

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">September 4, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Laura Brocklehurst. Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Blair Pritchett. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>Exhibits entered and marked P-2526 through to P-2542 . . . Pg. 4.</p> <p>Exhibit entered and marked P-2481 Pg. 312</p> <p>Exhibit entered and marked P-2544 Pg. 312</p>
<p>THIS PAGE ONLY REVISED NOVEMBER 18, 2008</p> <p style="text-align: center;">TABLE OF CONTENTS</p> <p>DR. DAVID GEORGE HAEGERT (SWORN)</p> <p>Examination by Bernard Coffey, Q.C. Pgs. 4 - 269 Examination by Mr. Daniel Simmons Pgs. 269 - 287 Examination by Ms. Jennifer Newbury Pgs. 287 - 298 Examination by Mr. Peter Browne Pgs. 298 - 312</p> <p>MR. PETER DAWE - RESUMES THE STAND</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 312 - 317 Examination by Ms. Jackie Brazil Pgs. 317 - 323 Examination by Mr. Daniel Simmons Pgs. 323 - 346 Examination by Ms. Jennifer Newbury Pgs. 346 - 371</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER: 2 Q. Please be seated. Mr. Coffey. 3 COFFEY, Q.C.: 4 Q. Thank you, Commissioner. The next witness is 5 Dr. David Haegert. 6 DR. DAVID GEORGE HAEGERT (SWORN) EXAMINATION BY BERNARD 7 COFFEY, Q.C. 8 REGISTRAR: 9 Q. Would you please state and spell your complete 10 name for the Commission? 11 DR. HAEGERT: 12 A. It's David George Haegert. David and George 13 are fairly obvious. Haegert is H-A-E-G-E-R-T. 14 REGISTRAR: 15 Q. Thank you. 16 COFFEY, Q.C.: 17 Q. Thank you, Doctor. Commissioner, there are 18 some new exhibits. They are exhibits P-2526 19 through P-2542 inclusive. 20 THE COMMISSIONER: 21 Q. Entered. 22 EXHIBITS ENTERED AND MARKED P-2526 THROUGH P-2542 23 COFFEY, Q.C.: 24 Q. Thank you, Commissioner. Registrar, when 25 you're ready, please, Exhibit P-2542? Doctor,</p>

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<p>1 the document there on the screen in front of</p> <p>2 you is entitled curriculum vitae and it's for</p> <p>3 David George Haegert and is that your CV?</p> <p>4 DR. HAEGERT:</p> <p>5 A. Yes, it is.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Okay, sir, and Doctor, it goes on for some</p> <p>8 length. I'm not going to take you through it</p> <p>9 in detail, but I am going to ask you to</p> <p>10 outline for the Commissioner, please, your</p> <p>11 educational and professional background.</p> <p>12 DR. HAEGERT:</p> <p>13 A. Yes, I graduated from the University of</p> <p>14 British Columbia, Faculty of Medicine, 1968,</p> <p>15 then interned at the Royal Victoria Hospital,</p> <p>16 1968 to '69. Then I trained in anatomic</p> <p>17 pathology at McGill teaching hospital from '69</p> <p>18 to '72. Then I went to the University of</p> <p>19 Cambridge to do research for two years.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. That would be in the UK?</p> <p>22 DR. HAEGERT:</p> <p>23 A. United Kingdom, yes, and then I returned to</p> <p>24 Montreal in 1975, in January, and I took up a</p> <p>25 position as a pathologist at Montreal General</p>	<p>1 the hospital, which is McGill University</p> <p>2 Hospital Centre.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. In Montreal?</p> <p>5 DR. HAEGERT:</p> <p>6 A. In Montreal, yes.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. And Doctor, you say you've had, in effect, a</p> <p>9 career in medicine spanning, approaching 40</p> <p>10 years? It's getting close.</p> <p>11 DR. HAEGERT:</p> <p>12 A. '68 to--yeah, 40 years.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. 40 years. Doctor, I'm going to ask you then,</p> <p>15 because you were in St. John's in the</p> <p>16 changeover from the General Hospital, Grace</p> <p>17 General and St. Clare's into the Health Care</p> <p>18 Corporation.</p> <p>19 DR. HAEGERT:</p> <p>20 A. Yes.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Okay, I'll be asking you about that, but</p> <p>23 before I get to that, your career as well</p> <p>24 would span, I gather, a fair amount of time</p> <p>25 involving the development of</p>
<p>1 Hospital. Initially, I was an assistant</p> <p>2 professor and then I was promoted to associate</p> <p>3 professor eventually, and then I moved to</p> <p>4 Newfoundland in 1991, to St. John's, where I</p> <p>5 was appointed professor and chair of the</p> <p>6 Department of Pathology at the University and</p> <p>7 clinical chief of the Department of Pathology</p> <p>8 at the General Hospital.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Yes.</p> <p>11 DR. HAEGERT:</p> <p>12 A. And then after that, 1996 roughly, the Health</p> <p>13 Care Corporation was formed, so then I became</p> <p>14 the clinical chief of what was called the</p> <p>15 Laboratory Medicine program, and I was there</p> <p>16 until 2002, or here actually until 2002,</p> <p>17 except for one year sabbatical in Montreal,</p> <p>18 and then 2002, I returned to Montreal as a</p> <p>19 professor of pathology and then in 2005, I was</p> <p>20 appointed professor and chair of the</p> <p>21 Department of Pathology.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. At McGill University?</p> <p>24 DR. HAEGERT:</p> <p>25 A. At McGill University, yes, and also chief of</p>	<p>1 immunohistochemistry and the usage of it, kind</p> <p>2 of more and more widespread usage in</p> <p>3 pathology?</p> <p>4 DR. HAEGERT:</p> <p>5 A. Yes.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Could you tell us, please, kind of looking</p> <p>8 back on it now, what you recall about it and</p> <p>9 it's impact, at least on your practice over</p> <p>10 the years?</p> <p>11 DR. HAEGERT:</p> <p>12 A. Well, when I was in Montreal, I think the</p> <p>13 immunohistochemistry was starting really in</p> <p>14 the 1980s, sometime in the late '80s, I would</p> <p>15 say. Do you want me to discuss what, the</p> <p>16 methodologies or what?</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Just in terms of in a general way, yes.</p> <p>19 DR. HAEGERT:</p> <p>20 A. Well, what became very clear early on, it was</p> <p>21 extremely helpful in dissecting between</p> <p>22 different types of tumours and also helpful in</p> <p>23 subclassification of tumours. I guess that's</p> <p>24 the same thing, but also over the years has</p> <p>25 become useful as a prognostic marker or</p>

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<p>1 predictive marker, things like estrogen 2 receptors, progesterone receptors, HER2/neu, 3 things like that. 4 COFFEY, Q.C.: 5 Q. Doctor, so you, in your practice, when do you 6 recall first being introduced to it? Did it 7 exist in the way immunohistochemistry, in a 8 practical sense, for pathologists when you 9 first started? 10 DR. HAEGERT: 11 A. No, it did not. I would say late, in the late 12 1970s, the first reports started to come out. 13 I guess it was--I think it followed after the 14 development of monoclonal antibodies. This is 15 quite sometime ago, you know. 16 COFFEY, Q.C.: 17 Q. Yes. 18 DR. HAEGERT: 19 A. But that's my recollection. 20 COFFEY, Q.C.: 21 Q. And Doctor, what I want to try and take 22 advantage of is in terms of your experience 23 and what you recall about it in terms of how 24 you were introduced to it as a pathologist and 25 how you learned about it, you and your</p>	<p>1 estrogen receptor is a nuclear stain, but CD20 2 is a common antibody. It's a membrane stain. 3 But a pathologist would know, I mean, it's 4 almost inherent in being a pathologist that 5 you would know this. 6 COFFEY, Q.C.: 7 Q. Doctor, when you came to St. John's, up to 8 then, arrived I take it in 1991? 9 DR. HAEGERT: 10 A. 1991, yes. 11 COFFEY, Q.C.: 12 Q. You were connected with Memorial's medical 13 school? 14 DR. HAEGERT: 15 A. Um-hm. 16 COFFEY, Q.C.: 17 Q. You've described that, and the General 18 Hospital, I take it, or the Health Sciences 19 Centre, we've used those two phrases - 20 DR. HAEGERT: 21 A. Yeah, more or less the same. 22 COFFEY, Q.C.: 23 Q. - interchangeably here. That was a stand- 24 alone institution at the time? 25 DR. HAEGERT:</p>
<p>1 colleagues, based upon your observations? I 2 mean, were there any courses available back 3 then in immunohistochemistry? 4 DR. HAEGERT: 5 A. Well, I would think most pathologists never 6 took courses in immunohistochemistry, but 7 mostly we learned from reading the literature, 8 becoming aware that there were certain 9 antibodies available and that people were 10 using them to make diagnoses or to help in 11 diagnosis, and then we'd read the literature 12 or actually more likely one of the individuals 13 in the department who had experience or 14 expertise would advise the others that indeed 15 there is this particular antibody available 16 and this was useful for these purposes, 17 whatever the purposes were. 18 COFFEY, Q.C.: 19 Q. And would there be discussions or literature 20 available about how to use a particular 21 antibody, in the sense of whether it was 22 membrane staining, nuclear staining? 23 DR. HAEGERT: 24 A. Well, all that would be part of the antibody 25 repertoire. Like for example, I mean,</p>	<p>1 A. Yes, it was. 2 COFFEY, Q.C.: 3 Q. Doctor, could you tell the Commissioner then, 4 during your time as discipline chair, I think 5 was the phrase? 6 DR. HAEGERT: 7 A. Yeah, discipline of pathology. 8 COFFEY, Q.C.: 9 Q. Discipline of pathology, discipline chair? 10 DR. HAEGERT: 11 A. Discipline chair, yes. 12 COFFEY, Q.C.: 13 Q. Could you tell us, please, what that involved? 14 Because you held the position for just over a 15 decade, you know, from '91 through 2002 with a 16 year off sabbatical in there. 17 DR. HAEGERT: 18 A. Um-hm. 19 COFFEY, Q.C.: 20 Q. What sorts of responsibilities did that 21 involve? 22 DR. HAEGERT: 23 A. Well, overall, the chairs of every department 24 were responsible for the teaching program, 25 recruitment of individuals into the</p>

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1 department, research and the teaching would
 2 involve teaching of undergraduate students,
 3 namely medical students. In our department,
 4 it also involved teaching of pharmacy
 5 students, development of research, training of
 6 residents, so residents in pathology and
 7 training residents in other disciplines who
 8 rotated into pathology. But one of the major
 9 issues was recruitment. I mean, that actually
 10 was explained to me when I first came by the
 11 dean at the time, David Hawkins. He said it
 12 was the biggest, one of the biggest issues in
 13 the university.
 14 COFFEY, Q.C.:
 15 Q. And this was recruiting doctors, pathologists,
 16 to be staff, to be professors, assistant
 17 professors, lecturers in the medical school?
 18 DR. HAEGERT:
 19 A. Yeah. Well, basically starting rank was
 20 assistant professor, but yes.
 21 COFFEY, Q.C.:
 22 Q. And why was that, when you arrived and kind of
 23 looked around and began to understand the
 24 local dynamics, why was that? What was your--
 25 did you make any conclusions, come to any

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1 conclusions about why recruiting was a
 2 problem?
 3 DR. HAEGERT:
 4 A. Well, it was actually more recruitment and
 5 retention.
 6 COFFEY, Q.C.:
 7 Q. Okay.
 8 DR. HAEGERT:
 9 A. In fact, that's what David Hawkins said and
 10 that was my experience. I think what we found
 11 is that often we recruit from outside. A lot
 12 of the people we recruited were--had trained
 13 in the United States, because the objective
 14 was to get people with subspecialty training,
 15 and a lot of them came here and, I mean,
 16 people leave--people come and they leave for
 17 various reasons, but I felt that a lot of the
 18 people left because they felt they would be
 19 better off elsewhere, for either personal or
 20 financial or other reasons. Often they didn't
 21 say why they left.
 22 COFFEY, Q.C.:
 23 Q. Doctor, these, the people being recruited out
 24 of the United States, what sorts of category
 25 did they fall into? We've heard references to

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1 J-1's.
 2 DR. HAEGERT:
 3 A. Yeah, most of the people had J-1 Visas, which
 4 means that they were--they had training visas,
 5 at least my understanding. I mean, I'm
 6 actually not really all that privy to it, but
 7 my understanding is that they have a--if you
 8 have a J-1 visa, it's a training visa and
 9 basically, you're allowed to stay in the
 10 United States as long as you're training.
 11 Once you're finished your training, you have
 12 to leave the United States.
 13 COFFEY, Q.C.:
 14 Q. And then these would be people then, I take
 15 it, in terms of recruitment that you would
 16 advertise positions available in St. John's,
 17 Newfoundland?
 18 DR. HAEGERT:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. That would come to their attention, and if
 22 they had to leave the United States, they
 23 might be prepared to come to St. John's to
 24 work, and that's how these people would be
 25 recruited? That's the -

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1 DR. HAEGERT:
 2 A. Yeah, well, we would advertise.
 3 COFFEY, Q.C.:
 4 Q. Sure. Doctor, during your tenure, how
 5 successful were you, in terms of recruitment?
 6 I'll ask you about retention in a minute, but
 7 how about recruitment.
 8 DR. HAEGERT:
 9 A. Well, whenever we had a position, we managed
 10 to recruit, but we--I mean, obviously the
 11 second half of it is the retention. We
 12 weren't so successful at retaining people, but
 13 we managed to recruit.
 14 COFFEY, Q.C.:
 15 Q. I appreciate that individual doctors might
 16 move on for personal reasons, as you've
 17 indicated, but in terms of the professional
 18 circumstances throughout the 1990s in St.
 19 John's, I mean, were there any--what, if
 20 anything, connected with being a pathologist
 21 in St. John's was challenging? I'll give you
 22 an obvious example, money is perhaps one
 23 potential thing. Facilities is another.
 24 Workload is another. So perhaps you could
 25 tell the Commissioner what you recall about

Page 17

1 that.

2 DR. HAEGERT:

3 A. I think one of the difficulties here was the--

4 certainly as the Health Care Corporation was

5 created, the mind set was that pathology or

6 laboratory medicine as a group or as a whole

7 and pathology as part of that was basically a

8 cost centre, in that one of the fundamental

9 issues was that the Health Care Corporation

10 did not have sufficient money to run the

11 organization, so we were asked, on several

12 occasions, to save money. So that was one of

13 the issues.

14 Another issue was salaries. I think

15 Newfoundland and Quebec were basically the

16 lowest in the country, and so it was difficult

17 to retain people who would come here. They

18 would establish themselves as landed

19 immigrants and then they'd realize they could

20 go elsewhere and get more money. So that was

21 actually a significant issue.

22 The workload, which you mentioned,

23 actually was--I mean, it's entirely a matter

24 of perspective, but one of the difficulties

25 was there was very little protected time. A

Page 18

1 lot of people who came from the United States

2 had academic aspirations. They wanted to do

3 academic pathology and the difficulty was they

4 were on service most of the time. So it was

5 actually quite difficult.

6 COFFEY, Q.C.:

7 Q. To find the time to devote to the academic or

8 research work?

9 DR. HAEGERT:

10 A. Yes. Oh yes, because I've read some of the

11 transcripts. I mean, Dr. Mullen, for example,

12 in Toronto said that he had 50 percent

13 protected time. Well I would think basically

14 nobody here had any approximation of that.

15 COFFEY, Q.C.:

16 Q. Doctor, when you first--well, for the first

17 four or five years you were here, it was just

18 the General Hospital as a stand-alone

19 institution. As the discipline chair,

20 Memorial University's medical school,

21 discipline chair for pathology, how much

22 interaction would you have with pathologists

23 outside the General Hospital? In your

24 capacity as discipline chair, what would that

25 involve?

Page 19

1 DR. HAEGERT:

2 A. Well, all the--as I recall, all the

3 pathologists had university appointments,

4 outside. So Dr. Pushpanathan, for example,

5 the people at the Grace and St. Clare's. I

6 can't remember the nature of these

7 appointments, but they all had appointments.

8 We did, from time to time, have inter hospital

9 rounds where there were--people would share

10 cases that are difficult or complicated and,

11 you know, present the case. People would have

12 an opportunity to discuss them. But we didn't

13 have--I mean, it's probably important to

14 recognize that there was no authority.

15 COFFEY, Q.C.:

16 Q. That's what I'm getting at, in terms of you

17 would--as the discipline chair at the time,

18 would not have perceived that you had any

19 authority over a pathologist at the Janeway or

20 at St. Clare's or at the Grace?

21 DR. HAEGERT:

22 A. Well, no authority in terms of the hospital

23 practice.

24 COFFEY, Q.C.:

25 Q. Hospital practice, and I take it that would be

Page 20

1 equally true in Corner Brook and Grand Falls

2 and Gander? You would not have -

3 DR. HAEGERT:

4 A. Well, we never had authority there, ever.

5 COFFEY, Q.C.:

6 Q. The appointments of pathologists at that time,

7 were any of the pathologists outside St.

8 John's associated with the university? Did

9 they have any positions, do you recall?

10 DR. HAEGERT:

11 A. I don't remember. I don't remember.

12 COFFEY, Q.C.:

13 Q. And certainly -

14 DR. HAEGERT:

15 A. Possibly.

16 COFFEY, Q.C.:

17 Q. - and if they did, it wasn't in significance

18 in the greater -

19 DR. HAEGERT:

20 A. It was weak, at the best.

21 COFFEY, Q.C.:

22 Q. Okay. Just on that point, Doctor, in your

23 day, did pathologists residents rotate outside

24 St. John's, do you recall?

25 DR. HAEGERT:

Page 21

1 A. No.
 2 COFFEY, Q.C.:
 3 Q. But within the city, they would rotate within
 4 the various hospitals within St. John's?
 5 DR. HAEGERT:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Doctor, the advent of and the formation and
 9 implementation of the Health Care Corporation
 10 of St. John's, which I gather occurred in the
 11 mid--began in the mid 1990s and continued on
 12 for a period of time. You've already
 13 described some of what you recall about the
 14 effect that had on the clinical laboratory
 15 program. Would you elaborate a bit upon that?
 16 Are you able to?
 17 DR. HAEGERT:
 18 A. You mean as -
 19 COFFEY, Q.C.:
 20 Q. As the discipline chair, in '95/96, there's a
 21 Health Care Corporation, but all these three
 22 institutions, or four institutions at the
 23 time, are still in four different buildings,
 24 and what do you recall about the move toward
 25 centralization of the clinical laboratory?

Page 22

1 DR. HAEGERT:
 2 A. Well, early on, I don't remember exactly when,
 3 1996 probably, I was appointed clinical chief,
 4 we had multiple meetings with the directors of
 5 the labs at each of the hospitals. We had
 6 many meetings. There was also a focus group
 7 that the Health Care Corporation set up and so
 8 what we tried to come up with, we discussed
 9 the various possible models, whether it should
 10 be a functional model or a site based model.
 11 Functional meaning should we have pathology,
 12 biochemistry, hematology, or should we be
 13 doing it by sites. So this is one of the
 14 things we discussed. Also, at the same time
 15 or around the same time, a program director
 16 was appointed. That was Mr. Whelan who was
 17 previously the laboratory manager at the
 18 General Hospital. The names changed, but the
 19 functions were sort of similar. We were asked
 20 to save money, significant amount of money.
 21 In addition, what happened was the structure
 22 of the laboratory actually changed. My
 23 understanding, at the Grace and St. Clare's,
 24 the way the reporting relationships worked in
 25 the pathology departments were quite

Page 23

1 different. The reporting relationships were
 2 to the chief of pathology, the head of
 3 pathology, whatever the name was. So for
 4 example, Dr. Cook would have been chief at St.
 5 Clare's and everyone would report to him,
 6 including the technologists. But when the
 7 Health Care Corporation was created, the model
 8 was changed, so that the program model was
 9 that there was kind of a parallel reporting
 10 system so that the professional people would
 11 report to me and basically the laboratory
 12 staff, technologists, secretaries and so on,
 13 would report to the manager. So that changed
 14 for these two other sites, including the
 15 Janeway, I suppose, yes.
 16 COFFEY, Q.C.:
 17 Q. And now what--before the Health Care
 18 Corporation was formed, what had been the
 19 model used in the General Hospital?
 20 DR. HAEGERT:
 21 A. The model in the General Hospital was similar
 22 to what the Health Care Corporation used.
 23 Basically, we had sort of a parallel reporting
 24 system where the chief, that was myself, and
 25 the--I keep getting the names mixed up, the

Page 24

1 laboratory manager, we worked together, but
 2 the reporting relationships were parallel
 3 basically.
 4 COFFEY, Q.C.:
 5 Q. And that had been the situation at the General
 6 when you first arrived in '91?
 7 DR. HAEGERT:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. So that's what you came into in St. John's
 11 yourself?
 12 DR. HAEGERT:
 13 A. Yes. It didn't actually significantly change
 14 for me, but it changed dramatically for the
 15 other hospitals outside of the General
 16 Hospital.
 17 COFFEY, Q.C.:
 18 Q. And so the--for example, at St. Clare's, your
 19 understanding was that before the Health Care
 20 Corporation was formed that at St. Clare's,
 21 for Donald Cook, he had been running, in
 22 effect, responsible for the laboratory at
 23 large?
 24 DR. HAEGERT:
 25 A. Yes. Well, it was Dr. Williams and then Dr.

Page 25

1 Cook.
 2 COFFEY, Q.C.:
 3 Q. Okay.
 4 DR. HAEGERT:
 5 A. Somewhere in there took over.
 6 COFFEY, Q.C.:
 7 Q. Whoever had the position, in terms of -
 8 DR. HAEGERT:
 9 A. Yes, that's what I--I think that's correct.
 10 COFFEY, Q.C.:
 11 Q. Okay, and your understanding is that that was
 12 also true at the Grace?
 13 DR. HAEGERT:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. Before Health Care Corporation and the
 17 Janeway. Doctor, so for you in a personal
 18 sense there was the Health Care Corporation,
 19 other than there being more people involved,
 20 the model didn't change, for you it was the
 21 same model before and after?
 22 DR. HAEGERT:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. In the General and Health Care Corporation.

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1 Doctor, you were wearing two hats, both
 2 discipline chair and clinical chief. Doctor,
 3 before the Health Care Corporation was formed
 4 you would have been as clinical chief, I take
 5 it, for the old General?
 6 DR. HAEGERT:
 7 A. Well, much of that is the name -
 8 COFFEY, Q.C.:
 9 Q. Or the -
 10 DR. HAEGERT:
 11 A. That was the function, whatever you call it,
 12 yeah.
 13 COFFEY, Q.C.:
 14 Q. You had reporting to you only the
 15 professional--the pathologists within the
 16 General Hospital site up to that site?
 17 DR. HAEGERT:
 18 A. Yes, plus the divisional chiefs.
 19 COFFEY, Q.C.:
 20 Q. Divisional. And the divisional chiefs were
 21 whom?
 22 DR. HAEGERT:
 23 A. Well, head of biochemistry, head of
 24 hematology, microbiology.
 25 COFFEY, Q.C.:

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1 Q. Then after the formation of the Health Care
 2 Corporation you had pathologists reporting to
 3 you located where, physically located where,
 4 at the other -
 5 DR. HAEGERT:
 6 A. Well, there was the General Hospital, St.
 7 Clare's, the Janeway and the Grace Hospital.
 8 COFFEY, Q.C.:
 9 Q. Your office was located where?
 10 DR. HAEGERT:
 11 A. At the General Hospital site, Health Science
 12 Centre, really.
 13 COFFEY, Q.C.:
 14 Q. And how often, for example, after the
 15 formation of the Health Care Corporation, how
 16 frequently would you get to go to, for
 17 example, St. Clare's or the Grace or the
 18 Janeway?
 19 DR. HAEGERT:
 20 A. Well, I went from time to time, but the
 21 frequency I can't say.
 22 COFFEY, Q.C.:
 23 Q. Okay.
 24 DR. HAEGERT:
 25 A. But certainly, I mean, it must have been

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

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<p>1 DR. HAEGERT: 2 A. Um-hm. 3 COFFEY, Q.C.: 4 Q. I gather there were laboratory managers 5 meetings, as well? 6 DR. HAEGERT: 7 A. Yes. 8 COFFEY, Q.C.: 9 Q. Okay. I'm going to ask you first of all to 10 deal with the site chiefs meetings. Before 11 the formation of the Health Care Corporation I 12 take it there would have been no site chief 13 meetings because there were no site chiefs? 14 DR. HAEGERT: 15 A. No, indeed that's correct. 16 COFFEY, Q.C.: 17 Q. Okay. After the formation of the Health Care 18 Corporation the site chief meetings started? 19 DR. HAEGERT: 20 A. Um-hm, yes. 21 COFFEY, Q.C.: 22 Q. And their purpose was what, who chaired them, 23 who attended, their purpose was what? 24 DR. HAEGERT: 25 A. Well, so remember I mentioned that we decided</p>	<p>1 COFFEY, Q.C.: 2 Q. Okay. 3 DR. HAEGERT: 4 A. We used to have them, I'm thinking once a 5 month, but, I mean, roughly it would be once a 6 month. 7 COFFEY, Q.C.: 8 Q. And who would attend those meetings? 9 DR. HAEGERT: 10 A. So it would be all the managers of the various 11 divisions, so pathology, biochemistry, 12 hematology, microbiology. I think that was 13 probably most of the--in the early days those 14 would be the different divisions. 15 COFFEY, Q.C.: 16 Q. And then after - 17 DR. HAEGERT: 18 A. And I would attend and Mr. Whelan, of course. 19 COFFEY, Q.C.: 20 Q. Then after the formation of the Health Care 21 Corporation, laboratory management meetings, 22 were there laboratory management meetings? I 23 take it there were? 24 DR. HAEGERT: 25 A. Yes, there were.</p>
<p>Page 30</p> <p>1 to have a functional program, so part of that- 2 -you have to remember it was pathology plus 3 other disciplines, like biochemistry, for 4 example, so the way we decided to handle 5 anatomic pathology or pathology was that we 6 would have at each site a site chief who would 7 then report to me. So the way we dealt with 8 this is that we basically had a rotation so 9 that, for example, if there was a meeting at 10 the General Hospital, the site chief at the 11 General Hospital, who was Dr. Khalifa for at 12 least a period of time, would chair at that 13 meeting; if we went to St. Clare's, it would 14 have been Dr. Cook who was the site chief; and 15 then we rotated, say, to the Grace, which 16 would be Dr. Sushil Parai. 17 COFFEY, Q.C.: 18 Q. And the laboratory management meetings, go 19 back to the General Hospital stand-alone days 20 first of all, the first four or five years you 21 were here, would the site routinely have 22 laboratory management meetings, Mr. Whelan, 23 yourself and anybody else? 24 DR. HAEGERT: 25 A. Yes, there were.</p>	<p>Page 32</p> <p>1 COFFEY, Q.C.: 2 Q. And who would attend then? 3 DR. HAEGERT: 4 A. I would attend as the clinical chief, Vern 5 Whelan would attend as the program manager and 6 then the various managers responsible for the 7 various divisions. 8 COFFEY, Q.C.: 9 Q. Do you recall any other kind of set meetings, 10 as it were, routine meetings? 11 DR. HAEGERT: 12 A. Well, we had discipline meetings from time to 13 time. 14 COFFEY, Q.C.: 15 Q. Okay. 16 DR. HAEGERT: 17 A. And then what we decided is that often the 18 major issues were hospital based, so we had 19 combined sort of discipline, we actually 20 called them discipline of laboratory 21 medicine/laboratory program meetings or 22 something to that effect. So we met on a 23 regular basis, but how--I mean, I would say 24 ever few months and if there were issues, then 25 we'd meet more often.</p>

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1 COFFEY, Q.C.:

2 Q. And the purpose of those meetings was what?

3 DR. HAEGERT:

4 A. Often they--sometimes we were bringing issues

5 that had arisen to the people to get feedback

6 to the, say the pathologists to get feedback

7 or to advise them of what was happening,

8 because sometimes the pathologists were

9 unaware of what was going on, so we'd tell

10 them this is what's happening, these are the

11 issues that are coming up. Like, for example,

12 we were being asked to save a million dollars

13 from the Health Care Corporation, so that

14 would have been discussed at one of the

15 discipline meetings.

16 COFFEY, Q.C.:

17 Q. And would these be site specific? Like -

18 DR. HAEGERT:

19 A. No, the discipline meetings were--once the

20 Health Care Corporation was created, this was

21 beyond the sites, this was the whole, all of

22 the sites.

23 COFFEY, Q.C.:

24 Q. So these discipline meetings in the late '90s,

25 after the formation of the Health Care

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1 Corporation, they would involve a meeting at a

2 particular location but would involve

3 pathologists from all the different

4 facilities?

5 DR. HAEGERT:

6 A. Yes.

7 COFFEY, Q.C.:

8 Q. Would be invited to come?

9 DR. HAEGERT:

10 A. Yes.

11 COFFEY, Q.C.:

12 Q. Who would chair those meetings?

13 DR. HAEGERT:

14 A. I did.

15 COFFEY, Q.C.:

16 Q. Doctor, with respect to the matter of meetings

17 to involve cases, to discuss cases, how was

18 that handled in the early days here and as the

19 '90s went on, what sorts of meetings--for

20 example at the General Hospital as a stand-

21 alone institution how frequently would

22 pathologists meet to discuss cases and in what

23 context?

24 DR. HAEGERT:

25 A. Well, we would meet in a formal way once a

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1 week to go over--what would happen is

2 pathology would bring to the meetings cases

3 that either were difficult or complicated or

4 unusual or had some unusual features, bring

5 them, and pathologists would meet as a group.

6 That was early on. What was the rest of the

7 question?

8 COFFEY, Q.C.:

9 Q. And then as time went on then and the Health

10 Care Corporation was formed, '95, '96, did the

11 attendance at those meetings change, where

12 they were held change? I mean how did they--

13 did they go on, first of all, did they

14 continue, and if so, where?

15 DR. HAEGERT:

16 A. They were basically site based.

17 COFFEY, Q.C.:

18 Q. And that means what in this context?

19 DR. HAEGERT:

20 A. Well, so the General Hospital pathologists

21 would review cases. But the other thing I was

22 going to say is that we would also review

23 cases on a regular basis one to one when there

24 was a problem case. Because often these

25 particular meetings were really to kind of

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1 say, oh, look, I've had this interesting case

2 and maybe I'll get a consensus as to what

3 people think. But we had a sort of an

4 internal consultation process went on on a

5 regular basis where people who had sort of

6 expertise in certain areas, one would show

7 them that individual case and say, okay, now,

8 could you look at this and what do you think

9 and, you know, what should I do with this case

10 and do you have an opinion, what further

11 studies do I need to do, do I need to do

12 further studies, do we need an external

13 opinion, that kind of thing. That was a

14 regular thing, basically every day.

15 Pathologists were always doing that.

16 COFFEY, Q.C.:

17 Q. Doctor, then as the--after the formation of

18 the Health Care Corporation these meetings,

19 pathologists' weekly meetings, were they at

20 times, would the term "rounds" be used to

21 describe them?

22 DR. HAEGERT:

23 A. Yeah, they would be like teaching rounds.

24 COFFEY, Q.C.:

25 Q. Teaching rounds. Doctor, you indicated that

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1 those meetings when they went on, after the
 2 formation of the Health Care Corporation,
 3 would be site specific?
 4 DR. HAEGERT:
 5 A. Um-hm.
 6 COFFEY, Q.C.:
 7 Q. St. Clare's would have theirs, the General,
 8 the Grace?
 9 DR. HAEGERT:
 10 A. Um-hm.
 11 COFFEY, Q.C.:
 12 Q. Would you attend those and, if so, which ones,
 13 and would you attend the General Hospital's or
 14 the St. Clare's -
 15 DR. HAEGERT:
 16 A. Just the ones at the General Hospital. I
 17 attended most of them when I could.
 18 COFFEY, Q.C.:
 19 Q. At the General itself?
 20 DR. HAEGERT:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. Who was responsible, from your perspective, at
 24 the time for organizing them and ensuring that
 25 they went ahead on these various sites?

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1 DR. HAEGERT:
 2 A. Well, normally that was the site chief's
 3 activity. Early on--one of the things I
 4 didn't say is that Dr. Fernandez early on was
 5 the division chief of pathology at the General
 6 Hospital, so she would organize them initially
 7 and then when we moved to the Health Care
 8 Corporation, the site chiefs would organize
 9 them. So that was Dr. Khalifa early on and
 10 then Dr. Parai later.
 11 COFFEY, Q.C.:
 12 Q. Doctor, I haven't asked you who you reported
 13 to. I've asked you about people reporting to
 14 you and your responsibilities. Who did you
 15 report to when you first came to St. John's
 16 and then as time went on?
 17 DR. HAEGERT:
 18 A. Okay, well, as the chair I reported to the
 19 dean.
 20 COFFEY, Q.C.:
 21 Q. As the discipline chair?
 22 DR. HAEGERT:
 23 A. Yes, the discipline chair.
 24 COFFEY, Q.C.:
 25 Q. Dean of medicine.

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1 DR. HAEGERT:
 2 A. As the chief of the department of pathology,
 3 laboratory medicine I reported to the medical
 4 director at the General Hospital, that was Dr.
 5 Eric Parsons. And then when Health Care
 6 Corporation was created, Dr. Parsons became
 7 what was called the vice president of medical
 8 affairs, I think it was, so we initially
 9 reported to him. And then he left I believe
 10 to Saudi Arabia or somewhere in the Middle
 11 East, and then Dr. Bob Williams took that
 12 position over and I reported to him.
 13 COFFEY, Q.C.:
 14 Q. Doctor, and that, I take it, continued up
 15 until the time you left St. John's?
 16 DR. HAEGERT:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. Doctor, with respect to what else you, I take
 20 it you are a researcher, I can see from your
 21 CV that you -
 22 DR. HAEGERT:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. - certainly and other witnesses have referred

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1 to you as doing a certain amount of work in
 2 that regard. We've heard references to the
 3 MAC, the medical advisory committee.
 4 DR. HAEGERT:
 5 A. The medical advisor committee, yes.
 6 COFFEY, Q.C.:
 7 Q. I'm going to ask you about that. Again,
 8 throughout your history in St. John's, from
 9 '91 through 2002 were you involved with the
 10 MAC and, if so, in what capacity and what
 11 interaction would you have as the discipline
 12 chair or as the clinical chief with the MAC?
 13 DR. HAEGERT:
 14 A. Well, initially at the General Hospital there
 15 was, of course, a medical advisory committee.
 16 We met once a month. It was chaired by Dr.
 17 Parsons, I'm pretty sure. I think he chaired
 18 that. And so all the chiefs would attend
 19 these meetings and we would discuss issues
 20 related to the General Hospital, either
 21 financial or personnel issues, which was often
 22 a recurrent theme, insufficient physicians to
 23 run, for example, the emergency. This seemed
 24 to be a recurrent theme, always, intensive
 25 care, that sort of thing.

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<p>1 COFFEY, Q.C.:</p> <p>2 Q. And then after the formation of the Health</p> <p>3 Care Corporation?</p> <p>4 DR. HAEGERT:</p> <p>5 A. Yes, so there was a medical advisory committee</p> <p>6 who used to meet once a month. It was at 5:00</p> <p>7 in the afternoon and we used to go to about</p> <p>8 7:30, 8:00 at night. It didn't provide food</p> <p>9 or water or coffee or anything. It was</p> <p>10 chaired by, originally it was chaired by Ron</p> <p>11 Whelan, who was a radiologist at St. Clare's,</p> <p>12 I think, and then subsequently by Dr. Whitman.</p> <p>13 And the people that attended it were all the</p> <p>14 senior management of the Health Care</p> <p>15 Corporation, so that would be Sister Elizabeth</p> <p>16 Davis, Mr. Tilley, well, later Bob Williams</p> <p>17 and other so called--well, the vice</p> <p>18 presidents, the people in charge of human</p> <p>19 resources and finances, whose names I don't</p> <p>20 remember. And then all the chiefs would</p> <p>21 attend.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Clinical. And the role of the MAC at the</p> <p>24 Health Care Corporation was what?</p> <p>25 DR. HAEGERT:</p>	<p>1 certainly we've bring it forward.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. If it had implications for treatment of</p> <p>4 patients in another program who were also</p> <p>5 being treated by another program, would they</p> <p>6 be expected to bring it forward? And example</p> <p>7 would be if something in your department,</p> <p>8 pathology, you thought, well, okay, we deal</p> <p>9 with oncologists, a lot of our work probably</p> <p>10 goes to oncology?</p> <p>11 DR. HAEGERT:</p> <p>12 A. Um-hm.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. If you became aware of something, would you be</p> <p>15 expected because it would affect oncologists'</p> <p>16 work, potentially, if it did, would you be</p> <p>17 expected to bring it forward at the MAC?</p> <p>18 DR. HAEGERT:</p> <p>19 A. That sounds like a normal expectation.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. Now, Doctor, within the hospital structures,</p> <p>22 okay, at the time, laboratory medicine, I take</p> <p>23 it, provided services that had ramifications</p> <p>24 for treatment throughout the hospital in quite</p> <p>25 a number of disciplines?</p>
<p>Page 42</p> <p>1 A. Was to provide advice to--I mean, I think it</p> <p>2 was kind of bi-directional, I mean, early on</p> <p>3 in the initial phases Sister Elizabeth</p> <p>4 outlined her model of the laboratory medicine</p> <p>5 program and most of the clinical chiefs spoke</p> <p>6 out vociferously against it. And subsequently</p> <p>7 then we talked about issues really in the</p> <p>8 Health Care Corporation, like finances,</p> <p>9 personnel, that sort of thing. People would</p> <p>10 bring issues forth from their programs.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. And was there an expectation, looking back on</p> <p>13 it, you know, you participated in the MAC in</p> <p>14 the Health Care Corporation days, was there an</p> <p>15 expectation of a clinical chief that he or</p> <p>16 she, if there was a problem or potential</p> <p>17 problem, that he or she bring forward the</p> <p>18 problem to the MAC to at least advise them</p> <p>19 that a potential existed or did exist?</p> <p>20 DR. HAEGERT:</p> <p>21 A. I would say it depends on the dimensions of</p> <p>22 the problem. If it was some internal issue</p> <p>23 that was relatively minor, we wouldn't bring</p> <p>24 it to the medical advisory committee. But if</p> <p>25 it was some more significant issue, then</p>	<p>Page 44</p> <p>1 DR. HAEGERT:</p> <p>2 A. Um-hm. Yes, indeed.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Yourself, diagnostic imaging would be another</p> <p>5 one, I take it? It's the sort of thing that</p> <p>6 because of the nature of the work, it could</p> <p>7 be, the work could probably could go to a</p> <p>8 surgeon or surgeons, it could go to</p> <p>9 oncologists, it could go to any one of a</p> <p>10 number of places? You're -</p> <p>11 DR. HAEGERT:</p> <p>12 A. I mean, I certainly would think it would</p> <p>13 impact on other disciplines, for sure.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Doctor, you've referred to attempts or</p> <p>16 requests that you save money? You, the -</p> <p>17 DR. HAEGERT:</p> <p>18 A. Yes.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. - department save money. Were attempts made</p> <p>21 in that regard?</p> <p>22 DR. HAEGERT:</p> <p>23 A. Indeed.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. And okay, as a practical matter, and I've</p>

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1 written down here you said that you were asked
 2 to save money. I'm going to ask you, in
 3 practice what did that mean?
 4 DR. HAEGERT:
 5 A. Well, okay, so as I--you know we have a
 6 program management model or program model. So
 7 the program director and myself met with Mr.
 8 Tilley and he said, you know, paraphrasing
 9 what was said, something to the effect that
 10 the corporate team wanted the laboratory
 11 program to find a million dollars in savings
 12 through the restructuring process.
 13 COFFEY, Q.C.:
 14 Q. And this would be, at approximately what time
 15 frame would that have occurred?
 16 DR. HAEGERT:
 17 A. Well, I wondered about this. I mean, I don't
 18 have the minutes, but I mean, I would think it
 19 would be late 1996, early 1997, something like
 20 that.
 21 COFFEY, Q.C.:
 22 Q. Go ahead, Doctor, then? We want you to save a
 23 million dollars, go ahead, what happened?
 24 DR. HAEGERT:
 25 A. Okay. So what we--so Mr. Whelan and I

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

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

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1 managers and that also meant laying off a
 2 large number of other managers. So the
 3 decisions that were made initially were that,
 4 for example, for pathology you would have two
 5 managers, each manager would be responsible
 6 for two sites. So, for example, Terry
 7 Gulliver, who was a manager, who became one of
 8 the managers in anatomic pathology was
 9 responsible for the General Hospital and the
 10 Janeway. And then there was another manager,
 11 Mr. Murphy, who was responsible for the Grace
 12 and St. Clare's. And that was the initial
 13 model. So that lead to, I mean, a significant
 14 number of lay offs, so that was one way of
 15 reducing the budget.
 16 The second way of reducing the budget was
 17 some people were close to retirement. Now I
 18 don't remember if we gave packages because
 19 actually the budget was mostly handled by the
 20 program director. I mean, I didn't really
 21 have significant input into the budget except
 22 we were asked to save money. So some people
 23 who were close to retirement or retirement,
 24 the decision was not to replace those
 25 individuals. So that was one way of reducing

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<p>1 things. I mentioned the consolidation of, 2 like, the common platforms, but the balance, 3 of course, is what we were trying to do is try 4 to save money, but to do the least harm to the 5 program. So what we ended up doing after 6 multiple meetings with the divisional chiefs 7 and the managers of various programs, we came 8 up with \$700,000.00 rather than a million 9 dollars, and we thought that was--actually we 10 discussed this, actually, was this a 11 reasonable amount of money to go back to the 12 senior management, Mr. Tilley, and we felt 13 actually that we would do this because we 14 thought that would probably be the least 15 damaging. Also we felt that probably what 16 would happen is they would come back and ask 17 us for more money, anyway, later because this 18 --as I mentioned, or I think I mentioned it, 19 the mindset really was this was a cost centre, 20 and I think often it's a common thought that 21 laboratory medicine is somewhat removed from 22 patient care. I mean, pathologists don't 23 think that, but--obviously, the Commission of 24 Inquiry clearly is based on the fact that it's 25 involved with patient care, but I think the</p>	<p>1 whose costs could be reduced? 2 DR. HAEGERT: 3 A. That's right. 4 COFFEY, Q.C.: 5 Q. That was the--the laboratory was seen that 6 way, at least in your perception? 7 DR. HAEGERT: 8 A. Yes. 9 THE COMMISSIONER: 10 Q. Excuse me, Mr. Coffey, but my past life just 11 keeps popping up occasionally. Was it your 12 view at this time that your particular 13 department was being asked to save more than 14 others, or was this one of those general 15 occasions when the directive might be each of 16 the cost centres you've got to cut "x" out of 17 your budget? 18 DR. HAEGERT: 19 A. I don't think we were advised as to what they 20 were doing in the other cost centres, but we 21 did know that, for example--I don't know what 22 the group is called, food services and 23 laundry, that I think for laundry, there was - 24 I mean, I'm not sure I remember this 25 correctly, but I think the feeling was that</p>
<p>1 mindset was more like this is more like 2 housekeeping or, you know, laundry services or 3 something, this is an area we can save money. 4 So we kind of felt that they would probably 5 come back, anyway. 6 COFFEY, Q.C.: 7 Q. And look for -- 8 DR. HAEGERT: 9 A. And ask for more. So we went--so we told--I 10 think I wrote Mr. Tilley and told him that we 11 could only find \$700,000.00, and our internal 12 feeling was this would be the least damaging 13 to our program. 14 COFFEY, Q.C.: 15 Q. And the phrase "cost centre" you used in this 16 context means what, that it costs a lot of 17 money and it's not very visible? 18 DR. HAEGERT: 19 A. Well, cost centre is just a term that people 20 use to describe--you know, in the program 21 there were multiple cost centres like peri- 22 operative, medicine, surgery, cancer care. 23 COFFEY, Q.C.: 24 Q. So the use of the phrase "cost centre" is not 25 so much pejorative as this was a cost centre</p>	<p>1 this could be sourced out to some other place. 2 So we did know that this was going on with 3 some of the other areas, but whether this was 4 uniform, I didn't know. 5 COFFEY, Q.C.: 6 Q. And you refer to it as the least damage, the 7 way you described it, suggesting that perhaps 8 there might be some damage, that's an 9 acknowledgement that there might be. What 10 sorts of damage might be envisaged or was 11 envisaged could occur in the laying off of 12 these--the elimination of management 13 positions? 14 DR. HAEGERT: 15 A. Well, I think one of the -- 16 COFFEY, Q.C.: 17 Q. In other words, what these managers were doing 18 that wouldn't get done after the elimination 19 of their positions? 20 DR. HAEGERT: 21 A. I think one of the feelings was that people 22 usually rise in management because they're 23 capable. Typically in St. John's, they've 24 risen through the ranks and become managers 25 because they are deemed to be high quality</p>

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<p>1 individuals. So what you're basically doing</p> <p>2 is moving a large number of the high quality</p> <p>3 people in the overall program and that the</p> <p>4 oversight of various areas becomes more</p> <p>5 problematic. It's much more difficult if</p> <p>6 you're a manager--to start again, it's</p> <p>7 relatively easy or easier if you're a manager</p> <p>8 on "a" site, but if you're a manager</p> <p>9 responsible for more than one site, it becomes</p> <p>10 more of a--it's more difficult to manage; how</p> <p>11 do you manage when you're not actually there.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. And oversight in this regard in the clinical</p> <p>14 laboratory program in the late 1990s, what</p> <p>15 sorts of oversight are we talking about in a</p> <p>16 practical way?</p> <p>17 DR. HAEGERT:</p> <p>18 A. Well, I didn't mention this, but when we talk</p> <p>19 about managers, of course, these managers</p> <p>20 reported to Mr. Whelan. The management model</p> <p>21 was a dual management, so that really most of</p> <p>22 their interaction would be up through him and</p> <p>23 not to me, but the way I would look at it as a</p> <p>24 chief is that what these people would be</p> <p>25 responsible for the budget within their own</p>	<p>1 things that happened in biochemistry is that</p> <p>2 they basically went from different types of</p> <p>3 biochemistry equipment at different sites to -</p> <p>4 much of the automated equipment was Becton.</p> <p>5 The technologists would have been trained on</p> <p>6 this equipment, so to actually know that they</p> <p>7 knew how to do this, there would be formal</p> <p>8 training. Similarly in pathology if there was</p> <p>9 new equipment, there would be formal training</p> <p>10 provided by the company of the people who</p> <p>11 would be using the equipment. The managers</p> <p>12 would be involved in this to a greater or</p> <p>13 lesser extent, but the people who are actually</p> <p>14 working with the equipment, they would be the</p> <p>15 ones who would get the formal training to make</p> <p>16 sure that they actually knew how to do it and</p> <p>17 how to troubleshoot and solve problems.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Quality assurance, quality control</p> <p>20 initiatives, would managers be involved--if</p> <p>21 there were such things, would managers in</p> <p>22 pathology be involved in those?</p> <p>23 DR. HAEGERT:</p> <p>24 A. Yes.</p> <p>25 COFFEY, Q.C.:</p>
<p>1 divisions, so that, for example, if there's</p> <p>2 two managers in pathology, they would be</p> <p>3 responsible jointly for the budget in</p> <p>4 pathology and report to Mr. Whelan. They</p> <p>5 would also be responsible for workload, the</p> <p>6 work flow, what technicians do what, the</p> <p>7 scheduling of the technologists, that kind of</p> <p>8 thing.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. What about quality assurance matters, quality</p> <p>11 control, quality assurance, education,</p> <p>12 continuing education because we've heard that</p> <p>13 the clinical laboratory has evolved over time,</p> <p>14 there were many more--new machinery, new</p> <p>15 technologies coming in stream throughout that</p> <p>16 whole time frame. So for education, quality</p> <p>17 control, quality assurance, those sorts of</p> <p>18 endeavours, would the managers in these sorts</p> <p>19 of positions be involved in that sort of</p> <p>20 activity, and the elimination of those</p> <p>21 positions would have what effect?</p> <p>22 DR. HAEGERT:</p> <p>23 A. Yes, they would be involved, but also the</p> <p>24 technologists--if, for example, you get new</p> <p>25 equipment, because as I recall, one of the</p>	<p>1 Q. And I take it if they didn't exist, the</p> <p>2 managers would be--if there were sufficient</p> <p>3 managers and sufficient time, would be</p> <p>4 expected to implement them as required,</p> <p>5 quality assurance programs?</p> <p>6 DR. HAEGERT:</p> <p>7 A. Yes.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Quality control programs.</p> <p>10 DR. HAEGERT:</p> <p>11 A. Yes.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. Doctor, the idea or the notion that by taking</p> <p>14 this particular approach that you've</p> <p>15 indicated, there was consensus, I take it,</p> <p>16 amongst the clinical laboratory management</p> <p>17 that we take a particular approach,</p> <p>18 potentially save \$700,000.00, and do the least</p> <p>19 damage--by doing--taking that approach to do</p> <p>20 the least damage?</p> <p>21 DR. HAEGERT:</p> <p>22 A. Yes, approach with least damage, yes.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. The idea that we are doing the least damage by</p> <p>25 doing this, was that ever conveyed to anybody</p>

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1 higher up in the organization than yourself?
 2 For example, was it conveyed to Sister Davis
 3 or Mr. Tilley, yes, I'm saying - this plan
 4 will save \$700,000.00, but it will come with a
 5 cost in terms of there will be--the idea that
 6 it would come with a potential cost in terms
 7 of clinical care perhaps ultimately, was that
 8 ever conveyed to the management of the Health
 9 Care Corporation, senior management?
 10 DR. HAEGERT:
 11 A. That's a good question. I certainly would
 12 have--I mean, it would seem reasonable that I
 13 would have said that to Mr. Tilley.
 14 COFFEY, Q.C.:
 15 Q. When you did tell him about the \$700,000.00,
 16 what was the reaction?
 17 DR. HAEGERT:
 18 A. I think he was somewhat disappointed in that
 19 he said that he would bring this back to the
 20 other of the senior management and they would
 21 discuss it.
 22 COFFEY, Q.C.:
 23 Q. Did you hear anything further on it?
 24 DR. HAEGERT:
 25 A. I think he wrote me back.

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1 COFFEY, Q.C.:
 2 Q. Okay.
 3 DR. HAEGERT:
 4 A. And said they would accept this.
 5 COFFEY, Q.C.:
 6 Q. What do you recall happened, was the
 7 \$700,000.00 actually saved?
 8 DR. HAEGERT:
 9 A. Well, they just remove it from the budget.
 10 COFFEY, Q.C.:
 11 Q. Okay, and this would be--\$700,000.00 would be
 12 an annual amount?
 13 DR. HAEGERT:
 14 A. No, this was a one time --
 15 COFFEY, Q.C.:
 16 Q. A one time.
 17 DR. HAEGERT:
 18 A. Yes, one time.
 19 COFFEY, Q.C.:
 20 Q. It was removed from the budget for that
 21 particular year -
 22 DR. HAEGERT:
 23 A. But that would be--of course, it would persist
 24 subsequently. Yes, they wouldn't put it back
 25 a subsequent year. That would be indeed a

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1 reduction. Yes, I follow your question now.
 2 COFFEY, Q.C.:
 3 Q. Doctor, that's the first year of this?
 4 DR. HAEGERT:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. What then happened in this regard?
 8 DR. HAEGERT:
 9 A. In terms of finances?
 10 COFFEY, Q.C.:
 11 Q. Yes, finances.
 12 DR. HAEGERT:
 13 A. Well, it's surprising really because I
 14 remembered this extremely vividly maybe
 15 because we spent so much effort trying to find
 16 the money. I know subsequently we were asked
 17 to save money, and what I think happened when
 18 in 1999 the Grace closed and we were asked to
 19 find subsequent--a further amount of money,
 20 but how much, I don't know.
 21 COFFEY, Q.C.:
 22 Q. And did you--was the attempt made, do you
 23 recall?
 24 DR. HAEGERT:
 25 A. Well, we would have tried.

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1 COFFEY, Q.C.:
 2 Q. And what was the outcome of that, do you
 3 recall?
 4 DR. HAEGERT:
 5 A. I think we would have saved something, but how
 6 much, I don't know. I mean, I think probably
 7 again it would have been--I mean, I really
 8 don't recall.
 9 COFFEY, Q.C.:
 10 Q. Any savings that were achieved at that time in
 11 terms of saving money, again what sorts of
 12 things would have, if there were any, were cut
 13 to save money?
 14 DR. HAEGERT:
 15 A. Well, again it would be--as I said before,
 16 most of the money in the budget was people, so
 17 I would have said whatever money was saved was
 18 probably reduction of a small number of
 19 people, but I don't know how much was asked, I
 20 can't remember.
 21 COFFEY, Q.C.:
 22 Q. So throughout your time as the clinical chief
 23 at the Health Care Corporation, your memory
 24 generally is that if we--any time we were
 25 asked to save money, we ended up focusing on

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<p>1 personnel costs and trying to reduce that?</p> <p>2 DR. HAEGERT:</p> <p>3 A. Yes, and were there ways to make things</p> <p>4 equally as efficient and perhaps reducing cost</p> <p>5 that way.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Doctor, if we could, please, Registrar, bring</p> <p>8 up Exhibit P-0479. Doctor, this is a multi-</p> <p>9 page exhibit. I'm just going to--the second</p> <p>10 page of it is entitled "Laboratory Medicine</p> <p>11 Program Clinical Chief/Discipline Chair", and</p> <p>12 the various personnel who held these positions</p> <p>13 over the years and their tenure periods are</p> <p>14 listed there. You're the first as clinical</p> <p>15 chief.</p> <p>16 DR. HAEGERT:</p> <p>17 A. Uh-hm.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. April 15th, 1991 through March 11th, 2002, and</p> <p>20 then you officially left the organization in</p> <p>21 October, 2002, according to this?</p> <p>22 DR. HAEGERT:</p> <p>23 A. Yes.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. Doctor, in the intervening time between March</p>	<p>1 A. Yes.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. And relinquished your position as clinical</p> <p>4 chief in the last six months or so you were</p> <p>5 here. Doctor, on the next page, page three,</p> <p>6 the document says, "Terms and Conditions, Dr.</p> <p>7 David G. Haegert", and this is February 25,</p> <p>8 1991. See that at the bottom of the page?</p> <p>9 DR. HAEGERT:</p> <p>10 A. Yes.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. In fact, it's the terms and conditions again</p> <p>13 of your appointment as a professor and chair</p> <p>14 of the discipline of pathology, at least your</p> <p>15 initial appointment. Doctor, do you ever</p> <p>16 recall there being a functional description,</p> <p>17 written description, of what the clinical</p> <p>18 chief did or was expected to do?</p> <p>19 DR. HAEGERT:</p> <p>20 A. It's difficult to answer that. I think there</p> <p>21 probably was because the Health Care</p> <p>22 Corporation was very good at creating typed</p> <p>23 descriptions of things, so I would imagine</p> <p>24 that there was.</p> <p>25 COFFEY, Q.C.:</p>
<p>1 11th, 2002, and October, 2002, what were you</p> <p>2 doing at that time? You were clinical chief</p> <p>3 up to March 11th '02. For the next six/seven</p> <p>4 months--it says Dr. Cook had taken over as</p> <p>5 clinical chief on March 12th. Were you</p> <p>6 continuing--did you continue on in St. John's?</p> <p>7 DR. HAEGERT:</p> <p>8 A. Yes, I did. I think I left, actually,</p> <p>9 September 1, because I had a month holiday,</p> <p>10 something like that.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. So you --</p> <p>13 DR. HAEGERT:</p> <p>14 A. So I would have continued as a pathologist and</p> <p>15 the chair.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. And if we look down below on this page,</p> <p>18 discipline chair, you're there from April</p> <p>19 15th, 1991, through August 31, 2002?</p> <p>20 DR. HAEGERT:</p> <p>21 A. Yes.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. So you stayed on in your role as discipline</p> <p>24 chair?</p> <p>25 DR. HAEGERT:</p>	<p>1 Q. Doctor, before we get to the period where Dr.</p> <p>2 Khalifa came to St. John's, I'm going to ask</p> <p>3 you about that, if we could bring up, please,</p> <p>4 Exhibit P-2527. This particular document is</p> <p>5 dated March 11th, 1994. It's a memo to all</p> <p>6 pathologists from yourself, policy on external</p> <p>7 consultation, and signed by yourself as Chair</p> <p>8 of the Department of Laboratory Medicine, and</p> <p>9 I take it here, in effect, as Chairman of the</p> <p>10 Department of Laboratory Medicine, would this</p> <p>11 be your university position or your clinical</p> <p>12 chief's position?</p> <p>13 DR. HAEGERT:</p> <p>14 A. Actually, it should have probably been written</p> <p>15 as clinical chief. That would have been a</p> <p>16 hospital--obviously, it's a hospital activity.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Doctor, the subject matter here is described</p> <p>19 as policy on external consultation, and you</p> <p>20 write in the second sentence, "Some time ago</p> <p>21 it was agreed that no case would be referred</p> <p>22 outside this institution to the CTRC, etc,</p> <p>23 without consulting the divisional chief or</p> <p>24 myself, in her absence", and Dr. Fernandez</p> <p>25 would have been the divisional chief?</p>

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<p>1 DR. HAEGERT:</p> <p>2 A. Yes.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. And you conclude by repeating, "It is the</p> <p>5 policy of the Department of Laboratory</p> <p>6 Medicine not to refer cases outside until</p> <p>7 consultation has been obtained at the</p> <p>8 divisional chief or chair level". Doctor,</p> <p>9 what was this about, this whole idea, why the</p> <p>10 necessity to send out this sort of a memo?</p> <p>11 DR. HAEGERT:</p> <p>12 A. Partly, I think, it was related to money, but</p> <p>13 more importantly, I think, it was related to</p> <p>14 the fact that there was considerable expertise</p> <p>15 within the department. The CTRC, I mean, it</p> <p>16 stands for Canadian Tumour Reference Centre,</p> <p>17 and what this is is a panel of pathologists</p> <p>18 who have expertise in something, for example,</p> <p>19 I don't know, say, ENT pathology. The idea</p> <p>20 here really is that if I'm a relatively junior</p> <p>21 pathologist and I see a case and it's</p> <p>22 difficult, there are several options. One, you</p> <p>23 could show it to people inside the department</p> <p>24 or you could send it outside for another</p> <p>25 opinion, but it's logical to first of all</p>	<p>1 they're benign or malignant. So what we would</p> <p>2 uniformly do is send them out for another</p> <p>3 opinion, mostly because people don't have the</p> <p>4 experience, but routine internal cases, we</p> <p>5 wouldn't send them out.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Doctor, I understand that Dr. Khalifa came to</p> <p>8 St. John's in the mid 1990s.</p> <p>9 DR. HAEGERT:</p> <p>10 A. Yes.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. Just before his--before he arrived in St.</p> <p>13 John's, immunohistochemistry was being</p> <p>14 conducted where?</p> <p>15 DR. HAEGERT:</p> <p>16 A. At the General Hospital site.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. And that had--in your time from the time you</p> <p>19 arrived here in 1991, was that true?</p> <p>20 DR. HAEGERT:</p> <p>21 A. Yes.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. It was concentrated in the General Hospital</p> <p>24 really from the time you arrived?</p> <p>25 DR. HAEGERT:</p>
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<p>1 refer it inside the department to see, in</p> <p>2 fact, if somebody who has seen 10, 15, 20, 50</p> <p>3 cases of this--because it depends entirely on</p> <p>4 the expertise within the department. I mean,</p> <p>5 Dr. Fernandez was particularly expert in</p> <p>6 really most areas in pathology, and her</p> <p>7 opinion I would have said was extremely</p> <p>8 valuable in almost every area. It made no</p> <p>9 sense to me that some straightforward case,</p> <p>10 you send it out to the CTRC for another</p> <p>11 opinion when there's really no need for it.</p> <p>12 So that was the main principle behind this.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. And so in what sorts of situations then--if</p> <p>15 you were, yourself or Dr. Fernandez was</p> <p>16 consulted, what sorts of factors determined</p> <p>17 whether it would--an outside opinion was</p> <p>18 sought?</p> <p>19 DR. HAEGERT:</p> <p>20 A. These would be cases outside the norm, unusual</p> <p>21 cases. Like, I think it was our normal</p> <p>22 policy, for example, with cartilaginous</p> <p>23 tumours of bone, most pathologists in St.</p> <p>24 John's rarely saw these, might see one a year,</p> <p>25 and it's often very, very hard to tell if</p>	<p>1 A. Yes.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Okay. Doctor, between the time you arrived</p> <p>4 and Dr. Khalifa's arrival, was there any</p> <p>5 particular pathologists or pathologists who</p> <p>6 were responsible for immunohistochemistry?</p> <p>7 DR. HAEGERT:</p> <p>8 A. No, because --</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Perhaps you could describe then --</p> <p>11 DR. HAEGERT:</p> <p>12 A. The way it--the way it really worked, I</p> <p>13 mentioned this dual management or parallel</p> <p>14 management thing. The way it really worked</p> <p>15 was immunohistochemistry reported to the</p> <p>16 manager. So what would happen is a</p> <p>17 pathologist wanted immunohistochemical stain,</p> <p>18 say, for example, a CD20 antibody stain, what</p> <p>19 --the pathologist would order that. The</p> <p>20 technologist would do it. The slides would</p> <p>21 come to the pathologist and the pathologist</p> <p>22 would then review it. If there was some issue</p> <p>23 with it, they would probably go back to the</p> <p>24 technologist and say, look, the staining is</p> <p>25 weak or there's some problem with the slide,</p>

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<p>1 you need to review this, or would go to the 2 manager. So the oversight was really a 3 manager's role. The divisional manager of 4 pathology would be the one responsible. So 5 the divisional chief, Dr. Fernandez, would be 6 the person who would be responsible for 7 liaising with the technologists and the 8 divisional manager, although it was somewhat 9 loose, so the pathologist would actually talk 10 to the technologist directly, but would not 11 say, oh, did you do this, did you do that. 12 That wouldn't be the pathologist's role. 13 COFFEY, Q.C.: 14 Q. The pathologist role would be to say, well, 15 the staining is not appropriate or there's no 16 staining at all? 17 DR. HAEGERT: 18 A. There's some problem with it, or the material 19 is not on the slide, or something to that 20 effect. 21 COFFEY, Q.C.: 22 Q. And having explained what the nature of the 23 problem was, how it might be addressed or 24 fixed would be whose responsibility, looking 25 back on it now?</p>	<p>1 and then utilizing it? 2 DR. HAEGERT: 3 A. Well, the normal process will be that the 4 divisional chief would just talk to the 5 manager and say we need stain "x" or "y" for 6 these purposes, and we need to purchase this 7 and then develop the staining methodology for 8 it. 9 COFFEY, Q.C.: 10 Q. Now the development of the--assuming the money 11 was there in the budget, presumably, the stain 12 would be purchased? 13 DR. HAEGERT: 14 A. Yes. 15 COFFEY, Q.C.: 16 Q. What would happen then, what was your 17 understanding of what the process was? The 18 stain arrives by Fedex, for example, whatever. 19 What happened then? 20 DR. HAEGERT: 21 A. Well, based on my research experience, what 22 would happen is the technologists would then 23 develop a methodology. 24 COFFEY, Q.C.: 25 Q. And what did that involve, again based upon</p>
<p>Page 70</p> <p>1 DR. HAEGERT: 2 A. I mean, the normal thing would be that the 3 technologists--I mean, I always assumed that 4 the technologists had the experience and 5 expertise to solve these problems, but, I 6 mean, if they couldn't solve them, then they 7 would consult the manager. 8 COFFEY, Q.C.: 9 Q. Doctor, we've heard from various witnesses 10 that certainly beginning in the late 1980s and 11 continuing throughout the 1990s more and more 12 immunohistochemical stains became available. 13 DR. HAEGERT: 14 A. Yes. 15 COFFEY, Q.C.: 16 Q. To be used--I mean, it's just--and what, if 17 any, procedure was there in place in the early 18 1990s in terms of how a stain or a particular 19 stain would become available to be utilized in 20 St. John's? I'm not a physician, but if you 21 picked a stain, for example, that first came 22 on the market in 1992, a particular stain, and 23 you or one of your colleagues at the General 24 Hospital wanted to utilize it, how--what was 25 the process for getting it in to St. John's</p>	<p>Page 72</p> <p>1 your experience--looking back on it in 1990s 2 here in St. John's, what did that involved? 3 Do you know how they would go about it? 4 DR. HAEGERT: 5 A. Well, typically what would happen with a 6 particular stain, it comes with a sheet which 7 is the product information from the 8 manufacturer. Like, Becton Dickinson makes 9 large numbers of antibodies, DAKO makes large 10 numbers of antibodies. What they do--they 11 would recommend uses, and what I would have 12 anticipated is what the laboratory would do is 13 first of all, they would do dilutions of the 14 antibody and test it on appropriate tissue 15 that should be positive and also tissue that 16 should be negative. So they would develop a 17 test, they would work it up to develop optimal 18 staining and find out under what conditions 19 they get the highest quality of staining, 20 which is still specific, but not getting non- 21 specific staining. 22 COFFEY, Q.C.: 23 Q. And would pathologists play any role in that 24 process in your experience here in St. John's? 25 DR. HAEGERT:</p>

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<p>1 A. I would say minimal.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. And the nature of their role if any was what?</p> <p>4 DR. HAEGERT:</p> <p>5 A. Well, basically it would be a consultative</p> <p>6 role. So if, for example, you brought, I</p> <p>7 don't know, an antibody to some molecule, one</p> <p>8 of the pathologists who had requested it, or</p> <p>9 perhaps a divisional chief, would then review</p> <p>10 the slides and try to form an opinion as to</p> <p>11 whether the test--whether the stain worked</p> <p>12 appropriately or not, whether the staining was</p> <p>13 weak, whether it--was it strong, was it non-</p> <p>14 specific, was there a high background, things</p> <p>15 like that.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. At the time in the early 1990s, 1991 through--</p> <p>18 well, in fact, during the whole of your time</p> <p>19 as clinical chief, was there any particular</p> <p>20 accepted procedure in place or policy in place</p> <p>21 and procedure in place as to how this was to</p> <p>22 be done for any antibody, antibody x, y, z?</p> <p>23 DR. HAEGERT:</p> <p>24 A. Well, initially it would go through the</p> <p>25 divisional chief. So initially if you wanted</p>	<p>1 the lab in terms of this optimization process,</p> <p>2 which is a phrase that might be used to</p> <p>3 describe, I think, what you otherwise said,</p> <p>4 which is using different dilutions, different</p> <p>5 whatever approaches, was there any policy in</p> <p>6 place as to how that was to be gone about?</p> <p>7 Did the divisional chiefs have to sign off</p> <p>8 saying that now we are satisfied that it's</p> <p>9 working properly and it's available generally</p> <p>10 to pathologists in Newfoundland or particular</p> <p>11 individual pathologists who happened to order</p> <p>12 it, would it be left to him or her to decide?</p> <p>13 DR. HAEGERT:</p> <p>14 A. Was there a written policy?</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Yes.</p> <p>17 DR. HAEGERT:</p> <p>18 A. I don't think there was a written policy, but</p> <p>19 I think it was the general flavour, or maybe</p> <p>20 that's not the right term exactly, but the</p> <p>21 general sort of principle that applied is that</p> <p>22 if you wanted a new antibody, I mean, the</p> <p>23 individual ordering it or requesting it would</p> <p>24 provide the appropriate material to the</p> <p>25 technologist. Sections would be cut and they</p>
<p>1 a new antibody, you'd discuss with the</p> <p>2 divisional chief. Perhaps we'd bring it to a</p> <p>3 meeting and discuss it, you know, if we buy</p> <p>4 this antibody, are people going to use it, do</p> <p>5 we think it's useful. It was more formalized</p> <p>6 when the Health Care Corporation was created</p> <p>7 because then we discussed it at the site</p> <p>8 chief's meetings. I know we discussed on</p> <p>9 several occasions different antibodies, what</p> <p>10 use they would be, what would we do with them,</p> <p>11 would people use them. I mean, one of the</p> <p>12 things we didn't want to do is buy antibodies</p> <p>13 that would be used once and then--I mean, it's</p> <p>14 basically a waste of money because they</p> <p>15 typically cost between 400 and 600 dollars for</p> <p>16 an antibody for one tube of antibody.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Okay, so the process of vetting, as it were,</p> <p>19 to get it in here at all to purchase it, there</p> <p>20 was a process in place, and it became more</p> <p>21 formalized under the Health Care Corporation?</p> <p>22 DR. HAEGERT:</p> <p>23 A. Yes.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. The process as to how it was to be handled in</p>	<p>1 would be stained. They would optimize it, and</p> <p>2 then the pathologist who asked for it or the</p> <p>3 divisional chief would review this.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. And that was, I take it, a general</p> <p>6 understanding?</p> <p>7 DR. HAEGERT:</p> <p>8 A. Yes.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. But there was nothing in writing to that</p> <p>11 effect?</p> <p>12 DR. HAEGERT:</p> <p>13 A. Well, I don't remember if there was. I mean,</p> <p>14 if there were --</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. You don't recall?</p> <p>17 DR. HAEGERT:</p> <p>18 A. I don't remember.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. The idea of a formal approval process in the</p> <p>21 sense of formal approval to bring it on line</p> <p>22 as opposed to order it in the first place,</p> <p>23 bringing it on line, making it generally</p> <p>24 available --</p> <p>25 DR. HAEGERT:</p>

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1 A. I mean, there may have been a memo that I sent
 2 out at one time, but I--or we certainly would
 3 have--I mean, this would be the kind of thing
 4 that would be discussed in the divisional
 5 meetings.
 6 COFFEY, Q.C.:
 7 Q. Doctor, in terms then of immunohistochemistry
 8 itself, there was no one pathologist or group
 9 of pathologists who were responsible for
 10 immunohistochemistry?
 11 DR. HAEGERT:
 12 A. Not formally responsible because of the
 13 reporting relationship. The divisional chief
 14 would have been the one early on who would
 15 have been the one who would be, if you want to
 16 call it liaison. The person that--the
 17 technologist would speak to--it was more
 18 informal. I mean, this is Newfoundland, so
 19 people tend to be somewhat informal. So the
 20 techs would feedback to the individual
 21 pathologist as well.
 22 COFFEY, Q.C.:
 23 Q. As time--as the divisional chief in the
 24 beginning, as time went on, did that change or
 25 did it always remain kind of--in your capacity

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1 as clinical chief, if you were called upon at
 2 the time to think about it as to who is
 3 responsible amongst the pathologist staff or
 4 IHC?
 5 DR. HAEGERT:
 6 A. Well, this was an understanding that the site
 7 chief took over, that would be one of his
 8 roles to be the person who would be overall
 9 responsible in terms of interacting with the
 10 immunohistochemistry laboratory.
 11 COFFEY, Q.C.:
 12 Q. And the divisional chief would have been
 13 Fernandez in your early days?
 14 DR. HAEGERT:
 15 A. Yes, and Dr. Fernandez came the site chief.
 16 COFFEY, Q.C.:
 17 Q. Site chief, and then finally Dr. Khalifa as
 18 site chief?
 19 DR. HAEGERT:
 20 A. Yeah.
 21 COFFEY, Q.C.:
 22 Q. And then --
 23 DR. HAEGERT:
 24 A. Parai.
 25 COFFEY, Q.C.:

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1 Q. At the very end, Dr. Parai?
 2 DR. HAEGERT:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. If we could bring up, please, Exhibit P-2423.
 6 Doctor, this is the curriculum vitae of Dr.
 7 Khalifa, Mahmoud Khalifa. This is a
 8 relatively current one in this particular form
 9 as it is now. It covers more time, a longer
 10 time frame than the one you would have seen
 11 back in the mid 1990s, but could you tell us,
 12 please, what you recall about the recruitment
 13 of Dr. Khalifa, his arrival here, and what he
 14 was asked to do in terms of being site chief?
 15 DR. HAEGERT:
 16 A. Okay. Well, initially he was not site chief.
 17 COFFEY, Q.C.:
 18 Q. No.
 19 DR. HAEGERT:
 20 A. He was recruited. He came as--well, we
 21 advertised. I think he had a J1 Visa in the
 22 United States. He applied. He came and gave
 23 a talk in the department. He met with
 24 individuals within the department where all of
 25 us were enthusiastic about his coming. He

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1 thought--I mean, one of the principles that we
 2 had was recruit people with subspecialty
 3 expertise and he had clearly had a lot of
 4 training in pathology, trained in Oklahoma--
 5 well, he had trained in the Armed Forces
 6 Institute of Pathology, and then Oklahoma, and
 7 then Georgetown. So he came here as a
 8 pathologist. When the Health Care Corporation
 9 was created, Dr. Fernandez said he was no
 10 longer interested in being--well, would have
 11 been site chief, so I asked Dr. Khalifa if he
 12 would be interested, and then I explained to
 13 him what I thought the role of a site chief
 14 was.
 15 COFFEY, Q.C.:
 16 Q. Doctor, did you ever--before Dr. Khalifa
 17 actually arrived on staff, do you recall ever
 18 having a conversation with Dr. Cook about how
 19 long Dr. Khalifa might stay?
 20 DR. HAEGERT:
 21 A. No.
 22 COFFEY, Q.C.:
 23 Q. At the time as the clinical chief and the
 24 discipline chair--I take it as discipline
 25 chair, in particular, of Memorial, you would

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<p>1 have been very interested in having Dr. 2 Khalifa come? 3 DR. HAEGERT: 4 A. Yes. 5 COFFEY, Q.C.: 6 Q. And stay, if possible. From your perspective 7 at the time in a professional sense, what were 8 the challenges in keeping someone with Dr. 9 Khalifa's background? You got him here is one 10 thing, but to keep him here. 11 DR. HAEGERT: 12 A. Well, one of the challenges was, first of all, 13 the research opportunities in the department. 14 He really wanted to do research, and the 15 reality in the department, there was only a 16 small number of us doing research, and I think 17 he was disappointed with that. It was really 18 only myself and Dr. Robb who were actually 19 doing any active research. That was one of 20 the things. The second issue for him, I 21 think, was salary. A lot of people's salary 22 is very important and I think he was--I mean, 23 he soon became aware that there was more money 24 to be obtained elsewhere. I think he had 25 personal elements too, which made it difficult</p>	<p>1 COFFEY, Q.C.: 2 Q. Doctor, do you recall--in terms of workload, 3 Dr. Khalifa, after his arrival here and as 4 time went on, did the matter of doing consults 5 from outside the General Hospital ever arise 6 as an issue in terms of him doing or being 7 asked to do more and more consults by people? 8 DR. HAEGERT: 9 A. Yes, it did arise, but the reality was we 10 always had done this. The pathologists at the 11 General Hospital had always done consultations 12 with the Newfoundland Cancer Treatment and 13 Research Foundation for patients who were 14 referred to the General Hospital. So a 15 patient would come from, say, Clarenville, for 16 surgery or something at the General Hospital 17 site, and one of the pathologists would have 18 done that. 19 COFFEY, Q.C.: 20 Q. And did that--were you ever asked by Dr. 21 Khalifa to pursue that, pursue the idea of him 22 being paid extra compensation? 23 DR. HAEGERT: 24 A. This was actually discussed not only with him, 25 but with others. We discussed it--I think it</p>
<p>1 to retain him. 2 COFFEY, Q.C.: 3 Q. Doctor, the salaries at the time, this would 4 be 1995/1996 through the end of your time in 5 St. John's -- 6 DR. HAEGERT: 7 A. Yes. 8 COFFEY, Q.C.: 9 Q. What was the situation for pathologist's 10 salaries in St. John's compared to elsewhere 11 in Canada? 12 DR. HAEGERT: 13 A. Well, they were lower than elsewhere. They 14 were--I think when I came, I thought they were 15 more or less the same as in Quebec, although 16 the salaries in Quebec were highly variable, 17 depending where you worked and what kind of 18 practise you had. Some people made a lot of 19 money, but a lot of people made less, but 20 elsewhere there was--it was certainly higher 21 than in St. John's. I don't remember what it 22 was elsewhere, but I know there was a 23 difference. I think the other issue for him 24 was workload. He felt the workload was far 25 too high and there was minimal protected time.</p>	<p>1 went to Bob Williams, who was at the time Vice 2 President of Medical Affairs, but then it also 3 went to Paul Gardner, who was--he was the 4 Medical Director of the NCTRF at the time. I 5 spoke to him about it, and I said, you know, 6 basically this is a medical/legal issue, not 7 just a financial issue. I said, you know, 8 basically we have a patient from, say, 9 Carbonear, who has had breast surgery, they 10 send it to the General Hospital, we review the 11 case, we report it, and basically what we are 12 doing is taking medical/legal responsibility 13 for all aspects of that case and there's no 14 financial remuneration, and the feeling in our 15 department was that they should be paying the 16 people in the department. I met him at least 17 once, and possibly twice, I think I wrote him 18 as well, and he basically said--my 19 recollection is, no, there's no money, and I 20 also think he--the bottom line, I think he 21 said, well, there never will be. Basically, 22 you kind of have to swallow it, tough beans, 23 more or less. 24 COFFEY, Q.C.: 25 Q. If you want to work in the General Hospital --</p>

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<p>1 DR. HAEGERT: 2 A. Yes, this is basically -- 3 COFFEY, Q.C.: 4 Q. It's part of it. 5 DR. HAEGERT: 6 A. I think he basically said there's no money 7 coming from the government. It was also a 8 time, you know--and that time everywhere there 9 was budget cuts. They were being cut, the 10 medical school was being cut, the Health Care 11 Corporation was also facing budget cuts. So I 12 think--I mean, it sounded plausible to me. 13 COFFEY, Q.C.: 14 Q. Doctor, if we could, please, bring up Exhibit 15 P-2421. Doctor, this is a letter dated April 16 28, 1999, addressed to yourself. It's from 17 Dr. Khalifa. It reads, "It was February 13th, 18 1996, when Des", and that would be Dr. Robb, I 19 take it? 20 DR. HAEGERT: 21 A. Yes. 22 COFFEY, Q.C.: 23 Q. "Myself", Dr. Khalifa, "sent a memorandum 24 announcing the beginning of a new weekly 25 surgical pathology conference. For over three</p>	<p>1 DR. HAEGERT: 2 A. Well, sometime around 1996 he was appointed, 3 yes. 4 COFFEY, Q.C.: 5 Q. And I take it this would be an example of, or 6 probably is at least at the General Hospital 7 site, this weekly meeting of pathologists you 8 referred to? 9 DR. HAEGERT: 10 A. Yes. 11 COFFEY, Q.C.: 12 Q. Doctor, do you know if this continued after 13 Dr. Khalifa left? 14 DR. HAEGERT: 15 A. I think we did this when Dr. Parai took over. 16 COFFEY, Q.C.: 17 Q. So as site chief, Dr. Khalifa would be 18 expected as the site chief at the General to 19 organize this sort of thing because Dr. Parai 20 did after him? 21 DR. HAEGERT: 22 A. Yes. 23 COFFEY, Q.C.: 24 Q. Dr. Cook would be expected to do it at St. 25 Clare's?</p>
<p style="text-align: right;">Page 86</p> <p>1 years, we came to the multi-headed microscope 2 almost every Tuesday at noon to share 3 interesting cases, discuss criteria, review 4 each other's diagnosis and teach residents. 5 Most importantly, we communicated and had lots 6 of fun doing it. One hundred and five of 7 these sessions are well documented in my files 8 with more than 780 cases discussed. Although 9 attendance varied because of our hectic 10 schedules, this conference averaged 3.2 staff 11 pathologists per session". He indicated he 12 enjoyed every single case and learned 13 tremendously, and he says he'd like to take 14 the opportunity to thank you for your 15 consistent input during the sessions. Doctor, 16 these sorts of weekly pathology conferences, 17 he described it here as a new weekly surgical 18 pathology conference begun in 1996, at least 19 initially by himself and Dr. Robb, at that 20 time was Dr. Khalifa, do you recall, probably 21 by then site chief? 22 DR. HAEGERT: 23 A. Yes. 1996? 24 COFFEY, Q.C.: 25 Q. Yes, this would be --</p>	<p style="text-align: right;">Page 88</p> <p>1 DR. HAEGERT: 2 A. Yes. 3 COFFEY, Q.C.: 4 Q. Was Dr. Khalifa, from your perspective as site 5 chief then, responsible for what if anything 6 else, and in particular the 7 immunohistochemistry? Was he responsible for, 8 as site chief, immunohistochemistry at the 9 General? 10 DR. HAEGERT: 11 A. I thought I already explained that, that 12 basically his role was to communicate with the 13 manager and if there were issues in the 14 immunohistochemistry lab, to communicate with 15 the technologists. 16 COFFEY, Q.C.: 17 Q. And from your perspective then, who was 18 responsible for immunohistochemistry? 19 DR. HAEGERT: 20 A. It was the management. 21 COFFEY, Q.C.: 22 Q. The management. That would be management in 23 the sense of the technologist's management? 24 DR. HAEGERT: 25 A. Yes.</p>

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<p>1 COFFEY, Q.C.:</p> <p>2 Q. Okay. Was that ever, do you recall, discussed</p> <p>3 at any point, like, explicitly discussed, for</p> <p>4 example, in the presence of Dr. Williams, the</p> <p>5 VP Medical? Yourself and Mr. Gulliver by 1999</p> <p>6 would have been reporting to Dr. Williams as</p> <p>7 VP Medical. Was responsibility for</p> <p>8 immunohistochemistry ever actually discussed?</p> <p>9 DR. HAEGERT:</p> <p>10 A. No, I don't think so.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. Do you recall when you first arrived in St.</p> <p>13 John's how ER and PR status was being</p> <p>14 determined?</p> <p>15 DR. HAEGERT:</p> <p>16 A. It was being done by a biochemical assay in</p> <p>17 the biochemistry laboratory at the General</p> <p>18 Hospital.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. When you first arrived, Doctor, who would</p> <p>21 initiate the request for determining ER and PR</p> <p>22 status, was that a pathologist?</p> <p>23 DR. HAEGERT:</p> <p>24 A. No, it typically came from a surgeon.</p> <p>25 COFFEY, Q.C.:</p>	<p>1 surgeon at the time of surgery?</p> <p>2 DR. HAEGERT:</p> <p>3 A. Yes.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. In order to take advantage of the fresh tissue</p> <p>6 requirement for biochemical assay?</p> <p>7 DR. HAEGERT:</p> <p>8 A. Yes.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Doctor, were you aware in those first four or</p> <p>11 five years whether or not any attempts were</p> <p>12 ever made to have ER/PR status determined with</p> <p>13 paraffin blocks outside the province for local</p> <p>14 patients?</p> <p>15 DR. HAEGERT:</p> <p>16 A. In the early years?</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Yes, in the early years.</p> <p>19 DR. HAEGERT:</p> <p>20 A. Not that I know of.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. And I ask that because we have heard from Dr.</p> <p>23 Neil from Corner Brook --</p> <p>24 DR. HAEGERT:</p> <p>25 A. Uh-hm.</p>
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<p>1 Q. It came from the surgeon at that time.</p> <p>2 DR. HAEGERT:</p> <p>3 A. Yes.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. And if the surgeon didn't do it, might it come</p> <p>6 from an oncologist?</p> <p>7 DR. HAEGERT:</p> <p>8 A. Are you talking in the biochemical assay?</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Yes, the biochemical assay.</p> <p>11 DR. HAEGERT:</p> <p>12 A. Biochemical assay required fresh tissue, so</p> <p>13 that if the tissue is already in formalin,</p> <p>14 it's my understanding that you cannot actually</p> <p>15 do it--you can't do a biochemical method, I</p> <p>16 think.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. So in terms then in the early days, your first</p> <p>19 four or five years here --</p> <p>20 DR. HAEGERT:</p> <p>21 A. Yes.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Before Dr. Khalifa came in, that if ER and PR</p> <p>24 status were to be determined locally for a</p> <p>25 patient, it would have to be initiated by the</p>	<p>1 COFFEY, Q.C.:</p> <p>2 Q. If I recall correctly, and if it's not him,</p> <p>3 it's Dr. Gown, I don't recall right off the</p> <p>4 top of my head which one, but one of them</p> <p>5 certainly indicated that they were utilizing a</p> <p>6 hospital in Nova Scotia at one point in the</p> <p>7 early 90s.</p> <p>8 DR. HAEGERT:</p> <p>9 A. Okay.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. So St. John's itself, to the best of your</p> <p>12 knowledge, wasn't doing so, all the ER and PR</p> <p>13 in St. John's was being done by biochemical?</p> <p>14 DR. HAEGERT:</p> <p>15 A. Well, in the early years, of course, I was</p> <p>16 only really responsible for the General</p> <p>17 Hospital site.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Yes.</p> <p>20 DR. HAEGERT:</p> <p>21 A. So the General Hospital, no, but the other</p> <p>22 sites, possibly, but I wouldn't necessarily</p> <p>23 know.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. And then Dr. Khalifa came along around the</p>

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1 time--well, in fact, he was here at the time
 2 of the Health Care Corporation initiation?
 3 DR. HAEGERT:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. As you said, he became site chief. The idea
 7 of instituting immunohistochemical paraffin
 8 block approach to ER/PR determination, whose
 9 idea was that in St. John's?
 10 DR. HAEGERT:
 11 A. It was Dr. Khalifa's.
 12 COFFEY, Q.C.:
 13 Q. Do you recall how that came about, when you
 14 first became aware that he was thinking about
 15 it or wanted to do that, and what was said?
 16 DR. HAEGERT:
 17 A. Well, I think it's fair to state that, you
 18 know, both of us were really in the General
 19 Hospital site close together. We used to talk
 20 a great deal. I mean, both of us were come
 21 from aways, if you would like to put it that
 22 way.
 23 COFFEY, Q.C.:
 24 Q. Yeah, sure.
 25 DR. HAEGERT:

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1 A. And we used to have common--we used to talk
 2 often about many of the issues, and he raised
 3 this issue with me. He said he thought that
 4 this was coming, you know, there's a movement
 5 in North America and Europe to move away from
 6 the biochemical testing to a
 7 immunohistochemical method and he wanted to--
 8 he thought he would like to initiate that.
 9 COFFEY, Q.C.:
 10 Q. And did he indicate to you whether he had any
 11 experience in that regard himself?
 12 DR. HAEGERT:
 13 A. Yeah, he said that he'd had considerable
 14 experience. I mean, he was in Oklahoma and
 15 then in Georgetown and he had considerable
 16 experience with that.
 17 COFFEY, Q.C.:
 18 Q. And when you discussed it with him, what was
 19 your reaction, what did you say, if any--what
 20 did you think?
 21 DR. HAEGERT:
 22 A. Well, I was well aware that, in fact, that
 23 this--there was a movement towards this. When
 24 I was in Montreal, we had--when I left in
 25 1991, the assay was still biochemical. We

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1 had, in our department, we had never initiated
 2 immunohistochemical testing, but I was aware
 3 that they were doing this elsewhere and I
 4 thought this would be reasonable and I had
 5 every confidence in Dr. Khalifa being able to
 6 develop this because he'd had previous
 7 experience and knowledge.
 8 COFFEY, Q.C.:
 9 Q. And so you discussed it. Do you recall how
 10 often you discussed it, just kind of the one
 11 long conversation, you say, well, you gave the
 12 approve it or what?
 13 DR. HAEGERT:
 14 A. Well, we discussed it, but also there was, I
 15 think we apprised Dr. Prabhakaran that we were
 16 considering this. Now, how we--I know I met
 17 with Dr. Prabhakaran at least once. We talked
 18 about this, you know, that there was a
 19 movement to move towards the
 20 immunohistochemical testing, but we wanted to
 21 do, first of all develop a methodology. Dr.
 22 Khalifa was going to do this together with the
 23 technologists. And we talked about it many
 24 times. We talked about what was going on, how
 25 it was progressing, you know -

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1 COFFEY, Q.C.:
 2 Q. You mean after he started the process?
 3 DR. HAEGERT:
 4 A. After, many times.
 5 COFFEY, Q.C.:
 6 Q. As the process went on?
 7 DR. HAEGERT:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Doctor, was it brought to anyone else's
 11 attention at the time in terms senior to you,
 12 the idea that we're going to move to ER/PR,
 13 IHC, paraffin block process, would you have
 14 discussed that, for example, with the VP
 15 medical at the time?
 16 DR. HAEGERT:
 17 A. No, because I think this was an internal
 18 matter as how do you do a test. I don't think
 19 the VP was interested in--I mean, say there's
 20 two ways of doing hemoglobin measurements,
 21 which I don't know whether there is or there
 22 isn't, but -
 23 COFFEY, Q.C.:
 24 Q. That's not the sort of -
 25 DR. HAEGERT:

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<p>1 A. It's really not relevant as long as it's 2 basically cost neutral. 3 COFFEY, Q.C.: 4 Q. At the time were there any inquiries made into 5 the cost issue, was that considered at the 6 time, do you recall? 7 DR. HAEGERT: 8 A. We thought, actually, it would be cost, either 9 cost neutral or maybe even cheaper to do it by 10 immunohistochemical methods. 11 COFFEY, Q.C.: 12 Q. And Dr. Prabhakaran? 13 DR. HAEGERT: 14 A. Prabhakaran, yeah. 15 COFFEY, Q.C.: 16 Q. The biochemist? 17 DR. HAEGERT: 18 A. Yes. 19 COFFEY, Q.C.: 20 Q. Whom did he report to at the time at the 21 hospital? 22 DR. HAEGERT: 23 A. So he would have reported to me. 24 COFFEY, Q.C.: 25 Q. In your capacity as clinical chief?</p>	<p>1 yourself and Mr. Whelan. Now, by this point 2 in time, early 1997, Mr. Whelan would have 3 been the program manager? 4 DR. HAEGERT: 5 A. Right. 6 COFFEY, Q.C.: 7 Q. Would be, yeah. 8 DR. HAEGERT: 9 A. Program director, I think it's called, but - 10 COFFEY, Q.C.: 11 Q. Program director, okay. 12 DR. HAEGERT: 13 A. - basically equivalent. 14 COFFEY, Q.C.: 15 Q. And Mr. Gulliver would have reported to him? 16 DR. HAEGERT: 17 A. Yes. 18 COFFEY, Q.C.: 19 Q. He's described here as the manager of anatomic 20 pathology at the General Hospital. And here 21 Dr. Khalifa writes "The ER/PR kit that we have 22 tried and which offered us very good and 23 reliable results has been totally consumed by 24 late last week." He describes the date. And 25 goes on to, in effect, complain or express</p>
<p>1 DR. HAEGERT: 2 A. Yes. 3 COFFEY, Q.C.: 4 Q. Did you yourself do any research at the time 5 in relation to ER/PR? 6 DR. HAEGERT: 7 A. No. 8 COFFEY, Q.C.: 9 Q. Any research then that was to be done, from 10 your perspective, you would have understood 11 that Dr. Khalifa would be, would conduct that, 12 any readings required or - 13 DR. HAEGERT: 14 A. Yes. As I said, you know, he had experience 15 and knowledge and I was confident that he 16 could do this and he would do whatever 17 appropriate reading was necessary. 18 COFFEY, Q.C.: 19 Q. Doctor, look, please, at Exhibit P-1889? 20 Doctor, this is a letter dated March 12th, 19- 21 -we'll it's dated two different dates, March 22 12th, 1997 and at the top left-hand side, then 23 a date here February 27th, 1997, Thursday, 24 3:45 p.m. It's addressed to Mr. Gulliver and 25 it's signed by Dr. Khalifa and it's copied to</p>	<p>1 concern about this. Just take you through 2 some of it. He says, "You knew this," that's 3 Mr. Gulliver did, and "We were trying to use a 4 new detection system in combination with an 5 old primary antibody that the laboratory had 6 for some time. This combination did not work. 7 I called you on Monday morning at the Janeway 8 Hospital and told you we were having an 9 emergency situation. Any trial of a new 10 technique needs to be done in parallel with 11 the well established one before a switch could 12 be safely made. I felt I conveyed this 13 message to you clearly and asked you to 14 replace the ER/PR kit as soon as possible. 15 This was an emergency situation because, at 16 the time, we had two cases referred from 17 Corner Brook and one in-house case from 1996 18 which we were waiting for this test to be 19 reliably performed. As of now the kit has not 20 arrived and I was told you were out of town. 21 Ordering such a kit in a timely fashion was 22 vital and a follow up on the order was even 23 more crucial. Mr. Gulliver, I do not think 24 you fully appreciate the delicacy of this 25 test, its clinical consequences and the</p>

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1 overall emotional charge in the public
 2 regarding this very sensitive procedure. I'm
 3 also uncertain whether our service is being
 4 run as smoothly as it should. The medico-
 5 legal implications of delaying this test are
 6 huge and I want to clearly document my
 7 concerns at this time. You willingly put me
 8 in a situation where I have to explain to
 9 other physicians why our results are being
 10 delayed. I do not want to be responsible for
 11 this. I'm also having a very difficult time
 12 communicating with you basically because you
 13 are either out of town, on another site or
 14 extremely busy within this site. I would have
 15 expected you to approach this issue with more
 16 precision since Monday morning, as you've told
 17 me and even more, not to have allowed the
 18 first kit to be consumed without obtaining a
 19 replacement in a timely manner." Now, Doctor,
 20 Dr. Khalifa has testified about this in front
 21 of the Commission, okay, the circumstances.
 22 But this was copied to you. Do you recall if
 23 you received this?
 24 DR. HAEGERT:
 25 A. Well, I mean, I've certainly read it recently.

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1 Did I receive it before? I think I was aware
 2 of it.
 3 COFFEY, Q.C.:
 4 Q. And there are a couple of aspects about it I
 5 wanted to ask you about. In the second
 6 paragraph Dr. Khalifa concludes by saying,
 7 "I'm also having a very difficult time
 8 communicating with you basically because you,"
 9 that would be Terry, "are either out of town,
 10 on another site or extremely busy within this
 11 site." Okay. Now, Mr. Gulliver was the
 12 manager of anatomic pathology?
 13 DR. HAEGERT:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. At that time he would have been responsible
 17 for which sites, do you know? This is 1997.
 18 DR. HAEGERT:
 19 A. So the General Hospital and the Janeway.
 20 COFFEY, Q.C.:
 21 Q. The Janeway. And they were separated by three
 22 quarters of a mile or so geographically,
 23 whatever it happens to be?
 24 DR. HAEGERT:
 25 A. Okay, yes, something like that. I don't know

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1 exactly.
 2 COFFEY, Q.C.:
 3 Q. A mile or so, probably a mile--actually, it
 4 would be well over a mile, actually.
 5 DR. HAEGERT:
 6 A. Okay.
 7 COFFEY, Q.C.:
 8 Q. So Mr. Gulliver, as clinical chief you would
 9 have understood Mr. Gulliver was required to
 10 be, at times, on both--at different sites
 11 throughout his working day?
 12 DR. HAEGERT:
 13 A. Right.
 14 COFFEY, Q.C.:
 15 Q. The assertion that Mr. Gulliver, or the
 16 observation by Dr. Khalifa that Mr. Gulliver
 17 was very busy, very busy, would that have been
 18 a surprise to you at the time?
 19 DR. HAEGERT:
 20 A. No. I think there was other things going on
 21 here. One of the things, now, I don't
 22 remember the time frame, but it would have
 23 been approximately this time frame Mr.
 24 Gulliver was also the manager for immunology,
 25 as I recall, and what happened, this was

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

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<p>1 technologists and he was the president of that 2 organization, so from time to time he went off 3 to meetings, I don't know where they were 4 held, Ottawa or somewhere.</p> <p>5 COFFEY, Q.C.: 6 Q. And as the manager of anatomic pathology at 7 the time Mr. Gulliver would have had the 8 immunohisto, the technologists who were doing 9 immunohistochemistry reporting to him?</p> <p>10 DR. HAEGERT: 11 A. Yes.</p> <p>12 COFFEY, Q.C.: 13 Q. And was there any particular technologist that 14 you were aware of that, amongst the kind of 15 the bench technologists who was responsible 16 for IHC?</p> <p>17 DR. HAEGERT: 18 A. Oh, there were two, there were Peggy Welsh and 19 Mary Butler. Those were the two. They were 20 the only ones, to my knowledge, that ever did 21 immunohistochemistry as long as I was there.</p> <p>22 COFFEY, Q.C.: 23 Q. And they reported to?</p> <p>24 DR. HAEGERT: 25 A. Terry Gulliver.</p>	<p>1 DR. HAEGERT: 2 A. I'm not sure whether that's redundant or not. 3 I mean, I think the main point here is that 4 this test is important for patient care and 5 needs to be done in a timely manner so that 6 clinicians can decide whether to treat the 7 patient with an anti-estrogen like Tamoxifen. 8 The delicacy, I'm not sure what he's driving 9 at there. I can't answer that.</p> <p>10 COFFEY, Q.C.: 11 Q. I was going to ask you about that. In terms 12 of the ER/PR, IHC process, using paraffin 13 blocks, in 1997, I mean, you would have been 14 familiar with the idea of using 15 immunohistochemistry?</p> <p>16 DR. HAEGERT: 17 A. Yeah, of course.</p> <p>18 COFFEY, Q.C.: 19 Q. Routinely ordered?</p> <p>20 DR. HAEGERT: 21 A. Yes, of course.</p> <p>22 COFFEY, Q.C.: 23 Q. IHC. Was there anything different to your 24 mind or understanding about ER/PR potentially 25 different compared to other types of IHC</p>
<p style="text-align: right;">Page 106</p> <p>1 COFFEY, Q.C.: 2 Q. Terry, yeah, Terry Gulliver directly at that -</p> <p>3 DR. HAEGERT: 4 A. Yes.</p> <p>5 COFFEY, Q.C.: 6 Q. At that stage?</p> <p>7 DR. HAEGERT: 8 A. Yes.</p> <p>9 THE COMMISSIONER: 10 Q. Wherever you can get an opportunity, we'll 11 take a break.</p> <p>12 COFFEY, Q.C.: 13 Q. Yes, thank you. Thank you, Commissioner. 14 Doctor, the reference to "I do not think you 15 fully appreciate the delicacy of this test, 16 it's clinical consequences and the overall 17 emotional charge in the public regarding this 18 very sensitive procedure." First of all, the 19 clinical consequences of the ER/PR test, 20 yourself, were you aware of those?</p> <p>21 DR. HAEGERT: 22 A. Yeah, of course.</p> <p>23 COFFEY, Q.C.: 24 Q. Okay. And the delicacy of this test, do you 25 know what, say, he was referring to there?</p>	<p style="text-align: right;">Page 108</p> <p>1 stains?</p> <p>2 DR. HAEGERT: 3 A. Well, you're asking me to go back to '97 -</p> <p>4 COFFEY, Q.C.: 5 Q. Yes.</p> <p>6 DR. HAEGERT: 7 A. - to what I knew then. I mean -</p> <p>8 COFFEY, Q.C.: 9 Q. Yes, at that time.</p> <p>10 DR. HAEGERT: 11 A. - it's difficult to know what I--I mean, 12 certainly I would be aware. I mean, what I 13 know now and I'm pretty sure I knew then was 14 that there are two types of 15 immunohistochemical testing, really, in broad 16 generalization. There's one where you use it 17 to help make diagnosis and the second type is 18 one where it actually has either prognostic or 19 therapeutic implications. So things that have 20 therapeutic implications would be like ER/PR, 21 HER2/neu, CD20, probably there's others but 22 they don't come to my mind. So I would have 23 been well aware that this is--has therapeutic 24 implications. But in terms of the actually 25 interpreting the slides, basically they're all</p>

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1 the same. Either you get membrane staining,
 2 cytoplasmic staining or nuclear staining. And
 3 ER/PR, of course, is nuclear. I mean, any
 4 pathologist can read these, but the reason you
 5 need a pathologist to read them is to tell
 6 whether you're looking at cancer, not cancer,
 7 that's what the real, the skill is, and also
 8 to recognize that for ER/PR is that the
 9 staining can be weak and often not easy to
 10 see.
 11 COFFEY, Q.C.:
 12 Q. And at least from your introduction to it.
 13 And I take it when Dr. Khalifa raised this
 14 first with you, the idea of getting into this,
 15 in your own clinical world you had never been
 16 involved in ER/PR?
 17 DR. HAEGERT:
 18 A. Never.
 19 COFFEY, Q.C.:
 20 Q. So this was in effect your introduction to it,
 21 as well?
 22 DR. HAEGERT:
 23 A. Right.
 24 COFFEY, Q.C.:
 25 Q. Commissioner, thank you, short break?

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1 THE COMMISSIONER:
 2 Q. All right, we'll take 15 minutes.
 3 (RECESS)
 4 THE COMMISSIONER:
 5 Q. Please be seated. Mr. Coffey?
 6 COFFEY, Q.C.:
 7 Q. Thank you, Commissioner. Exhibit P-0697?
 8 Now, Doctor, these are the minutes of a
 9 laboratory program, divisional managers'
 10 meeting of probably March 4th, 1997, 97/03/04.
 11 Now, Doctor, I appreciate you're not listed as
 12 being there. But there is in the middle of
 13 the page, the first page there, a reference
 14 to, if we could, financial issues. The
 15 January financial statements have been
 16 circled, the laboratory is \$120,000 in the
 17 red. And toward the bottom of that, the
 18 fourth paragraph under that heading it says,
 19 "Mr. Whelan and Dr. Haegert met with George
 20 Tilley on Friday regarding their concerns
 21 about the ability of the laboratory program to
 22 save a million dollars."
 23 DR. HAEGERT:
 24 A. Right.
 25 COFFEY, Q.C.:

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1 Q. "In the coming year's budget. Mr. Tilley will
 2 be meeting with the executive team and
 3 advising of their final decision probably this
 4 week." So this would be this time frame that
 5 you were telling the Commissioner about
 6 earlier?
 7 DR. HAEGERT:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Under "Information System," Doctor, it says,
 11 "Major problems are anticipated with reporting
 12 of results between sites, especially when
 13 instruments are interfaced. These will have
 14 to be addressed as they arise." Now, in this
 15 context I want to ask you about Meditech and
 16 the integration of Meditech between these
 17 hospital sites. I take it before the Health
 18 Care Corporation existed each site had its own
 19 Meditech system, is that -
 20 DR. HAEGERT:
 21 A. Well, I know we had it at the General site,
 22 but this I don't know if we had it at the
 23 other sites. I don't remember, actually.
 24 COFFEY, Q.C.:
 25 Q. Okay. In your capacity then as clinical chief

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1 after the formation of the Health Care
 2 Corporation, were you ever asked to get
 3 involved in issues relating to the integration
 4 of the Meditech systems, the ability of them
 5 to interface effectively and communicate?
 6 DR. HAEGERT:
 7 A. I know we talked about the interfacing between
 8 labs, but it wasn't really--this was really a
 9 management, hospital information system issue.
 10 I wasn't really involved.
 11 COFFEY, Q.C.:
 12 Q. You might have been kind of kept apprised -
 13 DR. HAEGERT:
 14 A. I was aware that there was an issue, but as I
 15 said, I wasn't even sure what system they had
 16 at the other sites.
 17 COFFEY, Q.C.:
 18 Q. Go on to the next page of the exhibit, Doctor.
 19 It says, "QI Issues." QI in this context would
 20 me what?
 21 DR. HAEGERT:
 22 A. Quality assurance.
 23 COFFEY, Q.C.:
 24 Q. Initiatives?
 25 DR. HAEGERT:

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

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1 DR. HAEGERT:
 2 A. Predham was the -
 3 COFFEY, Q.C.:
 4 Q. QI facilitator?
 5 DR. HAEGERT:
 6 A. - facilitator, yeah. And she, it was her
 7 initiative to--for each of the programs to set
 8 up a program and deal with issues within their
 9 programs.
 10 COFFEY, Q.C.:
 11 Q. Now, here looking down through it there's a
 12 divisional chief for biochemistry, for
 13 microbiology. Dr. Cook is there as the
 14 pathology site chief for St. Clare's. I take
 15 it you in your capacity as clinical chief,
 16 would you have been the pathology chief for
 17 the General? You wouldn't because Dr. Khalifa
 18 would have -
 19 DR. HAEGERT:
 20 A. Dr. Khalifa.
 21 COFFEY, Q.C.:
 22 Q. Would have been at the time. So in terms of
 23 representation from the General Hospital's
 24 pathologists on this, or in this group, and I
 25 notice -

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1 DR. HAEGERT:
 2 A. Well, I would have been able to speak about
 3 the issues at the General Hospital, but
 4 there's no formal individual specifically
 5 representing pathologists, no.
 6 COFFEY, Q.C.:
 7 Q. Pathologists. As well, the Grace is now, as
 8 well, doesn't have a rep here, a pathology
 9 rep, pathologists -
 10 DR. HAEGERT:
 11 A. What year was this, 1997.
 12 COFFEY, Q.C.:
 13 Q. This would be -
 14 DR. HAEGERT:
 15 A. I see it, '97.
 16 COFFEY, Q.C.:
 17 Q. Beginning of 1997. So you would have been,
 18 between yourself and Dr. Cook would have been
 19 the pathologists' representatives?
 20 DR. HAEGERT:
 21 A. Right.
 22 COFFEY, Q.C.:
 23 Q. Doctor, how developed did this become, do you
 24 recall?
 25 DR. HAEGERT:

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1 A. This committee?
 2 COFFEY, Q.C.:
 3 Q. Yes. How active?
 4 DR. HAEGERT:
 5 A. Now, it's difficult to remember, actually,
 6 surprising. But I think the facilitator, as
 7 mentioned, was Heather Predham, and I think
 8 this was an initiative from the Health Care
 9 Corporation to develop this committee. I
 10 can't say how many times we met. I actually
 11 don't remember.
 12 COFFEY, Q.C.:
 13 Q. Okay. And now at that time, when the Health
 14 Care Corporation was embarking upon this
 15 initiative, at the General Hospital site what
 16 sorts of QA or QI programs or initiatives
 17 existed at the General Hospital in pathology?
 18 DR. HAEGERT:
 19 A. Yeah, well, yeah, see, depends what you mean
 20 by QA.
 21 COFFEY, Q.C.:
 22 Q. Exactly. And I appreciate, you can elaborate
 23 on it.
 24 DR. HAEGERT:
 25 A. Yeah. I mean, really basically all it means

<p style="text-align: right;">Page 117</p> <p>1 is assurance of quality. So one of the things 2 that's relevant here is recruitment. What we 3 tried to recruit when we were recruiting 4 people with, if at all possible, people with 5 subspecialty expertise. The idea being that 6 what we would be doing is bringing in people 7 with--who would increase the knowledge base in 8 certain areas. Like, for example, we brought 9 in Dr. Khalifa when I was there, we brought in 10 Dr. Rasty who had a fellowship in 11 cytopathology, Dr. Gorecki, who I don't 12 remember what subspecialty she had. But that 13 was, I mean, to me that's actually a quality 14 issue, I mean, who are the people that are 15 working there, first of all. Then we had our 16 system of basically you can call it rounds or 17 teaching rounds or difficult case rounds, 18 whatever you want to call them, where 19 basically interesting or difficult or 20 challenges cases were brought and we discussed 21 the diagnostic criteria, reviewed them, 22 elaborated upon them, you know, what 23 additional tests might be relevant to making a 24 diagnosis. And then as I mentioned before, we 25 had this internal consultation process which</p>	<p style="text-align: right;">Page 119</p> <p>1 practice everywhere in the world, everybody-- 2 people are always asking for second opinions 3 or the surgeons ask for second opinions. And 4 that's actually a very positive quality 5 assurance when you have a case, you make a 6 diagnosis of this and you get a referral from 7 some place that's supposedly expert like the 8 Mayo Clinic or, you know, place in Vancouver 9 or Toronto or wherever send back and they get 10 the same diagnosis, that's a QA activity. I 11 mean, to me that's actually one of the key QA 12 activities. And actually, we welcome that, 13 you know. And then I think that's probably a 14 rough summary of what was going on. 15 COFFEY, Q.C.: 16 Q. Was there any external proficiency testing or- 17 -at that time? 18 DR. HAEGERT: 19 A. Yeah. Actually, external proficiency testings 20 are interesting. I mean, I could talk about 21 that a bit of you want. 22 COFFEY, Q.C.: 23 Q. If you--yes. 24 DR. HAEGERT: 25 A. Because what the--my experience with them is</p>
<p style="text-align: right;">Page 118</p> <p>1 actually Dr. Khalifa formalized. Previous, 2 prior to his arrival it was informal in that 3 what would happen is a pathologist would say, 4 okay, look, I have this difficult case, say, 5 for example, a difficult prostate biopsy or 6 difficult breast biopsy, I'm having a 7 significant difficulty with this, is it benign 8 or is it malignant, would show it to some 9 other pathologist with, you know, significant 10 experience. So, I mean, to me that's quality 11 assurance. And then what Dr. Khalifa did, he 12 was trying to move kind of improve the, like, 13 the paper trail in the department, so he 14 formalized that. So this then became a formal 15 process where, in fact, you would document, 16 you know, case No. so and so was shown to so 17 and so and their opinion was this and then 18 that individual would sign it. So that was a 19 quality assurance activity. I think also, you 20 know, external consultations is really a 21 quality assurance activity. Now, sometimes 22 that would be initiated inside the department, 23 it would also be initiated by patients who 24 were either unhappy with their diagnosis or 25 just wanted a second opinion. That's normal</p>	<p style="text-align: right;">Page 120</p> <p>1 this is a kind of thing that the lay public 2 and many organizations subscribe to, but in my 3 experience what these mostly test are unusual 4 cases. So what you mostly get if you ask--if 5 you have a--if you subscribe to one of these 6 things, I mean, it's not entirely true, and 7 this is what I remember, is that, you know, we 8 did have some proficiency testing from 9 outside. Now, I don't remember the 10 organization, it might have been ASCP, 11 American Society of Clinical Pathologists, but 12 often what they do is they show you some rare 13 thing and then ask you a bunch of questions 14 about it, and the real issue, when you're a 15 pathologist, is not the rare things, because 16 rare things, we all know how to deal with. 17 You know, either we have the internal 18 expertise or you send them out for 19 consultation. As I mentioned, the cartilaginous 20 bone tumours, most people have minimal 21 experience, we send them out. But the real 22 problem are things that are actually common, 23 which sounds peculiar, but it's true. I mean, 24 the key things would be like is this carcinoma 25 of the breast or is it some reactive process?</p>

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

8 COFFEY, Q.C.:

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

12 DR. HAEGERT:

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

25 COFFEY, Q.C.:

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

3 DR. HAEGERT:

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

8 COFFEY, Q.C.:

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

11 DR. HAEGERT:

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

25 COFFEY, Q.C.:

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

8 DR. HAEGERT:

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

10 COFFEY, Q.C.:

11 Q. In your own experience?

12 DR. HAEGERT:

13 A. No.

14 COFFEY, Q.C.:

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

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1 your colleagues?

2 DR. HAEGERT:

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

14 COFFEY, Q.C.:

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

18 DR. HAEGERT:

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

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1 COFFEY, Q.C.:

2 Q. And do you recall what types of cases were

3 being reviewed at the time?

4 DR. HAEGERT:

5 A. No, I think they were just randomly selected

6 cases.

7 COFFEY, Q.C.:

8 Q. Okay, and just to--and that particular

9 pathologist kind of looked at each of those

10 cases, made his or her own diagnosis.

11 DR. HAEGERT:

12 A. Yeah, and then we discussed within the

13 department.

14 COFFEY, Q.C.:

15 Q. And compared that to the original?

16 DR. HAEGERT:

17 A. Yeah, we discussed whether the reviews seemed

18 to be appropriate or not and whether the

19 original diagnosis and the final diagnosis

20 were consistent.

21 COFFEY, Q.C.:

22 Q. Whose idea was it to do that?

23 DR. HAEGERT:

24 A. Actually, Dr. Griffin initiated. I may have

25 spoken to her before, I don't remember, but

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1 she was there for a period of time and she was

2 interested in doing this.

3 COFFEY, Q.C.:

4 Q. And the idea of that sort of an approach, a

5 random audit, as it were -

6 DR. HAEGERT:

7 A. Um-hm.

8 COFFEY, Q.C.:

9 Q. - had you ever encountered that before, that

10 kind of--the idea of using that sort of

11 approach?

12 DR. HAEGERT:

13 A. Yeah, I think it was fairly well known that

14 this is done in certain departments and it is

15 a quality assurance issue or technique.

16 COFFEY, Q.C.:

17 Q. Technique.

18 DR. HAEGERT:

19 A. Method, I guess.

20 COFFEY, Q.C.:

21 Q. And was it--it wasn't continued afterward, I

22 take it?

23 DR. HAEGERT:

24 A. No.

25 COFFEY, Q.C.:

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1 Q. Why not?

2 DR. HAEGERT:

3 A. One of the issues was the number--did we have

4 adequate people to do this. I mean, I think

5 the consensus all across the nation is if

6 you're going to do quality assurance, you

7 actually need dedicated people. You need time

8 to do it. I mean, you alluded to this

9 interfacing between sites. Now, I don't

10 remember when that actually was done, but it's

11 obviously a problem if you're going to start

12 doing random selection of cases across sites.

13 I mean, you obviously need interfacing between

14 sites. But one of the key elements is having

15 sufficient people to do the work. You need a

16 technologist. You need somebody who actually--

17 -who understands what goes on in pathology to

18 actually do a lot of the work and then you

19 need some pathologists to review it. I always

20 felt that we were short staffed. We never had

21 enough people to do that kind of thing.

22 COFFEY, Q.C.:

23 Q. And Dr. Griffin, at the time, her position was

24 what?

25 DR. HAEGERT:

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1 A. She would have been assistant professor,

2 pathologist, and a staff pathologist.

3 COFFEY, Q.C.:

4 Q. And her particular interest in this idea of

5 using sort of random audit approach, did you

6 have any understanding of why she was

7 interested in that, why in particular?

8 DR. HAEGERT:

9 A. Well, I know we discussed it. Now I can't

10 remember whether I initiated it or we were

11 talking about, you know, sort of academic

12 activities that one could do in the

13 department. I mean, I know we discussed it.

14 I mean, this is, you know, 11 years ago. It's

15 hard to remember the precise basis of that.

16 COFFEY, Q.C.:

17 Q. And if we could, please, Exhibit P-2531?

18 Doctor, these are the minutes of anatomic

19 pathology site chiefs meeting of May 13th,

20 1997. There's apologies from yourself, but

21 all the others, I take it, are present, all

22 the other physicians and Mr. Gulliver and Mr.

23 Murphy. While you wouldn't have been present

24 for this particular meeting, I take it that

25 when the minutes were circulated, you'd get

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1 them the next time round?

2 DR. HAEGERT:

3 A. Yeah, of course. I'd always get a copy of the

4 minutes.

5 COFFEY, Q.C.:

6 Q. Sure. So here, Doctor, looking at the third

7 page under new business, ER and PR

8 immunoperoxidase receptors, paragraph A, it

9 reads "Dr. Khalifa reported to the committee

10 that there is correlation between the

11 biochemical assay and the immunoperoxidase

12 staining for breast receptors. It appears the

13 time may be right to implement the

14 immunoperoxidase breast receptors corporate

15 wide. Dr. Cook stated that there's a concern

16 amongst the pathologists at St. Clare's that

17 they should be the ones reporting the breast

18 receptors. Discussion then arose that if

19 individual pathologists are reporting these

20 receptors, then there's a need for

21 standardized criteria to determine what is

22 regarded as receptor positive and negative.

23 There was also discussion as to how the Mayo

24 Clinic reports its receptors. It was decided

25 that this issue should be brought to a

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1 discipline meeting to get a consensus amongst

2 pathologists. Hopefully such a meeting will

3 be held in June. Until then, it is agreed to

4 maintain the status quo, and Dr. Cook

5 recognized the amount of hard work Dr. Khalifa

6 had put into this."

7 Doctor, now this is halfway through 19--

8 well, almost halfway through 1997, and this

9 indicates that Dr. Khalifa is, you know, has

10 well embarked upon this effort, in the sense

11 of looking for correlation and so on. The

12 ER/PR is being done here in St. John's and

13 biochemical is continuing. I want to ask you,

14 so the Commissioner can get some sense as to

15 how involved, if at all, were you then in the

16 actual, this whole process? We're going to

17 see a number of documents now where Dr.

18 Khalifa is reporting from time to time as to

19 what's going to--what he's doing and what he's

20 finding.

21 DR. HAEGERT:

22 A. Right.

23 COFFEY, Q.C.:

24 Q. And what's proposed and other people's

25 thoughts. As the discipline chair of the day

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1 and the clinical chief of the day, how

2 involved were you in this? I appreciate you'd

3 be aware of it, but did you--other than being

4 aware of it?

5 DR. HAEGERT:

6 A. Well, I was certainly involved in the

7 discussions at every step of the way. I mean,

8 Dr. Khalifa and I met multiple times to talk

9 about this, and then we'd talk--I was well

10 aware of, you know, Dr. Cook's concern and

11 then Dr. Parai had similar concerns about who

12 should be reporting them. The concerns were

13 what was the appropriate level to say

14 something was positive or negative, and what

15 kind of format the report should take. Should

16 there be--I mean, it's not mentioned there,

17 but you know, Dr. Khalifa worked on a rider

18 which -

19 COFFEY, Q.C.:

20 Q. And we'll see that.

21 DR. HAEGERT:

22 A. - which could not be attached, and I was well

23 aware of all this.

24 COFFEY, Q.C.:

25 Q. Okay. So you were aware of it, and kept

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1 yourself informed on it. Would you have done

2 any research yourself to kind of look into

3 these issues about, for example, what should

4 be considered positive and negative or whether

5 or not a rider should or shouldn't be on?

6 DR. HAEGERT:

7 A. Well no, because, you know, I thought, you

8 know, here was Dr. Khalifa who's well trained.

9 He's got--he had the American boards in

10 anatomic pathology. Other pathologists either

11 had their fellowships or American boards.

12 They're perfectly capable, among the site

13 chiefs, to address this issue, and I mean, I

14 looked--I mean, I had complete confidence in

15 Dr. Khalifa to deal with this.

16 COFFEY, Q.C.:

17 Q. Doctor, here on the fifth line, it says "Dr.

18 Cook stated there's a concern amongst the

19 pathologists at St. Clare's that they should

20 be the ones reporting their breast receptors."

21 DR. HAEGERT:

22 A. Um-hm.

23 COFFEY, Q.C.:

24 Q. Do you recall what that was about? At this

25 point in time, we understand Dr. Khalifa was

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

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

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

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

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

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

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

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

24 COFFEY, Q.C.:
 25 Q. And the upshot of it was what?

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1 DR. HAEGERT:
 2 A. The decision at the time was to maintain the
 3 status quo and I think the feeling was that
 4 this could be revisited at a later date.

5 COFFEY, Q.C.:
 6 Q. And do you recall, during your tenure, if it
 7 was ever revisited?

8 DR. HAEGERT:
 9 A. No, we didn't ever revisit it.

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

20 DR. HAEGERT:
 21 A. Yeah, initially, yes.

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

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

4 DR. HAEGERT:
 5 A. Right.

6 COFFEY, Q.C.:
 7 Q. But he's not necessarily saying here have the
 8 individual pathologists report it. He's just
 9 saying roll it out. You know, it'll be
 10 available and it'll replace biochemical assay.

11 DR. HAEGERT:
 12 A. Um-hm.

13 COFFEY, Q.C.:
 14 Q. Dr. Cook says here, "well, if that's the case,
 15 we'd like to report our own. We, at St.
 16 Clare's, would like to report our own."
 17 That's what's referred to here.

18 DR. HAEGERT:
 19 A. Yes.

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

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1 DR. HAEGERT:
 2 A. No, I think the feeling was that overtime,
 3 this would devolve to the individual
 4 pathologist. So it would involve, you know,
 5 in the Health Care Corporation and outside.
 6 COFFEY, Q.C.:
 7 Q. Doctor, during your time as clinical chief, up
 8 to the time you left, did the idea ever
 9 resurface about kind of again concentrating
 10 ER/PR reporting in a small group of
 11 pathologists? Did it ever come back,
 12 resurface the idea of -
 13 DR. HAEGERT:
 14 A. Not that I remember, no.
 15 COFFEY, Q.C.:
 16 Q. I'm not suggesting it did.
 17 DR. HAEGERT:
 18 A. I don't think so.
 19 COFFEY, Q.C.:
 20 Q. Once the decisions that were made in 1997,
 21 early '98, about having everybody report their
 22 own, that's the way it stayed?
 23 DR. HAEGERT:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Doctor, here on the fourth page of the
 2 exhibit, under other business, "it was agreed
 3 to hold these meetings once a month. It's
 4 also agreed to rotate these meetings
 5 throughout the various sites with site chiefs
 6 acting as chairs of the meetings in their
 7 respective locations." So this, in effect, is
 8 the beginning of these site meetings. It's
 9 around this time.
 10 DR. HAEGERT:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. Exhibit P-1857, please? Now Doctor, this is
 14 minutes, this is the notice of a meeting, and
 15 then these are the minutes of a meeting of
 16 June 17th, 1997. Again, apologies from
 17 yourself, but certain other doctors are there,
 18 and technologists, a technologist. On page
 19 three of the exhibit, paragraph 3.4 and 3.5,
 20 3.4 reads "ER and PR receptor interpretation.
 21 This was discussed in detail. The majority of
 22 pathologists at St. Clare's, as well as the
 23 Grace Hospital, would like to interpret their
 24 own cases with control slides. Dr. Khalifa
 25 has agreed to provide a number of cases to the

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

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1 Q. Every day, and this would be--your sense of
 2 this would be no, this is for ER/PR
 3 immunoperoxidase?
 4 DR. HAEGERT:
 5 A. I would say, yeah. I can't imagine that could
 6 be for general immunoperoxidase, no.
 7 COFFEY, Q.C.:
 8 Q. And secondary, Doctor, ER and PR receptor
 9 interpretation, paragraph 3.4. Not only St.
 10 Clare's now, but the Grace, it's noted, would
 11 like to interpret their own cases with control
 12 slides. Control slides here would be external
 13 controls?
 14 DR. HAEGERT:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. The idea of utilizing internal controls for
 18 ER/PR, normal breast tissue as an internal
 19 control, do you recall whether that was
 20 discussed in this period, like in this roll
 21 out, you know, the introduction of ER/PR in
 22 St. John's?
 23 DR. HAEGERT:
 24 A. What I would say now everybody is well aware
 25 of this, but -

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<p>1 COFFEY, Q.C.:</p> <p>2 Q. Yes, now.</p> <p>3 DR. HAEGERT:</p> <p>4 A. - I think at the time, no, I was not aware. I</p> <p>5 don't think that we discussed this.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. And there's certainly no reference in the</p> <p>8 materials.</p> <p>9 DR. HAEGERT:</p> <p>10 A. No, I don't remember this at all.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. So at the time, from your perspective, and</p> <p>13 again, you've told the Commissioner before the</p> <p>14 break that this was, in effect, for you, your</p> <p>15 own introduction to this?</p> <p>16 DR. HAEGERT:</p> <p>17 A. Exactly.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. You understood it was nuclear staining you</p> <p>20 were to look for?</p> <p>21 DR. HAEGERT:</p> <p>22 A. Correct.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. And certainly to ensure the external controls</p> <p>25 were working?</p>	<p>1 A. No, no, I don't think so.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. So this would have been, for you, perhaps,</p> <p>4 your introduction to the idea of, you know,</p> <p>5 trying to look through a microscope and come</p> <p>6 to some conclusion about the percentage of</p> <p>7 tumour cells that were staining and report it?</p> <p>8 DR. HAEGERT:</p> <p>9 A. Yeah, I think that's correct. I would say</p> <p>10 that's probably correct.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. How were you--your introduction to that, in</p> <p>13 terms of how were you taught then how one was</p> <p>14 to go about doing that? How did you learn?</p> <p>15 DR. HAEGERT:</p> <p>16 A. How to learn look at percentages?</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Yes.</p> <p>19 DR. HAEGERT:</p> <p>20 A. Well, I think the bigger issue would be when</p> <p>21 you're looking at a slide, first of all, is it</p> <p>22 cancer? When you're looking at the stain, are</p> <p>23 you looking at cancer cells or non-cancerous</p> <p>24 cells. I mean, I think that's one of the</p> <p>25 reasons why pathologists do this, because it's</p>
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<p>1 DR. HAEGERT:</p> <p>2 A. Yes.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Nuclear staining. Doctor, ER/PR, we</p> <p>5 understand, involves percentage--at times</p> <p>6 involves percentages or some kind of</p> <p>7 interpretation and a determination as to</p> <p>8 whether it's considered positive or negative?</p> <p>9 DR. HAEGERT:</p> <p>10 A. Right.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. And percentages are used. Were there any</p> <p>13 other IHC stains at that time that utilized</p> <p>14 percentages, that you recall?</p> <p>15 DR. HAEGERT:</p> <p>16 A. I'm just thinking. I mean, the common stains</p> <p>17 would be for things like lymphomas and</p> <p>18 sarcomas. No, sometimes certain cases,</p> <p>19 certain tumours would--you know, only a small</p> <p>20 percentage of the tumour cells would stain</p> <p>21 positively, but that was well known.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. But you wouldn't be expected to report on the</p> <p>24 percentage?</p> <p>25 DR. HAEGERT:</p>	<p>1 actually not all that easy and is one of the</p> <p>2 fundamental issues in many of the</p> <p>3 immunohistochemical stains when you're looking</p> <p>4 down the microscope, are you looking at tumour</p> <p>5 cells or not tumour cells. But I think any</p> <p>6 pathologist can get a rough estimate of</p> <p>7 percentages.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Once you've determined which ones are the</p> <p>10 actual tumour cells?</p> <p>11 DR. HAEGERT:</p> <p>12 A. Yeah, but it's somewhat subjective. It's not--</p> <p>13 -I mean, the way it was certainly done then,</p> <p>14 it was a subjective measure.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. And so you would be--your understanding was</p> <p>17 you were expected, as a pathologist, if you</p> <p>18 were going to be involved in this, to look at</p> <p>19 a slide, determine in your field of vision as</p> <p>20 to which were tumour cells and which were</p> <p>21 normal cells, concentrate on the tumour cells</p> <p>22 and looking at them, determine what percentage</p> <p>23 of them -</p> <p>24 DR. HAEGERT:</p> <p>25 A. Yes.</p>

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<p>1 COFFEY, Q.C.: 2 Q. - had nuclei staining? 3 DR. HAEGERT: 4 A. Yes. 5 COFFEY, Q.C.: 6 Q. And make your--and give your estimate? 7 DR. HAEGERT: 8 A. Yes. 9 COFFEY, Q.C.: 10 Q. Do you recall whether there was any discussion 11 about--amongst the pathologists in St. John's 12 anyway, that you're aware of, about whether or 13 not that could be problematic, potentially 14 problematic? 15 DR. HAEGERT: 16 A. Well, we were well aware that staining could 17 be strong or weak. I mean, are you talking 18 about the percentages or the intensity of the 19 stain? 20 COFFEY, Q.C.: 21 Q. Percentages first. 22 DR. HAEGERT: 23 A. No, I mean, we didn't actually discuss this, 24 but any pathologist would know the difference 25 between five percent and ten percent is</p>	<p>1 mean, it's 11 years ago. I know we discussed 2 ER/PR staining in some detail. 3 COFFEY, Q.C.: 4 Q. That was in - 5 DR. HAEGERT: 6 A. It certainly was part of the reporting that, 7 you know, we reported positive and then we 8 reported whether there was strong or weak. So 9 it's hard to imagine that it wasn't discussed. 10 COFFEY, Q.C.: 11 Q. Here the idea is referred to here of Dr. 12 Khalifa providing a number of cases, examples, 13 I take it, to the Grace Hospital. 14 DR. HAEGERT: 15 A. Right. 16 COFFEY, Q.C.: 17 Q. Do you recall whether or not that was done at 18 the General? How was it handled at the 19 General, do you recall? 20 DR. HAEGERT: 21 A. I think at the General Hospital, we sat around 22 a scope, if I remember rightly, and what we 23 did is we looked at them and we looked at, you 24 know, different--we looked at positive 25 controls and, you know, what a negative</p>
<p>Page 150</p> <p>1 somewhat subjective. You know, I mean, 2 anybody could tell the difference between five 3 and 100, but you know, percentages is 4 actually, is often a subjective matter and if 5 you're dealing with weak staining, of course, 6 it's more, even more subjective. 7 COFFEY, Q.C.: 8 Q. And you're aware though, you indicated, that 9 there could be weak staining, weak intensity, 10 I take it? 11 DR. HAEGERT: 12 A. Right. 13 COFFEY, Q.C.: 14 Q. In terms of vividness or lack of it? 15 DR. HAEGERT: 16 A. Right. 17 COFFEY, Q.C.: 18 Q. And stronger staining? 19 DR. HAEGERT: 20 A. Right. 21 COFFEY, Q.C.: 22 Q. And that was discussed at these, in these 23 meetings talking about ER/PR? 24 DR. HAEGERT: 25 A. Well, I would think it would have been. I</p>	<p>Page 152</p> <p>1 control would look like, and basically that 2 would be the major approach that was used 3 there. 4 COFFEY, Q.C.: 5 Q. And who would have been doing the explaining? 6 DR. HAEGERT: 7 A. Dr. Khalifa. 8 COFFEY, Q.C.: 9 Q. Okay. The idea of or the discussion around 10 the introduction of ER/PR in St. John's, I 11 take it that, from what you've told us, that 12 it was openly discussed and often discussed at 13 the General Hospital? 14 DR. HAEGERT: 15 A. It was discussed, yeah, it was. 16 COFFEY, Q.C.: 17 Q. How about at the General and--I'm sorry, at 18 St. Clare's and the Grace, was it your 19 understanding that it was discussed there as 20 well, amongst the pathologists? 21 DR. HAEGERT: 22 A. Well, yeah, it was clear that it was, because 23 I mean, Dr. Cook was bringing back opinion of 24 his pathologists at that site and so was Dr. 25 Parai. I mean, it was absolutely clear that</p>

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1 they discussed it among themselves and that
 2 the pathologists wanted to report their own.
 3 COFFEY, Q.C.:
 4 Q. Other than looking at representative slides
 5 and Dr. Khalifa at the General introducing you
 6 to it, was there any other educational effort
 7 made that you recall concerning this, like
 8 articles dealing with it, publications?
 9 DR. HAEGERT:
 10 A. No, I think Dr. Khalifa had appended some
 11 references at the bottom of one of his
 12 recommended reports.
 13 COFFEY, Q.C.:
 14 Q. But other than that?
 15 DR. HAEGERT:
 16 A. No.
 17 COFFEY, Q.C.:
 18 Q. The idea, for example, looking at kind of
 19 colour pictures as it were or discussion in a
 20 journal?
 21 DR. HAEGERT:
 22 A. No, I don't remember this.
 23 COFFEY, Q.C.:
 24 Q. I'm not suggesting there was, I'm just asking.
 25 DR. HAEGERT:

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1 A. No, I don't remember.
 2 COFFEY, Q.C.:
 3 Q. Exhibit P-2411. This is a memorandum of
 4 August 21st, 1997 from Dr. Khalifa to a number
 5 of doctors, including yourself. It says
 6 "initiating ER/PR immunostaining of in-house
 7 cases. This is a reminder that the initiation
 8 of ER/PR immunostaining of our in-house cases
 9 remains the responsibility of the pathologist
 10 who first makes the diagnosis of invasive
 11 mammary malignancy and on the respective
 12 specimen. As you already know, this is done
 13 by filling in a request form and submitting it
 14 to our laboratory. Although currently ER/PR
 15 slides come to me for reporting, the procedure
 16 has to be initiated by the primary
 17 pathologist, since I have no access to the
 18 case in question at the time that a diagnosis
 19 is being made."
 20 Doctor, then how did this aspect of the
 21 matter then roll itself out over time, in
 22 terms of ordering of ER/PR? Because before
 23 this, you had been involved as a pathologist.
 24 DR. HAEGERT:
 25 A. Correct.

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1 COFFEY, Q.C.:
 2 Q. So here, what was being asked of yourself and
 3 your colleagues?
 4 DR. HAEGERT:
 5 A. It was basically a matter of the pathologist
 6 really remembering that this is a routine
 7 activity when you get a diagnosis of breast
 8 cancer, that you would initiate this.
 9 COFFEY, Q.C.:
 10 Q. Look, please, at Exhibit P-1859? Now Doctor,
 11 this site chiefs divisional managers meeting
 12 of October 8th, 1997. Yourself and a number
 13 of other physicians and others are present.
 14 Under new business, it notes "Dr. Khalifa
 15 presented results of an audit of steroid
 16 receptors of 19 breast cancer cases
 17 correlating immunohistochemistry and
 18 biochemical assays." The typed version says
 19 Dr. D. Cook. It turns out it was Dr. Parai,
 20 it's handwritten there, "recommended the
 21 Health Care Corporation continue performing
 22 the IHC tests and encourage doing them on
 23 endometrial carcinomas. He also mentioned
 24 that Dr. Thain in the Cancer Clinic still
 25 prefers to see the biochemical assay done.

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1 Standardization of reporting the results of
 2 IHC assay also seems to be a problem. Dr.
 3 Khalifa was asked to call upon other Canadian
 4 medical centres, Toronto General, to inquire
 5 about their protocols." He's actioned with
 6 it. "He was also asked to seek feedback from
 7 the Cancer Clinic staff," and he's actioned
 8 with that.
 9 So Doctor, this audit of steroid
 10 receptors that's referred to here, the final--
 11 and Dr. Khalifa has referred the Commissioner
 12 to the audit and gone through it. The final
 13 decision then to actually, later on, the final
 14 decision to implement this method, whose
 15 responsibility ultimately was that?
 16 DR. HAEGERT:
 17 A. Well, ultimately, it's mine, but what we did -
 18 COFFEY, Q.C.:
 19 Q. As the clinical chief?
 20 DR. HAEGERT:
 21 A. As the clinical chief, that would be mine, but
 22 what we did is we discussed it at, you know,
 23 the site chiefs meetings. I mean, what I'd
 24 look for was a consensus of agreement, but
 25 really the final responsibility was mine.

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1 COFFEY, Q.C.:

2 Q. And in terms of consensus of agreement, by the

3 time it was implemented, was there a consensus

4 of agreement?

5 DR. HAEGERT:

6 A. Oh yes, yes.

7 COFFEY, Q.C.:

8 Q. If there were any reservations, do you recall

9 who they were by and what the nature of them

10 was?

11 DR. HAEGERT:

12 A. Well, I think it alludes to some of that in

13 here, the standardization of reporting. The

14 reservations were what was the cut off, how we

15 should report, and I think that was eventually

16 what Dr. Khalifa came up with is a document

17 which more or less addressed the concerns of

18 everyone.

19 COFFEY, Q.C.:

20 Q. On that regard, Doctor, because I take it

21 these reports are going on to Meditech or

22 dictated onto Meditech, signed out on

23 Meditech?

24 DR. HAEGERT:

25 A. Right, right.

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1 COFFEY, Q.C.:

2 Q. But they're intended, ultimately, for

3 oncologists?

4 DR. HAEGERT:

5 A. Yes.

6 COFFEY, Q.C.:

7 Q. Were the oncologists, do you recall, consulted

8 at that time about this whole idea of

9 standardized reporting?

10 DR. HAEGERT:

11 A. Well, they must have been because, I mean, Dr.

12 Thain was a clinical oncologist.

13 COFFEY, Q.C.:

14 Q. And there's a reference -

15 DR. HAEGERT:

16 A. Indeed, it's clear that he was, at least he

17 was consulted and no doubt others were. I

18 mean, it's hard to imagine that Dr. Khalifa

19 wouldn't have discussed this. I think it's

20 almost buried within that, the concept that

21 they were consulted.

22 COFFEY, Q.C.:

23 Q. And because I take it they are the ones who

24 ultimately would use the ER/PR status -

25 DR. HAEGERT:

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1 A. Exactly.

2 COFFEY, Q.C.:

3 Q. It's for their benefit and the patients'

4 benefit. Exhibit P-0241--I'm sorry, P-1860.

5 Doctor, these are the minutes of a site

6 chiefs, divisional managers meeting of

7 December 16th, 1997. Again, you're present

8 along with others. And there's a reference to

9 the amendment of the first paragraph of the

10 minutes we just looked at. And then here at

11 paragraph 1, business arising, "Laboratory

12 utilization in anatomic pathology. Dr. Cook

13 was the division representative in the

14 laboratory utilization committee. A meeting

15 of this committee took place where the

16 following topics were discussed." And the

17 fourth bullet there is "Whether we completely

18 switch to immunoperoxidase assessment as

19 steroid receptors on paraffin sections." I

20 take it this is, there was a discussion at

21 some point which would involved amongst other-

22 -certainly it would have involved ER/PR

23 switching -

24 DR. HAEGERT:

25 A. Well, steroid receptors, that's the same.

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1 COFFEY, Q.C.:

2 Q. Yes, same thing.

3 DR. HAEGERT:

4 A. Basically the same.

5 COFFEY, Q.C.:

6 Q. And in the second paragraph here there's a

7 reference to turn-around time at St. Clare's

8 site and concerns being expressed about it.

9 Midway through that there's a sentence, "Mr.

10 Murphy acknowledged the problem and suggested

11 the low number of histotechnologists as being

12 its ideology." Do you recall what that was

13 about in terms of complaints about low numbers

14 or concerns about low numbers of

15 histotechnologists?

16 DR. HAEGERT:

17 A. Well, this was actually discussed in great

18 detail as to why there was an issue at St.

19 Clare's, because we became aware, I mean, as

20 clinical chief, that there was often delays in

21 generation of slides from cases. One of the

22 views was that it was the number of

23 technologists. The alternative view was that,

24 in fact, it was the number of technologists,

25 but that it was the way they did their--the

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1 way the technologists dealt with the tissue
 2 blocks and that, in fact, it was--so one of
 3 the things that was discussed was whether it
 4 was more efficient at the General Hospital
 5 than, say, at St. Clare's and that whether
 6 the--and if that was correct, how does one
 7 address that. And it was a bit interesting
 8 because Murphy, Mr. Murphy was in charge at
 9 St. Clare's and the Grace for anatomic
 10 pathology, Terry Gulliver was in charge at the
 11 Janeway and the General Hospital, as I
 12 mentioned, and what I was told basically at
 13 the various meetings was that the way they
 14 handled the blocks when they came off the
 15 machine was different a the two sites. Mr.
 16 Gulliver's argument was that it was actually,
 17 he thought it was more efficient at the
 18 General Hospital and he thought the St.
 19 Clare's should change the way they did things.
 20 And so there was some discussion of this and
 21 there was discussion of whether techs should
 22 go from the General Hospital to St. Clare's or
 23 techs should come from St. Clare's to the
 24 General Hospital. And the obviously idea
 25 would be that there would be uniformity of

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1 handling of the blocks at the different sites.
 2 COFFEY, Q.C.:
 3 Q. We have heard references here to the idea of
 4 tissue, of reprocessing.
 5 DR. HAEGERT:
 6 A. Right.
 7 COFFEY, Q.C.:
 8 Q. Were you aware, we understand that there was a
 9 certain amount of tissue reprocessing going on
 10 at St. Clare's.
 11 DR. HAEGERT:
 12 A. Right.
 13 COFFEY, Q.C.:
 14 Q. Around this time frame and afterward. Were
 15 you aware that that was so and if so, you
 16 know, in what context?
 17 DR. HAEGERT:
 18 A. Well, it's interesting you raise this,
 19 because, I mean, I've been trying to follow
 20 what's going on at the Commission. Of course,
 21 I haven't read everything. And to be honest,
 22 I don't think I was aware of this, at least I
 23 didn't remember this as an issue. And I was
 24 somewhat surprised, in fact, to read about
 25 this or to have, see people's testimony that

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1 this wasn't rare. I don't know if I was aware
 2 of this at the time.
 3 COFFEY, Q.C.:
 4 Q. At the General Hospital itself were you aware
 5 of tissue reprocessing going on?
 6 DR. HAEGERT:
 7 A. No. That would have been a rare event, if
 8 ever.
 9 COFFEY, Q.C.:
 10 Q. Here, Doctor, paragraph 3 reads, "Steroid
 11 receptors assessment in paraffin sections, Dr.
 12 Khalifa discussed this issue further and
 13 suggested the pathologists start reporting
 14 their own cases. A suggestion was made that
 15 Dr. Khalifa write up a proposal with the
 16 criteria, the cut off values, distribute it to
 17 the various pathologists and ask them for
 18 their feedback." So I take it that sort of
 19 approach would be consistent with the idea of
 20 building a consensus amongst the -
 21 DR. HAEGERT:
 22 A. Well, yeah, I mean, I think -
 23 COFFEY, Q.C.:
 24 Q. If possible?
 25 DR. HAEGERT:

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1 A. - what we realized is that if you don't have a
 2 consensus, people just do whatever they feel
 3 like. So what basically--unless you monitor
 4 very carefully what they're doing. So that
 5 the idea really was that people would try to
 6 do--if they generated a report, it would be
 7 the same across sites and between
 8 pathologists.
 9 COFFEY, Q.C.:
 10 Q. Now, was there at that time any criteria for
 11 how a pathologist was, for example, the format
 12 a pathologist's report should take, any
 13 particular stipulations as to how any
 14 pathology report was to look and what should
 15 or shouldn't be contained in it or must or
 16 must--must be contained in it? I'm just
 17 talking generally.
 18 DR. HAEGERT:
 19 A. Yeah, again, that's an interesting question.
 20 Because initially, of course, I was at the
 21 General Hospital and wasn't really familiar
 22 with what they did at St. Clare's or the
 23 Grace. But then what happened is when Dr.--
 24 one of the initiatives that Dr. Khalifa did,
 25 and this is actually is becoming sort of

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1 common practice in North America, is to
 2 introduce what's called cancer checklists.
 3 Basically what that means is that if, for
 4 example, you have a cancer of the breast,
 5 what--the oncologists look for certain things.
 6 And so if it's left up to the individual
 7 pathologist, the pathologist reports certain
 8 things but leaves out other things, not
 9 intentionally, but by accident. So what Dr.
 10 Khalifa did was introduced a variety of
 11 checklists which were then used across sites.
 12 And actually, I believe he also shared them
 13 with the pathologists outside the Health Care
 14 Corporation. So that what you--so that
 15 basically what you would end up with is a
 16 standardized report in pathology which would
 17 be more or less uniform between pathologists
 18 and which would capture all the information
 19 that pathologists--or actually, that the
 20 oncologists or the surgeons or people treating
 21 the patients want.
 22 COFFEY, Q.C.:
 23 Q. So in him introducing it, I take it then that
 24 there was--before he did that, that didn't
 25 exist at the General or elsewhere?

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1 DR. HAEGERT:
 2 A. No, it wasn't a standardized reporting format,
 3 no.
 4 COFFEY, Q.C.:
 5 Q. Exhibit P-2416, please? Doctor, this is again
 6 minutes of a meeting of site chiefs,
 7 divisional managers, anatomical pathology,
 8 January 8th, '98. And you're present, along
 9 with others. Under "Breast Receptors
 10 Immunoperoxidase Technique" as it reads, "It
 11 is agreed there's no longer a need for
 12 evaluation of the breast receptors by the
 13 bioassay technique. It was also agreed that
 14 in regards to reporting of breast receptors
 15 via the immunoperoxidase technique, that
 16 individual pathologists could report these
 17 results. It agreed that the estrogen and
 18 progesterone stains will be recorded as
 19 negative or positive with percentage of
 20 positivity given. It is also agreed that a
 21 rider will be given with the report, the exact
 22 wording of which is to be developed by Dr.
 23 Khalifa." So I wanted to ask you about this,
 24 Doctor. It states here, "It is agreed" and
 25 then it repeats, says "it was also agreed."

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1 "It is agreed," "it is also agreed," okay. In
 2 this context here in terms of it is agreed,
 3 would individual pathologists then be bound by
 4 the agreement? I mean, I'm trying to get some
 5 sense for the Commissioner in your capacity as
 6 clinical chief at the time, your view of if
 7 the site chiefs and divisional managers agree
 8 on something -
 9 MR. BROWNE:
 10 Q. There seems to a legal aspect to the question.
 11 COFFEY, Q.C.:
 12 Q. Oh, I'm certainly not--and I appreciate that.
 13 I'm certainly not--I apologize, go ahead, Mr.
 14 Browne.
 15 MR. BROWNE:
 16 Q. No, no, I just--the import of the question may
 17 lead to a number of different interpretations.
 18 I want to be clear that there's no sense -
 19 THE COMMISSIONER:
 20 Q. I'm taking Mr. Coffey to ask whether or not in
 21 his official capacity he would expect those
 22 who were reporting to him to conform with this
 23 or allow some deviation from the form.
 24 COFFEY, Q.C.:
 25 Q. Yeah. And I appreciate that, Commissioner,

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1 that's -
 2 THE COMMISSIONER:
 3 Q. Well, assuming the answer is yes, a very
 4 simple question.
 5 COFFEY, Q.C.:
 6 Q. Okay, good. So as a clinical chief, you would
 7 expect then that, look, if we've agreed on
 8 this as a group that you'd be surprised to
 9 learn someone else afterward, if they were
 10 aware of the agreement and the understanding
 11 that they weren't abiding by it?
 12 DR. HAEGERT:
 13 A. I would expect that people would follow it,
 14 yes.
 15 COFFEY, Q.C.:
 16 Q. Doctor, here the reference to reported, I'm
 17 sorry, "recorded as negative or positive with
 18 percentage of positivity given." Now, we have
 19 seen here a number of instances of pathology
 20 reports where ER/PR is said to be positive or
 21 negative and there's no percentage anywhere on
 22 the report, other cases where there is a
 23 percentage given. In your days at clinical--
 24 time as clinical chief, was there ever any
 25 kind of review undertaken in that regard to

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<p>1 see if people were actually giving 2 percentages? 3 DR. HAEGERT: 4 A. Good question. There probably wouldn't, I 5 don't think there was. 6 COFFEY, Q.C.: 7 Q. Okay. Did you ever get any complaints from 8 oncologists about that or expressions of 9 concern from oncologists about the lack of a 10 percentage being given? 11 DR. HAEGERT: 12 A. If there were complaints, they were not 13 addressed to me. Maybe they went to Dr. 14 Khalifa when--the site chief or Dr. Parai. 15 COFFEY, Q.C.: 16 Q. I'm not saying - 17 DR. HAEGERT: 18 A. No, they didn't address them to me. 19 COFFEY, Q.C.: 20 Q. I'm not suggesting that there were any, I just 21 want to ask you that. 22 DR. HAEGERT: 23 A. No, I never got any. 24 COFFEY, Q.C.: 25 Q. The idea being if you reported or--you don't</p>	<p>1 discontinue the biochemical ER and PR assays 2 of March 1, 1998. Give you some sense of it. 3 It's anticipated that's going to happen. 4 Here, Doctor, paragraph 4.3 under "New 5 Business" "Storage policy of blocks/slides, 6 intraoperative report, weight of mastectomy 7 specimens and automated immunoperoxidase 8 stainer." Okay. And it says it's discussed 9 briefly. Now, we've heard reference to here 10 what's referred to as a DAKO autostainer. 11 DR. HAEGERT: 12 A. Um-hm. 13 COFFEY, Q.C.: 14 Q. Were you involved in the obtaining of the DAKO 15 autostainer? Again, the leasing of it or the 16 purchase of it? 17 DR. HAEGERT: 18 A. Could we just go back up to the top? 19 COFFEY, Q.C.: 20 Q. Sure, certainly. 21 DR. HAEGERT: 22 A. Just to see who was at this meeting? 23 COFFEY, Q.C.: 24 Q. Yes, I certainly can, Doctor. It's Drs., it's 25 February 12, it's yourself -</p>
<p>1 recall anyone ever coming to you and saying, 2 well, look, Dr. X reported ER as positive and 3 an oncologist saying, well, what is positive, 4 you know, in the sense of what do you mean by 5 it? 6 DR. HAEGERT: 7 A. Yeah, I think it would depend--I mean, I'm not 8 sure what you're referring to exactly but it 9 depends if this rider was attached, because if 10 that rider that Dr. Khalifa created was 11 attached, that would have clarified what it 12 meant by positive versus negative. 13 COFFEY, Q.C.: 14 Q. Sure. 15 DR. HAEGERT: 16 A. But I didn't actually see these individual 17 examples so it's hard for me to comment, 18 really. 19 COFFEY, Q.C.: 20 Q. Exhibit P-1861, please? Doctor, again, these 21 are--page 2 of it here, minutes of a meeting 22 of site chiefs, divisional managers, 23 anatomical pathology, February 12th, '98 and 24 you were present. And paragraph 3.2 notes 25 ER/PR, and PR reporting and they're going to</p>	<p>1 DR. HAEGERT: 2 A. Yeah, I see. No, that's what I wanted to see 3 because--no. Now, I actually don't remember 4 the details of this meeting, but the issue--I 5 wasn't actually involved in this. We may have 6 discussed an automated immunostainer, but I 7 don't think we would have discussed the DAKO 8 instrument. And the reason I can't believe 9 that we did - 10 COFFEY, Q.C.: 11 Q. I'm not suggesting you did, I'm just - 12 DR. HAEGERT: 13 A. No, but I don't think we could have because if 14 that was discussed, because we'd had an issue 15 with it at the Montreal General Hospital. Not 16 me but the head of the department had 17 purchased a DAKO immunostainer, now, maybe it 18 was an older model, but there were certain 19 issues with it, there was some problem with 20 the antibody binding onto the slides and I was 21 well aware of that. And if we discussed it in 22 any substantial way at that meeting, other 23 than saying we're thinking about getting an 24 automated immunostainer, that would have 25 triggered it right away that the fact that,</p>

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1 you know, somewhere around 1990 or wherever it
 2 was that there was an issue -
 3 COFFEY, Q.C.:
 4 Q. In the institution where you had -
 5 DR. HAEGERT:
 6 A. Yeah, where I was before, in Montreal General
 7 Hospital. I mean, I was well aware of that.
 8 COFFEY, Q.C.:
 9 Q. And so your recollection would be that--well,
 10 by 1997, 1998 were you aware that they had a
 11 DAKO autostainer in the General?
 12 DR. HAEGERT:
 13 A. Yeah, sometime in 1998 because I knew that
 14 there was--in fact, there was some issue with
 15 some aspect of it and I made some comments to
 16 Mr. Gulliver about it and I told him about, in
 17 fact, what the issue was at the General
 18 Hospital in Montreal many years before.
 19 COFFEY, Q.C.:
 20 Q. Doctor, were you asked whether or not it was a
 21 good idea to get it and to utilize it in terms
 22 of were you asked as the clinical chief,
 23 should we get this or not, do you recall?
 24 DR. HAEGERT:
 25 A. I mean, it's difficult to know what the

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1 context of--I mean, one could talk about the
 2 advantages of an automated immunostainer, I
 3 mean, if that's what you're asking me. But I
 4 don't know if that's what you're asking me.
 5 COFFEY, Q.C.:
 6 Q. Well, no, in terms of do you recall--you don't
 7 recall actually being asked as the clinical
 8 chief is this a good idea?
 9 DR. HAEGERT:
 10 A. No, I don't remember that.
 11 COFFEY, Q.C.:
 12 Q. Okay.
 13 DR. HAEGERT:
 14 A. I mean, obviously we discussed it at that
 15 particular meeting, but it was probably a
 16 broad, generic discussion.
 17 COFFEY, Q.C.:
 18 Q. The responsibility for whether or not such an
 19 autostainer was acquired and utilized, whose
 20 responsibility in the lab would that be?
 21 Would that be the clinical chief's or would it
 22 be the manager's?
 23 DR. HAEGERT:
 24 A. Well, the automated immunostainer would be
 25 used for immunohistochemistry in the

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1 laboratory, so it would be a recommendation of
 2 Mr. Gulliver to the program director and then
 3 he would have to find money from the Health
 4 Care Corporation. But, I mean, it, the
 5 meeting is odd because it doesn't really give
 6 much information as to the tenor of the
 7 discussion. In fact, it doesn't say anything
 8 -
 9 COFFEY, Q.C.:
 10 Q. It doesn't, it just -
 11 DR. HAEGERT:
 12 A. - really, it just says it was discussed, but
 13 what was discussed, I can't say.

1 COFFEY, Q.C.:
 2 Q. In any case, it did end up there?
 3 DR. HAEGERT:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. Do you recall during your time as clinical
 7 chief whether you became aware of any problems
 8 with that particular autostainer?
 9 DR. HAEGERT:
 10 A. Well, it was mentioned that--in fact, I was
 11 walking down the corridor one day, and I
 12 remember this because--well, I remember we

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

14 COFFEY, Q.C.:

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

18 DR. HAEGERT:

19 A. No.

20 COFFEY, Q.C.:

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

24 DR. HAEGERT:

25 A. No.

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1 COFFEY, Q.C.:

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

4 DR. HAEGERT:

5 A. I beg your pardon?

6 COFFEY, Q.C.:

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

9 DR. HAEGERT:

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

19 COFFEY, Q.C.:

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

22 DR. HAEGERT:

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

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1 continued to use it.

2 COFFEY, Q.C.:

3 Q. Do you recall when this would have been?

4 DR. HAEGERT:

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

11 COFFEY, Q.C.:

12 Q. Exhibit P-1862, please. Doctor, again this is
 13 a memorandum advising of a meeting and the
 14 second page of the exhibit is the same thing,
 15 except this one has amended agenda items. I
 16 believe there's automatic slide stainer being
 17 added to the agenda, and the first item,
 18 though, is a follow up on ER/PR reporting, and
 19 then on the third page of the exhibit, these
 20 are the minutes of the meeting of March 19th,
 21 1998, site chiefs, divisional managers, and
 22 you were present. See that? There's an
 23 amendment to a paragraph in the previous
 24 meeting's minutes, and then under business
 25 arising, "Dr. Khalifa updated the committee

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

16 DR. HAEGERT:

17 A. Yes.

18 COFFEY, Q.C.:

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

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1 to this point in the documents we've been
2 looking at in terms of dealing with ER/PR,
3 there are references to St. Clare's, the
4 Grace, the General, the site chiefs and so on
5 from those areas, but not pathologists outside
6 St. John's. Do you recall whether or not there
7 was any interaction with pathologists outside
8 St. John's as to whether or not they wanted to
9 get involved in reporting ER/PR?
10 DR. HAEGERT:
11 A. I think there were discussions with--Dr.
12 Khalifa, I believe, discussed it and contacted
13 the pathologists at various sites, but I
14 wasn't involved in this.
15 COFFEY, Q.C.:
16 Q. Okay.
17 DR. HAEGERT:
18 A. He was the lead person here, so it seemed
19 reasonable that he would do this.
20 COFFEY, Q.C.:
21 Q. The first paragraph, he concludes here by
22 saying, "This technique", which is the ER/PR
23 IHC technique, "although has its own
24 limitations, has proven to be more practical
25 and cost effective than the traditional

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1 biochemical detection methods". At that time,
2 your understanding of its limitations was
3 what?
4 DR. HAEGERT:
5 A. I'm just thinking --
6 COFFEY, Q.C.:
7 Q. Yes.
8 DR. HAEGERT:
9 A. I mean, one potential limitation is the issue
10 of referral material in from outside. Then
11 the question arises as to adequacy of
12 fixation, timeliness of getting--timeliness of
13 getting the results back to the individual
14 labs, and I know there was also an issue of
15 controls because then the question is whether--
16 the main emphasis was an external controls
17 question and is do we run external controls
18 for each of the outside sites, and do we send
19 them back to them or do we do the external
20 controls in-house and review them in-house.
21 COFFEY, Q.C.:
22 Q. Now here in the second paragraph, he says,
23 "The Health Care Corporation has been
24 employing this technology for over a year.
25 Recent audits correlating IHC with biochemical

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1 results in selected specimens where both
2 techniques have been run in parallel have
3 shown high accuracy of the introduced IHC
4 detection. Results of these audits have been
5 discussed in several meetings and are
6 available for review". Now, Doctor, in terms
7 of the actual decision then to be satisfied
8 that the audits correlating IHC with
9 biochemical results, as the clinical chief at
10 the time, were you satisfied that sufficient
11 correlation had gone on?
12 DR. HAEGERT:
13 A. Yes. Well, let me respond to that. See at
14 the time the thinking was the biochemical
15 method was the gold standard, and so basically
16 what Dr. Khalifa did was actually compare the
17 immunohistochemical results that he got with
18 the biochemical results. I mean, I would
19 think actually in some places they probably
20 just introduced immunohistochemistry without
21 doing any correlation at all. So I think--I
22 mean, I was satisfied that, in fact, the
23 results were highly concordant, very, very
24 similar, and since we were using that as the
25 gold standard, it seemed quite reasonable, and

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1 also we know very well that outside of St.
2 John's in many institutions they had already
3 introduced immunohistochemistry and were
4 satisfied with it, but we were using the--as I
5 mentioned, the biochemical method is a gold
6 standard.
7 COFFEY, Q.C.:
8 Q. And I appreciate that, but in terms of the
9 sample size, because we've seen references--
10 seen a reference earlier to 19 cases.
11 DR. HAEGERT:
12 A. Uh-hm.
13 COFFEY, Q.C.:
14 Q. And if we look here in this particular
15 exhibit, page four of it, we'll see a
16 document, immunohistochemical staining of
17 steroid receptors, correlation with
18 biochemistry, a report of our experience over
19 a nine month period, January '97 to September
20 '97. It's by Drs. Khalifa and C. Pugh, and
21 again there's a number of cases listed here.
22 DR. HAEGERT:
23 A. Uh-hm.
24 COFFEY, Q.C.:
25 Q. I believe, if I recall correctly, there are

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<p>1 around 19 or so. So at the time, did you 2 think this was a large enough sample? 3 Yourself, were you satisfied at the time? 4 DR. HAEGERT: 5 A. I think it was large enough in view of the 6 fact, first of all, that outside in probably 7 many institutions, they didn't do any 8 comparison whatsoever, and what we were trying 9 to do was really the correlation. We were 10 actually trying to see whether there were 11 similarities or very, very similar results, 12 which there seemed to be. I thought actually 13 19 seemed like a reasonable number. 14 COFFEY, Q.C.: 15 Q. Was there, Doctor, at the time to your 16 knowledge any accepted approach to how this 17 should be done, the introduction of ER/PR IHC 18 into a particular institution? As a Canadian 19 pathologist at the time, was there any 20 accepted way one would go about this? 21 DR. HAEGERT: 22 A. In Canada--there are no guidelines in Canada 23 for doing this at all. It seemed reasonable 24 to compare it with the gold standard. If we 25 thought the gold standard was something else,</p>	<p>1 report results of his or her own cases as 2 indicated by the brown staining of nuclei of 3 the invasive neoplastic cells", and he says 4 that will start March 1, 1998, and he 5 describes how that will be done. Now he does 6 say, "With each run, I", and that will be Dr. 7 Khalifa, "will still be responsible for 8 reviewing the positive controls here in our 9 laboratory and the slides will not be mailed 10 to you unless adequate staining is noted in 11 the positive controls", and he says he will be 12 more than glad to continue being available to 13 answer any questions and address concerns. 14 So, Doctor, at that time, I take it positive 15 controls in your mind would have been external 16 controls? 17 DR. HAEGERT: 18 A. Yes. 19 COFFEY, Q.C.: 20 Q. And as the clinical chief then, is it your 21 understanding that Dr. Khalifa was taking this 22 upon himself in terms of before slides left 23 the General, the ER/PR slides left the General 24 Hospital, that he would examine the external 25 controls and be satisfied that they had</p>
<p>1 we would have done something else. 2 COFFEY, Q.C.: 3 Q. The idea of perhaps comparing the results in 4 St. John's, the ER/PR IHC results in that 5 first year to ER/PR IHC results at another 6 laboratory that was already established and 7 doing it, was that discussed? 8 DR. HAEGERT: 9 A. No, no, because as I mentioned--well, I 10 already said a couple of times that we thought 11 that the biochemical method was the gold 12 standard and what would be appropriate results 13 would be basically concordance with the 14 biochemical method. 15 THE COMMISSIONER: 16 Q. Mr. Coffey, when you find a convenient spot to 17 break. 18 COFFEY, Q.C.: 19 Q. Yes. Now here Dr. Khalifa has indicated that 20 --at the bottom of the first page he says, 21 "Phase 1", which he's gone through, 22 introductory phase, and then he says we're 23 going to go on to Phase 2 and 3. He describes 24 Phase 2 at the top of the second page of his 25 memo, "Each pathologist will be asked to</p>	<p>1 stained appropriately for that batch or run? 2 DR. HAEGERT: 3 A. Yes. 4 COFFEY, Q.C.: 5 Q. Now, Doctor, at the time as clinical chief, 6 did you think of that as Dr. Khalifa as Dr. 7 Khalifa, or Dr. Khalifa as the site chief, or 8 was it addressed at the time? 9 DR. HAEGERT: 10 A. Well, I would think probably dual because, I 11 mean, somebody obviously had to look at them 12 if we're going to send out controls - if we're 13 not going to send out controls. Therefore, 14 the logical person to do this would be the 15 site chief. So it was really more of a site 16 chief issue than a Dr. Khalifa issue, but, of 17 course, it happened that he developed the 18 methodology together with the text, so that it 19 was ideal. 20 COFFEY, Q.C.: 21 Q. And he then refers to a proposal for uniform 22 reporting, and when we look at--he then 23 concludes on this page by saying, "There's a 24 considerable host of publications addressing 25 this issue", and he'd be glad to share the</p>

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<p>1 material. Did you ever see any such material?</p> <p>2 DR. HAEGERT:</p> <p>3 A. No, I never reviewed any.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. I take it, though, that if you had asked, you</p> <p>6 would have expected he'd provide it?</p> <p>7 DR. HAEGERT:</p> <p>8 A. Yes, of course.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. And then here on the third page, Doctor, the</p> <p>11 proposal for uniform reporting of ER/PR</p> <p>12 immunohistochemical assessment, February,</p> <p>13 1998, he talks about having three components,</p> <p>14 that rider or comment at the end, is located</p> <p>15 in paragraph three here. Now your approach</p> <p>16 yourself was to do what, did you adopt this?</p> <p>17 DR. HAEGERT:</p> <p>18 A. Yes, I believe I did. I didn't see very many</p> <p>19 cases, but I saw some.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. And in terms of at least the cases that you</p> <p>22 reported, you don't ever recall receiving any</p> <p>23 complaints from oncologists or questions from</p> <p>24 oncologists about what it meant, ER/PR</p> <p>25 results?</p>	<p>1 involvement in this aspect of the matter?</p> <p>2 DR. HAEGERT:</p> <p>3 A. Well, we discussed this extensively as to</p> <p>4 whether this was appropriate to put this rider</p> <p>5 in, not appropriate to put the rider in.</p> <p>6 Finally the decision was made to put it in as</p> <p>7 an option.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. So that some pathologists would have been</p> <p>10 utilizing it and some not?</p> <p>11 DR. HAEGERT:</p> <p>12 A. That's correct.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. Depending upon their own judgment.</p> <p>15 DR. HAEGERT:</p> <p>16 A. Yes.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Do you recall whether or not the oncologists</p> <p>19 were consulted about that at the time, to your</p> <p>20 knowledge, anyway?</p> <p>21 DR. HAEGERT:</p> <p>22 A. I would say probably not. I don't remember</p> <p>23 them being consulted. I would say they</p> <p>24 probably weren't.</p> <p>25 COFFEY, Q.C.:</p>
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<p>1 DR. HAEGERT:</p> <p>2 A. No, I don't recall.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Or it being brought to your attention at all?</p> <p>5 DR. HAEGERT:</p> <p>6 A. No.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. Commissioner, after lunch then.</p> <p>9 THE COMMISSIONER:</p> <p>10 Q. All right then. We'll break and meet again at</p> <p>11 five after two.</p> <p>12 (ADJOURNED FOR LUNCH)</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. If we could look, please, at Exhibit 2535.</p> <p>15 Doctor, these are minutes of site chief's</p> <p>16 meeting of April 22nd, 1998. At paragraph "F"</p> <p>17 on the second page under "business arising",</p> <p>18 estrogen/receptors, "Dr. Cook wondered about</p> <p>19 the rider in the case where estrogen receptor</p> <p>20 stain less than 30 percent of the cells. Dr.</p> <p>21 Khalifa informed him of this rider is a</p> <p>22 recommendation only and is not part of the</p> <p>23 formal policy regarding the reporting of</p> <p>24 breast receptors". So, Doctor, at the time as</p> <p>25 the clinical chief what, if anything, was your</p>	<p>1 Q. Exhibit P-2417, please. Doctor, this is a</p> <p>2 memorandum of November 10, 1998, advising of a</p> <p>3 meeting and on the agenda, though, number</p> <p>4 three, ER/PR immunohistochemistry requests.</p> <p>5 If we could look, please, at Exhibit 2418.</p> <p>6 This is the minutes of a meeting of November</p> <p>7 12, 1998, Division of Anatomic Pathology,</p> <p>8 General Hospital site. As it turns out, in</p> <p>9 fact, you're not noted to be present here at</p> <p>10 this particular meeting, but under business</p> <p>11 arising, flagging breast cancer cases,</p> <p>12 "Members of the committee agreed to receive a</p> <p>13 note from the secretaries with every breast</p> <p>14 cancer case as a reminder for the submission</p> <p>15 of an ER/PR request. This process will be</p> <p>16 triggered by dictating a microscopic</p> <p>17 description or diagnosis". So, Doctor, this</p> <p>18 is toward the end of 1998. I take it then,</p> <p>19 getting people to order the ER/PR test, at</p> <p>20 least in the early first year or two at times</p> <p>21 was--required some reminders?</p> <p>22 DR. HAEGERT:</p> <p>23 A. Yes, I think it wasn't--it wasn't a reflex.</p> <p>24 So if we have breast cancer, order ER/PR.</p> <p>25 This was one of the ways of actually getting</p>

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1 people to do that.
 2 COFFEY, Q.C.:
 3 Q. Look, please, at Exhibit P-2536. Doctor,
 4 these are just some documents I'm going to
 5 take you through. Some of them touch upon
 6 things you've already told the Commissioner
 7 about earlier today, but they're documentary,
 8 they're documents that refer to reflect your
 9 comments. This is a laboratory medicine
 10 program annual report of 1997/1998. It's
 11 prepared February 28th, 1999, and the second
 12 page, the annual report for '97 to '98, there
 13 are certain divisions listed there, the first
 14 being anatomical pathology, and then in the
 15 overview, the second paragraph notes, "This
 16 past year many changes were attempted in the
 17 laboratory program. Many have gone quite well
 18 and others have been significant learning
 19 experiences. There still exist barriers.
 20 People have comfort zones, strong cultural
 21 ties and resist change, but overall
 22 significant changes have occurred for the
 23 better". Then it concludes, "These changes
 24 were the result of restructuring and
 25 consolidation. Each division implemented

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

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

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

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

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1 your time as clinical chief, improving the
 2 skill level of the staff, you've referred to
 3 the idea of perhaps learning from each other.
 4 DR. HAEGERT:
 5 A. Uh-hm, yes.
 6 COFFEY, Q.C.:
 7 Q. And what if any opportunities were there for
 8 pathologists at the time to attend educational
 9 functions outside the Health Care Corporation?
 10 DR. HAEGERT:
 11 A. Well, the opportunities were large. People
 12 could elect to go to, like, the International
 13 Academy of Pathology. It had meetings every
 14 year, the North American Division. They would
 15 rotate from the big cities typically in the
 16 United States or a few of the big cities in
 17 Canada. There's also the Canadian Association
 18 of Pathologists meetings, and there's meetings
 19 in Europe and elsewhere.
 20 COFFEY, Q.C.:
 21 Q. How about funding for it?
 22 DR. HAEGERT:
 23 A. Yes, I thought a bit about that. My
 24 recollection is that there was a small amount
 25 of funding for those who had a primary

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1 university appointment, but for the hospital,
 2 there was--I think people had to pay for it
 3 out of their own pocket. There was no money
 4 that was identified from the hospital, as far
 5 as I remember.
 6 COFFEY, Q.C.:
 7 Q. And certainly if there was, it was a small
 8 amount, relatively small amount, if there was
 9 any?
 10 DR. HAEGERT:
 11 A. Well --
 12 COFFEY, Q.C.:
 13 Q. And you can't recall --
 14 DR. HAEGERT:
 15 A. It certainly doesn't--I don't remember there
 16 being any.
 17 COFFEY, Q.C.:
 18 Q. And in paragraph "D" here, "Participate in
 19 extensive internal and external quality
 20 control programs". For pathologists, anyway,
 21 do you know what--you've described--other than
 22 what you've described already for the
 23 commissioner, is there anything else that you
 24 can think of that would fall into the category
 25 of internal and external quality control

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1 programs that were available for pathologists?
 2 DR. HAEGERT:
 3 A. No, I don't think so.
 4 COFFEY, Q.C.:
 5 Q. Page 12, please. Doctor, here under quality
 6 care issues, see that there --
 7 DR. HAEGERT:
 8 A. Uh-hm.
 9 COFFEY, Q.C.:
 10 Q. "Areas where the leadership team has concerns
 11 are; reduced or frozen budgets", refers to
 12 limiting the amount of new services that can
 13 be offered. Off-site blood collection is
 14 referred to. It says, "Resources to research
 15 utilization trends and conduct education
 16 programs regarding appropriate laboratory
 17 utilization or best practice policies", I take
 18 it that this being listed here in these
 19 bullets, was this to suggest that the reduced
 20 or frozen budgets were having a negative
 21 effect on the resources available to research
 22 utilization trends?
 23 DR. HAEGERT:
 24 A. Yes, I think the point really is that if
 25 you're going to do this, you need dedicated

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1 personnel, either full time equivalent or
 2 close to a full time equivalent person, and
 3 the reality was we reduced the personnel
 4 extensively, so there were no such people.
 5 COFFEY, Q.C.:
 6 Q. And finally, there were increased demands on
 7 laboratory services. I take it that the sheer
 8 number of tests being done in the clinical
 9 laboratory of various forms were going up, the
 10 sheer numbers?
 11 DR. HAEGERT:
 12 A. Yes, I think this is--I would say that's all
 13 over North America that the demand for lab
 14 services and pathology services increase every
 15 year.
 16 COFFEY, Q.C.:
 17 Q. And --
 18 DR. HAEGERT:
 19 A. And in pathology, the complexity goes up every
 20 year.
 21 COFFEY, Q.C.:
 22 Q. Exhibit P-2425.
 23 THE COMMISSIONER:
 24 Q. Can we go back to page four, which I think is
 25 the--yes, the organizational chart. Doctor

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1 Haegert, I notice that just in terms of the
 2 program director and the clinical chief, I
 3 recognize that below that section, as it were,
 4 there are those within the system that report
 5 to one or the other of you, as I understand
 6 that.
 7 DR. HAEGERT:
 8 A. That's correct.
 9 THE COMMISSIONER:
 10 Q. Essentially, the technological side reported
 11 to Mr. Whelan, and the pathologists would have
 12 reported to you?
 13 DR. HAEGERT:
 14 A. And also the divisional chiefs. I mean, I
 15 think the problem with that organizational
 16 chart, it doesn't capture all of the
 17 complexity.
 18 THE COMMISSIONER:
 19 Q. That was my question because I note, for
 20 example, that the two don't come back together
 21 again until you get to Sister Elizabeth Davis.
 22 I'm wondering in terms of the point that you
 23 raised, is it that this particular chart
 24 doesn't really reflect what was going on on
 25 the ground or is this organizational--are

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1 there problems with that organizational
 2 structure that you identified when you were
 3 operating under it?
 4 DR. HAEGERT:
 5 A. Well --
 6 THE COMMISSIONER:
 7 Q. Or perhaps both?
 8 DR. HAEGERT:
 9 A. I mean, I think the way I would see the
 10 organization, I mean, even though that's
 11 correct, is that the technologists, for
 12 example, would all report through to Mr.
 13 Whelan.
 14 THE COMMISSIONER:
 15 Q. Yes.
 16 DR. HAEGERT:
 17 A. And then the divisional chiefs and the
 18 pathologists would report to me--through a
 19 site chief and then to me.
 20 THE COMMISSIONER:
 21 Q. Uh-hm.
 22 DR. HAEGERT:
 23 A. But, I mean, one becomes more aware of these
 24 things in retrospect, the issues about it. I
 25 mean, it's clear in retrospect that there were

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

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1 least it doesn't really depend on the
 2 individuals within it.
 3 THE COMMISSIONER:
 4 Q. Okay. One of the other witnesses who has been
 5 here made a similar point, that is that while
 6 you will get people who will tell you that
 7 structure works very well in their
 8 institution, his view was that you shouldn't
 9 have a structure that depends on the
 10 personality of the individual involved or
 11 individuals involved. You need a structure
 12 that's going to deal with problems as they
 13 arise, whatever the personality of--the
 14 relationship --
 15 DR. HAEGERT:
 16 A. Well, when I was first here, I thought, well,
 17 this is fine, but it's clear that there are
 18 issues here, and, I mean, I can tell you that
 19 we have a similar structure where I am in
 20 Montreal and it actually works because the
 21 manager and I kind of--instead of saying,
 22 okay, this is my domain and this is your
 23 domain, and they are separate domains, we
 24 actually--we kind of interface and it sort of
 25 fuses, but it only--I mean, I don't know

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1 what's going to work subsequent. Say the
 2 manager leaves and there's a new manager, is
 3 it going to work the same way because it could
 4 easily break down. I mean, I could tell you--
 5 I don't know if you want me to tell you this,
 6 but I actually run the molecular pathology lab
 7 in Montreal, and in principle the
 8 technologists report to the manager, but the
 9 reality is the manager has no experience
 10 whatsoever in molecular biology, so in
 11 practice they report to me, but the
 12 organizational structure, if you look at it,
 13 they actually don't report to me. I'm really
 14 there as sort of a consultant/advisor, but, in
 15 fact, what they do whenever there's an issue,
 16 they talk to me. They don't talk to the
 17 manager because the manager has no knowledge.
 18 THE COMMISSIONER:
 19 Q. Okay, thank you, that's helpful. Mr. Coffey.
 20 COFFEY, Q.C.:
 21 Q. Thank you, Commissioner. Exhibit P-2425,
 22 please. Doctor, this is a letter from Dr.
 23 Khalifa, it's copied to yourself and Dr.
 24 Wadden. It's to Dr. Popadiuk, and it involves
 25 the GYN oncology pathology review, the

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

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1 service, some kind of a consultancy service,
 2 and I think you referred to that earlier.
 3 DR. HAEGERT:
 4 A. Correct.
 5 COFFEY, Q.C.:
 6 Q. And now, in his absence, or with his
 7 departure, would know--wouldn't be provided or
 8 he didn't anticipate that it would be provided
 9 because of manpower problems and resources.
 10 What I wanted to ask you about was this, is
 11 that is this an example of manpower problems,
 12 the effects that it has or can have and was
 13 having in St. John's?
 14 DR. HAEGERT:
 15 A. Yeah, I think one of the issues, I mean, we
 16 already talked about the referral cases to the
 17 Newfoundland Cancer Treatment Research
 18 Foundation, but Dr. Popadiuk was a
 19 gynecological surgeon with special expertise
 20 in oncology. So she was--I think she was
 21 bringing in patients from all over the
 22 province to her for management, and so what I
 23 would think is that there was a significant
 24 increase in the number of cases that were
 25 being referred in for management and it's

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<p>1 normal practice when one gets material from--</p> <p>2 or when a patient's referred, they kind of</p> <p>3 bring their pathology with them, so that it</p> <p>4 can be reviewed on site. The idea being that,</p> <p>5 you know, the Health Care Corporation was</p> <p>6 basically the referral centre. Now I'm not</p> <p>7 sure how many cases we're talking about or the</p> <p>8 level of difficulty, but I would have said</p> <p>9 that certainly we were--always we were</p> <p>10 talking--we had an issue about staff numbers</p> <p>11 and whether we had adequate staff. I would</p> <p>12 have said that we would have done our best</p> <p>13 within the Department to review these cases.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Now here it says "would be interested in</p> <p>16 discussing with you the reasons for these</p> <p>17 reviews." Now did you make any inquiries</p> <p>18 about the reasons for these reviews, and did</p> <p>19 they have anything to do with the output of</p> <p>20 the clinical laboratory?</p> <p>21 DR. HAEGERT:</p> <p>22 A. I think that's kind of -</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. I'm not suggesting that -</p> <p>25 DR. HAEGERT:</p>	<p>1 gynecologic malignancy.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. If we could look, please, at Exhibit 2420?</p> <p>4 Doctor, this is a division of anatomic</p> <p>5 pathology, minutes of a meeting of April 20th,</p> <p>6 1999, around the same time frame. Yourself</p> <p>7 and Dr. Khalifa and others attended. Here,</p> <p>8 Doctor, that referred in consult cases</p> <p>9 involving Dr. Popadiuk is referred to in</p> <p>10 paragraph three, but in paragraph four,</p> <p>11 there's a reference to "new site chief. A</p> <p>12 discussion took place around this topic with</p> <p>13 the intention of not trying to reach a</p> <p>14 decision, but rather voicing of opinions. Dr.</p> <p>15 Khalifa presented to members of the group a</p> <p>16 summary of chores he carried out during this</p> <p>17 serve period. He also presented some figures</p> <p>18 to summarize workload in various sites within</p> <p>19 the Health Care Corporation. A long</p> <p>20 discussion took place. Some of its highlights</p> <p>21 are summarized below." First bullet, "in Dr.</p> <p>22 Chittal's opinion, the best possible strategy</p> <p>23 was to combine the chair and site chief roles</p> <p>24 in one individual. Dr. Fernandez expressed</p> <p>25 her unwillingness to carry out the site chief</p>
<p>Page 209</p> <p>1 A. - a red herring really and not--I mean, I</p> <p>2 would have said the reasons for the reviews</p> <p>3 are fairly obvious.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Okay.</p> <p>6 DR. HAEGERT:</p> <p>7 A. Patients are referred. Therefore, you do the</p> <p>8 review. I mean, it's sort of normal practice.</p> <p>9 In fact, it is normal practice, not sort of</p> <p>10 normal practice. It's normal practice.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. So it didn't have anything to do with the</p> <p>13 quality of what was being turned out involving</p> <p>14 the slides? I'm not suggesting it did, I just</p> <p>15 wanted to ask you about it, in terms of -</p> <p>16 DR. HAEGERT:</p> <p>17 A. Where? You mean outside?</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. No, within -</p> <p>20 DR. HAEGERT:</p> <p>21 A. No, these would be--I mean, my interpretation</p> <p>22 of this would be that what's happening is</p> <p>23 cases are referred from Gander, Corner Brook,</p> <p>24 wherever, to St. John's for treatment, say for</p> <p>25 ovarian cancer or some other kind of</p>	<p>Page 211</p> <p>1 responsibilities. Dr. Robb, along with other</p> <p>2 members, emphasized the importance of</p> <p>3 maintaining collegiality and avoiding</p> <p>4 conflicts within the discipline and Dr.</p> <p>5 Haegert pointed out some of the options,</p> <p>6 including rotating responsibilities among</p> <p>7 various staff, not having a site chief,</p> <p>8 assigning a staff member from the General</p> <p>9 Hospital site or assigning a staff member from</p> <p>10 another site within the Health Care</p> <p>11 Corporation."</p> <p>12 Doctor, so I take it then this was an</p> <p>13 assessment or fresh assessment of the role of</p> <p>14 a site chief? That was being considered here,</p> <p>15 the idea of what a site chief might or might</p> <p>16 not do?</p> <p>17 DR. HAEGERT:</p> <p>18 A. Well, I think this is the time when Dr.</p> <p>19 Khalifa was leaving.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. He was leaving, exactly.</p> <p>22 DR. HAEGERT:</p> <p>23 A. So what we were trying to decide is what the</p> <p>24 next option was.</p> <p>25 COFFEY, Q.C.:</p>

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1 Q. And there's a discussion here of possible
 2 options.
 3 DR. HAEGERT:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. What happened?
 7 DR. HAEGERT:
 8 A. Well, this was approximately the time that the
 9 Grace Hospital was closing, so Dr. Parai moved
 10 over to the General Hospital and became site
 11 chief. Actually, I was being provocative
 12 there, just to see what people said. So I
 13 said these are the options. I don't think I
 14 was all that--being all that serious, to be
 15 perfectly honest.
 16 COFFEY, Q.C.:
 17 Q. Okay, at the time.
 18 DR. HAEGERT:
 19 A. No, I remember this, because I thought it was--
 20 -I thought, well, these are the options, and
 21 somebody minuted it, and I thought oh well.
 22 COFFEY, Q.C.:
 23 Q. But in terms of at the time, from your
 24 perspective, as the clinical chief then, you
 25 anticipated really that particularly with the

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

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1 middle of the page, they note "Dr. Haegert,
 2 clinical chief, is on sabbatical and Dr. D.
 3 Cook was appointed clinical chief acting, July
 4 1/99 to July 1, 2000." So that's while you
 5 were away in Montreal?
 6 DR. HAEGERT:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. Here, Doctor, there's a note here,
 10 resignations then were received during the
 11 year from Dr. Prabhakaran.
 12 DR. HAEGERT:
 13 A. Prabhakaran, at least that's how I pronounce
 14 it. I always pronounced it, for ten years,
 15 like that. Hopefully, correct.
 16 COFFEY, Q.C.:
 17 Q. Yes, I think you are. And Dr. Khalifa's
 18 resignation is noted and Dr. McIntosh's, the
 19 chief of cytology. The replacements, Dr.
 20 Randell replaced the head, chief of
 21 biochemistry and Dr. Wadden was appointed site
 22 chief acting, anatomical pathology at the
 23 General Hospital until April 30th, 2000, and
 24 then Dr. S. Parai is the permanent site chief,
 25 anatomical pathology at the General Hospital,

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

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1 COFFEY, Q.C.:

2 Q. And that would require time of yourself and

3 the site chiefs who might be involved in doing

4 it?

5 DR. HAEGERT:

6 A. Yeah, site chiefs and often we'd set up a

7 committee and get one of the persons to chair

8 the committee and then they'd bring people in.

9 They'd be interviewed by people, interviewed

10 at the committee, and then finally make a

11 recommendation, and then the individual would,

12 of course, have to apply and then would have

13 to go through the Newfoundland Medical Board

14 and whatever other processes were required,

15 and they have to meet certain criteria to be

16 accepted. That was part of it. The other

17 part is it's difficult to make plans as to how

18 we do things when, you know, the personnel

19 were not stable.

20 COFFEY, Q.C.:

21 Q. Doctor, you have a third going in one year, in

22 effect, because this only covers a year, this

23 period. Had that happened before? Like that

24 proportion in a year gone?

25 DR. HAEGERT:

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1 A. No, it seems unusually high.

2 COFFEY, Q.C.:

3 Q. Can you, now looking back on it, or at the

4 time, or now reflecting upon it, can you

5 attribute that kind of turnover, that

6 particular year to any one thing?

7 DR. HAEGERT:

8 A. No, I mean, what it mentions here is Dr.

9 Khalifa and Dr. McIntosh and Dr. Prabhakaran.

10 I mean, I know Dr. Prabhakaran had been

11 talking about it for a long time or thinking

12 about it for quite some time, and then he

13 finally decided to move. Dr. Khalifa, I mean,

14 he just advised us. Dr. McIntosh, I knew was

15 not happy there for personal reasons, and she

16 wanted to move. I don't know who the other

17 three people were. I mean, sometimes these

18 things all happen at once, unfortunately. I

19 mean, I can't say that there was anything in

20 the structure or the reporting relationships

21 or interpersonal factors that were really

22 relevant, as far as I know, but I think around

23 that time, there were one or two people who

24 came, stayed about a year, and then left, and

25 most of the time, people do not share their

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1 thinking about what they're doing. Some

2 people just come, they get landed immigrant

3 status and then they move on, and in fact, I

4 would say at least one or two people did that

5 around that time.

6 COFFEY, Q.C.:

7 Q. Page seven, please? There, Doctor, there's a

8 reference to--there's a list of challenges and

9 the first is noted to be "our greatest

10 challenge was to bring the service together on

11 two sites and contend with the challenges of

12 bringing staff together. Second is to offer

13 new procedures that are constantly being

14 developed in the field of laboratory medicine

15 within our existing human and financial

16 resources." And in relation to that, Doctor,

17 I take it, just to reiterate a point I

18 canvassed with you earlier today, there was no

19 written policy or procedure dealing with how

20 new procedures in pathology any way, in terms

21 of testing and so on, were to be instituted

22 within the Health Care Corporation. There was

23 no written structure.

24 DR. HAEGERT:

25 A. Within pathology, but normally, I mean, it was

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1 well recognized that if you wanted to do

2 something new, either they would go directly

3 to me or a site chief and then what we would

4 do is bring it to the site chiefs meeting,

5 including myself, and we would discuss it and

6 try to reach a consensus and then I'd make a

7 decision.

8 COFFEY, Q.C.:

9 Q. Doctor, did you ever have any occasion to

10 inquire into how much, if any, written

11 policies and procedures there were for

12 technologists, either in the General Hospital

13 or in the Health Care Corporation?

14 DR. HAEGERT:

15 A. Did I at the time?

16 COFFEY, Q.C.:

17 Q. Yes, while you were clinical chief.

18 DR. HAEGERT:

19 A. No, no.

20 COFFEY, Q.C.:

21 Q. From your perspective at the time, whose

22 responsibility would it be to ensure that if

23 there were to be such things, that they

24 existed and that they were maintained?

25 DR. HAEGERT:

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1 A. Well, normally that would come from the
 2 manager.
 3 COFFEY, Q.C.:
 4 Q. For pathologists themselves, were there any
 5 such written policies or procedures, you know,
 6 governing their practice?
 7 DR. HAEGERT:
 8 A. The reality is, you know, pathologists are
 9 professionals. So one--in many ways, one
 10 expects a pathologist, as a professional, to
 11 know what would be the appropriate type of
 12 activity. So for example, if you're on call
 13 for the operating room, you would know that
 14 you would have to--I mean, we obviously would
 15 have discussed it. We have normal operating
 16 room coverage hours. I think there it was
 17 eight to five, in the morning, so you're
 18 expected to be there at 8:00, be there until
 19 5:00 and be available, not downtown in the pub
 20 or some such thing. I mean, that would be
 21 sort of normal practice and then it would be
 22 also the expectations were that if you're on
 23 surgical pathology, for example, then you
 24 would be--it was your role to report the cases
 25 that would be arriving on the days that you're

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1 on call. I mean, everybody--this was common
 2 knowledge. It may not have been written down,
 3 but it was certainly everyone was well aware
 4 of it. I mean, no one could possibly have
 5 said "oh, I didn't know that."
 6 COFFEY, Q.C.:
 7 Q. So I take then though, Doctor, that though
 8 there were not actually any written policies
 9 or procedures for pathologists, as you pointed
 10 out, pathologists were -
 11 DR. HAEGERT:
 12 A. Well, I mean, it could have been, but I mean,
 13 it was common--most things were common
 14 knowledge.
 15 COFFEY, Q.C.:
 16 Q. Here, under the fifth last bullet, there's
 17 noted to be one of the challenges is
 18 maintaining staff morale. As the clinical
 19 chief, from your perspective, whose morale, if
 20 anyone, other than your own perhaps, did you
 21 have to or see it as your role and
 22 responsibility to try and maintain?
 23 DR. HAEGERT:
 24 A. Well, I would have said the morale of the
 25 people who reported to me. I think this was

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1 really referring to technologists' morale,
 2 because these are the ones who were most
 3 affected by the restructuring process. You
 4 know, if you change the reporting
 5 relationship, suddenly you close the person's
 6 laboratory. They have to move to another
 7 site. All of this is problematic, and you
 8 know, the culture changed. I mean, some of
 9 the pathologists had some difficulties with
 10 it, but primarily it was--that line is
 11 directed against the techs and not
 12 pathologists.
 13 COFFEY, Q.C.:
 14 Q. Doctor, in that regard, in terms of we've
 15 heard about concerns expressed by, at times by
 16 pathologists at St. Clare's about the future
 17 at the time and in the late '90s, the future
 18 of the lab at St. Clare's, and where it might
 19 be located, what it might be called upon to do
 20 and so on. What's your memory or recollection
 21 of that whole matter?
 22 DR. HAEGERT:
 23 A. Well, this was the kind of thing that was--we
 24 all discussed these issues, but we actually
 25 even had a retreat which brought together the

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1 managers and the site chiefs. I think those
 2 were the people there. Prior to the Grace
 3 closure, and one of the things we considered
 4 was what would be the best option to provide
 5 laboratory services. One option that was
 6 considered was to close all the labs, except
 7 the General Hospital laboratory. We actually
 8 decided, I mean, Vern Whelan and myself, we
 9 discussed it and Vern actually had a much
 10 better understanding of the technologists and
 11 the people, you know, most of the people than
 12 myself, because he actually was a technologist
 13 himself at one time and moved up through the
 14 ranks to become program director. We
 15 discussed this at some length and we felt that
 16 it would be such a cultural shock and huge
 17 blow to too many people if we actually said
 18 "okay, look the model we're going to come up
 19 with is a single site model." So we actually--
 20 so we didn't do that. We actually come up with
 21 a two-site model and there was still some
 22 unhappiness, for example, at the Grace.
 23 COFFEY, Q.C.:
 24 Q. And the advantages of a one-site model would
 25 have been what?

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<p>1 DR. HAEGERT:</p> <p>2 A. Well, it would have been--see, it's more,</p> <p>3 slightly more complicated than a one-site</p> <p>4 model because we could have had all the labs</p> <p>5 in one site, but the problem, one of the</p> <p>6 issues would be we wouldn't have had all the</p> <p>7 pathologists' offices at one site, because</p> <p>8 there's no space. So we would have had sort</p> <p>9 of a one-site model where all the--some of the</p> <p>10 pathologists were over at St. Clare's, and we</p> <p>11 thought--I mean, I don't know if we actually</p> <p>12 discussed that, but I mean, when we talk about</p> <p>13 it now, it's not logical really in some ways</p> <p>14 to do this, because I mean, also as long as</p> <p>15 surgery was going to be at St. Clare's, I</p> <p>16 mean, I think this is one of the things we</p> <p>17 picked up. As long as there was surgery or,</p> <p>18 you know, fine needle aspirates or biopsies at</p> <p>19 St. Clare's, it didn't make sense to close at</p> <p>20 least the pathology department. So finally,</p> <p>21 in 1999, what we came up with is a two-site</p> <p>22 model.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. Here, Doctor, the bottom bullet here is "to</p> <p>25 facilitate lines of communication with</p>	<p>1 immunohistochemistry, from time to time, there</p> <p>2 were issues.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Exhibit P-2537. Doctor, this is a laboratory</p> <p>5 management committee meeting number 11,</p> <p>6 September 20th, 2000. These are the minutes.</p> <p>7 You're listed as present. Paragraph 10.5,</p> <p>8 "proficiency programs. Wait until Dr. Whitman</p> <p>9 returns." See that? Dr. Whitman is not</p> <p>10 present, as you can see, there's regrets, Dr.</p> <p>11 L. Whitman, and do you recall what Dr.</p> <p>12 Whitman's involvement in this issue of</p> <p>13 proficiency programs was? Again, on this</p> <p>14 point, perhaps I could bring up as well, or</p> <p>15 ask the Registrar to bring up 2538. That was</p> <p>16 September 20th, 2000, the one we just looked</p> <p>17 at. These are the minutes of the same</p> <p>18 committee's meeting of January 17th, 2001.</p> <p>19 You're present and regrets from, amongst</p> <p>20 others, Dr. Whitman, and we go to the second</p> <p>21 page of the exhibit, 10.5, proficiency</p> <p>22 programs, in this case "(Canada wide) Atlantic</p> <p>23 Canada, awaiting Dr. Whitman." Do you recall</p> <p>24 what this was about?</p> <p>25 DR. HAEGERT:</p>
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<p>1 laboratory physicians and laboratory</p> <p>2 technologists." See that?</p> <p>3 DR. HAEGERT:</p> <p>4 A. Yeah, I see that.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. And this is listed under challenges. Now I'm</p> <p>7 going to ask you about the issue of</p> <p>8 communication between laboratory physicians</p> <p>9 and laboratory technologists. At times, were</p> <p>10 there concerns expressed about that, that were</p> <p>11 brought to your attention about any</p> <p>12 difficulties in communications, conflicting</p> <p>13 messages at times?</p> <p>14 DR. HAEGERT:</p> <p>15 A. Well, I think some of the managers felt that</p> <p>16 the communication should be really between the</p> <p>17 physician and the manager, not with the techs.</p> <p>18 But most pathologists spoke to the</p> <p>19 technologists as they felt it was appropriate.</p> <p>20 I mean, it wasn't abusive or anything, but it</p> <p>21 was more, you know, we're having some issue</p> <p>22 with this particular case or that particular</p> <p>23 case, and you know, the slides are poor</p> <p>24 quality. I mean, you know, it's always an</p> <p>25 issue. Regular staining, special stains,</p>	<p>1 A. No, I think I'm still waiting. I'm not sure.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Okay.</p> <p>4 DR. HAEGERT:</p> <p>5 A. I don't remember.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. You don't -</p> <p>8 DR. HAEGERT:</p> <p>9 A. If you give me a clue, probably it would come</p> <p>10 back to me, but I don't remember.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. What sort of position was Dr. Whitman?</p> <p>13 DR. HAEGERT:</p> <p>14 A. She was divisional chief of hematology.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Hematology, okay.</p> <p>17 DR. HAEGERT:</p> <p>18 A. Laboratory hematology.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. So it may have related to proficiency programs</p> <p>21 for hematology itself per se, as opposed to</p> <p>22 programs at large?</p> <p>23 DR. HAEGERT:</p> <p>24 A. I can't say. I really can't say.</p> <p>25 COFFEY, Q.C.:</p>

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1 Q. You can't recall, okay. Exhibit P-2399,
 2 please. Doctor, these are division of
 3 anatomical pathology, pathologists meeting.
 4 This is the notice of agenda, and when we look
 5 at the next page of the exhibit, these are the
 6 minutes themselves for February 21st, 2001,
 7 and there are a number of items discussed or
 8 noted to be discussed, but what I'd like to
 9 ask you about is item, paragraph 4.7,
 10 immunoperoxidase quality control. It reads "a
 11 survey has been undergoing" or has been
 12 ongoing, I presume, "for the quality control
 13 of immunoperoxidase staining. This will also
 14 be discussed in a site chiefs meeting to
 15 inform the pathologists of St. Clare's
 16 Hospital. A follow up will be given later
 17 on." Doctor, here, just to look back at this,
 18 you're noted to be present, as well as the
 19 other pathologists presumably at the General
 20 Hospital at the time, with the exception of
 21 Doctors Barron and M. Parai. Do you recall,
 22 Doctor, what this immunoperoxidase quality
 23 control matter was about?
 24 DR. HAEGERT:
 25 A. I think the--I'm pretty sure that the issue

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1 was whether on every run you put positive
 2 controls for every single antibody used. So if
 3 you're running a batch of ten different
 4 antibodies, do you put ten different controls
 5 or how often do you do the positive controls.
 6 I'd say that's the most probable explanation.
 7 I mean, it's -
 8 COFFEY, Q.C.:
 9 Q. It says "a survey has been undergoing." So
 10 what kind of--what would the survey--who would
 11 be surveyed?
 12 DR. HAEGERT:
 13 A. Presumably pathologists. I mean, it's
 14 unfortunate the minutes are not overly clear.
 15 COFFEY, Q.C.:
 16 Q. If I could, to elaborate a bit more, and
 17 that's February 21st, 2001, and that's the
 18 General Hospital site. If we could look,
 19 please, at Exhibit P-1874? Doctor, this is
 20 division of anatomical pathology, minutes of a
 21 meeting, site chiefs and divisional managers,
 22 February 22nd, 2001. Dr. Sushil Parai is the
 23 chair, chairs the meeting. You're there, as
 24 well as Dr. Cook and Mr. Gulliver and Mr.
 25 Murphy. If we look, Doctor, at page three of

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1 the exhibit, under paragraph 4.2, new
 2 business, "quality control of immunoperoxidase
 3 staining." It reads "there has been a study
 4 going on the quality of the immunoperoxidase
 5 staining for both sites. It is agreed the
 6 control for immunoperoxidase staining be run
 7 for every batch. A pathologist will check the
 8 control slide before sending the slide to the
 9 other site. Dr. S. Parai has agreed to do
 10 this. In case he is not available, another
 11 pathologist will be looking at the control,"
 12 and it goes on to talk about particular
 13 controls. Yes, it is a particular control,
 14 for a particular antibody. Doctor, does this
 15 assist in -
 16 DR. HAEGERT:
 17 A. Well, I think it seems that what I said before
 18 was right. In fact, what we're really talking
 19 about is positive controls for individual
 20 stains, for example CD20 or CD3 or whatever.
 21 COFFEY, Q.C.:
 22 Q. And was there some question about whether or
 23 not they were being run at all?
 24 DR. HAEGERT:
 25 A. Well, this--one of my interactions with Mr.

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1 Gulliver was possibly around this time is
 2 that--because I know we discussed the issue of
 3 positive controls and the question is how
 4 often do you run positive controls. Of
 5 course, in 2008 people do certain things; in
 6 2001 one of the issues was if you run a
 7 positive control an extra slide and you're
 8 using the Ventana equipment, which I don't
 9 know if it was a Ventana then or DAKO -
 10 COFFEY, Q.C.:
 11 Q. DAKO, DAKO would be the -
 12 DR. HAEGERT:
 13 A. I don't know how many slots there are in a
 14 DAKO instrument.
 15 COFFEY, Q.C.:
 16 Q. 48, probably.
 17 DR. HAEGERT:
 18 A. So if you're going to run--what it does is it
 19 gives you the option to run different
 20 antibodies staining different tissues and then
 21 the question is how many basic, I don't know,
 22 not really lanes, but how many slots would be
 23 occupied by the controls. So if you're
 24 running, say, 15 different antibodies, so you
 25 have 15 case antibodies and 15 antibodies,

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<p>1 first of all that occupies a lot of the 2 instrument and secondly, it's a cost issue. 3 And I remember talking to Mr. Gulliver about 4 this and he was very reluctant to include 5 antibodies on a routine basis, so we, I know 6 we discussed this at the site chiefs and the 7 divisional chiefs, but the resolution I can't 8 say, I don't recall. 9 COFFEY, Q.C.: 10 Q. So, for example, ER and PR slides that were 11 run on a particular day, would there 12 necessarily be an external control then? 13 DR. HAEGERT: 14 A. Oh, I think that's different. My 15 understanding is that they would have been. 16 But we're talking about other antibodies like- 17 -because often with other antibodies, like 18 CD20 or something, if you're staining a lymph 19 node, there would be normal cells and tumour 20 cells, so you can usually tell if the process 21 is working. 22 COFFEY, Q.C.: 23 Q. So in terms of this issue about whether or not 24 external positive controls should be run or 25 not related to some of the stains, some stains</p>	<p>1 anyone, was checking the external control 2 slides for ER/PR? 3 DR. HAEGERT: 4 A. It was Dr. Parai. 5 COFFEY, Q.C.: 6 Q. Okay. That was your - 7 DR. HAEGERT: 8 A. Yes. 9 COFFEY, Q.C.: 10 Q. And in his absence? 11 DR. HAEGERT: 12 A. Well then he would delegate the site chief 13 role to somebody else. I mean, it was normal 14 practice if I was away to delegate the role to 15 someone and if the site chief was away to 16 delegate it to somebody, so I mean, that would 17 be normal. 18 COFFEY, Q.C.: 19 Q. Were there any written records being kept of 20 that as to, like, the fact that Dr. Parai had 21 checked controls on a particular day and they 22 related to certain patients' slides? 23 DR. HAEGERT: 24 A. Well, I think our documentation probably 25 wasn't that great. I would suspect, no.</p>
<p>1 but you don't recall which particular ones, is 2 that - 3 DR. HAEGERT: 4 A. I think the--it's a bit hard to remember, but 5 I think one of the feelings was that if we're 6 going to be doing immunohistochemistry, we 7 should be running positive controls every day. 8 And then it was an issue, as I mentioned, of, 9 well, partly the equipment. I don't remember 10 how many DAKO immunostainers there were. I 11 think there was only one at the time. And so 12 if what you say is right, there's 48 slots, I 13 mean, you know, you could be running half your 14 slots for controls. 15 COFFEY, Q.C.: 16 Q. Doctor, here the assertion that a pathologist 17 will check the control slide before sending 18 the slide to the other site, this is between 19 St. Clare's - 20 DR. HAEGERT: 21 A. Yeah. 22 COFFEY, Q.C.: 23 Q. And the General back and forth. "Dr. Parai 24 has agreed to do this." What was your 25 understanding then in early 2001 about who, if</p>	<p>1 COFFEY, Q.C.: 2 Q. Were you aware at the time of the deficiency 3 in that regard, do you remember that kind of 4 being aware of, consciously aware of it at 5 that time? 6 DR. HAEGERT: 7 A. You mean of the documentation? 8 COFFEY, Q.C.: 9 Q. Yeah, the deficiency, as you've just said, 10 perhaps it was, you understand perhaps it was 11 deficient at the time, looking back on it now, 12 were you aware at the time, in 2001, that - 13 DR. HAEGERT: 14 A. Probably aware of it. You know, one of the 15 things you should recognize, perhaps, and 16 maybe the Commission should recognize, you 17 know, there is some--one of the external 18 reviewers came in and said, you know, one of 19 the things that she was surprised about was 20 the lack of standard operating procedures and 21 so that things were not documented, but that 22 was actually, I don't think that was all that 23 uncommon. Until one has an appropriate 24 external accrediting body looking at things, 25 standard operating procedures were not</p>

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<p>1 commonly written. So they were common in 2 Ontario because they had the quality 3 management program in Ontario, but I can tell 4 you at the--not the Health Care Corporation, 5 McGill University Health Centre in Montreal, 6 which is huge, and I would say probably 7 significantly larger than Mount Sinai 8 Hospital, though I never compared it, we were 9 accredited in 2007 and before the 10 accreditation someone said that we actually 11 had to write 500 standard operating procedures 12 because basically we didn't have any. And I 13 think that's not--it doesn't actually reflect 14 in any way either in the fact that the lab is 15 good or bad, it's actually--it's more or less 16 in some ways doesn't actually serve as a 17 measure of that. All it means is that these 18 things are documented. And what happens, of 19 course, I don't--one would wonder whether that 20 is actually--I mean, this is one of the 21 questions that has always been in my mind, is 22 this laboratory here being accredited by the, 23 you know, the Canadian Council of Health 24 Services Accreditation, because if it were, 25 many of the things that Trish what's her name,</p>	<p>1 context? 2 DR. HAEGERT: 3 A. Yeah, I think what's happened is that, you 4 know, in pathology the workload has gone up 5 progressively and the case complexity has gone 6 up progressively. Pathologists are spending 7 more and more time making diagnosis. I mean, 8 it used to be many years ago that, for 9 example, on something like a breast cancer was 10 actually you might have, say, ten slides on a 11 case. Nowadays it's routine to get 40, 50 or 12 more slides. Could take an hour or two hours 13 even to look at one case. So that it's much 14 more logical if you have somebody who's 15 adequately trained to process the gross so 16 that pathologists can actually do the tasks 17 which are the highest level of sophistication. 18 But of course the critical thing is to have 19 well trained pathology assistants. 20 COFFEY, Q.C.: 21 Q. And you then, I take it, were in favour of 22 them in 2001? 23 DR. HAEGERT: 24 A. Yes, of course. 25 COFFEY, Q.C.:</p>
<p>Page 237</p> <p>1 Wegrynowski, and I'm not sure how you 2 pronounce her name, criticized, all that stuff 3 would have been addressed. They would have 4 had to address it prior to the accreditation. 5 Didn't mean things were good or bad, it just 6 meant they weren't formally documented. 7 COFFEY, Q.C.: 8 Q. Exhibit P-2539? Doctor, this is a--an agenda 9 for and then the minutes of a meeting of April 10 24, 2001 by the Division of Anatomical 11 Pathology. Page 2 of the minutes--page 3, 3.8 12 "Pathologist Assistant." And the notes are 13 "Been much discussion on this issue, however, 14 Dr. Haegert will discuss with Dr. Williams in 15 the future. However, there is no money in the 16 budget to fund this position." Doctor, what 17 was your view of pathologist assistants? 18 DR. HAEGERT: 19 A. Well, pathology assistants are typically 20 individuals who are--have special training and 21 in my experience what they do is they 22 participate in the, or the help with the 23 grossing of surgical specimens. 24 COFFEY, Q.C.: 25 Q. And did you see them as desirable in this</p>	<p>Page 239</p> <p>1 Q. And did you talk to Dr. Williams about it? 2 DR. HAEGERT: 3 A. Yes, I did. 4 COFFEY, Q.C.: 5 Q. And he told you what? 6 DR. HAEGERT: 7 A. Huh, he said there was no money basically in 8 simplistic terms. 9 COFFEY, Q.C.: 10 Q. Okay. Exhibit P-1876. Doctor, these are the 11 minutes of a meeting of site chiefs and 12 divisional managers, April 25th, 2001. You're 13 noted, amongst others, to be there. There's 14 a--have a post-it note over it but there are a 15 number of individuals present, including 16 yourself. Under "Business Arising" paragraph 17 2, "Quality Control of Immunoperoxidase 18 Staining" says, "Generally the immunos appear 19 to be very good: there appears to be some 20 problems with the estrogen and progesterone 21 receptors. Positive controls are checked 22 daily by a pathologist. However, these need 23 to be documented. Dr. Parai will follow-up on 24 this. Note is also made of heavy utilization 25 of immuno services and the high volumes</p>

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1 encountered." And in terms of that, Doctor,
 2 heading "Quality Control of Immunoperoxidase
 3 Staining" I take it someone then was looking
 4 at it or examining this issue in April of
 5 2001?
 6 DR. HAEGERT:
 7 A. Well, I would have certainly have thought so,
 8 yes.
 9 COFFEY, Q.C.:
 10 Q. And "The immunos appear to be very good."
 11 Notes, "There appear to be some problems with
 12 the estrogen and progesterone receptors." Do
 13 you recall what those problems were?
 14 DR. HAEGERT:
 15 A. No, I'm afraid not, no.
 16 COFFEY, Q.C.:
 17 Q. The note that, "The positive controls are
 18 being checked daily by a pathologist. These
 19 need to be documented." which is the issue I
 20 just asked you about in terms of documented,
 21 as far as you know that afterward there was no
 22 amount of record kept, per se, on a log sheet,
 23 that you were aware?
 24 DR. HAEGERT:
 25 A. Well, I think what--I mean, it seems the

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1 essence here is that Dr. Parai as of then
 2 would document them. That would be my
 3 interpretation of that. It's hard to look
 4 back at minutes. You realize how badly the
 5 document phenomenon really what's going on and
 6 what are people saying and what's happening.
 7 COFFEY, Q.C.:
 8 Q. And now, Doctor, on this point, if we could
 9 bring up, please, Exhibit, I'll say P-2149?
 10 Doctor, this sort of form, it's a special
 11 procedure request form. This, I take it, was
 12 the sort of form utilized to have pathologists
 13 to order IHC stains?
 14 DR. HAEGERT:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. This particular one involves an ER and PR -
 18 DR. HAEGERT:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. And it happens to be dated January 28th, 2002.
 22 DR. HAEGERT:
 23 A. Right.
 24 COFFEY, Q.C.:
 25 Q. And here that ER/PR test was apparently done

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1 and then repeated twice. You see the dates
 2 down here? And the Commissioner has heard
 3 some evidence from the technologist in
 4 relation to this. I'll just take you through
 5 some others. Page 3 of the exhibit, it's an
 6 ER/PR. You'll see there again, this is an
 7 indicator to the Commissioner, this would
 8 indicate that it's a repeat. No, this could
 9 be a HER2/neu, perhaps, the ER/PR is the first
 10 and then the second one is the HER2/neu. At
 11 page 5 of the exhibit, it's an ER/PR case.
 12 Again, it's repeated, done February 27th,
 13 repeated March 1. And there are, when we look
 14 down through this, there are a number of cases
 15 where certainly in 2002, beginning early in
 16 2002 in these request forms that we have and
 17 it continues on at times into 2003, a number
 18 of instances where the ER and PR tests had to
 19 be repeated. You can -
 20 DR. HAEGERT:
 21 A. I can see this, yeah, okay.
 22 COFFEY, Q.C.:
 23 Q. And there were quite a number. I can take
 24 you, you can kind of sit here and go through
 25 them and the Commissioner has already had that

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1 done for her, okay. Do you recall that ever
 2 being brought to your attention?
 3 DR. HAEGERT:
 4 A. No, never.
 5 COFFEY, Q.C.:
 6 Q. Do you think it, as chair--I don't know if--I
 7 mean, as the clinical chief do you think it
 8 ought to have been if there was a problem at
 9 times of ER/PR tests having to be repeated for
 10 whatever reason and there are a number of
 11 different reasons been given to the
 12 Commissioner?
 13 DR. HAEGERT:
 14 A. Well, I would have thought if there was a
 15 problem and the problem persisted, then I
 16 should have been advised. I mean, it seems
 17 that what they're doing here is they're
 18 repeating it, I mean, one would imagine it's
 19 on the same block.
 20 COFFEY, Q.C.:
 21 Q. Yes.
 22 DR. HAEGERT:
 23 A. I mean nowadays, in 2008, you wouldn't do
 24 that. What you would do, I mean, what--
 25 depends what the problem was. I mean, if the

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

14 COFFEY, Q.C.:
 15 Q. Now, up to the time that you left St. John's
 16 in 2002, were you aware of the need in ER/PR
 17 cases to look for internal controls, up to the
 18 time you left St. John's?

19 DR. HAEGERT:
 20 A. No.

21 COFFEY, Q.C.:
 22 Q. When did you first become alerted to that?

23 DR. HAEGERT:
 24 A. Well, I moved to Montreal in 2002. I think
 25 one of the issues, actually, in the Health, or

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

9 COFFEY, Q.C.:
 10 Q. Okay. It was after you arrived in Montreal?

11 DR. HAEGERT:
 12 A. Yeah, I think it was common knowledge and when
 13 things are common knowledge everybody seems to
 14 suddenly find out about it.

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

23 DR. HAEGERT:
 24 A. No, no, I was never--that was never discussed,
 25 to my knowledge.

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1 COFFEY, Q.C.:
 2 Q. If it had happened, do you think as the
 3 clinical chief would you have expected to be
 4 told? Like if, for example, if a person
 5 reported as negative, negative and then was
 6 reported as, I don't know, a positive,
 7 positive or 80, 80, which presumably might
 8 have clinical ramifications or could have
 9 clinical ramifications, as clinical chief
 10 would you have expected to be told that?

11 DR. HAEGERT:
 12 A. I would have expected the pathologist involved
 13 would have at least discussed it with the site
 14 chief and if at that time it was Khalifa
 15 developing the methodology, then he would have
 16 told me. And if it wasn't him, I would have
 17 expected Dr. Paria or Dr. Cook or somebody
 18 else to tell me.

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

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

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

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

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<p>1 already existing program from another province 2 was entertained. Dr. Whitman and Dr. 3 Hutchinson to follow-up as to what is 4 available and conditions." Does that assist 5 you in any way in remembering what this 6 proficiency programs and Dr. Whitman involved? 7 First of all I'll ask you, what type of a 8 doctor was Dr. Hutchinson? 9 DR. HAEGERT: 10 A. He was a medical microbiologist. 11 COFFEY, Q.C.: 12 Q. So Dr. Whitman was a? 13 DR. HAEGERT: 14 A. Hematologist. 15 COFFEY, Q.C.: 16 Q. Which is a different - 17 DR. HAEGERT: 18 A. She was actually a clinical hematologist but 19 it moved into the laboratory, so she was 20 actually divisional chief of the lab and Dr. 21 Hutchinson was divisional chief of medical 22 microbiology. 23 COFFEY, Q.C.: 24 Q. So the divisional--two different divisional 25 chiefs?</p>	<p>1 DR. HAEGERT: 2 A. Well - 3 COFFEY, Q.C.: 4 Q. Interprovincial? 5 DR. HAEGERT: 6 A. - the proficiency program we're talking about, 7 is this a proficiency program for 8 professionals or for technologists? I mean, 9 it doesn't say and I can't say. I mean, we 10 were a part of programs in some of the 11 laboratories, sure. 12 COFFEY, Q.C.: 13 Q. And Exhibit P-1877? Doctor, this is are the 14 minutes of, page, beginning of page 2, minutes 15 of a meeting of June 26th, 2001, site chiefs 16 and divisional managers. Under "Business 17 Arising" paragraph 2, "HER2 expression, ER and 18 PR control. Controls for all these 19 immunostaining are checked by the site chief 20 or by a call pathologist when site chief is 21 not available." And you'll note here that you 22 are listed as being present with Doctors Parai 23 and Cook. So it was your understanding, I 24 take it, in mid 2001, that the General 25 Hospital was having someone check the</p>
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<p>1 DR. HAEGERT: 2 A. Correct. 3 COFFEY, Q.C.: 4 Q. And there's reference to pros and cons and the 5 option of joining an already existing program, 6 proficiency program, existing program from 7 another province. You can't recall what that 8 was about? Because it occurs a number of 9 times, I've referred you to two of them, Dr. 10 Whitman's - 11 DR. HAEGERT: 12 A. Actually, I don't remember this. 13 COFFEY, Q.C.: 14 Q. Okay. 15 DR. HAEGERT: 16 A. I mean, Dr. Whitman, as you showed, was not 17 there in two of the meetings and then this 18 meeting, I mean, the details aren't there and 19 I just can't remember. I mean, are we talking 20 Ontario? I can't say, actually. 21 COFFEY, Q.C.: 22 Q. So at the time, though, I take it, it was 23 known within the program that, in St. John's, 24 that the program was not part of any such 25 external proficiency?</p>	<p>1 controls? 2 DR. HAEGERT: 3 A. Yeah. 4 COFFEY, Q.C.: 5 Q. For these particular stains. In checking the 6 controls, Doctor, what was your understanding 7 as to what they were to be looking for? 8 DR. HAEGERT: 9 A. Well, as I already said, these were external 10 controls. It basically is a question-- 11 basically it's a test to see whether the 12 procedure is actually working, period. And so 13 they would be looking for the appropriate 14 staining and appropriate intensity of 15 staining. 16 COFFEY, Q.C.: 17 Q. What would be appropriate in this context, 18 what was your understanding of what was 19 appropriate in this context? 20 DR. HAEGERT: 21 A. Well - 22 COFFEY, Q.C.: 23 Q. For ER/PR? 24 DR. HAEGERT: 25 A. Well, see, I don't remember what the precise</p>

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<p>1 control was. I mean, I know there's a lot of 2 information available now about what type of 3 controls that one should use. But I would 4 have thought they would--I believe what we 5 used. I'm not sure what our control was. I 6 don't know if it was endometrium or another 7 breast case or, but what one expect is, at 8 least I think this is what was going on, is 9 that we would use a case that was strongly 10 positive. But I'm not entirely sure, really. 11 I know there was a control and I don't even 12 remember what the control was. I mean, there 13 are several options for controls. 14 COFFEY, Q.C.: 15 Q. If you expected strong staining, you know, 16 because of the nature of the control, if that 17 was expected and the external control stained 18 weakly, from your perspective what was the 19 appropriate approach then? 20 DR. HAEGERT: 21 A. Well, now, I mean, of course we know perfectly 22 well that that's a problem, I mean, that's 23 probably not the appropriate control. But 24 what I don't know is what we used then. I 25 mean, I would say that if we got weak staining</p>	<p>1 you know, studies and their conclusions about 2 certain aspects of ER/PR, at least that they 3 found in the UK, when did you first become 4 aware of that? 5 DR. HAEGERT: 6 A. Well, since I'm under oath, the honest answer 7 is since this is not an area that I really 8 read in, I only started, I thought, okay, I 9 should look up what the literature says a few 10 months ago and then, you know, I found this. 11 That's the truth of it. 12 COFFEY, Q.C.: 13 Q. I take it, Doctor, that in--because in your 14 current practice you do not deal with ER/PR 15 cases yourself? 16 DR. HAEGERT: 17 A. I do. 18 COFFEY, Q.C.: 19 Q. Oh, you do? 20 DR. HAEGERT: 21 A. Um-hm. 22 COFFEY, Q.C.: 23 Q. Okay. So in doing, dealing with them up until 24 recently you weren't aware of the Rhodes 25 publications, and there's a series of them?</p>
<p>1 now in something that we expect strong 2 staining, it clearly is a problem, presumably 3 a technical problem. But you've heard all 4 kinds of stuff about the controls, I mean, 5 there's masses of information and everybody--I 6 would say that there can't be--there's hardly 7 a pathologist in North America that's not well 8 aware of all of this. 9 COFFEY, Q.C.: 10 Q. Now? 11 DR. HAEGERT: 12 A. In many--yeah, of course. But to go back, you 13 know, a number of years and say what did I 14 know then is hard, difficult, actually. 15 COFFEY, Q.C.: 16 Q. Doctor, in that regard I wanted to ask you 17 something over the break. We have seen 18 references, anyway, to studies prepared by a 19 Dr. Rhodes published in the beginning of 2001, 20 a series of studies involving studies in the 21 UK involving ER/PR? 22 DR. HAEGERT: 23 A. Yeah. 24 COFFEY, Q.C.: 25 Q. When did you first become aware of the Rhodes,</p>	<p>1 DR. HAEGERT: 2 A. No. 3 COFFEY, Q.C.: 4 Q. Doctor, you have had a chance to review them 5 recently or relatively recently. I take it 6 would it be fair to say that Dr. Rhodes and 7 his colleagues expressed some significant 8 concerns about ER/PR testing at the time in 9 the UK? Would that be a fair? 10 DR. HAEGERT: 11 A. Correct, yes. 12 COFFEY, Q.C.: 13 Q. That's a characterization, I think. And in 14 reading it would it be fair to say that 15 there's no reason in reading what he's 16 written, what is written there, that it would 17 be limited to the UK, there's no reason to 18 believe it would be? 19 DR. HAEGERT: 20 A. No. I would imagine that's - 21 COFFEY, Q.C.: 22 Q. No. Probably - 23 DR. HAEGERT: 24 A. - generalizable. 25 COFFEY, Q.C.:</p>

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<p>1 Q. What I wanted to ask you, Doctor, was is this, 2 because these were journal articles and 3 they're published in reputable journals and 4 there are a number of them over a period of a 5 couple of years, was there any mechanism in 6 place at the time, 2000, 2001, 2002, in St. 7 John's, anyway, whereby that sort of warning 8 to pathologists in general that appears in 9 those articles concerning ER/PR testing, and 10 it is a warning, I think you'd agree with 11 that, I mean, he points out there are a number 12 of problems with this, potentially?</p> <p>13 DR. HAEGERT:</p> <p>14 A. Yeah, he does.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Was there any mechanism in place whereby that 17 could be--would be routinely brought to 18 pathologists' attention?</p> <p>19 DR. HAEGERT:</p> <p>20 A. Well, that would be the kind of thing that if 21 it was raised, it would be brought up at one 22 of our, you know, teaching rounds.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. Okay. And you certainly don't recall it ever 25 being brought up?</p>	<p>1 continue. 3, "Outstanding reports. This has 2 been in place for both sites and will continue 3 for both surgicals and autopsy." 4, "Canned 4 text. There is partial implementation of 5 canned text at the General Hospital site for 6 ER/PR and HER2/neu expression. It is 7 important to use standard specimen grossing 8 and reporting." 5, "Frozen section review. 9 It is important for every three months to 10 review the frozen section diagnosis and 11 compare with the final report." 6, 12 "Performance improvement program. 13 Institutional case review, (a) American 14 Colleague of Pathologists material will be 15 used as well, (b) American Society of Clinical 16 Pathologists check sample review." Go on to 17 the next page, paragraph 7, "Quality control 18 rounds. (a) Interdepartmental rounds 19 presently in place at both sites." And it 20 notes the ones that the Health Sciences Centre 21 has. "(b) Intradepartmental round. This has 22 been in place at both the sites." Describes 23 them, on which days they occur. "Inter- 24 hospital rounds. Monthly pathology rounds 25 participated by all the pathologists and</p>
<p>Page 257</p> <p>1 DR. HAEGERT:</p> <p>2 A. No.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. I take it? But you would have to rely upon, I 5 take it, at the time, in the structure that 6 then existed, someone to bring it up at a--to 7 come across it and to bring it up at a 8 teaching round, that's in effect what was 9 required?</p> <p>10 DR. HAEGERT:</p> <p>11 A. Yeah. Or the site chief at one of the sites 12 would identify it and advise others.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. In this regard, Doctor, and her under "New 15 Business" in this particular June 26th, 2001 16 minutes there's "Quality assurance program for 17 anatomical pathology/pathologists review." 18 See that? And "This meeting is dedicated for 19 the above items and the following points are 20 discussed." "System review" is No. 1. 21 "System review is not in place. It will be 22 discussed in the next meeting for possible 23 implementation of pathology report reviews by 24 system by a committee." 2, "Turn around time. 25 This has been in place for both sites and will</p>	<p>Page 259</p> <p>1 residents. Cases are discussed in depth with 2 up-to-date information. (d) Intradepartmental 3 consultation. Going on at both sites, 4 however, St. Clare's Hospital has proper 5 documentation of consultation and the General 6 this hasn't always been done." And you refer 7 to Dr. Khalifa, in fact, I think, having 8 expressed some interest in doing that earlier. 9 And "(e) Eternal consultation. This is in 10 place at both sites. The cases are referred 11 to CRCCP, ATIPP, etcetera." So, Doctor, as of 12 June, 2001 what was the impetus for this?</p> <p>13 DR. HAEGERT:</p> <p>14 A. Well, I think there had been a recognition for 15 sometime that it had been difficult to 16 initiate quality control activities within the 17 department, largely because of turn around of 18 staff, etcetera, and it was time to institute 19 that. And a lot of these things are already 20 in place. As you noticed, a lot of these 21 things are in place.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Yes. A number of them are noted, in fact, to 24 be in place.</p> <p>25 DR. HAEGERT:</p>

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<p>1 A. Yes.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. And there are others that are plans to put</p> <p>4 them in place. I take it then, Doctor, that</p> <p>5 there was a recognition at the time that there</p> <p>6 was perhaps a gap or a lack of kind of a full,</p> <p>7 full gamut approach to -</p> <p>8 DR. HAEGERT:</p> <p>9 A. I think there had always been a recognition</p> <p>10 that we needed to do more. But then, as I</p> <p>11 mentioned before, the question is then who's</p> <p>12 going to do it and do we have dedicated</p> <p>13 personnel to doing that. You can't do this on</p> <p>14 a sort of a, you know, 4:15 on a Friday</p> <p>15 afternoon and try to actually come up with</p> <p>16 some kind of a comprehensive quality assurance</p> <p>17 program. You have to actually have dedicated</p> <p>18 personnel who are dedicated technologists with</p> <p>19 pathologists involvement.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. Doctor, the reference there at paragraph 1,</p> <p>22 4.1 to a system review, do you remember what</p> <p>23 the system review was? In this context what</p> <p>24 would system review have been?</p> <p>25 DR. HAEGERT:</p>	<p>1 aware of the issues of fixation, it's common</p> <p>2 knowledge. You learn that as a resident. But</p> <p>3 were there exceptional -</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Yes.</p> <p>6 DR. HAEGERT:</p> <p>7 A. No, I was unaware of, really.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. And in particular, any issues involving ER/PR</p> <p>10 testing, related to ER/PR testing itself, any</p> <p>11 issues?</p> <p>12 DR. HAEGERT:</p> <p>13 A. You mean in fixation, is that what you were</p> <p>14 asking?</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. No, just generally.</p> <p>17 DR. HAEGERT:</p> <p>18 A. No.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. Okay. So there were none, in particular,</p> <p>21 related to fixation? I appreciate a</p> <p>22 particular slide might have a fixation</p> <p>23 problems and you've--you know, any pathologist</p> <p>24 would be expected to recognize that.</p> <p>25 DR. HAEGERT:</p>
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<p>1 A. I can't say. I mean, I really can't answer</p> <p>2 that.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Sure. I appreciate that. Pardon me?</p> <p>5 MR. SIMMONS:</p> <p>6 Q. (Inaudible).</p> <p>7 DR. HAEGERT:</p> <p>8 A. No, I mean, I wouldn't think it would be that.</p> <p>9 I mean, I could speculate, but I actually</p> <p>10 don't -</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. You don't recall?</p> <p>13 DR. HAEGERT:</p> <p>14 A. No.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. I appreciate that, Doctor. Doctor, did you</p> <p>17 ever become aware of any problems related to</p> <p>18 tissue fixation, tissue processing, tissue</p> <p>19 fixation that was brought to your attention?</p> <p>20 DR. HAEGERT:</p> <p>21 A. When I was there?</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Yes.</p> <p>24 DR. HAEGERT:</p> <p>25 A. Not really. I mean, every pathologist is well</p>	<p>1 A. Yeah.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. But in a more systematic way or a general</p> <p>4 problem, it was never brought to your</p> <p>5 attention that we have a problem with</p> <p>6 fixation?</p> <p>7 DR. HAEGERT:</p> <p>8 A. No, as a generic system type problem, no. I</p> <p>9 mean, obviously we know that from time to time</p> <p>10 cases come from the operating room and they</p> <p>11 never get into fixative, I mean, this is</p> <p>12 known, but as a general problem, no.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. And you've indicated that you were not made</p> <p>15 aware of any conversion in ER/PR testing, like</p> <p>16 first testing -</p> <p>17 DR. HAEGERT:</p> <p>18 A. No, I was never told this.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. And you were never made aware, I take it you</p> <p>21 never had any yourself that you were--you</p> <p>22 certainly never reordered an ER/PR test and</p> <p>23 had it convert?</p> <p>24 DR. HAEGERT:</p> <p>25 A. Not to my knowledge.</p>

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1 COFFEY, Q.C.:

2 Q. Not to your knowledge. Doctor, in terms of,

3 well, while I have you here, because you are--

4 hold the senior position in the institution

5 you're in, how is ER/PR handled in, ER/PR

6 testing handled in the hospital system that

7 you are a part of, is it limited to particular

8 people, overseen by particular people or is it

9 generally handled by all the pathologists

10 there?

11 DR. HAEGERT:

12 A. Well, generally we have a subspecialty

13 approach to pathology in general. But the

14 case volume is much, I would say is much

15 larger than here, it's far more than--more

16 than 60,000 surgicals a year. Now, I don't

17 know, but when I left here, it was roughly

18 30,000 or something like that and I think it's

19 around 64, 65 thousand. So what we try to do

20 is a subspecialty practice. But as mentioned

21 that one of the difficulties with a

22 subspecialty practice, and we have some--many

23 of the issues that were present in the Health

24 Care Corporation, people come and they go. We

25 have problems with recruitment and retention.

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1 And so what typically happens is even though

2 we have one person who's primarily the breast

3 pathologist, others such as myself do some

4 breast pathology. But a lot of the issues

5 about the estrogen receptor testing relates to

6 how the tissue is handled.

7 COFFEY, Q.C.:

8 Q. Yes.

9 DR. HAEGERT:

10 A. So, I mean, obviously you've been here every

11 day while I haven't been here every day. But

12 the way--and I don't know how the tissue is

13 handled here or in Toronto but my feeling is

14 that what some of the things that the external

15 consultant said about the way tissue is

16 handled does not apply in Montreal. Most of

17 it--I mean, I can tell you that most of the

18 cases in Montreal the diagnosis is made on

19 needle core, so I would say as a guess 90

20 percent of cases or maybe more are diagnosed

21 on needle core biopsies, so fixation is never

22 an issue. So basically take a number of

23 needle cores and they're put into Formalin

24 right away. And then the definitive surgery

25 is a lumpectomy or, you know, excisional

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1 biopsy of the tumour and then what happens,

2 the pathologist is called to the operating

3 room and we actually cut it together with

4 pathology assistant, we look at it and then we

5 actually take the cut sections and put them on

6 a cork board and then they're fixed. So most

7 of the issues that, you know, that Trish

8 Wegrynowski mentioned really do not apply in

9 our institution, I mean, because we--and I

10 don't know what's done here. I don't--I've

11 actually forgotten, to be honest, because I

12 went to a new place and we did something--it

13 was quite different when I went there and sort

14 of, I learned a new system. So most of the

15 time, things like fixations is not an issue,

16 and so basically, all of us who do breast

17 cancer pathology in Montreal, at McGill

18 University Health Centre, what we were doing

19 for a long time, we were doing estrogen

20 receptor and progesterone receptors and

21 HER2/neu on the core and also the final

22 excision. But then eventually what we did is

23 we stopped doing it on the needle core and did

24 it on excision, because what the oncologists

25 really wanted to know was what the estrogen

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1 receptor status was on the excisional biopsy,

2 and because of this Commission, I mean, I can

3 tell you that's what's happened is people have

4 become very much more alert to the issues

5 about what happens if the estrogen receptors

6 are negative, because the majority are

7 positive, of course, so what we tend to do is

8 we do--we repeat them on another block, if

9 there is another block, and if that's

10 negative, we also repeat it on another block.

11 So I mean, it's almost like -

12 COFFEY, Q.C.:

13 Q. Double and triple checking.

14 DR. HAEGERT:

15 A. It's sort of, yeah, basically sometimes you

16 end up doing three blocks, and we play--I

17 mean, of course, everybody knows now about the

18 importance of internal controls, so we look

19 very carefully at the internal controls and if

20 they're not strongly positive, we wonder about

21 whether there's an issue in fixation or

22 antigen retrieval or some technical issue, and

23 probably repeat on another block. But we're

24 all wise in retrospect, unfortunately.

25 COFFEY, Q.C.:

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1 Q. They're the questions I have, Commissioner.
 2 THE COMMISSIONER:
 3 Q. Thank you, Mr. Coffey. Do you have any
 4 questions, Mr. Pritchard?
 5 MR. PRITCHARD:
 6 Q. I don't have any questions for this witness.
 7 Thank you, Commissioner. Thank you, Dr.
 8 Haegert.
 9 THE COMMISSIONER:
 10 Q. Mr. Simmons, I'm just wondering whether I
 11 should give this witness a break before you
 12 ask your questions or are you going to tell me
 13 that you're going to be such a short period of
 14 time that -
 15 MR. SIMMONS:
 16 Q. Probably at least ten minutes and maybe that
 17 might be all.
 18 THE COMMISSIONER:
 19 Q. Can we do the room? Ms. Newbury, do you have
 20 any questions?
 21 MS. NEWBURY:
 22 Q. Five minutes.
 23 THE COMMISSIONER:
 24 Q. Mr. Pritchett?
 25 MR. PRITCHETT:

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1 Q. No questions, Commissioner.
 2 MR. PIKE:
 3 Q. No questions.
 4 THE COMMISSIONER:
 5 Q. Ms. Brocklehurst?
 6 MS. BROCKLEHURST:
 7 Q. No questions.
 8 THE COMMISSIONER:
 9 Q. Mr. Browne?
 10 MR. BROWNE:
 11 Q. Depending on my colleagues, I would say five
 12 to ten.
 13 THE COMMISSIONER:
 14 Q. Okay. Well, why don't we give him a break,
 15 and then we'll complete. Thank you.
 16 (BREAK)
 17 THE COMMISSIONER:
 18 Q. Please be seated. Mr. Simmons.
 19 DR. DAVID HAEGERT, EXAMINATION BY MR. DANIEL SIMMONS
 20 MR. SIMMONS:
 21 Q. Thank you, Commissioner. Good afternoon, Dr.
 22 Haegert. I'm Dan Simmons. I'm the lawyer for
 23 Eastern Health. A few questions for you
 24 arising out of some of the things that you've
 25 had to say this morning. First of all, you

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1 gave us a description of some of the effects
 2 of the consolidation that happened when the
 3 Health Care Corporation was formed back in
 4 1996, and one of those things being there had
 5 to be a reduction in the budget and there was
 6 a reduction in the number of managers, and you
 7 described all that for us this morning, I
 8 believe.
 9 DR. HAEGERT:
 10 A. Yes.
 11 MR. SIMMONS:
 12 Q. Through that same time period, when that was
 13 taking place, and the number of people who
 14 were managing the system was being reduced,
 15 what was happening with the workload and the
 16 volume of cases being handled by anatomical
 17 pathology in that time period? Was it
 18 stagnant? Was it decreasing or was it
 19 increasing?
 20 DR. HAEGERT:
 21 A. Well, I would say that the workload in
 22 anatomic pathology everywhere has gone up
 23 progressively, and as I think I said already
 24 that also the case complexity has gone up. So
 25 what one has to do with individual cases,

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1 certainly with cancer cases, has increased.
 2 So I would say definitely gone up here.
 3 MR. SIMMONS:
 4 Q. And was that the case also back in '96, '97,
 5 '98, the time period in which there was some
 6 downsizing in the number of managers in the
 7 laboratory services in St. John's?
 8 DR. HAEGERT:
 9 A. I would say. I mean, it's virtually
 10 impossible to imagine that it was not going
 11 up, because it is everywhere.
 12 MR. SIMMONS:
 13 Q. Yes. Following that period, when those cuts
 14 in management took place, up until when you
 15 left in 2002, was there any growth after that
 16 in the number of managers available? Did you
 17 manage to increase the number of managers
 18 after that, or did it pretty well stay the
 19 same until you left?
 20 DR. HAEGERT:
 21 A. No, it was--once we came up with the final
 22 model, the number of managers, it--ah, good
 23 question. Either it was static, but the
 24 intent was actually to reduce as the sites
 25 reduced. Now I don't recall whether we

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1 actually reduced them all. Oh, actually,
 2 yeah, we did, because I remember that at least
 3 some of the managers were reduced in numbers.
 4 MR. SIMMONS:
 5 Q. Even after that first round?
 6 DR. HAEGERT:
 7 A. During the period of time I was here. I mean,
 8 first of all, there was this large cut.
 9 MR. SIMMONS:
 10 Q. Yes.
 11 DR. HAEGERT:
 12 A. And then there was a second reduction, because
 13 I remember that--I mean, one of the examples,
 14 I remember two examples. The manager in--
 15 instead of having two managers in anatomic
 16 pathology, it was reduced to one.
 17 MR. SIMMONS:
 18 Q. Right.
 19 DR. HAEGERT:
 20 A. In hematology, it was reduced from two to one.
 21 Biochemistry, I'm not sure that I remember.
 22 But likely it was a similar model.
 23 MR. SIMMONS:
 24 Q. Right. So that by the time you left in 2002,
 25 there were even fewer managers in the lab than

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1 when you'd gone through that initial round of
 2 cuts when the Health Care Corporation was
 3 formed?
 4 DR. HAEGERT:
 5 A. Right.
 6 MR. SIMMONS:
 7 Q. Okay. Through, up until the time you left in
 8 2002, were there any positions in laboratory
 9 services where people were dedicated to
 10 quality assurance activities?
 11 DR. HAEGERT:
 12 A. No.
 13 MR. SIMMONS:
 14 Q. Was there any capacity to devote someone to a
 15 dedicated position like that, given the
 16 resources that you had available in that time
 17 period?
 18 DR. HAEGERT:
 19 A. No. The logical person would be a manager,
 20 but we didn't have--as you've heard, there
 21 wasn't a surplus of managers. It was really
 22 the opposite.
 23 MR. SIMMONS:
 24 Q. Right. So up until the time you left in 2002,
 25 what kind of expectations were there within

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1 the lab among the pathologists and lab
 2 leadership about what kind of resources could
 3 be made available for new initiatives? Was
 4 there a feeling that if there was a good new
 5 initiative, they could go and get the money
 6 for it? Was there the opposite feeling, that
 7 if there were things they wanted to do, that
 8 it would be very difficult to get new money
 9 for things? Was there any perception among
 10 lab leadership in that time period?
 11 DR. HAEGERT:
 12 A. Well, I mean, certainly myself and Vern Whelan
 13 were aware that if we could make a case, we
 14 could make a case through the Health Care
 15 Corporation to government to obtain additional
 16 funds, and we actually did do that.
 17 MR. SIMMONS:
 18 Q. So it would require then going, not just to
 19 the leadership within the Health Care
 20 Corporation, but beyond that, through to
 21 government, in order to find new funding for
 22 new initiatives?
 23 DR. HAEGERT:
 24 A. Yes, I think that's right. I mean, I think it
 25 was difficult in the Health Care Corporation,

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1 because they were being downsized, like
 2 everybody else as far as I can tell.
 3 MR. SIMMONS:
 4 Q. Yes. So when you'd talked about Mr. Tilley,
 5 for example, informing you that the lab had to
 6 find a million dollars in savings -
 7 DR. HAEGERT:
 8 A. Yes.
 9 MR. SIMMONS:
 10 Q. - that wasn't an initiative that was coming
 11 from within the Health Care Corporation. You
 12 understood that to be a broader based
 13 initiative where the government was going to
 14 the health sector looking for savings, did
 15 you?
 16 DR. HAEGERT:
 17 A. Well, that's a good question. I mean, I was
 18 aware that there was certainly a budget crunch
 19 in the Health Care Corporation. I mean, there
 20 was certainly awareness that we didn't have
 21 enough money and that the feeling that I had
 22 is the government failed to recognize when the
 23 Health Care Corporation made overtures to
 24 government that we needed this amount of
 25 money, that they actually didn't believe this.

<p style="text-align: right;">Page 276</p> <p>1 I mean, it seemed to be sort of a common theme 2 of understanding. I don't know if it--well, 3 of course, this was in the time of original 4 creation. So what they were doing is bringing 5 together these multiple sites and then they 6 were given a budget and I think the sense was 7 the budget was insufficient. Some of the 8 plants were old, like the Grace was an old 9 hospital and expensive to operate. 10 MR. SIMMONS: 11 Q. Okay. I had a specific question for you 12 related to that, about one of the documents, 13 P-1889, please. Now this is a letter you were 14 shown by Mr. Coffey, one written by Dr. 15 Khalifa to Mr. Gulliver, and this is February 16 of 1997, and in it, Dr. Khalifa was commenting 17 on the difficulty of making contact with Mr. 18 Gulliver and in talking about the circumstance 19 you described, all the different 20 responsibilities Mr. Gulliver had at that time 21 for areas other than pathology, my question 22 simply is, by the time these events occurred 23 described in this letter, was this after the 24 management structure had been shrunk, after 25 those cuts had been made or prior to that?</p>	<p style="text-align: right;">Page 278</p> <p>1 A. Yes. 2 MR. SIMMONS: 3 Q. When it came to the mechanics of getting it up 4 and running, you've told us that there would 5 be, I understood you to say, a series of test 6 slides prepared by the technologists in the 7 lab using different formulations for the use 8 of the antibody? 9 DR. HAEGERT: 10 A. That's what I would expect, yes. 11 MR. SIMMONS: 12 Q. Yes, and you mentioned that would be done, did 13 I understand you to say, on tissue that had 14 been provided or selected by a pathologist? 15 So the pathologist would select the tissue to 16 be used for these sample slides? 17 DR. HAEGERT: 18 A. Yes, of course. 19 MR. SIMMONS: 20 Q. Yes, and then the results of those slides 21 would be reviewed by the pathologist to select 22 the best formula or the best protocol to be 23 used for that particular antibody? 24 DR. HAEGERT: 25 A. I mean, that seems to be the most probable</p>
<p style="text-align: right;">Page 277</p> <p>1 DR. HAEGERT: 2 A. Well, it must have been, because there would 3 be no reason for him to be on other sites. 4 MR. SIMMONS: 5 Q. Okay, good, thank you. You were asked about 6 the process of introducing new antibodies into 7 the immunohistochemistry arsenal. You've 8 explained that, and I just wanted to make sure 9 I understood a couple of things about that. 10 Is it correct that the introduction of a new 11 antibody would be initiated at the request of 12 a pathologist, rather than at the request of 13 anyone among the technical staff in the 14 laboratory? 15 DR. HAEGERT: 16 A. It wouldn't come from the technical staff. It 17 would come from pathologists. 18 MR. SIMMONS: 19 Q. And then you've told us that there was a 20 process where that would be, in effect, vetted 21 by the site chief or clinical chief or lab 22 leadership to ensure that this was an antibody 23 that was appropriate to introduce into the 24 lab? 25 DR. HAEGERT:</p>	<p style="text-align: right;">Page 279</p> <p>1 sequence of events, yes. 2 MR. SIMMONS: 3 Q. So would it be correct to say then that the 4 use of a new antibody for testing patient 5 samples wouldn't begin until an appropriate 6 pathologist had reviewed the results of these 7 sample tests and was satisfied that the test 8 was working appropriately to put it into use? 9 DR. HAEGERT: 10 A. Well, it's difficult to imagine that it would 11 come about any other way. 12 MR. SIMMONS: 13 Q. Okay, good, thank you. You were asked about 14 external proficiency testing and you made some 15 comments about your views on the usefulness of 16 proficiency testing. We've heard through 17 other witnesses that there's different types 18 of proficiency testing available now for 19 pathology. One of those is through CAP, C-A- 20 P, and I understand that to be cases that are 21 presented by CAP which consists of a number of 22 slides, that pathologists would review the 23 slides and answer some questions about the 24 case and submit them back. Other types of 25 proficiency testing, such as from UK NEQAS in</p>

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<p>1 the UK, involve being given actual material</p> <p>2 where you prepare the slide, stain it, rate it</p> <p>3 and send it back. So one type of proficiency</p> <p>4 testing involves work in the lab, technical</p> <p>5 work?</p> <p>6 DR. HAEGERT:</p> <p>7 A. Yeah.</p> <p>8 MR. SIMMONS:</p> <p>9 Q. And the other is pathologists' assessment of</p> <p>10 cases that are presented, and I was wondering</p> <p>11 if your comments about the usefulness of</p> <p>12 proficiency testing were directed towards both</p> <p>13 types of proficiency testing or just to the</p> <p>14 CAP type?</p> <p>15 DR. HAEGERT:</p> <p>16 A. Well, it was directed really to the ones where</p> <p>17 we would receive a set of unknown cases and</p> <p>18 that pathology--you know, typically an H & E</p> <p>19 slide, which is a routine slide, and we'd be</p> <p>20 asked a number of questions, like what are the</p> <p>21 factors that do this or does this do that.</p> <p>22 No, I was talking about that. I wasn't</p> <p>23 talking about the other type of testing, no.</p> <p>24 MR. SIMMONS:</p> <p>25 Q. Okay. Now you've told us a bit about what</p>	<p>1 Q. Yes. Would you know, for example, whether</p> <p>2 your laboratory participates in the UK NEQAS</p> <p>3 program?</p> <p>4 DR. HAEGERT:</p> <p>5 A. No, it does not.</p> <p>6 MR. SIMMONS:</p> <p>7 Q. It does not?</p> <p>8 DR. HAEGERT:</p> <p>9 A. No.</p> <p>10 MR. SIMMONS:</p> <p>11 Q. There is a new program being developed, I</p> <p>12 understand, called CQIC that the B.C. Cancer</p> <p>13 Institute is involved in, that we've heard</p> <p>14 about. Would you know if your laboratory is</p> <p>15 participating in that?</p> <p>16 DR. HAEGERT:</p> <p>17 A. No, we're not, no.</p> <p>18 MR. SIMMONS:</p> <p>19 Q. Okay. Now we know that in Newfoundland there</p> <p>20 is no licensing of laboratories and no</p> <p>21 provincial accreditation program. We've heard</p> <p>22 from others that in Ontario there is.</p> <p>23 DR. HAEGERT:</p> <p>24 A. Yes.</p> <p>25 MR. SIMMONS:</p>
<p>Page 281</p> <p>1 happens at McGill University Hospital, is that</p> <p>2 where you are now?</p> <p>3 DR. HAEGERT:</p> <p>4 A. Yeah, McGill University Hospital Centre.</p> <p>5 MR. SIMMONS:</p> <p>6 Q. Hospital Centre.</p> <p>7 DR. HAEGERT:</p> <p>8 A. It's got a name in French, but I won't bother</p> <p>9 with belabouring you with it.</p> <p>10 MR. SIMMONS:</p> <p>11 Q. Okay, and I presume that your lab there</p> <p>12 engages in different types of proficiency</p> <p>13 testing for pathology and the</p> <p>14 immunohistochemistry service that you run or</p> <p>15 would you be familiar with what proficiency</p> <p>16 testing is carried out by your lab?</p> <p>17 DR. HAEGERT:</p> <p>18 A. Well, there is a director of the</p> <p>19 immunohistochemistry lab.</p> <p>20 MR. SIMMONS:</p> <p>21 Q. Yes.</p> <p>22 DR. HAEGERT:</p> <p>23 A. And you know, in that lab, we do multiple</p> <p>24 immunohistochemical stains.</p> <p>25 MR. SIMMONS:</p>	<p>Page 283</p> <p>1 Q. QMPLS program. What is the situation in</p> <p>2 Quebec about laboratory accreditation and</p> <p>3 licensing?</p> <p>4 DR. HAEGERT:</p> <p>5 A. Well, basically the accreditation comes</p> <p>6 through the Canadian Council of Health</p> <p>7 Services Accreditation.</p> <p>8 MR. SIMMONS:</p> <p>9 Q. That's CCHSA?</p> <p>10 DR. HAEGERT:</p> <p>11 A. Yes, sure, and so we were accredited actually</p> <p>12 in 2007.</p> <p>13 MR. SIMMONS:</p> <p>14 Q. Okay.</p> <p>15 DR. HAEGERT:</p> <p>16 A. And some people do the CAP accreditation, but</p> <p>17 it's not -</p> <p>18 MR. SIMMONS:</p> <p>19 Q. Pardon me?</p> <p>20 DR. HAEGERT:</p> <p>21 A. Some people use the College of American</p> <p>22 Pathologists accreditation as well, but it's a</p> <p>23 higher level of accreditation.</p> <p>24 MR. SIMMONS:</p> <p>25 Q. So there is no provincial program equivalent</p>

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<p>1 to QMPLS in Quebec?</p> <p>2 DR. HAEGERT:</p> <p>3 A. No.</p> <p>4 MR. SIMMONS:</p> <p>5 Q. Is there any provincial requirement for</p> <p>6 licensing of laboratories, aside from</p> <p>7 accreditation, that you're aware of?</p> <p>8 DR. HAEGERT:</p> <p>9 A. No, I don't think so. I think basically you</p> <p>10 have to be accredited by the CCHSA.</p> <p>11 MR. SIMMONS:</p> <p>12 Q. Okay. We've heard a little bit about the</p> <p>13 CCHSA accreditation in other evidence, and</p> <p>14 what we have heard is that in the last round</p> <p>15 of accreditation, the most recent one here,</p> <p>16 there was what I'll call a new emphasis placed</p> <p>17 on laboratories and more attention paid to the</p> <p>18 laboratory than had been in some of the</p> <p>19 preceding accreditations. Do you know if that</p> <p>20 had been the case at McGill as well, whether</p> <p>21 there was a greater emphasis on laboratories</p> <p>22 in your last CCHSA accreditation?</p> <p>23 DR. HAEGERT:</p> <p>24 A. I think they changed the whole--I mean, I was</p> <p>25 here for, I think, two accreditations. Then I</p>	<p>1 Complex or Centre, we spent practically two</p> <p>2 years preparing for the accreditation because,</p> <p>3 except for blood bank, I think most of the</p> <p>4 labs did not have any significant level of</p> <p>5 standard operating procedures. I mean, they</p> <p>6 had techniques that they used and the people</p> <p>7 knew what to follow, but all these things were</p> <p>8 not defined and formulated, and you know,</p> <p>9 there wasn't a massive paper trail so people</p> <p>10 knew exactly what was going on.</p> <p>11 MR. SIMMONS:</p> <p>12 Q. So would it be fair to say then that Ontario</p> <p>13 was ahead of the curve in regards to requiring</p> <p>14 laboratories to have standard operating</p> <p>15 procedures documented and in place, even</p> <p>16 compared to Quebec?</p> <p>17 DR. HAEGERT:</p> <p>18 A. Certainly ahead of Quebec.</p> <p>19 MR. SIMMONS:</p> <p>20 Q. Okay. Have you had any involvement with</p> <p>21 Canadian Association of Pathologists or any</p> <p>22 other of the national organizations regarding</p> <p>23 moves to develop national standards for</p> <p>24 immunohistochemistry?</p> <p>25 DR. HAEGERT:</p>
<p>Page 285</p> <p>1 went to McGill and we had it in 2007. It was</p> <p>2 completely different. The previous</p> <p>3 accreditations, the lab was hardly the focus,</p> <p>4 but in this latest accreditation, the lab was</p> <p>5 an enormous focus and they expected to have</p> <p>6 things like standard operating procedures and</p> <p>7 so on. I mean, many of the things, I think I</p> <p>8 talked about this already that Trish--I don't</p> <p>9 know how you pronounce her name, you know, the</p> <p>10 consultant from Ontario, I mean, a lot of</p> <p>11 those things, they actually demand that, you</p> <p>12 know, verify this, verify that.</p> <p>13 MR. SIMMONS:</p> <p>14 Q. Yes.</p> <p>15 DR. HAEGERT:</p> <p>16 A. Check the pH. I mean, the principle of those</p> <p>17 is interesting, the standard operating</p> <p>18 procedures. I mean, the idea behind it is</p> <p>19 that some novice could come into the lab and</p> <p>20 repeat the methodology. Of course, that in</p> <p>21 reality is probably naive, but what it really-</p> <p>22 -the idea is to show that a laboratory</p> <p>23 actually uses uniform methodology. But as I</p> <p>24 said, in our lab, before that, I mean, in</p> <p>25 fact, the whole of McGill University Health</p>	<p>Page 287</p> <p>1 A. Well, I'm well aware of this. I mean, I</p> <p>2 think, I mean, one of the triggers for this,</p> <p>3 of course, is the Commission of Inquiry here,</p> <p>4 and recognition that there's been, you know, a</p> <p>5 significant problem. I mean, one of the</p> <p>6 pathologists, I think in Toronto, said this</p> <p>7 was sort of a wake-up call, meaning that</p> <p>8 people needed to be much more aware of what</p> <p>9 the internal practices are in hospitals</p> <p>10 throughout the country, in the laboratories.</p> <p>11 So I'm well aware of this. I mean, Dr. Butany</p> <p>12 gave a press conference and there's, you know,</p> <p>13 presentation and there's a committee of the</p> <p>14 CAP, Canadian Association--they have the same</p> <p>15 initials, but the Canadian Association of</p> <p>16 Pathologists, as opposed to the College of</p> <p>17 American Pathologists.</p> <p>18 MR. SIMMONS:</p> <p>19 Q. Thank you very much, Dr. Haegert. That's all</p> <p>20 I have for you.</p> <p>21 DR. HAEGERT:</p> <p>22 A. Okay, thank you.</p> <p>23 THE COMMISSIONER:</p> <p>24 Q. Ms. Newbury.</p> <p>25 DR. DAVID HAEGERT, EXAMINATION BY MS. JENNIFER NEWBURY</p>

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<p>1 MS. NEWBURY: 2 Q. Good afternoon, Dr. Haegert. 3 DR. HAEGERT: 4 A. Good afternoon. 5 MS. NEWBURY: 6 Q. Jennifer Newbury for the Canadian Cancer 7 Society, Newfoundland and Labrador Division. 8 I just had a couple of questions for you on 9 the topic of quality assurance and in 10 particular, your reference to external 11 consultations as a form of quality assurance, 12 and would those types of consultations tend to 13 be for more complex or unusual cases? 14 DR. HAEGERT: 15 A. External consultations in my experience, you 16 consult for cases that are unusually 17 difficult, either because you don't have the 18 expertise in-house or because the differential 19 diagnosis is--you really cannot distinguish 20 between the differential diagnosis. 21 MS. NEWBURY: 22 Q. So it wouldn't include the more routine type 23 cases that are -- 24 DR. HAEGERT: 25 A. No, that would be unusual, no.</p>	<p>1 DR. HAEGERT: 2 A. Normally what would happen is that we would 3 receive back the report and either you put an 4 addendum or issue a new report, depending on 5 what would happen, and that would be attached 6 to the patient's record. I mean, it's 7 inconceivable that some other approach--I 8 mean, certainly we want--if there was a 9 discrepancy in the diagnosis; say, we made a 10 diagnosis--a lot of times there is no 11 diagnosis and you send it to a consultant to 12 get an opinion, but sometimes we make a 13 preliminary diagnosis and then you get an 14 external opinion. If there's a discrepancy, 15 then, of course, you advise the clinician 16 involved. 17 MS. NEWBURY: 18 Q. And would the fact that there had been an 19 outside consultation, would that be recorded 20 regardless of whether there was a disagreement 21 or discrepancy or if that were the only 22 diagnosis? 23 DR. HAEGERT: 24 A. Well, yeah, normally. That would be the 25 normal practice.</p>
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<p>1 MS. NEWBURY: 2 Q. And in light of your comment that these 3 consultations does act as a form of quality 4 assurance, was there any effort by the 5 department to attempt to compile the data from 6 the various consultations that might take 7 place over the years, and to analyze that to 8 look for trends for any particular problem 9 areas, any type of an overview? 10 DR. HAEGERT: 11 A. I can't say. I mean, possibly it was done 12 after I left, but I can't say. 13 MS. NEWBURY: 14 Q. You're not aware of that having occurred? 15 DR. HAEGERT: 16 A. No, I don't think so. 17 MS. NEWBURY: 18 Q. And would you say that the primary purpose of 19 these external consultations was for 20 individual patient care? 21 DR. HAEGERT: 22 A. Yes. 23 MS. NEWBURY: 24 Q. And would those external consultations be 25 always recorded in a patient file?</p>	<p>1 MS. NEWBURY: 2 Q. And in terms of the external consultations, 3 would that focus on interpretation of a 4 specimen as opposed to the--we've heard of 5 different phrases, post analytic, pre- 6 analytic, analytic phases in terms of getting 7 your specimen. Would those external 8 consultations cover all three of those 9 categories or would it focus on what I 10 understand to be the post analytic or the 11 interpretation? 12 DR. HAEGERT: 13 A. Basically it would be on, if you want to call 14 it that, post analytic. I mean, certainly 15 people use that term. It's basically the 16 diagnosis, what is this; is it this, is it 17 that, or is it something else. 18 MS. NEWBURY: 19 Q. Okay. 20 DR. HAEGERT: 21 A. And then, you know, we send the slides, 22 sometimes you send the blocks, it depends on 23 the institution, send both. They do 24 additional stains and they do molecular 25 studies.</p>

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<p>1 MS. NEWBURY:</p> <p>2 Q. Okay. So they might do some additional work</p> <p>3 that goes beyond simply interpretation, but</p> <p>4 the primary focus would be interpretation?</p> <p>5 DR. HAEGERT:</p> <p>6 A. Correct.</p> <p>7 MS. NEWBURY:</p> <p>8 Q. I guess the question is would they be trying</p> <p>9 to verify or double check any of the pre</p> <p>10 analytic work that might have been done to</p> <p>11 prepare that specific specimen?</p> <p>12 DR. HAEGERT:</p> <p>13 A. Well, I mean, we get a lot of consultations</p> <p>14 from outside in Montreal, and often we comment</p> <p>15 about the quality of the material. Sometimes</p> <p>16 it's extremely difficult to make diagnosis on</p> <p>17 materials submitted to us because of the</p> <p>18 quality, and it's either fixation or some</p> <p>19 other issue which we don't really--sometimes</p> <p>20 we don't understand what the issue is, but,</p> <p>21 you know, the immunohistochemistry doesn't</p> <p>22 work and there's all kinds of reasons. So, I</p> <p>23 mean, that would be part of the report, but</p> <p>24 the primary function, of course, is to make a</p> <p>25 diagnosis, to help the pathologist so that the</p>	<p>1 in this new CAP guidelines is they talk about</p> <p>2 how do you do this, and that's one of the</p> <p>3 thoughts that this is what you do, you do</p> <p>4 random sampling of the institution activities</p> <p>5 and review them, and identify problem areas,</p> <p>6 and then repeat it.</p> <p>7 MS. NEWBURY:</p> <p>8 Q. And is that--the CAP, is that the College of</p> <p>9 American Pathologists guidelines, or is this</p> <p>10 the Canadian?</p> <p>11 DR. HAEGERT:</p> <p>12 A. The Canadian, I'm sorry, Canadian.</p> <p>13 MS. NEWBURY:</p> <p>14 Q. Okay, I just wanted to clarify it. That's a</p> <p>15 fairly recently --</p> <p>16 DR. HAEGERT:</p> <p>17 A. Yes, that just came out in June.</p> <p>18 MS. NEWBURY:</p> <p>19 Q. I'm just wondering before that on a more</p> <p>20 informal basis, it was my impression based on</p> <p>21 some other evidence that we heard, that that</p> <p>22 might be done on an informal basis, we'll just</p> <p>23 randomly sample a number of cases, perhaps</p> <p>24 similar to Dr. Griffin's program --</p> <p>25 DR. HAEGERT:</p>
<p>1 pathologist can make a diagnosis that would</p> <p>2 impact on patient care.</p> <p>3 MS. NEWBURY:</p> <p>4 Q. I'm just wondering during your time in St.</p> <p>5 John's at the various institutions as they</p> <p>6 evolved over the years, was there ever a</p> <p>7 practice of inter-laboratory consultations or</p> <p>8 comparisons that were random in nature and not</p> <p>9 sort of falling under the description of an</p> <p>10 external consultation for patient care?</p> <p>11 DR. HAEGERT:</p> <p>12 A. I don't think it was ever random. It was</p> <p>13 more, Doctor so and so, you have experience</p> <p>14 with this, would you have a look at this and</p> <p>15 give me your opinion.</p> <p>16 MS. NEWBURY:</p> <p>17 Q. Are you aware of that type of a process being</p> <p>18 used generally in Canada, for example, as a</p> <p>19 method of quality assurance, just to take a</p> <p>20 random sampling, which would include not just</p> <p>21 your more complicated cases, but also the</p> <p>22 routine cases?</p> <p>23 DR. HAEGERT:</p> <p>24 A. I mean, Mr. Simmons over there, he mentioned -</p> <p>25 one of the things he--one of the things that's</p>	<p>1 A. Right.</p> <p>2 MS. NEWBURY:</p> <p>3 Q. But I understand that was internal?</p> <p>4 DR. HAEGERT:</p> <p>5 A. Yes, that's right. I mean, it's a lot easier</p> <p>6 when the resources are abundant.</p> <p>7 MS. NEWBURY:</p> <p>8 Q. Right.</p> <p>9 DR. HAEGERT:</p> <p>10 A. You know, I think people come from Ontario, my</p> <p>11 feeling of--I sort of see--I mean, for your</p> <p>12 information, I see Quebec and Newfoundland at</p> <p>13 least in many ways similar in terms of--at</p> <p>14 least in the past, available resources, and</p> <p>15 that it's a lot easier when resources are</p> <p>16 abundant, pathologists have a lot of protected</p> <p>17 time and so on.</p> <p>18 MS. NEWBURY:</p> <p>19 Q. Sure.</p> <p>20 DR. HAEGERT:</p> <p>21 A. It's much more difficult when there's minimal</p> <p>22 protected time and everybody is working</p> <p>23 really, really hard.</p> <p>24 MS. NEWBURY:</p> <p>25 Q. So if there were some desire to randomly</p>

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1 sample 5 or 10 percent or 2 percent of cases,
 2 you're saying that that would be problematic,
 3 or would have been problematic because of a
 4 resource issue here while you were in St.
 5 John's?
 6 DR. HAEGERT:
 7 A. Well, the question--yeah, the issue would be
 8 who is going to do it, how he's going to do
 9 it, how much time it would take, and how you
 10 pull up all the material. I mentioned the
 11 business of the interfacing between Meditech
 12 systems. I assume that was solved.
 13 MS. NEWBURY:
 14 Q. Okay.
 15 DR. HAEGERT:
 16 A. But if it wasn't solved, then, of course, it
 17 would be difficult; how do you do random
 18 sampling when you can't actually access the
 19 data in the computer.
 20 MS. NEWBURY:
 21 Q. Uh-hm.
 22 DR. HAEGERT:
 23 A. It would have been difficult.
 24 MS. NEWBURY:
 25 Q. So it would have been an impediment to even

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1 locate the cases to randomly sample because of
 2 the information system?
 3 DR. HAEGERT:
 4 A. Right.
 5 MS. NEWBURY:
 6 Q. Okay. Thank you, Dr. Haegert, those are all
 7 the questions.
 8 THE COMMISSIONER:
 9 Q. Thank you. Mr. Browne. Dr. Haegert, when you
 10 say protected time, does it mean anything more
 11 than time in which you are not expected to be
 12 working as a pathologist in front of your
 13 microscope?
 14 DR. HAEGERT:
 15 A. I mean, I think--you think about, there's
 16 community hospitals and then there's academic
 17 institutions. A community hospital, I think,
 18 the expectation is that probably people spend
 19 most of their time doing clinical service work
 20 and maybe some administration, and maybe a
 21 small amount of teaching, whereas the Health
 22 Care Corporation of St. John's was an academic
 23 institution so that what one would expect is
 24 that there would be protected time for doing
 25 things like research and teaching, and keeping

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1 up with the literature, reviewing literature,
 2 and so on.
 3 THE COMMISSIONER:
 4 Q. Thank you. Mr. Browne.
 5 MR. BROWNE:
 6 Q. I'm going to sit down now, Commissioner,
 7 because --
 8 THE COMMISSIONER:
 9 Q. Oh, that was your first question. Sorry.
 10 MR. BROWNE:
 11 Q. That's okay, I'll just make do and see if I
 12 can work around it.
 13 DR. DAVID HAEGERT - EXAMINATION BY MR. PETER BROWNE
 14 MR. BROWNE:
 15 Q. Doctor, I'll be a shorter amount of time,
 16 Doctor, you'll be glad to know.
 17 DR. HAEGERT:
 18 A. Okay.
 19 MR. BROWNE:
 20 Q. I just want to go over a couple of themes,
 21 Doctor, and just make sure I heard them from
 22 your evidence today, and it seems to be there
 23 were a number of prevalent themes throughout
 24 the time that you were clinical chief, and I
 25 guess the important--you were the first

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1 witness who held both the academic chair and
 2 the clinical chief chair, and you were there
 3 around the time the Health Care Corporation
 4 was formulated. Is it fair to say that there
 5 was a lot of emphasis on cost containment
 6 during your time at the Health Care
 7 Corporation?
 8 DR. HAEGERT:
 9 A. Yes, I already more or less summarized some of
 10 that.
 11 MR. BROWNE:
 12 Q. Okay, and there were issues with recruitment
 13 around those areas as well?
 14 DR. HAEGERT:
 15 A. This was an ongoing thing the whole time I was
 16 here.
 17 MR. BROWNE:
 18 Q. Issues with remuneration?
 19 DR. HAEGERT:
 20 A. Yes.
 21 MR. BROWNE:
 22 Q. And there was an emphasis--we saw through a
 23 number of documents you were shown today, an
 24 emphasis on--even though there was cost
 25 constraints or containment emphasized, there

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<p>1 was also an emphasis on efficiency on top of</p> <p>2 that. Was that a theme that was discussed at</p> <p>3 departmental levels?</p> <p>4 DR. HAEGERT:</p> <p>5 A. Yes, it was.</p> <p>6 MR. BROWNE:</p> <p>7 Q. Finally, just following on the heels of the</p> <p>8 Commissioners question to you, you had</p> <p>9 mentioned, I think, a comment that there was</p> <p>10 also--again I harken back to your, I guess,</p> <p>11 dual role as clinical chair, more than</p> <p>12 emphasis on the provision of clinical services</p> <p>13 than on academia and research, is that a fair</p> <p>14 observation as well?</p> <p>15 DR. HAEGERT:</p> <p>16 A. I think that's true. I mean, it's extremely</p> <p>17 difficult to think about doing anything other</p> <p>18 than service if it takes up most of your time.</p> <p>19 I think that was the major emphasis, it was</p> <p>20 difficult to find time to do research. So the</p> <p>21 reality was there was a small number of people</p> <p>22 doing academic things, and often they did it</p> <p>23 at night or on the weekends, you know, on</p> <p>24 their own time.</p> <p>25 MR. BROWNE:</p>	<p>1 you find a tumour that stains quite</p> <p>2 differently, and the question is what is it.</p> <p>3 I mean, it has features of two tumours, but</p> <p>4 you know it's one tumour and how do you deal</p> <p>5 with it; well, the only way you can address it</p> <p>6 is--you know, you could throw up your hands</p> <p>7 and say, oh, well, I better get an external</p> <p>8 opinion, which is--you know, takes time, might</p> <p>9 take a couple of weeks depending on the--or</p> <p>10 the alternate is to go to the literature. A</p> <p>11 lot of times things that you think are really</p> <p>12 extraordinary or unusual or never seen, in</p> <p>13 fact, somebody has published 30 cases of it.</p> <p>14 MR. BROWNE:</p> <p>15 Q. And just by way of example, Doctor, the</p> <p>16 Commissioner has heard some evidence from a</p> <p>17 couple of previous witnesses, for instance,</p> <p>18 lobular, the Commissioner has heard about</p> <p>19 classic lobular carcinoma.</p> <p>20 DR. HAEGERT:</p> <p>21 A. Right.</p> <p>22 MR. BROWNE:</p> <p>23 Q. But then there are also--you could have a</p> <p>24 lobular with ductal features, so there is</p> <p>25 mixed--we've heard mixed comedo and all, so</p>
<p>Page 301</p> <p>1 Q. And the Commissioner did ask you about</p> <p>2 protected time. Is that an important thing--</p> <p>3 putting aside just--I know again the academic</p> <p>4 side of it, but what about people who are just</p> <p>5 in the clinical practice itself, is that</p> <p>6 protected time important for them as well?</p> <p>7 DR. HAEGERT:</p> <p>8 A. Well, it is, you know, because, I mean,</p> <p>9 there's all kinds of textbooks on pathology</p> <p>10 and they describe classic cases, but patients</p> <p>11 tend not to read the textbooks and their</p> <p>12 cancers are often--they don't fall necessarily</p> <p>13 into some easily identifiable class. Sometimes</p> <p>14 they do, but a lot of times they're difficult.</p> <p>15 So this is a time that, you know, a practising</p> <p>16 pathologist needs to actually go to the</p> <p>17 literature and read and try to figure out--</p> <p>18 you know, expand his information or her</p> <p>19 information about the complexity of things.</p> <p>20 Some of it is in the books, but some of it is</p> <p>21 in the literature. Sometimes you'll find a</p> <p>22 case which-- I mean, we use</p> <p>23 immunohistochemistry for all kinds of things</p> <p>24 and we think that certain tumours stained with</p> <p>25 certain immunohistochemical stains, and then</p>	<p>Page 303</p> <p>1 it's not--I guess, the notion that a tumour</p> <p>2 can be pigeon-holed into a specific category</p> <p>3 is not necessarily--it's a bit of a naive</p> <p>4 understanding?</p> <p>5 DR. HAEGERT:</p> <p>6 A. They're not all homogeneous.</p> <p>7 MR. BROWNE:</p> <p>8 Q. Homogeneous.</p> <p>9 DR. HAEGERT:</p> <p>10 A. They're mixed--yes, quite true, this is indeed</p> <p>11 true.</p> <p>12 MR. BROWNE:</p> <p>13 Q. Okay.</p> <p>14 DR. HAEGERT:</p> <p>15 A. And that's where you really need time to look</p> <p>16 into the literature. I mean, it's fine to</p> <p>17 open a big standard text, but the standard</p> <p>18 texts, actually--the information is often</p> <p>19 limited.</p> <p>20 MR. BROWNE:</p> <p>21 Q. And you'd mentioned earlier as well the amount</p> <p>22 of time and the number of slides. Would that</p> <p>23 also involve looking at a number of slides to</p> <p>24 try to figure out all these various features</p> <p>25 as well because of the number of slides now</p>

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<p>1 that are generated in a breast cancer? You</p> <p>2 mentioned that earlier.</p> <p>3 DR. HAEGERT:</p> <p>4 A. Well, I think what's happened--I mentioned in</p> <p>5 the past patients were treated by radical</p> <p>6 mastectomy, and often you get ten slides.</p> <p>7 MR. BROWNE:</p> <p>8 Q. Right.</p> <p>9 DR. HAEGERT:</p> <p>10 A. That's when I was first starting out. Now</p> <p>11 they have small excisional biopsies maybe with</p> <p>12 axillary lymph nodes, and then there's</p> <p>13 multiple slides and often what you'll find is</p> <p>14 multiple tumours, and there's all kinds of</p> <p>15 gradations between the tumours. So you might</p> <p>16 have--I saw a case the other day that I think</p> <p>17 there were 20 different--I'm not sure of the</p> <p>18 number, but something like 20 different</p> <p>19 cancers in the breast. They were all tiny,</p> <p>20 they were all over the place. I mean, it</p> <p>21 takes ages to look at something like that, and</p> <p>22 then there's all these grey area lesions. I</p> <p>23 mean, it's not all black and white, like</p> <p>24 cancer versus benign. It's much more</p> <p>25 complicated than this.</p>	<p>1 going to do is going to have this management</p> <p>2 system where they were going to choose the</p> <p>3 clinical chiefs, and the chairs were furious</p> <p>4 with this comment, and I actually didn't speak</p> <p>5 against this. The reason I didn't speak</p> <p>6 against it was we had invited Sister Elizabeth</p> <p>7 to come to the laboratory to talk to us about</p> <p>8 her model, or what she was going to do with</p> <p>9 the Health Care Corp, thought we might as well</p> <p>10 find out what she was going to do. She came</p> <p>11 and she told us this is what she was going to</p> <p>12 do, and it was clear to me that this was her</p> <p>13 intention irrespective of what anybody said</p> <p>14 and indeed that was true. So what people did</p> <p>15 not like is that the--I don't know how they</p> <p>16 perceived them, maybe bureaucrats in the</p> <p>17 Health Care Corporation, but they weren't all</p> <p>18 bureaucrats, but they--you know, there were</p> <p>19 medical people too, were going to make the</p> <p>20 decisions as to who the clinical chiefs were</p> <p>21 going to be, and they didn't like this at all.</p> <p>22 So we discussed that for several meetings--</p> <p>23 well, we didn't actually discuss it, it was</p> <p>24 mostly, like, a statement of displeasure</p> <p>25 repeated over and over again. It was kind of</p>
<p style="text-align: right;">Page 305</p> <p>1 MR. BROWNE:</p> <p>2 Q. Lastly, Doctor, there was one comment you made</p> <p>3 today concerning a question from Mr. Coffey</p> <p>4 about MAC meeting around the time with the</p> <p>5 Health Care Corporation, and, I guess, the</p> <p>6 decision to implement program management, the</p> <p>7 CEO at the time was Sister Elizabeth Davis,</p> <p>8 and I think--I wrote down, "In the early</p> <p>9 phases, the clinical chiefs spoke out against</p> <p>10 Sister Davis' plan for lab medicine". What</p> <p>11 was it--there was, I guess, objection to, or</p> <p>12 people were speaking out in terms of --</p> <p>13 DR. HAEGERT:</p> <p>14 A. No, I think that's--hopefully that's not what</p> <p>15 I said.</p> <p>16 MR. BROWNE:</p> <p>17 Q. And I may have --</p> <p>18 DR. HAEGERT:</p> <p>19 A. What it was, was actually the initial meetings</p> <p>20 is before the clinical chiefs were identified,</p> <p>21 is that the chairs of the university</p> <p>22 departments were invited, and then they were</p> <p>23 told by Sister Elizabeth, well, myself</p> <p>24 included, that the model that she was using,</p> <p>25 the program management, and what they were</p>	<p style="text-align: right;">Page 307</p> <p>1 a major time waste there, but that's what went</p> <p>2 on--really went on for a few meetings, and</p> <p>3 then eventually people realized that this is</p> <p>4 what was going to happen.</p> <p>5 MR. BROWNE:</p> <p>6 Q. It was a fait accompli?</p> <p>7 DR. HAEGERT:</p> <p>8 A. Yes.</p> <p>9 MR. BROWNE:</p> <p>10 Q. Thank you, Doctor. Now normally at this time</p> <p>11 we invite--the Commission invites witnesses</p> <p>12 either to make any comments or observations or</p> <p>13 recommendations to the Commissioner, and this</p> <p>14 will be your opportunity if you wish to do so.</p> <p>15 DR. HAEGERT:</p> <p>16 A. Commissioner, if I could say something. One</p> <p>17 of the--I mean, I think for me this Commission</p> <p>18 of Inquiry has been a real eye opener. I</p> <p>19 mean, other people have expressed this, of</p> <p>20 course, I feel terrible for the patients and</p> <p>21 their families that have been affected, but</p> <p>22 one of the things I wanted to say really was</p> <p>23 one of the positive things that's come out of</p> <p>24 this, and I don't know if people have sort of</p> <p>25 alluded to this, is that it's been sort of a</p>

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

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

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1 here should be pleased in the province that
 2 they had leadership like himself at the time
 3 to actually bring this out into the open, try
 4 to figure out what the issues were. I think
 5 that's basically all I would like to say.
 6 THE COMMISSIONER:
 7 Q. Thank you, Mr. Browne. Do you have anything
 8 arising, Mr. Coffey.
 9 COFFEY, Q.C.:
 10 Q. Just one question, Doctor. You did in
 11 responding to a question, I believe from Mr.
 12 Simmons, refer to the fact that at McGill
 13 there is a Director of Immunohistochemistry?
 14 DR. HAEGERT:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. That person is what sort of a--is that a
 18 physician?
 19 DR. HAEGERT:
 20 A. Physician, yes, pathologist.
 21 COFFEY, Q.C.:
 22 Q. Pathologists, okay. So the background of a
 23 director at your institution--for the Director
 24 of Immunohistochemistry has been chosen to be
 25 a pathologist, a chosen pathologist?

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1 DR. HAEGERT:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. I just wanted to clarify that, Doctor. Thank
 5 you very much, Doctor.
 6 THE COMMISSIONER:
 7 Q. Thank you very much, Doctor Haegert, for
 8 coming to assist us, and we promised to get
 9 you to the airport on time, and I think we
 10 will do so.
 11 DR. HAEGERT:
 12 A. All right, thank you.
 13 THE COMMISSIONER:
 14 Q. You're going to take care of that, Mr. Browne.
 15 MR. BROWNE:
 16 Q. I will, Commissioner, as we speak.
 17 THE COMMISSIONER:
 18 Q. Okay. Now I think we're going to complete the
 19 evidence of Mr. Dawe. Thank you once again,
 20 Dr. Haegert.
 21 CHAYTOR, Q.C.:
 22 Q. Commissioner, there's two new exhibits for Mr.
 23 Dawe today, 2481 and 2544, and I know I said I
 24 was finished yesterday, but there is something
 25 Mr. Dawe would like to clarify in relation to

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1 one of those exhibits.
 2 THE COMMISSIONER:
 3 Q. Would you give me those numbers again, please,
 4 Ms. Chaytor?
 5 CHAYTOR, Q.C.:
 6 Q. Sure, it's 2481 and 2544.
 7 THE COMMISSIONER:
 8 Q. All right, those exhibits are entered. I'm
 9 afraid the humidity has made all of our desks
 10 wet, Mr. Dawe, there's not a thing we can do
 11 about it. We may have to switch over plugs.
 12 Ms. Chaytor.
 13 EXHIBIT ENTERED AND MARKED P- 2481
 14 EXHIBIT ENTERED AND MARKED P- 2544
 15 MR. PETER DAWE - EXAMINATION BY SANDRA CHAYTOR, Q.C.
 16 CHAYTOR, Q.C.:
 17 Q. Good afternoon, Mr. Dawe?
 18 MR. DAWE:
 19 A. Good afternoon.
 20 CHAYTOR, Q.C.:
 21 Q. Thank you for your indulgence in coming late
 22 in the afternoon.
 23 MR. DAWE:
 24 A. You're welcome.
 25 CHAYTOR, Q.C.:

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

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

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

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1 suggestion was much more relevant, and so it
 2 really was 1(a) and (b).
 3 CHAYTOR, Q.C.:
 4 Q. Yes.
 5 MR. DAWE:
 6 A. So I think where they didn't follow the first
 7 suggestion, the second suggestion was a moot
 8 point.
 9 CHAYTOR, Q.C.:
 10 Q. And then the final suggestion was about the
 11 growing concern over retro converters or false
 12 positives, "That again should be addressed
 13 with all breast cancer patients", and do you
 14 know whether or not there's been any follow up
 15 in that respect?
 16 MR. DAWE:
 17 A. I don't know of any, and I think it would
 18 still be an outstanding question that the
 19 Canadian Cancer Society would have of Eastern
 20 Health.
 21 CHAYTOR, Q.C.:
 22 Q. Thank you, Mr. Dawe, those are my questions.
 23 THE COMMISSIONER:
 24 Q. Mr. Pritchard.
 25 MR. PRITCHARD:

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1 Q. Thank you, Commissioner, Ms. Brazil is going
 2 to ask some questions.
 3 THE COMMISSIONER:
 4 Q. All right then.
 5 MR. PETER DAWE - EXAMINATION BY MS. JACQUELINE BRAZIL
 6 MS. BRAZIL:
 7 Q. Good afternoon, Mr. Dawe.
 8 MR. DAWE:
 9 A. Good afternoon.
 10 MS. BRAZIL:
 11 Q. My name is Jackie Brazil. I appear as counsel
 12 with Mr. Pritchard for the province, and I
 13 have a couple of very quick questions for you.
 14 Mr. Dawe, yesterday you confirmed--I think you
 15 stated in your testimony in chief that you had
 16 a good healthy relationship with the province,
 17 that the Canadian Cancer Society had a good
 18 healthy relationship with the province?
 19 MR. DAWE:
 20 A. Absolutely.
 21 MS. BRAZIL:
 22 Q. And particularly --
 23 MR. DAWE:
 24 A. The provincial government, absolutely.
 25 MS. BRAZIL:

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1 Q. In general.
 2 MR. DAWE:
 3 A. Yes, yeah.
 4 MS. BRAZIL:
 5 Q. Okay, thank you, and with--particularly with
 6 Mr. Wiseman, Minister Wiseman, as he is now,
 7 and John Abbott, Ministers Osborne and
 8 Ottenheimer?
 9 MR. DAWE:
 10 A. And even prior to that, absolutely, solid
 11 working functional relationships.
 12 MS. BRAZIL:
 13 Q. Right, and, you know, you gave some very frank
 14 testimony about the meetings that you had with
 15 Mr. Abbott, Mr. Ottenheimer, and Minister
 16 Wiseman, and you confirmed that there was no--
 17 that you didn't change your approach or your
 18 media strategy as a result of those
 19 discussions?
 20 MR. DAWE:
 21 A. Absolutely not.
 22 MS. BRAZIL:
 23 Q. Finally, Mr. Dawe, I just wonder--you
 24 mentioned that there have been--since those
 25 discussions, there have been some joint

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1 projects that the province and the Canadian
 2 Cancer Society participated in. I wonder if
 3 you could elaborate on some of those projects?
 4 MR. DAWE:
 5 A. Absolutely. The first one that comes to mind
 6 because we're so proud of the project is the
 7 Daffodil Place project, and it's a facility
 8 being built in St. John's for cancer patients
 9 to stay in when they come to St. John's for
 10 treatment. It's designed to get at the issue
 11 of the financial burden of a cancer diagnosis,
 12 so it would be a very nominal fee to stay
 13 there, etc, and you get your meals and
 14 transportation back and forth to treatment. We
 15 have met with any number of people within the
 16 Department of Health, and as a matter of fact,
 17 I can remember meeting with Minister Loyola
 18 Sullivan at the time, as finance minister,
 19 talking about the project, the need for it,
 20 and we got a tremendous amount of support from
 21 government. I think I mentioned yesterday
 22 there's always barriers in any project, and we
 23 certainly met some along the way, but at the
 24 end of the day in this particular project, the
 25 provincial government made a substantial

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

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1 will, on how he thinks we're doing with this,
 2 and we want to launch this as soon as
 3 possible.
 4 MS. BRAZIL:
 5 Q. Okay.
 6 MR. DAWE:
 7 A. Those would be the two major projects.
 8 There's any number of other advocacy issues.
 9 Mostly when we're dealing with government,
 10 we're dealing on advocacy issues and there's
 11 give and take and there's negatives and
 12 positives, and you never get exactly what you
 13 want, but you push hard. And tobacco is a
 14 great example. We've cooperated in many areas
 15 on the tobacco file, not just with the
 16 Department of Health, but the enforcement
 17 falls under other areas. Pesticide
 18 legislation comes to mind, and if you want to
 19 bring that back to Minister Johnson and tell
 20 her that we're still waiting for her comments
 21 on the pesticide file, that would be great
 22 too. So again absolutely, I would agree, any
 23 number of projects that we have a healthy
 24 relationship with the provincial government,
 25 back and forth. You never get exactly what

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1 you want, but you keep moving in the
 2 relationship, and it's been my experience that
 3 on the political side, people are there
 4 because they want to see better public policy,
 5 so there's very few - it's not very often that
 6 you run in on the political side to someone
 7 that says, well, you know, that suggestion
 8 doesn't make sense; it's probably more about
 9 the timing of moving on it or the extent that
 10 they feel that they can move on it. On the
 11 bureaucratic side, I'll be quite honest and
 12 say at times it's very frustrating dealing
 13 with the bureaucracy of the provincial
 14 government. It's probably no different than
 15 any bureaucracy, but again there's people
 16 there that are doing their job, as we do our
 17 jobs, and we make as much progress as we can
 18 on any given file in any given time period.
 19 MS. BRAZIL:
 20 Q. So, I guess, today, September 4, 2008, would
 21 you still say that that healthy relationship
 22 exists with the provincial government?
 23 MR. DAWE:
 24 A. Absolutely.
 25 MS. BRAZIL:

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1 Q. Okay, those are my questions, Commissioner.
 2 Thank you, Mr. Dawe.
 3 THE COMMISSIONER:
 4 Q. Mr. Simmons.
 5 MR. PETER DAWE - EXAMINATION BY MR. DAN SIMMONS
 6 MR SIMMONS:
 7 Q. Good afternoon, Mr. Dawe.
 8 MR. DAWE:
 9 A. Good afternoon.
 10 MR SIMMONS:
 11 Q. As you know, I'm Dan Simmons. I'm here for
 12 Eastern Health. I hope not to be too long
 13 either. You told us yesterday that your first
 14 indication that there were issues with ER/PR
 15 testing was in early October of 2005 when
 16 there was a media story in The Independent
 17 which you read concerning that, and you also
 18 told us, I believe, that it was not long after
 19 that that you had our first communication with
 20 Dr. Robert Williams concerning that?
 21 MR. DAWE:
 22 A. Yes.
 23 MR SIMMONS:
 24 Q. And if I understand, from that point on, you
 25 had relatively frequent and open communication

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1 with Dr. Williams concerning the issue?
 2 MR. DAWE:
 3 A. We had continuous communication, absolutely.
 4 MR SIMMONS:
 5 Q. And did you throughout that time period have
 6 any difficulty getting access to Dr. Williams
 7 or reaching him when you needed to, or
 8 arranging a meeting if you needed to speak
 9 with him concerning an issue in any way
 10 related to the ER/PR matter?
 11 MR. DAWE:
 12 A. I would say, no, absolutely not. There was
 13 times he was out of town, but even then if it
 14 was an important issue, I'd get a message to
 15 him and he'd get back to me.
 16 MR SIMMONS:
 17 Q. Yes, and when the issue first broke in the
 18 media in October and several months after
 19 that, you gave a number of media interviews
 20 and you were quite available to the media to
 21 make comment on the issue?
 22 MR. DAWE:
 23 A. Absolutely.
 24 MR SIMMONS:
 25 Q. Yes, and were you aware that Dr. Williams

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1 similarly was giving interviews and making
 2 media comment through that period as well?
 3 MR. DAWE:
 4 A. Yes.
 5 MR SIMMONS:
 6 Q. Did Dr. Williams at any time express any
 7 concern to you about anything you were saying
 8 in the media or the approach you were taking
 9 in the media, did you hear that from Dr.
 10 Williams?
 11 MR. DAWE:
 12 A. No.
 13 MR SIMMONS:
 14 Q. Now you told us that you had contact with Mr.
 15 Tilley who was the CEO of the organization as
 16 well?
 17 MR. DAWE:
 18 A. Yes.
 19 MR SIMMONS:
 20 Q. Similar questions. If you wanted to try to
 21 reach Mr. Tilley, was he available and
 22 accessible to you within the limits of
 23 logistics of getting in touch with each other?
 24 MR. DAWE:
 25 A. Absolutely.

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1 MR SIMMONS:
 2 Q. Did you ever have any occasion when Mr. Tilley
 3 expressed any concern whatsoever to you about
 4 comments you were making in the media about
 5 the ER/PR issue or the position that the
 6 Canadian Cancer Society was taking concerning
 7 it?
 8 MR. DAWE:
 9 A. No, and as I testified to yesterday, I
 10 arranged a specific meeting with him with the
 11 understanding that, you know, he may or the
 12 organization may have some issues they wanted
 13 to talk about, and certainly explicitly gave
 14 him the opportunity, but he did not, you know,
 15 give any examples or express any explicit
 16 concern about the media work we were doing.
 17 MR SIMMONS:
 18 Q. Yes, and that meeting that you referred to was
 19 the one that followed the conversations you'd
 20 had with Mr. Wiseman and Mr. Abbott with
 21 government, I believe, correct?
 22 MR. DAWE:
 23 A. Yes.
 24 MR SIMMONS:
 25 Q. And did I understand you earlier--yesterday to

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1 say that at that meeting with Mr. Tilley,
 2 although it was taking place, I gather, for
 3 the purpose of determining if they had any
 4 issues, as you described, you didn't actually
 5 tell him what you'd heard from Mr. Wiseman or
 6 Mr. Abbott?
 7 MR. DAWE:
 8 A. No.
 9 MR SIMMONS:
 10 Q. And that any other time did Mr. Tilley raise
 11 any concerns with you about the approach taken
 12 by the Canadian Cancer Society?
 13 MR. DAWE:
 14 A. No.
 15 MR SIMMONS:
 16 Q. You told us about dealing with Mrs. Pilgrim.
 17 MR. DAWE:
 18 A. Yes.
 19 MR SIMMONS:
 20 Q. She came on the scene a little bit later in
 21 the process, I believe?
 22 MR. DAWE:
 23 A. Right.
 24 MR SIMMONS:
 25 Q. And I gather that you've probably had

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1 relatively frequent contact with Ms. Pilgrim
 2 on a number of issues since she's responsible
 3 for the Cancer Care Program, the ER/PR matter
 4 being one of them?
 5 MR. DAWE:
 6 A. Absolutely.
 7 MR SIMMONS:
 8 Q. And you told us that there were occasions that
 9 you did have discussions with her about things
 10 she questioned, specific things she questioned
 11 about things you've said in the media?
 12 MR. DAWE:
 13 A. I can remember absolutely receiving--it
 14 happened more than once. It probably happened
 15 three or four times.
 16 MR SIMMONS:
 17 Q. Yes.
 18 MR. DAWE:
 19 A. Receiving a call from Pat Pilgrim questioning
 20 some factual information that had been
 21 presented. My experience was that it was
 22 interpretive--if you want to call a
 23 disagreement on what was said. It was more
 24 interpretive of what was said versus a hard
 25 cold fact that had to be corrected. The only

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1 time--I can remember one time specifically
 2 when I had stated in the media that my
 3 understanding was that families of deceased
 4 patients--the deceased patients hadn't all
 5 been retested, and I can remember Ms. Pilgrim
 6 calling me to say, no, you know, we did that
 7 several months ago, and that that was
 8 information for me that I absolutely then
 9 endeavoured to correct. I remember I actually
 10 wrote a letter to the Editor because I had
 11 mentioned this in a Telegram article.
 12 MR SIMMONS:
 13 Q. Yes.
 14 MR. DAWE:
 15 A. So I endeavoured to correct that.
 16 MR SIMMONS:
 17 Q. So those types of contacts with Ms. Pilgrim,
 18 were they any source of concern for you or
 19 would you just regard those are part of a
 20 healthy type of communication and relationship
 21 between the organizations?
 22 MR. DAWE:
 23 A. No, I don't consider it a part of a healthy
 24 relationship. The relationship, as I
 25 characterized it yesterday, wasn't healthy.

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1 My relationship with Pat Pilgrim was quite
 2 beneficial at times, and at other times it was
 3 unproductive, if you look at it from an
 4 outcome perspective. That's what I said
 5 yesterday. It comes down to what you
 6 accomplish with your conversations.
 7 MR SIMMONS:
 8 Q. Right.
 9 MR. DAWE:
 10 A. And --
 11 MR SIMMONS:
 12 Q. So the things that you or your organization
 13 wanted to see happen didn't always happen, but
 14 was the line of communication between you and
 15 Ms. Pilgrim one that was open such that she
 16 was accessible and you were able to talk--at
 17 least talk about these issues and get an
 18 opportunity to express your point of view?
 19 MR. DAWE:
 20 A. Absolutely, and I testified to that yesterday,
 21 the lines of communications have always been
 22 open.
 23 MR SIMMONS:
 24 Q. And Dr. Howell replaced Dr. Williams as the VP
 25 Medical and following that, I believe you told

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1 us that the first opportunity you had to sit
 2 down and talk to Dr. Howell was after the
 3 media technical briefing on the 11th of
 4 December, 2006?
 5 MR. DAWE:
 6 A. Yes.
 7 MR SIMMONS:
 8 Q. Had you had any occasion before that to try to
 9 contact Dr. Howell or to make any inquiries of
 10 him regarding the ER/PR issue?
 11 MR. DAWE:
 12 A. No.
 13 MR SIMMONS:
 14 Q. So it wasn't a case of Dr. Howell not having
 15 responded to any inquiries that had come from
 16 you?
 17 MR. DAWE:
 18 A. No.
 19 MR SIMMONS:
 20 Q. That was the first opportunity.
 21 MR. DAWE:
 22 A. Yes.
 23 MR SIMMONS:
 24 Q. At that meeting that you had with Dr. Howell
 25 on December 11th, I believe we saw in some of

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1 the documents that that was at 3 o'clock in
 2 the afternoon, and --
 3 MR. DAWE:
 4 A. Yes.
 5 MR SIMMONS:
 6 Q. Did Dr. Howell go over with you any of the
 7 information that had been presented at the
 8 technical briefing as part of that meeting?
 9 MR. DAWE:
 10 A. Not that I can recall.
 11 MR SIMMONS:
 12 Q. Did you learn at that meeting that the
 13 information had been released that there were
 14 117 patients who had had treatment changes as
 15 a result of changed test results, for example?
 16 Did you leave that meeting with Dr. Howell
 17 knowing that number, because that would seem
 18 to be an important piece of what happened in
 19 the technical briefing?
 20 MR. DAWE:
 21 A. I would have probably known that going into
 22 the meeting.
 23 MR SIMMONS:
 24 Q. Uh-hm, okay. So had you followed in some way
 25 the technical briefing or the information

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1 released in it before seeing Dr. Howell at 3
 2 o'clock in the afternoon?
 3 MR. DAWE:
 4 A. I would have had contact with people who had
 5 been in the technical briefing, absolutely.
 6 MR SIMMONS:
 7 Q. So do I take it then that you weren't relying
 8 on your discussion with Dr. Howell to learn
 9 those things, you had already informed
 10 yourself about what type of information had
 11 been released before going into the meeting
 12 with Dr. Howell, had you?
 13 MR. DAWE:
 14 A. Absolutely.
 15 MR. SIMMONS:
 16 Q. Yeah. Were there any questions you had about
 17 the information released at the technical
 18 meeting that you raised with Dr. Howell?
 19 MR. DAWE:
 20 A. No. The discussion with Dr. Howell was not
 21 technical in any way, shape or form.
 22 MR. SIMMONS:
 23 Q. Right, okay. And I'm going to move around a
 24 little bit just to hit some of the different
 25 areas.

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1 MR. DAWE:
 2 A. Yeah.
 3 MR. SIMMONS:
 4 Q. The chronology is not going to be strictly
 5 correct. You told us about meeting Dr.
 6 Williams back in October of 2005 and about
 7 some discussion about Dr. Williams'
 8 expectations about what the portion of or
 9 percentage of change results might be as a
 10 result of the retesting that was under way?
 11 MR. DAWE:
 12 A. Yes.
 13 MR. SIMMONS:
 14 Q. You recall that. Do you recall at that time
 15 that there were very few test results back
 16 from Mount Sinai and the bulk of the samples
 17 had not yet been retested? Does that sound
 18 correct?
 19 MR. DAWE:
 20 A. That sounds correct.
 21 MR. SIMMONS:
 22 Q. Right. And if I noted correctly, what you'd
 23 said on that was that your perception was that
 24 Dr. Williams was expecting ten percent of the
 25 retests to have changed results but you

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1 weren't certain if that was what had been
 2 conveyed to you by Dr. Williams? Did I get
 3 that wrong?
 4 MR. DAWE:
 5 A. I wouldn't be able to quote him accurately.
 6 MR. SIMMONS:
 7 Q. Yes.
 8 MR. DAWE:
 9 A. But again, the perception that I had and it
 10 was formed by Dr. Williams both in what we
 11 discussed one on one and with other public
 12 statements that he'd made was that there was
 13 a--the ten percent figure was being used. And
 14 I was certainly, had the impression that it
 15 was, it reflected a ten percent error rate and
 16 that whether I had ever--well, later on in the
 17 relationship with Dr. Williams I'd certainly
 18 asked for exact numbers but was never given
 19 them by Dr. Williams directly.
 20 MR. SIMMONS:
 21 Q. Right.
 22 MR. DAWE:
 23 A. But the ten percent number existed for some
 24 time.
 25 MR. SIMMONS:

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1 Q. Okay. I'm just going to show you one
 2 newspaper report at P-0345, page 2, please? I
 3 just want to see if this accords with your
 4 recollection or not. Okay, this is one we've
 5 looked at with a number of witnesses. This is
 6 an Evening Telegram--or The Telegram report,
 7 it's from October 5th, 2005. So this would
 8 have been very shortly after the original
 9 Independent article and probably around the
 10 time of that first meeting you had with Dr.
 11 Williams, would it be?
 12 MR. DAWE:
 13 A. I believe it was October 6th I had the
 14 meeting.
 15 MR. SIMMONS:
 16 Q. Yeah, okay. And this one is a little bit hard
 17 to read. See if I can make it a bit bigger
 18 here. If you start here on the second column
 19 at the very bottom, it says, "About 350 of the
 20 tests are done annually in this province with
 21 60 percent of the samples from Eastern Health
 22 Authority patients and 40 percent from
 23 patients treated at other regional centres.
 24 Williams said the lab at the General Hospital
 25 and the Health Sciences Centre in St. John's

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1 stains the specimens for these receptors.
 2 Results are read at referring hospitals. Most
 3 of the tests performed were positive, Williams
 4 said." And there's a quote then, "'We had
 5 about 73 percent of tests that were positive,
 6 so are only retesting the 27 percent or so
 7 that were negative' And from the early
 8 results Williams says it appears that only
 9 about ten percent of the overall tests
 10 performed over the past seven years show
 11 different results." So in this newspaper
 12 article it appears that the ten percent is ten
 13 percent of all tests and not just ten percent
 14 of the 27 percent that were negative. Do you
 15 see that?
 16 MR. DAWE:
 17 A. Now that you point it out to me, absolutely.
 18 MR. SIMMONS:
 19 Q. Yeah. Does that accord at all with your
 20 recollection or your perception of the
 21 information as conveyed to you by Dr.
 22 Williams?
 23 MR. DAWE:
 24 A. Again, my perception, and it lasted well over
 25 a year, as that--and again, speaking to Dr.

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1 Williams numerous times and Bob giving me
 2 updates on how many people had actually gone
 3 through the process and how many tests had
 4 gotten back because at one point that was the
 5 key discussion with Dr. Williams and myself
 6 was, you know, "Bob, is everybody back yet?
 7 You know, we're still getting calls. Has
 8 everybody been retested -
 9 MR. SIMMONS:
 10 Q. Yes, that was the issue.
 11 MR. DAWE:
 12 A. - that was supposed to be retested?" And the-
 13 -Dr. Williams again used the ten percent
 14 number throughout the conversations I had with
 15 him. I'd never clarified with him if it was
 16 ten percent of everybody who had breast cancer
 17 or if it was ten percent of the retests
 18 explicitly.
 19 MR. SIMMONS:
 20 Q. Yes.
 21 MR. DAWE:
 22 A. Although I did ask for numbers and was never
 23 given them.
 24 MR. SIMMONS:
 25 Q. Right, okay, good. You've alluded then to

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1 making inquiries about the progress of getting
 2 the samples back, the retest results back from
 3 Mount Sinai. So through 2005 then you were
 4 aware that there were delays encountered and
 5 the results weren't coming back as quickly as
 6 had been anticipated?
 7 MR. DAWE:
 8 A. Absolutely.
 9 MR. SIMMONS:
 10 Q. You told us that at one point you made
 11 suggestions about or inquired as to whether it
 12 might be possible to get Mount Sinai to
 13 prioritize -
 14 MR. DAWE:
 15 A. Right.
 16 MR. SIMMONS:
 17 Q. - the results. And I think that was P-0387,
 18 please? We looked at this before. This is
 19 your e-mail message of November 14th there.
 20 And do you know whether there was then
 21 anything to try and prioritize the results for
 22 the living patients ahead of those patients
 23 who were known to be deceased? Were you ever
 24 made aware of that?
 25 MR. DAWE:

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<p>1 A. My recollection is that, and I said yesterday, 2 I can remember having the conversation with 3 Bob Williams, not Pat Pilgrim, and that Bob 4 had told me that prioritizing the samples now 5 that they were up at Mount Sinai would be too 6 extensive a problem, just create too many 7 logistical problems.</p> <p>8 MR. SIMMONS: 9 Q. Right.</p> <p>10 MR. DAWE: 11 A. I certainly had knowledge at some point, and 12 whether it was close to this point in time or 13 not, but I had knowledge at some point in time 14 that Eastern Health had asked Mount Sinai to 15 differentiate between people who were living 16 and deceased and that let's get through the-- 17 you know, telling Mount Sinai to prioritize 18 the people that were living.</p> <p>19 MR. SIMMONS: 20 Q. So despite the initial response or reaction 21 you had from Dr. Williams you did learn later 22 that steps were taken to at least prioritize -</p> <p>23 MR. DAWE: 24 A. Absolutely.</p> <p>25 MR. SIMMONS:</p>	<p>1 MR. DAWE: 2 A. And it was around when people had been 3 diagnosed and should that have affected the 4 prioritization.</p> <p>5 MR. SIMMONS: 6 Q. Right. Did you learn at any point in the 7 process that there was a provision in place 8 whereby oncologists or treating physicians 9 could, in effect, pull patients out of the cue 10 and prioritize them by having their samples 11 sent to Mount Sinai as what they called a 12 consult?</p> <p>13 MR. DAWE: 14 A. I learned it. It actually--I learned that 15 through the media and not from Department of 16 Health, but I did have that knowledge at some 17 point.</p> <p>18 MR. SIMMONS: 19 Q. Good, okay. And I'd like to refer you also to 20 P-2509, which was a letter that you looked at 21 yesterday. Now, this is from June of 2006, 22 it's an e-mail message from you to Dr. Roy 23 West, who I believe then was chair of the 24 Newfoundland and Labrador Division of the 25 Cancer -</p>
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<p>1 Q. - results for the living. And if I can just 2 show you P-1805, please, that will confirm 3 that. Now, and this isn't a document you 4 would have seen before, but it's an e-mail 5 message from, actually, before yours, from 6 November 3rd, '05 from Heather Predham. And 7 it's addressed to Dr. Cook and to Dr. Mullen 8 at Mount Sinai saying "Upon Dr. Cook's and Dr. 9 William's request I have reviewed your list 10 and highlighted in yellow all those that are 11 now deceased." And there's a list which we 12 won't look here which is attached to that 13 identifying individual patients. So this 14 would accord with the knowledge you later 15 acquired, would it?</p> <p>16 MR. DAWE: 17 A. Yes.</p> <p>18 MR. SIMMONS: 19 Q. Okay.</p> <p>20 MR. DAWE: 21 A. Of course, Mr. Simmons, the requests that we 22 were getting about prioritization were from 23 living people, obviously.</p> <p>24 MR. SIMMONS: 25 Q. Yes.</p>	<p>1 MR. DAWE: 2 A. Yes.</p> <p>3 MR. SIMMONS: 4 Q. Canadian Cancer Society. You said in it, 5 "Here's a draft of the letter to Eastern 6 Health re hormone receptor testing. I know 7 there's no rush, but I don't want to lose the 8 issue. We've told the board we will vet it 9 through them also." And there's a draft of a 10 letter attached. Now, were you the author of 11 this draft?</p> <p>12 MR. DAWE: 13 A. Yes.</p> <p>14 MR. SIMMONS: 15 Q. Okay. It's a draft addressed to Ms. Joan 16 Dawe, who was the chair of the Eastern Health 17 Board. And you've told us that the letter was 18 never completed and sent, I gather?</p> <p>19 MR. DAWE: 20 A. Right.</p> <p>21 MR. SIMMONS: 22 Q. And there was some, I gather, discussion about 23 the tone of the letter and some disagreement 24 or failure to agree, perhaps, on your part and 25 Mr. West's on what tone to take in the letter,</p>

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<p>1 was it?</p> <p>2 MR. DAWE:</p> <p>3 A. On how--tone might be one way to describe it,</p> <p>4 absolutely, yes.</p> <p>5 MR. SIMMONS:</p> <p>6 Q. Yes, okay. But nevertheless, the particular</p> <p>7 draft we have here is the one that was</p> <p>8 prepared by you and proposed to Dr. West for</p> <p>9 his review?</p> <p>10 MR. DAWE:</p> <p>11 A. Yes.</p> <p>12 MR. SIMMONS:</p> <p>13 Q. And it is this draft that has the statement in</p> <p>14 it on the second page that, "In fact, it is</p> <p>15 our belief that the relationship has improved</p> <p>16 with the creation of the Eastern Health</p> <p>17 Authority." So having written that and</p> <p>18 proposed it to Dr. West can we take it that</p> <p>19 that was a view that at least at that time</p> <p>20 that you held that it was appropriate to</p> <p>21 communicate that information to the chair of</p> <p>22 the Eastern Health board?</p> <p>23 MR. DAWE:</p> <p>24 A. There was certainly a point in time when</p> <p>25 Eastern Health was created and the</p>	<p>1 MR. SIMMONS:</p> <p>2 Q. Good. Thank you, very much, Mr. Dawe. That's</p> <p>3 all I have for you.</p> <p>4 MR. DAWE:</p> <p>5 A. Thank you.</p> <p>6 THE COMMISSIONER:</p> <p>7 Q. Ms. Hennebury?</p> <p>8 MS. HENNEBURY:</p> <p>9 Q. I have no questions.</p> <p>10 THE COMMISSIONER:</p> <p>11 Q. Mr. Pritchett?</p> <p>12 MR. PRITCHETT:</p> <p>13 Q. I have no questions, Commissioner?</p> <p>14 THE COMMISSIONER:</p> <p>15 Q. Mr. Pike?</p> <p>16 MR. PIKE:</p> <p>17 Q. No questions, thank you.</p> <p>18 THE COMMISSIONER:</p> <p>19 Q. Ms. Brocklehurst?</p> <p>20 MS. BROCKLEHURST:</p> <p>21 Q. No questions, thank you.</p> <p>22 THE COMMISSIONER:</p> <p>23 Q. Ms. Newbury?</p> <p>24 MR. PETER DAWE, EXAMINATION BY MS. JENNIFER NEWBURY</p> <p>25 MS. NEWBURY:</p>
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<p>1 Newfoundland Cancer Treatment Research</p> <p>2 Foundation had been disbanded when the</p> <p>3 relationship with the Cancer Care program,</p> <p>4 from our perspective, was much more open.</p> <p>5 MR. SIMMONS:</p> <p>6 Q. Okay. And -</p> <p>7 MR. DAWE:</p> <p>8 A. And I believe that that sentence is a</p> <p>9 reflection of that.</p> <p>10 MR. SIMMONS:</p> <p>11 Q. Good. And the sentence is written in the</p> <p>12 present tense and the letter is dated June,</p> <p>13 2006, so can we take June, 2006 to be such a</p> <p>14 time when there was -</p> <p>15 MR. DAWE:</p> <p>16 A. No, because the, as I said, the letter was</p> <p>17 never sent and there was a lot of discussion</p> <p>18 between myself and Dr. West on exactly what we</p> <p>19 were trying to convey in the letter. And we</p> <p>20 obviously didn't come to agreement on it.</p> <p>21 MR. SIMMONS:</p> <p>22 Q. Was the draft ever presented to your board to</p> <p>23 be vetted?</p> <p>24 MR. DAWE:</p> <p>25 A. No, we didn't even create another draft.</p>	<p>1 Q. Good afternoon, Mr. Dawe. I understand that</p> <p>2 you may have some additional observations or</p> <p>3 comments on a couple of topic areas that you</p> <p>4 think might be of some benefit to the</p> <p>5 Commissioner.</p> <p>6 MR. DAWE:</p> <p>7 A. Hopefully.</p> <p>8 MS. NEWBURY:</p> <p>9 Q. And perhaps if we can go over a few of those</p> <p>10 briefly. First of all, you had spoken</p> <p>11 yesterday about patient right to know and</p> <p>12 public right to know. And I just wondered if</p> <p>13 there was anything that you wanted to add in</p> <p>14 relation to that and I know that there is an</p> <p>15 exhibit which I believe it related, P-2438,</p> <p>16 please? And perhaps you could explain what</p> <p>17 this exhibit is in relation to -</p> <p>18 MR. DAWE:</p> <p>19 A. Commissioner, this is a Canadian Prostate</p> <p>20 Cancer Network, it's a community volunteer</p> <p>21 network of prostate cancer survivors across</p> <p>22 the country. And they endeavoured some years</p> <p>23 ago to come up with what they are calling a</p> <p>24 Charter of Rights and it lays out, from their</p> <p>25 perspective, what would be the basic rights of</p>

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1 a patient with prostate cancer in any
 2 situation in any province in the country. And
 3 we brought it forward to highlight what we
 4 would think of as one of the main areas of
 5 concern of the Commission of Inquiry. And
 6 we've said from the beginning, obviously, what
 7 happened in the lab is why we're all here, but
 8 the follow-up from Eastern Health around the
 9 communications issues is and always has been
 10 one of the primary areas of concern for the
 11 Cancer Society. And it's from the perspective
 12 of representing cancer patients or people who
 13 might have cancer in the population of
 14 Newfoundland and Labrador. So we would put
 15 forward that there are--there is a necessity
 16 for groups like the Canadian Cancer Society,
 17 groups like the Prostate Cancer Network,
 18 governments, health care institutions to
 19 articulate clearly what people should expect
 20 when they enter the health care system. This
 21 particular one represents prostate cancer. We
 22 obviously would represent cancer patients in
 23 general. I would suggest that there is a
 24 broader need in the health care in general to
 25 articulate clearly what a fair expectation

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1 would be for any person entering the health
 2 care system, what you can expect as far as
 3 your understanding of, and we talked a little
 4 bit about the right to know, an individual's
 5 right to know and patients right to know has
 6 come up. What the Canadian Cancer Society
 7 would put forward was that was people actually
 8 have a right to actually understand, not just
 9 to know and be told, but to understand
 10 information begin given to them. And if you
 11 look at this particular exhibit, you get that
 12 sense that they're not just--these people have
 13 said we're not just looking for information,
 14 we want to be a full partner in our own health
 15 care, and that's what it comes down to for the
 16 Canadian Cancer Society. In this particular
 17 case where you've got mistakes that were made
 18 and on a large scale and a large number of
 19 people that were affected, you're even gone
 20 beyond--you get into the area that the
 21 professionals start putting particular names
 22 on, you know, whether it's--and the term is
 23 escaping me now that the Canadian Patient
 24 Safety Institute uses, adverse event. Whether
 25 it's an adverse event or not, you know, at the

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1 day if you flip that around from a patient
 2 perspective, it's a mistake that affected them
 3 quite negatively and so, the Cancer Society
 4 has a belief that there absolutely has to be
 5 articulated a basic level of rights for people
 6 entering the system, and then if there is
 7 going to be, and there always will be mistakes
 8 made, there has to be an articulation of what
 9 the patient rights are in that instant also,
 10 and there is organizations like the Canadian
 11 Patient Safety Institute who look at it much
 12 more from the institution perspective and from
 13 the professional perspective on what the
 14 institution is accountable for. We would
 15 suggest that there's an opportunity to look at
 16 it from the patient, dare I say person who has
 17 cancer perspective, and anybody entering the
 18 health care system, about what they have a
 19 right for.
 20 The other piece that you'd add onto that
 21 then, and that we've gotten into in this
 22 instance is there's an individual right, but
 23 then at some point, there's also a public
 24 right, and there's a public right to know
 25 about our health care institutions. They're

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1 public institutions. Even if they were
 2 private institutions, I think we have, in our
 3 society, an engrained belief that we have
 4 certain rights when we seek health care.
 5 And so from a public perspective, when
 6 there's knowledge or when there's mistakes
 7 make, at some point, again, there needs to be
 8 clearly articulated what the public's right is
 9 to know and to understand of situations, and
 10 this gets back to the public having confidence
 11 in the system, and understanding when they
 12 approach health care institutions what the
 13 institution is capable of delivering for them,
 14 and the role it plays in society and what it
 15 can expect not to happen. Again, you get into
 16 adverse events.
 17 THE COMMISSIONER:
 18 Q. Does your organization have any kind of a
 19 formal position in respect of the issue of
 20 public right to know as opposed to patient
 21 right to know?
 22 MR. DAWE:
 23 A. Right, and depending on the particular topic,
 24 we've been working on several. Right now,
 25 we're looking at, again revising--because

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1 there was an opportunity or an attempt seven
 2 or eight years ago, through the federal
 3 government, to bring in a charter of rights
 4 for people entering the health care system.
 5 So we're looking at the possibility of
 6 reviving that effort. There's similarities in
 7 some positions that we've worked through. One
 8 that I can think of is the work with the
 9 Federal Government on patient/public right to
 10 know around content, chemicals, etcetera, that
 11 exist in consumer products and that's a piece
 12 of work that's ongoing, almost finished. It's
 13 called Right to Know legislation, and I think
 14 we're going to try to mirror that from a
 15 health care perspective.
 16 But there hasn't been, to my knowledge, a
 17 whole lot of thought and energy put into the
 18 differentiation, and that's what you're asking
 19 me, between the patient right to know and the
 20 public right to know. So the shorter answer
 21 is, it's not there yet.
 22 THE COMMISSIONER:
 23 Q. Could there not even be a conflict between the
 24 two on occasion, in the sense of, I'm thinking
 25 particularly of small in size perhaps

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1 problems, and you get into privacy issues for
 2 patients and balancing that against a public
 3 right to know and how you protect the privacy
 4 of the patient while still informing the
 5 public?
 6 MR. DAWE:
 7 A. I think those are the issues that would have
 8 to be addressed. There are examples though,
 9 if you look at--there's certain hospitals in
 10 the United States, because it's a different
 11 system, that will--it's very public about
 12 their success rate or failure rate in any
 13 given procedure. That's all part of their
 14 sense of accountability and their marketing,
 15 if you will. And so, I think it's more about
 16 those types of issues that you can imagine the
 17 public would be interested in.
 18 So I think you could very well articulate
 19 the difference between public and private
 20 right to know without getting into privacy
 21 issues, and I think that there hasn't--the
 22 issue of accountability of our health care
 23 system is something that's been talked about a
 24 great deal. Certainly I've worked in the
 25 health care system all my career. But there

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1 hasn't been a whole lot of articulation of
 2 what that actually means, that accountability,
 3 and certainly as a side issue, we talked a
 4 little bit about board governance yesterday.
 5 Eastern Health have said that their board is
 6 accountable to the Minister and then the
 7 Minister would say well, he's accountable to
 8 the public. I think if you ask the average
 9 person, they would have an expectation that
 10 the hospital itself is accountable directly to
 11 them in some way. Now whether that's true
 12 from a legal perspective or not, but it's
 13 still the expectation and that's still what
 14 needs to be articulated.
 15 So you do get into an understanding, and
 16 this is a good example, the ER/PR test. The
 17 general public have any knowledge whatsoever
 18 that a test such as this could end up being a
 19 grey area versus something that's actually
 20 black and white and there doesn't seem to--you
 21 know, there's not inherent issues in it,
 22 inherent mistake issues in it. And I think,
 23 again, the average, being an individual
 24 entering the system or the public in general
 25 wouldn't have that level of knowledge, and so

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1 again, the Canadian Cancer Society would say,
 2 you know, that's not healthy. That's not
 3 where we're going in our health care system,
 4 and from an accountability perspective, these
 5 systems have to be open, much more open with
 6 their accountability, and that's from their
 7 perspective, but also from the individual,
 8 from a public perspective, an articulation has
 9 to be made of what the rights are.
 10 MS. NEWBURY:
 11 Q. Thank you. Mr. Dawe, you are a member of an
 12 ad hoc committee of the Canadian Association
 13 of Pathologists.
 14 MR. DAWE:
 15 A. Yes.
 16 MS. NEWBURY:
 17 Q. And you did speak about your involvement in
 18 that a little bit yesterday. I understand
 19 that you are now going to be looking at
 20 another initiative that's something within
 21 your area of expertise, and in that regard,
 22 I'm going to bring up Exhibit P-2437, and
 23 perhaps you can advise what this particular
 24 document is and how that relates to your
 25 involvement in the ad hoc committee of the

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1 Canadian Association of Pathologists?
 2 MR. DAWE:
 3 A. The Canadian Partnership Against Cancer is an
 4 organization or a partnership, if you will,
 5 that was created several years ago by the
 6 federal government and lobbied for for a
 7 number of years through people working on the
 8 Canadian Strategy for Cancer Control. And the
 9 Canadian Strategy for Cancer Control is a
 10 comprehensive plan to address cancer across
 11 the country.
 12 Canada has a--well, it's not unique, but
 13 there's very distinctive characteristics of
 14 health care in Canada. It's federally funded,
 15 but provincially delivered. The Canada Health
 16 Act addresses certain issues, but doesn't
 17 address other issues. It makes for reform and
 18 improvement in health care on a national level
 19 a very complex procedure.
 20 The Canadian Partnership Against Cancer
 21 is an attempt by government, federal and
 22 provincial government, cancer care delivery
 23 organizations, and partner organizations such
 24 as the Canadian Cancer Society, volunteer
 25 organizations, to bring as much knowledge,

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1 energy, synergy together as possible, knowing
 2 the complexities of the
 3 federal/provincial/territorial issues and yet
 4 still improve cancer care, cancer control in
 5 the country. If you drill into and look at
 6 the areas that they work in, one of the areas
 7 that the partnership would look at or is
 8 looking at is the whole area of standards and
 9 national standards in cancer treatment, for
 10 the most part. They call it guidelines, I
 11 think is the--Standards Action Group is the
 12 term they use, and they talk about--again,
 13 there's an interchangeable word, guidelines,
 14 standards, but it is intended to get at the
 15 need for national standards across the
 16 country, as relates to cancer control and
 17 through the work with the CAP committee, the
 18 Canadian Association of Pathologists
 19 committee, I'm going to attempt to, and I am
 20 liaising with the partnership group and try to
 21 tie the work of Dr. Torlakovic and the
 22 subcommittee with the work being done by the
 23 Standards Action Group, and I think that's a
 24 natural fit. I think it's something the
 25 Commission should know about because I think

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1 it is--they're federally funded and funded to
 2 a healthy level and so there's resources that
 3 can help with any type of, and lay the
 4 groundwork for national standards across the
 5 country. And again, the complexity of
 6 national standards being are they mandatory or
 7 voluntary and you get into all of these
 8 issues, and that's what the partnership was
 9 intended to address.
 10 MS. NEWBURY:
 11 Q. Now I understand, Mr. Dawe, that--and you've
 12 alluded to this many times over the last day
 13 or so, that you've had, on behalf of the
 14 Canadian Cancer Society, a number of efforts
 15 to communicate with the public, and there's an
 16 exhibit there that I would like you to quickly
 17 address. It's P-2523, please. And this is
 18 just a list of the attached exhibits. I'll
 19 turn to page two. Perhaps you can just
 20 identify what that document is?
 21 MR. DAWE:
 22 A. Again, this would have been from our efforts
 23 in the fall of '07 in preparation for the
 24 Inquiry, our attempt to do as much public
 25 consultation as we could, combined with our

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1 understanding that there was still people out
 2 there that may need more information, may need
 3 more help, and so we took it upon ourselves to
 4 do some public consultation, again, basically
 5 on a shoestring, to try to gather information,
 6 gather contacts in communities of people that
 7 might have been affected, how they wanted to
 8 see this Inquiry proceed and the outcomes they
 9 were hoping to get from the Inquiry. This
 10 would have been either a public service
 11 announcement or a paid advertisement.
 12 MS. NEWBURY:
 13 Q. And this one you spoke to yesterday, so I'll
 14 bring you to the third one, which is Call to
 15 Action, and the index for this document,
 16 actually the very beginning, page one,
 17 indicates that that was around May 2008,
 18 perhaps you could explain what that is.
 19 MR. DAWE:
 20 A. Again, this is a copy of one of the paid
 21 advertisements we would have used in the fall
 22 of '07. This is actually our community report
 23 that was distributed to over 127,000
 24 households in the province in May month of
 25 2008, and again, it's the ongoing attempt of

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1 the Canadian Cancer Society to reach out to
 2 people who might have been affected and felt
 3 are still in need of either information or
 4 support.
 5 MS. NEWBURY:
 6 Q. And there's an exhibit that I would like you
 7 to look at and comment upon for the
 8 Commissioner. It's P-2436, please. This is
 9 entitled Cancer Patient Navigation Evaluation
 10 Findings, and scrolling down, it's dated March
 11 2004 and on the second page, it's shown to be
 12 prepared for the Cancer Care Nova Scotia.
 13 Perhaps you could explain what this is and how
 14 you think that might relate to the work of the
 15 Commission?
 16 MR. DAWE:
 17 A. Patient Navigation is a concept that's been
 18 around for a little while, probably ten years
 19 or more, and it evolved out of the growing
 20 complexity of our health care system. The
 21 term, patient navigation, as it implies, it's
 22 someone entering the system and having to
 23 literally navigate their way through the maze
 24 of what can be the health care system.
 25 This particular report came from Cancer

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1 Care Nova Scotia, an umbrella group that looks
 2 at cancer care in Nova Scotia. They don't
 3 deliver services. They actually coordinate
 4 services across the province and they piloted
 5 a concept where they hired people as patient
 6 navigators and they worked with cancer
 7 patients entering the system and so they
 8 coordinated everything from actual
 9 appointments to when tests should be done and
 10 how people could access better information,
 11 and they worked with the system to achieve
 12 that end.
 13 They did an evaluation. Evaluation,
 14 well, to prove that it was working and they
 15 actually moved from a pilot to implementing
 16 this on a full-time basis, and I believe they
 17 tripled the number of--the pilot, I think, was
 18 six people. I think they doubled or tripled
 19 the number of people that they had as patient
 20 navigators and it's a well entrenched program
 21 in that system now.
 22 The relevance is that any time there's a
 23 person entering the health care system, and
 24 we're talking about cancer, so the cancer care
 25 system, it can be complicated. You've got a

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1 wide geographical area. You've got people
 2 moving back and forth for appointments. It
 3 can be stressful. Cancer in and of itself
 4 presents many challenges. It's a chronic
 5 disease. Treatment can take many months, with
 6 harsh side effects. Many implications, both
 7 socially and financially, and one of the areas
 8 that's always been expressed, and certainly to
 9 us, is how difficult people find it to get
 10 proper information and to literally have their
 11 care coordinated properly. Because you go
 12 from a system of diagnosis to a system of
 13 treatment, to a system of follow up, and
 14 perhaps even palliative care, and these can be
 15 different, delivered by what seemingly are
 16 different systems at different times.
 17 One of the beliefs that we had is that a
 18 patient navigation system is ideal for
 19 Newfoundland and Labrador and we presented
 20 this idea. We've talked about this with
 21 Eastern Health and with the provincial
 22 government. But in this particular case, with
 23 Eastern Health and with when these mistakes
 24 were made and when a group of people were
 25 affected, you could quite quickly see how the

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1 patient navigation concept would get to the
 2 heart of the matter for the people involved in
 3 giving them a particular person of contact who
 4 would help them navigate through, in this
 5 case, what could be an even, and what turned
 6 out to be an even more complex and complicated
 7 health delivery system because of the
 8 retesting, because of new treatment for many
 9 people and because of the need for new
 10 information.
 11 So we're bringing it forward because we
 12 believe it's a concept that the health care
 13 system needs in any event, but certainly in
 14 the Commission's study of what to do when
 15 mistakes are made, I think this gets to the
 16 heart of the matter of how to deal with the
 17 individuals involved, because no doubt the
 18 Commissioner will think about it from an
 19 institutional perspective. I guess, again,
 20 our role is here to remind the Commissioner
 21 that we'd want you to think about it from a
 22 person perspective also.
 23 MS. NEWBURY:
 24 Q. Thank you. Mr. Dawe, you've made references
 25 on occasion to the issue of retro converters,

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1 and I just wondered if you had anything that
 2 you wanted to add on that?
 3 MR. DAWE:
 4 A. Well, there are several things that still seem
 5 to be question marks that are left out there,
 6 and we saw in an exhibit yesterday that we did
 7 reference a question, and the exhibit again
 8 today, I think, in commenting on the letter
 9 that Eastern Health had sent out, the issue of
 10 retro converters. So this is the issue of
 11 false positives, and we've been talking about
 12 and the whole Inquiry is based on what went
 13 wrong with false negatives.
 14 We still have a question mark about the
 15 rest of the people involved who had breast
 16 cancer who had an ER/PR test and was
 17 originally tested positive, but there's no
 18 guarantees. There's been no effort to go back
 19 and look at and retest even a sampling of the
 20 people that were positive, and we would
 21 question why that wasn't done. We would
 22 question what the implications are if there
 23 are false positives, and we would also suggest
 24 that there was implications even within the
 25 process that was set up. We heard several

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1 women say that they were--or we saw through
 2 their histories, they were weak positives and
 3 had refused Tamoxifen or a similar drug,
 4 hormone therapy, based on the harsh side
 5 effects or their perceived harsh side effects,
 6 and that when their sample turned out to be
 7 negative and it ended up at the tumour board.
 8 Because they had refused hormonal treatment in
 9 the past, they were automatically said, well,
 10 you know, this person has refused hormonal
 11 treatment, so we won't even consider that at
 12 this time. So again, you're into an area of
 13 people who tested positive originally and what
 14 are the implications for many of these issues
 15 for this group of people.
 16 For us, and bringing it up at this point
 17 because we don't have any answers for it
 18 obviously, but we do still think it's an
 19 outstanding question and there's many
 20 questions around the issue.
 21 MS. NEWBURY:
 22 Q. Did you have anything that you wanted to add
 23 regarding the results of deceased patients and
 24 how that may have been handled?
 25 MR. DAWE:

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1 A. Well, just to reiterate it. We said it
 2 publicly. Mr. Simmons just brought it up
 3 again that there was a differentiation between
 4 people who were deceased getting their tests,
 5 getting the retest done and people who were
 6 still living, and that obviously it made sense
 7 from a prioritization point of view to
 8 prioritize people that were still living in
 9 getting the retests done. At some point,
 10 Eastern Health made the decision to retest all
 11 of the people who were deceased, but that they
 12 have still left it up to people, families of
 13 deceased, to contact them if they want to get
 14 the test result.
 15 It's something that we have said to
 16 Eastern Health that we believe that all of the
 17 people, the deceased people, their families,
 18 their loved ones, have a right to know what
 19 the test result was. Some of these people may
 20 not even realize that they have a loved one
 21 that was affected, and again, this goes back
 22 to our experience of people's lack of
 23 understanding of who was affected by this and
 24 the processes involved. You could literally
 25 have someone out there or a family out there,

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1 a loved one who--someone who lost a loved one
 2 who had no contact from Eastern Health, had
 3 someone who was deceased, and just assumes,
 4 because they've never had contact, that this
 5 issue has nothing to do with them.
 6 Again, it's a philosophical approach that
 7 we would say is just a basic right that if
 8 this information is held by Eastern Health
 9 that families deserve to be given the
 10 information. Obviously they can do whatever
 11 they want with the information. They can
 12 ignore it, if that's the case, but it's just a
 13 basic right that they should be automatically
 14 given the information.
 15 MS. NEWBURY:
 16 Q. And Mr. Dawe, one final topic. There's been
 17 some evidence about the cancer registry and
 18 the information contained in that, and do you
 19 have anything that you feel that you can
 20 comment on in that regard?
 21 MR. DAWE:
 22 A. Well, an organization, cancer organization
 23 very concerned with public policy, one of the
 24 absolute foundations of information to develop
 25 good public policy is the data on cancer in

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1 our particular province, and we would like to
 2 highlight for the Commissioner that whole area
 3 as she thinks about the evidence and as she
 4 considers recommendations that the data--we've
 5 heard a lot of evidence around the data
 6 management from within Eastern Health and it's
 7 wider than Eastern Health because it affects
 8 all the health authorities, that even at a
 9 most basic level, the cancer registry couldn't
 10 even provide the basic demographics of who
 11 exactly was affected. We've heard other
 12 evidence of not all cancer cases being
 13 reported, not all deaths being reported.

14 We believe that it is an absolute
 15 foundational block of healthy, good healthy
 16 public policy, in this case, cancer policy, to
 17 have cancer registry and affiliated services,
 18 so that you're not just collecting data, but
 19 you're actually mining the data from an
 20 epidemiological perspective. That is a
 21 fundamental that has to be fixed in this
 22 province and put in place and made
 23 accountable, you know, even through
 24 legislation, which it is in other areas, that
 25 that is working properly. Because without

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1 that in place, and we saw it--again, just from
 2 a most basic level of Eastern Health
 3 struggling with exactly who should be on the
 4 list, that's at a most basic level. But we
 5 would suggest that a registry working properly
 6 would have the possibility, if it was being
 7 analyzed properly on a go-forward basis, to
 8 actually even pick up issues like how many
 9 people are testing positive and negative for
 10 tests like ER/PR and proactively looking for
 11 systematic problems in the population as it
 12 relates to cancer control. So that
 13 possibility exists.

14 What I'm actually saying is that if we
 15 had a properly running system, that it might
 16 have picked up on this issue earlier.

17 THE COMMISSIONER:
 18 Q. Who keeps the cancer registry?
 19 MR. DAWE:
 20 A. Cancer registry was developed and maintained
 21 under Newfoundland Cancer Treatment Registry,
 22 Research Foundation, up until the spring of
 23 '05 when that organization was folded into
 24 Eastern Health. So it's housed under Eastern
 25 Health at this time and funded by the

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1 provincial government, through Eastern Health.
 2 MS. NEWBURY:
 3 Q. Thank you, Mr. Dawe. Is there anything else
 4 that you would like to add?
 5 MR. DAWE:
 6 A. Just on final comment, the Canadian Cancer
 7 Society obviously has taken the whole issue of
 8 the mistakes made with ER/PR testing quite
 9 seriously, devoted a lot of resources and
 10 energy. Limited resources and energy that we
 11 do have, we devoted a great deal into trying
 12 to make sure that people were served properly,
 13 and at the end of the day, not to try to make
 14 a grand statement of this, but that this whole
 15 process comes back to the people that were
 16 affected, and we've heard many, many, many
 17 side stories around the professionals involved
 18 and the institutions involved, and the
 19 technicalities of what happens in a lab, the
 20 politics that go with health care.

21 But again, I think the role of the Cancer
 22 Society in the Inquiry is to explicitly say to
 23 the Commissioner that this process is about
 24 the people that were affected and that every
 25 one of those people affected in any way

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1 deserve the full attention of the Commissioner
 2 as she looks forward and looks at her
 3 recommendations and that our due diligence is
 4 to put that squarely in front of you and
 5 entrust that you keep that in mind as you
 6 bring forward recommendations.

7 MS. NEWBURY:
 8 Q. Thank you.
 9 MR. DAWE:
 10 A. Thank you.
 11 THE COMMISSIONER:
 12 Q. Thank you. Anything arising, Ms. Chaytor?
 13 CHAYTOR, Q.C.:
 14 Q. I don't have anything arising.
 15 THE COMMISSIONER:
 16 Q. Thank you very much, Mr. Dawe, for your
 17 contribution. Thank you all. 9:30 in the
 18 morning.

CERTIFICATE

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

<p>-\$-</p> <p>\$109,000.00 [2] 193:6 193:17</p> <p>\$120,000 [1] 110:16</p> <p>\$205,000.00 [1] 193:5</p> <p>\$700,000.00 [9] 49:8 50:11 56:18 57:4,15 58:7 58:11 193:2,8</p> <p>\$720,500.00 [1] 193:17</p> <hr/> <p>-&-</p> <p>& [1] 280:18</p> <hr/> <p>-'-</p> <p>'02 [1] 62:3</p> <p>'05 [2] 341:6 369:23</p> <p>'07 [2] 358:23 359:22</p> <p>'68 [1] 7:12</p> <p>'69 [2] 5:16,17</p> <p>'72 [1] 5:18</p> <p>'80s [1] 8:14</p> <p>'90s [3] 33:24 34:19 222:17</p> <p>'91 [3] 12:15 24:6 40:9</p> <p>'95 [2] 35:10 104:5</p> <p>'95/96 [1] 21:20</p> <p>'96 [3] 35:10 104:5 271:4</p> <p>'97 [8] 108:3 115:15 139:24 183:19,20 192:12 196:25 271:4</p> <p>'97/'98 [1] 195:12</p> <p>'98 [7] 141:21 166:8 170:23 192:12 193:4 196:25 271:5</p> <p>'99 [2] 196:25 213:21</p> <p>'We [1] 337:4</p> <hr/> <p>---</p> <p>-at [1] 119:17</p> <p>-because [1] 232:17</p> <p>-certainly [1] 159:22</p> <p>-Dr [1] 338:13</p> <p>-I [2] 148:13 212:20</p> <p>-like [1] 245:20</p> <p>-the [2] 181:16 285:22</p> <p>-we'll [1] 98:21</p> 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