COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

September 4, 2008

Appearances:

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

Rolf Pritchard/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

LIST OF EXHIBITS

THIS PAGE ONLY REVISED NOVEMBER 18, 2008

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THE COMMISSIONER:
Q. Please be seated. Mr. Coffey.
COFFEY, Q.C.:
Q. Thank you, Commissioner. The next witness is Dr. David Haegert.
DR. DAVID GEORGE HAEGERT (SWORN) EXAMINATION BY BERNARD COFFEY, Q.C.
REGISTRAR:
Q. Would you please state and spell your complete name for the Commission?
DR. HAEGERT:
A. It's David George Haegert. David and George are fairly obvious. Haegert is H-A-E-G-E-R-T.
REGISTRAR:
Q. Thank you.
COFFEY, Q.C.:
Q. Thank you, Doctor. Commissioner, there are some new exhibits. They are exhibits P-2526 through P-2542 inclusive.
THE COMMISSIONER:
Q. Entered.
EXHIBITS ENTERED AND MARKED P-2526 THROUGH P-2542
COFFEY, Q.C.:
Q. Thank you, Commissioner. Registrar, when you're ready, please, Exhibit P-2542? Doctor,

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the document there on the screen in front of you is entitled curriculum vitae and it's for David George Haegert and is that your CV?

DR. HAEGERT:

A. Yes, it is.

COFFEY, Q.C.:

Q. Okay, sir, and Doctor, it goes on for some length. I'm not going to take you through it in detail, but I am going to ask you to outline for the Commissioner, please, your educational and professional background.

DR. HAEGERT:

A. Yes, I graduated from the University of British Columbia, Faculty of Medicine, 1968, then interned at the Royal Victoria Hospital, 1968 to '69. Then I trained in anatomic pathology at McGill teaching hospital from '69 to '72. Then I went to the University of Cambridge to do research for two years.

COFFEY, Q.C.:

Q. That would be in the UK?

DR. HAEGERT:

A. United Kingdom, yes, and then I returned to Montreal in 1975, in January, and I took up a position as a pathologist at Montreal General

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Hospital. Initially, I was an assistant professor and then I was promoted to associate professor eventually, and then I moved to Newfoundland in 1991, to St. John's, where I was appointed professor and chair of the Department of Pathology at the University and clinical chief of the Department of Pathology at the General Hospital.

COFFEY, Q.C.:

Q. Yes.

DR. HAEGERT:

A. And then after that, 1996 roughly, the Health Care Corporation was formed, so then I became the clinical chief of what was called the Laboratory Medicine program, and I was there until 2002, or here actually until 2002, except for one year sabbatical in Montreal, and then 2002, I returned to Montreal as a professor of pathology and then in 2005, I was appointed professor and chair of the Department of Pathology.

COFFEY, Q.C.:

Q. At McGill University?

DR. HAEGERT:

A. At McGill University, yes, and also chief of

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the hospital, which is McGill University Hospital Centre.

COFFEY, Q.C.:

Q. In Montreal?

DR. HAEGERT:

A. In Montreal, yes.

COFFEY, Q.C.:

Q. And Doctor, you say you've had, in effect, a career in medicine spanning, approaching 40 years? It's getting close.

DR. HAEGERT:

A. '68 to--yeah, 40 years.

COFFEY, Q.C.:

Q. 40 years. Doctor, I'm going to ask you then, because you were in St. John's in the changeover from the General Hospital, Grace General and St. Clare's into the Health Care Corporation.

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Okay, I'll be asking you about that, but before I get to that, your career as well would span, I gather, a fair amount of time involving the development of

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immunohistochemistry and the usage of it, kind of more and more widespread usage in pathology?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Could you tell us, please, kind of looking back on it now, what you recall about it and it's impact, at least on your practice over the years?

DR. HAEGERT:

A. Well, when I was in Montreal, I think the immunohistochemistry was starting really in the 1980s, sometime in the late '80s, I would say. Do you want me to discuss what, the methodologies or what?

COFFEY, Q.C.:

Q. Just in terms of in a general way, yes.

DR. HAEGERT:

A. Well, what became very clear early on, it was extremely helpful in dissecting between different types of tumours and also helpful in subclassification of tumours. I guess that's the same thing, but also over the years has become useful as a prognostic marker or

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predictive marker, things like estrogen receptors, progesterone receptors, HER2/neu, things like that.

COFFEY, Q.C.:

Q. Doctor, so you, in your practice, when do you recall first being introduced to it? Did it exist in the way immunohistochemistry, in a practical sense, for pathologists when you first started?

DR. HAEGERT:

A. No, it did not. I would say late, in the late 1970s, the first reports started to come out. I guess it was--I think it followed after the development of monoclonal antibodies. This is quite sometime ago, you know.

COFFEY, Q.C.:

Q. Yes.

DR. HAEGERT:

A. But that's my recollection.

COFFEY, Q.C.:

Q. And Doctor, what I want to try and take advantage of is in terms of your experience and what you recall about it in terms of how you were introduced to it as a pathologist and how you learned about it, you and your

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colleagues, based upon your observations? I mean, were there any courses available back then in immunohistochemistry?

DR. HAEGERT:

A. Well, I would think most pathologists never took courses in immunohistochemistry, but mostly we learned from reading the literature, becoming aware that there were certain antibodies available and that people were using them to make diagnoses or to help in diagnosis, and then we'd read the literature or actually more likely one of the individuals in the department who had experience or expertise would advise the others that indeed there is this particular antibody available and this was useful for these purposes, whatever the purposes were.

COFFEY, Q.C.:

Q. And would there be discussions or literature available about how to use a particular antibody, in the sense of whether it was membrane staining, nuclear staining?

DR. HAEGERT:

A. Well, all that would be part of the antibody repertoire. Like for example, I mean,

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estrogen receptor is a nuclear stain, but CD20 is a common antibody. It's a membrane stain. But a pathologist would know, I mean, it's almost inherent in being a pathologist that you would know this.

COFFEY, Q.C.:

Q. Doctor, when you came to St. John's, up to then, arrived I take it in 1991?

DR. HAEGERT:

A. 1991, yes.

COFFEY, Q.C.:

Q. You were connected with Memorial's medical school?

DR. HAEGERT:

A. Um-hm.

COFFEY, Q.C.:

Q. You've described that, and the General Hospital, I take it, or the Health Sciences Centre, we've used those two phrases -

DR. HAEGERT:

A. Yeah, more or less the same.

COFFEY, Q.C.:

Q. - interchangeably here. That was a stand-alone institution at the time?

DR. HAEGERT:

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A. Yes, it was.

COFFEY, Q.C.:

Q. Doctor, could you tell the Commissioner then, during your time as discipline chair, I think was the phrase?

DR. HAEGERT:

A. Yeah, discipline of pathology.

COFFEY, Q.C.:

Q. Discipline of pathology, discipline chair?

DR. HAEGERT:

A. Discipline chair, yes.

COFFEY, Q.C.:

Q. Could you tell us, please, what that involved? Because you held the position for just over a decade, you know, from '91 through 2002 with a year off sabbatical in there.

DR. HAEGERT:

A. Um-hm.

COFFEY, Q.C.:

Q. What sorts of responsibilities did that involve?

DR. HAEGERT:

A. Well, overall, the chairs of every department were responsible for the teaching program, recruitment of individuals into the

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department, research and the teaching would involve teaching of undergraduate students, namely medical students. In our department, it also involved teaching of pharmacy students, development of research, training of residents, so residents in pathology and training residents in other disciplines who rotated into pathology. But one of the major issues was recruitment. I mean, that actually was explained to me when I first came by the dean at the time, David Hawkins. He said it was the biggest, one of the biggest issues in the university.

COFFEY, Q.C.:

Q. And this was recruiting doctors, pathologists, to be staff, to be professors, assistant professors, lecturers in the medical school?

DR. HAEGERT:

A. Yeah. Well, basically starting rank was assistant professor, but yes.

COFFEY, Q.C.:

Q. And why was that, when you arrived and kind of looked around and began to understand the local dynamics, why was that? What was your-- did you make any conclusions, come to any

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conclusions about why recruiting was a problem?

DR. HAEGERT:

A. Well, it was actually more recruitment and retention.

COFFEY, Q.C.:

Q. Okay.

DR. HAEGERT:

A. In fact, that's what David Hawkins said and that was my experience. I think what we found is that often we recruit from outside. A lot of the people we recruited were--had trained in the United States, because the objective was to get people with subspecialty training, and a lot of them came here and, I mean, people leave--people come and they leave for various reasons, but I felt that a lot of the people left because they felt they would be better off elsewhere, for either personal or financial or other reasons. Often they didn't say why they left.

COFFEY, Q.C.:

Q. Doctor, these, the people being recruited out of the United States, what sorts of category did they fall into? We've heard references to

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J-1's.

DR. HAEGERT:

A. Yeah, most of the people had J-1 Visas, which means that they were--they had training visas, at least my understanding. I mean, I'm actually not really all that privy to it, but my understanding is that they have a--if you have a J-1 visa, it's a training visa and basically, you're allowed to stay in the United States as long as you're training. Once you're finished your training, you have to leave the United States.

COFFEY, Q.C.:

Q. And then these would be people then, I take it, in terms of recruitment that you would advertise positions available in St. John's, Newfoundland?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. That would come to their attention, and if they had to leave the United States, they might be prepared to come to St. John's to work, and that's how these people would be recruited? That's the -

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DR. HAEGERT:

A. Yeah, well, we would advertise.

COFFEY, Q.C.:

Q. Sure. Doctor, during your tenure, how successful were you, in terms of recruitment? I'll ask you about retention in a minute, but how about recruitment.

DR. HAEGERT:

A. Well, whenever we had a position, we managed to recruit, but we--I mean, obviously the second half of it is the retention. We weren't so successful at retaining people, but we managed to recruit.

COFFEY, Q.C.:

Q. I appreciate that individual doctors might move on for personal reasons, as you've indicated, but in terms of the professional circumstances throughout the 1990s in St. John's, I mean, were there any--what, if anything, connected with being a pathologist in St. John's was challenging? I'll give you an obvious example, money is perhaps one potential thing. Facilities is another. Workload is another. So perhaps you could tell the Commissioner what you recall about

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that.
DR. HAEGERT:
A. I think one of the difficulties here was the--certainly as the Health Care Corporation was created, the mind set was that pathology or laboratory medicine as a group or as a whole and pathology as part of that was basically a cost centre, in that one of the fundamental issues was that the Health Care Corporation did not have sufficient money to run the organization, so we were asked, on several occasions, to save money. So that was one of the issues.

Another issue was salaries. I think Newfoundland and Quebec were basically the lowest in the country, and so it was difficult to retain people who would come here. They would establish themselves as landed immigrants and then they'd realize they could go elsewhere and get more money. So that was actually a significant issue.

The workload, which you mentioned, actually was--I mean, it's entirely a matter of perspective, but one of the difficulties was there was very little protected time. A

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lot of people who came from the United States had academic aspirations. They wanted to do academic pathology and the difficulty was they were on service most of the time. So it was actually quite difficult.
COFFEY, Q.C.:
Q. To find the time to devote to the academic or research work?
DR. HAEGERT:
A. Yes. Oh yes, because I've read some of the transcripts. I mean, Dr. Mullen, for example, in Toronto said that he had 50 percent protected time. Well I would think basically nobody here had any approximation of that.
COFFEY, Q.C.:
Q. Doctor, when you first--well, for the first four or five years you were here, it was just the General Hospital as a stand-alone institution. As the discipline chair, Memorial University's medical school, discipline chair for pathology, how much interaction would you have with pathologists outside the General Hospital? In your capacity as discipline chair, what would that involve?

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DR. HAEGERT:
A. Well, all the--as I recall, all the pathologists had university appointments, outside. So Dr. Pushpanathan, for example, the people at the Grace and St. Clare's. I can't remember the nature of these appointments, but they all had appointments. We did, from time to time, have inter hospital rounds where there were--people would share cases that are difficult or complicated and, you know, present the case. People would have an opportunity to discuss them. But we didn't have--I mean, it's probably important to recognize that there was no authority.
COFFEY, Q.C.:
Q. That's what I'm getting at, in terms of you would--as the discipline chair at the time, would not have perceived that you had any authority over a pathologist at the Janeway or at St. Clare's or at the Grace?
DR. HAEGERT:
A. Well, no authority in terms of the hospital practice.
COFFEY, Q.C.:
Q. Hospital practice, and I take it that would be

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equally true in Corner Brook and Grand Falls and Gander? You would not have -
DR. HAEGERT:
A. Well, we never had authority there, ever.
COFFEY, Q.C.:
Q. The appointments of pathologists at that time, were any of the pathologists outside St. John's associated with the university? Did they have any positions, do you recall?
DR. HAEGERT:
A. I don't remember. I don't remember.
COFFEY, Q.C.:
Q. And certainly -
DR. HAEGERT:
A. Possibly.
COFFEY, Q.C.:
Q. - and if they did, it wasn't in significance in the greater -
DR. HAEGERT:
A. It was weak, at the best.
COFFEY, Q.C.:
Q. Okay. Just on that point, Doctor, in your day, did pathologists residents rotate outside St. John's, do you recall?
DR. HAEGERT:

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A. No.
COFFEY, Q.C.:
Q. But within the city, they would rotate within the various hospitals within St. John's?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, the advent of and the formation and implementation of the Health Care Corporation of St. John's, which I gather occurred in the mid--began in the mid 1990s and continued on for a period of time. You've already described some of what you recall about the effect that had on the clinical laboratory program. Would you elaborate a bit upon that? Are you able to?
DR. HAEGERT:
A. You mean as -
COFFEY, Q.C.:
Q. As the discipline chair, in '95/96, there's a Health Care Corporation, but all these three institutions, or four institutions at the time, are still in four different buildings, and what do you recall about the move toward centralization of the clinical laboratory?

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DR. HAEGERT:
A. Well, early on, I don't remember exactly when, 1996 probably, I was appointed clinical chief, we had multiple meetings with the directors of the labs at each of the hospitals. We had many meetings. There was also a focus group that the Health Care Corporation set up and so what we tried to come up with, we discussed the various possible models, whether it should be a functional model or a site based model. Functional meaning should we have pathology, biochemistry, hematology, or should we be doing it by sites. So this is one of the things we discussed. Also, at the same time or around the same time, a program director was appointed. That was Mr. Whelan who was previously the laboratory manager at the General Hospital. The names changed, but the functions were sort of similar. We were asked to save money, significant amount of money. In addition, what happened was the structure of the laboratory actually changed. My understanding, at the Grace and St. Clare's, the way the reporting relationships worked in the pathology departments were quite

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different. The reporting relationships were to the chief of pathology, the head of pathology, whatever the name was. So for example, Dr. Cook would have been chief at St. Clare's and everyone would report to him, including the technologists. But when the Health Care Corporation was created, the model was changed, so that the program model was that there was kind of a parallel reporting system so that the professional people would report to me and basically the laboratory staff, technologists, secretaries and so on, would report to the manager. So that changed for these two other sites, including the Janeway, I suppose, yes.
COFFEY, Q.C.:
Q. And now what--before the Health Care Corporation was formed, what had been the model used in the General Hospital?
DR. HAEGERT:
A. The model in the General Hospital was similar to what the Health Care Corporation used. Basically, we had sort of a parallel reporting system where the chief, that was myself, and the--I keep getting the names mixed up, the

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laboratory manager, we worked together, but the reporting relationships were parallel basically.
COFFEY, Q.C.:
Q. And that had been the situation at the General when you first arrived in '91?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. So that's what you came into in St. John's yourself?
DR. HAEGERT:
A. Yes. It didn't actually significantly change for me, but it changed dramatically for the other hospitals outside of the General Hospital.
COFFEY, Q.C.:
Q. And so the--for example, at St. Clare's, your understanding was that before the Health Care Corporation was formed that at St. Clare's, for Donald Cook, he had been running, in effect, responsible for the laboratory at large?
DR. HAEGERT:
A. Yes. Well, it was Dr. Williams and then Dr.

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Cook.
COFFEY, Q.C.:
Q. Okay.
DR. HAEGERT:
A. Somewhere in there took over.
COFFEY, Q.C.:
Q. Whoever had the position, in terms of -
DR. HAEGERT:
A. Yes, that's what I--I think that's correct.
COFFEY, Q.C.:
Q. Okay, and your understanding is that that was also true at the Grace?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Before Health Care Corporation and the Janeway. Doctor, so for you in a personal sense there was the Health Care Corporation, other than there being more people involved, the model didn't change, for you it was the same model before and after?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. In the General and Health Care Corporation.

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Doctor, you were wearing two hats, both discipline chair and clinical chief. Doctor, before the Health Care Corporation was formed you would have been as clinical chief, I take it, for the old General?
DR. HAEGERT:
A. Well, much of that is the name -
COFFEY, Q.C.:
Q. Or the -
DR. HAEGERT:
A. That was the function, whatever you call it, yeah.
COFFEY, Q.C.:
Q. You had reporting to you only the professional--the pathologists within the General Hospital site up to that site?
DR. HAEGERT:
A. Yes, plus the divisional chiefs.
COFFEY, Q.C.:
Q. Divisional. And the divisional chiefs were whom?
DR. HAEGERT:
A. Well, head of biochemistry, head of hematology, microbiology.
COFFEY, Q.C.:

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Q. Then after the formation of the Health Care Corporation you had pathologists reporting to you located where, physically located where, at the other -
DR. HAEGERT:
A. Well, there was the General Hospital, St. Clare's, the Janeway and the Grace Hospital.
COFFEY, Q.C.:
Q. Your office was located where?
DR. HAEGERT:
A. At the General Hospital site, Health Science Centre, really.
COFFEY, Q.C.:
Q. And how often, for example, after the formation of the Health Care Corporation, how frequently would you get to go to, for example, St. Clare's or the Grace or the Janeway?
DR. HAEGERT:
A. Well, I went from time to time, but the frequency I can't say.
COFFEY, Q.C.:
Q. Okay.
DR. HAEGERT:
A. But certainly, I mean, it must have been

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relatively frequently because we had on site meetings of the site chiefs and so those were every two months, so we would rotate. So, I don't know, divide that up by the number of months in a year, and I'm not sure.
COFFEY, Q.C.:
Q. And you -
DR. HAEGERT:
A. Four times a year at each site, for sure, and if there were other issues, I would go more often.
COFFEY, Q.C.:
Q. So that--and we were looking at some documents to reflect the site chiefs meetings, okay.
DR. HAEGERT:
A. Okay.
COFFEY, Q.C.:
Q. Again, if I can assist the Commissioner in getting some sense of what locations you would have to kind of routinely go to in your work month, for example, or work months in terms of how often you would be taken, have occasion to go to the St. Clare's site or the Grace site. Doctor, you've just now referred to site chief meetings?

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DR. HAEGERT:
A. Um-hm.
COFFEY, Q.C.:
Q. I gather there were laboratory managers meetings, as well?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Okay. I'm going to ask you first of all to deal with the site chiefs meetings. Before the formation of the Health Care Corporation I take it there would have been no site chief meetings because there were no site chiefs?
DR. HAEGERT:
A. No, indeed that's correct.
COFFEY, Q.C.:
Q. Okay. After the formation of the Health Care Corporation the site chief meetings started?
DR. HAEGERT:
A. Um-hm, yes.
COFFEY, Q.C.:
Q. And their purpose was what, who chaired them, who attended, their purpose was what?
DR. HAEGERT:
A. Well, so remember I mentioned that we decided

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to have a functional program, so part of that--you have to remember it was pathology plus other disciplines, like biochemistry, for example, so the way we decided to handle anatomic pathology or pathology was that we would have at each site a site chief who would then report to me. So the way we dealt with this is that we basically had a rotation so that, for example, if there was a meeting at the General Hospital, the site chief at the General Hospital, who was Dr. Khalifa for at least a period of time, would chair at that meeting; if we went to St. Clare's, it would have been Dr. Cook who was the site chief; and then we rotated, say, to the Grace, which would be Dr. Sushil Parai.
COFFEY, Q.C.:
Q. And the laboratory management meetings, go back to the General Hospital stand-alone days first of all, the first four or five years you were here, would the site routinely have laboratory management meetings, Mr. Whelan, yourself and anybody else?
DR. HAEGERT:
A. Yes, there were.

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COFFEY, Q.C.:
Q. Okay.
DR. HAEGERT:
A. We used to have them, I'm thinking once a month, but, I mean, roughly it would be once a month.
COFFEY, Q.C.:
Q. And who would attend those meetings?
DR. HAEGERT:
A. So it would be all the managers of the various divisions, so pathology, biochemistry, hematology, microbiology. I think that was probably most of the--in the early days those would be the different divisions.
COFFEY, Q.C.:
Q. And then after -
DR. HAEGERT:
A. And I would attend and Mr. Whelan, of course.
COFFEY, Q.C.:
Q. Then after the formation of the Health Care Corporation, laboratory management meetings, were there laboratory management meetings? I take it there were?
DR. HAEGERT:
A. Yes, there were.

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COFFEY, Q.C.:
Q. And who would attend then?
DR. HAEGERT:
A. I would attend as the clinical chief, Vern Whelan would attend as the program manager and then the various managers responsible for the various divisions.
COFFEY, Q.C.:
Q. Do you recall any other kind of set meetings, as it were, routine meetings?
DR. HAEGERT:
A. Well, we had discipline meetings from time to time.
COFFEY, Q.C.:
Q. Okay.
DR. HAEGERT:
A. And then what we decided is that often the major issues were hospital based, so we had combined sort of discipline, we actually called them discipline of laboratory medicine/laboratory program meetings or something to that effect. So we met on a regular basis, but how--I mean, I would say ever few months and if there were issues, then we'd meet more often.

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COFFEY, Q.C.:
Q. And the purpose of those meetings was what?
DR. HAEGERT:
A. Often they--sometimes we were bringing issues that had arisen to the people to get feedback to the, say the pathologists to get feedback or to advise them of what was happening, because sometimes the pathologists were unaware of what was going on, so we'd tell them this is what's happening, these are the issues that are coming up. Like, for example, we were being asked to save a million dollars from the Health Care Corporation, so that would have been discussed at one of the discipline meetings.
COFFEY, Q.C.:
Q. And would these be site specific? Like -
DR. HAEGERT:
A. No, the discipline meetings were--once the Health Care Corporation was created, this was beyond the sites, this was the whole, all of the sites.
COFFEY, Q.C.:
Q. So these discipline meetings in the late '90s, after the formation of the Health Care

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Corporation, they would involve a meeting at a particular location but would involve pathologists from all the different facilities?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Would be invited to come?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Who would chair those meetings?
DR. HAEGERT:
A. I did.
COFFEY, Q.C.:
Q. Doctor, with respect to the matter of meetings to involve cases, to discuss cases, how was that handled in the early days here and as the '90s went on, what sorts of meetings--for example at the General Hospital as a stand-alone institution how frequently would pathologists meet to discuss cases and in what context?
DR. HAEGERT:
A. Well, we would meet in a formal way once a

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week to go over--what would happen is pathology would bring to the meetings cases that either were difficult or complicated or unusual or had some unusual features, bring them, and pathologists would meet as a group. That was early on. What was the rest of the question?
COFFEY, Q.C.:
Q. And then as time went on then and the Health Care Corporation was formed, '95, '96, did the attendance at those meetings change, where they were held change? I mean how did they--did they go on, first of all, did they continue, and if so, where?
DR. HAEGERT:
A. They were basically site based.
COFFEY, Q.C.:
Q. And that means what in this context?
DR. HAEGERT:
A. Well, so the General Hospital pathologists would review cases. But the other thing I was going to say is that we would also review cases on a regular basis one to one when there was a problem case. Because often these particular meetings were really to kind of

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say, oh, look, I've had this interesting case and maybe I'll get a consensus as to what people think. But we had a sort of an internal consultation process went on on a regular basis where people who had sort of expertise in certain areas, one would show them that individual case and say, okay, now, could you look at this and what do you think and, you know, what should I do with this case and do you have an opinion, what further studies do I need to do, do I need to do further studies, do we need an external opinion, that kind of thing. That was a regular thing, basically every day. Pathologists were always doing that.
COFFEY, Q.C.:
Q. Doctor, then as the--after the formation of the Health Care Corporation these meetings, pathologists' weekly meetings, were they at times, would the term "rounds" be used to describe them?
DR. HAEGERT:
A. Yeah, they would be like teaching rounds.
COFFEY, Q.C.:
Q. Teaching rounds. Doctor, you indicated that

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those meetings when they went on, after the formation of the Health Care Corporation, would be site specific?

DR. HAEGERT:

A. Um-hm.

COFFEY, Q.C.:

Q. St. Clare's would have theirs, the General, the Grace?

DR. HAEGERT:

A. Um-hm.

COFFEY, Q.C.:

Q. Would you attend those and, if so, which ones, and would you attend the General Hospital's or the St. Clare's -

DR. HAEGERT:

A. Just the ones at the General Hospital. I attended most of them when I could.

COFFEY, Q.C.:

Q. At the General itself?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Who was responsible, from your perspective, at the time for organizing them and ensuring that they went ahead on these various sites?

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DR. HAEGERT:

A. Well, normally that was the site chief's activity. Early on--one of the things I didn't say is that Dr. Fernandez early on was the division chief of pathology at the General Hospital, so she would organize them initially and then when we moved to the Health Care Corporation, the site chiefs would organize them. So that was Dr. Khalifa early on and then Dr. Parai later.

COFFEY, Q.C.:

Q. Doctor, I haven't asked you who you reported to. I've asked you about people reporting to you and your responsibilities. Who did you report to when you first came to St. John's and then as time went on?

DR. HAEGERT:

A. Okay, well, as the chair I reported to the dean.

COFFEY, Q.C.:

Q. As the discipline chair?

DR. HAEGERT:

A. Yes, the discipline chair.

COFFEY, Q.C.:

Q. Dean of medicine.

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DR. HAEGERT:

A. As the chief of the department of pathology, laboratory medicine I reported to the medical director at the General Hospital, that was Dr. Eric Parsons. And then when Health Care Corporation was created, Dr. Parsons became what was called the vice president of medical affairs, I think it was, so we initially reported to him. And then he left I believe to Saudi Arabia or somewhere in the Middle East, and then Dr. Bob Williams took that position over and I reported to him.

COFFEY, Q.C.:

Q. Doctor, and that, I take it, continued up until the time you left St. John's?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Doctor, with respect to what else you, I take it you are a researcher, I can see from your CV that you -

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. - certainly and other witnesses have referred

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to you as doing a certain amount of work in that regard. We've heard references to the MAC, the medical advisory committee.

DR. HAEGERT:

A. The medical advisor committee, yes.

COFFEY, Q.C.:

Q. I'm going to ask you about that. Again, throughout your history in St. John's, from '91 through 2002 were you involved with the MAC and, if so, in what capacity and what interaction would you have as the discipline chair or as the clinical chief with the MAC?

DR. HAEGERT:

A. Well, initially at the General Hospital there was, of course, a medical advisory committee. We met once a month. It was chaired by Dr. Parsons, I'm pretty sure. I think he chaired that. And so all the chiefs would attend these meetings and we would discuss issues related to the General Hospital, either financial or personnel issues, which was often a recurrent theme, insufficient physicians to run, for example, the emergency. This seemed to be a recurrent theme, always, intensive care, that sort of thing.

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COFFEY, Q.C.:
Q. And then after the formation of the Health Care Corporation?
DR. HAEGERT:
A. Yes, so there was a medical advisory committee who used to meet once a month. It was at 5:00 in the afternoon and we used to go to about 7:30, 8:00 at night. It didn't provide food or water or coffee or anything. It was chaired by, originally it was chaired by Ron Whelan, who was a radiologist at St. Clare's, I think, and then subsequently by Dr. Whitman. And the people that attended it were all the senior management of the Health Care Corporation, so that would be Sister Elizabeth Davis, Mr. Tilley, well, later Bob Williams and other so called--well, the vice presidents, the people in charge of human resources and finances, whose names I don't remember. And then all the chiefs would attend.
COFFEY, Q.C.:
Q. Clinical. And the role of the MAC at the Health Care Corporation was what?
DR. HAEGERT:

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A. Was to provide advice to--I mean, I think it was kind of bi-directional, I mean, early on in the initial phases Sister Elizabeth outlined her model of the laboratory medicine program and most of the clinical chiefs spoke out vociferously against it. And subsequently then we talked about issues really in the Health Care Corporation, like finances, personnel, that sort of thing. People would bring issues forth from their programs.
COFFEY, Q.C.:
Q. And was there an expectation, looking back on it, you know, you participated in the MAC in the Health Care Corporation days, was there an expectation of a clinical chief that he or she, if there was a problem or potential problem, that he or she bring forward the problem to the MAC to at least advise them that a potential existed or did exist?
DR. HAEGERT:
A. I would say it depends on the dimensions of the problem. If it was some internal issue that was relatively minor, we wouldn't bring it to the medical advisory committee. But if it was some more significant issue, then

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certainly we've bring it forward.
COFFEY, Q.C.:
Q. If it had implications for treatment of patients in another program who were also being treated by another program, would they be expected to bring it forward? And example would be if something in your department, pathology, you thought, well, okay, we deal with oncologists, a lot of our work probably goes to oncology?
DR. HAEGERT:
A. Um-hm.
COFFEY, Q.C.:
Q. If you became aware of something, would you be expected because it would affect oncologists' work, potentially, if it did, would you be expected to bring it forward at the MAC?
DR. HAEGERT:
A. That sounds like a normal expectation.
COFFEY, Q.C.:
Q. Now, Doctor, within the hospital structures, okay, at the time, laboratory medicine, I take it, provided services that had ramifications for treatment throughout the hospital in quite a number of disciplines?

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DR. HAEGERT:
A. Um-hm. Yes, indeed.
COFFEY, Q.C.:
Q. Yourself, diagnostic imaging would be another one, I take it? It's the sort of thing that because of the nature of the work, it could be, the work could probably could go to a surgeon or surgeons, it could go to oncologists, it could go to any one of a number of places? You're -
DR. HAEGERT:
A. I mean, I certainly would think it would impact on other disciplines, for sure.
COFFEY, Q.C.:
Q. Doctor, you've referred to attempts or requests that you save money? You, the -
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. - department save money. Were attempts made in that regard?
DR. HAEGERT:
A. Indeed.
COFFEY, Q.C.:
Q. And okay, as a practical matter, and I've

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written down here you said that you were asked to save money. I'm going to ask you, in practice what did that mean?

DR. HAEGERT:

A. Well, okay, so as I--you know we have a program management model or program model. So the program director and myself met with Mr. Tilley and he said, you know, paraphrasing what was said, something to the effect that the corporate team wanted the laboratory program to find a million dollars in savings through the restructuring process.

COFFEY, Q.C.:

Q. And this would be, at approximately what time frame would that have occurred?

DR. HAEGERT:

A. Well, I wondered about this. I mean, I don't have the minutes, but I mean, I would think it would be late 1996, early 1997, something like that.

COFFEY, Q.C.:

Q. Go ahead, Doctor, then? We want you to save a million dollars, go ahead, what happened?

DR. HAEGERT:

A. Okay. So what we--so Mr. Whelan and I

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discussed this, or Vern Whelan and I discussed this and so what we did is we met--so part of the--if I remember correctly, what we discussed in detail how one could save a million dollars, because most of the money in the budget was personnel. There's a certain cost for what we call consumables like reagents, but these are relatively fixed, so even if you do what's called consolidation of work stations, meaning take work and put it from, say, work from two people to one person, you still use the same amount of reagents or almost the same amount of reagents. So that we felt that most of the savings would come through actually reduction of personnel, so that was one thing. The other way to save money would be to do things like use common technical platforms. This would mostly apply to things like biochemistry and hematology where a lot of the equipment was automated. So one of the feelings was if, for example, in biochemistry we used all of the same types of equipment, that you would be able to, first of all, have uniformity across sites but also save money by ordering large amounts of

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reagents. But the overall theme was really that the only way to save that kind of money would be to reduce personnel. So we had these discussions and then we met with the divisional chiefs to address the issues as how are we going to do this. And one of the things that became clear is that if we looked at, for example, St. Clare's, the Grace, the Janeway, the General Hospital, what--at each site there was a director of laboratories and usually there was at least a manager responsible for one or two of the divisions. For example, there might be somebody in charge of biochemistry, say, at the Grace. Now, I'm not 100 percent sure. That person wouldn't be responsible for two divisions. But we recognized that at multiple sites there were multiple managers. So we thought one of the things one could do and would be as a natural result of having the program is that you would have one program director that would be Mr. Whelan, and that--but initially, of course, there was one at the Janeway, one at St. Clare's, one at the Grace and General, so that basically that meant laying off three senior

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managers and that also meant laying off a large number of other managers. So the decisions that were made initially were that, for example, for pathology you would have two managers, each manager would be responsible for two sites. So, for example, Terry Gulliver, who was a manager, who became one of the managers in anatomic pathology was responsible for the General Hospital and the Janeway. And then there was another manager, Mr. Murphy, who was responsible for the Grace and St. Clare's. And that was the initial model. So that lead to, I mean, a significant number of lay offs, so that was one way of reducing the budget.

The second way of reducing the budget was some people were close to retirement. Now I don't remember if we gave packages because actually the budget was mostly handled by the program director. I mean, I didn't really have significant input into the budget except we were asked to save money. So some people who were close to retirement or retirement, the decision was not to replace those individuals. So that was one way of reducing

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things. I mentioned the consolidation of, like, the common platforms, but the balance, of course, is what we were trying to do is try to save money, but to do the least harm to the program. So what we ended up doing after multiple meetings with the divisional chiefs and the managers of various programs, we came up with $700,000.00 rather than a million dollars, and we thought that was--actually we discussed this, actually, was this a reasonable amount of money to go back to the senior management, Mr. Tilley, and we felt actually that we would do this because we thought that would probably be the least damaging. Also we felt that probably what would happen is they would come back and ask us for more money, anyway, later because this --as I mentioned, or I think I mentioned it, the mindset really was this was a cost centre, and I think often it's a common thought that laboratory medicine is somewhat removed from patient care. I mean, pathologists don't think that, but--obviously, the Commission of Inquiry clearly is based on the fact that it's involved with patient care, but I think the

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mindset was more like this is more like housekeeping or, you know, laundry services or something, this is an area we can save money. So we kind of felt that they would probably come back, anyway.

COFFEY, Q.C.:

Q. And look for --

DR. HAEGERT:

A. And ask for more. So we went--so we told--I think I wrote Mr. Tilley and told him that we could only find $700,000.00, and our internal feeling was this would be the least damaging to our program.

COFFEY, Q.C.:

Q. And the phrase "cost centre" you used in this context means what, that it costs a lot of money and it's not very visible?

DR. HAEGERT:

A. Well, cost centre is just a term that people use to describe--you know, in the program there were multiple cost centres like peri-operative, medicine, surgery, cancer care.

COFFEY, Q.C.:

Q. So the use of the phrase "cost centre" is not so much pejorative as this was a cost centre whose costs could be reduced?

DR. HAEGERT:

A. That's right.

COFFEY, Q.C.:

Q. That was the--the laboratory was seen that way, at least in your perception?

DR. HAEGERT:

A. Yes.

THE COMMISSIONER:

Q. Excuse me, Mr. Coffey, but my past life just keeps popping up occasionally. Was it your view at this time that your particular department was being asked to save more than others, or was this one of those general occasions when the directive might be each of the cost centres you've got to cut "x" out of your budget?

DR. HAEGERT:

A. I don't think we were advised as to what they were doing in the other cost centres, but we did know that, for example--I don't know what the group is called, food services and laundry, that I think for laundry, there was - I mean, I'm not sure I remember this correctly, but I think the feeling was that

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this could be sourced out to some other place. So we did know that this was going on with some of the other areas, but whether this was uniform, I didn't know.

COFFEY, Q.C.:

Q. And you refer to it as the least damage, the way you described it, suggesting that perhaps there might be some damage, that's an acknowledgement that there might be. What sorts of damage might be envisaged or was envisaged could occur in the laying off of these--the elimination of management positions?

DR. HAEGERT:

A. Well, I think one of the --

COFFEY, Q.C.:

Q. In other words, what these managers were doing that wouldn't get done after the elimination of their positions?

DR. HAEGERT:

A. I think one of the feelings was that people usually rise in management because they're capable. Typically in St. John's, they've risen through the ranks and become managers because they are deemed to be high quality

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individuals. So what you're basically doing is moving a large number of the high quality people in the overall program and that the oversight of various areas becomes more problematic. It's much more difficult if you're a manager--to start again, it's relatively easy or easier if you're a manager on "a" site, but if you're a manager responsible for more than one site, it becomes more of a--it's more difficult to manage; how do you manage when you're not actually there.

COFFEY, Q.C.:

Q. And oversight in this regard in the clinical laboratory program in the late 1990s, what sorts of oversight are we talking about in a practical way?

DR. HAEGERT:

A. Well, I didn't mention this, but when we talk about managers, of course, these managers reported to Mr. Whelan. The management model was a dual management, so that really most of their interaction would be up through him and not to me, but the way I would look at it as a chief is that what these people would be responsible for the budget within their own

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divisions, so that, for example, if there's two managers in pathology, they would be responsible jointly for the budget in pathology and report to Mr. Whelan. They would also be responsible for workload, the work flow, what technicians do what, the scheduling of the technologists, that kind of thing.

COFFEY, Q.C.:

Q. What about quality assurance matters, quality control, quality assurance, education, continuing education because we've heard that the clinical laboratory has evolved over time, there were many more--new machinery, new technologies coming in stream throughout that whole time frame. So for education, quality control, quality assurance, those sorts of endeavours, would the managers in these sorts of positions be involved in that sort of activity, and the elimination of those positions would have what effect?

DR. HAEGERT:

A. Yes, they would be involved, but also the technologists--if, for example, you get new equipment, because as I recall, one of the

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things that happened in biochemistry is that they basically went from different types of biochemistry equipment at different sites to - much of the automated equipment was Becton. The technologists would have been trained on this equipment, so to actually know that they knew how to do this, there would be formal training. Similarly in pathology if there was new equipment, there would be formal training provided by the company of the people who would be using the equipment. The managers would be involved in this to a greater or lesser extent, but the people who are actually working with the equipment, they would be the ones who would get the formal training to make sure that they actually knew how to do it and how to troubleshoot and solve problems.

COFFEY, Q.C.:

Q. Quality assurance, quality control initiatives, would managers be involved--if there were such things, would managers in pathology be involved in those?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

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Q. And I take it if they didn't exist, the managers would be--if there were sufficient managers and sufficient time, would be expected to implement them as required, quality assurance programs?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Quality control programs.

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Doctor, the idea or the notion that by taking this particular approach that you've indicated, there was consensus, I take it, amongst the clinical laboratory management that we take a particular approach, potentially save $700,000.00, and do the least damage--by doing--taking that approach to do the least damage?

DR. HAEGERT:

A. Yes, approach with least damage, yes.

COFFEY, Q.C.:

Q. The idea that we are doing the least damage by doing this, was that ever conveyed to anybody

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higher up in the organization than yourself? For example, was it conveyed to Sister Davis or Mr. Tilley, yes, I'm saying - this plan will save $700,000.00, but it will come with a cost in terms of there will be--the idea that it would come with a potential cost in terms of clinical care perhaps ultimately, was that ever conveyed to the management of the Health Care Corporation, senior management?

DR. HAEGERT:

A. That's a good question. I certainly would have--I mean, it would seem reasonable that I would have said that to Mr. Tilley.

COFFEY, Q.C.:

Q. When you did tell him about the $700,000.00, what was the reaction?

DR. HAEGERT:

A. I think he was somewhat disappointed in that he said that he would bring this back to the other of the senior management and they would discuss it.

COFFEY, Q.C.:

Q. Did you hear anything further on it?

DR. HAEGERT:

A. I think he wrote me back.

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COFFEY, Q.C.:

Q. Okay.

DR. HAEGERT:

A. And said they would accept this.

COFFEY, Q.C.:

Q. What do you recall happened, was the $700,000.00 actually saved?

DR. HAEGERT:

A. Well, they just remove it from the budget.

COFFEY, Q.C.:

Q. Okay, and this would be--$700,000.00 would be an annual amount?

DR. HAEGERT:

A. No, this was a one time --

COFFEY, Q.C.:

Q. A one time.

DR. HAEGERT:

A. Yes, one time.

COFFEY, Q.C.:

Q. It was removed from the budget for that particular year -

DR. HAEGERT:

A. But that would be--of course, it would persist subsequently. Yes, they wouldn't put it back a subsequent year. That would be indeed a

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reduction. Yes, I follow your question now.

COFFEY, Q.C.:

Q. Doctor, that's the first year of this?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. What then happened in this regard?

DR. HAEGERT:

A. In terms of finances?

COFFEY, Q.C.:

Q. Yes, finances.

DR. HAEGERT:

A. Well, it's surprising really because I remembered this extremely vividly maybe because we spent so much effort trying to find the money. I know subsequently we were asked to save money, and what I think happened when in 1999 the Grace closed and we were asked to find subsequent--a further amount of money, but how much, I don't know.

COFFEY, Q.C.:

Q. And did you--was the attempt made, do you recall?

DR. HAEGERT:

A. Well, we would have tried.

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COFFEY, Q.C.:

Q. And what was the outcome of that, do you recall?

DR. HAEGERT:

A. I think we would have saved something, but how much, I don't know. I mean, I think probably again it would have been--I mean, I really don't recall.

COFFEY, Q.C.:

Q. Any savings that were achieved at that time in terms of saving money, again what sorts of things would have, if there were any, were cut to save money?

DR. HAEGERT:

A. Well, again it would be--as I said before, most of the money in the budget was people, so I would have said whatever money was saved was probably reduction of a small number of people, but I don't know how much was asked, I can't remember.

COFFEY, Q.C.:

Q. So throughout your time as the clinical chief at the Health Care Corporation, your memory generally is that if we--any time we were asked to save money, we ended up focusing on

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personnel costs and trying to reduce that?
DR. HAEGERT:
A. Yes, and were there ways to make things equally as efficient and perhaps reducing cost that way.
COFFEY, Q.C.:
Q. Doctor, if we could, please, Registrar, bring up Exhibit P-0479. Doctor, this is a multi-page exhibit. I'm just going to--the second page of it is entitled "Laboratory Medicine Program Clinical Chief/Discipline Chair", and the various personnel who held these positions over the years and their tenure periods are listed there. You're the first as clinical chief.
DR. HAEGERT:
A. Uh-hm.
COFFEY, Q.C.:
Q. April 15th, 1991 through March 11th, 2002, and then you officially left the organization in October, 2002, according to this?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, in the intervening time between March

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11th, 2002, and October, 2002, what were you doing at that time? You were clinical chief up to March 11th '02. For the next six/seven months--it says Dr. Cook had taken over as clinical chief on March 12th. Were you continuing--did you continue on in St. John's?
DR. HAEGERT:
A. Yes, I did. I think I left, actually, September 1, because I had a month holiday, something like that.
COFFEY, Q.C.:
Q. So you --
DR. HAEGERT:
A. So I would have continued as a pathologist and the chair.
COFFEY, Q.C.:
Q. And if we look down below on this page, discipline chair, you're there from April 15th, 1991, through August 31, 2002?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. So you stayed on in your role as discipline chair?
DR. HAEGERT:

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A. Yes.
COFFEY, Q.C.:
Q. And relinquished your position as clinical chief in the last six months or so you were here. Doctor, on the next page, page three, the document says, "Terms and Conditions, Dr. David G. Haegert", and this is February 25, 1991. See that at the bottom of the page?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. In fact, it's the terms and conditions again of your appointment as a professor and chair of the discipline of pathology, at least your initial appointment. Doctor, do you ever recall there being a functional description, written description, of what the clinical chief did or was expected to do?
DR. HAEGERT:
A. It's difficult to answer that. I think there probably was because the Health Care Corporation was very good at creating typed descriptions of things, so I would imagine that there was.
COFFEY, Q.C.:

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Q. Doctor, before we get to the period where Dr. Khalifa came to St. John's, I'm going to ask you about that, if we could bring up, please, Exhibit P-2527. This particular document is dated March 11th, 1994. It's a memo to all pathologists from yourself, policy on external consultation, and signed by yourself as Chair of the Department of Laboratory Medicine, and I take it here, in effect, as Chairman of the Department of Laboratory Medicine, would this be your university position or your clinical chief's position?
DR. HAEGERT:
A. Actually, it should have probably been written as clinical chief. That would have been a hospital--obviously, it's a hospital activity.
COFFEY, Q.C.:
Q. Doctor, the subject matter here is described as policy on external consultation, and you write in the second sentence, "Some time ago it was agreed that no case would be referred outside this institution to the CTRC, etc, without consulting the divisional chief or myself, in her absence", and Dr. Fernandez would have been the divisional chief?

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DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. And you conclude by repeating, "It is the policy of the Department of Laboratory Medicine not to refer cases outside until consultation has been obtained at the divisional chief or chair level". Doctor, what was this about, this whole idea, why the necessity to send out this sort of a memo?
DR. HAEGERT:
A. Partly, I think, it was related to money, but more importantly, I think, it was related to the fact that there was considerable expertise within the department. The CTRC, I mean, it stands for Canadian Tumour Reference Centre, and what this is is a panel of pathologists who have expertise in something, for example, I don't know, say, ENT pathology. The idea here really is that if I'm a relatively junior pathologist and I see a case and it's difficult, there are several options. One, you could show it to people inside the department or you could send it outside for another opinion, but it's logical to first of all

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refer it inside the department to see, in fact, if somebody who has seen 10, 15, 20, 50 cases of this--because it depends entirely on the expertise within the department. I mean, Dr. Fernandez was particularly expert in really most areas in pathology, and her opinion I would have said was extremely valuable in almost every area. It made no sense to me that some straightforward case, you send it out to the CTRC for another opinion when there's really no need for it. So that was the main principle behind this.
COFFEY, Q.C.:
Q. And so in what sorts of situations then--if you were, yourself or Dr. Fernandez was consulted, what sorts of factors determined whether it would--an outside opinion was sought?
DR. HAEGERT:
A. These would be cases outside the norm, unusual cases. Like, I think it was our normal policy, for example, with cartilaginous tumours of bone, most pathologists in St. John's rarely saw these, might see one a year, and it's often very, very hard to tell if

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they're benign or malignant. So what we would uniformly do is send them out for another opinion, mostly because people don't have the experience, but routine internal cases, we wouldn't send them out.
COFFEY, Q.C.:
Q. Doctor, I understand that Dr. Khalifa came to St. John's in the mid 1990s.
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Just before his--before he arrived in St. John's, immunohistochemistry was being conducted where?
DR. HAEGERT:
A. At the General Hospital site.
COFFEY, Q.C.:
Q. And that had--in your time from the time you arrived here in 1991, was that true?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. It was concentrated in the General Hospital really from the time you arrived?
DR. HAEGERT:

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A. Yes.
COFFEY, Q.C.:
Q. Okay. Doctor, between the time you arrived and Dr. Khalifa's arrival, was there any particular pathologists or pathologists who were responsible for immunohistochemistry?
DR. HAEGERT:
A. No, because --
COFFEY, Q.C.:
Q. Perhaps you could describe then --
DR. HAEGERT:
A. The way it--the way it really worked, I mentioned this dual management or parallel management thing. The way it really worked was immunohistochemistry reported to the manager. So what would happen is a pathologist wanted immunohistochemical stain, say, for example, a CD20 antibody stain, what --the pathologist would order that. The technologist would do it. The slides would come to the pathologist and the pathologist would then review it. If there was some issue with it, they would probably go back to the technologist and say, look, the staining is weak or there's some problem with the slide,

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you need to review this, or would go to the manager. So the oversight was really a manager's role. The divisional manager of pathology would be the one responsible. So the divisional chief, Dr. Fernandez, would be the person who would be responsible for liaising with the technologists and the divisional manager, although it was somewhat loose, so the pathologist would actually talk to the technologist directly, but would not say, oh, did you do this, did you do that. That wouldn't be the pathologist's role.

COFFEY, Q.C.:

Q. The pathologist role would be to say, well, the staining is not appropriate or there's no staining at all?

DR. HAEGERT:

A. There's some problem with it, or the material is not on the slide, or something to that effect.

COFFEY, Q.C.:

Q. And having explained what the nature of the problem was, how it might be addressed or fixed would be whose responsibility, looking back on it now?

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DR. HAEGERT:

A. I mean, the normal thing would be that the technologists--I mean, I always assumed that the technologists had the experience and expertise to solve these problems, but, I mean, if they couldn't solve them, then they would consult the manager.

COFFEY, Q.C.:

Q. Doctor, we've heard from various witnesses that certainly beginning in the late 1980s and continuing throughout the 1990s more and more immunohistochemical stains became available.

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. To be used--I mean, it's just--and what, if any, procedure was there in place in the early 1990s in terms of how a stain or a particular stain would become available to be utilized in St. John's? I'm not a physician, but if you picked a stain, for example, that first came on the market in 1992, a particular stain, and you or one of your colleagues at the General Hospital wanted to utilize it, how--what was the process for getting it in to St. John's

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and then utilizing it?

DR. HAEGERT:

A. Well, the normal process will be that the divisional chief would just talk to the manager and say we need stain "x" or "y" for these purposes, and we need to purchase this and then develop the staining methodology for it.

COFFEY, Q.C.:

Q. Now the development of the--assuming the money was there in the budget, presumably, the stain would be purchased?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. What would happen then, what was your understanding of what the process was? The stain arrives by Fedex, for example, whatever. What happened then?

DR. HAEGERT:

A. Well, based on my research experience, what would happen is the technologists would then develop a methodology.

COFFEY, Q.C.:

Q. And what did that involve, again based upon

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your experience--looking back on it in 1990s here in St. John's, what did that involved? Do you know how they would go about it?

DR. HAEGERT:

A. Well, typically what would happen with a particular stain, it comes with a sheet which is the product information from the manufacturer. Like, Becton Dickinson makes large numbers of antibodies, DAKO makes large numbers of antibodies. What they do--they would recommend uses, and what I would have anticipated is what the laboratory would do is first of all, they would do dilutions of the antibody and test it on appropriate tissue that should be positive and also tissue that should be negative. So they would develop a test, they would work it up to develop optimal staining and find out under what conditions they get the highest quality of staining, which is still specific, but not getting non-specific staining.

COFFEY, Q.C.:

Q. And would pathologists play any role in that process in your experience here in St. John's?

DR. HAEGERT:

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A. I would say minimal.
COFFEY, Q.C.:
Q. And the nature of their role if any was what?
DR. HAEGERT:
A. Well, basically it would be a consultative role. So if, for example, you brought, I don't know, an antibody to some molecule, one of the pathologists who had requested it, or perhaps a divisional chief, would then review the slides and try to form an opinion as to whether the test--whether the stain worked appropriately or not, whether the staining was weak, whether it--was it strong, was it non-specific, was there a high background, things like that.
COFFEY, Q.C.:
Q. At the time in the early 1990s, 1991 through--well, in fact, during the whole of your time as clinical chief, was there any particular accepted procedure in place or policy in place and procedure in place as to how this was to be done for any antibody, antibody x, y, z?
DR. HAEGERT:
A. Well, initially it would go through the divisional chief. So initially if you wanted

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a new antibody, you'd discuss with the divisional chief. Perhaps we'd bring it to a meeting and discuss it, you know, if we buy this antibody, are people going to use it, do we think it's useful. It was more formalized when the Health Care Corporation was created because then we discussed it at the site chief's meetings. I know we discussed on several occasions different antibodies, what use they would be, what would we do with them, would people use them. I mean, one of the things we didn't want to do is buy antibodies that would be used once and then--I mean, it's basically a waste of money because they typically cost between 400 and 600 dollars for an antibody for one tube of antibody.
COFFEY, Q.C.:
Q. Okay, so the process of vetting, as it were, to get it in here at all to purchase it, there was a process in place, and it became more formalized under the Health Care Corporation?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. The process as to how it was to be handled in

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the lab in terms of this optimization process, which is a phrase that might be used to describe, I think, what you otherwise said, which is using different dilutions, different whatever approaches, was there any policy in place as to how that was to be gone about? Did the divisional chiefs have to sign off saying that now we are satisfied that it's working properly and it's available generally to pathologists in Newfoundland or particular individual pathologists who happened to order it, would it be left to him or her to decide?
DR. HAEGERT:
A. Was there a written policy?
COFFEY, Q.C.:
Q. Yes.
DR. HAEGERT:
A. I don't think there was a written policy, but I think it was the general flavour, or maybe that's not the right term exactly, but the general sort of principle that applied is that if you wanted a new antibody, I mean, the individual ordering it or requesting it would provide the appropriate material to the technologist. Sections would be cut and they

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would be stained. They would optimize it, and then the pathologist who asked for it or the divisional chief would review this.
COFFEY, Q.C.:
Q. And that was, I take it, a general understanding?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. But there was nothing in writing to that effect?
DR. HAEGERT:
A. Well, I don't remember if there was. I mean, if there were --
COFFEY, Q.C.:
Q. You don't recall?
DR. HAEGERT:
A. I don't remember.
COFFEY, Q.C.:
Q. The idea of a formal approval process in the sense of formal approval to bring it on line as opposed to order it in the first place, bringing it on line, making it generally available --
DR. HAEGERT:

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A. I mean, there may have been a memo that I sent out at one time, but I--or we certainly would have--I mean, this would be the kind of thing that would be discussed in the divisional meetings.

COFFEY, Q.C.:

Q. Doctor, in terms then of immunohistochemistry itself, there was no one pathologist or group of pathologists who were responsible for immunohistochemistry?

DR. HAEGERT:

A. Not formally responsible because of the reporting relationship. The divisional chief would have been the one early on who would have been the one who would be, if you want to call it liaison. The person that--the technologist would speak to--it was more informal. I mean, this is Newfoundland, so people tend to be somewhat informal. So the techs would feedback to the individual pathologist as well.

COFFEY, Q.C.:

Q. As time--as the divisional chief in the beginning, as time went on, did that change or did it always remain kind of--in your capacity

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as clinical chief, if you were called upon at the time to think about it as to who is responsible amongst the pathologist staff or IHC?

DR. HAEGERT:

A. Well, this was an understanding that the site chief took over, that would be one of his roles to be the person who would be overall responsible in terms of interacting with the immunohistochemistry laboratory.

COFFEY, Q.C.:

Q. And the divisional chief would have been Fernandez in your early days?

DR. HAEGERT:

A. Yes, and Dr. Fernandez came the site chief.

COFFEY, Q.C.:

Q. Site chief, and then finally Dr. Khalifa as site chief?

DR. HAEGERT:

A. Yeah.

COFFEY, Q.C.:

Q. And then --

DR. HAEGERT:

A. Parai.

COFFEY, Q.C.:

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Q. At the very end, Dr. Parai?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. If we could bring up, please, Exhibit P-2423. Doctor, this is the curriculum vitae of Dr. Khalifa, Mahmoud Khalifa. This is a relatively current one in this particular form as it is now. It covers more time, a longer time frame than the one you would have seen back in the mid 1990s, but could you tell us, please, what you recall about the recruitment of Dr. Khalifa, his arrival here, and what he was asked to do in terms of being site chief?

DR. HAEGERT:

A. Okay. Well, initially he was not site chief.

COFFEY, Q.C.:

Q. No.

DR. HAEGERT:

A. He was recruited. He came as--well, we advertised. I think he had a J1 Visa in the United States. He applied. He came and gave a talk in the department. He met with individuals within the department where all of us were enthusiastic about his coming. He

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thought--I mean, one of the principles that we had was recruit people with subspecialty expertise and he had clearly had a lot of training in pathology, trained in Oklahoma--well, he had trained in the Armed Forces Institute of Pathology, and then Oklahoma, and then Georgetown. So he came here as a pathologist. When the Health Care Corporation was created, Dr. Fernandez said he was no longer interested in being--well, would have been site chief, so I asked Dr. Khalifa if he would be interested, and then I explained to him what I thought the role of a site chief was.

COFFEY, Q.C.:

Q. Doctor, did you ever--before Dr. Khalifa actually arrived on staff, do you recall ever having a conversation with Dr. Cook about how long Dr. Khalifa might stay?

DR. HAEGERT:

A. No.

COFFEY, Q.C.:

Q. At the time as the clinical chief and the discipline chair--I take it as discipline chair, in particular, of Memorial, you would

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have been very interested in having Dr. Khalifa come?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. And stay, if possible. From your perspective at the time in a professional sense, what were the challenges in keeping someone with Dr. Khalifa's background? You got him here is one thing, but to keep him here.

DR. HAEGERT:

A. Well, one of the challenges was, first of all, the research opportunities in the department. He really wanted to do research, and the reality in the department, there was only a small number of us doing research, and I think he was disappointed with that. It was really only myself and Dr. Robb who were actually doing any active research. That was one of the things. The second issue for him, I think, was salary. A lot of people's salary is very important and I think he was--I mean, he soon became aware that there was more money to be obtained elsewhere. I think he had personal elements too, which made it difficult

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to retain him.

COFFEY, Q.C.:

Q. Doctor, the salaries at the time, this would be 1995/1996 through the end of your time in St. John's --

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. What was the situation for pathologist's salaries in St. John's compared to elsewhere in Canada?

DR. HAEGERT:

A. Well, they were lower than elsewhere. They were--I think when I came, I thought they were more or less the same as in Quebec, although the salaries in Quebec were highly variable, depending where you worked and what kind of practise you had. Some people made a lot of money, but a lot of people made less, but elsewhere there was--it was certainly higher than in St. John's. I don't remember what it was elsewhere, but I know there was a difference. I think the other issue for him was workload. He felt the workload was far too high and there was minimal protected time.

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COFFEY, Q.C.:

Q. Doctor, do you recall--in terms of workload, Dr. Khalifa, after his arrival here and as time went on, did the matter of doing consults from outside the General Hospital ever arise as an issue in terms of him doing or being asked to do more and more consults by people?

DR. HAEGERT:

A. Yes, it did arise, but the reality was we always had done this. The pathologists at the General Hospital had always done consultations with the Newfoundland Cancer Treatment and Research Foundation for patients who were referred to the General Hospital. So a patient would come from, say, Clarenville, for surgery or something at the General Hospital site, and one of the pathologists would have done that.

COFFEY, Q.C.:

Q. And did that--were you ever asked by Dr. Khalifa to pursue that, pursue the idea of him being paid extra compensation?

DR. HAEGERT:

A. This was actually discussed not only with him, but with others. We discussed it--I think it

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went to Bob Williams, who was at the time Vice President of Medical Affairs, but then it also went to Paul Gardner, who was--he was the Medical Director of the NCTRF at the time. I spoke to him about it, and I said, you know, basically this is a medical/legal issue, not just a financial issue. I said, you know, basically we have a patient from, say, Carbonear, who has had breast surgery, they send it to the General Hospital, we review the case, we report it, and basically what we are doing is taking medical/legal responsibility for all aspects of that case and there's no financial remuneration, and the feeling in our department was that they should be paying the people in the department. I met him at least once, and possibly twice, I think I wrote him as well, and he basically said--my recollection is, no, there's no money, and I also think he--the bottom line, I think he said, well, there never will be. Basically, you kind of have to swallow it, tough beans, more or less.

COFFEY, Q.C.:

Q. If you want to work in the General Hospital --

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DR. HAEGERT:
A. Yes, this is basically --
COFFEY, Q.C.:
Q. It's part of it.
DR. HAEGERT:
A. I think he basically said there's no money coming from the government. It was also a time, you know--and that time everywhere there was budget cuts. They were being cut, the medical school was being cut, the Health Care Corporation was also facing budget cuts. So I think--I mean, it sounded plausible to me.
COFFEY, Q.C.:
Q. Doctor, if we could, please, bring up Exhibit P-2421. Doctor, this is a letter dated April 28, 1999, addressed to yourself. It's from Dr. Khalifa. It reads, "It was February 13th, 1996, when Des", and that would be Dr. Robb, I take it?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. "Myself", Dr. Khalifa, "sent a memorandum announcing the beginning of a new weekly surgical pathology conference. For over three

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years, we came to the multi-headed microscope almost every Tuesday at noon to share interesting cases, discuss criteria, review each other's diagnosis and teach residents. Most importantly, we communicated and had lots of fun doing it. One hundred and five of these sessions are well documented in my files with more than 780 cases discussed. Although attendance varied because of our hectic schedules, this conference averaged 3.2 staff pathologists per session". He indicated he enjoyed every single case and learned tremendously, and he says he'd like to take the opportunity to thank you for your consistent input during the sessions. Doctor, these sorts of weekly pathology conferences, he described it here as a new weekly surgical pathology conference begun in 1996, at least initially by himself and Dr. Robb, at that time was Dr. Khalifa, do you recall, probably by then site chief?
DR. HAEGERT:
A. Yes. 1996?
COFFEY, Q.C.:
Q. Yes, this would be --

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DR. HAEGERT:
A. Well, sometime around 1996 he was appointed, yes.
COFFEY, Q.C.:
Q. And I take it this would be an example of, or probably is at least at the General Hospital site, this weekly meeting of pathologists you referred to?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, do you know if this continued after Dr. Khalifa left?
DR. HAEGERT:
A. I think we did this when Dr. Parai took over.
COFFEY, Q.C.:
Q. So as site chief, Dr. Khalifa would be expected as the site chief at the General to organize this sort of thing because Dr. Parai did after him?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Dr. Cook would be expected to do it at St. Clare's?

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DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Was Dr. Khalifa, from your perspective as site chief then, responsible for what if anything else, and in particular the immunohistochemistry? Was he responsible for, as site chief, immunohistochemistry at the General?
DR. HAEGERT:
A. I thought I already explained that, that basically his role was to communicate with the manager and if there were issues in the immunohistochemistry lab, to communicate with the technologists.
COFFEY, Q.C.:
Q. And from your perspective then, who was responsible for immunohistochemistry?
DR. HAEGERT:
A. It was the management.
COFFEY, Q.C.:
Q. The management. That would be management in the sense of the technologist's management?
DR. HAEGERT:
A. Yes.

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COFFEY, Q.C.:
Q. Okay. Was that ever, do you recall, discussed at any point, like, explicitly discussed, for example, in the presence of Dr. Williams, the VP Medical? Yourself and Mr. Gulliver by 1999 would have been reporting to Dr. Williams as VP Medical. Was responsibility for immunohistochemistry ever actually discussed?
DR. HAEGERT:
A. No, I don't think so.
COFFEY, Q.C.:
Q. Do you recall when you first arrived in St. John's how ER and PR status was being determined?
DR. HAEGERT:
A. It was being done by a biochemical assay in the biochemistry laboratory at the General Hospital.
COFFEY, Q.C.:
Q. When you first arrived, Doctor, who would initiate the request for determining ER and PR status, was that a pathologist?
DR. HAEGERT:
A. No, it typically came from a surgeon.
COFFEY, Q.C.:

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Q. It came from the surgeon at that time.
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. And if the surgeon didn't do it, might it come from an oncologist?
DR. HAEGERT:
A. Are you talking in the biochemical assay?
COFFEY, Q.C.:
Q. Yes, the biochemical assay.
DR. HAEGERT:
A. Biochemical assay required fresh tissue, so that if the tissue is already in formalin, it's my understanding that you cannot actually do it--you can't do a biochemical method, I think.
COFFEY, Q.C.:
Q. So in terms then in the early days, your first four or five years here --
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Before Dr. Khalifa came in, that if ER and PR status were to be determined locally for a patient, it would have to be initiated by the

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surgeon at the time of surgery?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. In order to take advantage of the fresh tissue requirement for biochemical assay?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, were you aware in those first four or five years whether or not any attempts were ever made to have ER/PR status determined with paraffin blocks outside the province for local patients?
DR. HAEGERT:
A. In the early years?
COFFEY, Q.C.:
Q. Yes, in the early years.
DR. HAEGERT:
A. Not that I know of.
COFFEY, Q.C.:
Q. And I ask that because we have heard from Dr. Neil from Corner Brook --
DR. HAEGERT:
A. Uh-hm.

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COFFEY, Q.C.:
Q. If I recall correctly, and if it's not him, it's Dr. Gown, I don't recall right off the top of my head which one, but one of them certainly indicated that they were utilizing a hospital in Nova Scotia at one point in the early 90s.
DR. HAEGERT:
A. Okay.
COFFEY, Q.C.:
Q. So St. John's itself, to the best of your knowledge, wasn't doing so, all the ER and PR in St. John's was being done by biochemical?
DR. HAEGERT:
A. Well, in the early years, of course, I was only really responsible for the General Hospital site.
COFFEY, Q.C.:
Q. Yes.
DR. HAEGERT:
A. So the General Hospital, no, but the other sites, possibly, but I wouldn't necessarily know.
COFFEY, Q.C.:
Q. And then Dr. Khalifa came along around the

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time--well, in fact, he was here at the time of the Health Care Corporation initiation?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. As you said, he became site chief. The idea of instituting immunohistochemical paraffin block approach to ER/PR determination, whose idea was that in St. John's?

DR. HAEGERT:

A. It was Dr. Khalifa's.

COFFEY, Q.C.:

Q. Do you recall how that came about, when you first became aware that he was thinking about it or wanted to do that, and what was said?

DR. HAEGERT:

A. Well, I think it's fair to state that, you know, both of us were really in the General Hospital site close together. We used to talk a great deal. I mean, both of us were come from aways, if you would like to put it that way.

COFFEY, Q.C.:

Q. Yeah, sure.

DR. HAEGERT:

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A. And we used to have common--we used to talk often about many of the issues, and he raised this issue with me. He said he thought that this was coming, you know, there's a movement in North America and Europe to move away from the biochemical testing to a immunohistochemical method and he wanted to--he thought he would like to initiate that.

COFFEY, Q.C.:

Q. And did he indicate to you whether he had any experience in that regard himself?

DR. HAEGERT:

A. Yeah, he said that he'd had considerable experience. I mean, he was in Oklahoma and then in Georgetown and he had considerable experience with that.

COFFEY, Q.C.:

Q. And when you discussed it with him, what was your reaction, what did you say, if any--what did you think?

DR. HAEGERT:

A. Well, I was well aware that, in fact, that this--there was a movement towards this. When I was in Montreal, we had--when I left in 1991, the assay was still biochemical. We

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had, in our department, we had never initiated immunohistochemical testing, but I was aware that they were doing this elsewhere and I thought this would be reasonable and I had every confidence in Dr. Khalifa being able to develop this because he'd had previous experience and knowledge.

COFFEY, Q.C.:

Q. And so you discussed it. Do you recall how often you discussed it, just kind of the one long conversation, you say, well, you gave the approve it or what?

DR. HAEGERT:

A. Well, we discussed it, but also there was, I think we apprised Dr. Prabhakaran that we were considering this. Now, how we--I know I met with Dr. Prabhakaran at least once. We talked about this, you know, that there was a movement to move towards the immunohistochemical testing, but we wanted to do, first of all develop a methodology. Dr. Khalifa was going to do this together with the technologists. And we talked about it many times. We talked about what was going on, how it was progressing, you know -

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COFFEY, Q.C.:

Q. You mean after he started the process?

DR. HAEGERT:

A. After, many times.

COFFEY, Q.C.:

Q. As the process went on?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Doctor, was it brought to anyone else's attention at the time in terms senior to you, the idea that we're going to move to ER/PR, IHC, paraffin block process, would you have discussed that, for example, with the VP medical at the time?

DR. HAEGERT:

A. No, because I think this was an internal matter as how do you do a test. I don't think the VP was interested in--I mean, say there's two ways of doing hemoglobin measurements, which I don't know whether there is or there isn't, but -

COFFEY, Q.C.:

Q. That's not the sort of -

DR. HAEGERT:

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A. It's really not relevant as long as it's basically cost neutral.
COFFEY, Q.C.:
Q. At the time were there any inquiries made into the cost issue, was that considered at the time, do you recall?
DR. HAEGERT:
A. We thought, actually, it would be cost, either cost neutral or maybe even cheaper to do it by immunohistochemical methods.
COFFEY, Q.C.:
Q. And Dr. Prabhakaran?
DR. HAEGERT:
A. Prabhakaran, yeah.
COFFEY, Q.C.:
Q. The biochemist?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Whom did he report to at the time at the hospital?
DR. HAEGERT:
A. So he would have reported to me.
COFFEY, Q.C.:
Q. In your capacity as clinical chief?

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DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Did you yourself do any research at the time in relation to ER/PR?
DR. HAEGERT:
A. No.
COFFEY, Q.C.:
Q. Any research then that was to be done, from your perspective, you would have understood that Dr. Khalifa would be, would conduct that, any readings required or -
DR. HAEGERT:
A. Yes. As I said, you know, he had experience and knowledge and I was confident that he could do this and he would do whatever appropriate reading was necessary.
COFFEY, Q.C.:
Q. Doctor, look, please, at Exhibit P-1889? Doctor, this is a letter dated March 12th, 19--we'll it's dated two different dates, March 12th, 1997 and at the top left-hand side, then a date here February 27th, 1997, Thursday, 3:45 p.m. It's addressed to Mr. Gulliver and it's signed by Dr. Khalifa and it's copied to

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yourself and Mr. Whelan. Now, by this point in time, early 1997, Mr. Whelan would have been the program manager?
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. Would be, yeah.
DR. HAEGERT:
A. Program director, I think it's called, but -
COFFEY, Q.C.:
Q. Program director, okay.
DR. HAEGERT:
A. - basically equivalent.
COFFEY, Q.C.:
Q. And Mr. Gulliver would have reported to him?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. He's described here as the manager of anatomic pathology at the General Hospital. And here Dr. Khalifa writes "The ER/PR kit that we have tried and which offered us very good and reliable results has been totally consumed by late last week." He describes the date. And goes on to, in effect, complain or express

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concern about this. Just take you through some of it. He says, "You knew this," that's Mr. Gulliver did, and "We 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 and told you we were having an emergency situation. Any trial of a new technique needs to be done in parallel with the well established one before a switch could be safely made. I felt I conveyed this message to you clearly and asked you to replace the ER/PR kit as soon as possible. This was an emergency situation because, at the time, we had two cases referred from Corner Brook and one in-house case from 1996 which we were waiting for this test to be reliably performed. As of now the kit has not arrived and I was told you were out of town. Ordering such a 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

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overall emotional charge in the public regarding this very sensitive procedure. I'm also uncertain whether our service is being run as smoothly as it should. The medico-legal implications of delaying this test are huge and I want to clearly document my concerns at this time. You willingly 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'm 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've told me and even more, not to have allowed the first kit to be consumed without obtaining a replacement in a timely manner." Now, Doctor, Dr. Khalifa has testified about this in front of the Commission, okay, the circumstances. But this was copied to you. Do you recall if you received this?

DR. HAEGERT:

A. Well, I mean, I've certainly read it recently.

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Did I receive it before? I think I was aware of it.

COFFEY, Q.C.:

Q. And there are a couple of aspects about it I wanted to ask you about. In the second paragraph Dr. Khalifa concludes by saying, "I'm also having a very difficult time communicating with you basically because you," that would be Terry, "are either out of town, on another site or extremely busy within this site." Okay. Now, Mr. Gulliver was the manager of anatomic pathology?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. At that time he would have been responsible for which sites, do you know? This is 1997.

DR. HAEGERT:

A. So the General Hospital and the Janeway.

COFFEY, Q.C.:

Q. The Janeway. And they were separated by three quarters of a mile or so geographically, whatever it happens to be?

DR. HAEGERT:

A. Okay, yes, something like that. I don't know exactly.

COFFEY, Q.C.:

Q. A mile or so, probably a mile--actually, it would be well over a mile, actually.

DR. HAEGERT:

A. Okay.

COFFEY, Q.C.:

Q. So Mr. Gulliver, as clinical chief you would have understood Mr. Gulliver was required to be, at times, on both--at different sites throughout his working day?

DR. HAEGERT:

A. Right.

COFFEY, Q.C.:

Q. The assertion that Mr. Gulliver, or the observation by Dr. Khalifa that Mr. Gulliver was very busy, very busy, would that have been a surprise to you at the time?

DR. HAEGERT:

A. No. I think there was other things going on here. One of the things, now, I don't remember the time frame, but it would have been approximately this time frame Mr. Gulliver was also the manager for immunology, as I recall, and what happened, this was

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originally in the medical school and the medical school budget was cut. So what happened is I had a meeting with David Hawkins, who was the dean, now I don't remember exactly when, '95, '96, something like that. And he said well, we're basically cutting this out of the medical school and moving it into the laboratory--moving it out of the medical school, into the General Hospital, so Terry Gulliver was also responsible for that. And also around this time immunology was done in Dr. Chandra's lab at the Janeway. And somewhere in this process it was also we decided that we would close that laboratory. And I wrote Dr. Chandra and told him that indeed we were going to move this to the General Hospital site. So he, Mr. Gulliver was also responsible for that. And somewhere around this time we were trying to develop the genetics, molecular genetics program and he had this responsibility. Plus he was, it mentions he was out of town. Somewhere in this period he was--now, I don't remember the name of the organization, but there's a Canadian organization for laboratory

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technologists and he was the president of that organization, so from time to time he went off to meetings, I don't know where they were held, Ottawa or somewhere.

COFFEY, Q.C.:

Q. And as the manager of anatomic pathology at the time Mr. Gulliver would have had the immunohisto, the technologists who were doing immunohistochemistry reporting to him?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. And was there any particular technologist that you were aware of that, amongst the kind of the bench technologists who was responsible for IHC?

DR. HAEGERT:

A. Oh, there were two, there were Peggy Welsh and Mary Butler. Those were the two. They were the only ones, to my knowledge, that ever did immunohistochemistry as long as I was there.

COFFEY, Q.C.:

Q. And they reported to?

DR. HAEGERT:

A. Terry Gulliver.

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COFFEY, Q.C.:

Q. Terry, yeah, Terry Gulliver directly at that -

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. At that stage?

DR. HAEGERT:

A. Yes.

THE COMMISSIONER:

Q. Wherever you can get an opportunity, we'll take a break.

COFFEY, Q.C.:

Q. Yes, thank you. Thank you, Commissioner. Doctor, the reference to "I do not think you fully appreciate the delicacy of this test, it's clinical consequences and the overall emotional charge in the public regarding this very sensitive procedure." First of all, the clinical consequences of the ER/PR test, yourself, were you aware of those?

DR. HAEGERT:

A. Yeah, of course.

COFFEY, Q.C.:

Q. Okay. And the delicacy of this test, do you know what, say, he was referring to there?

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DR. HAEGERT:

A. I'm not sure whether that's redundant or not. I mean, I think the main point here is that this test is important for patient care and needs to be done in a timely manner so that clinicians can decide whether to treat the patient with an anti-estrogen like Tamoxifen. The delicacy, I'm not sure what he's driving at there. I can't answer that.

COFFEY, Q.C.:

Q. I was going to ask you about that. In terms of the ER/PR, IHC process, using paraffin blocks, in 1997, I mean, you would have been familiar with the idea of using immunohistochemistry?

DR. HAEGERT:

A. Yeah, of course.

COFFEY, Q.C.:

Q. Routinely ordered?

DR. HAEGERT:

A. Yes, of course.

COFFEY, Q.C.:

Q. IHC. Was there anything different to your mind or understanding about ER/PR potentially different compared to other types of IHC

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stains?

DR. HAEGERT:

A. Well, you're asking me to go back to '97 -

COFFEY, Q.C.:

Q. Yes.

DR. HAEGERT:

A. - to what I knew then. I mean -

COFFEY, Q.C.:

Q. Yes, at that time.

DR. HAEGERT:

A. - it's difficult to know what I--I mean, certainly I would be aware. I mean, what I know now and I'm pretty sure I knew then was that there are two types of immunohistochemical testing, really, in broad generalization. There's one where you use it to help make diagnosis and the second type is one where it actually has either prognostic or therapeutic implications. So things that have therapeutic implications would be like ER/PR, HER2/neu, CD20, probably there's others but they don't come to my mind. So I would have been well aware that this is--has therapeutic implications. But in terms of the actually interpreting the slides, basically they're all

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the same. Either you get membrane staining, cytoplasmic staining or nuclear staining. And ER/PR, of course, is nuclear. I mean, any pathologist can read these, but the reason you need a pathologist to read them is to tell whether you're looking at cancer, not cancer, that's what the real, the skill is, and also to recognize that for ER/PR is that the staining can be weak and often not easy to see.

COFFEY, Q.C.:

Q. And at least from your introduction to it. And I take it when Dr. Khalifa raised this first with you, the idea of getting into this, in your own clinical world you had never been involved in ER/PR?

DR. HAEGERT:

A. Never.

COFFEY, Q.C.:

Q. So this was in effect your introduction to it, as well?

DR. HAEGERT:

A. Right.

COFFEY, Q.C.:

Q. Commissioner, thank you, short break?

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THE COMMISSIONER:

Q. All right, we'll take 15 minutes.

(RECESS)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey?

COFFEY, Q.C.:

Q. Thank you, Commissioner. Exhibit P-0697? Now, Doctor, these are the minutes of a laboratory program, divisional managers' meeting of probably March 4th, 1997, 97/03/04. Now, Doctor, I appreciate you're not listed as being there. But there is in the middle of the page, the first page there, a reference to, if we could, financial issues. The January financial statements have been circled, the laboratory is $120,000 in the red. And toward the bottom of that, the fourth paragraph under that heading it says, "Mr. Whelan and Dr. Haegert met with George Tilley on Friday regarding their concerns about the ability of the laboratory program to save a million dollars."

DR. HAEGERT:

A. Right.

COFFEY, Q.C.:

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Q. "In the coming year's budget. Mr. Tilley will be meeting with the executive team and advising of their final decision probably this week." So this would be this time frame that you were telling the Commissioner about earlier?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Under "Information System," Doctor, it says, "Major problems are anticipated with reporting of results between sites, especially when instruments are interfaced. These will have to be addressed as they arise." Now, in this context I want to ask you about Meditech and the integration of Meditech between these hospital sites. I take it before the Health Care Corporation existed each site had its own Meditech system, is that -

DR. HAEGERT:

A. Well, I know we had it at the General site, but this I don't know if we had it at the other sites. I don't remember, actually.

COFFEY, Q.C.:

Q. Okay. In your capacity then as clinical chief

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after the formation of the Health Care Corporation, were you ever asked to get involved in issues relating to the integration of the Meditech systems, the ability of them to interface effectively and communicate?

DR. HAEGERT:

A. I know we talked about the interfacing between labs, but it wasn't really--this was really a management, hospital information system issue. I wasn't really involved.

COFFEY, Q.C.:

Q. You might have been kind of kept apprised -

DR. HAEGERT:

A. I was aware that there was an issue, but as I said, I wasn't even sure what system they had at the other sites.

COFFEY, Q.C.:

Q. Go on to the next page of the exhibit, Doctor. It says, "QI Issues." QI in this context would me what?

DR. HAEGERT:

A. Quality assurance.

COFFEY, Q.C.:

Q. Initiatives?

DR. HAEGERT:

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A. Yeah, quality initiatives.
COFFEY, Q.C.:
Q. And it says, "The internal advisory committee for the laboratory program has been set up and the first meeting held. The membership is as follows." And Mr. Whelan and yourself and a long list of other people are there. It says, "Membership will rotate and the terms of reference are being established. Divisional subcommittees will be set up and will report back to the IAC," which would be internal advisory committee, "which will probably meet every second month. The IAC will report once a year to the senior advisory committee." Doctor, what was this internal advisory committee about, do you recall and what was the necessity for it, had it existed before at individual hospitals, why was it being set up here now?
DR. HAEGERT:
A. I think this was an initiative from the Health Care Corporation. I mean, it mentioned at the bottom there Heather Predham.
COFFEY, Q.C.:
Q. Yes.

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DR. HAEGERT:
A. Predham was the -
COFFEY, Q.C.:
Q. QI facilitator?
DR. HAEGERT:
A. - facilitator, yeah. And she, it was her initiative to--for each of the programs to set up a program and deal with issues within their programs.
COFFEY, Q.C.:
Q. Now, here looking down through it there's a divisional chief for biochemistry, for microbiology. Dr. Cook is there as the pathology site chief for St. Clare's. I take it you in your capacity as clinical chief, would you have been the pathology chief for the General? You wouldn't because Dr. Khalifa would have -
DR. HAEGERT:
A. Dr. Khalifa.
COFFEY, Q.C.:
Q. Would have been at the time. So in terms of representation from the General Hospital's pathologists on this, or in this group, and I notice -

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DR. HAEGERT:
A. Well, I would have been able to speak about the issues at the General Hospital, but there's no formal individual specifically representing pathologists, no.
COFFEY, Q.C.:
Q. Pathologists. As well, the Grace is now, as well, doesn't have a rep here, a pathology rep, pathologists -
DR. HAEGERT:
A. What year was this, 1997.
COFFEY, Q.C.:
Q. This would be -
DR. HAEGERT:
A. I see it, '97.
COFFEY, Q.C.:
Q. Beginning of 1997. So you would have been, between yourself and Dr. Cook would have been the pathologists' representatives?
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. Doctor, how developed did this become, do you recall?
DR. HAEGERT:

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A. This committee?
COFFEY, Q.C.:
Q. Yes. How active?
DR. HAEGERT:
A. Now, it's difficult to remember, actually, surprising. But I think the facilitator, as mentioned, was Heather Predham, and I think this was an initiative from the Health Care Corporation to develop this committee. I can't say how many times we met. I actually don't remember.
COFFEY, Q.C.:
Q. Okay. And now at that time, when the Health Care Corporation was embarking upon this initiative, at the General Hospital site what sorts of QA or QI programs or initiatives existed at the General Hospital in pathology?
DR. HAEGERT:
A. Yeah, well, yeah, see, depends what you mean by QA.
COFFEY, Q.C.:
Q. Exactly. And I appreciate, you can elaborate on it.
DR. HAEGERT:
A. Yeah. I mean, really basically all it means

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is assurance of quality. So one of the things that's relevant here is recruitment. What we tried to recruit when we were recruiting people with, if at all possible, people with subspecialty expertise. The idea being that what we would be doing is bringing in people with--who would increase the knowledge base in certain areas. Like, for example, we brought in Dr. Khalifa when I was there, we brought in Dr. Rasty who had a fellowship in cytopathology, Dr. Gorecki, who I don't remember what subspecialty she had. But that was, I mean, to me that's actually a quality issue, I mean, who are the people that are working there, first of all. Then we had our system of basically you can call it rounds or teaching rounds or difficult case rounds, whatever you want to call them, where basically interesting or difficult or challenges cases were brought and we discussed the diagnostic criteria, reviewed them, elaborated upon them, you know, what additional tests might be relevant to making a diagnosis. And then as I mentioned before, we had this internal consultation process which

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actually Dr. Khalifa formalized. Previous, prior to his arrival it was informal in that what would happen is a pathologist would say, okay, look, I have this difficult case, say, for example, a difficult prostate biopsy or difficult breast biopsy, I'm having a significant difficulty with this, is it benign or is it malignant, would show it to some other pathologist with, you know, significant experience. So, I mean, to me that's quality assurance. And then what Dr. Khalifa did, he was trying to move kind of improve the, like, the paper trail in the department, so he formalized that. So this then became a formal process where, in fact, you would document, you know, case No. so and so was shown to so and so and their opinion was this and then that individual would sign it. So that was a quality assurance activity. I think also, you know, external consultations is really a quality assurance activity. Now, sometimes that would be initiated inside the department, it would also be initiated by patients who were either unhappy with their diagnosis or just wanted a second opinion. That's normal

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practice everywhere in the world, everybody--people are always asking for second opinions or the surgeons ask for second opinions. And that's actually a very positive quality assurance when you have a case, you make a diagnosis of this and you get a referral from some place that's supposedly expert like the Mayo Clinic or, you know, place in Vancouver or Toronto or wherever send back and they get the same diagnosis, that's a QA activity. I mean, to me that's actually one of the key QA activities. And actually, we welcome that, you know. And then I think that's probably a rough summary of what was going on.

COFFEY, Q.C.:

Q. Was there any external proficiency testing or--at that time?

DR. HAEGERT:

A. Yeah. Actually, external proficiency testings are interesting. I mean, I could talk about that a bit of you want.

COFFEY, Q.C.:

Q. If you--yes.

DR. HAEGERT:

A. Because what the--my experience with them is

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this is a kind of thing that the lay public and many organizations subscribe to, but in my experience what these mostly test are unusual cases. So what you mostly get if you ask--if you have a--if you subscribe to one of these things, I mean, it's not entirely true, and this is what I remember, is that, you know, we did have some proficiency testing from outside. Now, I don't remember the organization, it might have been ASCP, American Society of Clinical Pathologists, but often what they do is they show you some rare thing and then ask you a bunch of questions about it, and the real issue, when you're a pathologist, is not the rare things, because rare things, we all know how to deal with. You know, either we have the internal expertise or you send them out for consultation. As I mentioned, the cartilagous bone tumours, most people have minimal experience, we send them out. But the real problem are things that are actually common, which sounds peculiar, but it's true. I mean, the key things would be like is this carcinoma of the breast or is it some reactive process?

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I mean, breast cancer and reactive process, to distinguish between them can be extremely difficult, and they would rarely, in my experience, at least, test those. Mostly what they would show you is something odd that you would rarely see. I mean, that wasn't always the case, but often the case.

COFFEY, Q.C.:

Q. It was, from your perspective, a potentially problematic aspect of the external proficiency approach?

DR. HAEGERT:

A. Yeah, at least the ones that we--the ones that I saw, I actually didn't find them very helpful to me in practice. The other aspect of this is most of us were terribly busy. So to actually use appropriate assessment of these external cases was difficult. You know, to find the time to sit down and review--now, I don't remember how many cases, but say for argument sake, ten cases and respond to all those questions is actually quite difficult. In normal practice, it may take a long time to make a diagnosis in certain cases.

COFFEY, Q.C.:

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Q. And particularly if these were, some of them would be esoteric?

DR. HAEGERT:

A. Yeah, a lot of them were. I mean, occasionally they were not, and this is what I remember. I mean, I'm hoping I'm giving you an honest assessment.

COFFEY, Q.C.:

Q. And that's what I'm--because your experience dates through this whole time frame.

DR. HAEGERT:

A. Yeah, that was my experience. It wasn't--I thought a lot of them were not helpful at all, because most of the problems that I had as a pathologist, and I've been doing it, as you pointed out, I've been in practice for 40 years, but not as a pathologist, but I got my fellowship in 1973, so it's a long time, 35 years. The real major problems are common things. Like in breast, is it carcinoma in situ of the breast or is it a related condition, but not carcinoma in situ? These are often not easy to tell. Often you need a second opinion.

COFFEY, Q.C.:

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Q. And the idea of proficiency, external proficiency programs such as have existed from time to time or have been available from time to time, whether or not they actually test how proficient one is, in that process, your observation would be you don't think it's been very effective in that regard?

DR. HAEGERT:

A. Well, I didn't find it so, no.

COFFEY, Q.C.:

Q. In your own experience?

DR. HAEGERT:

A. No.

COFFEY, Q.C.:

Q. Doctor, there's a reference here to performance evaluations on the second page. "Performance evaluations on staff should be started. At the present time, each site is using different forms. These will be standardized over the next year." Now do you know, or at least in your time as clinical chief, whether or not performance evaluations were done on or in relation to pathologists? Do you recall whether or not you were ever asked to fill out performance evaluations for

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your colleagues?

DR. HAEGERT:

A. I think most--the way we tended to do it is that the individual sites would do the performance evaluations and then so therefore in pathology, the site chiefs would do this, and some of this was--much of it was informal, because what we tended to do is monitor what was going on in terms of the practice. So things like delayed reports, turnaround times, did certain individuals have problems, either were there delayed cases and why were there delayed cases?

COFFEY, Q.C.:

Q. Doctor, was there any systematic process in place while you were clinical chief to kind of randomly review cases?

DR. HAEGERT:

A. Yeah, this was done on one occasion by one of the--one of the pathologists did this on a--did a random review of--now I don't remember the number of cases, but randomly selected a number of cases, but the numbers, I don't recall. Reviewed them, came up with a diagnosis and then we discussed the review.

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COFFEY, Q.C.:
Q. And do you recall what types of cases were being reviewed at the time?
DR. HAEGERT:
A. No, I think they were just randomly selected cases.
COFFEY, Q.C.:
Q. Okay, and just to--and that particular pathologist kind of looked at each of those cases, made his or her own diagnosis.
DR. HAEGERT:
A. Yeah, and then we discussed within the department.
COFFEY, Q.C.:
Q. And compared that to the original?
DR. HAEGERT:
A. Yeah, we discussed whether the reviews seemed to be appropriate or not and whether the original diagnosis and the final diagnosis were consistent.
COFFEY, Q.C.:
Q. Whose idea was it to do that?
DR. HAEGERT:
A. Actually, Dr. Griffin initiated. I may have spoken to her before, I don't remember, but

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she was there for a period of time and she was interested in doing this.
COFFEY, Q.C.:
Q. And the idea of that sort of an approach, a random audit, as it were -
DR. HAEGERT:
A. Um-hm.
COFFEY, Q.C.:
Q. - had you ever encountered that before, that kind of--the idea of using that sort of approach?
DR. HAEGERT:
A. Yeah, I think it was fairly well known that this is done in certain departments and it is a quality assurance issue or technique.
COFFEY, Q.C.:
Q. Technique.
DR. HAEGERT:
A. Method, I guess.
COFFEY, Q.C.:
Q. And was it--it wasn't continued afterward, I take it?
DR. HAEGERT:
A. No.
COFFEY, Q.C.:

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Q. Why not?
DR. HAEGERT:
A. One of the issues was the number--did we have adequate people to do this. I mean, I think the consensus all across the nation is if you're going to do quality assurance, you actually need dedicated people. You need time to do it. I mean, you alluded to this interfacing between sites. Now, I don't remember when that actually was done, but it's obviously a problem if you're going to start doing random selection of cases across sites. I mean, you obviously need interfacing between sites. But one of the key elements is having sufficient people to do the work. You need a technologist. You need somebody who actually--who understands what goes on in pathology to actually do a lot of the work and then you need some pathologists to review it. I always felt that we were short staffed. We never had enough people to do that kind of thing.
COFFEY, Q.C.:
Q. And Dr. Griffin, at the time, her position was what?
DR. HAEGERT:

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A. She would have been assistant professor, pathologist, and a staff pathologist.
COFFEY, Q.C.:
Q. And her particular interest in this idea of using sort of random audit approach, did you have any understanding of why she was interested in that, why in particular?
DR. HAEGERT:
A. Well, I know we discussed it. Now I can't remember whether I initiated it or we were talking about, you know, sort of academic activities that one could do in the department. I mean, I know we discussed it. I mean, this is, you know, 11 years ago. It's hard to remember the precise basis of that.
COFFEY, Q.C.:
Q. And if we could, please, Exhibit P-2531? Doctor, these are the minutes of anatomic pathology site chiefs meeting of May 13th, 1997. There's apologies from yourself, but all the others, I take it, are present, all the other physicians and Mr. Gulliver and Mr. Murphy. While you wouldn't have been present for this particular meeting, I take it that when the minutes were circulated, you'd get

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them the next time round?
DR. HAEGERT:
A. Yeah, of course. I'd always get a copy of the minutes.
COFFEY, Q.C.:
Q. Sure. So here, Doctor, looking at the third page under new business, ER and PR immunoperoxidase receptors, paragraph A, it reads "Dr. Khalifa reported to the committee that there is correlation between the biochemical assay and the immunoperoxidase staining for breast receptors. It appears the time may be right to implement the immunoperoxidase breast receptors corporate wide. Dr. Cook stated that there's a concern amongst the 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's 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

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discipline meeting to get a consensus amongst pathologists. Hopefully such a meeting will be held in June. Until then, it is agreed to maintain the status quo, and Dr. Cook recognized the amount of hard work Dr. Khalifa had put into this."

Doctor, now this is halfway through 19--well, almost halfway through 1997, and this indicates that Dr. Khalifa is, you know, has well embarked upon this effort, in the sense of looking for correlation and so on. The ER/PR is being done here in St. John's and biochemical is continuing. I want to ask you, so the Commissioner can get some sense as to how involved, if at all, were you then in the actual, this whole process? We're going to see a number of documents now where Dr. Khalifa is reporting from time to time as to what's going to--what he's doing and what he's finding.
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. And what's proposed and other people's thoughts. As the discipline chair of the day

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and the clinical chief of the day, how involved were you in this? I appreciate you'd be aware of it, but did you--other than being aware of it?
DR. HAEGERT:
A. Well, I was certainly involved in the discussions at every step of the way. I mean, Dr. Khalifa and I met multiple times to talk about this, and then we'd talk--I was well aware of, you know, Dr. Cook's concern and then Dr. Parai had similar concerns about who should be reporting them. The concerns were what was the appropriate level to say something was positive or negative, and what kind of format the report should take. Should there be--I mean, it's not mentioned there, but you know, Dr. Khalifa worked on a rider which -
COFFEY, Q.C.:
Q. And we'll see that.
DR. HAEGERT:
A. - which could not be attached, and I was well aware of all this.
COFFEY, Q.C.:
Q. Okay. So you were aware of it, and kept

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yourself informed on it. Would you have done any research yourself to kind of look into these issues about, for example, what should be considered positive and negative or whether or not a rider should or shouldn't be on?
DR. HAEGERT:
A. Well no, because, you know, I thought, you know, here was Dr. Khalifa who's well trained. He's got--he had the American boards in anatomic pathology. Other pathologists either had their fellowships or American boards. They're perfectly capable, among the site chiefs, to address this issue, and I mean, I looked--I mean, I had complete confidence in Dr. Khalifa to deal with this.
COFFEY, Q.C.:
Q. Doctor, here on the fifth line, it says "Dr. Cook stated there's a concern amongst the pathologists at St. Clare's that they should be the ones reporting their breast receptors."
DR. HAEGERT:
A. Um-hm.
COFFEY, Q.C.:
Q. Do you recall what that was about? At this point in time, we understand Dr. Khalifa was

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actually doing the reporting.
DR. HAEGERT:
A. That's correct.
COFFEY, Q.C.:
Q. Interpretation and reporting. What was your understanding about what the concern was as captured here, referencing Dr. Cook?
DR. HAEGERT:
A. Well, I think what Dr. Cook was really saying is that the diagnosis of breast cancer at St. Clare's would be made by the pathologists. This was completely part of the same activity. You know, this is just an immunohistochemical method used on sections from the same cancer and it would be only reasonable that the pathologist would report, so make a complete report on the case. I mean, the same principle would apply to some other test on the breast cancer.
COFFEY, Q.C.:
Q. At that point in time, this would be halfway through 1997, were there any types of IHC tests or interpretations that were limited to one or two pathologists?
DR. HAEGERT:

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A. No.
COFFEY, Q.C.:
Q. In the sense, because Dr. Khalifa up to this point, and I appreciate he's managing the implementation, so he's reporting everything for ER/PR at this point in time. Is there anything else that kind of similarly was limited to one or two pathologists, that you recall?
DR. HAEGERT:
A. Well, the only thing would be the immuno staining for kidney biopsies. Dr. Fernandez was the recognized expert on kidney pathology. They're immuno fluorescence, which is not immunoperoxidase but a similar kind of methodology. She would be doing those. Probably that's the only one. Most of the other--I would say basically immunoperoxidase was any pathologist, say if you were reporting a lymphoma, whoever was dealing with the case would be looking at the immunoperoxidase.
COFFEY, Q.C.:
Q. Doctor, you, yourself, as you pointed out to the Commissioner already twice, in terms of recruiting, were interested in

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subspecialization or subspecialist if you could find them and entice them to come to St. John's because they would bring particular experience and expertise and it would be available.
DR. HAEGERT:
A. Um-hm.
COFFEY, Q.C.:
Q. But the idea of actually limiting or having subspecialists within pathology in St. John's, was that a goal of yours and then if so, how practical did it turn out to be?
DR. HAEGERT:
A. Well, we discussed it at one of our meetings. Now I don't know what time frame this was, but Dr. Khalifa was there. I think it was discussed at the General Hospital site and we discussed it in terms of whether this was an appropriate thing to do at that time, and I was there, Dr. Khalifa. I remember this because it was actually an important issue whether this would be the right strategy or whether we should continue to have a more general approach. So I was there, Dr. Khalifa, Dr. Fernandez, Dr. Chittal was there.

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I think Dr. Morris-Larkin, Dr. Wadden. I'm pretty sure those people were there. Were there others, I can't say. Certainly, there was a division of opinion.
COFFEY, Q.C.:
Q. Rationales on both sides, do you recall what -
DR. HAEGERT:
A. Well, the advantages--okay, so the advantages of the subspecialization is that with time, assuming one was not already an expert, that you would acquire expertise and develop, and you know, become--probably provide a higher level of reporting over time than say people who don't do it. But the down side of that, of course, is what happens--because we're always faced with the issue of people leaving. What happens if that person leaves or gets sick or has a heart attack or something. You know, because this is--this was actually an issue when Dr. Fernandez was doing the kidney biopsies. What happened, she'd do them most of the time and then when she was on vacation, what would happen? This was devolved down to the rest of us and very few people in the department felt terribly comfortable, but with

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some routine thing, most of us could deal with it, but it was a problem. So that's--I mean, I think that's the down side of having the expertise. The other down side, of course, is that if you're moving from one place to another place is what are these people looking for. Are they looking for a subspecialist or are they looking for a generalist, you know, somebody with general expertise. So that would be the issues for, you know, having subspecialization. I mean, there's certainly advantages of it, but there are some disadvantages.

The general--to be sort of more generalist, if you want to call it that way, I think the question at the time that we had this meeting was whether this was the right time. One of the questions was how do we divide up the workload, because as with most practices, most of the volume is--I mean, now I'm trying to remember, but I would say certainly in Montreal, the big volume is GYN and GI. So how are you going to divide this up, because you're going to have--I mean, we weren't quite sure what to do with that.

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Breast, actually, at the General Hospital site was not--I mean, I don't know what the frequency of it was. It wasn't very high. So I think one of the big concerns was what about the--how are we going to distribute this workload and whether that was the right time to introduce it.

So I think the feeling, overall--I mean, there was a divergence of opinion, but certain people--I mean, for example, like lymphomas, I think there was a--the lymphoma practice at the General Hospital, there was a moderate number, but probably wasn't enough for a single person, and then lymphomas are often extremely difficult to diagnose, so if that person wasn't there or sick or whatever, who is going to report them, if you never saw them, if you didn't see them one year to the next? Then you'd have to send them all out. So I think that was kind of the tenure of the discussion. I mean, that seems like a reasonable kind of--that would be how I would look at it.

COFFEY, Q.C.:

Q. And the upshot of it was what?

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DR. HAEGERT:

A. The decision at the time was to maintain the status quo and I think the feeling was that this could be revisited at a later date.

COFFEY, Q.C.:

Q. And do you recall, during your tenure, if it was ever revisited?

DR. HAEGERT:

A. No, we didn't ever revisit it.

COFFEY, Q.C.:

Q. Doctor, the idea of limiting the interpretation of ER/PR IHC slides, limiting to a certain core group, an individual core group of pathologists, was that ever actually put forward as an option, or thought about? I'm asking you this in this context, Dr. Khalifa starts this and he's doing all the reporting, in effect, for the first year, he does it all. We've heard that.

DR. HAEGERT:

A. Yeah, initially, yes.

COFFEY, Q.C.:

Q. And then here, there's a reference here, midway through '97 and well, where are we going? Dr. Khalifa is saying it's time, in

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effect, to roll out ER/PR IHC throughout our system in the Health Care Corporation. He's saying that here.

DR. HAEGERT:

A. Right.

COFFEY, Q.C.:

Q. But he's not necessarily saying here have the individual pathologists report it. He's just saying roll it out. You know, it'll be available and it'll replace biochemical assay.

DR. HAEGERT:

A. Um-hm.

COFFEY, Q.C.:

Q. Dr. Cook says here, "well, if that's the case, we'd like to report our own. We, at St. Clare's, would like to report our own." That's what's referred to here.

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. And you've explained why that was. Was there ever any serious consideration given or discussion around the idea of "well, no, we'll not have everybody report their own. We'll still limit it to one or two or three people."

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DR. HAEGERT:
A. No, I think the feeling was that overtime, this would devolve to the individual pathologist. So it would involve, you know, in the Health Care Corporation and outside.
COFFEY, Q.C.:
Q. Doctor, during your time as clinical chief, up to the time you left, did the idea ever resurface about kind of again concentrating ER/PR reporting in a small group of pathologists? Did it ever come back, resurface the idea of -
DR. HAEGERT:
A. Not that I remember, no.
COFFEY, Q.C.:
Q. I'm not suggesting it did.
DR. HAEGERT:
A. I don't think so.
COFFEY, Q.C.:
Q. Once the decisions that were made in 1997, early '98, about having everybody report their own, that's the way it stayed?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:

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Q. Doctor, here on the fourth page of the exhibit, under other business, "it was agreed to hold these meetings once a month. It's also agreed to rotate these meetings throughout the various sites with site chiefs acting as chairs of the meetings in their respective locations." So this, in effect, is the beginning of these site meetings. It's around this time.
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. Exhibit P-1857, please? Now Doctor, this is minutes, this is the notice of a meeting, and then these are the minutes of a meeting of June 17th, 1997. Again, apologies from yourself, but certain other doctors are there, and technologists, a technologist. On page three of the exhibit, paragraph 3.4 and 3.5, 3.4 reads "ER and PR receptor interpretation. This was discussed in detail. The majority of pathologists at St. Clare's, as well as the Grace Hospital, would like to interpret their own cases with control slides. Dr. Khalifa has agreed to provide a number of cases to the

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Grace Hospital to review them to be familiar with the positive and negative results." And then at 3.5, "the immunoperoxidase staining, the turnaround time of immunoperoxidase staining takes at least one week or more from the time of sending the block to the time of receiving these slides. Dr. Parai mentioned whether this turnaround should be reduced by doing immunoperoxidase staining on a daily basis instead of twice a week, which is presently being done."
First of all, Doctor, in respect of this turnaround times, the practice at the General Hospital at the time, is that--does this what's written here accurately reflect the way IHC was handled? It was done on certain days?
DR. HAEGERT:
A. No, I think they're talking about immunoperoxidase for ER/PR.
COFFEY, Q.C.:
Q. Okay, here in this context?
DR. HAEGERT:
A. Yes, not for general--I would have thought they did this every day.
COFFEY, Q.C.:

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Q. Every day, and this would be--your sense of this would be no, this is for ER/PR immunoperoxidase?
DR. HAEGERT:
A. I would say, yeah. I can't imagine that could be for general immunoperoxidase, no.
COFFEY, Q.C.:
Q. And secondary, Doctor, ER and PR receptor interpretation, paragraph 3.4. Not only St. Clare's now, but the Grace, it's noted, would like to interpret their own cases with control slides. Control slides here would be external controls?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. The idea of utilizing internal controls for ER/PR, normal breast tissue as an internal control, do you recall whether that was discussed in this period, like in this roll out, you know, the introduction of ER/PR in St. John's?
DR. HAEGERT:
A. What I would say now everybody is well aware of this, but -

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COFFEY, Q.C.:
Q. Yes, now.
DR. HAEGERT:
A. - I think at the time, no, I was not aware. I don't think that we discussed this.
COFFEY, Q.C.:
Q. And there's certainly no reference in the materials.
DR. HAEGERT:
A. No, I don't remember this at all.
COFFEY, Q.C.:
Q. So at the time, from your perspective, and again, you've told the Commissioner before the break that this was, in effect, for you, your own introduction to this?
DR. HAEGERT:
A. Exactly.
COFFEY, Q.C.:
Q. You understood it was nuclear staining you were to look for?
DR. HAEGERT:
A. Correct.
COFFEY, Q.C.:
Q. And certainly to ensure the external controls were working?

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DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Nuclear staining. Doctor, ER/PR, we understand, involves percentage--at times involves percentages or some kind of interpretation and a determination as to whether it's considered positive or negative?
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. And percentages are used. Were there any other IHC stains at that time that utilized percentages, that you recall?
DR. HAEGERT:
A. I'm just thinking. I mean, the common stains would be for things like lymphomas and sarcomas. No, sometimes certain cases, certain tumours would--you know, only a small percentage of the tumour cells would stain positively, but that was well known.
COFFEY, Q.C.:
Q. But you wouldn't be expected to report on the percentage?
DR. HAEGERT:

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A. No, no, I don't think so.
COFFEY, Q.C.:
Q. So this would have been, for you, perhaps, your introduction to the idea of, you know, trying to look through a microscope and come to some conclusion about the percentage of tumour cells that were staining and report it?
DR. HAEGERT:
A. Yeah, I think that's correct. I would say that's probably correct.
COFFEY, Q.C.:
Q. How were you--your introduction to that, in terms of how were you taught then how one was to go about doing that? How did you learn?
DR. HAEGERT:
A. How to learn look at percentages?
COFFEY, Q.C.:
Q. Yes.
DR. HAEGERT:
A. Well, I think the bigger issue would be when you're looking at a slide, first of all, is it cancer? When you're looking at the stain, are you looking at cancer cells or non-cancerous cells. I mean, I think that's one of the reasons why pathologists do this, because it's

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actually not all that easy and is one of the fundamental issues in many of the immunohistochemical stains when you're looking down the microscope, are you looking at tumour cells or not tumour cells. But I think any pathologist can get a rough estimate of percentages.
COFFEY, Q.C.:
Q. Once you've determined which ones are the actual tumour cells?
DR. HAEGERT:
A. Yeah, but it's somewhat subjective. It's not--I mean, the way it was certainly done then, it was a subjective measure.
COFFEY, Q.C.:
Q. And so you would be--your understanding was you were expected, as a pathologist, if you were going to be involved in this, to look at a slide, determine in your field of vision as to which were tumour cells and which were normal cells, concentrate on the tumour cells and looking at them, determine what percentage of them -
DR. HAEGERT:
A. Yes.

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COFFEY, Q.C.:
Q. - had nuclei staining?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. And make your--and give your estimate?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Do you recall whether there was any discussion about--amongst the pathologists in St. John's anyway, that you're aware of, about whether or not that could be problematic, potentially problematic?
DR. HAEGERT:
A. Well, we were well aware that staining could be strong or weak. I mean, are you talking about the percentages or the intensity of the stain?
COFFEY, Q.C.:
Q. Percentages first.
DR. HAEGERT:
A. No, I mean, we didn't actually discuss this, but any pathologist would know the difference between five percent and ten percent is

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somewhat subjective. You know, I mean, anybody could tell the difference between five and 100, but you know, percentages is actually, is often a subjective matter and if you're dealing with weak staining, of course, it's more, even more subjective.
COFFEY, Q.C.:
Q. And you're aware though, you indicated, that there could be weak staining, weak intensity, I take it?
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. In terms of vividness or lack of it?
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. And stronger staining?
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. And that was discussed at these, in these meetings talking about ER/PR?
DR. HAEGERT:
A. Well, I would think it would have been. I

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mean, it's 11 years ago. I know we discussed ER/PR staining in some detail.
COFFEY, Q.C.:
Q. That was in -
DR. HAEGERT:
A. It certainly was part of the reporting that, you know, we reported positive and then we reported whether there was strong or weak. So it's hard to imagine that it wasn't discussed.
COFFEY, Q.C.:
Q. Here the idea is referred to here of Dr. Khalifa providing a number of cases, examples, I take it, to the Grace Hospital.
DR. HAEGERT:
A. Right.
COFFEY, Q.C.:
Q. Do you recall whether or not that was done at the General? How was it handled at the General, do you recall?
DR. HAEGERT:
A. I think at the General Hospital, we sat around a scope, if I remember rightly, and what we did is we looked at them and we looked at, you know, different--we looked at positive controls and, you know, what a negative

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control would look like, and basically that would be the major approach that was used there.
COFFEY, Q.C.:
Q. And who would have been doing the explaining?
DR. HAEGERT:
A. Dr. Khalifa.
COFFEY, Q.C.:
Q. Okay. The idea of or the discussion around the introduction of ER/PR in St. John's, I take it that, from what you've told us, that it was openly discussed and often discussed at the General Hospital?
DR. HAEGERT:
A. It was discussed, yeah, it was.
COFFEY, Q.C.:
Q. How about at the General and--I'm sorry, at St. Clare's and the Grace, was it your understanding that it was discussed there as well, amongst the pathologists?
DR. HAEGERT:
A. Well, yeah, it was clear that it was, because I mean, Dr. Cook was bringing back opinion of his pathologists at that site and so was Dr. Parai. I mean, it was absolutely clear that

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they discussed it among themselves and that the pathologists wanted to report their own.

COFFEY, Q.C.:

Q. Other than looking at representative slides and Dr. Khalifa at the General introducing you to it, was there any other educational effort made that you recall concerning this, like articles dealing with it, publications?

DR. HAEGERT:

A. No, I think Dr. Khalifa had appended some references at the bottom of one of his recommended reports.

COFFEY, Q.C.:

Q. But other than that?

DR. HAEGERT:

A. No.

COFFEY, Q.C.:

Q. The idea, for example, looking at kind of colour pictures as it were or discussion in a journal?

DR. HAEGERT:

A. No, I don't remember this.

COFFEY, Q.C.:

Q. I'm not suggesting there was, I'm just asking.

DR. HAEGERT:

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A. No, I don't remember.

COFFEY, Q.C.:

Q. Exhibit P-2411. This is a memorandum of August 21st, 1997 from Dr. Khalifa to a number of doctors, including yourself. It says "initiating ER/PR immunostaining of in-house cases. This is a reminder that the initiation of ER/PR immunostaining of our in-house cases remains the responsibility of the pathologist who first makes the diagnosis of invasive mammary malignancy and on the respective specimen. As you already know, this is done by filling in a request form and submitting it to our laboratory. Although currently ER/PR slides come to me for reporting, the procedure has to be initiated by the primary pathologist, since I have no access to the case in question at the time that a diagnosis is being made."

Doctor, then how did this aspect of the matter then roll itself out over time, in terms of ordering of ER/PR? Because before this, you had been involved as a pathologist.

DR. HAEGERT:

A. Correct.

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COFFEY, Q.C.:

Q. So here, what was being asked of yourself and your colleagues?

DR. HAEGERT:

A. It was basically a matter of the pathologist really remembering that this is a routine activity when you get a diagnosis of breast cancer, that you would initiate this.

COFFEY, Q.C.:

Q. Look, please, at Exhibit P-1859? Now Doctor, this site chiefs divisional managers meeting of October 8th, 1997. Yourself and a number of other physicians and others are present. Under new business, it notes "Dr. Khalifa presented results of an audit of steroid receptors of 19 breast cancer cases correlating immunohistochemistry and biochemical assays." The typed version says Dr. D. Cook. It turns out it was Dr. Parai, it's handwritten there, "recommended the Health Care Corporation continue performing the IHC tests and encourage doing them on endometrial carcinomas. He also mentioned that Dr. Thain in the Cancer Clinic still prefers to see the biochemical assay done.

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Standardization of reporting the results of IHC assay also seems to be a problem. Dr. Khalifa was asked to call upon other Canadian medical centres, Toronto General, to inquire about their protocols." He's actioned with it. "He was also asked to seek feedback from the Cancer Clinic staff," and he's actioned with that.

So Doctor, this audit of steroid receptors that's referred to here, the final-- and Dr. Khalifa has referred the Commissioner to the audit and gone through it. The final decision then to actually, later on, the final decision to implement this method, whose responsibility ultimately was that?

DR. HAEGERT:

A. Well, ultimately, it's mine, but what we did -

COFFEY, Q.C.:

Q. As the clinical chief?

DR. HAEGERT:

A. As the clinical chief, that would be mine, but what we did is we discussed it at, you know, the site chiefs meetings. I mean, what I'd look for was a consensus of agreement, but really the final responsibility was mine.

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COFFEY, Q.C.:
Q. And in terms of consensus of agreement, by the time it was implemented, was there a consensus of agreement?
DR. HAEGERT:
A. Oh yes, yes.
COFFEY, Q.C.:
Q. If there were any reservations, do you recall who they were by and what the nature of them was?
DR. HAEGERT:
A. Well, I think it alludes to some of that in here, the standardization of reporting. The reservations were what was the cut off, how we should report, and I think that was eventually what Dr. Khalifa came up with is a document which more or less addressed the concerns of everyone.
COFFEY, Q.C.:
Q. On that regard, Doctor, because I take it these reports are going on to Meditech or dictated onto Meditech, signed out on Meditech?
DR. HAEGERT:
A. Right, right.

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COFFEY, Q.C.:
Q. But they're intended, ultimately, for oncologists?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Were the oncologists, do you recall, consulted at that time about this whole idea of standardized reporting?
DR. HAEGERT:
A. Well, they must have been because, I mean, Dr. Thain was a clinical oncologist.
COFFEY, Q.C.:
Q. And there's a reference -
DR. HAEGERT:
A. Indeed, it's clear that he was, at least he was consulted and no doubt others were. I mean, it's hard to imagine that Dr. Khalifa wouldn't have discussed this. I think it's almost buried within that, the concept that they were consulted.
COFFEY, Q.C.:
Q. And because I take it they are the ones who ultimately would use the ER/PR status -
DR. HAEGERT:

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A. Exactly.
COFFEY, Q.C.:
Q. It's for their benefit and the patients' benefit. Exhibit P-0241--I'm sorry, P-1860. Doctor, these are the minutes of a site chiefs, divisional managers meeting of December 16th, 1997. Again, you're present along with others. And there's a reference to the amendment of the first paragraph of the minutes we just looked at. And then here at paragraph 1, business arising, "Laboratory utilization in anatomic pathology. Dr. Cook was the division representative in the laboratory utilization committee. A meeting of this committee took place where the following topics were discussed." And the fourth bullet there is "Whether we completely switch to immunoperoxidase assessment as steroid receptors on paraffin sections." I take it this is, there was a discussion at some point which would involved amongst other--certainly it would have involved ER/PR switching -
DR. HAEGERT:
A. Well, steroid receptors, that's the same.

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COFFEY, Q.C.:
Q. Yes, same thing.
DR. HAEGERT:
A. Basically the same.
COFFEY, Q.C.:
Q. And in the second paragraph here there's a reference to turn-around time at St. Clare's site and concerns being expressed about it. Midway through that there's a sentence, "Mr. Murphy acknowledged the problem and suggested the low number of histotechnologists as being its ideology." Do you recall what that was about in terms of complaints about low numbers or concerns about low numbers of histotechnologists?
DR. HAEGERT:
A. Well, this was actually discussed in great detail as to why there was an issue at St. Clare's, because we became aware, I mean, as clinical chief, that there was often delays in generation of slides from cases. One of the views was that it was the number of technologists. The alternative view was that, in fact, it was the number of technologists, but that it was the way they did their--the

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way the technologists dealt with the tissue blocks and that, in fact, it was--so one of the things that was discussed was whether it was more efficient at the General Hospital than, say, at St. Clare's and that whether the--and if that was correct, how does one address that. And it was a bit interesting because Murphy, Mr. Murphy was in charge at St. Clare's and the Grace for anatomic pathology, Terry Gulliver was in charge at the Janeway and the General Hospital, as I mentioned, and what I was told basically at the various meetings was that the way they handled the blocks when they came off the machine was different a the two sites. Mr. Gulliver's argument was that it was actually, he thought it was more efficient at the General Hospital and he thought the St. Clare's should change the way they did things. And so there was some discussion of this and there was discussion of whether techs should go from the General Hospital to St. Clare's or techs should come from St. Clare's to the General Hospital. And the obviously idea would be that there would be uniformity of

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handling of the blocks at the different sites.

COFFEY, Q.C.:

Q. We have heard references here to the idea of tissue, of reprocessing.

DR. HAEGERT:

A. Right.

COFFEY, Q.C.:

Q. Were you aware, we understand that there was a certain amount of tissue reprocessing going on at St. Clare's.

DR. HAEGERT:

A. Right.

COFFEY, Q.C.:

Q. Around this time frame and afterward. Were you aware that that was so and if so, you know, in what context?

DR. HAEGERT:

A. Well, it's interesting you raise this, because, I mean, I've been trying to follow what's going on at the Commission. Of course, I haven't read everything. And to be honest, I don't think I was aware of this, at least I didn't remember this as an issue. And I was somewhat surprised, in fact, to read about this or to have, see people's testimony that

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this wasn't rare. I don't know if I was aware of this at the time.

COFFEY, Q.C.:

Q. At the General Hospital itself were you aware of tissue reprocessing going on?

DR. HAEGERT:

A. No. That would have been a rare event, if ever.

COFFEY, Q.C.:

Q. Here, Doctor, paragraph 3 reads, "Steroid receptors assessment in paraffin sections, Dr. Khalifa discussed this issue further and suggested the pathologists start reporting their own cases. A suggestion was made that Dr. Khalifa write up a proposal with the criteria, the cut off values, distribute it to the various pathologists and ask them for their feedback." So I take it that sort of approach would be consistent with the idea of building a consensus amongst the -

DR. HAEGERT:

A. Well, yeah, I mean, I think -

COFFEY, Q.C.:

Q. If possible?

DR. HAEGERT:

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A. - what we realized is that if you don't have a consensus, people just do whatever they feel like. So what basically--unless you monitor very carefully what they're doing. So that the idea really was that people would try to do--if they generated a report, it would be the same across sites and between pathologists.

COFFEY, Q.C.:

Q. Now, was there at that time any criteria for how a pathologist was, for example, the format a pathologist's report should take, any particular stipulations as to how any pathology report was to look and what should or shouldn't be contained in it or must or must--must be contained in it? I'm just talking generally.

DR. HAEGERT:

A. Yeah, again, that's an interesting question. Because initially, of course, I was at the General Hospital and wasn't really familiar with what they did at St. Clare's or the Grace. But then what happened is when Dr.--one of the initiatives that Dr. Khalifa did, and this is actually is becoming sort of

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common practice in North America, is to introduce what's called cancer checklists. Basically what that means is that if, for example, you have a cancer of the breast, what--the oncologists look for certain things. And so if it's left up to the individual pathologist, the pathologist reports certain things but leaves out other things, not intentionally, but by accident. So what Dr. Khalifa did was introduced a variety of checklists which were then used across sites. And actually, I believe he also shared them with the pathologists outside the Health Care Corporation. So that what you--so that basically what you would end up with is a standardized report in pathology which would be more or less uniform between pathologists and which would capture all the information that pathologists--or actually, that the oncologists or the surgeons or people treating the patients want.

COFFEY, Q.C.:

Q. So in him introducing it, I take it then that there was--before he did that, that didn't exist at the General or elsewhere?

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DR. HAEGERT:

A. No, it wasn't a standardized reporting format, no.

COFFEY, Q.C.:

Q. Exhibit P-2416, please? Doctor, this is again minutes of a meeting of site chiefs, divisional managers, anatomical pathology, January 8th, '98. And you're present, along with others. Under "Breast Receptors Immunoperoxidase Technique" as it reads, "It is agreed there's no longer a need for evaluation of the breast receptors by the bioassay technique. It was also agreed that in regards to reporting of breast receptors via the immunoperoxidase technique, that individual pathologists could report these results. It agreed that the estrogen and progesterone stains will be recorded as negative or positive with percentage of positivity given. It is also agreed that a rider will be given with the report, the exact wording of which is to be developed by Dr. Khalifa." So I wanted to ask you about this, Doctor. It states here, "It is agreed" and then it repeats, says "it was also agreed."

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"It is agreed," "it is also agreed," okay. In this context here in terms of it is agreed, would individual pathologists then be bound by the agreement? I mean, I'm trying to get some sense for the Commissioner in your capacity as clinical chief at the time, your view of if the site chiefs and divisional managers agree on something -

MR. BROWNE:

Q. There seems to a legal aspect to the question.

COFFEY, Q.C.:

Q. Oh, I'm certainly not--and I appreciate that. I'm certainly not--I apologize, go ahead, Mr. Browne.

MR. BROWNE:

Q. No, no, I just--the import of the question may lead to a number of different interpretations. I want to be clear that there's no sense -

THE COMMISSIONER:

Q. I'm taking Mr. Coffey to ask whether or not in his official capacity he would expect those who were reporting to him to conform with this or allow some deviation from the form.

COFFEY, Q.C.:

Q. Yeah. And I appreciate that, Commissioner,

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that's -

THE COMMISSIONER:

Q. Well, assuming the answer is yes, a very simple question.

COFFEY, Q.C.:

Q. Okay, good. So as a clinical chief, you would expect then that, look, if we've agreed on this as a group that you'd be surprised to learn someone else afterward, if they were aware of the agreement and the understanding that they weren't abiding by it?

DR. HAEGERT:

A. I would expect that people would follow it, yes.

COFFEY, Q.C.:

Q. Doctor, here the reference to reported, I'm sorry, "recorded as negative or positive with percentage of positivity given." Now, we have seen here a number of instances of pathology reports where ER/PR is said to be positive or negative and there's no percentage anywhere on the report, other cases where there is a percentage given. In your days at clinical--time as clinical chief, was there ever any kind of review undertaken in that regard to

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see if people were actually giving percentages?
DR. HAEGERT:
A. Good question. There probably wouldn't, I don't think there was.
COFFEY, Q.C.:
Q. Okay. Did you ever get any complaints from oncologists about that or expressions of concern from oncologists about the lack of a percentage being given?
DR. HAEGERT:
A. If there were complaints, they were not addressed to me. Maybe they went to Dr. Khalifa when--the site chief or Dr. Parai.
COFFEY, Q.C.:
Q. I'm not saying -
DR. HAEGERT:
A. No, they didn't address them to me.
COFFEY, Q.C.:
Q. I'm not suggesting that there were any, I just want to ask you that.
DR. HAEGERT:
A. No, I never got any.
COFFEY, Q.C.:
Q. The idea being if you reported or--you don't

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recall anyone ever coming to you and saying, well, look, Dr. X reported ER as positive and an oncologist saying, well, what is positive, you know, in the sense of what do you mean by it?
DR. HAEGERT:
A. Yeah, I think it would depend--I mean, I'm not sure what you're referring to exactly but it depends if this rider was attached, because if that rider that Dr. Khalifa created was attached, that would have clarified what it meant by positive versus negative.
COFFEY, Q.C.:
Q. Sure.
DR. HAEGERT:
A. But I didn't actually see these individual examples so it's hard for me to comment, really.
COFFEY, Q.C.:
Q. Exhibit P-1861, please? Doctor, again, these are--page 2 of it here, minutes of a meeting of site chiefs, divisional managers, anatomical pathology, February 12th, '98 and you were present. And paragraph 3.2 notes ER/PR, and PR reporting and they're going to

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discontinue the biochemical ER and PR assays of March 1, 1998. Give you some sense of it. It's anticipated that's going to happen. Here, Doctor, paragraph 4.3 under "New Business" "Storage policy of blocks/slides, intraoperative report, weight of mastectomy specimens and automated immunoperoxidase stainer." Okay. And it says it's discussed briefly. Now, we've heard reference to here what's referred to as a DAKO autostainer.
DR. HAEGERT:
A. Um-hm.
COFFEY, Q.C.:
Q. Were you involved in the obtaining of the DAKO autostainer? Again, the leasing of it or the purchase of it?
DR. HAEGERT:
A. Could we just go back up to the top?
COFFEY, Q.C.:
Q. Sure, certainly.
DR. HAEGERT:
A. Just to see who was at this meeting?
COFFEY, Q.C.:
Q. Yes, I certainly can, Doctor. It's Drs., it's February 12, it's yourself -

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DR. HAEGERT:
A. Yeah, I see. No, that's what I wanted to see because--no. Now, I actually don't remember the details of this meeting, but the issue--I wasn't actually involved in this. We may have discussed an automated immunostainer, but I don't think we would have discussed the DAKO instrument. And the reason I can't believe that we did -
COFFEY, Q.C.:
Q. I'm not suggesting you did, I'm just -
DR. HAEGERT:
A. No, but I don't think we could have because if that was discussed, because we'd had an issue with it at the Montreal General Hospital. Not me but the head of the department had purchased a DAKO immunostainer, now, maybe it was an older model, but there were certain issues with it, there was some problem with the antibody binding onto the slides and I was well aware of that. And if we discussed it in any substantial way at that meeting, other than saying we're thinking about getting an automated immunostainer, that would have triggered it right away that the fact that,

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you know, somewhere around 1990 or wherever it was that there was an issue -

COFFEY, Q.C.:

Q. In the institution where you had -

DR. HAEGERT:

A. Yeah, where I was before, in Montreal General Hospital. I mean, I was well aware of that.

COFFEY, Q.C.:

Q. And so your recollection would be that--well, by 1997, 1998 were you aware that they had a DAKO autostainer in the General?

DR. HAEGERT:

A. Yeah, sometime in 1998 because I knew that there was--in fact, there was some issue with some aspect of it and I made some comments to Mr. Gulliver about it and I told him about, in fact, what the issue was at the General Hospital in Montreal many years before.

COFFEY, Q.C.:

Q. Doctor, were you asked whether or not it was a good idea to get it and to utilize it in terms of were you asked as the clinical chief, should we get this or not, do you recall?

DR. HAEGERT:

A. I mean, it's difficult to know what the

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context of--I mean, one could talk about the advantages of an automated immunostainer, I mean, if that's what you're asking me. But I don't know if that's what you're asking me.

COFFEY, Q.C.:

Q. Well, no, in terms of do you recall--you don't recall actually being asked as the clinical chief is this a good idea?

DR. HAEGERT:

A. No, I don't remember that.

COFFEY, Q.C.:

Q. Okay.

DR. HAEGERT:

A. I mean, obviously we discussed it at that particular meeting, but it was probably a broad, generic discussion.

COFFEY, Q.C.:

Q. The responsibility for whether or not such an autostainer was acquired and utilized, whose responsibility in the lab would that be? Would that be the clinical chief's or would it be the manager's?

DR. HAEGERT:

A. Well, the automated immunostainer would be used for immunohistochemistry in the

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laboratory, so it would be a recommendation of Mr. Gulliver to the program director and then he would have to find money from the Health Care Corporation. But, I mean, it, the meeting is odd because it doesn't really give much information as to the tenor of the discussion. In fact, it doesn't say anything -

COFFEY, Q.C.:

Q. It doesn't, it just -

DR. HAEGERT:

A. - really, it just says it was discussed, but what was discussed, I can't say.

COFFEY, Q.C.:

Q. In any case, it did end up there?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Do you recall during your time as clinical chief whether you became aware of any problems with that particular autostainer?

DR. HAEGERT:

A. Well, it was mentioned that--in fact, I was walking down the corridor one day, and I remember this because--well, I remember we

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were walking down the corridor and I think Terry Gulliver was there with a couple of the managers--not a couple of managers, but the two techs that were involved in immunohistochemistry and I just sort of said, you know, talking, you know, what was going on, and one of them said, well, there's some problem with the Dako immunostainer. Then I mentioned what the issue was at the Montreal General Hospital. Then the manager said, oh, that's not the issue, and basically I think he was more or less saying, well, look, it's our issue, we'll solve this.

COFFEY, Q.C.:

Q. And that's what I was going to ask you, after that conversation, were you involved any further in that?

DR. HAEGERT:

A. No.

COFFEY, Q.C.:

Q. Any other concerns about the autostainer during your time as clinical chief brought to your attention?

DR. HAEGERT:

A. No.

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COFFEY, Q.C.:

Q. The issue at the time, do you remember what it was or did they tell you?

DR. HAEGERT:

A. I beg your pardon?

COFFEY, Q.C.:

Q. The issue at the time that you were speaking to them about?

DR. HAEGERT:

A. Oh, they told me there was some problem of-- I think they said it was something to do with antibodies getting on the slides, or something to do with the staining, and I mentioned the fact that or my observation--well, actually, it wasn't even my observation, but what the head of the department had said there was a problem in Montreal, which I assume is fixed in Montreal.

COFFEY, Q.C.:

Q. And how about fixed locally, did you assume it was fixed?

DR. HAEGERT:

A. Well, it would think it would be logical that it was since they continued to use it. I mean, it's hard to imagine they would have

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continued to use it.

COFFEY, Q.C.:

Q. Do you recall when this would have been?

DR. HAEGERT:

A. It was some time shortly after they acquired the immunostainer. I think that was actually the first time that I was aware they had purchased this Dako immunostainer. I didn't really realize that that particular instrument was on the horizon.

COFFEY, Q.C.:

Q. Exhibit P-1862, please. Doctor, again this is a memorandum advising of a meeting and the second page of the exhibit is the same thing, except this one has amended agenda items. I believe there's automatic slide stainer being added to the agenda, and the first item, though, is a follow up on ER/PR reporting, and then on the third page of the exhibit, these are the minutes of the meeting of March 19th, 1998, site chiefs, divisional managers, and you were present. See that? There's an amendment to a paragraph in the previous meeting's minutes, and then under business arising, "Dr. Khalifa updated the committee

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about the current stage of ER/PR reporting by the requesting pathologists. The transition was going smooth. Dr. Cook made very positive remarks about the role played by Dr. Khalifa", and then paragraph three, "Dr. Khalifa suggested that a system be put in place for members of the committee to study requests submitted from various staff members for the addition of new antibodies to our existing panel", and they go on then to talk about that. Conclude by saying, "Final decisions have to be made jointly by members of the committee". This, I take it, is the process that eventually evolved in terms of adding stains that you referred to earlier?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Doctor, during--if we could, please, bring up Exhibit P-2414. I apologize, go to the final version, P-1850, please. Doctor, this is a memo of February 16, 1998, from Dr. Khalifa to all Newfoundland pathologists, reporting of estrogen/progesteronereceptor immunohistochemical results. Now, Doctor, up

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to this point in the documents we've been looking at in terms of dealing with ER/PR, there are references to St. Clare's, the Grace, the General, the site chiefs and so on from those areas, but not pathologists outside St. John's. Do you recall whether or not there was any interaction with pathologists outside St. John's as to whether or not they wanted to get involved in reporting ER/PR?

DR. HAEGERT:

A. I think there were discussions with--Dr. Khalifa, I believe, discussed it and contacted the pathologists at various sites, but I wasn't involved in this.

COFFEY, Q.C.:

Q. Okay.

DR. HAEGERT:

A. He was the lead person here, so it seemed reasonable that he would do this.

COFFEY, Q.C.:

Q. The first paragraph, he concludes here by saying, "This technique", which is the ER/PR IHC technique, "although has its own limitations, has proven to be more practical and cost effective than the traditional

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biochemical detection methods". At that time, your understanding of its limitations was what?

DR. HAEGERT:

A. I'm just thinking --

COFFEY, Q.C.:

Q. Yes.

DR. HAEGERT:

A. I mean, one potential limitation is the issue of referral material in from outside. Then the question arises as to adequacy of fixation, timeliness of getting--timeliness of getting the results back to the individual labs, and I know there was also an issue of controls because then the question is whether--the main emphasis was an external controls question and is do we run external controls for each of the outside sites, and do we send them back to them or do we do the external controls in-house and review them in-house.

COFFEY, Q.C.:

Q. Now here in the second paragraph, he says, "The Health Care Corporation has been employing this technology for over a year. Recent audits correlating IHC with biochemical

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results in selected specimens where both techniques have been run in parallel have shown high accuracy of the introduced IHC detection. Results of these audits have been discussed in several meetings and are available for review". Now, Doctor, in terms of the actual decision then to be satisfied that the audits correlating IHC with biochemical results, as the clinical chief at the time, were you satisfied that sufficient correlation had gone on?

DR. HAEGERT:

A. Yes. Well, let me respond to that. See at the time the thinking was the biochemical method was the gold standard, and so basically what Dr. Khalifa did was actually compare the immunohistochemical results that he got with the biochemical results. I mean, I would think actually in some places they probably just introduced immunohistochemistry without doing any correlation at all. So I think--I mean, I was satisfied that, in fact, the results were highly concordant, very, very similar, and since we were using that as the gold standard, it seemed quite reasonable, and

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also we know very well that outside of St. John's in many institutions they had already introduced immunohistochemistry and were satisfied with it, but we were using the--as I mentioned, the biochemical method is a gold standard.

COFFEY, Q.C.:

Q. And I appreciate that, but in terms of the sample size, because we've seen references--seen a reference earlier to 19 cases.

DR. HAEGERT:

A. Uh-hm.

COFFEY, Q.C.:

Q. And if we look here in this particular exhibit, page four of it, we'll see a document, immunohistochemical staining of steroid receptors, correlation with biochemistry, a report of our experience over a nine month period, January '97 to September '97. It's by Drs. Khalifa and C. Pugh, and again there's a number of cases listed here.

DR. HAEGERT:

A. Uh-hm.

COFFEY, Q.C.:

Q. I believe, if I recall correctly, there are

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around 19 or so. So at the time, did you think this was a large enough sample? Yourself, were you satisfied at the time?

DR. HAEGERT:

A. I think it was large enough in view of the fact, first of all, that outside in probably many institutions, they didn't do any comparison whatsoever, and what we were trying to do was really the correlation. We were actually trying to see whether there were similarities or very, very similar results, which there seemed to be. I thought actually 19 seemed like a reasonable number.

COFFEY, Q.C.:

Q. Was there, Doctor, at the time to your knowledge any accepted approach to how this should be done, the introduction of ER/PR IHC into a particular institution? As a Canadian pathologist at the time, was there any accepted way one would go about this?

DR. HAEGERT:

A. In Canada--there are no guidelines in Canada for doing this at all. It seemed reasonable to compare it with the gold standard. If we thought the gold standard was something else,

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we would have done something else.

COFFEY, Q.C.:

Q. The idea of perhaps comparing the results in St. John's, the ER/PR IHC results in that first year to ER/PR IHC results at another laboratory that was already established and doing it, was that discussed?

DR. HAEGERT:

A. No, no, because as I mentioned--well, I already said a couple of times that we thought that the biochemical method was the gold standard and what would be appropriate results would be basically concordance with the biochemical method.

THE COMMISSIONER:

Q. Mr. Coffey, when you find a convenient spot to break.

COFFEY, Q.C.:

Q. Yes. Now here Dr. Khalifa has indicated that --at the bottom of the first page he says, "Phase 1", which he's gone through, introductory phase, and then he says we're going to go on to Phase 2 and 3. He describes Phase 2 at the top of the second page of his memo, "Each pathologist will be asked to

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report results of his or her own cases as indicated by the brown staining of nuclei of the invasive neoplastic cells", and he says that will start March 1, 1998, and he describes how that will be done. Now he does say, "With each run, I", and that will be Dr. Khalifa, "will still be responsible for reviewing the positive controls here in our laboratory and the slides will not be mailed to you unless adequate staining is noted in the positive controls", and he says he will be more than glad to continue being available to answer any questions and address concerns. So, Doctor, at that time, I take it positive controls in your mind would have been external controls?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. And as the clinical chief then, is it your understanding that Dr. Khalifa was taking this upon himself in terms of before slides left the General, the ER/PR slides left the General Hospital, that he would examine the external controls and be satisfied that they had

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stained appropriately for that batch or run?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. Now, Doctor, at the time as clinical chief, did you think of that as Dr. Khalifa as Dr. Khalifa, or Dr. Khalifa as the site chief, or was it addressed at the time?

DR. HAEGERT:

A. Well, I would think probably dual because, I mean, somebody obviously had to look at them if we're going to send out controls - if we're not going to send out controls. Therefore, the logical person to do this would be the site chief. So it was really more of a site chief issue than a Dr. Khalifa issue, but, of course, it happened that he developed the methodology together with the text, so that it was ideal.

COFFEY, Q.C.:

Q. And he then refers to a proposal for uniform reporting, and when we look at--he then concludes on this page by saying, "There's a considerable host of publications addressing this issue", and he'd be glad to share the

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material. Did you ever see any such material?
DR. HAEGERT:
A. No, I never reviewed any.
COFFEY, Q.C.:
Q. I take it, though, that if you had asked, you would have expected he'd provide it?
DR. HAEGERT:
A. Yes, of course.
COFFEY, Q.C.:
Q. And then here on the third page, Doctor, the proposal for uniform reporting of ER/PR immunohistochemical assessment, February, 1998, he talks about having three components, that rider or comment at the end, is located in paragraph three here. Now your approach yourself was to do what, did you adopt this?
DR. HAEGERT:
A. Yes, I believe I did. I didn't see very many cases, but I saw some.
COFFEY, Q.C.:
Q. And in terms of at least the cases that you reported, you don't ever recall receiving any complaints from oncologists or questions from oncologists about what it meant, ER/PR results?

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DR. HAEGERT:
A. No, I don't recall.
COFFEY, Q.C.:
Q. Or it being brought to your attention at all?
DR. HAEGERT:
A. No.
COFFEY, Q.C.:
Q. Commissioner, after lunch then.
THE COMMISSIONER:
Q. All right then. We'll break and meet again at five after two.
(ADJOURNED FOR LUNCH)
COFFEY, Q.C.:
Q. If we could look, please, at Exhibit 2535. Doctor, these are minutes of site chief's meeting of April 22nd, 1998. At paragraph "F" on the second page under "business arising", estrogen/receptors, "Dr. Cook wondered about the rider in the case where estrogen receptor stain less than 30 percent of the cells. Dr. Khalifa informed him of this rider is a recommendation only and is not part of the formal policy regarding the reporting of breast receptors". So, Doctor, at the time as the clinical chief what, if anything, was your

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involvement in this aspect of the matter?
DR. HAEGERT:
A. Well, we discussed this extensively as to whether this was appropriate to put this rider in, not appropriate to put the rider in. Finally the decision was made to put it in as an option.
COFFEY, Q.C.:
Q. So that some pathologists would have been utilizing it and some not?
DR. HAEGERT:
A. That's correct.
COFFEY, Q.C.:
Q. Depending upon their own judgment.
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Do you recall whether or not the oncologists were consulted about that at the time, to your knowledge, anyway?
DR. HAEGERT:
A. I would say probably not. I don't remember them being consulted. I would say they probably weren't.
COFFEY, Q.C.:

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Q. Exhibit P-2417, please. Doctor, this is a memorandum of November 10, 1998, advising of a meeting and on the agenda, though, number three, ER/PR immunohistochemistry requests. If we could look, please, at Exhibit 2418. This is the minutes of a meeting of November 12, 1998, Division of Anatomic Pathology, General Hospital site. As it turns out, in fact, you're not noted to be present here at this particular meeting, but under business arising, flagging breast cancer cases, "Members of the committee agreed to receive a note from the secretaries with every breast cancer case as a reminder for the submission of an ER/PR request. This process will be triggered by dictating a microscopic description or diagnosis". So, Doctor, this is toward the end of 1998. I take it then, getting people to order the ER/PR test, at least in the early first year or two at times was--required some reminders?
DR. HAEGERT:
A. Yes, I think it wasn't--it wasn't a reflex. So if we have breast cancer, order ER/PR. This was one of the ways of actually getting

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people to do that.
COFFEY, Q.C.:
Q. Look, please, at Exhibit P-2536. Doctor, these are just some documents I'm going to take you through. Some of them touch upon things you've already told the Commissioner about earlier today, but they're documentary, they're documents that refer to reflect your comments. This is a laboratory medicine program annual report of 1997/1998. It's prepared February 28th, 1999, and the second page, the annual report for '97 to '98, there are certain divisions listed there, the first being anatomical pathology, and then in the overview, the second paragraph notes, "This past year many changes were attempted in the laboratory program. Many have gone 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". Then it concludes, "These changes were the result of restructuring and consolidation. Each division implemented

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procedures that were required to achieve an overall budget reduction of $700,000.00 from the previous year for the year ended March 31, '98. This target was not only achieved, but passed by $205,000.00. In addition, revenue was increased by $109,000.00", and it goes on from there. So, Doctor, would that be perhaps the $700,000.00 you referred to earlier?
DR. HAEGERT:
A. Yes.
THE COMMISSIONER:
Q. So you met your target after all, one way or another.
DR. HAEGERT:
A. Well, it would be pretty close.
COFFEY, Q.C.:
Q. $720,500.00 and $109,000.00. If you add them all up in terms of revenue --
DR. HAEGERT:
A. Oh, yes. The revenue, though, if I remember rightly, did not go to the department--did not go to laboratory medicine, it went into the Health Care Corporation. I'm pretty sure.
COFFEY, Q.C.:
Q. We heard references to that?

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THE COMMISSIONER:
Q. Another witness has said that.
COFFEY, Q.C.:
Q. Doctor, on the next page of the exhibit-- well, actually, page four of the exhibit, there's a diagram, laboratory program organizational chart, Health Care Corporation of St. John's, and you'll see your name here, clinical chief.
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. So just looking at this, does this at that time frame capture the existing relational structure within the clinical lab? Actually, I'm going to ask you to just kind of look through it briefly. Pathology, you'll note, is listed on each of the different sites, one from the General, St. Clare's, the Grace, and the Janeway. The Waterford Hospital wouldn't have pathology. Then they have reporting then from each of those sites to either Vern Whelan or yourself as the clinical chief?
DR. HAEGERT:
A. Right.

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COFFEY, Q.C.:
Q. And then Mr. Whelan at that time is shown to be reporting to Mr. Tilley, Senior Vice President, Corporate Affairs, and you report to Dr. Williams, VP Medical, and both Mr. Tilley and Dr. Williams report to Sister Elizabeth Davis.
DR. HAEGERT:
A. I think that's right, yes.
COFFEY, Q.C.:
Q. Doctor, here on the next page, activities and accomplishments, '97/'98, consolidation of testing, and it talks about--many bullets dealing with that. Other achievements not related to consolidation which have lead to improved quality and efficiency, and it lists a number, and then on the next page, page six of the exhibit, laboratory strategic directions, 1998 through 2001, I take it, would be a plan then for the three years, see that here. The third paragraph says, "Strategic directions are corporate-wide with implications for all sites. The directions are cognizant of the laboratory's role as the major referral centre for the province as well

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as its role with the medical school and other training institutions. The directions will be along the following guidelines; providing the highest quality of service possible with available resources, constantly seeking ways to be more efficient, reduce costs, and above all, improve quality". So I take it that this is kind of a general goal at the time, but I do note it says "with available resources", or "within available resources". At page eight of the exhibit, there's a particular thing there I want to ask you about. Under goal one, to provide a comprehensive quality service of the highest standards within available resources. Objectives, number three, improve quality of service, and under strategies on the right hand side, there's maintain adequate staffing levels, and you've referred to that and the challenge in pathology you were finding. Improved skill level of staff, implement latest technological procedures, participate in extensive internal and external quality control programs, provide a healthy work safe environment. Doctor, for pathologists at the time, '97, '98, '99, 2000, the latter part of

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your time as clinical chief, improving the skill level of the staff, you've referred to the idea of perhaps learning from each other.

DR. HAEGERT:

A. Uh-hm, yes.

COFFEY, Q.C.:

Q. And what if any opportunities were there for pathologists at the time to attend educational functions outside the Health Care Corporation?

DR. HAEGERT:

A. Well, the opportunities were large. People could elect to go to, like, the International Academy of Pathology. It had meetings every year, the North American Division. They would rotate from the big cities typically in the United States or a few of the big cities in Canada. There's also the Canadian Association of Pathologists meetings, and there's meetings in Europe and elsewhere.

COFFEY, Q.C.:

Q. How about funding for it?

DR. HAEGERT:

A. Yes, I thought a bit about that. My recollection is that there was a small amount of funding for those who had a primary

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university appointment, but for the hospital, there was--I think people had to pay for it out of their own pocket. There was no money that was identified from the hospital, as far as I remember.

COFFEY, Q.C.:

Q. And certainly if there was, it was a small amount, relatively small amount, if there was any?

DR. HAEGERT:

A. Well --

COFFEY, Q.C.:

Q. And you can't recall --

DR. HAEGERT:

A. It certainly doesn't--I don't remember there being any.

COFFEY, Q.C.:

Q. And in paragraph "D" here, "Participate in extensive internal and external quality control programs". For pathologists, anyway, do you know what--you've described--other than what you've described already for the commissioner, is there anything else that you can think of that would fall into the category of internal and external quality control

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programs that were available for pathologists?

DR. HAEGERT:

A. No, I don't think so.

COFFEY, Q.C.:

Q. Page 12, please. Doctor, here under quality care issues, see that there --

DR. HAEGERT:

A. Uh-hm.

COFFEY, Q.C.:

Q. "Areas where the leadership team has concerns are; reduced or frozen budgets", refers to limiting the amount of new services that can be offered. Off-site blood collection is referred to. It says, "Resources to research utilization trends and conduct education programs regarding appropriate laboratory utilization or best practice policies", I take it that this being listed here in these bullets, was this to suggest that the reduced or frozen budgets were having a negative effect on the resources available to research utilization trends?

DR. HAEGERT:

A. Yes, I think the point really is that if you're going to do this, you need dedicated

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personnel, either full time equivalent or close to a full time equivalent person, and the reality was we reduced the personnel extensively, so there were no such people.

COFFEY, Q.C.:

Q. And finally, there were increased demands on laboratory services. I take it that the sheer number of tests being done in the clinical laboratory of various forms were going up, the sheer numbers?

DR. HAEGERT:

A. Yes, I think this is--I would say that's all over North America that the demand for lab services and pathology services increase every year.

COFFEY, Q.C.:

Q. And --

DR. HAEGERT:

A. And in pathology, the complexity goes up every year.

COFFEY, Q.C.:

Q. Exhibit P-2425.

THE COMMISSIONER:

Q. Can we go back to page four, which I think is the--yes, the organizational chart. Doctor

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Haegert, I notice that just in terms of the program director and the clinical chief, I recognize that below that section, as it were, there are those within the system that report to one or the other of you, as I understand that.

DR. HAEGERT:

A. That's correct.

THE COMMISSIONER:

Q. Essentially, the technological side reported to Mr. Whelan, and the pathologists would have reported to you?

DR. HAEGERT:

A. And also the divisional chiefs. I mean, I think the problem with that organizational chart, it doesn't capture all of the complexity.

THE COMMISSIONER:

Q. That was my question because I note, for example, that the two don't come back together again until you get to Sister Elizabeth Davis. I'm wondering in terms of the point that you raised, is it that this particular chart doesn't really reflect what was going on on the ground or is this organizational--are

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there problems with that organizational structure that you identified when you were operating under it?

DR. HAEGERT:

A. Well --

THE COMMISSIONER:

Q. Or perhaps both?

DR. HAEGERT:

A. I mean, I think the way I would see the organization, I mean, even though that's correct, is that the technologists, for example, would all report through to Mr. Whelan.

THE COMMISSIONER:

Q. Yes.

DR. HAEGERT:

A. And then the divisional chiefs and the pathologists would report to me--through a site chief and then to me.

THE COMMISSIONER:

Q. Uh-hm.

DR. HAEGERT:

A. But, I mean, one becomes more aware of these things in retrospect, the issues about it. I mean, it's clear in retrospect that there were

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issues. This type of management structure, I think, is--in my personal view, is somewhat problematic, and the reason it's problematic is it works depending on who the people are in the structure. Like, for example, the program director and the clinical chief could work together or they could be really quite independent, and similarly if the divisional managers are reporting to the program director and really there's no interaction with the clinical chief or the site chief, for example, it creates difficulties. I mean, it really depends upon the individuals that are there. If the individuals there are kind of very supportive of a rigid structure, it's a problem. On the other hand, I mean, if you have a different type of relationship, the old fashioned sort of relationship which is also used in many places, and actually, I gather, is being changed in the Health Care Corporation--not the Health Care Corporation, Eastern Health Board, is that you have a more pyramidal structure so there's one person at the top of it and to whom everybody reports. Although it has its own issues, but it--at

least it doesn't really depend on the individuals within it.

THE COMMISSIONER:

Q. Okay. One of the other witnesses who has been here made a similar point, that is that while you will get people who will tell you that structure works very well in their institution, his view was that you shouldn't have a structure that depends on the personality of the individual involved or individuals involved. You need a structure that's going to deal with problems as they arise, whatever the personality of--the relationship --

DR. HAEGERT:

A. Well, when I was first here, I thought, well, this is fine, but it's clear that there are issues here, and, I mean, I can tell you that we have a similar structure where I am in Montreal and it actually works because the manager and I kind of--instead of saying, okay, this is my domain and this is your domain, and they are separate domains, we actually--we kind of interface and it sort of fuses, but it only--I mean, I don't know

what's going to work subsequent. Say the manager leaves and there's a new manager, is it going to work the same way because it could easily break down. I mean, I could tell you-- I don't know if you want me to tell you this, but I actually run the molecular pathology lab in Montreal, and in principle the technologists report to the manager, but the reality is the manager has no experience whatsoever in molecular biology, so in practice they report to me, but the organizational structure, if you look at it, they actually don't report to me. I'm really there as sort of a consultant/advisor, but, in fact, what they do whenever there's an issue, they talk to me. They don't talk to the manager because the manager has no knowledge.

THE COMMISSIONER:

Q. Okay, thank you, that's helpful. Mr. Coffey.

COFFEY, Q.C.:

Q. Thank you, Commissioner. Exhibit P-2425, please. Doctor, this is a letter from Dr. Khalifa, it's copied to yourself and Dr. Wadden. It's to Dr. Popadiuk, and it involves the GYN oncology pathology review, the

subject, and he notes--tells Dr. Popadiuk that he'll be leaving to go to Sunnybrook, relocating to Sunnybrook, and it says he discussed the status of the gynecologic oncology pathology case reviews after his departure, members of the group have been discussing it. This issue had to be considered in conjunction with other related topics such as manpower shortages and workload allocation in the discipline of pathology. The groups opinion was that until the department recruits a dedicated pathologist for oncology pathology reviews, it would be difficult to assign a staff member to review all gynecological oncology cases and it goes on, refer to Dr. Wadden being particularly interested in this, and "Dr. Haegert would also be interested in discussing with you the reasons for these reviews and whether you have particular concerns," and he thanks her for her assistance over the years. Doctor, and again, I don't want to get into the actual specifics of this particular gynecological oncology cases and that matter, but the idea here of--I take it Dr. Khalifa was providing a

service, some kind of a consultancy service, and I think you referred to that earlier.

DR. HAEGERT:

A. Correct.

COFFEY, Q.C.:

Q. And now, in his absence, or with his departure, would know--wouldn't be provided or he didn't anticipate that it would be provided because of manpower problems and resources. What I wanted to ask you about was this, is that is this an example of manpower problems, the effects that it has or can have and was having in St. John's?

DR. HAEGERT:

A. Yeah, I think one of the issues, I mean, we already talked about the referral cases to the Newfoundland Cancer Treatment Research Foundation, but Dr. Popadiuk was a gynecological surgeon with special expertise in oncology. So she was--I think she was bringing in patients from all over the province to her for management, and so what I would think is that there was a significant increase in the number of cases that were being referred in for management and it's

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normal practice when one gets material from-- or when a patient's referred, they kind of bring their pathology with them, so that it can be reviewed on site. The idea being that, you know, the Health Care Corporation was basically the referral centre. Now I'm not sure how many cases we're talking about or the level of difficulty, but I would have said that certainly we were--always we were talking--we had an issue about staff numbers and whether we had adequate staff. I would have said that we would have done our best within the Department to review these cases.

COFFEY, Q.C.:

Q. Now here it says "would be interested in discussing with you the reasons for these reviews." Now did you make any inquiries about the reasons for these reviews, and did they have anything to do with the output of the clinical laboratory?

DR. HAEGERT:

A. I think that's kind of -

COFFEY, Q.C.:

Q. I'm not suggesting that -

DR. HAEGERT:

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A. - a red herring really and not--I mean, I would have said the reasons for the reviews are fairly obvious.

COFFEY, Q.C.:

Q. Okay.

DR. HAEGERT:

A. Patients are referred. Therefore, you do the review. I mean, it's sort of normal practice. In fact, it is normal practice, not sort of normal practice. It's normal practice.

COFFEY, Q.C.:

Q. So it didn't have anything to do with the quality of what was being turned out involving the slides? I'm not suggesting it did, I just wanted to ask you about it, in terms of -

DR. HAEGERT:

A. Where? You mean outside?

COFFEY, Q.C.:

Q. No, within -

DR. HAEGERT:

A. No, these would be--I mean, my interpretation of this would be that what's happening is cases are referred from Gander, Corner Brook, wherever, to St. John's for treatment, say for ovarian cancer or some other kind of

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gynecologic malignancy.

COFFEY, Q.C.:

Q. If we could look, please, at Exhibit 2420? Doctor, this is a division of anatomic pathology, minutes of a meeting of April 20th, 1999, around the same time frame. Yourself and Dr. Khalifa and others attended. Here, Doctor, that referred in consult cases involving Dr. Popadiuk is referred to in paragraph three, but in paragraph four, there's a reference to "new site chief. A discussion took place around this topic with the intention of not trying to reach a decision, but rather voicing of opinions. Dr. Khalifa presented to members of the group a summary of chores he carried out during this serve period. He also presented some figures to summarize workload in various sites within the Health Care Corporation. A long discussion took place. Some of its highlights are summarized below." First bullet, "in Dr. Chittal's opinion, the best possible strategy was to combine the chair and site chief roles in one individual. Dr. Fernandez expressed her unwillingness to carry out the site chief

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responsibilities. Dr. Robb, along with other members, emphasized the importance of maintaining collegiality and avoiding conflicts within the discipline and Dr. Haegert pointed out some of the options, including rotating responsibilities among various staff, not having a site chief, assigning a staff member from the General Hospital site or assigning a staff member from another site within the Health Care Corporation."

Doctor, so I take it then this was an assessment or fresh assessment of the role of a site chief? That was being considered here, the idea of what a site chief might or might not do?

DR. HAEGERT:

A. Well, I think this is the time when Dr. Khalifa was leaving.

COFFEY, Q.C.:

Q. He was leaving, exactly.

DR. HAEGERT:

A. So what we were trying to decide is what the next option was.

COFFEY, Q.C.:

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Q. And there's a discussion here of possible options.
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. What happened?
DR. HAEGERT:
A. Well, this was approximately the time that the Grace Hospital was closing, so Dr. Parai moved over to the General Hospital and became site chief. Actually, I was being provocative there, just to see what people said. So I said these are the options. I don't think I was all that--being all that serious, to be perfectly honest.
COFFEY, Q.C.:
Q. Okay, at the time.
DR. HAEGERT:
A. No, I remember this, because I thought it was--I thought, well, these are the options, and somebody minuted it, and I thought oh well.
COFFEY, Q.C.:
Q. But in terms of at the time, from your perspective, as the clinical chief then, you anticipated really that particularly with the

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move from the Grace, the closing of the Grace and the reassignment of pathologists to St. Clare's and the General that there'd be just a new site chief would--if Dr. Khalifa left, and he was going now, that someone would replace him?
DR. HAEGERT:
A. Yes, that would be -
COFFEY, Q.C.:
Q. And the responsibilities would effectively continue on as they had been?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Okay, and that is what happened?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Exhibit P-1867? Doctor, this is a laboratory medicine program quality initiatives report of April 1st '99 to March 31, 2000 for the Health Care Corporation of St. John's. It's submitted by Mr. Whelan and Dr. Cook, and page three of the exhibit, it's entitled executive summary, the title is there, and then in the

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middle of the page, they note "Dr. Haegert, clinical chief, is on sabbatical and Dr. D. Cook was appointed clinical chief acting, July 1/99 to July 1, 2000." So that's while you were away in Montreal?
DR. HAEGERT:
A. Yes.
COFFEY, Q.C.:
Q. Here, Doctor, there's a note here, resignations then were received during the year from Dr. Prabhakaran.
DR. HAEGERT:
A. Prabhakaran, at least that's how I pronounce it. I always pronounced it, for ten years, like that. Hopefully, correct.
COFFEY, Q.C.:
Q. Yes, I think you are. And Dr. Khalifa's resignation is noted and Dr. McIntosh's, the chief of cytology. The replacements, Dr. Randell replaced the head, chief of biochemistry and Dr. Wadden was appointed site chief acting, anatomical pathology at the General Hospital until April 30th, 2000, and then Dr. S. Parai is the permanent site chief, anatomical pathology at the General Hospital,

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effective May 1, 2000. The chief of cytology is still vacant, and then they note "the division of anatomical pathology received resignations from six pathologists (approximately one-third of total pathologists manpower). All positions have been successfully filled." Okay. So Doctor, and I appreciate you were away some of this period, some of your sabbatical in the time period covered by this. You're on sabbatical some of it, but some of it you were there as clinical chief. Six pathologists being a third of the total at the Health Care Corporation, what effect, if any, did that have, that kind of turnover? As a clinical chief, looking at it from your perspective, what effect was that having?
DR. HAEGERT:
A. Well, I mean, in simplistic terms, it meant that, of course, we had to recruit and you know, advertise, set up a search committee, bring people in, interview them and recruit them on the one hand. Because that's one aspect of it, and the other aspect is the planning -

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COFFEY, Q.C.:
Q. And that would require time of yourself and the site chiefs who might be involved in doing it?
DR. HAEGERT:
A. Yeah, site chiefs and often we'd set up a committee and get one of the persons to chair the committee and then they'd bring people in. They'd be interviewed by people, interviewed at the committee, and then finally make a recommendation, and then the individual would, of course, have to apply and then would have to go through the Newfoundland Medical Board and whatever other processes were required, and they have to meet certain criteria to be accepted. That was part of it. The other part is it's difficult to make plans as to how we do things when, you know, the personnel were not stable.
COFFEY, Q.C.:
Q. Doctor, you have a third going in one year, in effect, because this only covers a year, this period. Had that happened before? Like that proportion in a year gone?
DR. HAEGERT:

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A. No, it seems unusually high.
COFFEY, Q.C.:
Q. Can you, now looking back on it, or at the time, or now reflecting upon it, can you attribute that kind of turnover, that particular year to any one thing?
DR. HAEGERT:
A. No, I mean, what it mentions here is Dr. Khalifa and Dr. McIntosh and Dr. Prabhakaran. I mean, I know Dr. Prabhakaran had been talking about it for a long time or thinking about it for quite some time, and then he finally decided to move. Dr. Khalifa, I mean, he just advised us. Dr. McIntosh, I knew was not happy there for personal reasons, and she wanted to move. I don't know who the other three people were. I mean, sometimes these things all happen at once, unfortunately. I mean, I can't say that there was anything in the structure or the reporting relationships or interpersonal factors that were really relevant, as far as I know, but I think around that time, there were one or two people who came, stayed about a year, and then left, and most of the time, people do not share their

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thinking about what they're doing. Some people just come, they get landed immigrant status and then they move on, and in fact, I would say at least one or two people did that around that time.
COFFEY, Q.C.:
Q. Page seven, please? There, Doctor, there's a reference to--there's a list of challenges and the first is noted to be "our greatest challenge was to bring the service together on two sites and contend with the challenges of bringing staff together. Second is to offer new procedures that are constantly being developed in the field of laboratory medicine within our existing human and financial resources." And in relation to that, Doctor, I take it, just to reiterate a point I canvassed with you earlier today, there was no written policy or procedure dealing with how new procedures in pathology any way, in terms of testing and so on, were to be instituted within the Health Care Corporation. There was no written structure.
DR. HAEGERT:
A. Within pathology, but normally, I mean, it was

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well recognized that if you wanted to do something new, either they would go directly to me or a site chief and then what we would do is bring it to the site chiefs meeting, including myself, and we would discuss it and try to reach a consensus and then I'd make a decision.
COFFEY, Q.C.:
Q. Doctor, did you ever have any occasion to inquire into how much, if any, written policies and procedures there were for technologists, either in the General Hospital or in the Health Care Corporation?
DR. HAEGERT:
A. Did I at the time?
COFFEY, Q.C.:
Q. Yes, while you were clinical chief.
DR. HAEGERT:
A. No, no.
COFFEY, Q.C.:
Q. From your perspective at the time, whose responsibility would it be to ensure that if there were to be such things, that they existed and that they were maintained?
DR. HAEGERT:

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A. Well, normally that would come from the manager.

COFFEY, Q.C.:

Q. For pathologists themselves, were there any such written policies or procedures, you know, governing their practice?

DR. HAEGERT:

A. The reality is, you know, pathologists are professionals. So one--in many ways, one expects a pathologist, as a professional, to know what would be the appropriate type of activity. So for example, if you're on call for the operating room, you would know that you would have to--I mean, we obviously would have discussed it. We have normal operating room coverage hours. I think there it was eight to five, in the morning, so you're expected to be there at 8:00, be there until 5:00 and be available, not downtown in the pub or some such thing. I mean, that would be sort of normal practice and then it would be also the expectations were that if you're on surgical pathology, for example, then you would be--it was your role to report the cases that would be arriving on the days that you're

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on call. I mean, everybody--this was common knowledge. It may not have been written down, but it was certainly everyone was well aware of it. I mean, no one could possibly have said "oh, I didn't know that."

COFFEY, Q.C.:

Q. So I take then though, Doctor, that though there were not actually any written policies or procedures for pathologists, as you pointed out, pathologists were -

DR. HAEGERT:

A. Well, I mean, it could have been, but I mean, it was common--most things were common knowledge.

COFFEY, Q.C.:

Q. Here, under the fifth last bullet, there's noted to be one of the challenges is maintaining staff morale. As the clinical chief, from your perspective, whose morale, if anyone, other than your own perhaps, did you have to or see it as your role and responsibility to try and maintain?

DR. HAEGERT:

A. Well, I would have said the morale of the people who reported to me. I think this was

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really referring to technologists' morale, because these are the ones who were most affected by the restructuring process. You know, if you change the reporting relationship, suddenly you close the person's laboratory. They have to move to another site. All of this is problematic, and you know, the culture changed. I mean, some of the pathologists had some difficulties with it, but primarily it was--that line is directed against the techs and not pathologists.

COFFEY, Q.C.:

Q. Doctor, in that regard, in terms of we've heard about concerns expressed by, at times by pathologists at St. Clare's about the future at the time and in the late '90s, the future of the lab at St. Clare's, and where it might be located, what it might be called upon to do and so on. What's your memory or recollection of that whole matter?

DR. HAEGERT:

A. Well, this was the kind of thing that was--we all discussed these issues, but we actually even had a retreat which brought together the

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managers and the site chiefs. I think those were the people there. Prior to the Grace closure, and one of the things we considered was what would be the best option to provide laboratory services. One option that was considered was to close all the labs, except the General Hospital laboratory. We actually decided, I mean, Vern Whelan and myself, we discussed it and Vern actually had a much better understanding of the technologists and the people, you know, most of the people than myself, because he actually was a technologist himself at one time and moved up through the ranks to become program director. We discussed this at some length and we felt that it would be such a cultural shock and huge blow to too many people if we actually said "okay, look the model we're going to come up with is a single site model." So we actually--so we didn't do that. We actually come up with a two-site model and there was still some unhappiness, for example, at the Grace.

COFFEY, Q.C.:

Q. And the advantages of a one-site model would have been what?

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DR. HAEGERT:
A. Well, it would have been--see, it's more, slightly more complicated than a one-site model because we could have had all the labs in one site, but the problem, one of the issues would be we wouldn't have had all the pathologists' offices at one site, because there's no space. So we would have had sort of a one-site model where all the--some of the pathologists were over at St. Clare's, and we thought--I mean, I don't know if we actually discussed that, but I mean, when we talk about it now, it's not logical really in some ways to do this, because I mean, also as long as surgery was going to be at St. Clare's, I mean, I think this is one of the things we picked up. As long as there was surgery or, you know, fine needle aspirates or biopsies at St. Clare's, it didn't make sense to close at least the pathology department. So finally, in 1999, what we came up with is a two-site model.
COFFEY, Q.C.:
Q. Here, Doctor, the bottom bullet here is "to facilitate lines of communication with

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laboratory physicians and laboratory technologists." See that?
DR. HAEGERT:
A. Yeah, I see that.
COFFEY, Q.C.:
Q. And this is listed under challenges. Now I'm going to ask you about the issue of communication between laboratory physicians and laboratory technologists. At times, were there concerns expressed about that, that were brought to your attention about any difficulties in communications, conflicting messages at times?
DR. HAEGERT:
A. Well, I think some of the managers felt that the communication should be really between the physician and the manager, not with the techs. But most pathologists spoke to the technologists as they felt it was appropriate. I mean, it wasn't abusive or anything, but it was more, you know, we're having some issue with this particular case or that particular case, and you know, the slides are poor quality. I mean, you know, it's always an issue. Regular staining, special stains,

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immunohistochemistry, from time to time, there were issues.
COFFEY, Q.C.:
Q. Exhibit P-2537. Doctor, this is a laboratory management committee meeting number 11, September 20th, 2000. These are the minutes. You're listed as present. Paragraph 10.5, "proficiency programs. Wait until Dr. Whitman returns." See that? Dr. Whitman is not present, as you can see, there's regrets, Dr. L. Whitman, and do you recall what Dr. Whitman's involvement in this issue of proficiency programs was? Again, on this point, perhaps I could bring up as well, or ask the Registrar to bring up 2538. That was September 20th, 2000, the one we just looked at. These are the minutes of the same committee's meeting of January 17th, 2001. You're present and regrets from, amongst others, Dr. Whitman, and we go to the second page of the exhibit, 10.5, proficiency programs, in this case "(Canada wide) Atlantic Canada, awaiting Dr. Whitman." Do you recall what this was about?
DR. HAEGERT:

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A. No, I think I'm still waiting. I'm not sure.
COFFEY, Q.C.:
Q. Okay.
DR. HAEGERT:
A. I don't remember.
COFFEY, Q.C.:
Q. You don't -
DR. HAEGERT:
A. If you give me a clue, probably it would come back to me, but I don't remember.
COFFEY, Q.C.:
Q. What sort of position was Dr. Whitman?
DR. HAEGERT:
A. She was divisional chief of hematology.
COFFEY, Q.C.:
Q. Hematology, okay.
DR. HAEGERT:
A. Laboratory hematology.
COFFEY, Q.C.:
Q. So it may have related to proficiency programs for hematology itself per se, as opposed to programs at large?
DR. HAEGERT:
A. I can't say. I really can't say.
COFFEY, Q.C.:

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Q. You can't recall, okay. Exhibit P-2399, please. Doctor, these are division of anatomical pathology, pathologists meeting. This is the notice of agenda, and when we look at the next page of the exhibit, these are the minutes themselves for February 21st, 2001, and there are a number of items discussed or noted to be discussed, but what I'd like to ask you about is item, paragraph 4.7, immunoperoxidase quality control. It reads "a survey has been undergoing" or has been ongoing, I presume, "for the quality control of immunoperoxidase staining. This will also be discussed in a site chiefs meeting to inform the pathologists of St. Clare's Hospital. A follow up will be given later on." Doctor, here, just to look back at this, you're noted to be present, as well as the other pathologists presumably at the General Hospital at the time, with the exception of Doctors Barron and M. Parai. Do you recall, Doctor, what this immunoperoxidase quality control matter was about?

DR. HAEGERT:

A. I think the--I'm pretty sure that the issue

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was whether on every run you put positive controls for every single antibody used. So if you're running a batch of ten different antibodies, do you put ten different controls or how often do you do the positive controls. I'd say that's the most probable explanation. I mean, it's -

COFFEY, Q.C.:

Q. It says "a survey has been undergoing." So what kind of--what would the survey--who would be surveyed?

DR. HAEGERT:

A. Presumably pathologists. I mean, it's unfortunate the minutes are not overly clear.

COFFEY, Q.C.:

Q. If I could, to elaborate a bit more, and that's February 21st, 2001, and that's the General Hospital site. If we could look, please, at Exhibit P-1874? Doctor, this is division of anatomical pathology, minutes of a meeting, site chiefs and divisional managers, February 22nd, 2001. Dr. Sushil Parai is the chair, chairs the meeting. You're there, as well as Dr. Cook and Mr. Gulliver and Mr. Murphy. If we look, Doctor, at page three of

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the exhibit, under paragraph 4.2, new business, "quality control of immunoperoxidase staining." It reads "there has been a study going on the quality of the immunoperoxidase staining for both sites. It is agreed the control for immunoperoxidase staining be run for every batch. A 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, another pathologist will be looking at the control," and it goes on to talk about particular controls. Yes, it is a particular control, for a particular antibody. Doctor, does this assist in -

DR. HAEGERT:

A. Well, I think it seems that what I said before was right. In fact, what we're really talking about is positive controls for individual stains, for example CD20 or CD3 or whatever.

COFFEY, Q.C.:

Q. And was there some question about whether or not they were being run at all?

DR. HAEGERT:

A. Well, this--one of my interactions with Mr.

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Gulliver was possibly around this time is that--because I know we discussed the issue of positive controls and the question is how often do you run positive controls. Of course, in 2008 people do certain things; in 2001 one of the issues was if you run a positive control an extra slide and you're using the Ventana equipment, which I don't know if it was a Ventana then or DAKO -

COFFEY, Q.C.:

Q. DAKO, DAKO would be the -

DR. HAEGERT:

A. I don't know how many slots there are in a DAKO instrument.

COFFEY, Q.C.:

Q. 48, probably.

DR. HAEGERT:

A. So if you're going to run--what it does is it gives you the option to run different antibodies staining different tissues and then the question is how many basic, I don't know, not really lanes, but how many slots would be occupied by the controls. So if you're running, say, 15 different antibodies, so you have 15 case antibodies and 15 antibodies,

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first of all that occupies a lot of the instrument and secondly, it's a cost issue. And I remember talking to Mr. Gulliver about this and he was very reluctant to include antibodies on a routine basis, so we, I know we discussed this at the site chiefs and the divisional chiefs, but the resolution I can't say, I don't recall.

COFFEY, Q.C.:

Q. So, for example, ER and PR slides that were run on a particular day, would there necessarily be an external control then?

DR. HAEGERT:

A. Oh, I think that's different. My understanding is that they would have been. But we're talking about other antibodies like--because often with other antibodies, like CD20 or something, if you're staining a lymph node, there would be normal cells and tumour cells, so you can usually tell if the process is working.

COFFEY, Q.C.:

Q. So in terms of this issue about whether or not external positive controls should be run or not related to some of the stains, some stains

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but you don't recall which particular ones, is that -

DR. HAEGERT:

A. I think the--it's a bit hard to remember, but I think one of the feelings was that if we're going to be doing immunohistochemistry, we should be running positive controls every day. And then it was an issue, as I mentioned, of, well, partly the equipment. I don't remember how many DAKO immunostainers there were. I think there was only one at the time. And so if what you say is right, there's 48 slots, I mean, you know, you could be running half your slots for controls.

COFFEY, Q.C.:

Q. Doctor, here the assertion that a pathologist will check the control slide before sending the slide to the other site, this is between St. Clare's -

DR. HAEGERT:

A. Yeah.

COFFEY, Q.C.:

Q. And the General back and forth. "Dr. Parai has agreed to do this." What was your understanding then in early 2001 about who, if

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anyone, was checking the external control slides for ER/PR?

DR. HAEGERT:

A. It was Dr. Parai.

COFFEY, Q.C.:

Q. Okay. That was your -

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. And in his absence?

DR. HAEGERT:

A. Well then he would delegate the site chief role to somebody else. I mean, it was normal practice if I was away to delegate the role to someone and if the site chief was away to delegate it to somebody, so I mean, that would be normal.

COFFEY, Q.C.:

Q. Were there any written records being kept of that as to, like, the fact that Dr. Parai had checked controls on a particular day and they related to certain patients' slides?

DR. HAEGERT:

A. Well, I think our documentation probably wasn't that great. I would suspect, no.

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COFFEY, Q.C.:

Q. Were you aware at the time of the deficiency in that regard, do you remember that kind of being aware of, consciously aware of it at that time?

DR. HAEGERT:

A. You mean of the documentation?

COFFEY, Q.C.:

Q. Yeah, the deficiency, as you've just said, perhaps it was, you understand perhaps it was deficient at the time, looking back on it now, were you aware at the time, in 2001, that -

DR. HAEGERT:

A. Probably aware of it. You know, one of the things you should recognize, perhaps, and maybe the Commission should recognize, you know, there is some--one of the external reviewers came in and said, you know, one of the things that she was surprised about was the lack of standard operating procedures and so that things were not documented, but that was actually, I don't think that was all that uncommon. Until one has an appropriate external accrediting body looking at things, standard operating procedures were not

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commonly written. So they were common in Ontario because they had the quality management program in Ontario, but I can tell you at the--not the Health Care Corporation, McGill University Health Centre in Montreal, which is huge, and I would say probably significantly larger than Mount Sinai Hospital, though I never compared it, we were accredited in 2007 and before the accreditation someone said that we actually had to write 500 standard operating procedures because basically we didn't have any. And I think that's not--it doesn't actually reflect in any way either in the fact that the lab is good or bad, it's actually--it's more or less in some ways doesn't actually serve as a measure of that. All it means is that these things are documented. And what happens, of course, I don't--one would wonder whether that is actually--I mean, this is one of the questions that has always been in my mind, is this laboratory here being accredited by the, you know, the Canadian Council of Health Services Accreditation, because if it were, many of the things that Trish what's her name,

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Wegrynowski, and I'm not sure how you pronounce her name, criticized, all that stuff would have been addressed. They would have had to address it prior to the accreditation. Didn't mean things were good or bad, it just meant they weren't formally documented.

COFFEY, Q.C.:

Q. Exhibit P-2539? Doctor, this is a--an agenda for and then the minutes of a meeting of April 24, 2001 by the Division of Anatomical Pathology. Page 2 of the minutes--page 3, 3.8 "Pathologist Assistant." And the notes are "Been much discussion on this issue, however, Dr. Haegert will discuss with Dr. Williams in the future. However, there is no money in the budget to fund this position." Doctor, what was your view of pathologist assistants?

DR. HAEGERT:

A. Well, pathology assistants are typically individuals who are--have special training and in my experience what they do is they participate in the, or the help with the grossing of surgical specimens.

COFFEY, Q.C.:

Q. And did you see them as desirable in this

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context?

DR. HAEGERT:

A. Yeah, I think what's happened is that, you know, in pathology the workload has gone up progressively and the case complexity has gone up progressively. Pathologists are spending more and more time making diagnosis. I mean, it used to be many years ago that, for example, on something like a breast cancer was actually you might have, say, ten slides on a case. Nowadays it's routine to get 40, 50 or more slides. Could take an hour or two hours even to look at one case. So that it's much more logical if you have somebody who's adequately trained to process the gross so that pathologists can actually do the tasks which are the highest level of sophistication. But of course the critical thing is to have well trained pathology assistants.

COFFEY, Q.C.:

Q. And you then, I take it, were in favour of them in 2001?

DR. HAEGERT:

A. Yes, of course.

COFFEY, Q.C.:

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Q. And did you talk to Dr. Williams about it?

DR. HAEGERT:

A. Yes, I did.

COFFEY, Q.C.:

Q. And he told you what?

DR. HAEGERT:

A. Huh, he said there was no money basically in simplistic terms.

COFFEY, Q.C.:

Q. Okay. Exhibit P-1876. Doctor, these are the minutes of a meeting of site chiefs and divisional managers, April 25th, 2001. You're noted, amongst others, to be there. There's a--have a post-it note over it but there are a number of individuals present, including yourself. Under "Business Arising" paragraph 2, "Quality Control of Immunoperoxidase Staining" says, "Generally the immunos appear to be very good: there appears to be some problems with the estrogen and progesterone receptors. Positive controls are checked daily by a pathologist. However, these need to be documented. Dr. Parai will follow-up on this. Note is also made of heavy utilization of immuno services and the high volumes

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encountered." And in terms of that, Doctor, heading "Quality Control of Immunoperoxidase Staining" I take it someone then was looking at it or examining this issue in April of 2001?

DR. HAEGERT:

A. Well, I would have certainly have thought so, yes.

COFFEY, Q.C.:

Q. And "The immunos appear to be very good." Notes, "There appear to be some problems with the estrogen and progesterone receptors." Do you recall what those problems were?

DR. HAEGERT:

A. No, I'm afraid not, no.

COFFEY, Q.C.:

Q. The note that, "The positive controls are being checked daily by a pathologist. These need to be documented." which is the issue I just asked you about in terms of documented, as far as you know that afterward there was no amount of record kept, per se, on a log sheet, that you were aware?

DR. HAEGERT:

A. Well, I think what--I mean, it seems the

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essence here is that Dr. Parai as of then would document them. That would be my interpretation of that. It's hard to look back at minutes. You realize how badly the document phenomenon really what's going on and what are people saying and what's happening.

COFFEY, Q.C.:

Q. And now, Doctor, on this point, if we could bring up, please, Exhibit, I'll say P-2149? Doctor, this sort of form, it's a special procedure request form. This, I take it, was the sort of form utilized to have pathologists to order IHC stains?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. This particular one involves an ER and PR -

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. And it happens to be dated January 28th, 2002.

DR. HAEGERT:

A. Right.

COFFEY, Q.C.:

Q. And here that ER/PR test was apparently done

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and then repeated twice. You see the dates down here? And the Commissioner has heard some evidence from the technologist in relation to this. I'll just take you through some others. Page 3 of the exhibit, it's an ER/PR. You'll see there again, this is an indicator to the Commissioner, this would indicate that it's a repeat. No, this could be a HER2/neu, perhaps, the ER/PR is the first and then the second one is the HER2/neu. At page 5 of the exhibit, it's an ER/PR case. Again, it's repeated, done February 27th, repeated March 1. And there are, when we look down through this, there are a number of cases where certainly in 2002, beginning early in 2002 in these request forms that we have and it continues on at times into 2003, a number of instances where the ER and PR tests had to be repeated. You can -

DR. HAEGERT:

A. I can see this, yeah, okay.

COFFEY, Q.C.:

Q. And there were quite a number. I can take you, you can kind of sit here and go through them and the Commissioner has already had that

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done for her, okay. Do you recall that ever being brought to your attention?

DR. HAEGERT:

A. No, never.

COFFEY, Q.C.:

Q. Do you think it, as chair--I don't know if--I mean, as the clinical chief do you think it ought to have been if there was a problem at times of ER/PR tests having to be repeated for whatever reason and there are a number of different reasons been given to the Commissioner?

DR. HAEGERT:

A. Well, I would have thought if there was a problem and the problem persisted, then I should have been advised. I mean, it seems that what they're doing here is they're repeating it, I mean, one would imagine it's on the same block.

COFFEY, Q.C.:

Q. Yes.

DR. HAEGERT:

A. I mean nowadays, in 2008, you wouldn't do that. What you would do, I mean, what--depends what the problem was. I mean, if the

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material is falling off the slide, then probably that's kind of technical thing, baking the material onto the slide, most likely. Whereas if, in fact, the estrogen preceptor--estrogen and receptor--estrogen receptor and progesterone receptor tests were done on a block and it appeared satisfactory and the control was satisfactory, and I mean, I think we're talking about external controls, then what we would do now is you would look at the--in 2008, of course, what you do is you do it on another block and also be looking at internal controls.

COFFEY, Q.C.:

Q. Now, up to the time that you left St. John's in 2002, were you aware of the need in ER/PR cases to look for internal controls, up to the time you left St. John's?

DR. HAEGERT:

A. No.

COFFEY, Q.C.:

Q. When did you first become alerted to that?

DR. HAEGERT:

A. Well, I moved to Montreal in 2002. I think one of the issues, actually, in the Health, or

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I guess it was the Health Care Corporation, yes, is that no one pathologist, except for Dr. Khalifa, looked at very many cases. So none of us were really all that apprised of the intensity of staining and so on. I mean, when I moved to Montreal, I mean, it seemed to be evident fairly soon after I was there, but I can't say when.

COFFEY, Q.C.:

Q. Okay. It was after you arrived in Montreal?

DR. HAEGERT:

A. Yeah, I think it was common knowledge and when things are common knowledge everybody seems to suddenly find out about it.

COFFEY, Q.C.:

Q. Here if we could go, Doctor, while I have this here, was it ever brought to your attention while you were in St. John's as clinical chief, circumstances where an ER/PR tests had--like, an original test was done and then for whatever reason it was repeated and the result was different on the repeat?

DR. HAEGERT:

A. No, no, I was never--that was never discussed, to my knowledge.

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COFFEY, Q.C.:

Q. If it had happened, do you think as the clinical chief would you have expected to be told? Like if, for example, if a person reported as negative, negative and then was reported as, I don't know, a positive, positive or 80, 80, which presumably might have clinical ramifications or could have clinical ramifications, as clinical chief would you have expected to be told that?

DR. HAEGERT:

A. I would have expected the pathologist involved would have at least discussed it with the site chief and if at that time it was Khalifa developing the methodology, then he would have told me. And if it wasn't him, I would have expected Dr. Paria or Dr. Cook or somebody else to tell me.

COFFEY, Q.C.:

Q. And Exhibit P-1876? Doctor, these are these April 25th, 2001 minutes. Just to the bottom of the page, "Terminology of Estrogen and Progesterone Reports: Mr. Gulliver will develop a canned text for reporting of estrogen and progesterone receptors;

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information for this will be obtained from Dr. Parai." Do you recall why that was felt to be necessary and if it was done?

DR. HAEGERT:

A. I mean, the idea of a canned text is just you have a text in the Meditech system that you can call up and, I mean, I think this was done for the checklist, but, you know, canned text and then you can modify the canned text accordingly. I would assume it was done because it's certainly nothing very exotic to do that. Just what it does it makes the pathologist's role easier and it also makes it easier for the secretaries so that they're faced with the same type of text every single time and only, you know, a few words are changed in the text.

COFFEY, Q.C.:

Q. If we could, please, Exhibit P-2401? These are laboratory management committee minutes of June 6, 2001, Doctor. You're noted to be present along with a number of others. Under "Business Arising" 7.5 "Proficiency Programs," it's noted, "Considerable discussion on the pros and cons on the option to join into an

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already existing program from another province was entertained. Dr. Whitman and Dr. Hutchinson to follow-up as to what is available and conditions." Does that assist you in any way in remembering what this proficiency programs and Dr. Whitman involved? First of all I'll ask you, what type of a doctor was Dr. Hutchinson?

DR. HAEGERT:

A. He was a medical microbiologist.

COFFEY, Q.C.:

Q. So Dr. Whitman was a?

DR. HAEGERT:

A. Hematologist.

COFFEY, Q.C.:

Q. Which is a different -

DR. HAEGERT:

A. She was actually a clinical hematologist but it moved into the laboratory, so she was actually divisional chief of the lab and Dr. Hutchinson was divisional chief of medical microbiology.

COFFEY, Q.C.:

Q. So the divisional--two different divisional chiefs?

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DR. HAEGERT:

A. Correct.

COFFEY, Q.C.:

Q. And there's reference to pros and cons and the option of joining an already existing program, proficiency program, existing program from another province. You can't recall what that was about? Because it occurs a number of times, I've referred you to two of them, Dr. Whitman's -

DR. HAEGERT:

A. Actually, I don't remember this.

COFFEY, Q.C.:

Q. Okay.

DR. HAEGERT:

A. I mean, Dr. Whitman, as you showed, was not there in two of the meetings and then this meeting, I mean, the details aren't there and I just can't remember. I mean, are we talking Ontario? I can't say, actually.

COFFEY, Q.C.:

Q. So at the time, though, I take it, it was known within the program that, in St. John's, that the program was not part of any such external proficiency?

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DR. HAEGERT:

A. Well -

COFFEY, Q.C.:

Q. Interprovincial?

DR. HAEGERT:

A. - the proficiency program we're talking about, is this a proficiency program for professionals or for technologists? I mean, it doesn't say and I can't say. I mean, we were a part of programs in some of the laboratories, sure.

COFFEY, Q.C.:

Q. And Exhibit P-1877? Doctor, this is are the minutes of, page, beginning of page 2, minutes of a meeting of June 26th, 2001, site chiefs and divisional managers. Under "Business Arising" paragraph 2, "HER2 expression, ER and PR control. Controls for all these immunostaining are checked by the site chief or by a call pathologist when site chief is not available." And you'll note here that you are listed as being present with Doctors Parai and Cook. So it was your understanding, I take it, in mid 2001, that the General Hospital was having someone check the

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controls?

DR. HAEGERT:

A. Yeah.

COFFEY, Q.C.:

Q. For these particular stains. In checking the controls, Doctor, what was your understanding as to what they were to be looking for?

DR. HAEGERT:

A. Well, as I already said, these were external controls. It basically is a question--basically it's a test to see whether the procedure is actually working, period. And so they would be looking for the appropriate staining and appropriate intensity of staining.

COFFEY, Q.C.:

Q. What would be appropriate in this context, what was your understanding of what was appropriate in this context?

DR. HAEGERT:

A. Well -

COFFEY, Q.C.:

Q. For ER/PR?

DR. HAEGERT:

A. Well, see, I don't remember what the precise

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control was. I mean, I know there's a lot of information available now about what type of controls that one should use. But I would have thought they would--I believe what we used. I'm not sure what our control was. I don't know if it was endometrium or another breast case or, but what one expect is, at least I think this is what was going on, is that we would use a case that was strongly positive. But I'm not entirely sure, really. I know there was a control and I don't even remember what the control was. I mean, there are several options for controls.

COFFEY, Q.C.:

Q. If you expected strong staining, you know, because of the nature of the control, if that was expected and the external control stained weakly, from your perspective what was the appropriate approach then?

DR. HAEGERT:

A. Well, now, I mean, of course we know perfectly well that that's a problem, I mean, that's probably not the appropriate control. But what I don't know is what we used then. I mean, I would say that if we got weak staining

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now in something that we expect strong staining, it clearly is a problem, presumably a technical problem. But you've heard all kinds of stuff about the controls, I mean, there's masses of information and everybody--I would say that there can't be--there's hardly a pathologist in North America that's not well aware of all of this.

COFFEY, Q.C.:

Q. Now?

DR. HAEGERT:

A. In many--yeah, of course. But to go back, you know, a number of years and say what did I know then is hard, difficult, actually.

COFFEY, Q.C.:

Q. Doctor, in that regard I wanted to ask you something over the break. We have seen references, anyway, to studies prepared by a Dr. Rhodes published in the beginning of 2001, a series of studies involving studies in the UK involving ER/PR?

DR. HAEGERT:

A. Yeah.

COFFEY, Q.C.:

Q. When did you first become aware of the Rhodes,

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you know, studies and their conclusions about certain aspects of ER/PR, at least that they found in the UK, when did you first become aware of that?

DR. HAEGERT:

A. Well, since I'm under oath, the honest answer is since this is not an area that I really read in, I only started, I thought, okay, I should look up what the literature says a few months ago and then, you know, I found this. That's the truth of it.

COFFEY, Q.C.:

Q. I take it, Doctor, that in--because in your current practice you do not deal with ER/PR cases yourself?

DR. HAEGERT:

A. I do.

COFFEY, Q.C.:

Q. Oh, you do?

DR. HAEGERT:

A. Um-hm.

COFFEY, Q.C.:

Q. Okay. So in doing, dealing with them up until recently you weren't aware of the Rhodes publications, and there's a series of them?

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DR. HAEGERT:

A. No.

COFFEY, Q.C.:

Q. Doctor, you have had a chance to review them recently or relatively recently. I take it would it be fair to say that Dr. Rhodes and his colleagues expressed some significant concerns about ER/PR testing at the time in the UK? Would that be a fair?

DR. HAEGERT:

A. Correct, yes.

COFFEY, Q.C.:

Q. That's a characterization, I think. And in reading it would it be fair to say that there's no reason in reading what he's written, what is written there, that it would be limited to the UK, there's no reason to believe it would be?

DR. HAEGERT:

A. No. I would imagine that's -

COFFEY, Q.C.:

Q. No. Probably -

DR. HAEGERT:

A. - generalizable.

COFFEY, Q.C.:

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Q. What I wanted to ask you, Doctor, was is this, because these were journal articles and they're published in reputable journals and there are a number of them over a period of a couple of years, was there any mechanism in place at the time, 2000, 2001, 2002, in St. John's, anyway, whereby that sort of warning to pathologists in general that appears in those articles concerning ER/PR testing, and it is a warning, I think you'd agree with that, I mean, he points out there are a number of problems with this, potentially?

DR. HAEGERT:

A. Yeah, he does.

COFFEY, Q.C.:

Q. Was there any mechanism in place whereby that could be--would be routinely brought to pathologists' attention?

DR. HAEGERT:

A. Well, that would be the kind of thing that if it was raised, it would be brought up at one of our, you know, teaching rounds.

COFFEY, Q.C.:

Q. Okay. And you certainly don't recall it ever being brought up?

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DR. HAEGERT:

A. No.

COFFEY, Q.C.:

Q. I take it? But you would have to rely upon, I take it, at the time, in the structure that then existed, someone to bring it up at a--to come across it and to bring it up at a teaching round, that's in effect what was required?

DR. HAEGERT:

A. Yeah. Or the site chief at one of the sites would identify it and advise others.

COFFEY, Q.C.:

Q. In this regard, Doctor, and her under "New Business" in this particular June 26th, 2001 minutes there's "Quality assurance program for anatomical pathology/pathologists review." See that? And "This meeting is dedicated for the above items and the following points are discussed." "System review" is No. 1. "System review is not in place. It will be discussed in the next meeting for possible implementation of pathology report reviews by system by a committee." 2, "Turn around time. This has been in place for both sites and will

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continue. 3, "Outstanding reports. This has been in place for both sites and will continue for both surgicals and autopsy." 4, "Canned text. There is partial implementation of canned text at the General Hospital site for ER/PR and HER2/neu expression. It is important to use standard specimen grossing and reporting." 5, "Frozen section review. It is important for every three months to review the frozen section diagnosis and compare with the final report." 6, "Performance improvement program. Institutional case review, (a) American Colleague of Pathologists material will be used as well, (b) American Society of Clinical Pathologists check sample review." Go on to the next page, paragraph 7, "Quality control rounds. (a) Interdepartmental rounds presently in place at both sites." And it notes the ones that the Health Sciences Centre has. "(b) Intradepartmental round. This has been in place at both the sites." Describes them, on which days they occur. "Inter-hospital rounds. Monthly pathology rounds participated by all the pathologists and

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residents. Cases are discussed in depth with up-to-date information. (d) Intradepartmental consultation. Going on at both sites, however, St. Clare's Hospital has proper documentation of consultation and the General this hasn't always been done." And you refer to Dr. Khalifa, in fact, I think, having expressed some interest in doing that earlier. And "(e) Eternal consultation. This is in place at both sites. The cases are referred to CRCCP, ATIPP, etcetera." So, Doctor, as of June, 2001 what was the impetus for this?

DR. HAEGERT:

A. Well, I think there had been a recognition for sometime that it had been difficult to initiate quality control activities within the department, largely because of turn around of staff, etcetera, and it was time to institute that. And a lot of these things are already in place. As you noticed, a lot of these things are in place.

COFFEY, Q.C.:

Q. Yes. A number of them are noted, in fact, to be in place.

DR. HAEGERT:

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A. Yes.
COFFEY, Q.C.:
Q. And there are others that are plans to put them in place. I take it then, Doctor, that there was a recognition at the time that there was perhaps a gap or a lack of kind of a full, full gamut approach to -
DR. HAEGERT:
A. I think there had always been a recognition that we needed to do more. But then, as I mentioned before, the question is then who's going to do it and do we have dedicated personnel to doing that. You can't do this on a sort of a, you know, 4:15 on a Friday afternoon and try to actually come up with some kind of a comprehensive quality assurance program. You have to actually have dedicated personnel who are dedicated technologists with pathologists involvement.
COFFEY, Q.C.:
Q. Doctor, the reference there at paragraph 1, 4.1 to a system review, do you remember what the system review was? In this context what would system review have been?
DR. HAEGERT:

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A. I can't say. I mean, I really can't answer that.
COFFEY, Q.C.:
Q. Sure. I appreciate that. Pardon me?
MR. SIMMONS:
Q. (Inaudible).
DR. HAEGERT:
A. No, I mean, I wouldn't think it would be that. I mean, I could speculate, but I actually don't -
COFFEY, Q.C.:
Q. You don't recall?
DR. HAEGERT:
A. No.
COFFEY, Q.C.:
Q. I appreciate that, Doctor. Doctor, did you ever become aware of any problems related to tissue fixation, tissue processing, tissue fixation that was brought to your attention?
DR. HAEGERT:
A. When I was there?
COFFEY, Q.C.:
Q. Yes.
DR. HAEGERT:
A. Not really. I mean, every pathologist is well

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aware of the issues of fixation, it's common knowledge. You learn that as a resident. But were there exceptional -
COFFEY, Q.C.:
Q. Yes.
DR. HAEGERT:
A. No, I was unaware of, really.
COFFEY, Q.C.:
Q. And in particular, any issues involving ER/PR testing, related to ER/PR testing itself, any issues?
DR. HAEGERT:
A. You mean in fixation, is that what you were asking?
COFFEY, Q.C.:
Q. No, just generally.
DR. HAEGERT:
A. No.
COFFEY, Q.C.:
Q. Okay. So there were none, in particular, related to fixation? I appreciate a particular slide might have a fixation problems and you've--you know, any pathologist would be expected to recognize that.
DR. HAEGERT:

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A. Yeah.
COFFEY, Q.C.:
Q. But in a more systematic way or a general problem, it was never brought to your attention that we have a problem with fixation?
DR. HAEGERT:
A. No, as a generic system type problem, no. I mean, obviously we know that from time to time cases come from the operating room and they never get into fixative, I mean, this is known, but as a general problem, no.
COFFEY, Q.C.:
Q. And you've indicated that you were not made aware of any conversion in ER/PR testing, like first testing -
DR. HAEGERT:
A. No, I was never told this.
COFFEY, Q.C.:
Q. And you were never made aware, I take it you never had any yourself that you were--you certainly never reordered an ER/PR test and had it convert?
DR. HAEGERT:
A. Not to my knowledge.

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COFFEY, Q.C.:
Q. Not to your knowledge. Doctor, in terms of, well, while I have you here, because you are--hold the senior position in the institution you're in, how is ER/PR handled in, ER/PR testing handled in the hospital system that you are a part of, is it limited to particular people, overseen by particular people or is it generally handled by all the pathologists there?
DR. HAEGERT:
A. Well, generally we have a subspecialty approach to pathology in general. But the case volume is much, I would say is much larger than here, it's far more than--more than 60,000 surgicals a year. Now, I don't know, but when I left here, it was roughly 30,000 or something like that and I think it's around 64, 65 thousand. So what we try to do is a subspecialty practice. But as mentioned that one of the difficulties with a subspecialty practice, and we have some--many of the issues that were present in the Health Care Corporation, people come and they go. We have problems with recruitment and retention.

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And so what typically happens is even though we have one person who's primarily the breast pathologist, others such as myself do some breast pathology. But a lot of the issues about the estrogen receptor testing relates to how the tissue is handled.
COFFEY, Q.C.:
Q. Yes.
DR. HAEGERT:
A. So, I mean, obviously you've been here every day while I haven't been here every day. But the way--and I don't know how the tissue is handled here or in Toronto but my feeling is that what some of the things that the external consultant said about the way tissue is handled does not apply in Montreal. Most of it--I mean, I can tell you that most of the cases in Montreal the diagnosis is made on needle core, so I would say as a guess 90 percent of cases or maybe more are diagnosed on needle core biopsies, so fixation is never an issue. So basically take a number of needle cores and they're put into Formalin right away. And then the definitive surgery is a lumpectomy or, you know, excisional

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biopsy of the tumour and then what happens, the pathologist is called to the operating room and we actually cut it together with pathology assistant, we look at it and then we actually take the cut sections and put them on a cork board and then they're fixed. So most of the issues that, you know, that Trish Wegrynowski mentioned really do not apply in our institution, I mean, because we--and I don't know what's done here. I don't--I've actually forgotten, to be honest, because I went to a new place and we did something--it was quite different when I went there and sort of, I learned a new system. So most of the time, things like fixations is not an issue, and so basically, all of us who do breast cancer pathology in Montreal, at McGill University Health Centre, what we were doing for a long time, we were doing estrogen receptor and progesterone receptors and HER2/neu on the core and also the final excision. But then eventually what we did is we stopped doing it on the needle core and did it on excision, because what the oncologists really wanted to know was what the estrogen

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receptor status was on the excisional biopsy, and because of this Commission, I mean, I can tell you that's what's happened is people have become very much more alert to the issues about what happens if the estrogen receptors are negative, because the majority are positive, of course, so what we tend to do is we do--we repeat them on another block, if there is another block, and if that's negative, we also repeat it on another block. So I mean, it's almost like -
COFFEY, Q.C.:
Q. Double and triple checking.
DR. HAEGERT:
A. It's sort of, yeah, basically sometimes you end up doing three blocks, and we play--I mean, of course, everybody knows now about the importance of internal controls, so we look very carefully at the internal controls and if they're not strongly positive, we wonder about whether there's an issue in fixation or antigen retrieval or some technical issue, and probably repeat on another block. But we're all wise in retrospect, unfortunately.
COFFEY, Q.C.:

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Q. They're the questions I have, Commissioner.
THE COMMISSIONER:
Q. Thank you, Mr. Coffey. Do you have any questions, Mr. Pritchard?
MR. PRITCHARD:
Q. I don't have any questions for this witness. Thank you, Commissioner. Thank you, Dr. Haegert.
THE COMMISSIONER:
Q. Mr. Simmons, I'm just wondering whether I should give this witness a break before you ask your questions or are you going to tell me that you're going to be such a short period of time that -
MR. SIMMONS:
Q. Probably at least ten minutes and maybe that might be all.
THE COMMISSIONER:
Q. Can we do the room? Ms. Newbury, do you have any questions?
MS. NEWBURY:
Q. Five minutes.
THE COMMISSIONER:
Q. Mr. Pritchett?
MR. PRITCHETT:

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Q. No questions, Commissioner.
MR. PIKE:
Q. No questions.
THE COMMISSIONER:
Q. Ms. Brocklehurst?
MS. BROCKLEHURST:
Q. No questions.
THE COMMISSIONER:
Q. Mr. Browne?
MR. BROWNE:
Q. Depending on my colleagues, I would say five to ten.
THE COMMISSIONER:
Q. Okay. Well, why don't we give him a break, and then we'll complete. Thank you.
(BREAK)
THE COMMISSIONER:
Q. Please be seated. Mr. Simmons.
DR. DAVID HAEGERT, EXAMINATION BY MR. DANIEL SIMMONS
MR. SIMMONS:
Q. Thank you, Commissioner. Good afternoon, Dr. Haegert. I'm Dan Simmons. I'm the lawyer for Eastern Health. A few questions for you arising out of some of the things that you've had to say this morning. First of all, you

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gave us a description of some of the effects of the consolidation that happened when the Health Care Corporation was formed back in 1996, and one of those things being there had to be a reduction in the budget and there was a reduction in the number of managers, and you described all that for us this morning, I believe.
DR. HAEGERT:
A. Yes.
MR. SIMMONS:
Q. Through that same time period, when that was taking place, and the number of people who were managing the system was being reduced, what was happening with the workload and the volume of cases being handled by anatomical pathology in that time period? Was it stagnant? Was it decreasing or was it increasing?
DR. HAEGERT:
A. Well, I would say that the workload in anatomic pathology everywhere has gone up progressively, and as I think I said already that also the case complexity has gone up. So what one has to do with individual cases,

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certainly with cancer cases, has increased. So I would say definitely gone up here.
MR. SIMMONS:
Q. And was that the case also back in '96, '97, '98, the time period in which there was some downsizing in the number of managers in the laboratory services in St. John's?
DR. HAEGERT:
A. I would say. I mean, it's virtually impossible to imagine that it was not going up, because it is everywhere.
MR. SIMMONS:
Q. Yes. Following that period, when those cuts in management took place, up until when you left in 2002, was there any growth after that in the number of managers available? Did you manage to increase the number of managers after that, or did it pretty well stay the same until you left?
DR. HAEGERT:
A. No, it was--once we came up with the final model, the number of managers, it--ah, good question. Either it was static, but the intent was actually to reduce as the sites reduced. Now I don't recall whether we

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actually reduced them all. Oh, actually, yeah, we did, because I remember that at least some of the managers were reduced in numbers.

MR. SIMMONS:

Q. Even after that first round?

DR. HAEGERT:

A. During the period of time I was here. I mean, first of all, there was this large cut.

MR. SIMMONS:

Q. Yes.

DR. HAEGERT:

A. And then there was a second reduction, because I remember that--I mean, one of the examples, I remember two examples. The manager in--instead of having two managers in anatomic pathology, it was reduced to one.

MR. SIMMONS:

Q. Right.

DR. HAEGERT:

A. In hematology, it was reduced from two to one. Biochemistry, I'm not sure that I remember. But likely it was a similar model.

MR. SIMMONS:

Q. Right. So that by the time you left in 2002, there were even fewer managers in the lab than

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when you'd gone through that initial round of cuts when the Health Care Corporation was formed?

DR. HAEGERT:

A. Right.

MR. SIMMONS:

Q. Okay. Through, up until the time you left in 2002, were there any positions in laboratory services where people were dedicated to quality assurance activities?

DR. HAEGERT:

A. No.

MR. SIMMONS:

Q. Was there any capacity to devote someone to a dedicated position like that, given the resources that you had available in that time period?

DR. HAEGERT:

A. No. The logical person would be a manager, but we didn't have--as you've heard, there wasn't a surplus of managers. It was really the opposite.

MR. SIMMONS:

Q. Right. So up until the time you left in 2002, what kind of expectations were there within

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the lab among the pathologists and lab leadership about what kind of resources could be made available for new initiatives? Was there a feeling that if there was a good new initiative, they could go and get the money for it? Was there the opposite feeling, that if there were things they wanted to do, that it would be very difficult to get new money for things? Was there any perception among lab leadership in that time period?

DR. HAEGERT:

A. Well, I mean, certainly myself and Vern Whelan were aware that if we could make a case, we could make a case through the Health Care Corporation to government to obtain additional funds, and we actually did do that.

MR. SIMMONS:

Q. So it would require then going, not just to the leadership within the Health Care Corporation, but beyond that, through to government, in order to find new funding for new initiatives?

DR. HAEGERT:

A. Yes, I think that's right. I mean, I think it was difficult in the Health Care Corporation,

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because they were being downsized, like everybody else as far as I can tell.

MR. SIMMONS:

Q. Yes. So when you'd talked about Mr. Tilley, for example, informing you that the lab had to find a million dollars in savings -

DR. HAEGERT:

A. Yes.

MR. SIMMONS:

Q. - that wasn't an initiative that was coming from within the Health Care Corporation. You understood that to be a broader based initiative where the government was going to the health sector looking for savings, did you?

DR. HAEGERT:

A. Well, that's a good question. I mean, I was aware that there was certainly a budget crunch in the Health Care Corporation. I mean, there was certainly awareness that we didn't have enough money and that the feeling that I had is the government failed to recognize when the Health Care Corporation made overtures to government that we needed this amount of money, that they actually didn't believe this.

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I mean, it seemed to be sort of a common theme of understanding. I don't know if it--well, of course, this was in the time of original creation. So what they were doing is bringing together these multiple sites and then they were given a budget and I think the sense was the budget was insufficient. Some of the plants were old, like the Grace was an old hospital and expensive to operate.

MR. SIMMONS:

Q. Okay. I had a specific question for you related to that, about one of the documents, P-1889, please. Now this is a letter you were shown by Mr. Coffey, one written by Dr. Khalifa to Mr. Gulliver, and this is February of 1997, and in it, Dr. Khalifa was commenting on the difficulty of making contact with Mr. Gulliver and in talking about the circumstance you described, all the different responsibilities Mr. Gulliver had at that time for areas other than pathology, my question simply is, by the time these events occurred described in this letter, was this after the management structure had been shrunk, after those cuts had been made or prior to that?

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DR. HAEGERT:

A. Well, it must have been, because there would be no reason for him to be on other sites.

MR. SIMMONS:

Q. Okay, good, thank you. You were asked about the process of introducing new antibodies into the immunohistochemistry arsenal. You've explained that, and I just wanted to make sure I understood a couple of things about that. Is it correct that the introduction of a new antibody would be initiated at the request of a pathologist, rather than at the request of anyone among the technical staff in the laboratory?

DR. HAEGERT:

A. It wouldn't come from the technical staff. It would come from pathologists.

MR. SIMMONS:

Q. And then you've told us that there was a process where that would be, in effect, vetted by the site chief or clinical chief or lab leadership to ensure that this was an antibody that was appropriate to introduce into the lab?

DR. HAEGERT:

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A. Yes.

MR. SIMMONS:

Q. When it came to the mechanics of getting it up and running, you've told us that there would be, I understood you to say, a series of test slides prepared by the technologists in the lab using different formulations for the use of the antibody?

DR. HAEGERT:

A. That's what I would expect, yes.

MR. SIMMONS:

Q. Yes, and you mentioned that would be done, did I understand you to say, on tissue that had been provided or selected by a pathologist? So the pathologist would select the tissue to be used for these sample slides?

DR. HAEGERT:

A. Yes, of course.

MR. SIMMONS:

Q. Yes, and then the results of those slides would be reviewed by the pathologist to select the best formula or the best protocol to be used for that particular antibody?

DR. HAEGERT:

A. I mean, that seems to be the most probable

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sequence of events, yes.

MR. SIMMONS:

Q. So would it be correct to say then that the use of a new antibody for testing patient samples wouldn't begin until an appropriate pathologist had reviewed the results of these sample tests and was satisfied that the test was working appropriately to put it into use?

DR. HAEGERT:

A. Well, it's difficult to imagine that it would come about any other way.

MR. SIMMONS:

Q. Okay, good, thank you. You were asked about external proficiency testing and you made some comments about your views on the usefulness of proficiency testing. We've heard through other witnesses that there's different types of proficiency testing available now for pathology. One of those is through CAP, C-A-P, and I understand that to be cases that are presented by CAP which consists of a number of slides, that pathologists would review the slides and answer some questions about the case and submit them back. Other types of proficiency testing, such as from UK NEQAS in

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the UK, involve being given actual material where you prepare the slide, stain it, rate it and send it back. So one type of proficiency testing involves work in the lab, technical work?

DR. HAEGERT:

A. Yeah.

MR. SIMMONS:

Q. And the other is pathologists' assessment of cases that are presented, and I was wondering if your comments about the usefulness of proficiency testing were directed towards both types of proficiency testing or just to the CAP type?

DR. HAEGERT:

A. Well, it was directed really to the ones where we would receive a set of unknown cases and that pathology--you know, typically an H & E slide, which is a routine slide, and we'd be asked a number of questions, like what are the factors that do this or does this do that. No, I was talking about that. I wasn't talking about the other type of testing, no.

MR. SIMMONS:

Q. Okay. Now you've told us a bit about what

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happens at McGill University Hospital, is that where you are now?

DR. HAEGERT:

A. Yeah, McGill University Hospital Centre.

MR. SIMMONS:

Q. Hospital Centre.

DR. HAEGERT:

A. It's got a name in French, but I won't bother with belabouring you with it.

MR. SIMMONS:

Q. Okay, and I presume that your lab there engages in different types of proficiency testing for pathology and the immunohistochemistry service that you run or would you be familiar with what proficiency testing is carried out by your lab?

DR. HAEGERT:

A. Well, there is a director of the immunohistochemistry lab.

MR. SIMMONS:

Q. Yes.

DR. HAEGERT:

A. And you know, in that lab, we do multiple immunohistochemical stains.

MR. SIMMONS:

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Q. Yes. Would you know, for example, whether your laboratory participates in the UK NEQAS program?

DR. HAEGERT:

A. No, it does not.

MR. SIMMONS:

Q. It does not?

DR. HAEGERT:

A. No.

MR. SIMMONS:

Q. There is a new program being developed, I understand, called CQIC that the B.C. Cancer Institute is involved in, that we've heard about. Would you know if your laboratory is participating in that?

DR. HAEGERT:

A. No, we're not, no.

MR. SIMMONS:

Q. Okay. Now we know that in Newfoundland there is no licensing of laboratories and no provincial accreditation program. We've heard from others that in Ontario there is.

DR. HAEGERT:

A. Yes.

MR. SIMMONS:

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Q. QMPLS program. What is the situation in Quebec about laboratory accreditation and licensing?

DR. HAEGERT:

A. Well, basically the accreditation comes through the Canadian Council of Health Services Accreditation.

MR. SIMMONS:

Q. That's CCHSA?

DR. HAEGERT:

A. Yes, sure, and so we were accredited actually in 2007.

MR. SIMMONS:

Q. Okay.

DR. HAEGERT:

A. And some people do the CAP accreditation, but it's not -

MR. SIMMONS:

Q. Pardon me?

DR. HAEGERT:

A. Some people use the College of American Pathologists accreditation as well, but it's a higher level of accreditation.

MR. SIMMONS:

Q. So there is no provincial program equivalent

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to QMPLS in Quebec?
DR. HAEGERT:
A. No.
MR. SIMMONS:
Q. Is there any provincial requirement for licensing of laboratories, aside from accreditation, that you're aware of?
DR. HAEGERT:
A. No, I don't think so. I think basically you have to be accredited by the CCHSA.
MR. SIMMONS:
Q. Okay. We've heard a little bit about the CCHSA accreditation in other evidence, and what we have heard is that in the last round of accreditation, the most recent one here, there was what I'll call a new emphasis placed on laboratories and more attention paid to the laboratory than had been in some of the preceding accreditations. Do you know if that had been the case at McGill as well, whether there was a greater emphasis on laboratories in your last CCHSA accreditation?
DR. HAEGERT:
A. I think they changed the whole--I mean, I was here for, I think, two accreditations. Then I

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went to McGill and we had it in 2007. It was completely different. The previous accreditations, the lab was hardly the focus, but in this latest accreditation, the lab was an enormous focus and they expected to have things like standard operating procedures and so on. I mean, many of the things, I think I talked about this already that Trish--I don't know how you pronounce her name, you know, the consultant from Ontario, I mean, a lot of those things, they actually demand that, you know, verify this, verify that.
MR. SIMMONS:
Q. Yes.
DR. HAEGERT:
A. Check the pH. I mean, the principle of those is interesting, the standard operating procedures. I mean, the idea behind it is that some novice could come into the lab and repeat the methodology. Of course, that in reality is probably naive, but what it really--the idea is to show that a laboratory actually uses uniform methodology. But as I said, in our lab, before that, I mean, in fact, the whole of McGill University Health

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Complex or Centre, we spent practically two years preparing for the accreditation because, except for blood bank, I think most of the labs did not have any significant level of standard operating procedures. I mean, they had techniques that they used and the people knew what to follow, but all these things were not defined and formulated, and you know, there wasn't a massive paper trail so people knew exactly what was going on.
MR. SIMMONS:
Q. So would it be fair to say then that Ontario was ahead of the curve in regards to requiring laboratories to have standard operating procedures documented and in place, even compared to Quebec?
DR. HAEGERT:
A. Certainly ahead of Quebec.
MR. SIMMONS:
Q. Okay. Have you had any involvement with Canadian Association of Pathologists or any other of the national organizations regarding moves to develop national standards for immunohistochemistry?
DR. HAEGERT:

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A. Well, I'm well aware of this. I mean, I think, I mean, one of the triggers for this, of course, is the Commission of Inquiry here, and recognition that there's been, you know, a significant problem. I mean, one of the pathologists, I think in Toronto, said this was sort of a wake-up call, meaning that people needed to be much more aware of what the internal practices are in hospitals throughout the country, in the laboratories. So I'm well aware of this. I mean, Dr. Butany gave a press conference and there's, you know, presentation and there's a committee of the CAP, Canadian Association--they have the same initials, but the Canadian Association of Pathologists, as opposed to the College of American Pathologists.
MR. SIMMONS:
Q. Thank you very much, Dr. Haegert. That's all I have for you.
DR. HAEGERT:
A. Okay, thank you.
THE COMMISSIONER:
Q. Ms. Newbury.
DR. DAVID HAEGERT, EXAMINATION BY MS. JENNIFER NEWBURY

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MS. NEWBURY:
Q. Good afternoon, Dr. Haegert.
DR. HAEGERT:
A. Good afternoon.
MS. NEWBURY:
Q. Jennifer Newbury for the Canadian Cancer Society, Newfoundland and Labrador Division. I just had a couple of questions for you on the topic of quality assurance and in particular, your reference to external consultations as a form of quality assurance, and would those types of consultations tend to be for more complex or unusual cases?
DR. HAEGERT:
A. External consultations in my experience, you consult for cases that are unusually difficult, either because you don't have the expertise in-house or because the differential diagnosis is--you really cannot distinguish between the differential diagnosis.
MS. NEWBURY:
Q. So it wouldn't include the more routine type cases that are --
DR. HAEGERT:
A. No, that would be unusual, no.

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MS. NEWBURY:
Q. And in light of your comment that these consultations does act as a form of quality assurance, was there any effort by the department to attempt to compile the data from the various consultations that might take place over the years, and to analyze that to look for trends for any particular problem areas, any type of an overview?
DR. HAEGERT:
A. I can't say. I mean, possibly it was done after I left, but I can't say.
MS. NEWBURY:
Q. You're not aware of that having occurred?
DR. HAEGERT:
A. No, I don't think so.
MS. NEWBURY:
Q. And would you say that the primary purpose of these external consultations was for individual patient care?
DR. HAEGERT:
A. Yes.
MS. NEWBURY:
Q. And would those external consultations be always recorded in a patient file?

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DR. HAEGERT:
A. Normally what would happen is that we would receive back the report and either you put an addendum or issue a new report, depending on what would happen, and that would be attached to the patient's record. I mean, it's inconceivable that some other approach--I mean, certainly we want--if there was a discrepancy in the diagnosis; say, we made a diagnosis--a lot of times there is no diagnosis and you send it to a consultant to get an opinion, but sometimes we make a preliminary diagnosis and then you get an external opinion. If there's a discrepancy, then, of course, you advise the clinician involved.
MS. NEWBURY:
Q. And would the fact that there had been an outside consultation, would that be recorded regardless of whether there was a disagreement or discrepancy or if that were the only diagnosis?
DR. HAEGERT:
A. Well, yeah, normally. That would be the normal practice.

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MS. NEWBURY:
Q. And in terms of the external consultations, would that focus on interpretation of a specimen as opposed to the--we've heard of different phrases, post analytic, pre-analytic, analytic phases in terms of getting your specimen. Would those external consultations cover all three of those categories or would it focus on what I understand to be the post analytic or the interpretation?
DR. HAEGERT:
A. Basically it would be on, if you want to call it that, post analytic. I mean, certainly people use that term. It's basically the diagnosis, what is this; is it this, is it that, or is it something else.
MS. NEWBURY:
Q. Okay.
DR. HAEGERT:
A. And then, you know, we send the slides, sometimes you send the blocks, it depends on the institution, send both. They do additional stains and they do molecular studies.

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MS. NEWBURY:
Q. Okay. So they might do some additional work that goes beyond simply interpretation, but the primary focus would be interpretation?
DR. HAEGERT:
A. Correct.
MS. NEWBURY:
Q. I guess the question is would they be trying to verify or double check any of the pre analytic work that might have been done to prepare that specific specimen?
DR. HAEGERT:
A. Well, I mean, we get a lot of consultations from outside in Montreal, and often we comment about the quality of the material. Sometimes it's extremely difficult to make diagnosis on materials submitted to us because of the quality, and it's either fixation or some other issue which we don't really--sometimes we don't understand what the issue is, but, you know, the immunohistochemistry doesn't work and there's all kinds of reasons. So, I mean, that would be part of the report, but the primary function, of course, is to make a diagnosis, to help the pathologist so that the

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pathologist can make a diagnosis that would impact on patient care.
MS. NEWBURY:
Q. I'm just wondering during your time in St. John's at the various institutions as they evolved over the years, was there ever a practice of inter-laboratory consultations or comparisons that were random in nature and not sort of falling under the description of an external consultation for patient care?
DR. HAEGERT:
A. I don't think it was ever random. It was more, Doctor so and so, you have experience with this, would you have a look at this and give me your opinion.
MS. NEWBURY:
Q. Are you aware of that type of a process being used generally in Canada, for example, as a method of quality assurance, just to take a random sampling, which would include not just your more complicated cases, but also the routine cases?
DR. HAEGERT:
A. I mean, Mr. Simmons over there, he mentioned - one of the things he--one of the things that's

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in this new CAP guidelines is they talk about how do you do this, and that's one of the thoughts that this is what you do, you do random sampling of the institution activities and review them, and identify problem areas, and then repeat it.
MS. NEWBURY:
Q. And is that--the CAP, is that the College of American Pathologists guidelines, or is this the Canadian?
DR. HAEGERT:
A. The Canadian, I'm sorry, Canadian.
MS. NEWBURY:
Q. Okay, I just wanted to clarify it. That's a fairly recently --
DR. HAEGERT:
A. Yes, that just came out in June.
MS. NEWBURY:
Q. I'm just wondering before that on a more informal basis, it was my impression based on some other evidence that we heard, that that might be done on an informal basis, we'll just randomly sample a number of cases, perhaps similar to Dr. Griffin's program --
DR. HAEGERT:

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A. Right.
MS. NEWBURY:
Q. But I understand that was internal?
DR. HAEGERT:
A. Yes, that's right. I mean, it's a lot easier when the resources are abundant.
MS. NEWBURY:
Q. Right.
DR. HAEGERT:
A. You know, I think people come from Ontario, my feeling of--I sort of see--I mean, for your information, I see Quebec and Newfoundland at least in many ways similar in terms of--at least in the past, available resources, and that it's a lot easier when resources are abundant, pathologists have a lot of protected time and so on.
MS. NEWBURY:
Q. Sure.
DR. HAEGERT:
A. It's much more difficult when there's minimal protected time and everybody is working really, really hard.
MS. NEWBURY:
Q. So if there were some desire to randomly

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sample 5 or 10 percent or 2 percent of cases, you're saying that that would be problematic, or would have been problematic because of a resource issue here while you were in St. John's?

DR. HAEGERT:

A. Well, the question--yeah, the issue would be who is going to do it, how he's going to do it, how much time it would take, and how you pull up all the material. I mentioned the business of the interfacing between Meditech systems. I assume that was solved.

MS. NEWBURY:

Q. Okay.

DR. HAEGERT:

A. But if it wasn't solved, then, of course, it would be difficult; how do you do random sampling when you can't actually access the data in the computer.

MS. NEWBURY:

Q. Uh-hm.

DR. HAEGERT:

A. It would have been difficult.

MS. NEWBURY:

Q. So it would have been an impediment to even

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locate the cases to randomly sample because of the information system?

DR. HAEGERT:

A. Right.

MS. NEWBURY:

Q. Okay. Thank you, Dr. Haegert, those are all the questions.

THE COMMISSIONER:

Q. Thank you. Mr. Browne. Dr. Haegert, when you say protected time, does it mean anything more than time in which you are not expected to be working as a pathologist in front of your microscope?

DR. HAEGERT:

A. I mean, I think--you think about, there's community hospitals and then there's academic institutions. A community hospital, I think, the expectation is that probably people spend most of their time doing clinical service work and maybe some administration, and maybe a small amount of teaching, whereas the Health Care Corporation of St. John's was an academic institution so that what one would expect is that there would be protected time for doing things like research and teaching, and keeping

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up with the literature, reviewing literature, and so on.

THE COMMISSIONER:

Q. Thank you. Mr. Browne.

MR. BROWNE:

Q. I'm going to sit down now, Commissioner, because --

THE COMMISSIONER:

Q. Oh, that was your first question. Sorry.

MR. BROWNE:

Q. That's okay, I'll just make do and see if I can work around it.

DR. DAVID HAEGERT - EXAMINATION BY MR. PETER BROWNE

MR. BROWNE:

Q. Doctor, I'll be a shorter amount of time, Doctor, you'll be glad to know.

DR. HAEGERT:

A. Okay.

MR. BROWNE:

Q. I just want to go over a couple of themes, Doctor, and just make sure I heard them from your evidence today, and it seems to be there were a number of prevalent themes throughout the time that you were clinical chief, and I guess the important--you were the first

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witness who held both the academic chair and the clinical chief chair, and you were there around the time the Health Care Corporation was formulated. Is it fair to say that there was a lot of emphasis on cost containment during your time at the Health Care Corporation?

DR. HAEGERT:

A. Yes, I already more or less summarized some of that.

MR. BROWNE:

Q. Okay, and there were issues with recruitment around those areas as well?

DR. HAEGERT:

A. This was an ongoing thing the whole time I was here.

MR. BROWNE:

Q. Issues with remuneration?

DR. HAEGERT:

A. Yes.

MR. BROWNE:

Q. And there was an emphasis--we saw through a number of documents you were shown today, an emphasis on--even though there was cost constraints or containment emphasized, there

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was also an emphasis on efficiency on top of that. Was that a theme that was discussed at departmental levels?

DR. HAEGERT:

A. Yes, it was.

MR. BROWNE:

Q. Finally, just following on the heels of the Commissioners question to you, you had mentioned, I think, a comment that there was also--again I harken back to your, I guess, dual role as clinical chair, more than emphasis on the provision of clinical services than on academia and research, is that a fair observation as well?

DR. HAEGERT:

A. I think that's true. I mean, it's extremely difficult to think about doing anything other than service if it takes up most of your time. I think that was the major emphasis, it was difficult to find time to do research. So the reality was there was a small number of people doing academic things, and often they did it at night or on the weekends, you know, on their own time.

MR. BROWNE:

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Q. And the Commissioner did ask you about protected time. Is that an important thing--putting aside just--I know again the academic side of it, but what about people who are just in the clinical practice itself, is that protected time important for them as well?

DR. HAEGERT:

A. Well, it is, you know, because, I mean, there's all kinds of textbooks on pathology and they describe classic cases, but patients tend not to read the textbooks and their cancers are often--they don't fall necessarily into some easily identifiable class. Sometimes they do, but a lot of times they're difficult. So this is a time that, you know, a practising pathologist needs to actually go to the literature and read and try to figure out--you know, expand his information or her information about the complexity of things. Some of it is in the books, but some of it is in the literature. Sometimes you'll find a case which--I mean, we use immunohistochemistry for all kinds of things and we think that certain tumours stained with certain immunohistochemical stains, and then

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you find a tumour that stains quite differently, and the question is what is it. I mean, it has features of two tumours, but you know it's one tumour and how do you deal with it; well, the only way you can address it is--you know, you could throw up your hands and say, oh, well, I better get an external opinion, which is--you know, takes time, might take a couple of weeks depending on the--or the alternate is to go to the literature. A lot of times things that you think are really extraordinary or unusual or never seen, in fact, somebody has published 30 cases of it.

MR. BROWNE:

Q. And just by way of example, Doctor, the Commissioner has heard some evidence from a couple of previous witnesses, for instance, lobular, the Commissioner has heard about classic lobular carcinoma.

DR. HAEGERT:

A. Right.

MR. BROWNE:

Q. But then there are also--you could have a lobular with ductal features, so there is mixed--we've heard mixed comedo and all, so

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it's not--I guess, the notion that a tumour can be pigeon-holed into a specific category is not necessarily--it's a bit of a naive understanding?

DR. HAEGERT:

A. They're not all homogeneous.

MR. BROWNE:

Q. Homogeneous.

DR. HAEGERT:

A. They're mixed--yes, quite true, this is indeed true.

MR. BROWNE:

Q. Okay.

DR. HAEGERT:

A. And that's where you really need time to look into the literature. I mean, it's fine to open a big standard text, but the standard texts, actually--the information is often limited.

MR. BROWNE:

Q. And you'd mentioned earlier as well the amount of time and the number of slides. Would that also involve looking at a number of slides to try to figure out all these various features as well because of the number of slides now

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that are generated in a breast cancer? You mentioned that earlier.

DR. HAEGERT:

A. Well, I think what's happened--I mentioned in the past patients were treated by radical mastectomy, and often you get ten slides.

MR. BROWNE:

Q. Right.

DR. HAEGERT:

A. That's when I was first starting out. Now they have small excisional biopsies maybe with axillary lymph nodes, and then there's multiple slides and often what you'll find is multiple tumours, and there's all kinds of gradations between the tumours. So you might have--I saw a case the other day that I think there were 20 different--I'm not sure of the number, but something like 20 different cancers in the breast. They were all tiny, they were all over the place. I mean, it takes ages to look at something like that, and then there's all these grey area lesions. I mean, it's not all black and white, like cancer versus benign. It's much more complicated than this.

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MR. BROWNE:

Q. Lastly, Doctor, there was one comment you made today concerning a question from Mr. Coffey about MAC meeting around the time with the Health Care Corporation, and, I guess, the decision to implement program management, the CEO at the time was Sister Elizabeth Davis, and I think--I wrote down, "In the early phases, the clinical chiefs spoke out against Sister Davis' plan for lab medicine". What was it--there was, I guess, objection to, or people were speaking out in terms of --

DR. HAEGERT:

A. No, I think that's--hopefully that's not what I said.

MR. BROWNE:

Q. And I may have --

DR. HAEGERT:

A. What it was, was actually the initial meetings is before the clinical chiefs were identified, is that the chairs of the university departments were invited, and then they were told by Sister Elizabeth, well, myself included, that the model that she was using, the program management, and what they were

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going to do is going to have this management system where they were going to choose the clinical chiefs, and the chairs were furious with this comment, and I actually didn't speak against this. The reason I didn't speak against it was we had invited Sister Elizabeth to come to the laboratory to talk to us about her model, or what she was going to do with the Health Care Corp, thought we might as well find out what she was going to do. She came and she told us this is what she was going to do, and it was clear to me that this was her intention irrespective of what anybody said and indeed that was true. So what people did not like is that the--I don't know how they perceived them, maybe bureaucrats in the Health Care Corporation, but they weren't all bureaucrats, but they--you know, there were medical people too, were going to make the decisions as to who the clinical chiefs were going to be, and they didn't like this at all. So we discussed that for several meetings--well, we didn't actually discuss it, it was mostly, like, a statement of displeasure repeated over and over again. It was kind of

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a major time waste there, but that's what went on--really went on for a few meetings, and then eventually people realized that this is what was going to happen.

MR. BROWNE:

Q. It was a fait accompli?

DR. HAEGERT:

A. Yes.

MR. BROWNE:

Q. Thank you, Doctor. Now normally at this time we invite--the Commission invites witnesses either to make any comments or observations or recommendations to the Commissioner, and this will be your opportunity if you wish to do so.

DR. HAEGERT:

A. Commissioner, if I could say something. One of the--I mean, I think for me this Commission of Inquiry has been a real eye opener. I mean, other people have expressed this, of course, I feel terrible for the patients and their families that have been affected, but one of the things I wanted to say really was one of the positive things that's come out of this, and I don't know if people have sort of alluded to this, is that it's been sort of a

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wake up call across the country in the pathology departments. First of all, the Canadian Associations of Pathologists has recognized that there need to be national guidelines. I mean, basically we can't just have--I mean, basically there have to be national guidelines for things like immunohistochemistry, but other aspects of the laboratory, and I think that's a positive thing, at least in my opinion. One of the concerns I had really was the negative impact the Commission--I mean, I know that's not the intent, and obviously it's bringing everything out into the open, which is a positive thing, but the concern I have is the impact this has on the pathologists here. I mean, I no longer practice here, but I certainly feel that this has probably been a devastating blow to the pathologists, and there was an editorial in the Canadian Medical Association Journal by Dr. Butany who was the President of the Canadian Association of Pathologists, maybe still is actually, but what he said is one has to remember, and I think it's useful for the people of this province to remember, that

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estrogen receptor and progesterone receptor testing was one--even though it had huge implications, it's one small activity in pathology, and my experience here was that the pathologists were competent, caring, and very careful, and that one could trust the opinions that come out of the pathology department here, and I think one of the concerns I had is whether this is going to sort of tar the pathologists here with a black brush. You know, this is--I mean, it's probably fairly evident, but I sort of felt like I should say this because I certainly was here, and I feel that this is true. The other thing I feel-- I mean, I'd just like to--I mentioned, obviously, the patients, but I just think that --I think it must have been extremely difficult for Dr. Cook because he was the clinical chief and took on the role after myself, and I would have thought this must have been extremely difficult and challenging for him to deal with this and actually extraordinarily stressful. I thought--I mean, from what I can gather, he dealt with this in the appropriate way and I think the people

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here should be pleased in the province that they had leadership like himself at the time to actually bring this out into the open, try to figure out what the issues were. I think that's basically all I would like to say.

THE COMMISSIONER:

Q. Thank you, Mr. Browne. Do you have anything arising, Mr. Coffey.

COFFEY, Q.C.:

Q. Just one question, Doctor. You did in responding to a question, I believe from Mr. Simmons, refer to the fact that at McGill there is a Director of Immunohistochemistry?

DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. That person is what sort of a--is that a physician?

DR. HAEGERT:

A. Physician, yes, pathologist.

COFFEY, Q.C.:

Q. Pathologists, okay. So the background of a director at your institution--for the Director of Immunohistochemistry has been chosen to be a pathologist, a chosen pathologist?

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DR. HAEGERT:

A. Yes.

COFFEY, Q.C.:

Q. I just wanted to clarify that, Doctor. Thank you very much, Doctor.

THE COMMISSIONER:

Q. Thank you very much, Doctor Haegert, for coming to assist us, and we promised to get you to the airport on time, and I think we will do so.

DR. HAEGERT:

A. All right, thank you.

THE COMMISSIONER:

Q. You're going to take care of that, Mr. Browne.

MR. BROWNE:

Q. I will, Commissioner, as we speak.

THE COMMISSIONER:

Q. Okay. Now I think we're going to complete the evidence of Mr. Dawe. Thank you once again, Dr. Haegert.

CHAYTOR, Q.C.:

Q. Commissioner, there's two new exhibits for Mr. Dawe today, 2481 and 2544, and I know I said I was finished yesterday, but there is something Mr. Dawe would like to clarify in relation to

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one of those exhibits.
THE COMMISSIONER:
Q. Would you give me those numbers again, please, Ms. Chaytor?
CHAYTOR, Q.C.:
Q. Sure, it's 2481 and 2544.
THE COMMISSIONER:
Q. All right, those exhibits are entered. I'm afraid the humidity has made all of our desks wet, Mr. Dawe, there's not a thing we can do about it. We may have to switch over plugs. Ms. Chaytor.
EXHIBIT ENTERED AND MARKED P- 2481
EXHIBIT ENTERED AND MARKED P- 2544
MR. PETER DAWE - EXAMINATION BY SANDRA CHAYTOR, Q.C.
CHAYTOR, Q.C.:
Q. Good afternoon, Mr. Dawe?
MR. DAWE:
A. Good afternoon.
CHAYTOR, Q.C.:
Q. Thank you for your indulgence in coming late in the afternoon.
MR. DAWE:
A. You're welcome.
CHAYTOR, Q.C.:

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Q. Mr. Dawe, if we could have, please, P-2544. Mr. Dawe, this is a two page exhibit which includes two e-mails from yourself to Ms. Pilgrim, and those were produced by your counsel this morning to us, and I understand after you left here yesterday, you realized that those existed and that they've now been produced to the Commission. Yesterday in your evidence, it involves, I believe, the draft letter which Eastern Health had sent to you, which they intended to send out to patients, and perhaps then you'd like to clarify that aspect of your evidence from yesterday.
MR. DAWE:
A. Thank you for the opportunity, and at one point you were questioning me yesterday about us, CCS, and myself, being given the opportunity to have input into the letter that was sent out to patients, and at one point I indicated that we'd seen a draft and that I think, though, at the end of the questioning, you reiterated the question or you re-asked the question and I said, no, we hadn't had input, but actually we had. I went and checked and there's two e-mails to Pat

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Pilgrim, and this first one indicates that we did get a copy of the letter and I'm giving her some very small minor feedback on it, and then there's a second e-mail where I again give some direct feedback on the letter that they were planning on sending out. So I just wanted to clarify that we did indeed have an opportunity to see the draft, which I had said, but that we did comment to it, and there it is.
CHAYTOR, Q.C.:
Q. Okay, and on page two of the exhibit, you mentioned a couple of comments, and it appears perhaps there's three suggestions that you have. The first being, "Our suggestion is that all breast cancer patients receive this information for the time period in question as they have many questions also". Is it your understanding was that suggestion accepted by Eastern Health, did all breast cancer patients receive --
MR. DAWE:
A. I don't believe so, no, and again based on the calls that we were getting, we knew we were getting calls from people who were confused

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and they may have been never retested even, but because they had breast cancer, they'd maybe been tested positive, not everybody follows their own information very closely at times, or over time forget certain information, but we knew there was confusion with more than just the group that had been retested. So we suggested sending information, and again we weren't looking at this as an apology letter, that's what it turned into. Our suggestion had nothing to do with an apology letter, it was a letter providing information, but I don't think that was the case, the suggestion wasn't followed.
CHAYTOR, Q.C.:
Q. Okay, and the second suggestion concerns the background material. You mention, "There's no reference to who was retested and why. This would be good for all breast cancer patients to understand also". Do you know whether or not there was any explanation sent out as to who, in fact, composed the retest group?
MR. DAWE:
A. Well, again it followed--if you were going to follow the first suggestion, the second

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suggestion was much more relevant, and so it really was 1(a) and (b).

CHAYTOR, Q.C.:

Q. Yes.

MR. DAWE:

A. So I think where they didn't follow the first suggestion, the second suggestion was a moot point.

CHAYTOR, Q.C.:

Q. And then the final suggestion was about the growing concern over retro converters or false positives, "That again should be addressed with all breast cancer patients", and do you know whether or not there's been any follow up in that respect?

MR. DAWE:

A. I don't know of any, and I think it would still be an outstanding question that the Canadian Cancer Society would have of Eastern Health.

CHAYTOR, Q.C.:

Q. Thank you, Mr. Dawe, those are my questions.

THE COMMISSIONER:

Q. Mr. Pritchard.

MR. PRITCHARD:

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Q. Thank you, Commissioner, Ms. Brazil is going to ask some questions.

THE COMMISSIONER:

Q. All right then.

MR. PETER DAWE - EXAMINATION BY MS. JACQUELINE BRAZIL

MS. BRAZIL:

Q. Good afternoon, Mr. Dawe.

MR. DAWE:

A. Good afternoon.

MS. BRAZIL:

Q. My name is Jackie Brazil. I appear as counsel with Mr. Pritchard for the province, and I have a couple of very quick questions for you. Mr. Dawe, yesterday you confirmed--I think you stated in your testimony in chief that you had a good healthy relationship with the province, that the Canadian Cancer Society had a good healthy relationship with the province?

MR. DAWE:

A. Absolutely.

MS. BRAZIL:

Q. And particularly --

MR. DAWE:

A. The provincial government, absolutely.

MS. BRAZIL:

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Q. In general.

MR. DAWE:

A. Yes, yeah.

MS. BRAZIL:

Q. Okay, thank you, and with--particularly with Mr. Wiseman, Minister Wiseman, as he is now, and John Abbott, Ministers Osborne and Ottenheimer?

MR. DAWE:

A. And even prior to that, absolutely, solid working functional relationships.

MS. BRAZIL:

Q. Right, and, you know, you gave some very frank testimony about the meetings that you had with Mr. Abbott, Mr. Ottenheimer, and Minister Wiseman, and you confirmed that there was no--that you didn't change your approach or your media strategy as a result of those discussions?

MR. DAWE:

A. Absolutely not.

MS. BRAZIL:

Q. Finally, Mr. Dawe, I just wonder--you mentioned that there have been--since those discussions, there have been some joint

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projects that the province and the Canadian Cancer Society participated in. I wonder if you could elaborate on some of those projects?

MR. DAWE:

A. Absolutely. The first one that comes to mind because we're so proud of the project is the Daffodil Place project, and it's a facility being built in St. John's for cancer patients to stay in when they come to St. John's for treatment. It's designed to get at the issue of the financial burden of a cancer diagnosis, so it would be a very nominal fee to stay there, etc, and you get your meals and transportation back and forth to treatment. We have met with any number of people within the Department of Health, and as a matter of fact, I can remember meeting with Minister Loyola Sullivan at the time, as finance minister, talking about the project, the need for it, and we got a tremendous amount of support from government. I think I mentioned yesterday there's always barriers in any project, and we certainly met some along the way, but at the end of the day in this particular project, the provincial government made a substantial

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donation to the capital campaign, and I explained yesterday we don't take operating funds from government for a capital expenditure like this, a one time donation, we would accept funds. That transpired and certainly we received a lot of moral, I would say, and verbal support along the way for that project also. The other one that comes to mind immediately is a provincial cancer control strategy which is a comprehensive approach to cancer control in the province. We've been--we initiated this based on the Canadian Cancer Control or the Canadian Strategy for Cancer Control. We met with--gee whiz, it was probably John Ottenheimer was the original minister at the time, and then every minister since then have been pushing that big ball up a hill, a very comprehensive strategy that now involves all the health authorities, the Department of Health and Community Services, and any number--literally hundreds of stakeholders, consultation processes, and we're actually at the stage now where we're anticipating a meeting with Minister Wiseman to get his final input, final word, if you

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will, on how he thinks we're doing with this, and we want to launch this as soon as possible.

MS. BRAZIL:

Q. Okay.

MR. DAWE:

A. Those would be the two major projects. There's any number of other advocacy issues. Mostly when we're dealing with government, we're dealing on advocacy issues and there's give and take and there's negatives and positives, and you never get exactly what you want, but you push hard. And tobacco is a great example. We've cooperated in many areas on the tobacco file, not just with the Department of Health, but the enforcement falls under other areas. Pesticide legislation comes to mind, and if you want to bring that back to Minister Johnson and tell her that we're still waiting for her comments on the pesticide file, that would be great too. So again absolutely, I would agree, any number of projects that we have a healthy relationship with the provincial government, back and forth. You never get exactly what

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you want, but you keep moving in the relationship, and it's been my experience that on the political side, people are there because they want to see better public policy, so there's very few - it's not very often that you run in on the political side to someone that says, well, you know, that suggestion doesn't make sense; it's probably more about the timing of moving on it or the extent that they feel that they can move on it. On the bureaucratic side, I'll be quite honest and say at times it's very frustrating dealing with the bureaucracy of the provincial government. It's probably no different than any bureaucracy, but again there's people there that are doing their job, as we do our jobs, and we make as much progress as we can on any given file in any given time period.

MS. BRAZIL:

Q. So, I guess, today, September 4, 2008, would you still say that that healthy relationship exists with the provincial government?

MR. DAWE:

A. Absolutely.

MS. BRAZIL:

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Q. Okay, those are my questions, Commissioner. Thank you, Mr. Dawe.

THE COMMISSIONER:

Q. Mr. Simmons.

MR. PETER DAWE - EXAMINATION BY MR. DAN SIMMONS

MR SIMMONS:

Q. Good afternoon, Mr. Dawe.

MR. DAWE:

A. Good afternoon.

MR SIMMONS:

Q. As you know, I'm Dan Simmons. I'm here for Eastern Health. I hope not to be too long either. You told us yesterday that your first indication that there were issues with ER/PR testing was in early October of 2005 when there was a media story in The Independent which you read concerning that, and you also told us, I believe, that it was not long after that that you had our first communication with Dr. Robert Williams concerning that?

MR. DAWE:

A. Yes.

MR SIMMONS:

Q. And if I understand, from that point on, you had relatively frequent and open communication

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with Dr. Williams concerning the issue?
MR. DAWE:
A. We had continuous communication, absolutely.
MR SIMMONS:
Q. And did you throughout that time period have any difficulty getting access to Dr. Williams or reaching him when you needed to, or arranging a meeting if you needed to speak with him concerning an issue in any way related to the ER/PR matter?
MR. DAWE:
A. I would say, no, absolutely not. There was times he was out of town, but even then if it was an important issue, I'd get a message to him and he'd get back to me.
MR SIMMONS:
Q. Yes, and when the issue first broke in the media in October and several months after that, you gave a number of media interviews and you were quite available to the media to make comment on the issue?
MR. DAWE:
A. Absolutely.
MR SIMMONS:
Q. Yes, and were you aware that Dr. Williams

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similarly was giving interviews and making media comment through that period as well?
MR. DAWE:
A. Yes.
MR SIMMONS:
Q. Did Dr. Williams at any time express any concern to you about anything you were saying in the media or the approach you were taking in the media, did you hear that from Dr. Williams?
MR. DAWE:
A. No.
MR SIMMONS:
Q. Now you told us that you had contact with Mr. Tilley who was the CEO of the organization as well?
MR. DAWE:
A. Yes.
MR SIMMONS:
Q. Similar questions. If you wanted to try to reach Mr. Tilley, was he available and accessible to you within the limits of logistics of getting in touch with each other?
MR. DAWE:
A. Absolutely.

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MR SIMMONS:
Q. Did you ever have any occasion when Mr. Tilley expressed any concern whatsoever to you about comments you were making in the media about the ER/PR issue or the position that the Canadian Cancer Society was taking concerning it?
MR. DAWE:
A. No, and as I testified to yesterday, I arranged a specific meeting with him with the understanding that, you know, he may or the organization may have some issues they wanted to talk about, and certainly explicitly gave him the opportunity, but he did not, you know, give any examples or express any explicit concern about the media work we were doing.
MR SIMMONS:
Q. Yes, and that meeting that you referred to was the one that followed the conversations you'd had with Mr. Wiseman and Mr. Abbott with government, I believe, correct?
MR. DAWE:
A. Yes.
MR SIMMONS:
Q. And did I understand you earlier--yesterday to

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say that at that meeting with Mr. Tilley, although it was taking place, I gather, for the purpose of determining if they had any issues, as you described, you didn't actually tell him what you'd heard from Mr. Wiseman or Mr. Abbott?
MR. DAWE:
A. No.
MR SIMMONS:
Q. And that any other time did Mr. Tilley raise any concerns with you about the approach taken by the Canadian Cancer Society?
MR. DAWE:
A. No.
MR SIMMONS:
Q. You told us about dealing with Mrs. Pilgrim.
MR. DAWE:
A. Yes.
MR SIMMONS:
Q. She came on the scene a little bit later in the process, I believe?
MR. DAWE:
A. Right.
MR SIMMONS:
Q. And I gather that you've probably had

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relatively frequent contact with Ms. Pilgrim on a number of issues since she's responsible for the Cancer Care Program, the ER/PR matter being one of them?

MR. DAWE:

A. Absolutely.

MR SIMMONS:

Q. And you told us that there were occasions that you did have discussions with her about things she questioned, specific things she questioned about things you've said in the media?

MR. DAWE:

A. I can remember absolutely receiving--it happened more than once. It probably happened three or four times.

MR SIMMONS:

Q. Yes.

MR. DAWE:

A. Receiving a call from Pat Pilgrim questioning some factual information that had been presented. My experience was that it was interpretive--if you want to call a disagreement on what was said. It was more interpretive of what was said versus a hard cold fact that had to be corrected. The only

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time--I can remember one time specifically when I had stated in the media that my understanding was that families of deceased patients--the deceased patients hadn't all been retested, and I can remember Ms. Pilgrim calling me to say, no, you know, we did that several months ago, and that that was information for me that I absolutely then endeavoured to correct. I remember I actually wrote a letter to the Editor because I had mentioned this in a Telegram article.

MR SIMMONS:

Q. Yes.

MR. DAWE:

A. So I endeavoured to correct that.

MR SIMMONS:

Q. So those types of contacts with Ms. Pilgrim, were they any source of concern for you or would you just regard those are part of a healthy type of communication and relationship between the organizations?

MR. DAWE:

A. No, I don't consider it a part of a healthy relationship. The relationship, as I characterized it yesterday, wasn't healthy.

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My relationship with Pat Pilgrim was quite beneficial at times, and at other times it was unproductive, if you look at it from an outcome perspective. That's what I said yesterday. It comes down to what you accomplish with your conversations.

MR SIMMONS:

Q. Right.

MR. DAWE:

A. And --

MR SIMMONS:

Q. So the things that you or your organization wanted to see happen didn't always happen, but was the line of communication between you and Ms. Pilgrim one that was open such that she was accessible and you were able to talk--at least talk about these issues and get an opportunity to express your point of view?

MR. DAWE:

A. Absolutely, and I testified to that yesterday, the lines of communications have always been open.

MR SIMMONS:

Q. And Dr. Howell replaced Dr. Williams as the VP Medical and following that, I believe you told

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us that the first opportunity you had to sit down and talk to Dr. Howell was after the media technical briefing on the 11th of December, 2006?

MR. DAWE:

A. Yes.

MR SIMMONS:

Q. Had you had any occasion before that to try to contact Dr. Howell or to make any inquiries of him regarding the ER/PR issue?

MR. DAWE:

A. No.

MR SIMMONS:

Q. So it wasn't a case of Dr. Howell not having responded to any inquiries that had come from you?

MR. DAWE:

A. No.

MR SIMMONS:

Q. That was the first opportunity.

MR. DAWE:

A. Yes.

MR SIMMONS:

Q. At that meeting that you had with Dr. Howell on December 11th, I believe we saw in some of

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the documents that that was at 3 o'clock in the afternoon, and --

MR. DAWE:

A. Yes.

MR SIMMONS:

Q. Did Dr. Howell go over with you any of the information that had been presented at the technical briefing as part of that meeting?

MR. DAWE:

A. Not that I can recall.

MR SIMMONS:

Q. Did you learn at that meeting that the information had been released that there were 117 patients who had had treatment changes as a result of changed test results, for example? Did you leave that meeting with Dr. Howell knowing that number, because that would seem to be an important piece of what happened in the technical briefing?

MR. DAWE:

A. I would have probably known that going into the meeting.

MR SIMMONS:

Q. Uh-hm, okay. So had you followed in some way the technical briefing or the information

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released in it before seeing Dr. Howell at 3 o'clock in the afternoon?

MR. DAWE:

A. I would have had contact with people who had been in the technical briefing, absolutely.

MR SIMMONS:

Q. So do I take it then that you weren't relying on your discussion with Dr. Howell to learn those things, you had already informed yourself about what type of information had been released before going into the meeting with Dr. Howell, had you?

MR. DAWE:

A. Absolutely.

MR. SIMMONS:

Q. Yeah. Were there any questions you had about the information released at the technical meeting that you raised with Dr. Howell?

MR. DAWE:

A. No. The discussion with Dr. Howell was not technical in any way, shape or form.

MR. SIMMONS:

Q. Right, okay. And I'm going to move around a little bit just to hit some of the different areas.

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MR. DAWE:

A. Yeah.

MR. SIMMONS:

Q. The chronology is not going to be strictly correct. You told us about meeting Dr. Williams back in October of 2005 and about some discussion about Dr. Williams' expectations about what the portion of or percentage of change results might be as a result of the retesting that was under way?

MR. DAWE:

A. Yes.

MR. SIMMONS:

Q. You recall that. Do you recall at that time that there were very few test results back from Mount Sinai and the bulk of the samples had not yet been retested? Does that sound correct?

MR. DAWE:

A. That sounds correct.

MR. SIMMONS:

Q. Right. And if I noted correctly, what you'd said on that was that your perception was that Dr. Williams was expecting ten percent of the retests to have changed results but you

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weren't certain if that was what had been conveyed to you by Dr. Williams? Did I get that wrong?

MR. DAWE:

A. I wouldn't be able to quote him accurately.

MR. SIMMONS:

Q. Yes.

MR. DAWE:

A. But again, the perception that I had and it was formed by Dr. Williams both in what we discussed one on one and with other public statements that he'd made was that there was a--the ten percent figure was being used. And I was certainly, had the impression that it was, it reflected a ten percent error rate and that whether I had ever--well, later on in the relationship with Dr. Williams I'd certainly asked for exact numbers but was never given them by Dr. Williams directly.

MR. SIMMONS:

Q. Right.

MR. DAWE:

A. But the ten percent number existed for some time.

MR. SIMMONS:

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Q. Okay. I'm just going to show you one newspaper report at P-0345, page 2, please? I just want to see if this accords with your recollection or not. Okay, this is one we've looked at with a number of witnesses. This is an Evening Telegram--or The Telegram report, it's from October 5th, 2005. So this would have been very shortly after the original Independent article and probably around the time of that first meeting you had with Dr. Williams, would it be?

MR. DAWE:

A. I believe it was October 6th I had the meeting.

MR. SIMMONS:

Q. Yeah, okay. And this one is a little bit hard to read. See if I can make it a bit bigger here. If you start here on the second column at the very bottom, it says, "About 350 of the tests are done annually in this province with 60 percent of the samples from Eastern Health Authority patients and 40 percent from patients treated at other regional centres. Williams said the lab at the General Hospital and the Health Sciences Centre in St. John's

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stains the specimens for these receptors. Results are read at referring hospitals. Most of the tests performed were positive, Williams said." And there's a quote then, "'We had about 73 percent of tests that were positive, so are only retesting the 27 percent or so that were negative' And from the early results Williams says it appears that only about ten percent of the overall tests performed over the past seven years show different results." So in this newspaper article it appears that the ten percent is ten percent of all tests and not just ten percent of the 27 percent that were negative. Do you see that?

MR. DAWE:

A. Now that you point it out to me, absolutely.

MR. SIMMONS:

Q. Yeah. Does that accord at all with your recollection or your perception of the information as conveyed to you by Dr. Williams?

MR. DAWE:

A. Again, my perception, and it lasted well over a year, as that--and again, speaking to Dr.

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Williams numerous times and Bob giving me updates on how many people had actually gone through the process and how many tests had gotten back because at one point that was the key discussion with Dr. Williams and myself was, you know, "Bob, is everybody back yet? You know, we're still getting calls. Has everybody been retested -

MR. SIMMONS:

Q. Yes, that was the issue.

MR. DAWE:

A. - that was supposed to be retested?" And the--Dr. Williams again used the ten percent number throughout the conversations I had with him. I'd never clarified with him if it was ten percent of everybody who had breast cancer or if it was ten percent of the retests explicitly.

MR. SIMMONS:

Q. Yes.

MR. DAWE:

A. Although I did ask for numbers and was never given them.

MR. SIMMONS:

Q. Right, okay, good. You've alluded then to

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making inquiries about the progress of getting the samples back, the retest results back from Mount Sinai. So through 2005 then you were aware that there were delays encountered and the results weren't coming back as quickly as had been anticipated?

MR. DAWE:

A. Absolutely.

MR. SIMMONS:

Q. You told us that at one point you made suggestions about or inquired as to whether it might be possible to get Mount Sinai to prioritize -

MR. DAWE:

A. Right.

MR. SIMMONS:

Q. - the results. And I think that was P-0387, please? We looked at this before. This is your e-mail message of November 14th there. And do you know whether there was then anything to try and prioritize the results for the living patients ahead of those patients who were known to be deceased? Were you ever made aware of that?

MR. DAWE:

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A. My recollection is that, and I said yesterday, I can remember having the conversation with Bob Williams, not Pat Pilgrim, and that Bob had told me that prioritizing the samples now that they were up at Mount Sinai would be too extensive a problem, just create too many logistical problems.

MR. SIMMONS:

Q. Right.

MR. DAWE:

A. I certainly had knowledge at some point, and whether it was close to this point in time or not, but I had knowledge at some point in time that Eastern Health had asked Mount Sinai to differentiate between people who were living and deceased and that let's get through the-- you know, telling Mount Sinai to prioritize the people that were living.

MR. SIMMONS:

Q. So despite the initial response or reaction you had from Dr. Williams you did learn later that steps were taken to at least prioritize -

MR. DAWE:

A. Absolutely.

MR. SIMMONS:

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Q. - results for the living. And if I can just show you P-1805, please, that will confirm that. Now, and this isn't a document you would have seen before, but it's an e-mail message from, actually, before yours, from November 3rd, '05 from Heather Predham. And it's addressed to Dr. Cook and to Dr. Mullen at Mount Sinai saying "Upon Dr. Cook's and Dr. William's request I have reviewed your list and highlighted in yellow all those that are now deceased." And there's a list which we won't look here which is attached to that identifying individual patients. So this would accord with the knowledge you later acquired, would it?

MR. DAWE:

A. Yes.

MR. SIMMONS:

Q. Okay.

MR. DAWE:

A. Of course, Mr. Simmons, the requests that we were getting about prioritization were from living people, obviously.

MR. SIMMONS:

Q. Yes.

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MR. DAWE:

A. And it was around when people had been diagnosed and should that have affected the prioritization.

MR. SIMMONS:

Q. Right. Did you learn at any point in the process that there was a provision in place whereby oncologists or treating physicians could, in effect, pull patients out of the cue and prioritize them by having their samples sent to Mount Sinai as what they called a consult?

MR. DAWE:

A. I learned it. It actually--I learned that through the media and not from Department of Health, but I did have that knowledge at some point.

MR. SIMMONS:

Q. Good, okay. And I'd like to refer you also to P-2509, which was a letter that you looked at yesterday. Now, this is from June of 2006, it's an e-mail message from you to Dr. Roy West, who I believe then was chair of the Newfoundland and Labrador Division of the Cancer -

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MR. DAWE:

A. Yes.

MR. SIMMONS:

Q. Canadian Cancer Society. You said in it, "Here's a draft of the letter to Eastern Health re hormone receptor testing. I know there's no rush, but I don't want to lose the issue. We've told the board we will vet it through them also." And there's a draft of a letter attached. Now, were you the author of this draft?

MR. DAWE:

A. Yes.

MR. SIMMONS:

Q. Okay. It's a draft addressed to Ms. Joan Dawe, who was the chair of the Eastern Health Board. And you've told us that the letter was never completed and sent, I gather?

MR. DAWE:

A. Right.

MR. SIMMONS:

Q. And there was some, I gather, discussion about the tone of the letter and some disagreement or failure to agree, perhaps, on your part and Mr. West's on what tone to take in the letter,

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was it?
MR. DAWE:
A. On how--tone might be one way to describe it, absolutely, yes.
MR. SIMMONS:
Q. Yes, okay. But nevertheless, the particular draft we have here is the one that was prepared by you and proposed to Dr. West for his review?
MR. DAWE:
A. Yes.
MR. SIMMONS:
Q. And it is this draft that has the statement in it on the second page that, "In fact, it is our belief that the relationship has improved with the creation of the Eastern Health Authority." So having written that and proposed it to Dr. West can we take it that that was a view that at least at that time that you held that it was appropriate to communicate that information to the chair of the Eastern Health board?
MR. DAWE:
A. There was certainly a point in time when Eastern Health was created and the

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Newfoundland Cancer Treatment Research Foundation had been disbanded when the relationship with the Cancer Care program, from our perspective, was much more open.
MR. SIMMONS:
Q. Okay. And -
MR. DAWE:
A. And I believe that that sentence is a reflection of that.
MR. SIMMONS:
Q. Good. And the sentence is written in the present tense and the letter is dated June, 2006, so can we take June, 2006 to be such a time when there was -
MR. DAWE:
A. No, because the, as I said, the letter was never sent and there was a lot of discussion between myself and Dr. West on exactly what we were trying to convey in the letter. And we obviously didn't come to agreement on it.
MR. SIMMONS:
Q. Was the draft ever presented to your board to be vetted?
MR. DAWE:
A. No, we didn't even create another draft.

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MR. SIMMONS:
Q. Good. Thank you, very much, Mr. Dawe. That's all I have for you.
MR. DAWE:
A. Thank you.
THE COMMISSIONER:
Q. Ms. Hennebury?
MS. HENNEBURY:
Q. I have no questions.
THE COMMISSIONER:
Q. Mr. Pritchett?
MR. PRITCHETT:
Q. I have no questions, Commissioner?
THE COMMISSIONER:
Q. Mr. Pike?
MR. PIKE:
Q. No questions, thank you.
THE COMMISSIONER:
Q. Ms. Brocklehurst?
MS. BROCKLEHURST:
Q. No questions, thank you.
THE COMMISSIONER:
Q. Ms. Newbury?
MR. PETER DAWE, EXAMINATION BY MS. JENNIFER NEWBURY
MS. NEWBURY:

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Q. Good afternoon, Mr. Dawe. I understand that you may have some additional observations or comments on a couple of topic areas that you think might be of some benefit to the Commissioner.
MR. DAWE:
A. Hopefully.
MS. NEWBURY:
Q. And perhaps if we can go over a few of those briefly. First of all, you had spoken yesterday about patient right to know and public right to know. And I just wondered if there was anything that you wanted to add in relation to that and I know that there is an exhibit which I believe it related, P-2438, please? And perhaps you could explain what this exhibit is in relation to -
MR. DAWE:
A. Commissioner, this is a Canadian Prostate Cancer Network, it's a community volunteer network of prostate cancer survivors across the country. And they endeavoured some years ago to come up with what they are calling a Charter of Rights and it lays out, from their perspective, what would be the basic rights of

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a patient with prostate cancer in any situation in any province in the country. And we brought it forward to highlight what we would think of as one of the main areas of concern of the Commission of Inquiry. And we've said from the beginning, obviously, what happened in the lab is why we're all here, but the follow-up from Eastern Health around the communications issues is and always has been one of the primary areas of concern for the Cancer Society. And it's from the perspective of representing cancer patients or people who might have cancer in the population of Newfoundland and Labrador. So we would put forward that there are--there is a necessity for groups like the Canadian Cancer Society, groups like the Prostate Cancer Network, governments, health care institutions to articulate clearly what people should expect when they enter the health care system. This particular one represents prostate cancer. We obviously would represent cancer patients in general. I would suggest that there is a broader need in the health care in general to articulate clearly what a fair expectation

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would be for any person entering the health care system, what you can expect as far as your understanding of, and we talked a little bit about the right to know, an individual's right to know and patients right to know has come up. What the Canadian Cancer Society would put forward was that was people actually have a right to actually understand, not just to know and be told, but to understand information begin given to them. And if you look at this particular exhibit, you get that sense that they're not just--these people have said we're not just looking for information, we want to be a full partner in our own health care, and that's what it comes down to for the Canadian Cancer Society. In this particular case where you've got mistakes that were made and on a large scale and a large number of people that were affected, you're even gone beyond--you get into the area that the professionals start putting particular names on, you know, whether it's--and the term is escaping me now that the Canadian Patient Safety Institute uses, adverse event. Whether it's an adverse event or not, you know, at the

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day if you flip that around from a patient perspective, it's a mistake that affected them quite negatively and so, the Cancer Society has a belief that there absolutely has to be articulated a basic level of rights for people entering the system, and then if there is going to be, and there always will be mistakes made, there has to be an articulation of what the patient rights are in that instant also, and there is organizations like the Canadian Patient Safety Institute who look at it much more from the institution perspective and from the professional perspective on what the institution is accountable for. We would suggest that there's an opportunity to look at it from the patient, dare I say person who has cancer perspective, and anybody entering the health care system, about what they have a right for.

The other piece that you'd add onto that then, and that we've gotten into in this instance is there's an individual right, but then at some point, there's also a public right, and there's a public right to know about our health care institutions. They're

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public institutions. Even if they were private institutions, I think we have, in our society, an engrained belief that we have certain rights when we seek health care.

And so from a public perspective, when there's knowledge or when there's mistakes make, at some point, again, there needs to be clearly articulated what the public's right is to know and to understand of situations, and this gets back to the public having confidence in the system, and understanding when they approach health care institutions what the institution is capable of delivering for them, and the role it plays in society and what it can expect not to happen. Again, you get into adverse events.

THE COMMISSIONER:

Q. Does your organization have any kind of a formal position in respect of the issue of public right to know as opposed to patient right to know?

MR. DAWE:

A. Right, and depending on the particular topic, we've been working on several. Right now, we're looking at, again revising--because

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there was an opportunity or an attempt seven or eight years ago, through the federal government, to bring in a charter of rights for people entering the health care system. So we're looking at the possibility of reviving that effort. There's similarities in some positions that we've worked through. One that I can think of is the work with the Federal Government on patient/public right to know around content, chemicals, etcetera, that exist in consumer products and that's a piece of work that's ongoing, almost finished. It's called Right to Know legislation, and I think we're going to try to mirror that from a health care perspective.

But there hasn't been, to my knowledge, a whole lot of thought and energy put into the differentiation, and that's what you're asking me, between the patient right to know and the public right to know. So the shorter answer is, it's not there yet.

THE COMMISSIONER:

Q. Could there not even be a conflict between the two on occasion, in the sense of, I'm thinking particularly of small in size perhaps

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problems, and you get into privacy issues for patients and balancing that against a public right to know and how you protect the privacy of the patient while still informing the public?

MR. DAWE:

A. I think those are the issues that would have to be addressed. There are examples though, if you look at--there's certain hospitals in the United States, because it's a different system, that will--it's very public about their success rate or failure rate in any given procedure. That's all part of their sense of accountability and their marketing, if you will. And so, I think it's more about those types of issues that you can imagine the public would be interested in.

So I think you could very well articulate the difference between public and private right to know without getting into privacy issues, and I think that there hasn't--the issue of accountability of our health care system is something that's been talked about a great deal. Certainly I've worked in the health care system all my career. But there

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hasn't been a whole lot of articulation of what that actually means, that accountability, and certainly as a side issue, we talked a little bit about board governance yesterday. Eastern Health have said that their board is accountable to the Minister and then the Minister would say well, he's accountable to the public. I think if you ask the average person, they would have an expectation that the hospital itself is accountable directly to them in some way. Now whether that's true from a legal perspective or not, but it's still the expectation and that's still what needs to be articulated.

So you do get into an understanding, and this is a good example, the ER/PR test. The general public have any knowledge whatsoever that a test such as this could end up being a grey area versus something that's actually black and white and there doesn't seem to--you know, there's not inherent issues in it, inherent mistake issues in it. And I think, again, the average, being an individual entering the system or the public in general wouldn't have that level of knowledge, and so

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again, the Canadian Cancer Society would say, you know, that's not healthy. That's not where we're going in our health care system, and from an accountability perspective, these systems have to be open, much more open with their accountability, and that's from their perspective, but also from the individual, from a public perspective, an articulation has to be made of what the rights are.

MS. NEWBURY:

Q. Thank you. Mr. Dawe, you are a member of an ad hoc committee of the Canadian Association of Pathologists.

MR. DAWE:

A. Yes.

MS. NEWBURY:

Q. And you did speak about your involvement in that a little bit yesterday. I understand that you are now going to be looking at another initiative that's something within your area of expertise, and in that regard, I'm going to bring up Exhibit P-2437, and perhaps you can advise what this particular document is and how that relates to your involvement in the ad hoc committee of the

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Canadian Association of Pathologists?

MR. DAWE:

A. The Canadian Partnership Against Cancer is an organization or a partnership, if you will, that was created several years ago by the federal government and lobbied for for a number of years through people working on the Canadian Strategy for Cancer Control. And the Canadian Strategy for Cancer Control is a comprehensive plan to address cancer across the country.

Canada has a--well, it's not unique, but there's very distinctive characteristics of health care in Canada. It's federally funded, but provincially delivered. The Canada Health Act addresses certain issues, but doesn't address other issues. It makes for reform and improvement in health care on a national level a very complex procedure.

The Canadian Partnership Against Cancer is an attempt by government, federal and provincial government, cancer care delivery organizations, and partner organizations such as the Canadian Cancer Society, volunteer organizations, to bring as much knowledge,

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energy, synergy together as possible, knowing the complexities of the federal/provincial/territorial issues and yet still improve cancer care, cancer control in the country. If you drill into and look at the areas that they work in, one of the areas that the partnership would look at or is looking at is the whole area of standards and national standards in cancer treatment, for the most part. They call it guidelines, I think is the--Standards Action Group is the term they use, and they talk about--again, there's an interchangeable word, guidelines, standards, but it is intended to get at the need for national standards across the country, as relates to cancer control and through the work with the CAP committee, the Canadian Association of Pathologists committee, I'm going to attempt to, and I am liaising with the partnership group and try to tie the work of Dr. Torlakovic and the subcommittee with the work being done by the Standards Action Group, and I think that's a natural fit. I think it's something the Commission should know about because I think

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it is--they're federally funded and funded to a healthy level and so there's resources that can help with any type of, and lay the groundwork for national standards across the country. And again, the complexity of national standards being are they mandatory or voluntary and you get into all of these issues, and that's what the partnership was intended to address.

MS. NEWBURY:

Q. Now I understand, Mr. Dawe, that--and you've alluded to this many times over the last day or so, that you've had, on behalf of the Canadian Cancer Society, a number of efforts to communicate with the public, and there's an exhibit there that I would like you to quickly address. It's P-2523, please. And this is just a list of the attached exhibits. I'll turn to page two. Perhaps you can just identify what that document is?

MR. DAWE:

A. Again, this would have been from our efforts in the fall of '07 in preparation for the Inquiry, our attempt to do as much public consultation as we could, combined with our

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understanding that there was still people out there that may need more information, may need more help, and so we took it upon ourselves to do some public consultation, again, basically on a shoestring, to try to gather information, gather contacts in communities of people that might have been affected, how they wanted to see this Inquiry proceed and the outcomes they were hoping to get from the Inquiry. This would have been either a public service announcement or a paid advertisement.

MS. NEWBURY:

Q. And this one you spoke to yesterday, so I'll bring you to the third one, which is Call to Action, and the index for this document, actually the very beginning, page one, indicates that that was around May 2008, perhaps you could explain what that is.

MR. DAWE:

A. Again, this is a copy of one of the paid advertisements we would have used in the fall of '07. This is actually our community report that was distributed to over 127,000 households in the province in May month of 2008, and again, it's the ongoing attempt of

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the Canadian Cancer Society to reach out to people who might have been affected and felt are still in need of either information or support.

MS. NEWBURY:

Q. And there's an exhibit that I would like you to look at and comment upon for the Commissioner. It's P-2436, please. This is entitled Cancer Patient Navigation Evaluation Findings, and scrolling down, it's dated March 2004 and on the second page, it's shown to be prepared for the Cancer Care Nova Scotia. Perhaps you could explain what this is and how you think that might relate to the work of the Commission?

MR. DAWE:

A. Patient Navigation is a concept that's been around for a little while, probably ten years or more, and it evolved out of the growing complexity of our health care system. The term, patient navigation, as it implies, it's someone entering the system and having to literally navigate their way through the maze of what can be the health care system.

This particular report came from Cancer

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Care Nova Scotia, an umbrella group that looks at cancer care in Nova Scotia. They don't deliver services. They actually coordinate services across the province and they piloted a concept where they hired people as patient navigators and they worked with cancer patients entering the system and so they coordinated everything from actual appointments to when tests should be done and how people could access better information, and they worked with the system to achieve that end.

They did an evaluation. Evaluation, well, to prove that it was working and they actually moved from a pilot to implementing this on a full-time basis, and I believe they tripled the number of--the pilot, I think, was six people. I think they doubled or tripled the number of people that they had as patient navigators and it's a well entrenched program in that system now.

The relevance is that any time there's a person entering the health care system, and we're talking about cancer, so the cancer care system, it can be complicated. You've got a

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wide geographical area. You've got people moving back and forth for appointments. It can be stressful. Cancer in and of itself presents many challenges. It's a chronic disease. Treatment can take many months, with harsh side effects. Many implications, both socially and financially, and one of the areas that's always been expressed, and certainly to us, is how difficult people find it to get proper information and to literally have their care coordinated properly. Because you go from a system of diagnosis to a system of treatment, to a system of follow up, and perhaps even palliative care, and these can be different, delivered by what seemingly are different systems at different times.

One of the beliefs that we had is that a patient navigation system is ideal for Newfoundland and Labrador and we presented this idea. We've talked about this with Eastern Health and with the provincial government. But in this particular case, with Eastern Health and with when these mistakes were made and when a group of people were affected, you could quite quickly see how the

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patient navigation concept would get to the heart of the matter for the people involved in giving them a particular person of contact who would help them navigate through, in this case, what could be an even, and what turned out to be an even more complex and complicated health delivery system because of the retesting, because of new treatment for many people and because of the need for new information.

So we're bringing it forward because we believe it's a concept that the health care system needs in any event, but certainly in the Commission's study of what to do when mistakes are made, I think this gets to the heart of the matter of how to deal with the individuals involved, because no doubt the Commissioner will think about it from an institutional perspective. I guess, again, our role is here to remind the Commissioner that we'd want you to think about it from a person perspective also.

MS. NEWBURY:

Q. Thank you. Mr. Dawe, you've made references on occasion to the issue of retro converters,

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and I just wondered if you had anything that you wanted to add on that?

MR. DAWE:

A. Well, there are several things that still seem to be question marks that are left out there, and we saw in an exhibit yesterday that we did reference a question, and the exhibit again today, I think, in commenting on the letter that Eastern Health had sent out, the issue of retro converters. So this is the issue of false positives, and we've been talking about and the whole Inquiry is based on what went wrong with false negatives.

We still have a question mark about the rest of the people involved who had breast cancer who had an ER/PR test and was originally tested positive, but there's no guarantees. There's been no effort to go back and look at and retest even a sampling of the people that were positive, and we would question why that wasn't done. We would question what the implications are if there are false positives, and we would also suggest that there was implications even within the process that was set up. We heard several

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women say that they were--or we saw through their histories, they were weak positives and had refused Tamoxifen or a similar drug, hormone therapy, based on the harsh side effects or their perceived harsh side effects, and that when their sample turned out to be negative and it ended up at the tumour board. Because they had refused hormonal treatment in the past, they were automatically said, well, you know, this person has refused hormonal treatment, so we won't even consider that at this time. So again, you're into an area of people who tested positive originally and what are the implications for many of these issues for this group of people.

For us, and bringing it up at this point because we don't have any answers for it obviously, but we do still think it's an outstanding question and there's many questions around the issue.

MS. NEWBURY:

Q. Did you have anything that you wanted to add regarding the results of deceased patients and how that may have been handled?

MR. DAWE:

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A. Well, just to reiterate it. We said it publicly. Mr. Simmons just brought it up again that there was a differentiation between people who were deceased getting their tests, getting the retest done and people who were still living, and that obviously it made sense from a prioritization point of view to prioritize people that were still living in getting the retests done. At some point, Eastern Health made the decision to retest all of the people who were deceased, but that they have still left it up to people, families of deceased, to contact them if they want to get the test result.

It's something that we have said to Eastern Health that we believe that all of the people, the deceased people, their families, their loved ones, have a right to know what the test result was. Some of these people may not even realize that they have a loved one that was affected, and again, this goes back to our experience of people's lack of understanding of who was affected by this and the processes involved. You could literally have someone out there or a family out there,

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a loved one who--someone who lost a loved one who had no contact from Eastern Health, had someone who was deceased, and just assumes, because they've never had contact, that this issue has nothing to do with them.

Again, it's a philosophical approach that we would say is just a basic right that if this information is held by Eastern Health that families deserve to be given the information. Obviously they can do whatever they want with the information. They can ignore it, if that's the case, but it's just a basic right that they should be automatically given the information.

MS. NEWBURY:

Q. And Mr. Dawe, one final topic. There's been some evidence about the cancer registry and the information contained in that, and do you have anything that you feel that you can comment on in that regard?

MR. DAWE:

A. Well, an organization, cancer organization very concerned with public policy, one of the absolute foundations of information to develop good public policy is the data on cancer in

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our particular province, and we would like to highlight for the Commissioner that whole area as she thinks about the evidence and as she considers recommendations that the data--we've heard a lot of evidence around the data management from within Eastern Health and it's wider than Eastern Health because it affects all the health authorities, that even at a most basic level, the cancer registry couldn't even provide the basic demographics of who exactly was affected. We've heard other evidence of not all cancer cases being reported, not all deaths being reported.

We believe that it is an absolute foundational block of healthy, good healthy public policy, in this case, cancer policy, to have cancer registry and affiliated services, so that you're not just collecting data, but you're actually mining the data from an epidemiological perspective. That is a fundamental that has to be fixed in this province and put in place and made accountable, you know, even through legislation, which it is in other areas, that that is working properly. Because without

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that in place, and we saw it--again, just from a most basic level of Eastern Health struggling with exactly who should be on the list, that's at a most basic level. But we would suggest that a registry working properly would have the possibility, if it was being analyzed properly on a go-forward basis, to actually even pick up issues like how many people are testing positive and negative for tests like ER/PR and proactively looking for systematic problems in the population as it relates to cancer control. So that possibility exists.

What I'm actually saying is that if we had a properly running system, that it might have picked up on this issue earlier.

THE COMMISSIONER:

Q. Who keeps the cancer registry?

MR. DAWE:

A. Cancer registry was developed and maintained under Newfoundland Cancer Treatment Registry, Research Foundation, up until the spring of '05 when that organization was folded into Eastern Health. So it's housed under Eastern Health at this time and funded by the

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provincial government, through Eastern Health.

MS. NEWBURY:

Q. Thank you, Mr. Dawe. Is there anything else that you would like to add?

MR. DAWE:

A. Just on final comment, the Canadian Cancer Society obviously has taken the whole issue of the mistakes made with ER/PR testing quite seriously, devoted a lot of resources and energy. Limited resources and energy that we do have, we devoted a great deal into trying to make sure that people were served properly, and at the end of the day, not to try to make a grand statement of this, but that this whole process comes back to the people that were affected, and we've heard many, many, many side stories around the professionals involved and the institutions involved, and the technicalities of what happens in a lab, the politics that go with health care.

But again, I think the role of the Cancer Society in the Inquiry is to explicitly say to the Commissioner that this process is about the people that were affected and that every one of those people affected in any way

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deserve the full attention of the Commissioner as she looks forward and looks at her recommendations and that our due diligence is to put that squarely in front of you and entrust that you keep that in mind as you bring forward recommendations.

MS. NEWBURY:

Q. Thank you.

MR. DAWE:

A. Thank you.

THE COMMISSIONER:

Q. Thank you. Anything arising, Ms. Chaytor?

CHAYTOR, Q.C.:

Q. I don't have anything arising.

THE COMMISSIONER:

Q. Thank you very much, Mr. Dawe, for your contribution. Thank you all. 9:30 in the morning.

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 4th day of September, 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 4th day of September, A.D., 2008

Judy Moss

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