was going to close, so during that time frame, you know, we

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were planning for those physical plant closures and we knew at some point most of the services I was responsible for would be physically located or relocated under one roof, but, I mean, it took three or four years to get there.
CHAYTOR, Q.C.:
Q. And you were involved, I take it, in those changeovers as well?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. In terms of the physical move of the other laboratories?
MR. GULLIVER:
A. Oh, yes.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, then in terms of your workload, did you perceive in 1996 with the creation of the Health Care Corporation that your workload increased?
MR. GULLIVER:
A. It certainly did.
CHAYTOR, Q.C.:
Q. And was there anything done to offset that?

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For example, were there people appointed or did you put in place other people at the next tier below you to help you manage?

MR. GULLIVER:

A. Yes. Every lab had senior staff, and I think every supervisor and manager has their own style of how they interact with staff and how you work with your people. For example, in immunology - I go with immunology to give you a good example. That was an area of lab medicine that really was not a part of our initial training program. You touched upon some of the theory, but in practice it's a very highly specialised dedicated part of lab medicine. Today we have two technologists who work in flow cytometry, and they're the only two in Newfoundland. We have three technologists who work in H & A tissue typing for bone marrow transplants and kidney transplants and they're the only three technologists in Newfoundland. So when I took over that service, I have to admit, I mean, I'm not a technical expert or background in that part of lab medicine, so at the time our senior technologist, Mr. Ernie Stapleton, you

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

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

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CHAYTOR, Q.C.:

Q. And you, yourself, in terms of any technical work up to this point in time then, it would have been ten years since you had performed work yourself in any area?

MR. GULLIVER:

A. By '96?

CHAYTOR, Q.C.:

Q. By '96, '97.

MR. GULLIVER:

A. That's sort of half true.

CHAYTOR, Q.C.:

Q. Okay, so what experience did you have in that ten year period?

MR. GULLIVER:

A. Well, we've always had these occasions where the unionized staff have withdrawn their services, i.e. there's been a strike.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. And when that happens, the manager is expected to be able to go back on the bench and at least perform to a certain level - well, provide sort of emergency stat services for

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the pathologist and pathology, or overall to any physician in the hospital. So even though by 1986, I've been in management for nine or ten years at this time, '97 - yes, I wouldn't say my technical skills were equal to the techs, but there were many occasions where I would have had to go back on the bench and do some of those things.

CHAYTOR, Q.C.:

Q. Whenever there was job interruption?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And -

MR. GULLIVER:

A. I would say, though, Ms. Chaytor, I mean, from that point onwards, if there was something like that, I really didn't have the technical skill to go back on the bench and do IHC testing, for example, in pathology.

CHAYTOR, Q.C.:

Q. Yes, right.

MR. GULLIVER:

A. But I could certainly do your basic embedding, your basic cutting, H & E's, and other things.

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I mean, some of those things are like riding a bike, once you learn it, you learn it, and you kind of don't forget it.

CHAYTOR, Q.C.:

Q. At the time you were appointed then pathology manager in 1996 for the Health Science and the Janeway -

MR. GULLIVER:

A. The corporation, yeah.

CHAYTOR, Q.C.:

Q. Right, the Health Care Corporation. So you have two sites, the Health Science and the Janeway. Who is appointed your equivalent for the Grace and St. Clare's?

MR. GULLIVER:

A. There was a - I guess the way things worked out, there were ten positions approved at the management level for labs for the City of St. John's, and again I think there was 21 in the city existing. However, one of our managers decided to leave and took another position over at Canadian Blood Services, and the vast majority of others were pretty well close to or at retirement age. So no one really got downsized and cut, but pretty well most of the

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senior managers then at the time were offered, I guess, some kind of incentive or package, they called it, to either take early retirement or they were at retirement. So there were ten of us left and there were ten slots to fill. We applied for positions. You know, there were two positions for pathology for the city, there were two hematology managers for the city, there were two chemistry managers for the city, and two micro managers for the city, and some managers applied for four or five different jobs, you know, just to make sure they had a foot in one or the other. So how it ended up was there were three - at the time there were three managers in hematology left in the system of the ten, and two of the hematology managers were given the new positions, and the third person that was sort of left out of the hematology side, Mr. John Murphy, at St. Clare's, and he had been working in hematology blood bank for a number of years, he was offered the position of pathology manager for St. Clare's and the Grace.

CHAYTOR, Q.C.:

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Q. And did he have any background in pathology?

MR. GULLIVER:

A. Not to my knowledge, no.

CHAYTOR, Q.C.:

Q. Were you asked to do anything then to assist Mr. Murphy in his -

MR. GULLIVER:

A. I wasn't formally asked in sort of a formal written way. You know, at the time, I guess Mr. Whelan and Dr. Haegert had a decision to make. If they felt Mr. Murphy was not the best candidate for that pathology position, they would have to re-advertise and they pretty well would have to look at him, you know, here was a man with 30 years service, you know, wasn't close enough to retirement age to avail of any kind of incentive, and do you just cut him loose and lay him off. So Mr. Whelan and Dr. Haegert spoke to me and they said, you know, Terry, you know the Grace is going to close at some point for pathology, but, you know, would you sort of keep an eye out for John Murphy over at St. Clare's and Grace, and I said I would. What they meant was keep an eye out so, like, when John first

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

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senior staff at the Grace and St. Clare's, they had no problem picking up the phone and calling me up and asking, Terry, listen, we have an issue over here, or we need this and we need that.

CHAYTOR, Q.C.:

Q. And that happened from time to take, I take it?

MR. GULLIVER:

A. That happened fairly frequently.

CHAYTOR, Q.C.:

Q. So you were keeping an eye out, so to speak, on what's going on at the Grace?

MR. GULLIVER:

A. And we did set up - I guess, another big piece of the restructuring that I think was an important piece - we're talking now solely administrative side of the lab, the new program structure. On the clinical side of the program, there was also a huge change, that each site had -

CHAYTOR, Q.C.:

Q. I'll get to that. I just want -

MR. GULLIVER:

A. Oh, okay.

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CHAYTOR, Q.C.:

Q. Before we leave, though, the issue of the management of the pathology lab at St. Clare's and the Grace.

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. So you offered up to Mr. Murphy any assistance that you could render from time to time. Frequently you say that the staff there knew you and they would contact you and ask for advice or input. How about Mr. Murphy, himself, did he have occasion to continue or to avail of your services and take you up on your offer?

MR. GULLIVER:

A. Oh, yes. I mean, John called me on a regular basis, and we actually met - we tried to meet on sort of a monthly basis, or a bi-monthly basis, myself and him, and at the time whoever our site chiefs were on the clinical side of pathology. We did meet regularly, you know, formally meet, and talk about common issues amongst pathology at the Grace and at the time St. Clare's, Health Sciences, Janeway, and

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talking about bigger issues, like, well, the Janeway is going to close, the Grace is going to close, and getting our heads around the long term of what is pathology going to look like at some point in the future.

CHAYTOR, Q.C.:

Q. So it was acknowledged by the clinical chief of the day and Mr. Whelan, who would have been your direct supervisor, and that of Mr. Murphy, that he lacked experience in the pathology side of the lab. Was there anything, do you know, in addition to you keeping an eye out and answering any queries that may come your way, was there anything additional done for Mr. Murphy to enable him to take on the position of the pathology manager at St. Clare's and the Grace?

MR. GULLIVER:

A. I don't believe there was, no.

CHAYTOR, Q.C.:

Q. And what kinds of questions or issues would arise that your assistance would have been sought from those two sites over that period of time?

MR. GULLIVER:

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A. I really can't give you a whole list of specific things, but it could be anything. It could be anything from any piece of pathology. It may be staffing issues, it may be budgeting issues.

CHAYTOR, Q.C.:

Q. I guess staffing and budgeting, though, he would have had experience in how to do that? He was hematology manager for years.

MR. GULLIVER:

A. I would have assumed -

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Other issues, he really didn't understand Meditech, the computer system from the pathology side could be issues. He would - and sometimes it would be very basic things, you know, basic technical questions in pathology. A lot of them, though, were more focused on processes, systems kind of things, and processes kinds of things.

CHAYTOR, Q.C.:

Q. And how long did Mr. Murphy remain in that position?

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MR. GULLIVER:

A. John stayed in that position, actually, until late 2001, early 2002.

CHAYTOR, Q.C.:

Q. You were going to say there was also changes with the Health Care Corporation in terms of the clinical side of the laboratory?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. So perhaps you could tell us about that?

MR. GULLIVER:

A. Again prior to the Health Care Corporation, all four of the major hospitals in the city, they had a lab manager, and some of them had a - I think all of them did, then had a clinical side, a pathologist, who was - they had different names. At the Health Sciences, our clinical chief was also university chair. St. Clare's, for example, their pathologist, I think, was also called laboratory director, and I think the manager was called laboratory manager, and I think that's the way it operated at the Grace also where the clinical person was called the lab director, and the

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administrative person, like myself, and was called the lab manager. At the Health Sciences, it was laboratory manager and it was the clinical chief, I guess, because it was a much more extensive service. So during that restructuring - and then the other hospitals, Ms. Chaytor, didn't have clinical people like in hematology, microbiology, and chemistry, as the Health Sciences did. We were the tertiary care reference centre for the province. We had that level of expertise also available to us. So in the clinical side of restructuring there was a division manager for hematology, and then there was a division chief appointed for hematology for the city of St. John's. At the time that was Dr. Cindy Whitman, who is still with us.

CHAYTOR, Q.C.:

Q. And she would be in that position for all four sites?

MR. GULLIVER:

A. Yes, on a clinical side.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

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A. We appointed at the time Dr. Prabhakaran. He was the chief biochemist at the Health Sciences and he became the chief biochemist for the city of St. John's, and Dr. Randell, who at the time was the biochemist at the Janeway, still remained in that role on the pediatric side of biochemistry. Dr. Jim Hutchinson was the chief at Health Sciences and he assumed the greater role to become the division chief, microbiology for the city of St. John's. At the time in cytology in '96, I don't remember who was our division chief there.

CHAYTOR, Q.C.:

Q. But there was one, I take it for the entire city.

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And what happened with pathology?

MR. GULLIVER:

A. And pathology was different.

CHAYTOR, Q.C.:

Q. Why is that? Tell us about that.

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

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MR. GULLIVER:

A. None whatsoever.

CHAYTOR, Q.C.:

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

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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A. I think so.

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

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pathologists to be able to voice their concerns or opinions too, for pathologists on those sites to be able to go for advice or for expertise, I think it's a good thing. I don't know necessarily if it was the right thing for the way the Health Care Corporation was being restructured and if it was the right thing for program based management. I think that when--and if you put it in the bigger picture, we know the Grace is going to close, that the decision has been made by government. We know the Janeway is going to move into a new building. And having four chiefs, I think, hindered that process to a certain extent.

CHAYTOR, Q.C.:

Q. So, it hindered the consolidation or bringing together of the program, is that what you're saying?

MR. GULLIVER:

A. It was my experience. And not for--I think it's more self preservation kind of mode as opposed to not agreeing with something or not wanting to change or do something differently, you really have to understand that, you know, when you've got staff or physicians who are

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use to their culture and used to their setup, you know, everyone is different, you know. You can show through my whole career, I love change. I embrace change because I don't want to do what I did yesterday. And maybe I'm on the other end of the spectrum, but certainly I have encountered technical staff, management staff and physician staff who are on the other side. Their comfort zone is, this is where I came to work, this is where I like to work, this is the way I do things, and I really don't want to change the way I do things. So having the four site chiefs in place, I think in theory it was a really good--it was needed to provide that clinical leadership to the pathologists on all sites and to really allay their fears of what's going to happen when the Grace closed and when the Janeway closed and where are services going to move to and where are pathologists going to move to? But I think over on the big picture schemes of the organization side, I don't think it helped the process a lot.

CHAYTOR, Q.C.:

Q. So I guess it made it more difficult to get

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consensus on how to move forward with the program?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Because you have that many more people who have a say in it. Did it impede in any way the effect of operation of the Laboratory Medicine Program?

MR. GULLIVER:

A. You mean laboratory overall in general?

CHAYTOR, Q.C.:

Q. Yeah, the overall--did you see it on a practical basis that it had any effect?

MR. GULLIVER:

A. I would have to say no because even though the pathology structure was different than the other six divisions, the pathologist site chiefs were pretty well only, really involved interested in, you know, what their profession is, as pathology. They didn't really have much impact or say on how hematology was restructured or organized or how services were developed or offered or biochemistry, because we did have a clinical leadership there along

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with our division managers. So really, I mean the question is outside of pathology had very little or no effect; within pathology, it's debateable. I mean, did it have, did it impeded progress or maybe it slowed down process and made us think more.

CHAYTOR, Q.C.:

Q. What did -

THE COMMISSIONER:

Q. Excuse me, there's just one small little detail that I need clarification on. We're talking about the four site chiefs.

MR. GULLIVER:

A. Site chiefs, yes.

THE COMMISSIONER:

Q. And I'm just a little unclear as to what you said about the position of clinical chief for pathology?

MR. GULLIVER:

A. Well there's no clinical chief for pathology.

THE COMMISSIONER:

Q. Well that's my point, is there just four equal level site chiefs or does one of the site chiefs also act in another capacity?

MR. GULLIVER:

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A. No, there's a clinical chief, Dr. David Haegert for all laboratory services, including pathology and microchemistry.
THE COMMISSIONER:
Q. Okay.
MR. GULLIVER:
A. And the next organizational level down, you have your manager structure and administrative structure; on the clinical side we have a similar structure as the managers, on the clinical side with hematology and chemistry and microcytology.
THE COMMISSIONER:
Q. Un-hm.
MR. GULLIVER:
A. But on the pathology side then, there were four other pathologists who had a designated role as site chief for the four different individual sites.
THE COMMISSIONER:
Q. Okay, so what was called -
MR. GULLIVER:
A. And they reported up through the clinical chief.
THE COMMISSIONER:

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Q. So that's really what I wanted to make sure about, what happened is it went from clinical chief laboratory to, in everything except pathology, a person who is--was responsible for their particular special branch of the service throughout the whole of the city; whereas on the side of pathology, it branched into four.
MR. GULLIVER:
A. Right.
THE COMMISSIONER:
Q. So there would be no one person to whom the clinical chief could say, ask questions or have a discussion vis-a-vis pathology in its totality.
MR. GULLIVER:
A. Exactly.
THE COMMISSIONER:
Q. Okay, all right. Thank you.
CHAYTOR, Q.C.:
Q. The clinical chief would have to deal with four people on that.
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:

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Q. And try and reach consensus.
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And in terms of then the technical staff and in terms of looking for any direction from the clinical side, who would they go to if they needed direction from the clinical side?
MR. GULLIVER:
A. Are you talking, because my structure is Health Sciences Janeway.
CHAYTOR, Q.C.:
Q. Yeah, so who would they go--they'd go to whichever is their site chief at their particular site, is that how that would work?
MR. GULLIVER:
A. It would all depend on what they're looking for. If they're looking for--if it's a budgeting issue or supplies issue or equipment issue -
CHAYTOR, Q.C.:
Q. No, clinical.
MR. GULLIVER:
A. Oh clinical issue. Oh, clinical you would go to your site chief. So, for example, I mean

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at the Janeway it was very simple because, you know, you had Mr. Dyer there as the technologist.
CHAYTOR, Q.C.:
Q. Yes, but St. Clare's would speak to whoever who the site chief was there -
MR. GULLIVER:
A. Exactly.
CHAYTOR, Q.C.:
Q. Take direction from the clinical side, from ever who the site chief is there.
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. Health Science would be ever who is there and Grace, so on.
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. Did the existence of the four site chiefs for pathology impede in any way Meditech consolidation across the four sites?
MR. GULLIVER:
A. I guess you're referring to when the Health Care Corporation decided to go to one computer

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system and not have multiple systems in place.
CHAYTOR, Q.C.:
Q. Yes, you had come together in 1996, it's going--it's one corporation -
MR. GULLIVER:
A. No, but that doesn't happen until--Meditech consolidation doesn't start until maybe '98 we started on that project.
CHAYTOR, Q.C.:
Q. And was that at all influenced by the fact that you had four site chiefs?
MR. GULLIVER:
A. Again, it's a yes and no answer. No, it had no impact whatsoever on the actual consolidation of Meditech. And yes, it had impact on trying to standardize things within Meditech.
CHAYTOR, Q.C.:
Q. For the pathology lab is what I'm asking about.
MR. GULLIVER:
A. Yes. So the actual consolidation had no impact.
CHAYTOR, Q.C.:
Q. Takes place, but how does it affect your

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

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

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

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testing. Are you able to say that lack of standardization in terms of test names or procedures and what you're talking about in terms of the nitty gritty actual forms and how the information is to be kept, did that impact or make your job more difficult in 2005 and 2006 for identifying patients?

MR. GULLIVER:

A. I guess, are you trying to ask me that if we had to do a better job of consolidation in '98, would it have been easier to do the patient searches in 2005?

CHAYTOR, Q.C.:

Q. Sure.

MR. GULLIVER:

A. I don't think so.

CHAYTOR, Q.C.:

Q. And why not?

MR. GULLIVER:

A. Because we all agreed upon the procedure codes and the pneumonics and test names, I mean, all that stuff was done and implemented and finished. I guess if you really wanted to look at it and I still wouldn't be able to give you--it's just my best opinion, if you

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look back at 1998, the kinds of things that we were trying to get agreement upon, I mean, you're probably going to look, think about standardized reporting formats, I mean, that's what you're talking about. However, we were talking about standardized report formats in this is how the report is going to look, this is how the report will print and how it will be laid out, so when a physician or surgeon receives a path report from any lab in the city, it will look the same, it will flow the same and follow the same. We were never talking about within that report having a standardized format for how pathologists interpreted or dictated their reports. That was never discussed, but to go back to -

CHAYTOR, Q.C.:

Q. So any difficulties -

MR. GULLIVER:

A. - and to answer your question in theory that in 1998 we had to have sort of every path report, that if this was a breast cancer report, in '98 we went through a whole consolidation and standardization. If we had to put in a standardized, not just a report

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format, but what goes in the report -

CHAYTOR, Q.C.:

Q. The content as well, yes.

MR. GULLIVER:

A. The content in the report, maybe that might have helped with the searches in 2005 in that it would have given us a second avenue to cross-reference the searches that I had done in 2005 by searching the procedure codes.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. But again, it's a stretch to say, you know, I can't say for sure if it would have really helped or it would have been any better or worse.

CHAYTOR, Q.C.:

Q. Do you have any reason to believe that the difficulties you were having in standardizing the actual format were any different for the individuals who were trying to standardize the content?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

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Q. You do have reason to believe that it's different?

MR. GULLIVER:

A. You're saying -

CHAYTOR, Q.C.:

Q. Do you have any reason to believe that if you encountered difficulties in 1998 and trying to standardize the format of the form, that perhaps the individuals who were trying to standardize the content that went into the form were also dealing with the same issues and encountering the same obstacles that you encountered?

MR. GULLIVER:

A. I would have to say I think so, yes.

THE COMMISSIONER:

Q. Mr. Gulliver, when the consolidation of Meditech was being or the standardization of Meditech or however you want to phrase that, the process of putting the Meditech system -

MR. GULLIVER:

A. Into one.

THE COMMISSIONER:

Q. Into one. What was the level of involvement of Meditech itself and was there any

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consideration at that time about things like search fields, the kinds of little buzz words that we now know assist us in trying to extract information out of your systems.

MR. GULLIVER:

A. There was very little involvement from Meditech at the lab level. Meditech was involved at the organizational level in dealing with IM&T in how this will roll out and making decisions, okay, once you've decided upon your St. John's wide menu or system, how it was going to work by then, stopping the Grace and then implementing the new and stopping the Janeway with the new. But what we used, Justice Cameron, the pathology module that existed in Meditech at the Health Sciences, because it was the largest module and it was the largest database, pretty well all what we did, we changed the dictionaries in the Health Sciences system and incorporated many good things that were taking place at the Grace and St. Clare's and Janeway, that their practices were better than the Health Sciences in some cases and they were behind Health Sciences in

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others. We took the best of all of them and we put them all into the Health Sciences system and it was like Meditech then flicked a switch and said, now, that's the system that the Grace is now using and that's the system that the St. Clare's is now using.

THE COMMISSIONER:

Q. So it really wasn't - I'm just trying to get into my mind the -

MR. GULLIVER:

A. It was not a Meditech upgrade.

THE COMMISSIONER:

Q. The nature of the -

MR. GULLIVER:

A. Exactly.

THE COMMISSIONER:

Q. It was a case of melding, not a case of saying, okay, what is the best kind of system now at this stage in our lives?

MR. GULLIVER:

A. No, it was not, no.

THE COMMISSIONER:

Q. And we'll all up this into the best system as opposed to one that actually gets together?

MR. GULLIVER:

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A. Right.

THE COMMISSIONER:

Q. Thank you.

CHAYTOR, Q.C.:

Q. Mr. Gulliver, when was the switch flicked?

MR. GULLIVER:

A. When was the switch flicked? I can't tell you the exact date.

CHAYTOR, Q.C.:

Q. What year?

MR. GULLIVER:

A. I think in '99, the Grace came on to the system. Well, St. Clare's did first, then the Grace, and then the Janeway came on before 2000, and really -

CHAYTOR, Q.C.:

Q. The Janeway would have been moved in '99, is that right? The Janeway physically moves in 1999?

MR. GULLIVER:

A. Maybe Janeway came on first and then the Grace, but they came on within fairly close time frame to each other, and they had to come on first, you're right, I mean, the physical plants were closing.

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CHAYTOR, Q.C.:

Q. So by 2000, though -

MR. GULLIVER:

A. Yes, certainly by late '99, early 2000, were all operating - not just pathology, but all laboratories are all operating under the one Meditech system for the city of St. John's, all the nurse order entries operating for the city of St. John's, so, you know, a nurse at the Waterford can order a blood test and the order just goes into the system, and even though it's getting tested at the Health Sciences, it can be collected over there, bar coded and sent over, so all that starts to take place around 2000.

CHAYTOR, Q.C.:

Q. Mr. Gulliver, I'd like to ask you now some questions about Dr. Khalifa and your knowledge of him and what he accomplished while he was here in St. John's. Did you have, yourself, a good working relationship with Dr. Khalifa, and perhaps you can tell the Commissioner what you actually remember about Dr. Khalifa and his involvement here?

MR. GULLIVER:

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A. Well, Dr. Khalifa was appointed site chief for the Health Sciences. I loved working with Dr. Khalifa. I thought he was an excellent pathologist and I think he exhibited skills that you rarely find in physicians, and that would be administrative skills. I think he was a very good administrator, I think he was an excellent communicator, and I think the biggest part he probably played - and that's at my level, as the manager, and interacting with Dr. Khalifa and working with him, I think the biggest role he played for us was pretty well as a teacher. I think that he taught our technologists who worked with him directly an awful lot. I think he instilled confidence in our staff, and I actually believe that he taught our pathologists a fair bit.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. And not just myself, I think many of us were so disappointed and sad when he decided to leave and go - leave Newfoundland.

CHAYTOR, Q.C.:

Q. What do you recall about his role in initiative ER/PR as IHC tests?

MR. GULLIVER:

A. Obviously, he was the key player, he was the lead role in implementing and transferring this science from a biochemical assay methodology in our chemistry lab, you know, now to the IHC part of our pathology lab.

CHAYTOR, Q.C.:

Q. So he introduced you to that notion. Were you even aware that these antibodies, ER and PR, existed through the IHC method at that point?

MR. GULLIVER:

A. At that point, probably not, Ms. Chaytor. I certainly did know that estrogen and progesterone was a methodology that was performed over in biochemistry.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. I knew that much, but certainly to have that level of knowledge that Dr. Khalifa possessed, no, I did not.

CHAYTOR, Q.C.:

Q. And this is now, I take it, into the late 1990s?

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MR. GULLIVER:

A. I guess, you know -

CHAYTOR, Q.C.:

Q. That time period, '97.

MR. GULLIVER:

A. Late '96, early '97, when he's talking about this and starting to do - working with Dr. Prabhakaran and I guess doing correlations and those things.

CHAYTOR, Q.C.:

Q. Okay, and at that point in time then, at the time that Dr. Khalifa is looking at bringing on ER/PR, how many other antibodies would it have been available at the Health Science, how many IHC antibodies were you using at that time?

MR. GULLIVER:

A. By '97, I mean, this is just a guesstimate. I mean, I would assume it could be up in the 40s, 50s, 60s, or 70s. By that time, there were antibodies for most of your major cancer sites in the body. There were antibodies in development and in production and in use around the world for prostate cancers, lung cancers, and lymphomas, carcinomas, and brain cancers. So by that time, IHC testing is fairly well established within pathology, not pathology in St. John's, but pathology, in general, within the country.

CHAYTOR, Q.C.:

Q. And how many antibodies would you have available here at the Health Science at the time?

MR. GULLIVER:

A. You mean today or at that time?

CHAYTOR, Q.C.:

Q. At that time.

MR. GULLIVER:

A. I think it was probably in the 40s or 50s. That's my best estimate.

CHAYTOR, Q.C.:

Q. Are there any records that still exist which would tell us which antibodies you would have had in that time period?

MR. GULLIVER:

A. What kind of records would you be looking for?

CHAYTOR, Q.C.:

Q. Well, whatever you have.

MR. GULLIVER:

A. We can give you the actual physical slides.

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CHAYTOR, Q.C.:
Q. Yes, but in terms of actual documents to say -
MR. GULLIVER:
A. And to me - to me, the permanent record - in pathology, we always consider your permanent record is the actual -
CHAYTOR, Q.C.:
Q. So for you to tell me that, you'd have to go to a slide?
MR. GULLIVER:
A. Is actually the block and the slide. That's our permanent record.
CHAYTOR, Q.C.:
Q. So for you to tell me or answer at, you'd have to go and actually pull the slides and blocks?
MR. GULLIVER:
A. No, what I have to do -
THE COMMISSIONER:
Q. Did a requisition form reflect what it is you were offering at that -
MR. GULLIVER:
A. Well, we don't keep paper requisitions for ten years. So what I would have to do, I would have to go into the Meditech system and pretty well go and do a search to look for what

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antibodies were performed in the year 1997. So whether it was LCA, EMA, you know, all the list, it may be there.
CHAYTOR, Q.C.:
Q. So the checklist that we see for the requisition that you now have where the pathologists can tick off what they wanted, would there be such a form that would exist at different points in time?
MR. GULLIVER:
A. Well, Dr. Khalifa, actually, I think, was the one who put all that form together, but I - the actual hard copies of those requisitions are not kept ten years later.
CHAYTOR, Q.C.:
Q. But the standard form -
THE COMMISSIONER:
Q. We're just looking for one of them, though, in the sense of do you have some kind of a file which contains not forms from a particular person, but the development - which would demonstrate the development of the form over time, including the addition of various new tests available, you know, in 2000 or - sorry, more in 2002 and 2003, etc?

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MR. GULLIVER:
A. That generally is practice, Justice Cameron, that if you been using this form for five years and you switch to a newer form -
THE COMMISSIONER:
Q. Uh-hm.
MR. GULLIVER:
A. You generally do keep a copy of the old form, and I can't say if we have one or not. I've seen evidence here where you've had copies of those forms.
CHAYTOR, Q.C.:
Q. Two different forms. Yeah, we've seen at least two different forms.
MR. GULLIVER:
A. And I don't know if there is, like I said, an older copy of any older forms.
CHAYTOR, Q.C.:
Q. Okay, well, maybe that's something if you wouldn't mind if you could check for us and see if there are the different forms over time.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:

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Q. That might be helpful.
MR. SIMMONS:
Q. If I can help with that, there have been quite a few copies of requisition forms supplied, and I just checked my notes and there are ones from as early as 1996.
MR. GULLIVER:
A. That's what I thought too.
THE COMMISSIONER:
Q. It seems to me I remember a witness talking about the changing - the forms reflecting the change because they were adding various things, but I don't remember which form - which witness, sorry.
CHAYTOR, Q.C.:
Q. What we're looking for is what would have been through the whole course in time, whether or not we have all of them or not, and I don't know that we know that. Mr. Gulliver, how would you, as the manager in that time frame, 1997/1998, how would you keep apprised as to the developments in the IHC area?
MR. GULLIVER:
A. You mean at the technical level?
CHAYTOR, Q.C.:

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Q. In terms of you to be able to do your job as manager of the people who are actually performing the tests, what would you do to keep apprised as to, well, these are the number of antibodies they now have, here's what's happening in the IHC lab, here are other developments, other things that may be coming on stream? How did you keep yourself apprised?

MR. GULLIVER:

A. Well, I guess some of the things - well, everyone has their own role. At that time, Dr. Khalifa certainly was our key lead person. You know, the technical staff relied upon him, as did I, that if there are new advancements in IHC - not just Dr. Khalifa, you know, we had multiple pathologists practising at the Health Sciences who were ordering and reading and interpreting IHC tests. We had many occasions where, Dr. Mathieson who for a long time was our newer pathologist, and he would come with information and say that there's a new antibody coming out that we could use for newer pathology for certain brain tumours. You know, we would go to either Khalifa or the

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

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of changes from ad administrative side, like, technology changes, or if there were new improvements in the kinds of reagents that we're using and the company is offering us, look, for an extra ten bucks, you know, a pop, we can give you new and improved type of stuff. I mean, those are the things I'd be more involved in. On the clinical decision side, that really was left to the pathologists.

CHAYTOR, Q.C.:

Q. And in terms of your overseeing of the staff and what the technologists are actually doing with the staining, what role did you play in that?

MR. GULLIVER:

A. Do you mean in assessing the quality of the stain?

CHAYTOR, Q.C.:

Q. In assessing - overseeing their work as their manager, what role did you play?

MR. GULLIVER:

A. Well, certainly in overseeing their work, I mean, within the pathology environment, and it's different than other parts of the lab,

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within the pathology environment the technical staff and myself, as the manager, we certainly rely upon a lot of feedback from the pathologists who - you know, as you've heard here before, every slide that's produced by the technologist is read and interpreted by a pathologist. So we rely upon the pathologist for constructive feedback. If they find that someone's work isn't up to scratch, they would certainly come to me and tell me so, and as the manager, I mean, it was my duty to deal with that. If no pathologist ever came and had an issue, I certainly just assumed that the technical staff, in general, not just IHC staff, but all the staff, you know, are performing their work as per protocol.

CHAYTOR, Q.C.:

Q. So no news is good news?

MR. GULLIVER:

A. Not necessarily. You know, I don't think that within the pathology lab - the work in there is so technical, it's so hands on, and the volume of work in there, you know, it would be impossible to go in the run of a week and not have a complaint on something. Whether it was

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this particular slide, the tissue was folded over, and had to recut a block to get a better section, or whether it was, I don't know if the H & Es are really that crisp today, you know, go in and troubleshoot and see, maybe the hematoxin is getting a bit off, and you need to filter it or replace it. That's the kind of environment that pathology is whereas if you looked at the other divisions, if you looked at in chemistry where a lot of their work is based upon these million dollar analyzers, pretty well you're putting blood specimens in, it's giving you a cholesterol results or glucose result, and if all those results fall within this exact parameter and the controls are working, then there's never an issue. Pathology is different.

CHAYTOR, Q.C.:

Q. My point being, though, you relied on pathologists to bring any issues to your attention and along life's way, complaints did come forward?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

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Q. And you would then deal with your technologists on it?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Would it also - you'd have feedback, I take it, directly from your staff as well?

MR. GULLIVER:

A. Oh, certainly, I mean -

CHAYTOR, Q.C.:

Q. Coming to you and looking for assistance?

MR. GULLIVER:

A. Obviously, all the time, and I'm not saying that I did this all the time, I was certainly a manager who felt very close to the staff and worked very well with all the staff, and, you know, I have an open door policy, you can come and speak to me about anything, and they did come and speak about anything, and I also felt it was important to have feedback from my viewpoint to the staff, I also felt it was really critical to have staff give feedback to me of how they felt my performance was. So - and as you can - you've heard through all the testimony about the workloads and all those

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things. I did make a concerted effort to meet on a fairly regular basis with staff individually and just talk about, you know, how do you feel here? Do you think you're doing good work? Do you feel I'm supporting you? Do you feel there's something else I can do? And if I had issues with the staff, that's the time where we would talk about it.

CHAYTOR, Q.C.:

Q. And you've spoken a bit about how you keep apprised and you're not sitting in your office, I'm hearing you, reading a book, but you're out and about and you're going to conferences and you're involved in your voluntary efforts. What about the technologists who are actually doing the staining and doing the work, what opportunities were made available to them to attend conferences where they could learn?

MR. GULLIVER:

A. I would have to say, I mean, you know, certainly the Health Care Corporation, through all the--through whatever, you know, we didn't have millions of dollars lying around for education budgets that we could send staff off

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to annual conferences or to get--to keep apprised of things. A lot of it, you know, a part of our profession is that we--you kind of expect that med-lab science is med-lab science. It's an evolving science every day. We couldn't do HIV testing 15 years ago as we can do today. I mean, everything advances. A part of our life-long career is to self learn and to keep up with the new advances and new technology. But Mary and Peggy, who were the two techs primarily doing the testing, you know, for most of the years, they attended many of the conferences I did. I sat in lecture rooms, similar to this room, with myself and Mary and Peggy, listening to a lecture from a doctor or pathologist or another technologist, some -

CHAYTOR, Q.C.:

Q. Where IHC was discussed?

MR. GULLIVER:

A. Yes, sometimes -

CHAYTOR, Q.C.:

Q. Okay, here in the City?

MR. GULLIVER:

A. Yeah.

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CHAYTOR, Q.C.:
Q. Okay, and who would have been giving the lectures at that point in time in IHC?
MR. GULLIVER:
A. My gosh, I can't tell you all the many of them over the years that I've attended.
CHAYTOR, Q.C.:
Q. Who would have been -
MR. GULLIVER:
A. For example, Brian Hewlett, who's been called here now, be testifying next week. I mean, Brian has been in St. John's and given a workshop in IHC that our techs participated years--this is many, this is going back 15-20 years. Through our national professional conferences, which I know Mary and Peggy has attended a fair number of them, they would make a point of if there was a lecture on IHC testing or pathology in general, they would make a point to attend them and any new information, they would bring it back to the lab.
Our annual provincial lab conference in Newfoundland, I myself have given some lectures back in the early days in IHC testing

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and pathology in general. Peggy has given them. Pathologists have given them. So I mean, there's been numerous occasions where we've been able to, you know, attend lectures in IHC. However, I don't--I mean, even--that just keeps us in the periphery, you know. It doesn't mean that they've been off to do sort of a really in-depth two week, you know, training in troubleshooting or interpretation or those things, which we've heard from, you know, from Trish Wegrynowski in Mount Sinai. You know, we have to realize, we've practised down here in St. John's, you know. We're on the far reaches of the country and you know, we're not in the mainstream.
CHAYTOR, Q.C.:
Q. No, but you're a tertiary care centre offering the same service that Trish Wegrynowski is offering. So are you saying that -
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. - the training of your staff would be any less than what they would be for her staff?
MR. GULLIVER:

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A. No. I don't think that we're offering the same service either.
CHAYTOR, Q.C.:
Q. Well, you're offering--well, in terms of what we're dealing with here.
MR. GULLIVER:
A. I think Mount Sinai--we offer a similar service, but I think Mount Sinai sort of offers, also offers service where you can -
CHAYTOR, Q.C.:
Q. But in terms of the ER/PR tests.
MR. GULLIVER:
A. - but you can send and get expert interpretation and opinions and you can, as consult and those things. We never offered that level of service to say that we can-- "send us your work and we'll do a consult for you." I'm just saying in the environment in Toronto, for example, where Trish--at Mount Sinai and other techs who I know, you know, they have a networking process within Toronto, within Greater Toronto, within Hamilton, McMaster, London University Health Network, you know, there's greater opportunities there to stay in tune with your coworkers in IHC or

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your pathologists that we don't have that luxury here, never did.
CHAYTOR, Q.C.:
Q. So at the time that the ER and PR is introduced then through the IHC method by Dr. Khalifa, did you understand that there was anything peculiar about ER and PR as opposed to the other antibodies that were being offered at the time?
MR. GULLIVER:
A. I certainly knew through Dr. Khalifa and through, I think it was Mary, I think Mary did most of the work with Dr. Khalifa in doing the correlations and I'd say Peggy probably had a hand in it also, but yes, I certainly was aware that there was a new step being added for the antigen retrieval process, that these two markers were prognostic and they were very difficult antibodies that I knew that there could be lots of things could go wrong with it in the antigen retrieval and this was--that was a new step being added to our IHC methodology.
CHAYTOR, Q.C.:
Q. And would this have been the first time that

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the staff would have to do antigen retrieval?
MR. GULLIVER:
A. Yes, certainly.
CHAYTOR, Q.C.:
Q. And what were they--what instruction were they given then to how to carry out the procedure?
MR. GULLIVER:
A. Again, I mean, Dr. Khalifa--I mean, I certainly didn't instruct them.
CHAYTOR, Q.C.:
Q. And Dr. Khalifa would instruct them from a technical point of view?
MR. GULLIVER:
A. Dr. Khalifa, certainly, and the main instruction though came from, Ms. Chaytor, DAKO. As you are aware, were--that's where we were purchasing most of our antibodies and reagents and subsequently reagents and detection kits, you know, they provided to the lab here, I mean, and before all this stuff comes to the marketplace, I mean, there are years of research put into this by companies, you know, and they recommended to their customers that if you're going to do ER/PR, here is the antigen retrieval process that

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

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Q. Ms. Chaytor, wherever you can find an appropriate spot, we'll take the morning break.
CHAYTOR, Q.C.:
Q. Okay. Actually, this is a good spot, please, Commissioner.
THE COMMISSIONER:
Q. All right. We'll take 15 minutes.
(BREAK)
THE COMMISSIONER:
Q. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, I'd like to just canvas a little bit more about the training of the staff in the IHC area. And Registrar, if we could please the transcript of Trish Wegrynowski, June 25, 2008? I'm at page 33, please, Registrar. Mr. Gulliver, I'm not sure, perhaps you were here when Ms. Wegrynowski was giving her evidence or -
MR. GULLIVER:
A. I was not, no.
CHAYTOR, Q.C.:

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

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

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always kept by our microscope."

She goes on to say "and so that's just part, just of that portion, and then the technologist would start moving on to what we call the sort and handling desk which is where if you have 400 slides looking at you, you have to find a way to put them in some semblance of order," and then she continues on the next page with "many of them will start with very simple techniques, which is a kidney biopsy. If it comes in cut on a microtome," and she goes on to talk about "and from there, in a very slow organized fashion, they move on to being able to work on the equipment, understanding the equipment, what the alarms mean, if there is a problem with set up, how do we change drops and that is gone over in a very slow fashion. From there, we'll start working on getting the slides out and then sitting down together and finally reading the controls together."

And so then I asked her "how long does all that--how long does it all take? How long a process is it before the technologist is then actually left on their own to do their

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

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different, so we spend a lot of time going over troubleshooting issues."

So I just wanted to show that to you and then, please, Registrar, if we could have July 15th, 2008, and this is an excerpt from Mr. Simms' testimony here at the Commission, Les Simms, and it's page 305, please. And you'll see here, I asked Mr. Simms "when did you actually start? What was your start date at the Health Sciences?" and he said "March 18th, 2003." "And so, when you went there, what training did you then receive in IHC?" "My training then was Peggy was the lead tech there, that was my understanding from when I was moved in, and I was--the first week I was there, I don't think I was on IHC the first week. I think it was the second week, and I followed Peggy around while she actually did the stains. I made my own notes and followed there and for that week and the following week, if I remember correctly, then I did them and Peggy kept an eye on what I was doing." "So for the first week, you think you were not doing--you were doing something other than IHC?" "Probably just getting orientated into

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

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absolutely sure, I would ask Ken or Mary." "Okay, and so they were nearby?" "Yes. Even though they weren't in the rotation, you were in there by yourself, you could check with them. They were in shouting distance."

And then if we go on to the next page, 309, "Okay, and Peggy taught you to use that?" and you'll see we're talking about the DAKO machine. "Okay, and other than actually using the machine, what else were you--what other instruction, in terms of IHC were you given or was the focus mostly on the operation of the machine or were you given anything in terms of the theory, for example, of IHC?" "The focus was mainly on the machine, the operation of the machine. It was my own, my own responsibility to find textbooks and so on and the theory, if I was so interested, you know, in the theory at the time. I would focus, it was my responsibility to go find textbooks and journals and whatever else." "And did you do that?" "Yes, I did." "So you sought out extra information?" "I sought out extra reading material, yes." "And when you began in March of 2003, how many antibodies were

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there, approximately?" and he says "between 70 and 80."

And then, Registrar, if we could have, please, July 8th, 2008, and this is Peggy Welsh's portion of her evidence about how she was trained, and she indicates, Mr. Gulliver, that it would have been you that trained her, and it's page, please, 115.

So I ask "okay, and who then taught you about IHC? You haven't learned it in your schooling, and so how were you taught or trained to do IHC procedures?" "Dr. Wong," I guess that should be Dr. Wang, is that right? "showed Terry how to do them and Terry showed me." "Okay, and what exactly did Mr. Gulliver show you?" "We just learned the basic procedure, how to--exactly what you did. We had a procedure that we followed just to make up the antibodies, put them on the slides, incubate the slides. We didn't have very much, other than just hands on training from the person who was doing it." "So whatever you learned it was through Mr. Gulliver?" "Um-hm." "And then, you said there was a procedure that you followed. So was there a written

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procedure?" "I don't recall if it was a written procedure or not. I probably made notes when he was teaching me, but I don't recall if there was ever a written procedure. I think there probably would have been, but I just don't remember that." "Okay, and do you recall were you provided any textbooks?" "No, we had no textbooks." "Were you provided anything in the way of seminar or conference that you could attend where you could learn from it?" "No."

And then if we could have, please, page 269 of the same transcript?

MR. GULLIVER:

A. If you--can you just go back a page, that same page?

CHAYTOR, Q.C.:

Q. Back a page before?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. The page before or the one we were looking at before?

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

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

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

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

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

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

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

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

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MR. GULLIVER:
A. When I read her report -
CHAYTOR, Q.C.:
Q. Do you disagree with that? Do you disagree with that?
MR. GULLIVER:
A. Disagree with what?
CHAYTOR, Q.C.:
Q. That Trish Wegrynowski found that your technologists had a lot to learn in terms of the theory, this is in 2005 that she felt that the technologists had a lot to learn in terms of the theory of IHC?
MR. GULLIVER:
A. Well, see, in 2005, and certainly I can't disagree with her opinion. I mean, if that's Trish's opinion, I mean, I can't disagree with it -
CHAYTOR, Q.C.:
Q. Yes, and I'm wondering what your opinion is as their manager?
MR. GULLIVER:
A. Well, my opinion in 2005 I wasn't the manager. I had not been the manager in pathology since 2001.

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CHAYTOR, Q.C.:
Q. Well, you're the director of the program, a step above at that point?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And responsible for, and their manager would be reporting to you?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. So what was your -
MR. GULLIVER:
A. I know, and I'm responsible for 250 other technologists in every other lab.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. So I can't be on the bench with every technologist ensuring that they know exactly, that exactly what they're doing and they can troubleshoot. I think Trish's point is that when she came in 2005, you know, Mary Butler was still there, who had been there a long time, and Peggy was there since 1985, that,

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you know, at that time Les Simms was fairly new to the IHC lab, you know, through Peggy retiring and Les coming in, Ken Green moved over St. Clare's -
CHAYTOR, Q.C.:
Q. But he was a very senior technologist?
MR. GULLIVER:
A. In pathology, yes.
CHAYTOR, Q.C.:
Q. Right.
MR. GULLIVER:
A. But Les then was working in IHC, he had less than two years experience in IHC lab when Trish came in. And Ken had less than three years experience, maybe less, he had less than three years experience.
CHAYTOR, Q.C.:
Q. So that does make a difference. I just want to be clear. So that makes a difference, that they have little experience in IHC regardless of how many years you have in pathology?
MR. GULLIVER:
A. I have to agree with that, yes. Because as Trish states, I mean, IHC testing, and it's not that it's different, Ms. Chaytor, in being

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

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MR. GULLIVER:
A. I don't know. I think when--you know, and I did hear a fair bit of Peggy's testimony. I think Peggy's statement overall was that she learned a lot from Trish's report in things that Trish recommended in having standard operating procedures and policies and documentation and the level of documentation that Mount Sinai performs that she would have expected us to be performing here. I don't know if it was Peggy's intent she learned a lot of knowledge of IHC testing and the theory. I think she learned a lot of what came out of Trish's recommendations.
CHAYTOR, Q.C.:
Q. She certainly talked about it as being Ms. Wegrynowski's evidence. There was a reference to her report or whether or not she'd actually read the report when I asked it her that, it was, she said, "I've learned a lot in the past month that I had never heard in all the time I was doing the work." And I asked her who it was that she'd learned that from and she indicated the woman from Mount Sinai. "Yeah, things that she talked about, I had never

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heard before."
MR. GULLIVER:
A. And again, I can't speak for Peggy. Whether she never heard about internal controls or whether she never heard about fixation issues or whether she never heard there were problems with the procedures, I can't say -
CHAYTOR, Q.C.:
Q. So I just want to be clear that you as the manager of the pathology lab until 2001 when you became the director of the overall program and continued on in that position until today, you feel that your technologists were well trained, well informed and capable of doing the job?
MR. GULLIVER:
A. I have to say yes.
CHAYTOR, Q.C.:
Q. And you have no concerns as to even with everything that you've heard, any concerns that they were other than well trained, well informed and knew how to do their job and did their job properly?
MR. GULLIVER:
A. I would have to say yes.

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CHAYTOR, Q.C.:
Q. Why is it that over the years there wasn't more done in terms of bringing on something like IHC, why weren't there more opportunities for them to have more formal training as to how to do the procedure or to be educated in the theory?
MR. GULLIVER:
A. Well, I guess--do you mean why there wasn't more opportunity created by us in the workplace, by the Health Care Corporation or do you mean in general?
CHAYTOR, Q.C.:
Q. Yeah, I'm just wondering, like, someone comes in to the program and why isn't there a more formal--like, we've heard Mr. Simms say, well, you know, I job shadowed, I job shadowed for -
MR. GULLIVER:
A. I know. Well -
CHAYTOR, Q.C.:
Q. - a week or two. You know, why -
MR. GULLIVER:
A. I guess, I mean, and it's like many parts of the laboratory, you know, as I mentioned in my opening testimony that, you know, we're

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trained as general medical lab technologists where you receive the basic knowledge and training and the foundation, really, to build upon that in the workplace. Within the lab environment we have, you know, four or five hundred staff that work at Eastern Health laboratories and they're at various stages. You have entry level technologists, which would make up a portion of your workforce, you have then the next level, technologist twos, technologist threes, technologists fours. So depending upon the experience they've gained and depending upon the expertise they've acquired or the knowledge they've gained and being specialized, in those specialized parts of the lab, there really is very few formal training programs where you can actually go and say, okay, I'm now a certified IHC technologist. It doesn't exist.
CHAYTOR, Q.C.:
Q. Well how about something within, though, within your program itself so that someone comes in and it's not one or two or three weeks job shadowing with somebody, it's, you know, here's what we're going to do. There's

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going to be a classroom component for two or three, we're going to have, you know, people work with you in that regard and then your period of job shadowing is going to be much more extensive. I mean, now they're up to over 100 stains, for example?

MR. GULLIVER:

A. Yeah. Well, I'm thinking, you know, for there's a--if there's a classroom time -

CHAYTOR, Q.C.:

Q. No, I mean, that's just an example.

MR. GULLIVER:

A. I know. Well, obviously for classroom time, you'd need someone to teach it.

CHAYTOR, Q.C.:

Q. Yes. And so you don't have clinical educators that we've heard other programs would have?

MR. GULLIVER:

A. Right. And we don't, so we don't have someone to teach in the classroom.

CHAYTOR, Q.C.:

Q. Why would that be, why isn't there any clinical educator component for the laboratory medicine program?

MR. GULLIVER:

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A. It's not something that we've ever had.

CHAYTOR, Q.C.:

Q. Is it something you ever sought?

MR. GULLIVER:

A. I personally, I have never asked for a clinical educator. What we have within the lab environment, we have senior technologists in all our divisions when our students in training at CONA, when they come into the workplace to spend their clinical component, we have senior technologists in all divisions who work with those students in helping them go through their competency profiles and what they must learn to become an entry level medical lab technologist. What we don't have within the programs are senior technologists who have expertise that can actually transfer that expertise to the person replacing their job. For example, and a good point is here, you know, Peggy Welsh, who in my opinion was well qualified to work in our IHC lab and pathology lab, as Mary Butler was, when Peggy decided that she was going to leave our lab after many, many, many years, her replacement was Les Simms and we didn't have--we don't

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

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testing. I would submit that if you really wanted to have technologists who were experts in IHC testing, you would need to probably have another six months post RT training and maybe ten years pathology experience first and then do a dedicated training or formal training in IHC testing.

CHAYTOR, Q.C.:

Q. Registrar, if you could bring up, please, September 30th, 2008? This is the transcript of Maria Tracey. And in answering a question put to her by Mr. Simms about the type of training that happens, it's at page 27, please, the type of happens for a new nurse starting in the perioperative program within Eastern Health. Mr. Simmons says, "Mr. Coffey asked you a moment ago about communicating policies and procedures to new staff who join the perioperative service. Can you explain a bit about the process of orienting new nursing staff to the operating room, how long it takes, what sort of things are involved and what the process is, please? The actual orientation to the operating room is the most extensive orientation provided to any service

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

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procedures are very rigid. Staff have to be familiar with all of them and they have to follow the practice, is very much delineated and there cannot be any deviation. So that's the way we ensure that all our patients receive safe care that we always have the right patient getting the right surgery." So, Mr. Gulliver, I'm just thinking about this as an analogy for what goes on in the IHC lab. Why couldn't a similar type of orientation take place in the lab?

MR. GULLIVER:

A. Well, you're talking about the IHC lab, Ms. Chaytor, and IHC lab is one piece of a pathology lab. Before technologists even get to the IHC lab, they've probably already had many, many years experience in our pathology department, so they're only building up what they've already learned in pathology for many years. If you want me to compare lab training to nursing training, it's very difficult. But if I look across the lab program, for example, if we have a new technologist, even if they've got many years experience in, say, biochemistry, and it happens quite frequently,

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if a new technologist goes to our microbiology laboratory, our microbiology lab looks at that person as a new technologist, they don't have technical training in micro. And sometimes it takes up to a year before that new technologist is actually doing any back end work in microbiology, because they're introduced to a whole new field within lab medicine. So the IHC piece is a very--you know, it's one component of our pathology training. IHC lab is one, there's one in Newfoundland, only one. There's an operating room in every hospital in Newfoundland. So you're probably pooling from a pool of nurses that has probably got other experience in somewhere else that are being introduced now to the operating procedures at the Health Sciences or St. Clare's. So I really don't think we're comparing apples to apples.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. But to go to read--to look at the resources that our nursing profession can avail of, that when they have a new nurse go to the OR, that

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they can actually take that nurse and spend four months to go through a classroom section and ensure that nurse is up to scratch before they go into the operating room, I'd love to have that kind of resources for the lab medicine program.

CHAYTOR, Q.C.:

Q. Yes. Well, and did you ever look for those kinds of resources?

MR. GULLIVER:

A. I have to say no. But, I mean, these resources, this is not just resources, this is cultural.

CHAYTOR, Q.C.:

Q. So explain that, what does that mean?

MR. GULLIVER:

A. You're getting into an issue that's cultural. Culturally within the health care system I believe physicians and nurses are granted a lot more recognition and a lot more resources than other parts of the health care system, not just medical laboratories. This is something that's been in place, I would say, for decades. This didn't come in because of the Health Care Corporation. This didn't come

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

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CHAYTOR, Q.C.:

Q. And that's, I guess that's my question in terms of it's obvious and I know you didn't have that in past, but on a go-forward basis, can you see a formal protocol similar to what Ms. Tracey has articulated exists for the perioperative program might be of some assistance to the laboratory medicine program?

MR. GULLIVER:

A. I think in certain parts certainly could be. Now, if we flip forward to today, you know, I'm talking about retirements, you've had--we've had two of our former technologists here, Ms. Butler and Mr. Simms who have testified and since they've testified they've both retired in our IHC lab. And here we are faced again with staff turnover and in a very highly specialized part of our pathology lab. And you know, almost a year ago in anticipation of this and I would say it's only because of who Mary and Les are that they gave us a much, much notice of their intent to retire and we did recruit and replace Mary and Les six months before their proposed retirement date so we could actually have

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those staff in the lab with our current three IHC techs and the new staff are undergoing, I would submit to you a training program very similar to what Ms. Wegrynowski recommends in her report. We have much more pathologists involvement, we do have a theory lecture component of the training, we've added, as you know, a new PhD level to that part of the lab to look after the quality control and quality assurance, and that's only happened because we have resources to do it now. It's not--I have to say, it's not because the wish was never there to do it before. We have not had the dedicated staff or resources or the time or additional time to free up staff time to do that level of in-house training.

CHAYTOR, Q.C.:

Q. And it's not something, though, over the years, either, that you went looking for?

MR. GULLIVER:

A. It's not, no, I didn't look for, like, clinical educators, I have to say that.

CHAYTOR, Q.C.:

Q. No, but even the measures that you've now indicated that are put in place, those weren't

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things which were included in your budget submissions over the years?

MR. GULLIVER:

A. No. I think before you can even get to this level of an organized training, in-house training programs with different parts of your--of laboratories as they do for nursing, I think we have to put the foundation in first to be able to do that.

CHAYTOR, Q.C.:

Q. Um-hm.

MR. GULLIVER:

A. And if that's--I think that's the piece where we're to right now is putting the foundation in place and being able to identify staff within the program who could provide this level of training to our new staff.

CHAYTOR, Q.C.:

Q. Your new IHC technologists, how close are they to retirement?

MR. GULLIVER:

A. They're a lot further away than I am. I would say maybe 15, 20 years, so they're--and, you know, we have to follow, we have to follow human resources guidelines and union

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

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

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

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

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you think this person is going to be able to complete the process. So it's -

CHAYTOR, Q.C.:

Q. Yes, and we've heard one of your candidates was removed or didn't complete the process, so that was based on that assessment?

MR. GULLIVER:

A. Exactly, yes.

CHAYTOR, Q.C.:

Q. And I'm going to talk to you a little bit about the PAs later on, in terms of utilizing technologists as opposed to people who may have a different background, because I think there's some debate on that as well, as to is it a technologist or a Bachelor of Science person, but we'll come to that, or other training.

MR. GULLIVER:

A. Bachelor of Science person will still be a technologist.

CHAYTOR, Q.C.:

Q. Yes, but whether or not they need that on top of.

MR. GULLIVER:

A. Right.

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CHAYTOR, Q.C.:

Q. Yes.

THE COMMISSIONER:

Q. Excuse me, just on that latter point, Mr. Gulliver. When one is filling a position, I'm thinking particularly going into these specialist areas of a lab, it seems to me that even there is a question about the very issue you raised, and that is the retirement of your staff, because if there is a education component, are you potentially educating people who as soon as they're trained are going to walk out the door because they're ready to retire, and that would seem to be using resources which are not going to be of benefit to you down the road.

MR. GULLIVER:

A. And you know, when I answered Ms. Chaytor about the two new techs in IHC, you know, "how many years do they have left?" I said we're kind of lucky that the two senior applicants who met the qualifications do have a fair number of years left, so the amount of investment that we will make into those two technologists is for the long term. But

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you're right, we do have cases where a retiree, after 35 years retires, they've been doing this senior level job for maybe the last ten years. So no one else has had the opportunity to get into that position and the next person in the position got two years left to retire, and that's what the labs are facing, and it's all across all of our laboratories, and it is an issue. For example, I just said, in microbiology, we brought back one of our retirees last year, who does have a wealth of knowledge, to help with our newer staff.

THE COMMISSIONER:

Q. So is demographics a problem in labs as well?

MR. GULLIVER:

A. Huge. It's--and you talk about nursing, it's probably worse than nursing.

THE COMMISSIONER:

Q. All right.

CHAYTOR, Q.C.:

Q. I want to take you back now then and go back to Dr. Khalifa's days, and Dr. Khalifa bringing in ER/PR and you've touched on that earlier in your evidence, and I understood

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from what you said that basically Dr. Khalifa worked with the technologists at the time, Mary and Peggy, and you didn't have, yourself, much involvement in the process in introducing ER/PR to the IHC?

MR. GULLIVER:

A. Not, nothing from a technical level or clinical level, nothing like that.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. I certainly was well aware of it, you know, that it was taking place.

CHAYTOR, Q.C.:

Q. If we could look, please, at P-1889? This is a letter written to yourself from Dr. Khalifa and it's copied to Dr. Haegert and Mr. Whelan, Dr. Haegert being the clinical chief and I take it, Mr. Whelan would have been your immediate supervisor?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay, and it's two different dates, March 12th 1997 and February 27th 1997. Do you recall,

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Mr. Gulliver, did you receive this letter at that time?

MR. GULLIVER:

A. I know in preparation for the Inquiry, back months and months ago when we were supplying documents, I was shown this by my counsel and asked, you know, the same question, like "what do you remember of it?" and I had to say that I don't ever--didn't ever remember seeing it or receiving it. I can't say that I did not. I can't say that I did.

CHAYTOR, Q.C.:

Q. Well, I'm just going to take you through a bit of it, but--and I know you've been through -

MR. GULLIVER:

A. But I've certainly read it -

CHAYTOR, Q.C.:

Q. - it before, yes.

MR. GULLIVER:

A. - I've certainly read it since.

CHAYTOR, Q.C.:

Q. Yes, you've been through it since.

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

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Q. And it's somewhat critical of you, so I'm wondering had you received this, do you think that's something you would remember, something that would stick in your mind?

MR. GULLIVER:

A. I know, and that's--at the time when I was shown this, you know, I think it was back in December some time, you know, and my point was what you just said, that you know, if I had--I don't remember it, and you know, I generally remember most stuff, and knowing that the second paragraph, Dr. Khalifa is kind of mad with me there that one of the kits ran out and it hasn't been, you know, replenished in a timely manner.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. And he couldn't locate me, that would have jogged my memory to say "oh yeah, I remember exactly that." But I really don't.

CHAYTOR, Q.C.:

Q. So what about then, the subject matter, and again, I'll take you through it in a little bit of detail, but what about then the subject

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matter of that? Do you recall, regardless of whether you received the letter or not, do you recall Dr. Khalifa coming to you and raising these concerns that it's difficult for him to get in touch with you, that he's trying to validate this test and his kit has run out. Do you recall that being the subject of discussion with you?

MR. GULLIVER:

A. I don't know, at this particular time, Ms. Chaytor, but I--and I do--and I kind of look back and at this particular time, in 1997 is when--and I had received permission from our CEO at the time, I had put my name forward to be--to run for president of our national professional association, CSMLS. Well, at the time, it was CSLT, Canadian Society of Laboratory Technologists. And you know, I was voted in by the members across the country and this particular year was the year I was serving as president, and pretty well almost once a month, usually on a like Thursday, Friday, Saturday, Sunday, I would be out of the province attending board meetings for our professional association or doing matters like

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that. I think this particular week -

CHAYTOR, Q.C.:

Q. So that's a volunteer position that you took on?

MR. GULLIVER:

A. Yes, yeah, but I had to seek permission from our CEO to put my name forward. If I was elected president, it involved some time away from work to deal with those issues.

CHAYTOR, Q.C.:

Q. And that would have been right after Health Care Corporation came together -

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. - in 1996, that you took that on?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And you took on the responsibilities for the Janeway site?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay.

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

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

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MR. GULLIVER:
A. But he may have brought back some kind of primary antibody that was being researched or tried out somewhere else.
CHAYTOR, Q.C.:
Q. ER/PR?
MR. GULLIVER:
A. He could have, yeah.
CHAYTOR, Q.C.:
Q. At the same time that Dr. Khalifa is trying to validate and introduce this?
MR. GULLIVER:
A. I'm not sure, but I'm saying that's my only--my best guess, if there's something else here that Dr. Khalifa is saying.
CHAYTOR, Q.C.:
Q. So do you have any recollection that that in fact was the case -
MR. GULLIVER:
A. No, I don't.
CHAYTOR, Q.C.:
Q. - that Dr. Chittal was involved in this?
MR. GULLIVER:
A. Oh, Chittal was not involved with the ER/PR, no, no, and I don't know if you asked Dr.

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Khalifa when he was testifying about this letter or not. I don't know what he said.
CHAYTOR, Q.C.:
Q. And the idea that he's trying to optimize the test and he says to you "any trial of a new technique need to be done in parallel with a well established one before the switch can be safely made," at the time in 1997 that he's stating this, would you know that? Would that be something that you would be well familiar with?
MR. GULLIVER:
A. Well, the new technique he's talking about switching is from the biochemical assay technique -
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. - to the IHC lab. It's not switching--trying a new procedure in pathology, an old pathology procedure versus a new pathology procedure. It's a whole new methodology he's talking about.
CHAYTOR, Q.C.:
Q. Yes, and the idea of doing that and the

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

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clinical consequences?
MR. GULLIVER:
A. I have to say he's right.
CHAYTOR, Q.C.:
Q. He's right, you wouldn't have understood that at the time?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. I mean, it was a new test coming into our pathology lab. I mean, certainly Dr. Khalifa and I would assumed other pathologists and Dr. Prabhakaran in chemistry, I mean, they would appreciate more than I would, you know, the clinical implications of this particular test. It was brand new to the lab. Certainly if you ask me today, I'll give you a different answer.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. But back -
CHAYTOR, Q.C.:

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Q. So in 1997, you wouldn't have appreciated it.
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. So this would have been a fair statement he's making?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. Would your technologists have fully appreciated the delicacy and sensitivity of the test and its clinical consequences?
MR. GULLIVER:
A. Did you ask them?
CHAYTOR, Q.C.:
Q. What's your knowledge of what they knew or understood?
MR. GULLIVER:
A. Well, speaking for them, I would think that they would have understood that the actual procedure itself in introducing the new antigen retrieval process that we had not done before with the other IHC tests, I think they'd understand that yes, that is a delicacy there in performing the test. I don't think

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

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and the reason why I got involved with it, because I was told that test is going to cost a hundred dollars a patient, very expensive to do it. However, it was like $35,000 for one patient to go on this Herceptin therapy. But it was around that time where I got more understanding about the ER/PR and the hormonal therapy piece of the treatment side of this test.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. And that may have been 2000 or 2001, you know. It's not 2005. I mean, it certainly--it was after this here, but -

CHAYTOR, Q.C.:

Q. So it's three or four years into doing ER/PR?

MR. GULLIVER:

A. That's my best guess.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Yeah, and I was certainly still pathology manager, so I became program director in -

CHAYTOR, Q.C.:

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Q. In 2001.

MR. GULLIVER:

A. - late 2001, so you know, it's got to be somewhere in that time frame.

CHAYTOR, Q.C.:

Q. So some period up before you became director of the program?

MR. GULLIVER:

A. Yeah, yeah.

CHAYTOR, Q.C.:

Q. Okay. He goes on to say "I am also uncertain whether our service is being run as smoothly as it should. The medical legal implications of delaying this test are huge, and I want to clearly document my concerns at this time. You willingly have put me in a situation where I have to explain to other physicians why our results are being delayed. I do not want to be responsible for this. I am also having a very difficult time communicating with you basically because you are either out of town, on another site, or extremely busy within this site. I would have expected you to approach this issue with more precision since Monday morning, as you had told me, and

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even more not to have allowed the first kit to be consumed without obtaining a replacement in a timely manner."

So his assertion that he has "concerns about our service being run as smoothly as it should," was that discussed with you then, Mr. Gulliver, at this time?

MR. GULLIVER:

A. Dr. Khalifa, and I'm wondering through his testimony, have you seen any other documentation where Dr. Khalifa has an issue with the service or an issue with me as the manager at the time? Again, when I read this here, I was surprised. I still don't know if I ever--I don't remember reading it ten years ago. I would just have to say that my relationship and working relationship with Dr. Khalifa, for all the years he was there, was fantastic, and you know, I would have assumed if I got this, I would have explained to him why I was away. I do know, at some point, with DAKO, you know, the way things process works, you know, the manager is responsible for ordering supplies and you need to have a manager's signature to get things authorized

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within the system. I know I did put a process in place with DAKO for Mary and Peggy. We did sort of a standard, a standing PO, purchase order number where Mary and Peggy could just call DAKO immediately and say "PO number 123456, we need this, this, this and this" without having to go through paper requisitions and going to purchasing and get purchasing to call. So we kind of sped the process up. But that probably happened in '98, I think.

CHAYTOR, Q.C.:

Q. Okay. In terms of though the idea that the service not being run as smoothly as it should and your--it appears he has issues with your availability and being able to be available at a timely fashion. He speaks about you being out of town and being busy at another site from time to time, and I take it that would mean the Janeway site at this point in time?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. You don't recall that issue being discussed with you by Dr. Khalifa?

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

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

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it. He felt, as he says here, important to document his concerns. Would you have felt it important to document your response?
MR. GULLIVER:
A. No. The way I operate, if Dr. Khalifa - if I had seen this here and Khalifa sent it to me, I would have went over to his office and sat down, chatted and spoke about it. We're together on the same site.
CHAYTOR, Q.C.:
Q. Could we have, please, P -
MR. GULLIVER:
A. Can I ask you a question?
CHAYTOR, Q.C.:
Q. Sure.
MR. GULLIVER:
A. Have you ever received documentation that I actually received this, this letter, or memo?
CHAYTOR, Q.C.:
Q. Well, you certainly didn't provide us with your copy of the letter.
MR. GULLIVER:
A. I know.
CHAYTOR, Q.C.:
Q. That's the best I can tell you about that, not

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

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CHAYTOR, Q.C.:
Q. We don't have, to our knowledge, your copy of this letter.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. But can we read anything into that, are you someone who tends to keep things or do you tend to be more of the type of person after a period of time to -
MR. GULLIVER:
A. I clean up. I clean house.
CHAYTOR, Q.C.:
Q. Yes. So if you did receive it, it could also be just as likely that it got thrown out along life's way?
MR. GULLIVER:
A. It's a possibility, yes.
CHAYTOR, Q.C.:
Q. This is a minute of anatomic pathology site chiefs and divisional managers, May 13th, 1997, and it takes place at St. Clare's Hospital and you'll see that Dr. Khalifa, yourself, Dr. Cook, Drs. Parai, Pushpanathan, yourself, and Mr. John Murphy are in

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attendance, and Dr. Haegert is not there. If we look at page three of the exhibit, scroll down here, we'll see under new business, ER/PR immunoperoxidase receptors, "Dr. Khalifa reported to the committee that there is a good correlation between the biochemical assay and immunoperoxidase staining for breast receptors. It appears that the time may be right to implement the immunoperoxidase breast receptors corporate-wide. Dr. Cook stated that there is a concern amongst pathologists at St. Clare's that they should be the ones reporting the breast receptors. Discussion then arose that if individual pathologists are reporting these receptors, then there is a need for standardized criteria to determine what is regarded as receptor positive and negative. There was also discussion as to how the Mayo Clinic reports its receptors. It was decided that this issue should be brought to a discipline meeting to get a consensus amongst pathologists. Hopefully, such a meeting will be held in June. Until then, it was agreed to maintain the status quo. Dr. Cook also recognized the amount of hard work Dr. Khalifa

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had given the project". So Dr. Khalifa is reporting basically that he has had good correlation between the two methods, and it's now time to go with the service corporate-wide and I take it that meant across the -
MR. GULLIVER:
A. City.
CHAYTOR, Q.C.:
Q. Across the city. What do you recall about this discussion around the pathologists at St. Clare's being concerned about reporting their own cases?
MR. GULLIVER:
A. I can't - I really can't give you a lot more information than what's already there, you know, in the minutes. You know, I just remember that when it was started, Dr. Khalifa, to my understanding, had had experience in breast pathology, that he was comfortable in doing the ER/PR interpretations, and I think it was his viewpoint that he would continue on doing the interpretations for all the ER/PRs, and do them as consults from across the province. I don't remember any real discussion at this

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particular meeting, except for what's there in the meetings - what's there in the minutes, sorry. I would - I think Dr. Cook's concern would be, you know, if Dr. Khalifa left - again even going back to, like, I mentioned earlier, our technologists level. You got senior technologists who got expertise. You know, when they leave, that knowledge goes with them. I don't know if it was Dr. Cook's concern here, you know, if we put all of our eggs in the one basket, and that person leaves, you know, we now have no pathologist who got this skill to interpret ER/PR.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, from the technologists point of view then, this service is about to be transferred from the biochemical to -
MR. GULLIVER:
A. I think it was ongoing for a good while, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. At this point in time, yes, but at the time that the transfer is made that Dr. Khalifa feels that it's now good correlation. So at the time that it's taken over by pathology,

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

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A. Yes, for a lab technologist to do a batch, it was almost a full day's work. So we batched them. So as requests came in, you get on Monday, a couple on Tuesday, maybe got one Thursday, so generally the practice was on a Friday was the ER/PR day. So Mary or Peggy, whoever was assigned, on Fridays they would do the ER/PR procedure.
CHAYTOR, Q.C.:
Q. So it was a full day procedure, you say?
MR. GULLIVER:
A. Pretty well a full day, yeah.
CHAYTOR, Q.C.:
Q. So in terms of that adding to their workload, and that would be, I take it, they're still rotating, alternating, so one week it's a day out of Mary's five day week, and the next week it's a day out of Peggy's five day week?
MR. GULLIVER:
A. Well - Mary could be on IHC all this week - all week long.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. But on Friday, they did ER/PRs.

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CHAYTOR, Q.C.:
Q. So one of her days then -
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. Is devoted to just ER/PR once it comes over from biochemical?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. Biochemistry portion of the lab. So what in terms of then additional resources were offered to the pathology lab to compensate for that increase in workload?
MR. GULLIVER:
A. There was no additional staffing resources added to the lab. By this time, I think too - this is maybe '97, '98, here, Ms. Chaytor?
CHAYTOR, Q.C.:
Q. This particular - what is happening here in these minutes is 1997.
MR. GULLIVER:
A. '97.
CHAYTOR, Q.C.:
Q. March - May of 1997.

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

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really doing non-technologist work. I think through those other innovations we're able to be able to take on some extra volume and workload.

CHAYTOR, Q.C.:

Q. So once the ER/PR came on, the person who, whether it's Mary or Peggy for that week assigned to the IHC, and I would take it they must have had a five day - enough work to fill five days before. You're saying that to compensate for now we've got another full day of work to do with these ER/PRs because you now have to go through your antigen retrieval, and all that -

MR. GULLIVER:

A. Well -

CHAYTOR, Q.C.:

Q. You're saying there was new technology offered to them to make their jobs easier?

MR. GULLIVER:

A. No, no, no, in the general pathology laboratory, when Mary and Peggy were doing - primarily they were doing - they weren't doing primarily IHC testing all day long both of them. They were our two technologists who

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were primarily designated as the two techs for IHC testing when the IHC tests needed to be done. So if you don't have enough work to fill your day - I mean, Mary and Peggy were very skilled technologists in doing routine cutting, or routine embedding, or routine staining. So there were days when Mary and Peggy still cut blocks every single day for their routine pathology lab, but as more work became in IHC, we took away those duties from Mary and Peggy, but most of those duties were replaced by technology.

CHAYTOR, Q.C.:

Q. So when they're doing - even though they're assigned that week to IHC, they may not, in fact, be in the IHC portion of what was then a portion of the lab?

MR. GULLIVER:

A. It's the back bench of the lab, yeah.

CHAYTOR, Q.C.:

Q. So they may not, in fact, be there assigned strictly to just doing those tests?

MR. GULLIVER:

A. If there were no tests to perform, there's nothing to do down there, so -

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CHAYTOR, Q.C.:

Q. And was that the situation that there were -

MR. GULLIVER:

A. You know, there's lots of days they might have only had two slides to do, or five slides to do. I mean, that's not going to take them a full day's work, so they're skilled as general technologists in pathology, so if you come in today and there's no orders for IHC, well, you go and do - you cut blocks or you stain slides, or you do other skills that you've gained in pathology.

CHAYTOR, Q.C.:

Q. So as their manager at the time, what inquiries did you make of them - once ER/PR was introduced, what inquiries did you make of them as to what their workload was and whether or not they needed to have any additional resources assigned to them to be able to cope with the additional work?

MR. GULLIVER:

A. Well, neither one of them said it was an issue or a problem.

THE COMMISSIONER:

Q. Ms. Chaytor, we're going to break in a minute.

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CHAYTOR, Q.C.:

Q. Mr. Gulliver, the idea that in running the tests then at this point in time when it started up, we understand it wasn't - the DAKO machine wasn't in place first when the tests -

MR. GULLIVER:

A. That comes a year later.

CHAYTOR, Q.C.:

Q. Yes, a year later. So for this period of time in doing the tests, in doing the antigen retrieval, that would be Mary and Peggy performing those tests and just Mary and Peggy?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And at that point in time, were they also pooling the tests and doing it on Friday?

MR. GULLIVER:

A. To my knowledge, yeah, my recollection when we were doing ER/PRs, and for a long time, I think Friday was batch day for ER/PRs. I think we reached some point too where sometimes they might have done two batches in one week, depending on the number of requests

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that were coming in, how frequently they were coming in.

CHAYTOR, Q.C.:

Q. Okay, and we spoke in the last letter that I showed you from Khalifa about when you became aware of the different sensitivities of the ER/PR antibodies and the importance of the test. The significance of percentages in positivity for ER and PR, were you aware of that at the time?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. When did you first become aware that there may be any significance to percentage of positivity?

MR. GULLIVER:

A. In the summer of 2005.

CHAYTOR, Q.C.:

Q. So that's after the issue -

MR. GULLIVER:

A. Once we started dealing with, you know, the index case and started down this route, that's pretty well where I think for a lot of people from the lab side, that there was a

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significance in the percent of positivity. I mean, I work in a lab environment, something is positive or something is negative. You know, hearing someone say, well, it was only 30 percent positive, that's foreign to me. It was until '05 before I really understood the significance of the application of the test and the positivity rates.

CHAYTOR, Q.C.:

Q. And do you think that the technologists would have had that understanding?

MR. GULLIVER:

A. I don't think so, no.

CHAYTOR, Q.C.:

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

THE COMMISSIONER:

Q. All right, we'll meet at ten after two. Thank you.

(BREAK)

THE COMMISSIONER:

Q. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Good afternoon, Commissioner. Good afternoon, Mr. Gulliver.

MR. GULLIVER:

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A. Good afternoon, Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Registrar, if we could have, please, P-2935. Mr. Gulliver, this is a letter that you wrote to Ms. Bertha Paulse at the Newfoundland Cancer Treatment and Research Foundation on November 17th, 1998, and it's a two page letter, and you start off by saying, "Dear Ms. Paulse, I am writing this letter in regard to requests from your centre for pathology consultations. I have received two types of consults, and I will address each type individually", and the first one is concerning routine pathology consultations, and you point out to her that your staff spend a great deal of time trying to determine where to request the pathology slides and blocks in order that our pathologists can review them for your physicians. In future, would you please inform your staff that they must include where the patient had their surgery and pathology work performed. If the information is not provided, then I have instructed my staff to simply return the consultation request form to the centre as not providing the proper

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information. Then the second issues concerns consultation requests for estrogen and progesterone receptors, HER2/neu, and perhaps you can just tell us what do you recall about this, why you wrote this letter to Ms. Paulse?

MR. GULLIVER:

A. It was really talking about the process, Ms. Chaytor. Where the pathology lab at the Health Sciences was the reference centre for the province, and as many other parts of the lab, routinely other pathology labs across the province, if patients were seen - referred in to the Cancer Centre, the physicians in the Cancer Centre would then reflex a request to get either patient information or lab information or have additional testing done on those patients, and what the process that used to happen would be the patient would go to the Cancer Clinic, the Cancer Clinic would go back to the original site - just say, for example, it was Western Memorial, it could be anywhere, they would request Western Memorial, we need to get blocks on patient "A". They would send the blocks in to our pathology lab, sometimes the right information didn't come in. We

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

CHAYTOR, Q.C.:

Q. Okay. So you write, "As you are probably aware, since the spring of this year", so that would be the spring of 1998?

MR. GULLIVER:

A. That's when they were fully - Dr. Khalifa kind of fully put them in place for, I think, the whole province.

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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A. Yeah.

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

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

CHAYTOR, Q.C.:

Q. Okay, and you go on to talk about received requests across the province for this service. Was Health Care Corporation able to then bill the other areas in the province for providing the ER/PR service?

MR. GULLIVER:

A. We billed for IHC testing.

CHAYTOR, Q.C.:

Q. Which included ER/PR?

MR. GULLIVER:

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

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

CHAYTOR, Q.C.:

Q. So in terms of greatly increasing your workload in pathology, you're not - you're talking about the logistics of having the block there, having the block identified from a technical point of view?

MR. GULLIVER:

A. That's part of it.

CHAYTOR, Q.C.:

Q. But no major increase in the workload of the technologists who are offering this service throughout the -

MR. GULLIVER:

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

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time in the steps of adding solutions to every single slide and doing all the washings in between each step. I mean, that was really the time consuming piece of doing the IHC testing. By this time, DAKO is already in operating.

CHAYTOR, Q.C.:

Q. Okay, and you go on in your letter then to Ms. Paulse to say, "All of the requests from the Cancer Clinic are coming directly to our laboratory, even though the majority of the patients being seen by your physicians have been referred from hospitals across the province. As you can see, this means that my staff are spending a great deal of time in ascertaining (a) where the patient originated from, and (b) did they already have ER/PR performed. The only consultation forms for ER/PRs", and then somebody has handwritten in, HER2/neu. Is that your handwriting?

MR. GULLIVER:

A. It's not mine, no.

CHAYTOR, Q.C.:

Q. So you didn't make that change to the letter?

MR. GULLIVER:

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A. No.

CHAYTOR, Q.C.:

Q. "That we need to see from your centre are for those patients that originated from within the General Hospital. On those cases we will perform the ER/PRs, and one of the pathologists will provide the interpretation. For all other patients that have been referred to your centre from across the province who require ER/PRs, the consultation requests by your physicians should be completed and sent to the pathology lab at the site where the patient had surgery. It will then be up to the pathologists at that site to request our laboratory to perform ER/PRs if they haven't already been performed. The originating site will then send us the pathology blocks on the patient and we will fulfil the request and send the slides to the requesting pathologist". So what happened after that, Mr. Gulliver? Is your suggestion as you put forward here, is that what then started to happen?

MR. GULLIVER:

A. Yes. I mean, I'm not sure of the timelines,

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Ms. Chaytor, but at this point too, as you're well aware, up until the very beginning of performing this test, we had, you know, dedicated pathologists, mostly Dr. Khalifa, who was doing the interpretations for all the labs in the province, and then at some point we reached a decision where all pathologists in the province will be interpreting their own ER/PRs. So again it meant a different way in the processes of setting it up and slides going back, and there were - you know, we had cases in from outside St. John's, and the testing was performed, the slides went back to that pathologists, we had no record in St. John's of the interpretation or the results of those.

CHAYTOR, Q.C.:

Q. Okay, and then - so in terms of what you're suggesting to help alleviate the burden on your staff in having to coordinate this, so from this point onwards, or sometime shortly after you wrote in November, 1998, if the patient originated from outside the Health Care Corporation area, then that person would be referred in by the pathologist from out in

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the outlying regions?

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. Okay. If we could have, please, P-1893. This is the contract, I understand, for the DAKO machine, the acquisition of the DAKO machine, and it's dated May 27th, 1998, and it's signed by yourself as well as Susan Tanguay of DAKO Diagnostics. I just want to take you through a bit of this. Is this, in fact - this is the DAKO autostainer we've heard about in this inquiry, I take it, is it, Mr. Gulliver?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, and it says, "Pursuant to a tender number, and in compliance with the conditions outlined therein, we submit the following proposal for blanket purchase order number covering the purchase of both the DAKO autostainer and DAKO reagents. The price of the autostainer is quoted in the tender as $54,000.00, plus HST, for a total of $62,675.00. On a monthly basis, and for a

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period of 60 months, Health Care Corporation of St. John's will be invoiced an amount of $3,750.00 under blanket purchase order number for an annual total cost of $45,000.00. A minimum of $10,000.00 from these funds must be allocated towards the overall purchase price of $62,675.00, and at the end of March of each year, a detailed purchase analysis will be supplied by DAKO with an adjustment of a credit note or invoice reconciling the reagent usage. Health Care Corporation of St. John's will also at this time be invoiced in the amount of $5,000.00 to cover the service contract for each year". That's signed on May 27th, 1998. Mr. Gulliver, was the DAKO machine, in fact, in usage prior to this contract being signed?

MR. GULLIVER:

A. I'm not 100 percent sure. It might have been in within a few weeks, but usually the machine would come in, their technical support would come in and set it up, and while that's ongoing, the final details of the contract could be worked out, but I think it was in May where their technical guy, Dan Bolechowski

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actually physically came into St. John's, and I think he spent three, four, or five days in the lab setting it up, and training Mary and Peggy on the actual instrument.

CHAYTOR, Q.C.:

Q. So sometime around May of 1998 is your best recollection of when the machine actually got up and running?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And prior to that, the test being done by IHC method was being done through the kits and not through -

MR. GULLIVER:

A. On the bench.

CHAYTOR, Q.C.:

Q. On the bench, the manual -

MR. GULLIVER:

A. Using petri dishes.

CHAYTOR, Q.C.:

Q. Yes, the petri dishes that you described for us earlier.

MR. GULLIVER:

A. Yeah.

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CHAYTOR, Q.C.:

Q. So in entering into this kind of a contract then, do I understand that the total cost of the machine and the reagents was to be $62,675.00 inclusive of the -

MR. GULLIVER:

A. That's the price of the machine itself.

CHAYTOR, Q.C.:

Q. That's the machine itself, okay.

MR. GULLIVER:

A. But before this for many, many years, we were already spending a fair amount of dollars per year. In purchasing DAKO, you know, their primary antibodies, linking reagents, and different things from the company, so we're a high volume spender with DAKO before we do this contract.

CHAYTOR, Q.C.:

Q. And then you're going to purchase a certain volume of reagents from DAKO and that's going to be applied against the purchase price, is that correct?

MR. GULLIVER:

A. A portion of it, yes. This is like a standard, what we call a reagent lease within

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the lab. We have some of them as high as three million dollars a year. It's a combination of we provide the equipment, you commit over a period of time to use our reagents, they provide the maintenance support and service, and you agree upon doing a five year agreement. It's not much different than leasing a car, a fairly similar thing.

CHAYTOR, Q.C.:

Q. So the value - the cost of the machine at the time it was acquired in May of 1998 was over $62,000.00?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. If we could have then, please, P-2889. This document, Mr. Gulliver, says that it's sales, January 1st, 1997, to December 31st, 2004, and over on the - there's handwriting over on the side here which says DAKO sales record.

MR. GULLIVER:

A. That's my writing.

CHAYTOR, Q.C.:

Q. Are you able to tell us what these documents are?

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MR. GULLIVER:
A. I was asked actually to gather - if I could gather, and I called DAKO - and actually I think it was Mr. Dyer who called DAKO. I had a request come from a different group of lawyers in a different process asking could we have a list of all the reagents we have purchased from DAKO over the years, and this is what DAKO supplied to us.
CHAYTOR, Q.C.:
Q. Okay, and when did you make that request?
MR. GULLIVER:
A. I made this request in, I think, maybe 2006. I made the request - this is for the class action lawsuit.
CHAYTOR, Q.C.:
Q. Okay, and so what was your purpose then in making the request at that time, what is it that you were trying to show?
THE COMMISSIONER:
Q. I think you said all the reagents purchased over the years.
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:

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Q. In that time period?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. Was there anything in particular, though, to the ER/PR issue?
MR. GULLIVER:
A. For this here, in particular?
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. No, it was - I was asked to provide a list of all the reagents that we used from DAKO, and also to look to see if at some points during this procedure, because we're seven or eight years with DAKO, and you can see when maybe DAKO came out with a different block, different reagent, or a new and improved -
CHAYTOR, Q.C.:
Q. For the ER and PR antibody?
MR. GULLIVER:
A. Well, for IHC, in general.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, whose decision was it to obtain the DAKO autostainer?

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

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

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that kind of a detail or would he have consulted?

MR. GULLIVER:

A. I don't think so, no.

CHAYTOR, Q.C.:

Q. He's, in fact, I think said that he didn't realize that it was--that the DAKO machine had been acquired until after the fact and he's told that to the Commissioner, he was walking down the corridor one day shortly after it had arrived and he recalled a conversation, I believe, that you were having with a couple of technologists about some difficulties with the DAKO autostainer and that's when he first became aware. Do you recall that? Do you recall him approaching you then and telling you any concern he had about the DAKO autostainer?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. I believe he said that he explained that when he was at Montreal General, there had been some problems with the antibody staying on the slides or something along those lines, do you

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recall any discussion with Dr. Haegert about that?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And do you recall shortly after the machine was acquired any problems that you were having?

MR. GULLIVER:

A. Not that I--now, I mean, again, Peggy and Mary were the two technologists who were directly using the equipment. I don't recollect, you know, anything major happening shortly after acquiring it. I do remember the guy Dan who came in and did the set up and showed Peggy and Mary how to operate it. You know, with any new piece of equipment, if there was a software computer came with the system, sort of an operational software package, you know, I'm sure they had probably ongoing questions or something once Dan went back to Ontario and there was, you know, a phone number and a phone line to call with any concerns or questions that they would help you over the phone.

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CHAYTOR, Q.C.:

Q. Okay, so nothing sticks out in your mind as to shortly after it's acquired having any particular type of problem?

MR. GULLIVER:

A. Not that I know, no.

CHAYTOR, Q.C.:

Q. And in terms of the actual involvement of the clinical chief in that kind of a discussion that we're now going to go this automated route and here's the machine we're looking at acquiring, that wouldn't have happened at that level, I take it?

MR. GULLIVER:

A. I can't remember. I mean, this--the clinical chief is, you know, is the chief of all laboratories, you know, you have site chiefs and divisional chiefs and divisional managers, I mean, this is operational stuff at the divisional level. So generally it would be your site chief and the techs who using it and the manager who would be doing the assessment. Obviously when any new piece of equipment come in, you'd go through sort of an assessment period to make sure it meets all your needs,

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to make sure it meets the tender specs. And remember, though, it's not--this is not automating the procedure. This is just simply a robotic arm that's dispensing liquids on the slides at a certain time period, as opposed to a technologist doing that, that function.

CHAYTOR, Q.C.:

Q. So that type of a decision, you wouldn't see any need to consult with the clinical chief?

MR. GULLIVER:

A. I don't remember if I consulted with them or not. And I don't know if Dr. Khalifa did, I mean, Dr. Khalifa was certainly the site chief and he would be involved.

CHAYTOR, Q.C.:

Q. The autostainer itself, the machine, did it come with the computer on board, the computer is included with it?

MR. GULLIVER:

A. The computer came with it, but it was, you know, a separate computer plugged into the machine.

CHAYTOR, Q.C.:

Q. And would--is it anything special about that computer or would any computer be able to

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operate with the machine?
MR. GULLIVER:
A. I don't know if there's anything special about the computer. I just think maybe any computer could be--it's their software was really the key thing that came with the instrument, but you know, in the price of the instrument, the computer came with it.
CHAYTOR, Q.C.:
Q. Included the computer for the $62,000, that included the computer.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And whether or not it was anything--any particular type of computer that was required to run the machine?
MR. GULLIVER:
A. I don't think there was any kind of specialized computer. Understand in the laboratory at this time, as most parts of the system, where our computerized system is sort of a hard drive Meditech system, we don't have a lot of PCs around the system at that point.
CHAYTOR, Q.C.:

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Q. And the software came as well with it.
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Included in the price.
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. If we could have, please, P-2536? And this is the annual report for the Laboratory Medicine Program from 1997 to 1998 and it's dated February 28th, 1999. And would you have been involved in any preparation of this?
MR. GULLIVER:
A. I think I provided this to you, this is something that would have been prepared by, you know, Vern Whelan, the former director and Dr. Haegert. I think the involvement here, you would go to your divisions and ask, Vern would ask do you have anything to include in our annual report type of thing.
CHAYTOR, Q.C.:
Q. So for example, when the division of anatomical pathology, you would have been--you would have provided information.

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

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

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system, improve working schedules. And I realize again this is for the entire program, but would that be accurate in terms of your portion of the program, the pathology portion, that there was cost reductions which were met and that there were some measures, those measures ended up limiting things such as educational activities?

MR. GULLIVER:

A. I think that's a fair assessment, it applied to the whole laboratory program and you will probably see many documents, this is one, but of many years like this.

CHAYTOR, Q.C.:

Q. Yes, now I don't know that I see too many afterwards, though, where they actually happen to make your reductions and achieve that by another $200,000?

MR. GULLIVER:

A. I know, I'm six years as director, I haven't balanced a budget yet.

CHAYTOR, Q.C.:

Q. And we'll talk a bit about that. If we look at page 6 of this document, there's laboratory strategic directions for 1998 through to 2001.

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And the directions will be along the following guidelines, "providing the highest quality service possible within available resources, constantly seeking ways to be more efficient, reduce costs and above all, improve quality" and Mr. Gulliver and we will look at some of the further annual reports when you take over in 2001 for, as the director, but I'm just wondering what your opinion is on the ability to provide the highest quality service possible while at the same time seeking ways to be more efficient, reducing costs. How do you improve quality while you reduce costs and become more efficient?

MR. GULLIVER:

A. Well obviously it's much more difficult. It all depends what your main outcome is and what your main focus is. If your main focus is to, you know, to continuously improve quality, you know, having an environment of constraint reduced costs and budget constraints and staff reductions really is not conducive to improving quality, it's more conducive to improving productivity and improving efficiencies. It doesn't mean to say that

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through these years that lab services in general, and this is Vern's report, I mean, it's not my report, that lab services in general have not improved overall quality either in parts of the, could be in chemistry division or other divisions, but again, yes, I mean, it is very difficult.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-2150? And this document you are the source of and it's entitled "IHC Timelines" and then there's a number of items, the first being technology and equipment, then antibodies used. Number three is your reagents, solutions and other; number four is staffing; and then number five is space and physical environment. Did you create this document, Mr. Gulliver?

MR. GULLIVER:

A. Yes, I did.

CHAYTOR, Q.C.:

Q. And what was your purpose for creating this?

MR. GULLIVER:

A. I was asked for this information for the class action lawsuit.

CHAYTOR, Q.C.:

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Q. And so when would this have been created?

MR. GULLIVER:

A. I'm thinking maybe 2006.

CHAYTOR, Q.C.:

Q. And here it indicates again, the 1980's through early 1998. It's May 1998 that the DAKO autostainer was installed and the DAKO water bath for antigen retrieval, October, 1999, what does that refer to?

MR. GULLIVER:

A. Oh, I mean, these are showing some of the things, Ms. Chaytor, when--you know, we've been following pretty well the same procedure and the same protocols for years, but DAKO, as our main vendor, if they came out with improvements, we certainly would like to switch to those improvements. So prior to this here when Mary and Peggy were doing the antigen retrieval piece for ER/PR and you've heard them testify it's pretty well, you have a hot plate, you put your--on the hot plate, you boil the slides. This here was just a small piece--like a water bath that you could use as you're boiling your substrate solution.

CHAYTOR, Q.C.:

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Q. Yes, and then it goes on with some detail with other dates and then antibodies used, your clones. For example, ER ID5, 1997 through April, 2004. You give a history of ER/PR kit system, then Ventana clones and then the reagent solutions, the staffing, as I said, and then the physical space. And I'm wondering what did you have of assistance to you when you prepared this for the class action to be able to fill in all this detail on these dates as to when certain clones were used and when certain techniques were used. What documentation was available to you?

MR. GULLIVER:

A. It was certainly a combination of multiple sources, I mean, it was going directly to the technologists in the lab to see what documentation either Mary, Peggy and Barry had, you see the list of all the reagents, that's what I asked DAKO could they supply me, you know, on their records, could they supply me with a list of the reagents that we had used over the years from DAKO and when you see the purchase orders, you can kind of see the dates -

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CHAYTOR, Q.C.:

Q. So this information would come from the exhibit I showed you, P-2889?

MR. GULLIVER:

A. Yes, pretty well, a lot of that would, yes.

CHAYTOR, Q.C.:

Q. And you piece together from that exhibit, that document.

MR. GULLIVER:

A. Exactly, yes.

CHAYTOR, Q.C.:

Q. So in terms of documentation, you would have had DAKO's sales record for number three, reagent solutions.

MR. GULLIVER:

A. For that there and I mean, there were still a fair bit of, you know, over the lab, there were still some documentation there that, you know, in a binder where there were sheets here and Mary had written dates down when they came in and when they used them and it certainly wasn't complete records. By this time, as you're aware in 2004, that part of our lab underwent a severe flood and a lot of the paper stuff was--had to be discarded from

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asbestos contamination, but yeah, most of the stuff here, I took out of the DAKO information they sent me.

CHAYTOR, Q.C.:

Q. And so the ER/PR pre-diluted antibodies from October, 1997 through to April, 1998, that time period, how would you figure that out, that that's when you used your pre-diluted -

MR. GULLIVER:

A. I think that came off the DAKO sheets that early on DAKO had pre-diluted ER/PR's that came in and then at some point, you know, they switched over, they came up with a primary ER/PR antibody where you did your own dilutions. And this here, pretty well, Ms. Chaytor, this is just my--just from my memory, the timelines is -

CHAYTOR, Q.C.:

Q. This is, the technologist -

MR. GULLIVER:

A. The timelines of when I was the bench technologist and then Mary and Peggy, when Ken transferred up to St. Clare's, Peggy resigned, Les comes from St. Clare's and then again, to present, as you can see now, Mary and Les are

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both retired.

CHAYTOR, Q.C.:

Q. Yes. This wasn't necessarily done consulting any personnel records, this was just based on your own recollection of when -

MR. GULLIVER:

A. Oh, and asking Ken, exactly, Ken, when did you move over to Health Sciences.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Which was, I think he said St. Patrick's day in March, 2002.

CHAYTOR, Q.C.:

Q. And how about the date in which Peggy finished up?

MR. GULLIVER:

A. Well, I knew that Peggy had resigned at that time, that's when she left. We had her resignation letter.

CHAYTOR, Q.C.:

Q. In March of 2003?

MR. GULLIVER:

A. That's right.

CHAYTOR, Q.C.:

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Q. Her resignation letter or her date of actually finishing up?
MR. GULLIVER:
A. I think her resignation letter. I'm not sure.
CHAYTOR, Q.C.:
Q. And then under number five, "Space. Physical environment," it's indicated that "The IHC testing, both manual and semi-manual with the DAKO autostainer performed in the main pathology laboratory staff."
MR. GULLIVER:
A. "Space."
CHAYTOR, Q.C.:
Q. Sorry, "space," sorry.
MR. GULLIVER:
A. "Space."
CHAYTOR, Q.C.:
Q. "Space." "December 2003 with the installation of the new Ventana system the process was started to move all IHC testing reagents, equipment to separate space from the main lab." So it was in December of '03 before the Ventana system came in that everything started to move, all the IHC started--I'm sorry, before the Ventana came in, the IHC was moved

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

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

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

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Ventana instrument.
CHAYTOR, Q.C.:
Q. And if we could look, please, at P-2936, Registrar? This document, Mr. Gulliver, is dated 1998 and it's not pathology, it's hematology. And it's College of American Pathologists. And it appears to be referring to proficiency testing. Perhaps you can tell us what this is?
MR. GULLIVER:
A. This is, again, I think I supplied this to the class action lawsuit -
CHAYTOR, Q.C.:
Q. Well, you supplied it to us, anyhow.
MR. GULLIVER:
A. documentation. What?
CHAYTOR, Q.C.:
Q. You supplied it to us. You're indicated to be the source on our records.
MR. GULLIVER:
A. I think whatever I gave them, I supplied to the Commission, also. This was to show some records about laboratories in general. This was copies that I found in old filing cabinets belonging to my former director showing the,

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some of the CAP surveys, this is external proficiency testing.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. That, you know, back in 1998 here are some of the things that the hematology division participated in from an external proficiency testing perspective.
CHAYTOR, Q.C.:
Q. And were there--and this was done for hematology and, I take it, for a number of other divisions -
MR. GULLIVER:
A. And there'd be chemistry, immunology and other divisions, also, yes. We've just seen some more went past. HLA, tissue typing.
CHAYTOR, Q.C.:
Q. Yes, when we go through the documents. None for pathology. And I'm just wondering why there wasn't external proficiency testing, as well, for the pathology division?
MR. GULLIVER:
A. Well, at the time the external proficiency testing that the pathologists, I mean, it was

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their decision to participate in whatever they wanted to participate in. They participated in ASCP, that there were CAP checks, where it was more of a pathologist proficiency testing but just there was nothing in place for the technical side of proficiency testing in pathology.
CHAYTOR, Q.C.:
Q. For the--yeah, for a review of producing slides and the quality of the slides -
MR. GULLIVER:
A. Right. Now, back in '98 I don't even know if I'm aware of even if CAP offered any kind of technical external proficiency testing, in particular, for IHC.
CHAYTOR, Q.C.:
Q. Did you ever inquire?
MR. GULLIVER:
A. Not to my knowledge, no.
CHAYTOR, Q.C.:
Q. And what about 1999, 2000, through to 2005, did you ever make any inquiry as to whether or not there would be such proficiency testing available?
MR. GULLIVER:

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

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MR. GULLIVER:
A. For external--for pathology?
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. Well, in 2001 I'm not the manager, so up to 2001 when I was the manager of pathology -
CHAYTOR, Q.C.:
Q. 2001 to 2005 you're the director.
MR. GULLIVER:
A. Program director.
CHAYTOR, Q.C.:
Q. Yes. Did you ever make any inquiries as to what may exist in terms of proficiency testing?
MR. GULLIVER:
A. No, because as I said, I mean, that was always the domain of the pathologists to decide.
CHAYTOR, Q.C.:
Q. Including anything that would assess or evaluate the quality of the product that your technologists are performing?
MR. GULLIVER:
A. Right, because it's still a pathologist who's reading and assessing the quality.

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

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

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MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. In 19 -
MR. GULLIVER:
A. And we have those up to current.
CHAYTOR, Q.C.:
Q. Right. And he had this in his possession in 1998 as the director of the program?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. Mr. Gulliver, in terms of--and I just want to understand that because what you're telling us is that you didn't make any inquiries and nor was it--did it become the subject of discussion with the clinical side, so there was no discussion as to, well, we might have a gap here, is there some way we can fill this gap. So you didn't make any inquiries about it, you thought it was more the domain of the clinical side of the program to do that, and there was no discussion between you or the clinical side about the absence of this?

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

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

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

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

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

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sort of the--but there is the fall out, when you're saying what's the fallout from Dr. Khalifa stopped interpretation.

CHAYTOR, Q.C.:

Q. Okay. And so--sorry, go ahead.

MR. GULLIVER:

A. And, you know, we're talking about two--I mean, almost leading into two things. So when Dr. Khalifa stopped the interpretations, it meant the practice would change for the techs in the numbers of controls and who's going to be reading cases. And, but he was still there to provide guidance and he was still there for the technologists to go to if they had any issues or concerns.

CHAYTOR, Q.C.:

Q. Did you ever raise any concern about the number of controls that were having to be run?

MR. GULLIVER:

A. Certainly did, yes.

CHAYTOR, Q.C.:

Q. Okay. And who did you raise that with and what was the source of your concern?

MR. GULLIVER:

A. I generally raised it through our monthly site

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chiefs meetings with, you know, the various site chiefs in pathology and myself and Mr. Murphy, the other pathology manager. And I raised it for a couple of issues. It was one, who's going to read the controls and document reading controls. And number two, as you've seen, you know, back in those days it was a fairly expensive--in pathology this is the most expensive technical side of pathology to run, and for every slide you run you're paying for it, so--and I had an issue with why are we running four and five controls of the same control in the same batch, it's costing four and five times the amount, the cost.

CHAYTOR, Q.C.:

Q. And so you were proposing that one control be run and that there'd be a pathologist in charge for, or responsible for reading that control?

MR. GULLIVER:

A. I guess so, because that's what we had been--we set this service up in that fashion and that's what I would liked to have continued that way.

CHAYTOR, Q.C.:

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Q. Was there ever any agreement reached amongst at least the hospitals within the city that that could happen, that one of them would be responsible -

MR. GULLIVER:

A. It did. You know, after talking through multiple meetings about this and it could have went on for months and months, there was another process in place where if there were multiple patients from the city hospitals looking for the same antibody, that we would run one control and then a pathologist at Health Sciences would read the control, verify it was positive and then would send the slides to the pathologist.

CHAYTOR, Q.C.:

Q. Okay, so -

MR. GULLIVER:

A. And that happened for awhile, it didn't happen for all the time.

CHAYTOR, Q.C.:

Q. So what was the problem, why didn't that agreement last?

MR. GULLIVER:

A. I can't tell you exactly why it didn't last.

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It started off at the Health Sciences where-- and I think Mary did up, and I can remember asking her, did up like this here, got a logbook and drew the lines and paper and put it in a reporting room for the pathologist for this was to document that I'm the pathologist on today and I'm going to read the IHC controls and verify them, then the slides go out. That lasted for awhile. And it was just like they just didn't fill it out any more.

CHAYTOR, Q.C.:

Q. And so was this for all the IHC controls or is this just ER and PR that this -

MR. GULLIVER:

A. No, for all controls.

CHAYTOR, Q.C.:

Q. This was for all IHC controls?

MR. GULLIVER:

A. For my knowledge, yes, all controls.

CHAYTOR, Q.C.:

Q. So not only ER/PR, any antibody that was requested, they wanted a separate -

MR. GULLIVER:

A. From the IHC lab, yeah.

CHAYTOR, Q.C.:

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Q. For anything from the IHC lab, they wanted a separate control. So it wasn't anything unique to ER/PR?

MR. GULLIVER:

A. No, no, no. If we had five antibodies requested on a patient case from St. Clare's and the same five from the Grace and the same five from Health Sciences, you're talking about running 15 controls and 15 patient slides. You know what I mean, it was some days you probably ran as many controls or more than you did patient slides, because of multiple pathologists requesting the same, the same antibody.

CHAYTOR, Q.C.:

Q. Okay. And in terms of you said there were a couple of things, cost was one concern in your mind, but the other thing being, you know, who's going to be responsible and document that the controls were, in fact, run and read, and were appropriate. I take it you were expecting that the pathologist assigned responsibility would, in fact, document that, would -

MR. GULLIVER:

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A. I would assume, yes.

CHAYTOR, Q.C.:

Q. Okay. And what you had in mind in terms of documentation was this logbook that you asked Ms. Butler to create?

MR. GULLIVER:

A. (No audible response).

CHAYTOR, Q.C.:

Q. Okay. Would there be any kind of electronic recording of the fact that controls have been read, ran, read, and appropriate?

MR. GULLIVER:

A. No electronic documentation of the control, that they read a control. From a lab perspective, though, when a procedure was requested by the pathologist a lot of our procedures in the routine pathology lab, histochemical staining and then the immunohistochemical staining had control slides. And I guess, you know, I've said earlier, in pathology what we call our record is the hard copy. You know, we keep the slides, we keep the blocks, and we keep them for 20 years. The electronic side of it, in Meditech when a procedure was ordered, if that

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procedure required a external positive control, the technologist would order a control and when it was completed, they would go into Meditech and they would go in and capture, really it was being done from a workload perspective. They would go into the Meditech system and they would say that today in our pathology lab we did an auramine control, a masdon control (phonetic) and we did ten peroxidase controls. And it was more documenting that we did them and captured the workload measurement for it, really, as opposed to documenting that we did this control today for this patient.

CHAYTOR, Q.C.:

Q. Yes. And, Mr. Gulliver, I think there was a volume of documents that we received this week when we -

MR. GULLIVER:

A. Just Tuesday, yeah.

CHAYTOR, Q.C.:

Q. That's just in the last couple of days on that.

MR. GULLIVER:

A. Yeah.

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CHAYTOR, Q.C.:
Q. And I must confess, I haven't looked at all, I don't know, 200 pages or whatever is there, but what I did go through, there wasn't really any record kept. There was one I found where it said that there was a control run, but there was no consistent reference to whether or not there's controls or not. Like, that, am I wrong in saying that, have you had a chance to look through it in any greater detail and satisfy yourself that that is, in fact, the electronic record of controls that were run?
MR. GULLIVER:
A. On those sheets that you see, everything you see there is actual controls that were run and completed.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. What's not on those sheets that we didn't put in there was saying the control was verified that it worked.
CHAYTOR, Q.C.:
Q. Yes.

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MR. GULLIVER:
A. You know, that's the next level of documentation.
CHAYTOR, Q.C.:
Q. And does it tell you controls for what?
MR. GULLIVER:
A. The test procedure names are there.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. You mean for IHC or for pathology in general?
CHAYTOR, Q.C.:
Q. Yeah, well, when I was looking at it, I mean, you tell me what you saw in it because when I'm looking at it -
MR. GULLIVER:
A. Okay, so -
CHAYTOR, Q.C.:
Q. - it'll say immunoperoxidase test.
MR. GULLIVER:
A. Exactly, okay.
CHAYTOR, Q.C.:
Q. Right.
MR. GULLIVER:
A. So in pathology when the pathology Meditech system came in in 1987, by that time there were many, many, many standard procedures that had been well established in pathology. All those procedures were put into the computer system and each of them that required a known positive external control to be run, we also put in a procedure code for quality control slide that was run. Now, IHC testing had started to come on stream in the late '80s. For IHC testing on the Meditech side you could order an ER, a PR, an LCA, and EMA, most of the antibodies we had a separate procedure code for each individual antibody or a stain that was run on a daily basis. On the quality control side of the Meditech we just had a basic QC and procedure code for IHC testing. And you will see quality control, peroxidase or quality control, immuno. And you may see QC 15, QC 2 or QC 35. That doesn't tell you the exact quality control slide that was run, whether it was ER/PR or LCA, EMA or CD30 or whatever it may be. On the histochemical side, you will see a QC auramine QC gram, QC GMS. Those procedures had a direct procedure code and a direct QC procedure code. But I

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have to confess to you, we did all that work and the technologists did it, they put all that into the computer system, it really was not done to document that we ran controls.
CHAYTOR, Q.C.:
Q. It was documented for their workload?
MR. GULLIVER:
A. It was done to document for the workload. You know, I can't say--I can't sit here and say, oh, yes, we documented those all those years, but it is a certain level of documentation but it certainly doesn't meet today's criteria.
CHAYTOR, Q.C.:
Q. And you can't look through that and tell us what controls were run for which antibodies, like, that's not a electronic or -
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. - any kind of documentation that would be able to tell this Commission that controls were run for ER/PR tests on the following days?
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:

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Q. You can't tell that?
MR. GULLIVER:
A. I can't tell you that except for if we pull the patients slides and the control slides that are filed, then we can actually produce the hard control slide.
CHAYTOR, Q.C.:
Q. So I just want to be clear. In terms of what that does show us or what you're saying that would show is that this was a record for documenting for workload purposes for the technologists, controls that they were running for whatever was being run on that particular day?
MR. GULLIVER:
A. Exactly.
CHAYTOR, Q.C.:
Q. And whatever was on that particular day, it's not a record of that in terms of what types of antibodies?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. All right.
THE COMMISSIONER:

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Q. So do I take from that that even on a particular run there might have been a number of--I mean, as I understand it, at least more recently you can run all kinds of different tests on the one machine as long as your machine knows what--on the one run of the machine as long as -
MR. GULLIVER:
A. Right, antibodies.
THE COMMISSIONER:
Q. - the machine is programmed to know precisely what it is it's required to do. So it's not like you've got to save up all your ER/PRs and only put ER/PR on the particular -
MR. GULLIVER:
A. Correct.
THE COMMISSIONER:
Q. - run on that particular day?
MR. GULLIVER:
A. Yeah.
THE COMMISSIONER:
Q. So do I take it that all we can learn from the material which has been provided is that there was a control on a particular day?
MR. GULLIVER:

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A. Pretty well it, yeah.
THE COMMISSIONER:
Q. Okay. So we don't know whether that control might have related to which particular test you were running on that day, if there were--unless you knew that it happened to be a day in which you ran only one kind of test?
MR. GULLIVER:
A. Right, yeah.
THE COMMISSIONER:
Q. Then you could be reasonably assured that that's -
MR. GULLIVER:
A. That that control was with that test -
THE COMMISSIONER:
Q. - that's the control for that?
MR. GULLIVER:
A. Yeah.
THE COMMISSIONER:
Q. But otherwise you can't make that match?
MR. GULLIVER:
A. Not electronically, no.
THE COMMISSIONER:
Q. Other than going back into all of the files -
MR. GULLIVER:

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A. Exactly.
THE COMMISSIONER:
Q. - and seeing if you can find that elusive control slide which if more than one were done on the one day, I understand, might be filed with any one of the tests that were run on that one day?
MR. GULLIVER:
A. Exactly.
THE COMMISSIONER:
Q. Okay. Thank you.
CHAYTOR, Q.C.:
Q. And you had said earlier that ER/PRs were saved up and ran on Fridays?
MR. GULLIVER:
A. They were mostly done in batches, and mostly Fridays.
CHAYTOR, Q.C.:
Q. Okay. So would most of the Fridays in that batch you would expect to be ER/PR tests? In that batch of documents, I mean, now.
MR. GULLIVER:
A. No, not necessarily.
CHAYTOR, Q.C.:
Q. Could be anything?

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

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CHAYTOR, Q.C.:
Q. So were you concerned then when that happened, when you realized that there was no longer any real documentation of controls taking place?
MR. GULLIVER:
A. I can't say that I was overly concerned. I would be concerned if no one was reading the controls.
CHAYTOR, Q.C.:
Q. And what documentation did you have then to tell you that they were reading them?
MR. GULLIVER:
A. I guess the documentation is that they read the case, they interpreted it, and they signed the case out.
CHAYTOR, Q.C.:
Q. And was it the norm then that it would be referred to on the pathology report that, in fact, controls had been read?
MR. GULLIVER:
A. I don't know.
CHAYTOR, Q.C.:
Q. You went through all of those pathology reports at the end of the day -
MR. GULLIVER:

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

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Q. Is that when it was?
MR. GULLIVER:
A. Yeah, I mean, it's - well, I was the pathology manager in 2001, and I clearly remember, you know, when I was still manager there, you know, talking about controls, talking to pathologists and site chiefs about, well, who is going to read the IHC controls. We tried the logbook, and I know I brought it back to people's attention that no one is filling the logbook out, and I think that's as much as I could do. You know, it's not - I'm not the one who's interpreting the slide, I'm not the one who's doing a report, I'm not the one who's signing my name to a report. So if you feel comfortable enough to read a control and know in your mind as pathologist that the control worked, and I'm going to read my patients, without writing it down, well, that's their decision to make.
CHAYTOR, Q.C.:
Q. So you didn't raise any concern after that in terms of the logbook not -
MR. GULLIVER:
A. Not that I remember, no.

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CHAYTOR, Q.C.:
Q. And suggest, well, maybe there's some other way we can be doing this, or perhaps you need to be making sure that you recorded somewhere, pathologists, that these controls, in fact, have been read?
MR. GULLIVER:
A. Not that I remember, no.
CHAYTOR, Q.C.:
Q. And now, Mr. Gulliver, you did go, and we'll talk in some detail at some point about what you did in reviewing all the pathology reports for ER/PR in 2005 and beyond that time period, but mostly 2005. So you would have read through all of the pathology repots for ER and PR, or certainly a significant number of them. What did you see in terms of the trend for pathologists recording controls, whether it's external controls, internal controls? Did most of the pathologists in your review refer to controls in their pathology reports?
MR. GULLIVER:
A. Well, we're talking about approximately 3,000 reports, and, yes, I have - the amount of time it took to read those and sort them, but to

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answer your question as best I can, I would have to say that if I took the reports from 1997 when Dr. Khalifa and we had one person interpreting and documenting, I think his repots were excellent. You will find, and I can't say in all the cases, you will find in the vast majority of his reports that he documents in the patient's report that the positive control was positive, which is the external technical control which we talked about, and you will find many cases where he says, "and the internal control worked fine".
CHAYTOR, Q.C.:
Q. Yes, and what about the other pathologists? Dr. Khalifa, you happened to note, would have referred to his controls?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. External and internal.
MR. GULLIVER:
A. I certainly seen - I certainly seen that level of documentation on some reports. I would say that it's probably not until maybe 2003 or 2004 that you kind of start to see that's the

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- like, if you read all of '97, you can see the major trend is sort of a standard format Dr. Khalifa used, you can see pretty well most of the time mentioned the positive external control and most of the time he mentions the internal control for the patient, and if you went through every year like that, I don't think you'll find another year as sort of standard as that until maybe 2004.
CHAYTOR, Q.C.:
Q. After Dr. Ejeckam -
MR. GULLIVER:
A. And I have to say it's probably after -
CHAYTOR, Q.C.:
Q. And after Dr. Ejeckam's memo?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And then you start seeing more regularly reference to controls in the pathology reports?
MR. GULLIVER:
A. Yeah, you do.
CHAYTOR, Q.C.:
Q. And the interim period after Dr. Khalifa stops

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doing the centralized reporting for those tests, until that period of time in 2004, most of the reports would not refer to controls, is that fair?
MR. GULLIVER:
A. No, I can't say most, Ms. Chaytor. I would certainly - I would feel comfortable in saying in that time frame if there were, I don't know how many, I would say there's a fair number where there is documentation in the patient's report of the external control, even lesser for internal control, and maybe 25 percent would be my estimate of, you know, that time frame, or less than 25 percent.
CHAYTOR, Q.C.:
Q. Referring to controls?
MR. GULLIVER:
A. Where it's documented in the patient's reports, yes.
CHAYTOR, Q.C.:
Q. So less than 25 percent referring to controls in the patient's report?
MR. GULLIVER:
A. That would be a good estimate, I think.
CHAYTOR, Q.C.:

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Q. So when I said "most" didn't refer to controls -

MR. GULLIVER:

A. Yeah, you said most -

CHAYTOR, Q.C.:

Q. Seventy-five percent is most -

MR. GULLIVER:

A. Yeah, and again I could not be 100 percent correct. I could be 50/50, but you're right, there was a significant number that doesn't mention either internal controls or external controls.

CHAYTOR, Q.C.:

Q. If we could then, please, have P-1874. This is another meeting of the Division of Anatomical Pathology, site chiefs and divisional managers, of the Health Care Corporation, February 22nd, 2001, and Dr. Parai is the chair, Dr. Haegert, Dr. Cook, yourself, and Mr. Murphy, and if we look at page three under 4.2, "Quality control of immunoperoxidase staining. There has been a study going on. The quality of the immunoperoxidase staining for both sites, it is agreed that controls for immunoperoxidase

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staining be run for every batch. The pathologist will check the control slide before sending the slide to the other site. Dr. S. Parai has agreed to do this. In case he is not available, anther pathologist will be looking at the controls". What was the study going as to the quality of the immunoperoxidase staining for the two sites?

MR. GULLIVER:

A. I really do believe whoever typed the minutes for this meeting - that certainly is not what was discussed. I think at most of these meetings that I was involved with - because this was our site chiefs meeting, it wasn't just the pathologists only meeting. Most of this here had to do with the pathologists at St. Clare's expressing concern over the turnaround times, and sometimes the delays in getting slides back from the Health Sciences for IHC testing, and there was never any study, to my knowledge, of the quality of the IHC stains, it was all about the timing and how long it took sometimes to get slides back.

CHAYTOR, Q.C.:

Q. Okay. Now, Mr. Gulliver, at this point in

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time, you still haven't taken over your position as director. That happens later in 2001, I understand?

MR. GULLIVER:

A. That happens later, yes.

CHAYTOR, Q.C.:

Q. So you're still the manager for pathology for the two sites, the Janeway and the Health Science. Well, I guess it's all into the one lab at that point in time.

MR. GULLIVER:

A. Yeah, by this time it's only St. Clare's, Health Sciences operating with pathology labs now.

CHAYTOR, Q.C.:

Q. So the Grace is also closed at this point in time?

MR. GULLIVER:

A. Yes, yeah.

CHAYTOR, Q.C.:

Q. And Dr. Parai has taken over - he's chairman, so he is now, I take it -

MR. GULLIVER:

A. No, he's site chief.

CHAYTOR, Q.C.:

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Q. He's site chief at the Health Sciences.

MR. GULLIVER:

A. For Health Sciences. This is just chair of this group, the committee, of the meeting. This is not chairman of the - Dr. Haegert is the chairman, clinical chief.

CHAYTOR, Q.C.:

Q. So Dr. Khalifa has moved on at this point in time?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And what effect did that have on the IHC service, of Dr. Khalifa leaving?

MR. GULLIVER:

A. Well, I think that everyone who worked with Dr. Khalifa certainly respected his knowledge. I think everyone really appreciated the time he took to help our technologist staff, and I really believe our pathologist staff also. I think Dr. Khalifa leaving - I was very upset. I mean, he was - I always thought he was excellent to deal with, we had a good relationship, and I always thought he was going to stay in St. John's and become our

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clinical chief some day. I think Dr. Khalifa leaving really did leave a vacuum in the laboratory, and, you know, I think it did have a fairly significant impact on our pathology lab.

CHAYTOR, Q.C.:

Q. And in terms of the role that he filled that you described earlier today in terms of his interaction with technologists, did anyone else take up that role and provide that kind of guidance to the technologists doing IHC?

MR. GULLIVER:

A. Well, I mentioned earlier, when we started earlier, I mean, ten years before this, fifteen years by this time, Dr. Chittal, which was a staff pathologist, you know, we all got along famously with Dr. Chittal, he was an excellent person to deal with. He had expressed interest in IHC over the years, but again even Dr. Chittal, himself, you know, he would go on extended sabbaticals to France for a year and he wouldn't be available in the lab, and when he'd come back, he'd be doing research work, so it's - if he was around, the staff would still go to him, but he was not

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around also to be there as a constant source of guidance or a constant source of information.

CHAYTOR, Q.C.:

Q. So it's fair to say the vacuum that you're talking about included the loss of that kind of constant resource to the technologists?

MR. GULLIVER:

A. I feel so, yes.

CHAYTOR, Q.C.:

Q. And when, if ever, is that filled again?

MR. GULLIVER:

A. You mean for IHC, in particular?

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. I have to be honest, I don't think we've seen another pathologist who expressed, you know, that level of interest until Dr. Ejeckam comes back to work in St. John's at the Health Sciences, and after - I think maybe after three or four months where he's back on staff - well, he was at the Grace before - before the Grace closed. I have to say, I mean, that was the next significant time where we had a

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pathologist who had the interest in IHC and wanted to spend the time in the lab and look at things.

CHAYTOR, Q.C.:

Q. And that's 2002, I take it?

MR. GULLIVER:

A. I have to say it was probably not until 2003. He was back at work, and he didn't immediately jump in and say I want to get into the IHC lab, but -

CHAYTOR, Q.C.:

Q. So it's the spring of 2003 then, in that time period?

MR. GULLIVER:

A. Or maybe the winter, you know, something like that.

CHAYTOR, Q.C.:

Q. Where we see his memos coming in April?

MR. GULLIVER:

A. Yeah, yeah.

THE COMMISSIONER:

Q. Ms. Chaytor, wherever you can find a spot for the afternoon break?

CHAYTOR, Q.C.:

Q. Okay, so in the interim then from when Dr.

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Khalifa left in 1999, I understand, until then the winter of 2003 when Dr. Ejeckam gets involved, who would the technologist--who would assist the technologist, for example in choosing appropriate specimens to use as external controls?

MR. GULLIVER:

A. It could be a multiple of pathologists, you know, and I have to say this too, I mean, you're alluding that when Dr. Khalifa left, I think he left a vacuum on both sides of our laboratory, both the technical side and our clinical side. And I think during that timeframe, whoever Mary and Peggy could go speak to and say we need to verify this control, they would have run some samples and they'd bring it to a pathologist and say, look, how does this control look like compared to the last one? I mean, that's the way things went on during that timeframe.

CHAYTOR, Q.C.:

Q. And what if they need to validate a new lot number of an antibody or a brand new antibody?

MR. GULLIVER:

A. I think they would do the same process. The

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

CHAYTOR, Q.C.:

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

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

A. We tried to.

CHAYTOR, Q.C.:

Q. But that never came up?

MR. GULLIVER:

A. That specific question that you're asking -

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CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

THE COMMISSIONER:

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

(RECESS)

THE COMMISSIONER:

Q. Please be seated. Ms. Chaytor.

CHAYTOR, Q.C.:

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

MR. GULLIVER:

A. About two years.

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CHAYTOR, Q.C.:

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

MR. GULLIVER:

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A. All the laboratories, yes.
CHAYTOR, Q.C.:
Q. All the laboratories, yes. And after Dr. Ejeckam arrived and took an interest in IHC, was that something that Dr. Ejeckam approached you about as the program director or discussed with you?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And how did you then become aware that he had a particular interest?
MR. GULLIVER:
A. I'm pretty sure it was through--I'm in the same building as Dr. Ejeckam, you know, my pathology manger is there and the staff, Dr. Cook. I just think through general consensus, I think people sensed that he was interested in IHC, but I think it was pretty well Dr. Cook who more or less said to me that Dr. Ejeckam is interested in the IHC part of the pathology lab.
CHAYTOR, Q.C.:
Q. Okay, and by that point in time then, Dr. Cook would have been the clinical chief?

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

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

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

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and stenos who are typing a dictation on all this gross description, but there was discussions by this time talking about standardizing grossing practices.

CHAYTOR, Q.C.:

Q. And what happened with that? Were any decisions made around that?

MR. GULLIVER:

A. I'm aware that Barry and I thought he was working with one of the pathologists, Mira Parai, looking at doing some of the standardized canned text for grossing. I do recall, though, that Dr. Cook asked--our pathologists would meet on a fairly regular basis, not every month. I remember at one pathologist meeting that he was having at the Health Sciences, he invited myself and Barry to attend that meeting and it was talking about standardizing some grossing practices and techniques. I'm not sure of the timeframe, Ms. Chaytor, I mean, it might have been 2004, it could have been late 2003.

CHAYTOR, Q.C.:

Q. And if we could have then, please, P-2539? And this is another meeting of a division of

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the anatomical pathology, this one is pathologists' meeting at the General Hospital site, April 24th, 2001. And if we look at page 3 of this document, under business arising, item 3.8 "Pathologist Assistants". There has been much discussion on this issue; however, Dr. Haegert will discuss with Dr. Williams in future; however, there is no money in the budget to fund this position. Dr. S. Parai will talk to Terry Gulliver exploring the possibility of training two senior technologists for doing additional grossing." What do you recall in this time period, Mr. Gulliver, about discussions regarding having senior technologists doing additional grossing?

MR. GULLIVER:

A. Well certainly I was the manager and I remember this very clearly, that our pathologists, at the time both sites were talking about their workloads. We have heard that well documented through this inquiry. We've had a huge turnover in our pathologist staff over the years and there were times where we didn't even have one resident in

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

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sometimes 30, 40, 50 percent of the specimens do not require an actual surgical dissection. It's more the specimen comes in from the operating room or from daycare somewhere, has more of actually taking the specimen from the bottle and dictating to a microphone and a tape that I have a specimen on, you know, Mr. Terry Gulliver, MCP number, the type of specimen it is and you open it up, you make a cassette that you've seen the block or cassette and you place the tissue directly into the cassette and there's no more function than that. And that's time consuming. So it was more of taking that workload away from the pathologist and we could give it to our senior technologists.

CHAYTOR, Q.C.:

Q. And if we could look, please, at P-2540 and it's page 3 then of this document and you can see this is another meeting, Division of Anatomical Pathologist meeting at the General Hospital site, June 14th, 2001. And at page 3 we see under "business arising" the same topic, 3.4, "Pathologist Assistant. Much discussion on this issue. It is unlikely that

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the corporation will fund for pathologist assistant; however, we have three senior technologists who will be willing to do additional grossing if their jobs are reclassified to technologist III level. It is expected that we will know this information very soon. There have been some errors recently in specimen labelling and handling. Dr. S. Parai will discuss with Terry Gulliver about this problem." So at this point in them then, by June of 2001, did that happen, were these three senior technologists reassigned or reclassified as being technologists III?

MR. GULLIVER:

A. They weren't reclassified, coincidentally through all this timeframe and I think it was October 2000 we had an illegal strike by our lab and x-ray staff in this province. It was over an issue of government had offered and performed an occupation review of other professions in the health care system and they did not extend that to the medical lab technologists or diagnostic imaging technologists and that caused an illegal walkout from the staff. Pursuant to that, all

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the medical lab staff went under an occupation review and these staff positions were kind of classified through that process, coincidentally. But the actual start of this function here now, Ms. Chaytor, there's two differences here because we're talking about pathology assistants and we're talking about technologists being skilled up to do the basic non dissecting specimens. In the advent that we don't have pathologist assistants and pathologist assistants, as you know today we have them, is someone who actually can do almost all the full grossing function that a pathologist would normally perform. So since we didn't have money for, to make new positions for PAs, the next best scenario was, well could we at least take some of this workload away from the pathologists or really the non-dissecting stuff and give it to our technologists to do. And that's what we started to do.

CHAYTOR, Q.C.:

Q. So without creating PA positions at the pay level, I would take it of a PA, you were able to move technologists in to take over some of

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that workload?

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. And in essence though, would they be performing the job of PAs?

MR. GULLIVER:

A. Not even close, no.

CHAYTOR, Q.C.:

Q. So they were just doing some of the grossing, but -

MR. GULLIVER:

A. Dictation really and physically taking a specimen from the bottle with formalin in it and just placing that specimen into a cassette and closing the cover on the cassette. There was no dissection involved.

CHAYTOR, Q.C.:

Q. Was there any--did anyone go looking for the funding at this point in time in 2001 for those positions?

MR. GULLIVER:

A. For pathologist assistants?

CHAYTOR, Q.C.:

Q. Yes.

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MR. GULLIVER:

A. That was certainly requested over multiple years, you know, back in 2000--this is 2001, I take it, isn't it?

CHAYTOR, Q.C.:

Q. 2001, June of 2001.

MR. GULLIVER:

A. And, you know, certainly in 2000 and this time 2001 through various avenues, this request had gone up the line, we had the support from Dr. Robb at the time who was our university chair, certainly support from me, as the manager, you know, it was something--and keep in mind this is through a time period where we've gone through major downsizing and cutbacks. And, you know, really still continue to or we haven't even balanced the budget yet within the lab program, and I think generally in the health care system, you know, trying to get resources for new staff was one of the most difficult things you could do. I don't think it was, laboratory was no different than other parts of the system, in my belief, that all kinds of parts of the system were crying out for new staff and additional resources. It

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just wasn't forthcoming.
CHAYTOR, Q.C.:
Q. So this would be put forward in the budget each year, but it would never be approved?
MR. GULLIVER:
A. It's a combination, sometimes it would go through, you could go through the budget; other times you could do a direct request to your VP and have the VP advocate on your program's behalf to executive and to the finance people.
CHAYTOR, Q.C.:
Q. And that happened for pathologist assistants?
MR. GULLIVER:
A. Yes, it did.
CHAYTOR, Q.C.:
Q. And all of that, whatever was done in terms of requests through whatever mechanism, it was always turned down?
MR. GULLIVER:
A. I can't say it was turned down, no one ever told me directly you're not getting money for pathology assistants. What came back was here's what funding is approved for and that was not one of them.

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CHAYTOR, Q.C.:
Q. And so isn't that the same as it -
MR. GULLIVER:
A. I guess it's the same outcome.
CHAYTOR, Q.C.:
Q. If it's not on the list of what's approved -
MR. GULLIVER:
A. It's the same outcome, but no one ever told me directly, no, you can't have money for pathology assistants.
CHAYTOR, Q.C.:
Q. But you never received it?
MR. GULLIVER:
A. But never received it, no.
CHAYTOR, Q.C.:
Q. And who, Mr. Gulliver, made those decisions? Who would send back the list of what had been approved and the list not containing funding for pathologist assistants?
MR. GULLIVER:
A. I really can't answer that question completely because the budgeting process, I mean -
CHAYTOR, Q.C.:
Q. Well what would you get back and who would it be communicated to you through?

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MR. GULLIVER:
A. What we would do, and as a matter of fact, this Sunday I have to work to put my budget in for next year, to start the process. It starts six months ahead, our fiscal year is ending, we're starting our budget process. So the budget process would work, you work within your team, you submit items that you feel are inflationary or unavoidable costs on your budget. You submit items for new tests, new procedures that you have to implement or people are asking to do. You submit requests for service agreements and contracts and equipment that will increase your budget cost. You submit requests for additional or new staff in through that process. You meet with senior finance people in executive within the Health Care Corporation at the time. They then meet with the Department of Health officials to go over the health care submission budget and at some point, six months or eight months later, usually four months after your year begins, you finally hear something back and say, and here's what is approved for your budget submission.

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CHAYTOR, Q.C.:
Q. Yes, and who do you hear that back from?
MR. GULLIVER:
A. Well it comes back through our finance department.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. Through our finance people.
CHAYTOR, Q.C.:
Q. And where it gets cut along the way -
MR. GULLIVER:
A. I don't know.
CHAYTOR, Q.C.:
Q. You don't know. So have you ever asked that? Have you ever asked, well did it ever get put forward and proposed to government, for example?
MR. GULLIVER:
A. I've never asked that question.
CHAYTOR, Q.C.:
Q. So you don't know if it was done at senior -
MR. GULLIVER:
A. But lately, I know this is back in--but now when we do our budget submissions, there's a

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point where now the program leadership teams, we actually meet with, in conjunction with our finance people, there is a government representative at the table, so you can kind of speak directly to government officials. And this has happened the last couple of years now.

CHAYTOR, Q.C.:

Q. That's a new process.

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. So back in the days when pathologist assistants--the funding for that is being requested and turned down, at what level that decision is made, you don't know.

MR. GULLIVER:

A. I don't know.

CHAYTOR, Q.C.:

Q. The lab program was looking for it and it was always turned down.

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. But who made that decision, whether it was

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within your own organization or beyond, you're not able to say?

MR. GULLIVER:

A. I can't say, no.

CHAYTOR, Q.C.:

Q. And you've never asked that question?

THE COMMISSIONER:

Q. You know, what--as I understand it, there's an opportunity for the organization seeking funding to indicate priorities when they're looking to government for funding. Do you have any knowledge of what priority, for example, pathologist assistants might have been given by your organization?

MR. GULLIVER:

A. At that time, Justice Cameron, the budgeting process didn't ask to identify priorities within the program. You know, the organization may have presented priorities to government, but right now, for example, as I said, Sunday we're working we do my budget. We have, within the programs we're now asked to identify within your program if these are your requests, what are the priorities within your program? Rank them one, two, three,

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four, five. That's the process that we do follow now, but we didn't follow that, like five, six years ago at that time.

CHAYTOR, Q.C.:

Q. So in the process then, back in those days, was there ever any opportunity for you to be able to make a submission and tell people, well here's what I think the negative effects will be if you don't approve certain aspects?

MR. GULLIVER:

A. There really wasn't, no.

CHAYTOR, Q.C.:

Q. And is there an opportunity for that kind of dialogue today?

MR. GULLIVER:

A. It is, I have to say it's much improved today. Again, having the ability to, once within Eastern Health, for example, now when we've kind of finalized our submission for a budget, we have to submit briefing notes on your priority request and then at some point we would get to meet with a government official from Finance or Department of Health, the financial side of it, and we can actually make our pitch directly to that person with our

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senior team there.

CHAYTOR, Q.C.:

Q. And did the pitch ever get made in terms of pathology assistants what they can do in terms of taking the workload off pathologists and also lead to the standardization of the grossing, the benefits to the quality of the product, plus the alleviation of the workload issue with the pathologists, did you ever have an opportunity to make that pitch?

MR. GULLIVER:

A. I certainly did, yes.

CHAYTOR, Q.C.:

Q. And who did you make the pitch to?

MR. GULLIVER:

A. And that pitch was not done really through the normal budgeting channels. That pitch was made directly to our VP.

CHAYTOR, Q.C.:

Q. And that would be Dr. Williams, I take it?

MR. GULLIVER:

A. Dr. Williams, yes, at the time. And we made to Dr. Williams and I know that Dr. Williams supported it, so I know it's not something that Dr. Williams did not, you know, bring

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forward to his counterparts.

CHAYTOR, Q.C.:

Q. So he took it forward to the best of your knowledge?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And where it got lost or cut along the way after that, you're not able to say. Is there anything--do you keep in writing for now, today, would there be any written record of anything that gets put forward, in terms of warnings to the quality of lab services if certain items aren't in fact funded?

MR. GULLIVER:

A. It's our process now, when we started this, maybe one budget cycle or two, that yes, that in that process when you do your briefing notes, a part of that, that summary that goes in there is, for example, if it was the PAs now, if we're asking now, you know, which we have them, it would include why do you need PAs, how does it impact on your efficiencies in the program, how does it affect patient care in the program and what would be the sort

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of one time cost and ongoing cost to maintain this? So it is a fairly in-depth submission now that you go through.

CHAYTOR, Q.C.:

Q. And when was that started? That's the last couple of years, is it?

MR. GULLIVER:

A. I think this will be my third time, Ms. Chaytor, preparing, so maybe in the last couple of years it started. I think the budgeting process now within, you know, with this government, I mean and our Eastern Health, I think it's a much more better process than we had for years prior.

CHAYTOR, Q.C.:

Q. If we could have please, P-1876? And this is another meeting of site chiefs and divisional managers. And it's April 25th, 2001 and you will see that you are in attendance, along with Drs. Cook, Parai, Haegert, Mr. Murphy and perhaps others. And if we look at page three of this document, no, here it is on the first page, actually, under business arising, "Quality control of immunoperoxidase staining. Generally the immunos appear to be very good,

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there appears to be some problems with estrogen and progesterone receptors. The positive controls are checked daily by pathologists; however, these need to be documented. Dr. Parai will follow up on this. Note is also made of the heavy utilization of immunoservices and the high volumes encountered." Now this is April of '01, so Mr. Gulliver, you're still the pathology manager at this point. And what do you recall being discussed here? There's a couple of things and the first being the problems with the estrogen and progesterone receptors, what do you recall about that?

MR. GULLIVER:

A. I don't remember anything specific, Ms. Chaytor, into problems with ER/PR receptors, you know, who was taking the minutes of this meeting? Was it Dr. Cook? Well whoever was taking the minutes or writing this down, so whoever it is, they're saying that generally the immunos appear to be very good. I don't remember any discussion over what the problems were with the ER/PR at that particular meeting.

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CHAYTOR, Q.C.:

Q. And your practice -

MR. GULLIVER:

A. I do remember the utilization piece, though.

CHAYTOR, Q.C.:

Q. Okay. Your practice--just a moment, then. The practice though in terms of who recorded the minutes, you don't know who normally would do that, whether--you don't know who would do it?

MR. GULLIVER:

A. It was never--it wasn't me that I remember.

CHAYTOR, Q.C.:

Q. Okay. But this is the practice certainly would be then the minutes of the previous meeting would then be approved. You can see here the minutes of the previous meeting you, in fact, have seconded the approval. So I take it then that the minutes then get approved and if there's any error in the minutes, it would be brought up at the next meeting?

MR. GULLIVER:

A. Right, you go through that standard meeting protocol, yeah.

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CHAYTOR, Q.C.:
Q. Yes, right, okay. So you have no recollection as to what would have been referred to here about the problems with the ER/PR?
MR. GULLIVER:
A. I don't, I'm sorry, no.
CHAYTOR, Q.C.:
Q. Receptors?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And but you do recall what's being referred to in terms of the heavy utilization?
MR. GULLIVER:
A. Utilization. And I recall it as being an issue not specifically on February 22nd, 2001, whatever that day is. Some of the issues we used to talk about the heavy utilization of immuno services was really in the proper utilization of the immuno services. For example, if you had a lymphoma case that needed to be investigated, one pathologist may order 20 antibodies, another one may order three. One pathologist might order 20 antibodies and five blocks from the same case

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and someone else would have a different one. So there was always the issues talking about that in the over utilization of immuno services. And I remember saying to our pathologists that, you know, why is it that we need to do, you know, 15 antibodies on the same patient of three different blocks and that was certainly recognized as being an issue. And I know amongst the pathologist group, that's something that they discussed.
CHAYTOR, Q.C.:
Q. Okay. And the issue, and we saw on another meeting around this same time frame about surveying. You don't recall anything about that. So -
MR. GULLIVER:
A. The quality--yeah, no, nothing.
CHAYTOR, Q.C.:
Q. On quality of slides or anything like that?
MR. GULLIVER:
A. No. It was more about turn around, I'm sure it was about turn around times, the length of time it took to get slides back and forth from Health Sciences to St. Clare's.
CHAYTOR, Q.C.:

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Q. And I may not be recalling this correctly, but I thought that we heard evidence from one of the pathologists, I thought it was Dr. Pari, who discussed receiving feedback from quite a number of pathologists in providing you feedback about issues about the quality of slides. Do you recall anything about that?
MR. GULLIVER:
A. For the quality of immuno slides, I don't, no.
CHAYTOR, Q.C.:
Q. Okay. And there's nothing else then, nothing else that you have any recollection about the ER/PR slides or overall in this time period being involved in getting any feedback on quality of immuno slides?
MR. GULLIVER:
A. I don't, no.
CHAYTOR, Q.C.:
Q. And if we could have, please, 1877? And this is a meeting then of anatomical pathology, the site chiefs, again, divisional managers. 1877. And it's now June 26th, 2001. And present is Dr. Parai, Dr. Cook and Dr. Haegert. You're not in attendance, nor is Mr. Murphy. And it looks like the minutes of the

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previous meeting were adopted with some changes in item seven of the new business. So it appears that the minutes were adopted, including the portion that I had brought you to. And under "New Business" "Quality assurance program for anatomical pathology/pathologists review. This meeting is dedicated for the above items" and the following points are discussed. "System review. This system review is not in place. It will be discussed in the next meeting for possible implementation of pathology report review by system by a committee. Turn around times, outstanding reports, canned text. There is partial implementation for canned text at the General Hospital site for ER/PR and HER2/neu expression. It is important to use standard specimen grossing and reporting. Frozen section review, performance improvement program."
MR. GULLIVER:
A. Do you mind stopping there, Ms. Chaytor?
CHAYTOR, Q.C.:
Q. Sure.
MR. GULLIVER:

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A. Again, we've mentioned earlier, this is where pathologists would talk about proficiency testing and performance review where the cases that they are involved in with the CAP and the ASCP check samples.

CHAYTOR, Q.C.:

Q. Okay. "Quality control rounds. Intradepartmental round, interhospital rounds, intradepartmental consultation, external consultation." And what do you recall--and I realize you're not at this particular meeting, but what do you recall around this time period in terms of a new business being quality assurance program for anatomical pathology?

MR. GULLIVER:

A. Well, I think what you see there is the list. I think it was the pathologists as a group were looking at putting in some kind of documented quality assurance processes for the pathologists. Because, I mean, you look at the list of items they're talking about, the outstanding reports, the turn around time reports, their standardized canned text, frozen sections, the CAP, ASCP checks, I don't think they're talking about what we would see

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today, Ms. Chaytor, as a full quality assurance program today.

CHAYTOR, Q.C.:

Q. Um-hm.

MR. GULLIVER:

A. I think this is very focused on pathologists.

CHAYTOR, Q.C.:

Q. Okay. And was there ever any discussion with you then in terms of looking at that fuller program which would include both sides of the program?

MR. GULLIVER:

A. Not back in, not back then. I think, you know, when I move on to the directors role and the new manager comes in, Mr. Dyer, I know early into his new position it's something that he and Dr. Parai were going to work towards.

CHAYTOR, Q.C.:

Q. Okay. And, Mr. Gulliver, then I'd like to move on and talk to you a little bit about the HAY report. And the Commissioner has heard some things about that. By the time the HAY report is filed, are you in your director's position at that point in time?

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MR. GULLIVER:

A. Maybe a week. I was--I know I took over the position of director of the program for Health Care Corporation and I know I think that was pretty well my first big thing to hit was that the corporation was bringing in an external consultant who were going to review all parts of the health care system, including the laboratory. And, you know, that happened early on into my new position.

CHAYTOR, Q.C.:

Q. Okay. And perhaps then you can tell the Commissioner whether or not you had any concerns coming out of the HAY report with respect to the laboratory medicine program and, if so, what those concerns were and what you did to try and have the concerns addressed?

MR. GULLIVER:

A. Well, the HAY review, actually, before the report, but the HAY reviewers who came in, they certainly met with all the directors and clinical directors and program directors. It actually had two components for different programs. If you were strictly an

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

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

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

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

CHAYTOR, Q.C.:

Q. About a day.

MR. GULLIVER:

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

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CHAYTOR, Q.C.:

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

MR. GULLIVER:

A. For all the lab, yes.

CHAYTOR, Q.C.:

Q. Hematology, the whole thing?

MR. GULLIVER:

A. Yes, yes.

CHAYTOR, Q.C.:

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

MR. GULLIVER:

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

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at the time, they would do the testing on the specimen that they could perform, subsequently if there was any specialized testing, they were repacked up and reshipped to the Health Sciences because the Health Sciences was the only lab in the province that was able to perform almost all laboratory testing. We received samples and tests from Corner Brook, Lab City, Carbonear every day looking for specialized testing. So one of the things from that outcome was, you know, Dr. Manley agreed and said, you know, you should send your specimens directly from Waterford directly to Health Sciences where there's no further delays, all the testing can be done on one site and done on the same day, type of thing.

CHAYTOR, Q.C.:

Q. And did any of that discussion involve anything to do with the IHC lab?

MR. GULLIVER:

A. No, it didn't, no.

CHAYTOR, Q.C.:

Q. The idea of a core lab, you said core lab set up, what does that mean, a core lab?

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MR. GULLIVER:

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

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important now that like the night shifts and the evening and weekend shifts, so in those cases instead of having four staff on a shift per weekend, a hematology tech, a chemistry tech, a coag tech, a blood bank tech, you could utilize your staff maybe have two staff on because the volume wouldn't be there to warrant four, so if you had them all together working under the same roof. And that's a core lab kind of concept.

CHAYTOR, Q.C.:

Q. Okay. And so you meet with the reviewers, you go through the whole process and then the report is forthcoming. And when you get--when you received the report, did you have any concerns and, if so, what -

MR. GULLIVER:

A. Oh, I was shocked.

CHAYTOR, Q.C.:

Q. You were shocked. And perhaps you can tell the Commissioner then about that?

MR. GULLIVER:

A. Well, when I was reading through the report and after, you know, spending time--and I guess maybe again I could have been naive,

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

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something, there's sort of an overrider in their report that they could not dispute what I said, nor could they verify, so based upon that, they would amend their amount of cutbacks and stuff for the laboratory.

CHAYTOR, Q.C.:

Q. And what was the outcome at the end of the day?

MR. GULLIVER:

A. At the end of the day, we sort of did a division by division review of what operational savings we could achieve, and at the end of the day, I think we agreed upon a consensus of, I think, nine or maybe ten FTE's that will be achieved through attrition or various means, no layoffs being issued, but even that nine or ten, you know, while I had to achieve that, I can't say it was something that was done -

CHAYTOR, Q.C.:

Q. I'm sorry, you can't say?

MR. GULLIVER:

A. I can't say that I enjoyed doing it, you know, I don't think I still fully agreed with even losing that number of staff.

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CHAYTOR, Q.C.:

Q. And in terms of - that would have been for your overall program, nine or ten positions. How many, if any, were part of the pathology lab?

MR. GULLIVER:

A. Oh, let me think. I think - see in the recommendations, and, I guess, I took it to be that the people who are writing the report, they probably got input from Dr. Manley, combined his assessment recommendations with the administrative side of this review, and came up with these list of recommendations for the laboratory. In there, there was sort of - it wasn't really quite clear. They were saying about we should reduce one technologist in pathology, and we should reduce two technologists in cytology, and then train them as PA's, and when we reviewed it, it was, like, well, our cytology technologists who read all the pap smears for the province, you know, those staff have an additional two years training after they finish our RT program, and we don't have a training school in Newfoundland, and it was, like, well, we

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certainly ain't going to get rid of two of our cyto technologists, that's a skill mix that we don't have and we can't place, and we certainly didn't agree with losing one of our technologists in pathology because of our workload and volumes. While we agreed with having positions of PAs, we did not agree to trade of two cyto technologists and a pathology technologist for the creation of PA's.

CHAYTOR, Q.C.:

Q. Perhaps I'll take you then to P-0901. I understand this document to be your response to the HAY operational review. It's dated March 3rd, 2002. It's written to Dr. Williams, VP Medical Services, by yourself as the Program Director, and it appears you've met with Dr. Williams, "Further to our meeting of February 22nd, 2002, the following is a more detailed response to the HAY operational review report, based upon the revised statistics as provided by Ms. Sharon Lehr, Director of Budgeting". So I take it before you would come up with this written response, you've had discussions with and meetings with

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Dr. Williams about your opposition to this report?

MR. GULLIVER:

A. Oh, certainly, oh, yes.

CHAYTOR, Q.C.:

Q. And the -

MR. GULLIVER:

A. I wouldn't have done this here without Dr. Williams support to say, go ahead, get me documentation, get me figures, so we can verify what I have been saying.

CHAYTOR, Q.C.:

Q. Okay, and the first part here is a table which is indicated to be Exhibit 5.29, laboratory workload on FTEs [revised]. For anatomical pathology, there's asterisk which says that - I saw the asterisk down here, "includes anatomical pathology, surgical pathology, autopsy and diagnostic cytology".

MR. GULLIVER:

A. That's how the HAY -

CHAYTOR, Q.C.:

Q. Grouped it?

MR. GULLIVER:

A. Grouped people together.

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CHAYTOR, Q.C.:
Q. For anatomical pathology.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. So this chart here is taken - is this directly from the HAY report?
MR. GULLIVER:
A. No, this is my report.
CHAYTOR, Q.C.:
Q. This is your assessment.
MR. GULLIVER:
A. This is my response to say to the HAY people, here's the actual workload within these categories, here are the number of FTEs that we were working with over this time frame, here are the number of FTEs that we currently have, and you're telling me we have to go even further - down further now.
CHAYTOR, Q.C.:
Q. Okay, so what you've done here then, you have patient care workload units, and it's broken down, 1999 -
MR. GULLIVER:
A. And remember we talked about the quality

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control about taking workload units -
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. Staff are trained for all the tests we perform and procedures to take your workload units because we always - we base our staffing levels on the workload units produced by the laboratory staff.
CHAYTOR, Q.C.:
Q. Yes. So Mr. Gulliver, what does it tell us? From 1999 to 2000, you have indicated there to be over 3,221,198 workload units.
MR. GULLIVER:
A. In that category.
CHAYTOR, Q.C.:
Q. Patient care, right.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And then continuing on then, the following year that's reduced down to 3,050,000, and then 2001/2002, it's at 3,147,000 thereabouts. So for overall percentage change, you've indicated to be down by 2.3 percent.

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MR. GULLIVER:
A. Yeah, and -
CHAYTOR, Q.C.:
Q. And then -
MR. GULLIVER:
A. And workload units, they're updated every year through CIHI, and sometimes workload units changed, the values decreased for procedures and tests. So when you change that value, you may see a decrease in your workload units, but then you may see an increase in your overall number of tests and procedures performed, and remember too in this fiscal year, we had an illegal strike. So during that time frame there's no work getting done.
CHAYTOR, Q.C.:
Q. So that's in the '01 -
MR. GULLIVER:
A. That'll reduce your workload also.
CHAYTOR, Q.C.:
Q. So that would account for the 2000/2001 decrease, is that correct?
MR. GULLIVER:
A. I would say that's a portion of it, yeah.
CHAYTOR, Q.C.:

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Q. Yes.
MR. GULLIVER:
A. But this is showing overall, Ms. Chaytor, for the laboratory for St. John's.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. In '99, you can see we had full time equivalent staff, and now -- two years later we're down to 240. So there's a five percent reduction in our FTE equivalents, but yet there's an increase, 4 percent increase in our workload.
CHAYTOR, Q.C.:
Q. Right, so that's overall for your -
MR. GULLIVER:
A. So our work is going up, staff is going down.
CHAYTOR, Q.C.:
Q. That's overall for your entire program?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And I was just looking at, though, your anatomical pathology which would be the area, am I right, that we're dealing with?

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MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And so your workload - patient care workload units are down in that time period, but your FTEs are also down, is this what this is saying?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And they're down by -
MR. GULLIVER:
A. 3 percent.
CHAYTOR, Q.C.:
Q. 3.18 percent.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. Whereas your workload units are down. Why would it be that - I just want to understand, based on what we've talked about here today in terms of - I was having the impression that your workload was continuing to increase over that time period. So why would your patient care workload units be shown to be down?

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

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Q. So at this point in time, even though these numbers are saying that your workload is down by a little over 2 percent -
MR. GULLIVER:
A. That's pathology.
CHAYTOR, Q.C.:
Q. Yeah, in the pathology lab. Would that be accurate?
MR. GULLIVER:
A. Workload units.
CHAYTOR, Q.C.:
Q. Yes, would that be accurate?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. This is -
MR. GULLIVER:
A. This is saying workload units.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. Workload units is a capture of the value attached to every test procedure you perform. It doesn't necessarily mean that the volume of work is decreased. So you may have 100 tests

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this year and each test is valued at 10 workload units to give you 1000 units. This year the workload unit drops to 8, but you do 120 tests, so showing your workload units are pretty well the same, but your volume of work has gone up.
CHAYTOR, Q.C.:
Q. Right.
MR. GULLIVER:
A. What you're not seeing here in this submission is the number of tests performed in each of those categories because the HAY group were only focused on the workload units.
CHAYTOR, Q.C.:
Q. So in terms of you putting this forward, though, as the analysis, what you're saying is that this is how they decided to do the analysis?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. But there's a piece of the puzzle missing here?
MR. GULLIVER:
A. Exactly.

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CHAYTOR, Q.C.:
Q. But in your response going back, you don't address that?
MR. GULLIVER:
A. No, because I had - I had to respond to how they're doing their assessment, and even in this assessment, they had underestimated our workload, I think - I can't remember offhand, Ms. Chaytor, but it was like significant, it was like two or three million workload units that they were not acknowledging us for doing.
CHAYTOR, Q.C.:
Q. Okay. i'm just going to take you then to page five of - this is still your response, the same document, and you write, "The anatomical pathology revised figures were the same as the original figure of 0.0219". I'm sorry, I should give that some context for you because you're now talking about productivity comparisons.
MR. GULLIVER:
A. For pathology.
CHAYTOR, Q.C.:
Q. Yes, and this is for pathology, "The anatomical pathology figures are compiled from

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our division of cytology and division of surgical and autopsy pathology. The report recommends the reduction of two FTEs in cytology and one in - one full time equivalent in pathology. Upon further review, I separated out statistics for cytology and pathology labs at the General and St. Clare's. The statistics show the following", and then you break down that, "and based upon the statistics, I plan to reduce by a minimum of 1.6 FTEs in cytology and one by one full time equivalent in pathology at St. Clare's". So your proposal after doing your analysis is that you -
MR. GULLIVER:
A. To meet those targets.
CHAYTOR, Q.C.:
Q. Yes, you can take away -
MR. GULLIVER:
A. That's what we would have to do to meet their targets, and the cytology reductions took place eventually through accommodation of attrition and we moved our cytology service to what we call liquid-based technology, and that's - this only happened in the last couple

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of years. It didn't happen anywhere near close to 2002.
CHAYTOR, Q.C.:
Q. So the actual reduction by one full time equivalent pathology at St. Clare's, did that happen, did you lose a person out of there?
MR. GULLIVER:
A. Well, yes and no. At St. Clare's, we had two staff who were funded at half time each, but both of those staff were working full time hours, and what we did, we combined them and made one permanent full time position. So technically on the books from budget size, we reduced our budget expenditure, our worked hours, but we didn't actually reduce a staff person.
THE COMMISSIONER:
Q. (Inaudible).
MR. GULLIVER:
A. It's - in our pathology lab at the time at St. Clare's, we had two employees.
THE COMMISSIONER:
Q. Uh-hm.
MR. GULLIVER:
A. They both owned a half time job.

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THE COMMISSIONER:
Q. Uh-hm.
MR. GULLIVER:
A. We were giving them additional hours, which we really didn't have money for in the budget, because we had closed the Grace and people were getting amalgamated and we were getting used to all this new stuff, and when this came out, what we did, we took two half time jobs and posted one permanent full time job. So there was one full time employee there, and we stopped giving the extra hours in our budget. So our FTEs funded didn't change, but we actually reduced our expenditures because we weren't overspending.
THE COMMISSIONER:
Q. Sorry, I --
MR. GULLIVER:
A. We stopped paying overtime, we stopped paying extra hours.
THE COMMISSIONER:
Q. But if you had one full time position, doesn't that still mean that you now go to one person where you had two?
MR. GULLIVER:

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A. Instead of two half time people that were funded, we had one full time person funded.
THE COMMISSIONER:
Q. Yes.
MR. GULLIVER:
A. But those two half times were putting in the work of two people.
THE COMMISSIONER:
Q. Yes.
MR. GULLIVER:
A. And the additional money - we had no money in our budget for it. So I was going over budget.
THE COMMISSIONER:
Q. Yes.
MR. GULLIVER:
A. So we kept a full time person, but we stopped paying extra hours, what we call workload increase, and we stopped paying overtime to reduce our budget expenditures.
THE COMMISSIONER:
Q. So you still had to get rid of one person, though, didn't you?
MR. GULLIVER:
A. Well, we --
THE COMMISSIONER:

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Q. Either by attrition or otherwise?
MR. GULLIVER:
A. Yeah, we didn't get - they went to another part of the program.
CHAYTOR, Q.C.:
Q. The work of that one person stopped being done?
MR. GULLIVER:
A. Pretty well, yes.
CHAYTOR, Q.C.:
Q. So you reduced by one full time equivalent?
MR. GULLIVER:
A. Yes, pretty well, yes.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. But it wasn't a person who left.
THE COMMISSIONER:
Q. A person got transferred to some place else?
MR. GULLIVER:
A. Right, yeah.
CHAYTOR, Q.C.:
Q. Okay. I'm on page six now of the document because you have a list of recommendations there, and number -- these come out of the -

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MR. GULLIVER:
A. Ms. Chaytor, this is with consultation with Dr. Cook and our leadership team about our response to this.
CHAYTOR, Q.C.:
Q. So this is the program management got together and came up with this?
MR. GULLIVER:
A. Yes, this is what we agree with -
CHAYTOR, Q.C.:
Q. This is just not your -
MR. GULLIVER:
A. This is what we don't agree with.
CHAYTOR, Q.C.:
Q. All right, so you say, "I disagree with having a single manager for pathology and cytology for the Health Care Corporation. This means that one manager would have the responsibility for almost 70 staff", and then you go on with, "The laboratory program has recently downsized from ten division managers to seven".
MR. GULLIVER:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. "This allows for only one manager for each

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

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recently downsized from ten to seven. What happened around that period of time?

MR. GULLIVER:

A. When I became the program director in October 2001--go back to the Health Corporation days when we had four facilities operating, there were two positions for hematology managers for the city of St. John's. There were two positions for chemistry; there were two positions for micro; two positions for pathology. Each manager had a set--there was a Health Sciences/Janeway group, a St. Clare's and Grace group and there was ten positions. And they had been cut from 21 down to ten at that time. When I took over, the Grace had physically closed, the Janeway had physically closed and I still had ten positions. I had a couple of mangers who were getting close to retirement and I thought as director of the program that we should have one division manager for each service. As we had one manager for cytology all along. But we had multiple managers in some divisions. And it was an opportunity to restructure our management functions and set up and that was

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the outcome from it, that we went down from ten to seven.

CHAYTOR, Q.C.:

Q. And in going down from ten to seven at that point in time, did you plan to replace the three management positions with managers to fulfil other functions?

MR. GULLIVER:

A. Good question. Yes, I did.

CHAYTOR, Q.C.:

Q. Okay, and what was your plan?

MR. GULLIVER:

A. Well, it was--I seen that if we were able to, you know, make our hematology manager corporate wide as opposed to having separate sites, I thought that structure with the division chief would lend to better decision making. And you're taking the responsibilities for decisions into a core team. And the other positions that we could have reassigned, a part of this too, Ms. Chaytor, was to backfill at my position because I moved up from pathology manager to program director, but I was pathology manager, I was genetics manager and I was immunology

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manager. So, I recommended that immunology and genetics and pathology be separated. That pathology now have one manager for the city, instead of two like before, myself and Mr. Murphy. And instead of immunology and genetics having to share a manger with pathology, that those divisions had grown so much by that time, that they warranted to have a separate division manager with their division chief.

The vacancies that would occur around this here, it was my view, at the time, that we could reassign or reuse that money and have a manager for utilization of lab services. I had hope for a manager for the LIS system which is the Lab Information Systems, to have a dedicated person in that position and I had hoped to have a dedicated manager for quality for laboratory services.

CHAYTOR, Q.C.:

Q. For quality.

MR. GULLIVER:

A. Um-hm.

CHAYTOR, Q.C.:

Q. Okay. And did you make that submission for

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utilization manager, for lab information services manager and quality manager for lab services, did you make that submission in writing to anybody?

MR. GULLIVER:

A. I don't know if I made the submission through the budgeting side. I know I certainly spoke to Dr. Williams about it and, you know, as my VP and advocate for laboratory, that he would speak to executive team. I do remember getting correspondence from our VP of HR at the time telling me that the plan to have one manager for all of our divisions looked fine to him. I remember having that correspondence. I don't know if I put a detailed proposal to executive team. I know I spoke to Dr. Williams about it. But what, I guess, the outcome was--the answer was no and it was $245,000.00 for the salaries and benefits for those positions and I just lost it from the budget.

CHAYTOR, Q.C.:

Q. Okay. And that happened, you went ahead and decreased from your ten to your seven with your plan being to create these three

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managerial positions, one of which would have included a manager for quality.

MR. GULLIVER:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And in terms of that plan and your plans in that regard, going forward, you talked to Dr. Williams about it, whether or not it was committed to writing or not, you're not sure.

MR. GULLIVER:

A. I can't remember.

CHAYTOR, Q.C.:

Q. But you went ahead and made the reductions in your managers and that money, in the next budget, just disappears.

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Was this the first time that you had planned or proposed to have a manager for quality for the lab?

MR. GULLIVER:

A. Yeah, this is just--I'm the director of several months at this point. This is very new.

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CHAYTOR, Q.C.:

Q. And do you know whether or not your predecessor or anybody else had ever put forward for a manger for quality?

MR. GULLIVER:

A. I don't remember Mr. Whelan putting something in. I can't say yes or no, Ms. Chaytor, to that. I don't remember it.

CHAYTOR, Q.C.:

Q. What niche, at that point in time, did you think needed to be filled by a manager of quality?

MR. GULLIVER:

A. Repeat the question.

CHAYTOR, Q.C.:

Q. What niche did you think needed to be filled by a manager of quality.

MR. GULLIVER:

A. Oh, what niche?

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. I didn't know what word you said.

CHAYTOR, Q.C.:

Q. I'm sorry.

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MR. GULLIVER:

A. I don't know -

CHAYTOR, Q.C.:

Q. Vacuum is your word.

MR. GULLIVER:

A. I know and I don't know if it was a niche that needed to be filled. I mean, when I was looking at this, 2001, as documented, you know, many years of downsizing and cutbacks, when I looked at, as the director of the program, I would have to say, I mean, I came into this position with an extensive amount of experience in pathology. I also came to the position, as I mentioned, with an extensive amount of experience through my volunteer work, you know, having served for four years on our national board of directors for our association and profession, having the opportunity to meet with counterparts in Ontario, Alberta, other provinces. I've certainly had the opportunity to see a lot of other labs in the country and I felt that our program could be better served--this is in 2002 now, early, that you know, the future, where we're going in this province, that

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having a dedicated manager for utilization of lab services will be a good thing. Having a manager dedicate for quality management to put a whole program in place for lab services would be a good thing.

CHAYTOR, Q.C.:

Q. So, that's something based on your liaison with others across the country and -

MR. GULLIVER:

A. And my -

MR. GULLIVER:

A. - attending conferences was a position that was available in other centres.

MR. GULLIVER:

A. Certainly so, yes.

CHAYTOR, Q.C.:

Q. And on that note, in your attendance at conferences and your involvement at the national level and your volunteer efforts and visiting other labs across the country, did you ever make any inquiries about external proficiency testing and whether or not that service was available?

MR. GULLIVER:

A. Well, I knew external proficiency testing was

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available in most parts of laboratory. We were participating in them actively in most parts of the program. What I would be interested in, Ms. Chaytor, and through--and it's not through my work environment, but through my volunteer environment, was certainly interested in looking at lab standards and looking at accreditation which we know that our province has been lacking in.

CHAYTOR, Q.C.:

Q. So, whether or not any of your conferences, the idea of external proficiency testing for the--and the technical component.

MR. GULLIVER:

A. That wouldn't even be on the radar; it wouldn't be on the radar.

CHAYTOR, Q.C.:

Q. And the technical component and whether or not that was available or being availed of by others across the country. That didn't come up in any of your discussion or anything that you took part in?

MR. GULLIVER:

A. No, and I didn't see it either. The quality manager position, you said that you discussed

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with Dr. Williams your plan that you would do this management restructuring and reduce down to seven with the idea that these three other positions would then be created or you'd have the funding, over two hundred thousand dollars to create -

MR. GULLIVER:

A. No, I wasn't asking for funding.

CHAYTOR, Q.C.:

Q. You weren't asking for that. You had it, you thought, yourself.

MR. GULLIVER:

A. I was saying we have the funding now in our program, the money is there, instead of spending it on this position and this position or this position, we've got it there to spend and it's got to be used this way.

CHAYTOR, Q.C.:

Q. Yes, but you had that discussion with Dr. Williams, is that right?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. You had that. Whether or not you put anything in writing to him, you had that discussions.

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MR. GULLIVER:

A. I don't know.

CHAYTOR, Q.C.:

Q. Did he agree with your proposal?

MR. GULLIVER:

A. I don't remember him disagreeing and I think Dr. Williams certainly, I mean, he was someone who was a greater supporter of laboratory medicine and I would have thought that Dr. Williams would have brought that forward to executive team.

CHAYTOR, Q.C.:

Q. And at the end of the day -

MR. GULLIVER:

A. Understand, we're talking about now early 2002 and the Health Care Corporation has got this humongous report in their hand from Hey that says cut, chop, cut, chop and then cut some more. And I'm assuming executive had looked -

CHAYTOR, Q.C.:

Q. But that happens before, doesn't it, according to this you're saying that I've already lost my seven--I'm down to seven managers.

MR. GULLIVER:

A. I know, but we know at this point in time, Hay

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has been in for months, we know what's going to come down the pipeline. And I'm assuming, I mean, if I'm executive team, they're going to look at some areas where what is the less traumatic to the organization? What is the less traumatic to the staff in the organization? If we know we have this millions of dollars to have to come out of the health care system through -

CHAYTOR, Q.C.:

Q. Did you know that? Did you know that's what was coming down? I thought you were shocked by the outcome?

MR. GULLIVER:

A. It was no shock to anybody really that what the Hay Group were coming in for.

CHAYTOR, Q.C.:

Q. So, Mr. Gulliver -

MR. GULLIVER:

A. I think the shock was when a report finally came in, the magnitude of what these people were saying, how we should cut beds and we should cut medicine beds, we should cut the laboratory, we should cut surgery, that's all they talked about.

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CHAYTOR, Q.C.:
Q. Okay. So, the loss to your budget of those three managerial positions, that had happened before the Hay Report comes out?
MR. GULLIVER:
A. It's around the same time.
CHAYTOR, Q.C.:
Q. And what you're saying here is that well, we've already lost three managerial positions, so for whatever reason, those positions are already gone before they Hay report comes out.
MR. GULLIVER:
A. But the Hay people are in months before we get the report. I'm sure people like George Tilley and executive had a fair good idea by the time the Hay people went away to write their reports which came in, you know, later one, what kinds of things were going to be in that report.
CHAYTOR, Q.C.:
Q. Okay. And this person, the manager, that you proposed to be the quality manager, would you envision--what did you envision in terms of what their role would be? For example, did you envision that they would be responsible

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for assuring that appropriate policies and procedures were in place for the laboratory medicine program?
MR. GULLIVER:
A. Certainly, not just pathology, but for laboratory medicine program.
CHAYTOR, Q.C.:
Q. Has that position, Mr. Gulliver, or a position equivalent, similar position ever been approved?
MR. GULLIVER:
A. We got one last July, July '07.
THE COMMISSIONER:
Q. Ms. Chaytor, it's getting close to 5, so where you can find a place to break, you can do that.
CHAYTOR, Q.C.:
Q. Perhaps we can take it up there another day.
THE COMMISSIONER:
Q. Okay, we'll meet at 9:30 on Monday. Thank you.
Upon conclusion.

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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 3rd day of October, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.
Dated at St. John's, Newfoundland and Labrador this 3rd day of October, A.D., 2008
Judy Moss

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