COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

September 5, 2008

Appearances:

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

Rolf Pritchard/Jackie Brazil . . . . Her Majesty in Right of NL

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

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

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

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

LIST OF EXHIBITS

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Exhibit entered and marked P-2525 . . . . Pg. 4

Exhibit entered and marked C-0224 . . . . Pg. 4

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DR. JEHAN ZAID SIDDIQUI (AFFIRMED)
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Certificate

1 SEPTEMBER 5, 2008
2 THE COMMISSIONER:
3 Q. Mr. Coffey.
4 COFFEY, Q.C.:
5 Q. Thank you, Commissioner. The next witness is
6 Dr. Gary Baker.
7 DR. GARY BAKER (SWORN) EXAMINATION BY BERNARD COFFEY,
8 Q.C.
9 COFFEY, Q.C.:
10 Q. Commissioner, there are three new exhibits,
11 Exhibits P-2524 and 2525, and C-224.
12 THE COMMISSIONER:
13 Q. Entered.
14 EXHIBIT ENTERED AND MARKED P- 2524
15 EXHIBIT ENTERED AND MARKED P- 2525
16 EXHIBIT ENTERED AND MARKED C- 0224
17 COFFEY, Q.C.:
18 Q. Thank you, Commissioner. Dr. Baker, could you
19 outline for the Commissioner, please, your
20 educational and professional background?
21 DR. BAKER:
22 A. Sure. I went to Memorial University of
23 Newfoundland, obtained my Bachelor of Medical
24 Science in 1974--1975, sorry. In 1977, I
25 obtained my MD degree. Did a rotating

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1 internship from 1977 to 1978, and then I went
2 into the residency in pathology, a general
3 pathology residency program for five years,
4 and finished that program in 1983. From
5 there, I moved --
6 COFFEY, Q.C.:
7 Q. That was in St. John's?
8 DR. BAKER:
9 A. It was in Memorial University, yes, Medical
10 School in the pathology department there.
11 Then I moved to my present position in
12 Carbonear in 1983, and took on the position of
13 staff pathologist there and Director of
14 Laboratory Medicine for that area at the
15 Carbonear Hospital. Carbonear Hospital was a
16 standalone hospital at that particular time,
17 and I have been there as a staff pathologist
18 up until the present. Will I outline any
19 other positions I held all the way as well.
20 COFFEY, Q.C.:
21 Q. Sure.
22 DR. BAKER:
23 A. Okay. I held the position of pathologist up
24 until--and still do, but additional
25 responsibilities when the boards were

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1 reorganized in 1995. I took on a part time
2 medical directorship at the Avalon Health Care
3 Institutions Boards. In 1997, I became a
4 medical examiner for the Province of
5 Newfoundland and Labrador, and still am to the
6 present day, and when the boards were
7 reorganized again in 2005, I became clinical
8 chief for rural Avalon for medical services,
9 and I'm still a staff pathologist there as
10 well.
11 COFFEY, Q.C.:
12 Q. Doctor, I'm going to take advantage of your
13 presence here this morning and have you
14 perhaps outline for the Commissioner in a bit
15 more detail actually some of the changes that
16 have occurred over the decades, okay.
17 DR. BAKER:
18 A. Sure.
19 COFFEY, Q.C.:
20 Q. First of all, to go back to when you first
21 went to--well, actually to your residency days
22 first of all, okay. We've heard a fair amount
23 of evidence about immunohistochemistry, in
24 particular now ER/PR via immunohistochemistry.
25 DR. BAKER:

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1 A. Uh-hm.
2 COFFEY, Q.C.:
3 Q. We understand that before paraffin block
4 ER/PR, there was biochemical assays. I want
5 to ask you this, when you first started when
6 you were in your residency, ER and PR, did
7 pathologists at that point as best you can
8 recall have any involvement in ER/PR itself?
9 DR. BAKER:
10 A. No, there was no--to my knowledge, and during
11 my residency which was five years, I didn't
12 have any involvement or had no knowledge of
13 immunohistochemistry being done at the Health
14 Sciences at that particular point in time, and
15 no recollection of ER/PR being done at that
16 point in time.
17 COFFEY, Q.C.:
18 Q. And you went to Carbonear in 1983?
19 DR. BAKER:
20 A. Correct, yes.
21 COFFEY, Q.C.:
22 Q. Doctor, can you tell the Commissioner, please
23 --you said it was a standalone hospital. What
24 size of a hospital?
25 DR. BAKER:

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1 A. Carbonear Hospital at the time was a 100 bed
2 hospital and it had general surgery,
3 obstetrics and gynecology, it had general
4 practice involvement, and radiology,
5 anesthesia. So it had all the basic
6 specialties providing general surgery services
7 and also internal medicine as well.
8 COFFEY, Q.C.:
9 Q. And how many pathologists were there at the
10 time you arrived?
11 DR. BAKER:
12 A. Just one, myself.
13 COFFEY, Q.C.:
14 Q. Had there been a pathologist there before you
15 arrived?
16 DR. BAKER:
17 A. For a very brief period of time. In 1991, the
18 late Eric Pike, who was a well known
19 pathologist in the province, was asked by the
20 Department of Health to go out and conduct a
21 five or six month study to determine the need
22 for a pathologist in the area. He went there
23 in 1981. I think he was there from about
24 September to December of that year, or January
25 of the following year, and did an assessment.

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1 He also worked as a staff pathologist there
2 doing the actual surgical pathology workload
3 and he submitted his report to government and
4 recommended that a pathologist position be
5 placed in Carbonear.
6 COFFEY, Q.C.:
7 Q. And hence you were --
8 DR. BAKER:
9 A. I was recruited for the position, yes.
10 COFFEY, Q.C.:
11 Q. Doctor, since 1983, which is 25 years ago now,
12 how many pathologists have been on staff
13 there?
14 DR. BAKER:
15 A. Just myself.
16 COFFEY, Q.C.:
17 Q. So you're, in effect, a sole practitioner in
18 that regard?
19 DR. BAKER:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Could you describe, please, then the clinical
23 laboratory. I take it there is a clinical
24 laboratory in the hospital?
25 DR. BAKER:

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1 A. Yes, there is, yes. It has all the major
2 sections of a clinical laboratory. It has an
3 area where blood taking is taking place, it
4 has blood banking, it has a hematology
5 section, biochemistry, microbiology, and
6 pathology.
7 COFFEY, Q.C.:
8 Q. I take it that had existed before you ever
9 arrived?
10 DR. BAKER:
11 A. Yes, it did, yes, with the exception of
12 pathology.
13 COFFEY, Q.C.:
14 Q. Pathology.
15 DR. BAKER:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And the pathology then related to the hospital
19 before your arrival, you would have understood
20 was being done out of where?
21 DR. BAKER:
22 A. St. John's.
23 COFFEY, Q.C.:
24 Q. St. John's itself. Doctor, you're a
25 pathologist. Did you have any other position

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1 initially other than being a staff
2 pathologist?
3 DR. BAKER:
4 A. No.
5 COFFEY, Q.C.:
6 Q. You weren't a medical director or anything
7 like that?
8 DR. BAKER:
9 A. No, just a staff pathologist. I was involved
10 as Director of Laboratory Medicine. I sat on
11 the MAC as the Director of Laboratory
12 Medicine. The MAC was composed of all the
13 chairs of the various departments, surgery,
14 ob, gyne, all those, and so on.
15 COFFEY, Q.C.:
16 Q. The MAC, though, at that time throughout the
17 1980s would have been particular to that
18 particular hospital?
19 DR. BAKER:
20 A. Correct, yes.
21 COFFEY, Q.C.:
22 Q. So you were the staff pathologist and--sorry,
23 the --
24 DR. BAKER:
25 A. Director of Laboratory Medicine during that

Page 12

1 time, yes.
2 COFFEY, Q.C.:
3 Q. And in that capacity sat on the MAC?
4 DR. BAKER:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. As the Director of Laboratory Medicine in a
8 standalone hospital --
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Who did you report to?
13 DR. BAKER:
14 A. I reported to the Assistant Executive
15 Director, which was Edgar Clarke.
16 COFFEY, Q.C.:
17 Q. And was he a physician?
18 DR. BAKER:
19 A. No, he was a layperson.
20 COFFEY, Q.C.:
21 Q. A non-physician.
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And, Doctor, who reported to you then in your

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1 capacity as director?
2 DR. BAKER:
3 A. We had a manager within the laboratory who
4 directed the administrative duties of the
5 laboratory. He essentially was almost solely
6 responsible to Edgar Clarke, but he did have
7 an indirect line of authority--responsibility
8 to me as well. He would consult me on various
9 clinical issues, administrative issues, and so
10 on, and kept me in the loop with major things
11 that were going on within the lab, even though
12 he was essentially directly responsible to
13 Edgar Clarke.
14 COFFEY, Q.C.:
15 Q. And the people who reported to him were the
16 technologists?
17 DR. BAKER:
18 A. The senior technologist. There would be a
19 Technologist II in each section, with the
20 exception of pathology, who would report
21 directly to the lab manager, yes.
22 COFFEY, Q.C.:
23 Q. And in pathology there was what?
24 DR. BAKER:
25 A. There was a Tech I, but he essentially would

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1 report to the manager as well, but he wasn't
2 classified as a Tech II, he was a Tech I.
3 COFFEY, Q.C.:
4 Q. So that's the structure when you first
5 arrived?
6 DR. BAKER:
7 A. Correct.
8 COFFEY, Q.C.:
9 Q. How long did that structure continue to exist?
10 DR. BAKER:
11 A. That structure has essentially--well, remained
12 in that capacity in that way until the mid 90s
13 when the boards were reorganized and we became
14 the Avalon Health Care Institutions Board.
15 COFFEY, Q.C.:
16 Q. And I'll be taking you through that.
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. So from the time you arrived really in 1983 up
21 until the mid 1990s, reorganization in the mid
22 1990s, that structure was in place.
23 DR. BAKER:
24 A. Now there was a change in board structure
25 midway between when I arrived in '83 and that

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1 change in '95.
2 COFFEY, Q.C.:
3 Q. Would you tell us then about that?
4 DR. BAKER:
5 A. Yes, the original board was the Carbonear
6 Hospital Board and it became the Trinity
7 Conception Board. That was a change to
8 encompass the Old Perlican Hospital site under
9 the jurisdiction of the Carbonear Hospital
10 Board. So that essentially added some
11 responsibility to the position of Director of
12 Laboratories and also to the Manager of the
13 laboratory because we took on responsibility
14 for the Old Perlican Hospital and the
15 laboratory services there as well.
16 COFFEY, Q.C.:
17 Q. Were there any pathology services in Old
18 Perlican?
19 DR. BAKER:
20 A. No, no, it was a small laboratory service just
21 peculiar to the hospital with no other --
22 COFFEY, Q.C.:
23 Q. Do you recall when that occurred?
24 DR. BAKER:
25 A. That was in the late 80s, I think, to the best

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1 of my recollection.
2 COFFEY, Q.C.:
3 Q. Doctor, throughout the period, the mid 1990s
4 reorganization, do you recall when that was,
5 the exact year?
6 DR. BAKER:
7 A. That happened around 1995 was the change, when
8 the structure started changing and we became
9 known as the Avalon Health Care Institutions
10 Board and that board encompassed the Placentia
11 area, Whitbourne area, Old Perlican area, and
12 also brought in the long term care facilities
13 in our area, Interfaith Home and Harbour
14 Lodge.
15 COFFEY, Q.C.:
16 Q. I'll deal with that in a moment. Between 1983
17 and 1995, during that twelve year period, ER
18 and PR, were you involved in ER/PR that you
19 recall then?
20 DR. BAKER:
21 A. Yes, in the capacity of preparing the tissue
22 to be sent to St. John's for biochemical
23 assay.
24 COFFEY, Q.C.:
25 Q. Would you tell the Commissioner then what your

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1 involvement was and how that worked back then?
2 DR. BAKER:
3 A. In the initial phase of the ER/PR testing it
4 was a biochemical assay, and we were
5 essentially asked just to prepare the tissue
6 at our site. A sample would come down from
7 the OR, whether it would be a mastectomy
8 specimen with tumour inside that we would take
9 a sample of, or whether it was the biopsy
10 itself that we took a sample from. We would
11 take a sample of the tumour tissue, freeze it
12 in liquid nitrogen, and wrap it in tin foil
13 several layers of it, and then put it on dry
14 ice in a styrofoam container and ship it
15 immediately to St. John's by courier.
16 COFFEY, Q.C.:
17 Q. Where the biochemical assay would be
18 performed?
19 DR. BAKER:
20 A. Yes, in the biochemical department at the
21 Health Science Centre.
22 COFFEY, Q.C.:
23 Q. And at that time, Doctor, the initiative to
24 order an ER/PR test came from whom?
25 DR. BAKER:

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1 A. The initiative to order--well, the order came
2 from my department over my signature, but the
3 reports were primarily sent back to the
4 attending physician who had responsibility for
5 the patient. Their name would be put on the
6 requisition for the report to be returned to.
7 COFFEY, Q.C.:
8 Q. Doctor, you've indicated that during your
9 residency you don't really recall
10 immunohistochemistry being done in your
11 residency days?
12 DR. BAKER:
13 A. No.
14 COFFEY, Q.C.:
15 Q. Your first introduction to
16 immunohistochemistry yourself occurred
17 approximately when and in what context?
18 DR. BAKER:
19 A. It occurred when essentially I received a memo
20 from Dr. Khalifa in 1998. I mean, the
21 preparation of the tissue was, I suppose, an
22 initial step involvement with ER/PR, but it
23 was just a preparation of tissue, but the
24 actual involvement in interpretation phase
25 started in 1998 in the spring.

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1 COFFEY, Q.C.:
2 Q. And I'll come to that, and that's certainly
3 related to ER and PR?
4 DR. BAKER:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. How about immunohistochemistry more generally?
8 DR. BAKER:
9 A. No, there was no--I had no direct involvement
10 in immunohistochemistry at all before that
11 point in time.
12 COFFEY, Q.C.:
13 Q. Before Dr. Khalifa's memo of early 1998, were
14 you ever ordering immunohistochemistry tests
15 on any sort of --
16 DR. BAKER:
17 A. No, I wasn't, no.
18 COFFEY, Q.C.:
19 Q. So your practice up until then had involved
20 solely --
21 DR. BAKER:
22 A. Routine histology, H & E slides, some special
23 stains that weren't involved or classed as
24 immunohistochemistry.
25 COFFEY, Q.C.:

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1 Q. And I'll come to Dr. Khalifa's memo in a
2 moment.
3 DR. BAKER:
4 A. Okay.
5 COFFEY, Q.C.:
6 Q. But again chronologically --
7 DR. BAKER:
8 A. Sure.
9 COFFEY, Q.C.:
10 Q. So in 1995 there was a reorganization. You've
11 described that?
12 DR. BAKER:
13 A. Correct.
14 COFFEY, Q.C.:
15 Q. Did your title position change?
16 DR. BAKER:
17 A. It did. I became the ACEO in 1996, which is
18 Assistant Chief Executive Officer for
19 diagnostics, which included--diagnostics and
20 pharmacy, which included the laboratory
21 diagnostic imaging, x-ray, and pharmacy, and
22 also the medical services aspect of that too
23 as well, recruitment and retention, and
24 administrative issues related to medical
25 services.

1 COFFEY, Q.C.:
2 Q. So in 1995, you're still the sole --
3 DR. BAKER:
4 A. Pathologist.
5 COFFEY, Q.C.:
6 Q. Pathologist there.
7 DR. BAKER:
8 A. Uh-hm.
9 COFFEY, Q.C.:
10 Q. You are still the Director of--were you the
11 director of the laboratory?
12 DR. BAKER:
13 A. Yes, still essentially, yes.
14 COFFEY, Q.C.:
15 Q. Of the lab.
16 DR. BAKER:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. You also became Assistant --
20 DR. BAKER:
21 A. CEO.
22 COFFEY, Q.C.:
23 Q. And responsible for the things you just noted?
24 DR. BAKER:
25 A. Yes.

1 COFFEY, Q.C.:
2 Q. With the reorganization, did the pathology
3 aspect of the lab of your involvement change
4 with the involvement of these other places?
5 DR. BAKER:
6 A. No, not essentially, it stayed the same. The
7 commitment was still the same. My position as
8 ACEO was a part time position. It took about
9 25 to 30 percent of my time, and most of that
10 time would have been added on after hours.
11 COFFEY, Q.C.:
12 Q. And, Doctor, as you've indicated, when the Old
13 Perlican Hospital came under your--became part
14 of your responsibility, there was not actually
15 --although they had a laboratory, it didn't
16 have any pathology?
17 DR. BAKER:
18 A. No.
19 COFFEY, Q.C.:
20 Q. In the lab. So these other institutions
21 became part of the reorganization in 1995?
22 DR. BAKER:
23 A. Uh-hm.
24 COFFEY, Q.C.:
25 Q. The reorganized entity. Were there any

1 pathology labs in those other --
2 DR. BAKER:
3 A. No, standard basic laboratory with
4 biochemistry, hematology, and bloodletting,
5 and so on.
6 COFFEY, Q.C.:
7 Q. But the pathology itself remained limited to
8 the Carbonear Hospital itself?
9 DR. BAKER:
10 A. Correct, yes.
11 COFFEY, Q.C.:
12 Q. While I'm at it, did that ever change?
13 DR. BAKER:
14 A. No.
15 COFFEY, Q.C.:
16 Q. Pathology always involved just the Carbonear
17 Hospital?
18 DR. BAKER:
19 A. Correct.
20 COFFEY, Q.C.:
21 Q. With that reorganization in 1995, did the
22 reporting structures within the laboratory
23 change?
24 DR. BAKER:
25 A. Yes, they did, because the manager who before

1 that time reported to the--well, they actually
2 reported to me then rather than to another
3 individual within the administration because I
4 was part of the administration after the 1995
5 change.
6 COFFEY, Q.C.:
7 Q. So as the Assistant CEO, who was reporting to
8 you?
9 DR. BAKER:
10 A. The manager of the laboratories, the manager
11 of pharmacy, and the manager of diagnostic
12 imaging.
13 COFFEY, Q.C.:
14 Q. And you reported to?
15 DR. BAKER:
16 A. I reported to the CEO.
17 COFFEY, Q.C.:
18 Q. So, Doctor, in terms of the clinical
19 laboratory aspect of the matter, who is the
20 senior physician in the administrative chain?
21 DR. BAKER:
22 A. I was.
23 COFFEY, Q.C.:
24 Q. You were, yourself.
25 DR. BAKER:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Can you then take us on then through the next
4 reorganization, when did that occur?
5 DR. BAKER:
6 A. Well, after '95, we went through a number--
7 seven or eight years. The next reorganization
8 happened when the announcement came through in
9 2004, the reorganization of the boards into--
10 well, combining the boards across the island
11 and we became part of the Eastern Health
12 region in 2005.
13 COFFEY, Q.C.:
14 Q. I'll revisit that, okay, but in the period
15 between 1995 and 2005 --
16 DR. BAKER:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. Approximately a decade, could you describe, if
20 there was such a thing, a typical day for you
21 for the Commissioner. You're a practising
22 pathologist?
23 DR. BAKER:
24 A. Uh-hm.
25 COFFEY, Q.C.:

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1 Q. And you're also an administrator?
2 DR. BAKER:
3 A. Uh-hm.
4 COFFEY, Q.C.:
5 Q. In terms of your pathology work and how it
6 integrated with your administrative work,
7 perhaps a typical day or a typical week for
8 the Commissioner?
9 DR. BAKER:
10 A. Well, the morning usually started with
11 pathology, doing interpretation, surgical
12 pathology review of slides. That lasted the
13 majority of the morning. I would tend to
14 after lunch visit the administrative area that
15 I was responsible for on the eight floor and
16 tend to any duties that were in that
17 particular area, and then in the afternoon--
18 well, maybe for an hour or two in the
19 afternoon. Then towards the middle of the
20 afternoon, I would return to pathology and do
21 my gross examination and preparation of tissue
22 for processing for the following day, and in
23 the evening I'd be back with other
24 administrative duties.
25 COFFEY, Q.C.:

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1 Q. In the Carbonear Hospital, the tissue that you
2 would be preparing, grossing and preparing for
3 processing, would come, I take it, almost
4 exclusively from the operating room?
5 DR. BAKER:
6 A. The majority would, but there would be out-
7 patient samples from various clinics and so on
8 within the hospital, obstetrics/gynecology
9 clinics, there would be samples from general
10 practitioner's offices, and also from out-
11 patient procedures that the surgeons were
12 doing in out-patient clinics and so on within
13 the hospital.
14 COFFEY, Q.C.:
15 Q. So the specimens, and I'll use, for example, a
16 breast specimen --
17 DR. BAKER:
18 A. Uh-hm.
19 COFFEY, Q.C.:
20 Q. They would certainly generally come from the
21 operating room?
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Who's responsible for transporting them?

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1 DR. BAKER:
2 A. They would be transported by a porter who
3 would take the specimen from the OR and
4 transport it to our pathology department.
5 COFFEY, Q.C.:
6 Q. And would it arrive in formalin?
7 DR. BAKER:
8 A. Yes, all--from the very start of my position
9 there in 1983, all specimens that were taken
10 in the OR setting were put in formalin
11 directly immediately. There was never any
12 time when specimens were left in a fresh state
13 or transported in a fresh state. They were
14 all in formalin immediately and transported to
15 pathology.
16 COFFEY, Q.C.:
17 Q. And I take it then they might arrive in
18 pathology--was there any particular time of
19 day they would arrive in pathology?
20 DR. BAKER:
21 A. Well, specimens that were taken in the morning
22 would mostly arrive by mid to late morning.
23 Most of the ORs would finish off pretty well
24 around 1 to 1:30 in the afternoon. So any--
25 and the major cases would tend to come down

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1 later in the day and so on, like the bowel
2 resections or the mastectomies, that kind of
3 stuff and so on, but any smaller specimens
4 would tend to come down earlier in the morning
5 and they would be the ones that were done
6 primarily earlier in the morning.
7 COFFEY, Q.C.:
8 Q. So then when you would arrive in the
9 afternoon, what would you expect to find?
10 DR. BAKER:
11 A. A number of specimens, including biopsies,
12 mastectomies, bowel resections, ovarian
13 resections, that kind of stuff.
14 COFFEY, Q.C.:
15 Q. So you would expect--on a particular day, a
16 Monday, you would expect to find when you came
17 to do the grossing on Monday afternoon, any of
18 the surgical specimens that had been excised
19 that day?
20 DR. BAKER:
21 A. Correct.
22 COFFEY, Q.C.:
23 Q. Now, Doctor, what was the practise then in
24 Carbonear in terms of then how they would be
25 processed? To use a breast specimen, as an

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1 example, who's responsible for doing what?
2 DR. BAKER:
3 A. I would do all of the grossing of the tissue
4 specimens in Carbonear, and have done so from
5 the very beginning. I would start my--well,
6 when the specimens were received in pathology,
7 they would be given a number, a specific
8 excision number, and in the older days back
9 when I first arrived there, we used large
10 ledger books to put the specimen in, the name
11 of the individual, the specimen number, where
12 the specimen came from, and that type of
13 information, and they were recorded in large
14 ledger books on a daily basis. Just recently
15 within the past probably three years, we've
16 been using Meditech System and entered them in
17 on computer.
18 COFFEY, Q.C.:
19 Q. So these ledger books continued up until?
20 DR. BAKER:
21 A. Up until--into 2003 probably.
22 COFFEY, Q.C.:
23 Q. And we will be coming back and revisiting
24 that.
25 DR. BAKER:

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1 A. Okay.
2 COFFEY, Q.C.:
3 Q. Doctor, so it would be identified?
4 DR. BAKER:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. Either in a ledger book or in a computer
8 system?
9 DR. BAKER:
10 A. Correct, yes.
11 COFFEY, Q.C.:
12 Q. Go ahead then, who was responsible for doing
13 identification?
14 DR. BAKER:
15 A. That would be done by the technologist in
16 pathology, and after all the specimens were
17 entered in for the day, they would be brought
18 into the pathology grossing room and placed
19 there until I came to do the actual grossing
20 of the specimen.
21 COFFEY, Q.C.:
22 Q. And your practise then in terms of grossing a
23 breast specimen was what?
24 DR. BAKER:
25 A. My practise in terms of grossing a breast

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1 specimen is that the specimen would be taken
2 and examined, and if--would you like me to go
3 through something like a mastectomy specimen?
4 COFFEY, Q.C.:
5 Q. If you would, please.
6 DR. BAKER:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. And this, in particular, is an --
10 DR. BAKER:
11 A. Example, okay. With a mastectomy specimen,
12 the sample would be taken out of the
13 formaldehyde, examined very briefly. It would
14 be scored, or a term that's being used now is
15 breadloafed, but--and the specimen would be
16 returned to the formaldehyde or formalin and--
17 to fix overnight, and then be processed the
18 next day in a similar fashion in grossing.
19 COFFEY, Q.C.:
20 Q. And then when you--so on the day of surgery,
21 the scoring, as you put it, or breadloafing
22 would occur?
23 DR. BAKER:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Is there any particular practise that you had
2 or understood should be used with a mastectomy
3 specimen in terms of the thickness of the
4 tissue slices?
5 DR. BAKER:
6 A. No, I just tended to score them in an even
7 fashion across the whole breadth of the
8 specimen, average thickness of probably a
9 couple of centimetres. Depending on the size
10 of the specimen too as well. Some of them are
11 obviously larger than others, you know.
12 COFFEY, Q.C.:
13 Q. Doctor, the breadloafing is, in effect,
14 slicing?
15 DR. BAKER:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. Of the specimen. Return to formalin--was
19 there any--we've heard references to wicking
20 and wicking material?
21 DR. BAKER:
22 A. No, I didn't use the process of wicking. I
23 haven't used that at all.
24 COFFEY, Q.C.:
25 Q. And return to formalin and left to --

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1 DR. BAKER:
2 A. Fix.
3 COFFEY, Q.C.:
4 Q. Fix overnight?
5 DR. BAKER:
6 A. For a 24 hour period.
7 COFFEY, Q.C.:
8 Q. Doctor, to your knowledge, was there ever a
9 time that you're aware of that a breast
10 specimen would be left overnight in formalin
11 without having been scored?
12 DR. BAKER:
13 A. No. To the best of my recollection, every
14 time a specimen came down, I would be
15 personally involved in it, handle it, and
16 score it.
17 COFFEY, Q.C.:
18 Q. And before you left for the day, no matter how
19 late--if the specimen was late, relatively
20 late in the afternoon coming down, you'd stay
21 on do the scoring?
22 DR. BAKER:
23 A. Yes, I would be there probably until about
24 5:30/6 o'clock in the afternoon. So all the
25 specimens for the day would be down by that

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1 time and, you know--there have been occasions
2 where specimens have come down late in the day
3 and I would make sure before I left for the
4 day that things were tended to. Even though
5 the technologist may have been gone, I would
6 do it myself.
7 COFFEY, Q.C.:
8 Q. Doctor, then the next day we'll go on to.
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. I take it this would be true not only of
13 mastectomy specimens, but any large specimen?
14 DR. BAKER:
15 A. Correct, yes.
16 COFFEY, Q.C.:
17 Q. Then in terms of picking up the process for
18 larger specimens --
19 DR. BAKER:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. The next day then, how would it be handled?
23 DR. BAKER:
24 A. I would start my grossing. I would do most of
25 the smaller specimens first, and put them

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1 through the grossing procedure, examination,
2 and taking sections, putting them in cassettes
3 and passing them off to my technologist who
4 would return them to formalin. The larger
5 specimens I would tend to leave to the very
6 end of my grossing because they took a larger
7 amount of time and needed more attention, and
8 I would take the large specimen out, for
9 example, the breast, it already had been
10 scored. I would examine the breast
11 externally, look at the skin, the anterior
12 surface first, determine where the previous
13 biopsy had been done, and then I would turn
14 over the specimen and I'll also do
15 measurements as well of the anterior surface,
16 the skin segment, and I would turn over the
17 specimen, examine the back, and also do full
18 dimension measurements of the entire breast
19 because most of the breast that I received,
20 even though occasionally were simple
21 mastectomies, a lot of them were what's termed
22 modified radical mastectomies, which included
23 axillary tail and lymph nodes from the axilla,
24 and I would do an overall dimension
25 measurement of the whole breast, including

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1 axillary tail. I would identify them from the
2 posterior aspect, the biopsy site, and try to
3 determine if there was any residual tumour
4 there on gross examination. If I did suspect
5 residual tumour or see gross residual tumour
6 there, I would take sections and I'll go
7 through the sections with you in a standard
8 way. I would take, initially take sections
9 from the biopsy site area because there would
10 be a cavity left after the previous biopsy had
11 been done, take sections from that area around
12 the periphery of the actual biopsy cavity and
13 any lesions that I did see there or any
14 residual tumour. I would take sections from
15 each of the quadrants of the breast to make
16 sure that there was no tumour in the--we would
17 divide the breast into four quadrants and I
18 would take them from the upper, outer and the
19 outer quadrants and also the inner quadrants
20 as well and label them specifically,
21 individually in cassettes. I would take
22 sections from the margins of the breast, the
23 upper, lower, the medial and the deep margin
24 of the breast to find out if there's an
25 extension of tumour from those areas. And

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1 then I would take a section from the nipple
2 area to make sure there's no involvement of
3 the nipple and also then I would do a detail
4 sectioning of the axillary tail to find the
5 lymph nodes, and that would involve taking
6 multiple, multiple sections of the axillary
7 tail for identification of lymph nodes.
8 COFFEY, Q.C.:
9 Q. And these would all be placed in cassettes?
10 DR. BAKER:
11 A. Placed in cassettes. They would be given the
12 accession number of the main specimen and they
13 would given an alphabetical, they'd be given a
14 letter starting with A right through the
15 alphabet and redoubled if necessary to go
16 through again.
17 COFFEY, Q.C.:
18 Q. And this, I take it, Doctor, this practice or
19 approach goes back to what time?
20 DR. BAKER:
21 A. Goes back to my residency.
22 COFFEY, Q.C.:
23 Q. Back to the beginning?
24 DR. BAKER:
25 A. Yes, the very beginning.

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1 COFFEY, Q.C.:
2 Q. After being then given back--then place the
3 tissue samples, placed in cassettes?
4 DR. BAKER:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. And given to the -
8 DR. BAKER:
9 A. Technologist.
10 COFFEY, Q.C.:
11 Q. Technologist. What was the technologist then
12 expected to do with them?
13 DR. BAKER:
14 A. Technologist took the cassettes with tissue
15 samples at the end of the day, brought them to
16 the processing area, processing machine, put
17 them into a steel basket in an orderly fashion
18 and put them into the main chamber of the
19 processing unit which had formalin in it,
20 closed the chamber and then set the processing
21 machine to process in an overnight fashion.
22 The processing machine would run for
23 approximately 12 hours and would go through
24 formalin, alcohol and so on and actually, you
25 know, prepare the tissue for the next day for

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1 embedding in paraffin wax.
2 COFFEY, Q.C.:
3 Q. And, Doctor, so I take it then this 12-hour
4 process, tissue processing process -
5 DR. BAKER:
6 A. It would run approximately from 5:30 to 5:30
7 or 6 the next morning.
8 COFFEY, Q.C.:
9 Q. It would be ready or finished the process by
10 the time the technologist came in the next
11 day?
12 DR. BAKER:
13 A. Yeah, at 8:00.
14 COFFEY, Q.C.:
15 Q. While we're talking about tissue processing,
16 Doctor, who was responsible in the Carbonear
17 Hospital over the 25 years you've been there,
18 for maintaining the tissue processor?
19 DR. BAKER:
20 A. The technologist would look after the day-to-
21 day maintenance of the machine, changing of
22 the chemicals in the machine on a periodic
23 basis. But if there was any major problem
24 with the machine that couldn't be fixed by the
25 technologist or by the senior technologist in

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1 the lab--in the laboratory we had a senior
2 tech 3, lead tech, I guess he was called, and
3 also he looked after some quality control in
4 the lab, but he was the lead tech and probably
5 one of the more experienced technologists in
6 the lab, he would probably be asked to come
7 have a look at the machine, see if there was
8 anything that he could give an advice and so
9 on. If he couldn't fix it, then we would go
10 automatically to the manufacturer.
11 COFFEY, Q.C.:
12 Q. Who would send out somebody to service it?
13 DR. BAKER:
14 A. A biomedical person out to fix it, yes.
15 COFFEY, Q.C.:
16 Q. And, Doctor, in terms of that, were there any
17 records kept, do you know, of maintenance of
18 the machine, routine and otherwise
19 maintenance?
20 DR. BAKER:
21 A. Not specifically, no. It was done according
22 to a routine that the technologist had set
23 down and that routine was based on his
24 experience and training. When I first moved
25 to Carbonear in 1983, a technologist had to be

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1 trained in pathology. The technologist that
2 was chosen at the time was sent to St. John's
3 for training in all aspects of pathology and
4 in the use of the processing equipment and he
5 would have had that training and that
6 information as to when and how and how often
7 to do things with the machinery and so on.
8 That would be--to my knowledge there wasn't
9 any specific documentation done.
10 COFFEY, Q.C.:
11 Q. Or maintained over the years?
12 DR. BAKER:
13 A. No.
14 COFFEY, Q.C.:
15 Q. How many technologists have worked in
16 pathology over the years? When you first
17 started, there was the one, I take it?
18 DR. BAKER:
19 A. The one. There still is only the one. The
20 one that started out with me in 1983 worked
21 with me up until, and well, he's on loan now
22 to the Health Sciences for the past year, but
23 he worked with me for about 24 years.
24 COFFEY, Q.C.:
25 Q. So that in terms of the processing then of the

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1 fixation process and the tissue processing of
2 pathology specimens in the Carbonear Hospital,
3 the people involved in it would be, well, the
4 surgeons?
5 DR. BAKER:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Initially?
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Whomever else might have handled the tissue in
13 the OR?
14 DR. BAKER:
15 A. Correct.
16 COFFEY, Q.C.:
17 Q. Placing it in formalin?
18 DR. BAKER:
19 A. Um-hm.
20 COFFEY, Q.C.:
21 Q. The porter?
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Who would transport the specimen. Yourself?

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1 DR. BAKER:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. And the technologist?
5 DR. BAKER:
6 A. Correct.
7 COFFEY, Q.C.:
8 Q. This particular individual?
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Doctor, were there any records kept over the
13 years in Carbonear, was it ever the practice
14 to keep records of the time, the amount of
15 time that any particular specimen would have
16 spent in formalin?
17 DR. BAKER:
18 A. No, no, that was never recorded on the
19 requisition.
20 COFFEY, Q.C.:
21 Q. Was there any accepted practice as to or rule
22 of thumb as to how long specimens should
23 remain in formalin?
24 DR. BAKER:
25 A. No, there was no specific guidelines like

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1 that, no.
2 COFFEY, Q.C.:
3 Q. Doctor, while we're on the topic, the new
4 technologist, I take it you have somebody?
5 DR. BAKER:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Because you loaned out -
9 DR. BAKER:
10 A. Yes, in a temporary position, just until the
11 other--the previous one comes back.
12 COFFEY, Q.C.:
13 Q. Comes back. The technologist you have there
14 presently, do you know how he or she was
15 trained in pathology?
16 DR. BAKER:
17 A. Well, she was trained by my senior
18 technologist who left on loan. She was given
19 orientation for about three to four weeks and
20 was, you know, assessed on a day-to-day basis
21 by a technologist and once the technologist
22 had a comfort level with that individual, they
23 were allowed to do solo work.
24 COFFEY, Q.C.:
25 Q. Doctor, the routine of scoring on the day of

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1 surgery?
2 DR. BAKER:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Then grossing on day two, I suppose?
6 DR. BAKER:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. And take up then the narrative there, after
10 the tissue had gone through the tissue
11 processor at night, what would happen then the
12 next day, whatever the next day was, and I'll
13 come to that in a minute because sometimes it
14 might be over the weekend?
15 DR. BAKER:
16 A. Right.
17 COFFEY, Q.C.:
18 Q. But next working day what would happen then?
19 DR. BAKER:
20 A. The technologist would take the tissue from
21 the processing unit the next morning and begin
22 the next stage of the process, which would be
23 to embed the tissue in paraffin blocks and
24 prepare them for actual sectioning and placing
25 on glass slides for staining. That would

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1 occur the next morning; his initial
2 preparation would be the embedding in
3 paraffin. After all the specimens had been
4 embedded in paraffin, they would be moved over
5 to another section of the lab for sectioning
6 on a microtome. And the thin paraffin
7 sections then would be floated off into a
8 water bath and onto the slides and then
9 prepared for staining.
10 COFFEY, Q.C.:
11 Q. And I take it, we'll come to this, we'll take
12 up the narrative with ER/PR in particular.
13 But the staining then would occur generally,
14 for example, a H & E stain for a breast
15 tissue?
16 DR. BAKER:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. Would occur when on day three?
20 DR. BAKER:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Third day. The day it came off the tissue
24 processor?
25 DR. BAKER:

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1 A. Would be the day that it would be stained.
2 COFFEY, Q.C.:
3 Q. Stained. And the slide would be prepared and
4 stained?
5 DR. BAKER:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. And then when would you see it?
9 DR. BAKER:
10 A. I would--those slides would most likely come
11 to me late in the day of the third day and I
12 wouldn't see those slides until the next day,
13 wouldn't examine them -
14 COFFEY, Q.C.:
15 Q. The fourth working day?
16 DR. BAKER:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. As it were. Doctor, I have just referred to
20 the idea of the weekend intervening or a
21 holiday intervening. What would happen in
22 relation to that in this process, if, like,
23 day two or day three was a holiday? Would
24 everything get, I take it, moved off to the
25 next working day?

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1 DR. BAKER:
2 A. Correct, yeah. As far as the bedding process
3 and so on?
4 COFFEY, Q.C.:
5 Q. Yes.
6 DR. BAKER:
7 A. In that stage -
8 COFFEY, Q.C.:
9 Q. The tissue processing.
10 DR. BAKER:
11 A. Yes, yes, that's right, everything would be
12 moved on, it would be moved onto the next
13 working day, yes.
14 COFFEY, Q.C.:
15 Q. Doctor, fixation as a process, dating back to
16 your residency days, what did you learn or
17 what were you taught about the importance of
18 fixation and the process?
19 DR. BAKER:
20 A. Well, you know, the importance was that a
21 tissue had to be fixed in order to be able to
22 be stained properly and examined properly
23 under the microscope. If the tissue wasn't
24 fixed appropriately, then the staining process
25 would be impaired and the actual

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1 interpretation of the slides would be
2 impaired.
3 COFFEY, Q.C.:
4 Q. And I take it that that was true before you
5 ever got involved with IHC?
6 DR. BAKER:
7 A. Correct, yes.
8 COFFEY, Q.C.:
9 Q. Goes back to the H & E, back to your own days
10 of training and before?
11 DR. BAKER:
12 A. It was a standard that you kept and adhered to
13 to make sure that the--you really had good
14 quality slides.
15 COFFEY, Q.C.:
16 Q. Doctor, were you ever--what were you taught,
17 if anything, about recognition of slides or
18 tissue that was problematic due to fixation
19 problems, how would you recognize a fixation
20 problem?
21 DR. BAKER:
22 A. Fixation would be, you know, improperly--not
23 taking up the stain appropriately, distortion
24 of the actual tissue, not being able to see
25 good detail of cells in examining of the

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1 tissue under the microscope, so you would pick
2 up problems in that respect and then raise
3 those concerns to the technologist and would
4 most likely go back and take additional
5 samples of the actual tissue.
6 COFFEY, Q.C.:
7 Q. And where would those samples come from?
8 DR. BAKER:
9 A. From the previous specimen.
10 COFFEY, Q.C.:
11 Q. Which had been, I take it, maintained in the
12 meantime -
13 DR. BAKER:
14 A. Formaldehyde. Yeah, the specimen are
15 maintained in formaldehyde, in our
16 institution, anyway, for three months.
17 COFFEY, Q.C.:
18 Q. So after the tissue goes into the cassettes,
19 initially, on the first process, the tissue
20 itself though it maintained, the remaining
21 tissue?
22 DR. BAKER:
23 A. Any residual tissue, the specimen itself is
24 retained for three months.
25 COFFEY, Q.C.:

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1 Q. And the reason for that?
2 DR. BAKER:
3 A. To make it available if you want to return to
4 take additional samples for additional
5 examination of the lesion or of any other
6 portion of the tissue specimen.
7 COFFEY, Q.C.:
8 Q. Did you ever encounter fixation problems in
9 Carbonear?
10 DR. BAKER:
11 A. To my knowledge, no.
12 COFFEY, Q.C.:
13 Q. I say problems, you would recognize them on
14 the slide as a -
15 DR. BAKER:
16 A. Yeah, it would give me great difficulty in
17 trying to interpret things on the slide. If I
18 saw a slide that was not picking up stain
19 appropriately or there was distortion of cells
20 or anything of that type, I would, you know,
21 immediately ask for additional sections,
22 either additional sections from that to see if
23 it was a staining problem or go back and take
24 additional tissue from the actual specimen, if
25 there was additional tissue to take from.

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1 COFFEY, Q.C.:
2 Q. Did that ever occur?
3 DR. BAKER:
4 A. Not to my recollection.
5 COFFEY, Q.C.:
6 Q. Okay. So that would have been your practice
7 if you were called upon to do it?
8 DR. BAKER:
9 A. Yes, I would, yes.
10 COFFEY, Q.C.:
11 Q. Doctor, are there any--I want to ask you
12 about--I will be asking you later about what
13 the current situation is in Carbonear, but
14 before 2005 were there any written policies
15 and procedures relating to fixation in that
16 institution?
17 DR. BAKER:
18 A. No, there wasn't.
19 COFFEY, Q.C.:
20 Q. The practice you've described?
21 DR. BAKER:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. But not, to your knowledge it wasn't written
25 down anywhere?

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1 DR. BAKER:
2 A. No written policy as such, no. It was a
3 standard that I adhered to that I had been
4 trained in.
5 COFFEY, Q.C.:
6 Q. Going back to your days at the General
7 Hospital?
8 DR. BAKER:
9 A. Correct.
10 COFFEY, Q.C.:
11 Q. In St. John's. What type of formalin was
12 used, do you know, Doctor? Who was
13 responsible for purchasing the formalin and
14 maintaining it and which one was used?
15 DR. BAKER:
16 A. The technologist. We mixed our own formalin
17 in the lab up until just recently. And -
18 COFFEY, Q.C.:
19 Q. Recently means what in this context?
20 DR. BAKER:
21 A. We now have been provided premixed formalin by
22 Eastern Health. It comes out from the
23 storage, stores and so on to our facility,
24 ordered to our facility.
25 COFFEY, Q.C.:

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1 Q. When did that start?
2 DR. BAKER:
3 A. Within the past probably two or three months,
4 three or four months, somewhere in that
5 general area.
6 COFFEY, Q.C.:
7 Q. So before that in Carbonear they were -
8 DR. BAKER:
9 A. We mixed our own.
10 COFFEY, Q.C.:
11 Q. - the practice was you mixed your own?
12 DR. BAKER:
13 A. Correct.
14 COFFEY, Q.C.:
15 Q. Who was responsible for doing that?
16 DR. BAKER:
17 A. The technologist.
18 COFFEY, Q.C.:
19 Q. And who was responsible--and was that the
20 pathology technologist?
21 DR. BAKER:
22 A. Correct, yes.
23 COFFEY, Q.C.:
24 Q. The individual that was with you all those
25 years?

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1 DR. BAKER:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Do you know if there was any testing process
5 to follow then or to ascertain whether or not
6 the formalin was appropriately mixed?
7 DR. BAKER:
8 A. He mixed it according to a formula that he has
9 been using for years, a formula that he, I'm
10 not sure where he obtained the formula from, I
11 would assume it was obtained from his training
12 at the Health Science Centre, and he's been
13 using that formula of mixing for all these
14 years.
15 COFFEY, Q.C.:
16 Q. Doctor, do you know if after the formula was
17 initially mixed, any one batch of it mixed,
18 about whether or not any--was it ever
19 periodically tested to ascertain that it was
20 still, you know, of appropriate chemical
21 composition?
22 DR. BAKER:
23 A. No.
24 COFFEY, Q.C.:
25 Q. To your knowledge he wasn't -

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1 DR. BAKER:
2 A. No, to my knowledge he wasn't.
3 COFFEY, Q.C.:
4 Q. - go back and testing its pH?
5 DR. BAKER:
6 A. No.
7 COFFEY, Q.C.:
8 Q. Routinely?
9 DR. BAKER:
10 A. To my knowledge it wasn't.
11 COFFEY, Q.C.:
12 Q. Were you aware, Doctor, that at least there is
13 a view that it should be tested from time to
14 time?
15 DR. BAKER:
16 A. Yes, I've come to learn that view recently and
17 things have been introduced within our
18 laboratory now as quality control to test the
19 pH of the, even the premixed one that we are
20 availing of now.
21 COFFEY, Q.C.:
22 Q. I take it that that's occurred since,
23 certainly since 2005?
24 DR. BAKER:
25 A. Correct.

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1 COFFEY, Q.C.:
2 Q. That this, the changes that have occurred?
3 DR. BAKER:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. Have occurred since 2005?
7 DR. BAKER:
8 A. As part of the quality initiatives.
9 COFFEY, Q.C.:
10 Q. And I'll be coming to that. Doctor, to go
11 back then in time and pick up the narrative,
12 you've indicated that your introduction to
13 immunohistochemistry, or tests in the
14 immunohistochemistry was, began with Dr.
15 Khalifa's memo?
16 DR. BAKER:
17 A. Correct, yes.
18 COFFEY, Q.C.:
19 Q. And I'm going to ask you, Doctor, when did you
20 first meet Dr. Khalifa, do you recall?
21 DR. BAKER:
22 A. I have never met Dr. Khalifa.
23 COFFEY, Q.C.:
24 Q. Okay. When did you first become aware of him?
25 DR. BAKER:

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1 A. Through the memo, that's all.
2 COFFEY, Q.C.:
3 Q. Okay. And I want to, if you can, outline for
4 the Commissioner, then, kind of circa the
5 1990s, what interaction you would--did have
6 with pathologists elsewhere within the
7 province or outside the province? You're a
8 sole practitioner?
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And as a pathologist and you had other duties
13 as well?
14 DR. BAKER:
15 A. Um-hm.
16 COFFEY, Q.C.:
17 Q. What sort of interaction would you have with
18 pathologists?
19 DR. BAKER:
20 A. The interaction that mostly I had with
21 pathologists was telephone conversations on
22 consultations, periodic meetings of the
23 Newfoundland Association of Pathologists and
24 basically that was it. There was no other
25 formal interaction.

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1 COFFEY, Q.C.:
2 Q. And, Doctor, within the Carbonear Hospital
3 itself were there rounds that you would take
4 part in?
5 DR. BAKER:
6 A. No, not specifically, no. We're a small
7 hospital and the only rounds that would be
8 ongoing would be internal medicine rounds;
9 occasionally I would be involved in those.
10 There weren't any surgical rounds, as such, we
11 only have two surgeons there. And
12 occasionally there would be some outside
13 speakers that would come in in topics related
14 to laboratory medicine and so on that we would
15 attend, a subspecialist from St. John's in
16 hematology or biochemistry and so on, that
17 type of thing.
18 COFFEY, Q.C.:
19 Q. Were there ever any such presentations
20 involving pathology, do you recall?
21 DR. BAKER:
22 A. Not to my knowledge, no.
23 COFFEY, Q.C.:
24 Q. I take it then in terms of your interaction
25 with the surgeons, the two surgeons, that

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1 would be informal?
2 DR. BAKER:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. But frequent?
6 DR. BAKER:
7 A. But frequent, yes, that's right.
8 COFFEY, Q.C.:
9 Q. So if you had a concern about something, you
10 knew where to find the surgeon and the surgeon
11 certainly knew where to find you?
12 DR. BAKER:
13 A. Correct.
14 COFFEY, Q.C.:
15 Q. And you would talk about particular cases if
16 there was a concern?
17 DR. BAKER:
18 A. Correct, yes.
19 COFFEY, Q.C.:
20 Q. So before receiving Dr. Khalifa's memo of
21 early 1998, up to that point ER and PR, at
22 least in Carbonear, followed this process of
23 fresh tissue, liquid nitrogen?
24 DR. BAKER:
25 A. Yes. Dry ice.

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1 COFFEY, Q.C.:
2 Q. Dry ice, and shipment to St. John's?
3 DR. BAKER:
4 A. Correct, yes.
5 COFFEY, Q.C.:
6 Q. And a report going from a biochemist to the
7 attending physician?
8 DR. BAKER:
9 A. Correct.
10 COFFEY, Q.C.:
11 Q. If we bring up, please, Registrar, Exhibit P-
12 1850? I should ask you, Doctor, some of the
13 pathologists who have been here to testify, of
14 course, are connected with the medical school
15 here. Do you have any position with the
16 medical school itself?
17 DR. BAKER:
18 A. No, I don't.
19 COFFEY, Q.C.:
20 Q. Would there ever be any residents, pathology
21 residents, say, come through the hospital in
22 Carbonear?
23 DR. BAKER:
24 A. No. We've had surgical residents come
25 through, internal medicine and so on but not

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1 pathology residents.
2 COFFEY, Q.C.:
3 Q. And while I'm on the topic, oncology over the
4 years, could you tell us, please, how oncology
5 services worked at the Carbonear Hospital?
6 DR. BAKER:
7 A. We didn't have any visiting oncologists. The
8 oncologists would be on a consultation basis
9 over the phone available to the internal
10 medicine people. Primarily the internal
11 medicine people at our hospital handled the
12 chemotherapy unit at our hospital. The orders
13 would be written by the oncologists after
14 having seen the patient, consultation in St.
15 John's.
16 COFFEY, Q.C.:
17 Q. Okay.
18 DR. BAKER:
19 A. And they would be referred back to our
20 facility with written orders for chemotherapy
21 after--and then the chemotherapy would be
22 organized and supervised by the internal
23 medicine group at the hospital and/or the
24 surgeons or the obstetricians and
25 gynecologists, depending on where the actual

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1 malignancy was from.
2 COFFEY, Q.C.:
3 Q. The actual oncologists, if a patient from
4 Carbonear, a patient who had surgery in
5 Carbonear goes to an oncologist in connection
6 with their treatment, they would have to come
7 to St. John's for that?
8 DR. BAKER:
9 A. Correct, yes.
10 COFFEY, Q.C.:
11 Q. And that was true when you began in 1983?
12 DR. BAKER:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. And I take it that's still true today?
16 DR. BAKER:
17 A. Correct, yes.
18 COFFEY, Q.C.:
19 Q. Doctor, this is a memo dated February 16th,
20 1998. It's from--it's on Health Care
21 Corporation of St. John's letterhead titled
22 "Memorandum" from Dr. Mahmoud Khalifa to all
23 Newfoundland pathologists, February 16th,
24 1998. The reference is "Reporting of estrogen
25 and progesterone receptor immunohistochemical

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1 results."
2 DR. BAKER:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. Okay?
6 DR. BAKER:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. Is this the memo you're referring to?
10 DR. BAKER:
11 A. Yes, I am. It is.
12 COFFEY, Q.C.:
13 Q. Doctor, this particular memo, this particular
14 exhibit, it's page 2 of it. Just go down
15 through it, go on to page 3, which has got a
16 proposal for uniform reporting of ER/PR
17 immunohistochemical assessment.
18 DR. BAKER:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. February of 1998. And examples. And then
22 this particular exhibit, 1850, on page 4 has a
23 page entitled, "Immunohistochemical Staining
24 of Steroid Receptors Correlation With
25 Biochemistry."

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1 DR. BAKER:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. And that particular document extends over two
5 pages. Actually, sorry, over three.
6 DR. BAKER:
7 A. Um-hm.
8 COFFEY, Q.C.:
9 Q. Including a comments section and references.
10 The memo that you received back in 1998 which
11 begins at page 1 of this exhibit, did that
12 contain a memo, have appended to it or
13 accompany this?
14 DR. BAKER:
15 A. No, it didn't.
16 COFFEY, Q.C.:
17 Q. Okay, the study.
18 DR. BAKER:
19 A. No.
20 COFFEY, Q.C.:
21 Q. I'll refer to it as the concordance study.
22 DR. BAKER:
23 A. No. First time I've seen this, actually.
24 COFFEY, Q.C.:
25 Q. Right, as we sit here now?

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1 DR. BAKER:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Now, Doctor, then, so I'll concentrate on the
5 first three pages of the exhibit itself.
6 DR. BAKER:
7 A. Um-hm.
8 COFFEY, Q.C.:
9 Q. Did you have any heads up or warning or, you
10 know, prior notification that you were going
11 to get such a memo?
12 DR. BAKER:
13 A. No. I just received it in the mail one day
14 and read through it.
15 COFFEY, Q.C.:
16 Q. And, Doctor, then, what--you got the memo, you
17 read it?
18 DR. BAKER:
19 A. Um-hm.
20 COFFEY, Q.C.:
21 Q. What then, what if anything did you do?
22 DR. BAKER:
23 A. Essentially I read the memo and from the memo
24 I understood that the ER/PR service, the
25 reporting aspect of the ER/PR services would

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1 be transferred to the pathologists, well
2 essentially to pathologists in each individual
3 region and that I would be responsible then
4 for reporting on tissue that was received for
5 my area.
6 COFFEY, Q.C.:
7 Q. And what about the actual ordering of the
8 test, how was that to be done?
9 DR. BAKER:
10 A. That would have been done from my area, as
11 well, from the pathology department at
12 Carbonear.
13 COFFEY, Q.C.:
14 Q. So you understood that, in fact, the onus
15 would be upon the local pathologist -
16 DR. BAKER:
17 A. Correct.
18 COFFEY, Q.C.:
19 Q. - in this case would be you to actually order
20 the ER/PR?
21 DR. BAKER:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. Doctor, we look through the memo, and of
25 course it says, "As you all know," I take it

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1 "it has been suggested that assessment of
2 ER/PR status and mammary invasive carcinomas
3 be performed immunohistochemically on formalin
4 paraffin embedded tissues." I take it that
5 you hadn't known that before this?
6 DR. BAKER:
7 A. No, no, I didn't.
8 COFFEY, Q.C.:
9 Q. And the reference to in the second paragraph,
10 "The division of pathology in the Health Care
11 Corporation of St. John's having employed this
12 technology for over a year," had you been
13 aware that that was going on?
14 DR. BAKER:
15 A. No.
16 COFFEY, Q.C.:
17 Q. In St. John's?
18 DR. BAKER:
19 A. I didn't know it at all.
20 COFFEY, Q.C.:
21 Q. And in the second paragraph there is a
22 reference to, it says, "Recent audits
23 correlating IHC with biochemical results and
24 selected specimens where both techniques have
25 been running parallel have shown high accuracy

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1 of the introduced IHC detection. Results of
2 these audits have been discussed in several
3 meetings and are available for review." Now,
4 this correlation, Doctor, we've heard evidence
5 that, in fact, pages 4, 5 and 6, in fact, at
6 least, deals with the -
7 DR. BAKER:
8 A. Correlation.
9 COFFEY, Q.C.:
10 Q. Some of the, certainly some of the correlation
11 that went on. Did you make any inquiries at
12 the time about those audits?
13 DR. BAKER:
14 A. No, I didn't.
15 COFFEY, Q.C.:
16 Q. And, Doctor, overall then what was your
17 reaction to this in terms of -
18 DR. BAKER:
19 A. My reaction to it was that it was a stain that
20 was essentially being done in St. John's that
21 I felt was a routine stain that was being
22 transferred to the regions for interpretation
23 there. I didn't see any red flags raised here
24 in this memo that indicated to me that there
25 should be any concern or anything of any

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1 significance that I should be, you know,
2 really aware of in interpretation and that I,
3 you know, I felt it was a stain that I could
4 interpret as if it was any other stain that I
5 would order on a routine basis in my own lab,
6 any special stain.
7 COFFEY, Q.C.:
8 Q. Now, Doctor, while you mention that, at that
9 time, and this is 1998, early 1998, what
10 stains were being--what types of stains were
11 being done in your lab in Carbonear?
12 DR. BAKER:
13 A. Just regular routine, the regular H & E
14 stains, alician blues, formucin, you know,
15 Masson's trichrome (phonetic) for--the basic
16 histopathology stains that would be done in
17 any basic pathology laboratory, nothing out of
18 the ordinary, nothing in relation to IHC,
19 nothing like that, but just basic stains that
20 would require controls, external controls.
21 COFFEY, Q.C.:
22 Q. Doctor, if for patients out of--I'm sorry.
23 DR. BAKER:
24 A. That would require external controls for
25 assessment.

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1 COFFEY, Q.C.:
2 Q. You were or weren't doing them that would
3 require external controls?
4 DR. BAKER:
5 A. For the basic stains, yes, they would require
6 external controls.
7 COFFEY, Q.C.:
8 Q. External controls, yes, yes. So the idea of
9 certainly using an external control was -
10 DR. BAKER:
11 A. Was not foreign.
12 COFFEY, Q.C.:
13 Q. Was not foreign to you?
14 DR. BAKER:
15 A. No.
16 COFFEY, Q.C.:
17 Q. For patients in Carbonear at the time, because
18 we understand that there were certainly other
19 IHC stains that were being done in St. John's,
20 the lab here was doing other, other than
21 ER/PR, there were some other?
22 DR. BAKER:
23 A. Yes, but -
24 COFFEY, Q.C.:
25 Q. For patients in Carbonear, who would be

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1 ordering those?
2 DR. BAKER:
3 A. I wasn't ordering them. They would be done on
4 consultation specimens that were sent in from
5 the Carbonear site. For example, I'll just
6 give you one example, it would a lymph node
7 that I would have diagnosed a lymphoma and I
8 would require consultation for confirmation as
9 to the type of lymphoma. So I would send it
10 to St. John's to the people who are most
11 interested in lymphomas, who had a special
12 interest in it, and they would order the
13 specialized IHC stains to determine what type
14 of lymphoma it was, whether it was B cell, T
15 cell, so on.
16 COFFEY, Q.C.:
17 Q. Sure, and your lymphoma example, these people
18 would be other pathologists?
19 DR. BAKER:
20 A. Other pathologists in St. John's, yes, and
21 they would interpret those slides and send the
22 report confirming, you know, the presence of a
23 lymphoma and also the type of lymphoma, based
24 on the IHC stains.
25 COFFEY, Q.C.:

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1 Q. And if in the course of doing that, of
2 conducting their analysis of the patient
3 status, IHC, if one or more of them are
4 required, they'd do the ordering and get the
5 results?
6 DR. BAKER:
7 A. They would do the ordering and interpretation,
8 yes.
9 COFFEY, Q.C.:
10 Q. Interpretation of it?
11 DR. BAKER:
12 A. Yeah.
13 COFFEY, Q.C.:
14 Q. So in effect, the ER/PR then was the first IHC
15 stain that you were involved in?
16 DR. BAKER:
17 A. Yes, correct.
18 COFFEY, Q.C.:
19 Q. Doctor, here then, we've noted--well, Dr.
20 Khalifa refers to phase one on the
21 introductory phase at the bottom of the first
22 page, and phase two, "each pathologist will be
23 asked to report results of his or her own
24 cases as indicated by the brown staining of
25 nuclei of the invasive neoplastic cells."

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1 Doctor, nuclei staining, at that time, early
2 1998, were there any other nuclei staining
3 that you were involved in interpreting?
4 DR. BAKER:
5 A. Well, I mean, some of the basic stains and so
6 on, you would be looking for, you know,
7 staining within the cell and so on. So I was
8 familiar with looking at stains within the
9 cell. Nuclei staining, probably this is the
10 first one.
11 COFFEY, Q.C.:
12 Q. And the other types of staining being?
13 DR. BAKER:
14 A. Like alician blue, you're looking for actually
15 mucin within the cell itself and so on versus
16 actually, you know, within the actual nuclei
17 in the cells.
18 COFFEY, Q.C.:
19 Q. Cytoplasmic staining, I take it?
20 DR. BAKER:
21 A. Cytoplasmic staining, yes.
22 COFFEY, Q.C.:
23 Q. And membrane staining, I take it, would be -
24 DR. BAKER:
25 A. Yeah, this probably would have been the first

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1 nuclei one.
2 COFFEY, Q.C.:
3 Q. Here, Doctor, he says, in phase two, "this
4 phase will start March 1, 1998, at which time
5 your immunostained slides will be mailed back
6 to you with positive controls whenever it is
7 technically possible." What did you interpret
8 that--the positive controls here meant what to
9 you, positive external controls?
10 DR. BAKER:
11 A. Would mean that they were using a piece of
12 tissue that stained positively for the actual
13 stain that they were using to make sure that
14 the stain was working appropriately.
15 COFFEY, Q.C.:
16 Q. This would be an external control?
17 DR. BAKER:
18 A. External control, yes.
19 COFFEY, Q.C.:
20 Q. And whenever it is technically possible, you
21 interpreted that to mean what?
22 DR. BAKER:
23 A. Whenever--basically, whenever they were able
24 to send me back control slides, they would.
25 That's all. I didn't take anything else from

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1 it.
2 COFFEY, Q.C.:
3 Q. And he goes on to say "with each run, I will
4 still be responsible for reviewing the
5 positive controls here in our laboratory and
6 the slides will not be mailed to you unless
7 adequate staining is noted in the positive
8 controls," and he concludes by saying "I will
9 be more than glad to continue being available
10 to answer any questions and address concerns."
11 Now did you ever have occasion to contact Dr.
12 Khalifa about this?
13 DR. BAKER:
14 A. No, I didn't.
15 COFFEY, Q.C.:
16 Q. Or anyone else in St. John's?
17 DR. BAKER:
18 A. No.
19 COFFEY, Q.C.:
20 Q. Did you get any contact from them, other than
21 the memo?
22 DR. BAKER:
23 A. No.
24 COFFEY, Q.C.:
25 Q. And in the aftermath of the memo, when you

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1 started to do the--order the tests and report
2 the results, no concerns expressed from St.
3 John's?
4 DR. BAKER:
5 A. No, not at all.
6 COFFEY, Q.C.:
7 Q. Doctor, in terms of the phase two description
8 here, your understanding, I take it, was "if
9 they can send me the positive external
10 controls, they will." But if they didn't, if
11 they could not, for some reason, and you had
12 the patient slides come back to you, ER/PR
13 slides, what, if anything, did you understand
14 about what had happened in relation to the
15 external controls?
16 DR. BAKER:
17 A. That they would have been interpreted by a
18 pathologist at the Health Science Centre as
19 being adequate or positive and that the test
20 was appropriate to be interpreted.
21 COFFEY, Q.C.:
22 Q. It was safe for you then to -
23 DR. BAKER:
24 A. To interpret.
25 COFFEY, Q.C.:

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1 Q. You're relying upon that, I take it?
2 DR. BAKER:
3 A. The interpretation of the control slides at
4 the Health Sciences by a pathologist there.
5 COFFEY, Q.C.:
6 Q. And you're relying upon the assertion that you
7 wouldn't get the patient slides unless some
8 other pathologist was satisfied the external
9 controls stained appropriately?
10 DR. BAKER:
11 A. Correct.
12 COFFEY, Q.C.:
13 Q. In relation to that patient's slides?
14 DR. BAKER:
15 A. Correct. There were very few occasions when I
16 didn't get external controls, and when the
17 external controls didn't come, there would
18 almost always be a notation on the bottom of
19 the requisition that was sent in originally
20 with the specimen saying that the pathologist
21 had read the control slides, they were
22 adequate, and there would be an initial or
23 signature of the pathologist at the bottom of
24 the page.
25 COFFEY, Q.C.:

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1 Q. Doctor, after the reference to phase three,
2 and the discontinuance of biochemical assays,
3 Dr. Khalifa goes on, "attached, please find a
4 proposal for uniform reporting of ER/PR
5 immunohistochemical staining. This proposal
6 was discussed with many of my colleagues who
7 mostly agree with its content and accepted it
8 as a policy, so I encourage you to adopt the
9 attached proposal in your reporting to
10 maintain uniformity. It should be clearly
11 stated that this is only a proposal." I'm
12 sorry, apologize. What approach did you adopt
13 then to how ER/PR would be reported?
14 DR. BAKER:
15 A. I adopted the proposal of reporting the
16 specimen as either negative or positive, and
17 after either the negative or positive, I would
18 put in the percentage of cells in brackets.
19 COFFEY, Q.C.:
20 Q. So as we'll see then on the next page. So you
21 adopted the proposal, Dr. Khalifa's
22 suggestion?
23 DR. BAKER:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. You understood it was a proposal, it wasn't an
2 order?
3 DR. BAKER:
4 A. That's correct, yeah.
5 COFFEY, Q.C.:
6 Q. But your practice was to adopt the suggestion?
7 DR. BAKER:
8 A. Correct, it was, yes.
9 COFFEY, Q.C.:
10 Q. That's what you did. Doctor, he also
11 concludes by saying "there is a host of"--I'm
12 sorry, "there is a considerable host of
13 publications addressing this issue. I'm glad
14 to share any of the material I already have
15 with you. I would extremely appreciate your
16 feedback on this matter." Did you ever seek
17 any of the material he refers to?
18 DR. BAKER:
19 A. No, I didn't.
20 COFFEY, Q.C.:
21 Q. Did you ever conduct any research yourself in
22 relation to, you know, ER/PR and IHC testing?
23 DR. BAKER:
24 A. No, I had one textbook that I consulted
25 occasionally and so on, but it was a very

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1 general textbook. It just gave some general
2 principles that outlined not only ER/PR, but
3 the other stains as well, but it wasn't
4 consulted on a frequent basis.
5 COFFEY, Q.C.:
6 Q. So at the time, and even subsequently, you
7 didn't go and look at a journal article or a
8 textbook in relation to ER/PR IHC staining?
9 DR. BAKER:
10 A. No, I didn't, no.
11 COFFEY, Q.C.:
12 Q. Look to the next page, Doctor, page three.
13 This is proposal for uniform reporting of ER
14 and PR immunohistochemical assessment, refers
15 to having three components, and now, Doctor,
16 your understanding then of the usage here of
17 the word "positive", the words "positive" and
18 "negative," to you positive, you understood
19 positive meant what?
20 DR. BAKER:
21 A. Positive meant anything--to me, positive meant
22 anything above zero.
23 COFFEY, Q.C.:
24 Q. And negative then was zero itself?
25 DR. BAKER:

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1 A. Zero, yes.
2 COFFEY, Q.C.:
3 Q. And so if you described--your practice was
4 then, if you saw, for example, even in the
5 early days, 1998, 1999, if you saw what you
6 considered to be ten percent of the tumour
7 cells for staining -
8 DR. BAKER:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. - ten percent of the nuclei were staining, you
12 would report it how?
13 DR. BAKER:
14 A. I would report it as positive and the
15 percentage of cells would be in brackets, 5 to
16 10 percent, 10 to 20 percent.
17 COFFEY, Q.C.:
18 Q. And did you utilize the comment?
19 DR. BAKER:
20 A. No, I didn't.
21 COFFEY, Q.C.:
22 Q. Why is that, Doctor?
23 DR. BAKER:
24 A. I felt that if there was any degree of
25 positivity in the specimen at all, I would

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1 want to relay that without any qualification
2 to the end user of the report, be it the
3 oncologist or the surgeon, to allow him to
4 make his determination as to whether or not
5 there may be some chance that there may be
6 benefit to this patient, without any, I
7 suppose, interference by me in telling him
8 that, you know, this is probably negative and
9 so on.
10 COFFEY, Q.C.:
11 Q. Which you would have interpreted this
12 reference to the 1990 journal article?
13 DR. BAKER:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. So from your perspective, your approach was?
17 DR. BAKER:
18 A. To allow the end user of the report to
19 determine whether or not there was any--the
20 information that I provided was of use to the
21 patient and to allow them to make
22 determination as to whether to use any
23 additional drugs or treatment of the patient.
24 COFFEY, Q.C.:
25 Q. So in effect, I take it then, Doctor, your

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1 approach was either to use example one, which
2 is here, which is in effect, estrogen receptor
3 is whatever positive, and positive, you use
4 the word positive if it was anything from one
5 up to 100?
6 DR. BAKER:
7 A. Correct.
8 COFFEY, Q.C.:
9 Q. And if it was zero percent, it would just
10 simply read, for example, estrogen receptors
11 is negative zero percent of cells?
12 DR. BAKER:
13 A. Correct.
14 COFFEY, Q.C.:
15 Q. That was your -
16 DR. BAKER:
17 A. That was my--the way I interpreted things.
18 COFFEY, Q.C.:
19 Q. No editorializing, it was just kind of
20 "whatever I say"?
21 DR. BAKER:
22 A. Here are the facts.
23 COFFEY, Q.C.:
24 Q. Here are the facts, okay. Now, Doctor, prior
25 to this, had you ever been involved in trying

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1 to do an estimate of percentages of cells?
2 Did your practice, you know, the type of work
3 you did, require you to make an estimate of
4 two percent, 100 percent, 80 percent?
5 DR. BAKER:
6 A. Not to my recollection, no.
7 COFFEY, Q.C.:
8 Q. So how did you go about that, kind of
9 determining a percentage, what was your
10 practice?
11 DR. BAKER:
12 A. My practice would be to take--well, first of
13 all, I would get back the specimen. It would
14 contain the ER/PR stained slides of the
15 specimen that I sent in. Most times I would
16 get back the external controls of both the ER
17 and PR, and also a stained slide, H & E slide
18 of the specimen that I sent in, they would
19 prepare one in town and send it back to me
20 from St. John's.
21 COFFEY, Q.C.:
22 Q. So before, perhaps I'll go back and I'll take
23 you through that.
24 DR. BAKER:
25 A. Okay, all right.

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1 COFFEY, Q.C.:
2 Q. I'm glad you started to tell me about that.
3 In terms then, okay, you get this memo, read
4 it, and make up your own mind about how I'm
5 going to report it. You thought about it,
6 obviously.
7 DR. BAKER:
8 A. Um-hm.
9 COFFEY, Q.C.:
10 Q. You gave some independent thought to it.
11 DR. BAKER:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And then, okay, so I'm going to--you
15 determine, "I'm going to do this."
16 DR. BAKER:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. And as you pointed out, there's nothing--you
20 don't see, there's no kind of red flag or
21 warnings here in this memo that there's
22 anything particular to look out for, and you
23 set about then ordering ER/PR on the first and
24 second and third and fourth patients.
25 DR. BAKER:

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1 A. Correct.
2 COFFEY, Q.C.:
3 Q. Then how would you go about it, Doctor, in
4 terms of determining which blocks to use?
5 What was your approach?
6 DR. BAKER:
7 A. My approach would be to review my original
8 slides of the specimen, the ones which
9 contained the carcinoma, and I would take a
10 good representative sample or a paraffin block
11 or a slide that contained a significant
12 portion of tumour cells, and that's the one I
13 would take. I would ask my technologist to
14 draw out the paraffin block then, and send
15 that block into St. John's for the ER/PR
16 stains.
17 COFFEY, Q.C.:
18 Q. And from some material we've seen, I gather,
19 certainly in the early days, pathologists
20 throughout the province at times had to send
21 letters, were actually sending a covering
22 letter, as it were?
23 DR. BAKER:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Asking that it be done, and then eventually
2 forms became available?
3 DR. BAKER:
4 A. Correct.
5 COFFEY, Q.C.:
6 Q. Is that what you--your memory of it?
7 DR. BAKER:
8 A. That was the standard format, yes. In the
9 beginning, we would, I think, use our own
10 requisition form, a blank requisition form,
11 and put the actual patient information on it
12 and request the ER/PR and send it in that way.
13 It would be letterheaded from our facility,
14 Carbonear General Hospital.
15 COFFEY, Q.C.:
16 Q. And then as time went on, the General Hospital
17 provided requisition forms that you could
18 check off which -
19 DR. BAKER:
20 A. Yeah, it contained a list of all the IHC
21 stains that were available in the facility in
22 St. John's, and we would just provide the
23 patient information and circle the ER/PR
24 section.
25 COFFEY, Q.C.:

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1 Q. And you would specify on the form which block
2 you wanted sent?
3 DR. BAKER:
4 A. Yes. The patient information would include
5 the patient number, the surgical number, and
6 also the block.
7 COFFEY, Q.C.:
8 Q. And you would identify for the technologist
9 "this is the block I want," your local
10 technologist?
11 DR. BAKER:
12 A. Yeah, I would first examine the slides, ask
13 him to draw the slides, examine the best
14 section, the best representative section of
15 the tumour and ask him to draw out the
16 corresponding block labelled similar to the
17 slide, whether it was A or C or D.
18 COFFEY, Q.C.:
19 Q. And the technologist then would send that off
20 to St. John's with the requisition form or the
21 covering letter, depending on which you were
22 using at the time?
23 DR. BAKER:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Then what would happen?
2 DR. BAKER:
3 A. There would be a space of time, probably a
4 week, a week to ten days, and I suppose it
5 would depend on the volume they had in town.
6 Week to ten days, and the slides would be
7 returned via courier to me, and I would take
8 them out and examine them.
9 COFFEY, Q.C.:
10 Q. And how would you go about doing that then?
11 DR. BAKER:
12 A. Well, as I just previously indicated, I had--
13 there was a set of slides came back to me.
14 They were all numbered, both with my surgical
15 number and also the referred in number that
16 the Health Sciences had given them. They
17 would have a referred in number on the top of
18 the slide as well, as well as my corresponding
19 surgical number, so that there could be
20 correlation between the two if there was any
21 problems, and I would receive five slides
22 essentially, the stained ER, stained PR,
23 control ER, control PR, and an H & E slide.
24 COFFEY, Q.C.:
25 Q. Now the stained ER and PR slides would be

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1 labelled with the numbers you've referred to?
2 DR. BAKER:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. How about the control slides?
6 DR. BAKER:
7 A. Control slides would be labelled positive PR
8 control, positive ER control.
9 COFFEY, Q.C.:
10 Q. Would they be dated or cross-referenced with
11 the patient slides?
12 DR. BAKER:
13 A. No, I don't remember dates on them. They
14 would just come in the package, that's all.
15 COFFEY, Q.C.:
16 Q. Did your office then do anything to cross-
17 reference those particular control slides with
18 the patient slides?
19 DR. BAKER:
20 A. No. We would make sure that they were just
21 packaged together and put in our files. When
22 we returned the slides to the file, they would
23 be put in separate containers, our cardboard
24 little slot, slotted envelopes, and they would
25 be all packaged together in one package.

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1 COFFEY, Q.C.:
2 Q. So the practice in your institution was when
3 you got the control slides, external control
4 slides back from St. John's, from then on,
5 they would accompany that patient's slides?
6 DR. BAKER:
7 A. That's right. Now on occasion, when there
8 were probably one or two samples that went in
9 from our facility at the same time, we may not
10 get back control slides on both specimens. We
11 would get back a control set of slides for
12 both specimens. So there wouldn't be always
13 individual control slides for each specimen.
14 COFFEY, Q.C.:
15 Q. In those instances, when that would happen, I
16 take it that would be relatively infrequent?
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. In those instances, was there any record kept
21 to cross-reference? Because the control
22 slides could only go with one patient's
23 slides?
24 DR. BAKER:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. So would there be any cross-reference saying
3 to the other patient?
4 DR. BAKER:
5 A. No, the only way that we could--well, we'd put
6 them with either one or the other of the
7 specimens when we were storing them away in
8 the files. The only way that we could--there
9 was no cross-reference done, but we do have,
10 we did have a record book whereby when the
11 specimens were sent in, we wrote the
12 information down in a record book saying
13 "specimen sent to St. John's for ER/PR slides"
14 and if there were two of them there at the
15 same date, then two of them could be drawn out
16 and if one contained the ER/PR slides, then
17 they can be just--we would know that only one
18 set of ER/PR slides came back with those two
19 specimens.
20 COFFEY, Q.C.:
21 Q. So you would get the five slides per patient?
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Or at least if it was one patient, five

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1 slides. What would you do then?
2 DR. BAKER:
3 A. I would examine them under the microscope. I
4 would look at--first of all, look at the H & E
5 stained slide and look at the tumour and so on
6 again, get myself oriented to the tissue to
7 see where the tumour was lying within the
8 tissue segment. Then I would take
9 individually. First I would generally go to
10 the ER slides, look at the ER control, make
11 sure that it was positive and working
12 properly.
13 COFFEY, Q.C.:
14 Q. What criteria would you use to determine that?
15 What thought process?
16 DR. BAKER:
17 A. Just adequate staining of the nuclei in the
18 tissue that was used for the control.
19 COFFEY, Q.C.:
20 Q. What would be adequate?
21 DR. BAKER:
22 A. Staining. I didn't pay particular attention
23 to the intensity. Most times, to my
24 recollection, the staining intensity of the
25 tissue and controls was strong, and I would

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1 have--I would think it was selected for that
2 purpose, especially selected tissue that was
3 known to be strong for ER and/or PR was
4 selected for controls. That's usually the way
5 that things are done when you're using tissue
6 for control.
7 COFFEY, Q.C.:
8 Q. Did you ever encounter weak staining of the
9 external controls or what you considered weak?
10 DR. BAKER:
11 A. Not to my recollection, no. Not to my
12 recollection.
13 COFFEY, Q.C.:
14 Q. What would the significance be of weak
15 staining of the external controls, if one
16 encountered it?
17 DR. BAKER:
18 A. I would still consider it as being a positive
19 control. The intensity of the staining, I
20 didn't think, was a major problem.
21 COFFEY, Q.C.:
22 Q. Doctor, okay, go ahead then in the process.
23 You'd look at the external ER control and
24 then?
25 DR. BAKER:

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1 A. And then I would look at the actual ER stain
2 of the tissue that I had sent in and for my
3 orientation from the H & E section, I would
4 locate the tumour tissue area, the main tumour
5 cell bulk area, and I would tend to look at
6 anywhere from four to six fields of the tumour
7 cells and zero in on the tumour cells, look
8 for the nuclear staining, and then I would
9 tend to count the cells in those particular
10 areas and get an average of the percentage of
11 positivity, if there was positivity, and move
12 to the next field and do the same, same for
13 each subsequent field, and then work out an
14 average.
15 COFFEY, Q.C.:
16 Q. For each of the fields?
17 DR. BAKER:
18 A. Yeah, of positivity, if there was positivity.
19 COFFEY, Q.C.:
20 Q. And what would happen then? Go through that,
21 do the arithmetic?
22 DR. BAKER:
23 A. Yeah.
24 COFFEY, Q.C.:
25 Q. And then what?

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1 DR. BAKER:
2 A. And I would do the same for the PR, and I
3 would make notation, you know, for the ER, if
4 it was 20 percent, 20 or 30 percent, I would
5 make notation and the same way for the PR, I
6 would make notation, and dictate it as an
7 addendum to the report of the previous biopsy
8 or mastectomy specimen, using the format
9 example one.
10 COFFEY, Q.C.:
11 Q. Doctor, did you, in that process, give any
12 consider--well, we've heard reference,
13 numerous references here to the idea or
14 process of using internal controls, normal
15 tissue, normal breast tissue. Did you do that
16 at the time?
17 DR. BAKER:
18 A. No, I didn't.
19 COFFEY, Q.C.:
20 Q. The idea of utilizing internal controls or
21 normal tissue, normal breast tissue for
22 internal control purposes in ER/PR, when did
23 you first become aware of that?
24 DR. BAKER:
25 A. When I received a memo from Dr. Ejeckam in

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1 2003.
2 COFFEY, Q.C.:
3 Q. Okay, so we'll move ahead to then, but so in
4 the meantime, I take it that, in terms of
5 between 1998 and 2003, you were looking for as
6 much tumour in a block as you could?
7 DR. BAKER:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. As the most representative sample.
11 DR. BAKER:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And there might or might not be normal tissue?
15 DR. BAKER:
16 A. Yes, there might or might not be, correct.
17 COFFEY, Q.C.:
18 Q. And when you would get the slides, you would
19 not look to see whether the normal tissue was
20 staining or not?
21 DR. BAKER:
22 A. No, I didn't.
23 COFFEY, Q.C.:
24 Q. And for example, if there was no staining in
25 the tumour that you could see, you wouldn't

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1 address your mind to whether or not the normal
2 tissue had or hadn't stained?
3 DR. BAKER:
4 A. No, I didn't.
5 COFFEY, Q.C.:
6 Q. Doctor, I appreciate you didn't use the
7 comment that Dr. Khalifa had suggested. Did
8 you ever speak to anybody about whether or not
9 other pathologists were using a comment or
10 not?
11 DR. BAKER:
12 A. No, I didn't.
13 COFFEY, Q.C.:
14 Q. You weren't aware that Dr. Cook had -
15 DR. BAKER:
16 A. I had no idea who or who wasn't using the
17 comment, you know.
18 COFFEY, Q.C.:
19 Q. So you then, Doctor, have, after Dr. Khalifa's
20 memo arrived in 1998, you embarked on this
21 process.
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And did you ever have occasion to have to

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1 reorder an ER/PR?
2 DR. BAKER:
3 A. No. I thought about that, and I can't
4 recollect any time that I had to reorder one.
5 No, not at all.
6 COFFEY, Q.C.:
7 Q. And reordering could be occasioned by, for
8 example, an external control not staining
9 appropriately.
10 DR. BAKER:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. You don't ever recall that happening with
14 ER/PR?
15 DR. BAKER:
16 A. No, not at all.
17 COFFEY, Q.C.:
18 Q. And then the other thing that might cause it,
19 I gather, is that well, the slides were
20 uninterpretable or not appropriate to be
21 interpreted, and you don't ever recall that?
22 DR. BAKER:
23 A. I don't remember ever having--ever reordered
24 any repeats of ER/PR slides or testing,
25 staining.

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1 COFFEY, Q.C.:
2 Q. Doctor, did you ever become aware that within
3 the laboratory at the General Hospital, that
4 on a number of occasions, certainly in 2001,
5 2002, 2003, that for ER/PR tests that they
6 were having to be rerun?
7 DR. BAKER:
8 A. No, I wasn't made aware of that at all.
9 COFFEY, Q.C.:
10 Q. You weren't made aware of that?
11 DR. BAKER:
12 A. No.
13 COFFEY, Q.C.:
14 Q. Because there's a fair amount of material that
15 the Commissioner has seen in relation to, and
16 technologists have testified that at times
17 they would have to rerun--they'd be requested
18 to rerun it at times.
19 DR. BAKER:
20 A. Okay.
21 COFFEY, Q.C.:
22 Q. By the pathologist.
23 DR. BAKER:
24 A. I was never made aware of those circumstances.
25 THE COMMISSIONER:

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1 Q. I'm sorry, Mr. Coffey. Dr. Baker, could you
2 tell me about how many ER/PRs would be done
3 out of Carbonear, on average?
4 DR. BAKER:
5 A. On the average, 20 a year.
6 THE COMMISSIONER:
7 Q. Okay, thank you.
8 COFFEY, Q.C.:
9 Q. Thank you, Commissioner. And that's going
10 back to 1998 and continuing to today?
11 DR. BAKER:
12 A. That's correct. That's about the average.
13 We'd be at one to two a month.
14 COFFEY, Q.C.:
15 Q. Doctor, did you ever have occasion to have
16 another physician, attending physician of any
17 sort, a surgeon, oncologist, ask or request
18 that an ER/PR be rerun or that the test--you
19 had given your report, whatever it might be,
20 of ER/PR status and you were asked to -
21 DR. BAKER:
22 A. The only occasion that I can remember was when
23 the problems started in 2005.
24 COFFEY, Q.C.:
25 Q. 2005, okay.

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1 DR. BAKER:
2 A. And there were some requests that came through
3 then, through some of the oncologists, to have
4 some of the testing redone. That was in the
5 early stages, even probably before I received
6 the phone call from Don Cook. There may have
7 been one or two requests that came through
8 from the oncologists saying "would you mind
9 repeating this test for me?"
10 COFFEY, Q.C.:
11 Q. For a particular patient?
12 DR. BAKER:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. That they identified?
16 DR. BAKER:
17 A. Yes, that's correct.
18 COFFEY, Q.C.:
19 Q. Did they explain why at the time?
20 DR. BAKER:
21 A. No, they didn't. They just said "I'd like to
22 have a repeat on this test" or "the clinical
23 situation of the patient has changed" or
24 "doesn't fit the pattern of the way things are
25 going," some simple comment like that, and

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1 "I'd like to have a repeat of the test."
2 COFFEY, Q.C.:
3 Q. Do you recall when you first received that
4 sort of request?
5 DR. BAKER:
6 A. It may have been April or May.
7 COFFEY, Q.C.:
8 Q. Of 2005?
9 DR. BAKER:
10 A. Yeah.
11 COFFEY, Q.C.:
12 Q. Okay, and looking back, at the time, you
13 wouldn't have known about the problem in St.
14 John's.
15 DR. BAKER:
16 A. No.
17 COFFEY, Q.C.:
18 Q. I take it you did eventually. You know, you
19 eventually became aware.
20 DR. BAKER:
21 A. No, I wasn't aware of anything going on during
22 that period of time, and until I received a
23 phone call from Don Cook in late May, early
24 June.
25 COFFEY, Q.C.:

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1 Q. But now, looking back on it, you've kind of
2 pieced it together.
3 DR. BAKER:
4 A. Yeah.
5 COFFEY, Q.C.:
6 Q. Well, Don Cook called me in late May, early
7 June about this, and it went on from there,
8 but you had, in the preceding month or two,
9 received some phone calls, some few phone
10 calls from oncologists asking that ER/PR be
11 rerun?
12 DR. BAKER:
13 A. Yeah, there was only one or two occasions that
14 I can remember.
15 COFFEY, Q.C.:
16 Q. And do you recall who the oncologists were?
17 DR. BAKER:
18 A. I can't be--they would have been either Joy
19 McCarthy or--mostly, it was probably Joy
20 McCarthy. There may have been a request from
21 Kara Laing, I'm not sure.
22 COFFEY, Q.C.:
23 Q. And did you rerun them at the time?
24 DR. BAKER:
25 A. I sent them off for running, yeah, at that--I

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1 did, yeah.
2 COFFEY, Q.C.:
3 Q. And you sent them to where?
4 DR. BAKER:
5 A. They were sent to Mount Sinai.
6 COFFEY, Q.C.:
7 Q. At that point in time, they were?
8 DR. BAKER:
9 A. Yeah, sent to Mount Sinai. The request came
10 through to send them off to Mount Sinai.
11 Yeah, I'm almost certain it was. I'm almost
12 certain it was, but I stand to be corrected.
13 COFFEY, Q.C.:
14 Q. Okay, and I'll be taking you through that 2005
15 era shortly. So Doctor, then after Dr.
16 Khalifa's memo in early 1998 and you embarked
17 on this process, when did the ER/PR--I take it
18 it was just one more test?
19 DR. BAKER:
20 A. Correct, yeah.
21 COFFEY, Q.C.:
22 Q. From your perspective. Never any problems
23 that you were aware of?
24 DR. BAKER:
25 A. Correct, that's the way I viewed it, yes.

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1 COFFEY, Q.C.:
2 Q. And you've referred to Dr. Ejeckam's memo,
3 memos.
4 DR. BAKER:
5 A. Um-hm.
6 COFFEY, Q.C.:
7 Q. Just one moment, please, Commissioner. Bring
8 up, please, Exhibit P-0113. Doctor, the
9 Commissioner has seen these memos numerous
10 times. There are three of them that we are
11 aware of, one of April 4th, 2003, which is
12 there on the screen right now.
13 DR. BAKER:
14 A. Um-hm.
15 COFFEY, Q.C.:
16 Q. And there's one of May 2nd, 2003, which is
17 page two of that particular exhibit, that's on
18 the screen now. And then there's one of June
19 19th, 2003, which is page five of the exhibit.
20 DR. BAKER:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Which of these memos did you receive?
24 DR. BAKER:
25 A. I remember receiving the second one

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1 distinctly. The first one -
2 COFFEY, Q.C.:
3 Q. That's the May 2nd one?
4 DR. BAKER:
5 A. Yes. The first one, I may or may not have
6 received. I just can't remember it. I don't
7 remember receiving it, but it very well could
8 have come across my desk and I just can't
9 remember it.
10 COFFEY, Q.C.:
11 Q. This particular one of April 4th, 2003, to
12 pathologists and you would fall into the
13 category of out-of-town hospitals, I take it?
14 DR. BAKER:
15 A. Correct, yes.
16 COFFEY, Q.C.:
17 Q. Did you know who Dr. Ejeckam was?
18 DR. BAKER:
19 A. No, I knew he was a pathologist at the Health
20 Science Centre, but I didn't know him other
21 than that. I hadn't met the individual at
22 all.
23 COFFEY, Q.C.:
24 Q. Have you ever met him?
25 DR. BAKER:

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1 A. No.
2 COFFEY, Q.C.:
3 Q. Have you ever spoken with him?
4 DR. BAKER:
5 A. No.
6 COFFEY, Q.C.:
7 Q. That you recall?
8 DR. BAKER:
9 A. No.
10 COFFEY, Q.C.:
11 Q. Here, Doctor, the memo itself, you say may or
12 may not have come to you. It says "kindly
13 note that the immunohistochemical stains with
14 the following antibodies," and there are eight
15 of them listed.
16 DR. BAKER:
17 A. Um-hm.
18 COFFEY, Q.C.:
19 Q. ER/PR, the last two, "have remained
20 unreliable, erratic and therefore unhelpful
21 for diagnostic purposes" and he says "they'll
22 stop forthwith until they can solve the
23 reliability, sensitivity and specificity
24 problems." And "a solution, I hope, will be
25 found within the next four to six weeks." And

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1 Doctor, leaving aside the ER/PR for a moment,
2 these other six stains that are listed there,
3 by this point in time, April of 2003, were you
4 involved in ordering any of them?
5 DR. BAKER:
6 A. No, I wasn't.
7 COFFEY, Q.C.:
8 Q. Again, they fell into this category of if they
9 were ordered for a patient, they were done by
10 some other -
11 DR. BAKER:
12 A. Yes, would have been done on a consultation
13 that I had sent in for another pathologist to
14 consult on.
15 COFFEY, Q.C.:
16 Q. So up until then, April and May of 2003, what,
17 if any, IHC stains were your ordering?
18 DR. BAKER:
19 A. Just the ER/PR.
20 COFFEY, Q.C.:
21 Q. Were the only two?
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And while I'm on the topic, Doctor, in fact

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1 then has that ever changed?
2 DR. BAKER:
3 A. No, it hasn't. It still remains.
4 COFFEY, Q.C.:
5 Q. Still remains so, and we'll go on through
6 that. Page two, the May 2nd memo, the one you
7 did, do recall receiving?
8 DR. BAKER:
9 A. Yes, I do.
10 COFFEY, Q.C.:
11 Q. What was your reaction when you received this,
12 Doctor?
13 DR. BAKER:
14 A. That the problem had been corrected and he was
15 providing me with information for my use in
16 processing and interpreting ER/PR from then
17 on.
18 COFFEY, Q.C.:
19 Q. While I'm on it, Doctor, the June 19th memo,
20 did you ever receive that, that you recall?
21 It's not addressed to you.
22 DR. BAKER:
23 A. No, I didn't, no.
24 COFFEY, Q.C.:
25 Q. Go back then to the May 2nd memo. I take it

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1 there was information in this that was new to
2 you at the time?
3 DR. BAKER:
4 A. Correct, yes.
5 COFFEY, Q.C.:
6 Q. And did this cause you to do any further
7 research or make any further inquiry?
8 DR. BAKER:
9 A. No, I took the information in the memo and
10 tried to incorporate it into my daily, you
11 know, process of dealing with the tissues,
12 those affecting, you know, the breast CA, the
13 ER/PR. No, but I didn't consult any other
14 further journals or any other text.
15 COFFEY, Q.C.:
16 Q. Did you pass this on to the staff or any other
17 staff at the General Hospital--I'm sorry, at
18 the Carbonear Hospital? The technologists,
19 for example.
20 DR. BAKER:
21 A. I can't recollect. I may or may not have.
22 I'm not sure.
23 COFFEY, Q.C.:
24 Q. And here, for example, and refer to this at
25 the bottom of the page, the last five lines.

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1 "It is advisable to maintain a regular"--four
2 lines, I'm sorry. "It is advisable to
3 maintain a regular check on the pH for
4 buffered formalin, even if it is procured
5 commercially."
6 DR. BAKER:
7 A. Um-hm.
8 COFFEY, Q.C.:
9 Q. So that wasn't done until recently, I take it,
10 that -
11 DR. BAKER:
12 A. Yeah, that information probably wasn't
13 transferred.
14 COFFEY, Q.C.:
15 Q. To the technologists. And now on page two of
16 the memo, paragraph three refers to "checking
17 normal breast acini in your sections as
18 internal controls." Did that cause you to do
19 anything differently?
20 DR. BAKER:
21 A. Well, in subsequent ER/PRs that came back, I
22 tended to look for the internal controls. I
23 still relied heavily on my external controls,
24 as I had done so in the past. The comment
25 here by Dr. Ejeckam was an information

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1 comment, as far as I was concerned. He didn't
2 place, you know, strong emphasis on saying
3 that the internal control was absolutely
4 necessary to be interpreted for interpretation
5 of these stains. He put some qualifying marks
6 on the end of it there that nuclear staining
7 of normal breast tissue is heterogeneous and
8 varies with menstrual cycle. So I thought
9 there was some variability in this internal
10 control, and that it wouldn't probably be as
11 reliable as the external control.
12 COFFEY, Q.C.:
13 Q. And so I take it that you didn't, having read
14 paragraph three and bearing in mind your level
15 of knowledge at the time, you didn't interpret
16 this as kind of a red flag?
17 DR. BAKER:
18 A. No, I didn't. I would have expected that if
19 it was a red flag, that he would really have
20 emphasized and said something to that effect.
21 COFFEY, Q.C.:
22 Q. Doctor, the paragraph four refers to "in
23 carcinoma of the breast, most PR positive
24 tumours are also ER positive. However, ten
25 percent of PR positive tumours are ER

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1 negative," and had you been aware of that sort
2 of statistic?
3 DR. BAKER:
4 A. No, I hadn't.
5 COFFEY, Q.C.:
6 Q. The idea that ER negative PR positive tumours
7 were relatively rare, at least according to
8 this?
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. I mean, only one in ten might be, using that
13 statistic. So you, if you hadn't been aware
14 of that statistic, you wouldn't have been
15 looking at or thinking about it in doing your
16 interpretation, if you came to the conclusion
17 a particular patient is PR positive ER
18 negative, it wasn't crossing your mind at the
19 time, before this certainly, it wasn't
20 crossing your mind that well, this is a one in
21 ten case?
22 DR. BAKER:
23 A. No, that's right. I was doing small numbers
24 at the time too, as well. I was doing one or
25 two a month, you know, average of 20 a year,

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1 so I wouldn't--you know, if you did one or two
2 a month, some months you may not do any,
3 depending on, summer time, that kind of thing
4 and so on, and you wouldn't be reflecting on
5 trends and so on with small numbers like that.
6 COFFEY, Q.C.:
7 Q. And Doctor, in relation to that, as well,
8 paragraph seven refers to ER positive tumours
9 or certain tumours tend to be ER positive, and
10 there are four of them listed here, and Dr.
11 Ejeckam, in fact, has told the Commissioner he
12 should have included lobular as well in this
13 listing.
14 DR. BAKER:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Were you aware that certain types of breast
18 tumours should be or were expected to be ER
19 positive?
20 DR. BAKER:
21 A. Well, all these tumours that are listed here
22 are invasive tumours, so the most common ones
23 that I saw were ductal and saw the occasional
24 mucinous. Papillary were very infrequent for
25 me to be seeing, and tubular as well. So I

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1 was of the understanding that the invasive
2 carcinomas would tend to be ER positive, yes.
3 COFFEY, Q.C.:
4 Q. Had you known that before this?
5 DR. BAKER:
6 A. Well, this is new information to me.
7 COFFEY, Q.C.:
8 Q. New for you, okay, and in fact, it doesn't
9 list lobular, so when--and we understand that
10 generally lobular invasive tumours would be
11 positive.
12 DR. BAKER:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. When did you first become aware of that?
16 DR. BAKER:
17 A. Just within the past, I'd say within the past
18 couple of years.
19 COFFEY, Q.C.:
20 Q. And so as this was new information to you in
21 2003, did this make any change to your
22 practice or approach?
23 DR. BAKER:
24 A. Well, I was obviously--I would pay more strict
25 attention to the type of tumour and to my

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1 reporting of the tumour, as far as the ER/PR
2 staining.
3 COFFEY, Q.C.:
4 Q. And paragraph eight, in fact, goes on to talk
5 about low nuclear grade tumours being usually
6 positive and so on. So it did, the
7 information contained in paragraph seven and
8 eight, then in the future then, did play a
9 part in your approach?
10 DR. BAKER:
11 A. It was extremely significant, yes, and played
12 a part in further interpretation, yes. Some
13 information that we didn't have previously.
14 That I didn't have previously.
15 COFFEY, Q.C.:
16 Q. He does conclude by saying "we are working on
17 the remaining antibodies and hopefully all
18 normal immunostains will resume soon" and he
19 had said at the beginning of the memo that "I
20 am glad to inform you, we have rectified the
21 difficulties and can now resume regular
22 requests for these antibody stains."
23 DR. BAKER:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. So Doctor, in relation to this, and I
2 appreciate you weren't doing or ordering the
3 other IHC stains -
4 DR. BAKER:
5 A. Correct.
6 COFFEY, Q.C.:
7 Q. - or any other IHC stains, but reflecting upon
8 it, is it more or less likely that you would
9 have received that April 4th memo?
10 DR. BAKER:
11 A. Probably more likely. I just don't remember
12 receiving it. I know, I can remember that
13 there was a lull or a short period of time
14 where we couldn't send samples in. So whether
15 the information came through the lab
16 technologist to me or some other route, there
17 was a period of time, I think of about four or
18 five weeks, where we held our ER/PR requests
19 and then we sent them in after the problems
20 were rectified.
21 COFFEY, Q.C.:
22 Q. Here, Doctor, in that April 4th memo, the
23 language used, as Dr. Ejeckam uses the words,
24 are remained, "have remained unreliable,
25 erratic and therefore unhelpful for diagnostic

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1 purposes." Do you ever recall, in 2003, being
2 aware that at least a pathologist in St.
3 John's, who had the authority to suspend
4 testing, you ever remember that sort of bald
5 and bold assertion being brought to your
6 attention?
7 DR. BAKER:
8 A. No, it was never brought to my attention.
9 COFFEY, Q.C.:
10 Q. If it was, Doctor, do you think you'd remember
11 it? What would it have caused you to do, if
12 anything, that kind of an assertion?
13 DR. BAKER:
14 A. I would have had concerns, and I would have
15 just abided by his request to refrain from,
16 you know, sending things in, and waited until
17 the problem was rectified. But other than
18 that, that would be the only actions I would
19 have taken.
20 COFFEY, Q.C.:
21 Q. At the time, and this is early April 2003, and
22 then we have the May memo, if you had been
23 told that, would you have had any concerns
24 about any patients that you reported in the
25 months before?

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1 DR. BAKER:
2 A. No, I don't think so. I viewed it as a
3 problem that had happened, had been
4 discovered, and was being rectified and they
5 were moving forward with it.
6 COFFEY, Q.C.:
7 Q. And Doctor, at any time in 2003, did it ever
8 occur to you, the idea of perhaps retesting
9 some patients?
10 DR. BAKER:
11 A. No, I never entertained that idea at all.
12 COFFEY, Q.C.:
13 Q. If we could, Doctor, looking at the May 2nd
14 memo, and just paragraph five talks about the
15 reporting of ER/PR and did that cause you to,
16 in any way, change what was--or written there,
17 change your approach?
18 DR. BAKER:
19 A. No. At that particular point in time, I just
20 reported the same as I had always been
21 reporting, with the ER positive ER negative
22 and percentage of cells.
23 COFFEY, Q.C.:
24 Q. And I take it there was nothing in this that
25 was inconsistent with that?

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1 DR. BAKER:
2 A. No, not to my knowledge, or not to my reading
3 of it.
4 COFFEY, Q.C.:
5 Q. Paragraph six, Doctor, says "all cytoplasmic
6 staining and ER/PR immunostain are to be
7 considered as negative." Had you been aware
8 of that?
9 DR. BAKER:
10 A. No, I wasn't aware of that comment until I
11 read it in the memo.
12 COFFEY, Q.C.:
13 Q. Now in the meantime, you had been looking for
14 nuclear, nuclei staining?
15 DR. BAKER:
16 A. Yeah, because it had been indicated and
17 specified in the original memo from Dr.
18 Khalifa.
19 COFFEY, Q.C.:
20 Q. So how had you handled then any cytoplasmic
21 staining in the intervening years?
22 DR. BAKER:
23 A. I don't ever remember seeing cytoplasmic
24 staining, tell you the truth. I can't
25 remember a specimen where I've saw some. It

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1 was always identified as nuclear staining.
2 COFFEY, Q.C.:
3 Q. Doctor, if we could go to--I appreciate you
4 did not receive the June 19th memo. When did
5 you--you have had, certainly over the past,
6 recent past, had a chance to see or at least
7 learn of the existence of this June 19th memo?
8 DR. BAKER:
9 A. Yeah, I was shown it, yes, just recently
10 though.
11 COFFEY, Q.C.:
12 Q. And this is a memo from Dr. Ejeckam to Terry
13 Gulliver, and it's copied to a number of other
14 individuals, I'll just show you now, within
15 the Health Care Corporation: Desmond Robb, at
16 the time the chair of the discipline of
17 laboratory medicine; Dr. Cook, the clinical
18 chief; Dr. Parai, the site chief at the Health
19 Sciences Centre; Mr. Dyer, the manager of
20 histopathology at the General Hospital.
21 Doctor, midway down that first paragraph, I'm
22 going to read the first several words and then
23 midway down it. "The following persistent,
24 erratic results of immunostains in our
25 laboratory." Doctor, would it have been of

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1 interest to you to be told that at least Dr.
2 Ejeckam had come to the conclusion there had
3 been persistent, erratic stains?
4 DR. BAKER:
5 A. Yes, it would have been useful, but I never
6 was.
7 COFFEY, Q.C.:
8 Q. And the assertion that "the state of
9 immunostain at the General Hospital,
10 Department of Laboratory Medicine and
11 Pathology, is still unsatisfactory," where you
12 were utilizing it for ER/PR staining, would
13 that have been of interest to you to know?
14 DR. BAKER:
15 A. For sure, yes, it would have been.
16 COFFEY, Q.C.:
17 Q. Paragraph six, Doctor, I apologize. Midway
18 through that paragraph, Dr. Ejeckam writes
19 "diagnosis based on inappropriate immunostain
20 will surely jeopardize patient care and may
21 even expose the Health Care Corporation of St.
22 John's to litigation. Therefore, it will be
23 ill advised to operate an unreliable and
24 erratic immunohistochemical procedures in our
25 laboratory," and the memo overall, Doctor,

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1 would it have been of interest to you at the
2 time, as a person who was utilizing the
3 services of that laboratory?
4 DR. BAKER:
5 A. Yes, I would have liked to have received it.
6 COFFEY, Q.C.:
7 Q. Or at least be apprised of what's in it?
8 DR. BAKER:
9 A. That's right, yes.
10 COFFEY, Q.C.:
11 Q. As a utilizer of it and as, at the time, in
12 the mid '90s on, as the assistant CEO of your
13 institution, do you think you should have been
14 told this?
15 DR. BAKER:
16 A. I think that I should have been given some
17 information about it, yes.
18 COFFEY, Q.C.:
19 Q. Doctor, after the Dr. Ejeckam memo, 2003, you
20 made the adjustments that you described to the
21 Commissioner, did you make any others, other
22 than the ones you've described in your
23 approach?
24 DR. BAKER:
25 A. No, I don't think so. They're the only ones,

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1 I think.
2 COFFEY, Q.C.:
3 Q. When did you next hear of ER/PR?
4 DR. BAKER:
5 A. The next communication about ER/PR was when I
6 received a phone call from Don Cook. That was
7 either late May, early June. He indicated to
8 me that they were doing retesting of samples
9 in the year 2002. That there was some issues
10 with patients that there had been conversions
11 and that they were requesting that all 2002
12 specimens from our facility be sent to St.
13 John's for retesting.
14 COFFEY, Q.C.:
15 Q. Okay. Now, Commissioner, I'm going to take up
16 the narrative there, if we could do the
17 morning break.
18 THE COMMISSIONER:
19 Q. Take the morning break, yes, of course.
20 COFFEY, Q.C.:
21 Q. Okay.
22 THE COMMISSIONER:
23 Q. We'll take 15 minutes.
24 (BREAK)
25 THE COMMISSIONER:

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1 Q. Please be seated. Mr. Coffey.
2 COFFEY, Q.C.:
3 Q. Thank you, Commissioner. So Doctor, resume
4 then with your reference to your phone call
5 from Dr. Cook, but in the meantime, between
6 Dr. Khalifa's memo of 1998, and other than Dr.
7 Ejeckam's May 2nd memo of 2003 and perhaps the
8 April 4th one, you can't recall whether you
9 saw that or not, but other than that, were you
10 ever at all alerted to any concern involving
11 ER/PR stains?
12 DR. BAKER:
13 A. No.
14 COFFEY, Q.C.:
15 Q. That if there were any concerns internally
16 within St. John's about it, other than Dr.
17 Ejeckam's memos -
18 DR. BAKER:
19 A. I wasn't aware of it.
20 COFFEY, Q.C.:
21 Q. - weren't aware of it. Doctor, if we could,
22 you get a phone call from Dr. Cook, and did
23 you know Dr. Cook personally?
24 DR. BAKER:
25 A. Yes, I did.

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1 COFFEY, Q.C.:
2 Q. And how long have you known Dr. Cook?
3 DR. BAKER:
4 A. I've known Dr. Cook since residency training
5 back in the late 70s, early 80s.
6 COFFEY, Q.C.:
7 Q. You would have been contemporaries really?
8 DR. BAKER:
9 A. Yes, he was about a year or two behind in the
10 program.
11 COFFEY, Q.C.:
12 Q. And what did Dr. Cook tell you about it, if
13 anything, about how he'd become aware of this?
14 I'm just trying to get some sense of -
15 DR. BAKER:
16 A. The only comments that he made to me when I
17 had the conversation with him that morning was
18 that there had been some--he used the word
19 conversions of patients from the year 2002
20 that had converted from negative to positive,
21 and they had identified several cases, and
22 that they wanted to do further retesting on
23 that particular year, and they were extending
24 the--as well as their own samples in St.
25 John's, they were extending the retesting to

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1 all areas outside St. John's, and that he
2 requested that I collect together all the
3 specimens that we had referred in for that
4 period, that year 2002, to them for staining
5 and resubmit them to them for retesting.
6 COFFEY, Q.C.:
7 Q. And did he indicate to you at the time, the
8 conversions that had occurred, where they had
9 originated?
10 DR. BAKER:
11 A. No, he didn't. No, he wasn't specific like
12 that.
13 COFFEY, Q.C.:
14 Q. Did he indicate to you at the time as to how
15 they'd come to do any retesting at all?
16 DR. BAKER:
17 A. No, he didn't. It was a very brief
18 conversation, matter of a couple of minutes
19 and that was it.
20 COFFEY, Q.C.:
21 Q. Your reaction at the time, did you ask him any
22 questions?
23 DR. BAKER:
24 A. No, nothing specific. My reaction was that
25 "yes, we will, you know, abide by the request

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1 and get together the samples as soon as
2 possible, and send them in to you" and that
3 was basically it.
4 COFFEY, Q.C.:
5 Q. And the idea that--if you're being asked
6 outside St. John's to send material to St.
7 John's for retesting, did it occur to you that
8 some of your own cases might end up being
9 conversion--might end up converting upon
10 retesting?
11 DR. BAKER:
12 A. That crossed my mind, yes.
13 COFFEY, Q.C.:
14 Q. Crossed your mind at the time?
15 DR. BAKER:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. Doctor, at the time, did you and Dr. Cook
19 discuss the ramifications for patients of a
20 conversion?
21 DR. BAKER:
22 A. No, there was no detail in the conversation to
23 that.
24 COFFEY, Q.C.:
25 Q. And from your perspective at the time, you

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1 being told about conversions from negative to
2 positive, what did you understand, if
3 anything, that that might mean for individual
4 patients?
5 DR. BAKER:
6 A. That the patients who originally termed as
7 being negative and had converted to positive
8 status, they would be eligible for Tamoxifen.
9 COFFEY, Q.C.:
10 Q. And what -
11 DR. BAKER:
12 A. Or actually be considered for Tamoxifen.
13 COFFEY, Q.C.:
14 Q. Considered for it, yes, and or perhaps another
15 hormone therapy?
16 DR. BAKER:
17 A. Sure, yes.
18 COFFEY, Q.C.:
19 Q. 2002, you indicated that was the year in
20 particular he had in mind?
21 DR. BAKER:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. Was there any discussion about why 2002?
25 DR. BAKER:

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1 A. No. The initial part of the conversation was
2 that they just had identified a couple, a few,
3 a couple, he didn't specify numbers, of
4 specimens that had converted and that they
5 were doing the study to determine if there was
6 any problem in that year, any more potential
7 conversions in that particular year.
8 COFFEY, Q.C.:
9 Q. Doctor, had you ever gotten any similar call
10 from Dr. Cook about any kind of similar sort
11 of retesting for any type of specimens before?
12 DR. BAKER:
13 A. No, never.
14 COFFEY, Q.C.:
15 Q. So this would be--in your world, this would be
16 an unusual occurrence?
17 DR. BAKER:
18 A. Yes, it was the first.
19 COFFEY, Q.C.:
20 Q. Now you've told the Commissioner earlier today
21 that the only request for retesting from
22 attending physicians, oncologists, surgeons or
23 whatever over the years, that you can recall
24 for ER/PR occurred around this time, you know,
25 around 2005?

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1 DR. BAKER:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Was that before Dr. Cook called you?
5 DR. BAKER:
6 A. My recollection is that it was. As I said,
7 there was only, I think, probably one or two
8 and reflecting on it now, I did indicate
9 earlier in my testimony that I think they went
10 to Mount Sinai, but I think they were retested
11 in town.
12 COFFEY, Q.C.:
13 Q. At that point, it would be St. John's.
14 DR. BAKER:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. You understood from the conversation with Dr.
18 Cook certainly that the retesting was going to
19 occur in St. John's initially?
20 DR. BAKER:
21 A. No, that -
22 COFFEY, Q.C.:
23 Q. Or did you have any understanding about where
24 it would be?
25 DR. BAKER:

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1 A. No, I just had the understanding that they
2 were going to be retested. I didn't know
3 where.
4 COFFEY, Q.C.:
5 Q. And you believe it was--you told the
6 Commissioner, it was probably Dr. McCarthy who
7 had called you about ordering -
8 DR. BAKER:
9 A. I think it was Dr. McCarthy and/or it could
10 have been Dr. Laing as well, or at times, in
11 these types of situations where there may have
12 been a request come through, there would have
13 been sometimes a fax come through with a
14 patient's name, the surgical number and the
15 attending oncologist signed signature and
16 saying "would you please repeat this test,
17 this ER/PR test."
18 COFFEY, Q.C.:
19 Q. And so was there a phone conversation and a
20 fax, a follow-up fax?
21 DR. BAKER:
22 A. With the oncologist?
23 COFFEY, Q.C.:
24 Q. Yes.
25 DR. BAKER:

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1 A. No. It would have been one or the other.
2 COFFEY, Q.C.:
3 Q. Do you know, are you able, without naming the
4 patient, are you able to recall who the
5 patient was?
6 DR. BAKER:
7 A. No, I don't recall offhand.
8 COFFEY, Q.C.:
9 Q. Would that be able to be ascertained? I mean,
10 did you order the retest?
11 DR. BAKER:
12 A. Yes, we ordered the retest. It could be in
13 the records, yeah.
14 COFFEY, Q.C.:
15 Q. Okay. And if it's possible, could you
16 ascertain who that was and pass that on to Mr.
17 Browne?
18 DR. BAKER:
19 A. Sure, yeah.
20 COFFEY, Q.C.:
21 Q. And this would have been, again, an unusual
22 event?
23 DR. BAKER:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. The explanation you were offered as to why it
2 was necessary or thought necessary was what?
3 DR. BAKER:
4 A. If it was a phone conversation, it may have
5 been given some brief explanation that the
6 patient wasn't--the patient wasn't responding
7 appropriately or that the patient--the type of
8 tumour that the patient had, I just wanted to
9 have a repeat of the ER/PR to see what the
10 status was, if anything had changed. A very
11 simple conversation.
12 COFFEY, Q.C.:
13 Q. If we could look, please, at Exhibit P-2525?
14 Doctor, this is a copy of a memo of June 14th,
15 2005 to all laboratory directors. You're
16 second on the list there.
17 DR. BAKER:
18 A. Um-hm.
19 COFFEY, Q.C.:
20 Q. And it's from Dr. Cook. And I take it you
21 would have received a copy of this?
22 DR. BAKER:
23 A. Yes, I did.
24 COFFEY, Q.C.:
25 Q. And this would have been following your

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1 conversation with Dr. Cook?
2 DR. BAKER:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. He had, in effect, given you a phone call or a
6 heads up?
7 DR. BAKER:
8 A. Yeah. I think it was probably early June and
9 this followed, you know, a week, ten days
10 afterwards.
11 COFFEY, Q.C.:
12 Q. Doctor, reading this, having read this, what
13 was your impression of the nature of the
14 problem, if there was a problem, what the
15 nature of it was?
16 DR. BAKER:
17 A. I tended to view it as a technical problem
18 with--because he references the newer Ventana
19 benchmark system and I--in some of the
20 retesting that was done, so I just tended to
21 view it as a technical problem with their
22 systems, with their staining systems.
23 COFFEY, Q.C.:
24 Q. He doesn't here specify how many. He says,
25 refer to "a number of negative that have

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1 converted."
2 DR. BAKER:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. And then the first two lines, converted on
6 repeat. And then the fourth lines says, "Most
7 of these false negatives have occurred during
8 the year 2002."
9 DR. BAKER:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. Suggesting, perhaps, that there were false
13 negatives in other year--one or more in a year
14 other than 2002. At the time you received
15 this, by mid June, 2005, did you have any
16 understanding or did you take any
17 understanding from this as to the numbers that
18 might be involved?
19 DR. BAKER:
20 A. No, no, I didn't.
21 COFFEY, Q.C.:
22 Q. He says, "We are in the process of retesting
23 all negative ERs and PRs for that particular
24 year."
25 DR. BAKER:

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1 A. Um-hm.
2 COFFEY, Q.C.:
3 Q. "Ask you to forward all negative ER and PR
4 cases for 2002 to Mr. Dyer."
5 DR. BAKER:
6 A. In my own particular case it would have been a
7 small number.
8 COFFEY, Q.C.:
9 Q. Sure, I appreciate that, because -
10 DR. BAKER:
11 A. But I wouldn't have known the numbers across
12 the island.
13 COFFEY, Q.C.:
14 Q. But in your case it would be, if there were 20
15 breast cancer cases in 2002 in Carbonear, then
16 whatever number of those were negative?
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. It would only involve that number?
21 DR. BAKER:
22 A. Correct.
23 COFFEY, Q.C.:
24 Q. On that point, Doctor, you took from this
25 which cases were to be identified and sent?

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1 DR. BAKER:
2 A. The negative ER/PR.
3 COFFEY, Q.C.:
4 Q. Was that ER negative or PR negative or cases
5 that were both ER and PR negative?
6 DR. BAKER:
7 A. All negative ER and negative PR.
8 COFFEY, Q.C.:
9 Q. So if they were negative in either?
10 DR. BAKER:
11 A. Category.
12 COFFEY, Q.C.:
13 Q. Either category or both categories?
14 DR. BAKER:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. You were to identify and send them?
18 DR. BAKER:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. As well, and with them was to accompany, he's
22 got there, the H & E slides, the blocks and -
23 DR. BAKER:
24 A. Correct.
25 COFFEY, Q.C.:

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1 Q. - the original ER/PR slides, including
2 controls?
3 DR. BAKER:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. Having received this, Doctor, I'll ask you,
7 between the phone call and the memo did you
8 take any steps after the phone call but before
9 you got the memo to do anything?
10 DR. BAKER:
11 A. I gave instruction to my staff within my own
12 section verbally to extract these paraffin
13 blocks and slides--well, first of all we had
14 to go through the system to identify them.
15 COFFEY, Q.C.:
16 Q. Um-hm.
17 DR. BAKER:
18 A. Our system was a manual system.
19 COFFEY, Q.C.:
20 Q. In 2002, I take it?
21 DR. BAKER:
22 A. 2002. We didn't get into an electronic system
23 until around 2004. So in effect, right from
24 up until that time we would have to go back
25 and go through hundreds of reports in a manual

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1 system searching for the breast carcinomas.
2 COFFEY, Q.C.:
3 Q. So how was that approached then, Doctor,
4 perhaps you could tell the Commissioner,
5 initially for 2002 and then as it expanded,
6 what approach was taken?
7 DR. BAKER:
8 A. Well, our reports were filed in large binders,
9 okay, they were filed by year. And we do
10 approximately 2500 specimens a year, total of
11 everything, so they would have been filed by
12 year. So it would have necessitated going
13 through a larger number of files on a yearly
14 basis to look and identify for, first of all,
15 the breast biopsies, whether they were--and
16 identify whether they were benign or malignant
17 and then separate out the malignant ones and
18 identify whether they were ER/PR negative or
19 positive and separating them that way.
20 COFFEY, Q.C.:
21 Q. And who was tasked in your organization with
22 actually doing the actual -
23 DR. BAKER:
24 A. Well, it would have been a combination of both
25 the technologist in my area and also my

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1 secretary.
2 COFFEY, Q.C.:
3 Q. And in terms of like identifying negative ER
4 and negative PR, at least in the initial
5 stages, they would have--you gave them to
6 understand what did negative mean?
7 DR. BAKER:
8 A. Negative as being negative on the report.
9 COFFEY, Q.C.:
10 Q. If the word "negative" was on the report?
11 DR. BAKER:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. For ER or PR or both, they were to give you
15 the report?
16 DR. BAKER:
17 A. The report. Well, they wouldn't give it to
18 me, they would select them out, put them to
19 one side and then the technologist would go
20 retrieve the slides and the blocks. Because
21 if the slides and the blocks were previous
22 years, we only retain on site blocks of slides
23 for about a year, all the rest beyond that
24 time, going back many, many years, are
25 retained off site in a warehouse area.

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1 COFFEY, Q.C.:
2 Q. And, Doctor, with Dr. Cook's phone call and
3 then this memo in mid June, did you get any
4 sense at the time of whether or not there was
5 any urgency associated with this?
6 DR. BAKER:
7 A. I don't remember him expressing any urgency.
8 He would just--he just asked us to get them
9 all together, to get them in, you know, as
10 soon as possible, I suppose may have been the
11 words he used, but, you know, he didn't say it
12 was extremely urgent that he get them in, you
13 know, within a time frame.
14 COFFEY, Q.C.:
15 Q. And then what--you tasked the people in your
16 organization with doing this?
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. And how was it then--how did it progress?
21 DR. BAKER:
22 A. Well, when we got all the blocks and slides
23 together and the reports for the blocks and
24 slides, that corresponded, we packaged them up
25 and sent them on in to Mr. Barry Dyer.

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1 COFFEY, Q.C.:
2 Q. And that was for the year 2002?
3 DR. BAKER:
4 A. Correct.
5 COFFEY, Q.C.:
6 Q. Do you recall when it was that they were sent?
7 DR. BAKER:
8 A. The specific date I can't give you, but the
9 month would probably be July of 2005.
10 COFFEY, Q.C.:
11 Q. What then happened, Doctor, in terms of this?
12 What did you next hear?
13 DR. BAKER:
14 A. There was another telephone call that came,
15 again, the time frame was probably in July,
16 maybe before the specimens had been sent in,
17 there was another phone call came from Dr.
18 Cook saying that they were expanding the
19 retesting to encompass other years. He gave
20 me a verbal on the years that he was expanding
21 to, from May of '97 to April, May of 2005, I
22 think it was, four.
23 COFFEY, Q.C.:
24 Q. Four?
25 DR. BAKER:

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1 A. Sorry. And that he would like for us to
2 retrieve all the slides in a similar manner
3 and the reports, all the blocks and slides and
4 send them in as soon as possible.
5 COFFEY, Q.C.:
6 Q. Did he indicate at that time the basis for
7 choosing that time period?
8 DR. BAKER:
9 A. No, he didn't. He said we expanded the time--
10 the scope of retesting and we wanted to retest
11 a larger quantity of specimens.
12 COFFEY, Q.C.:
13 Q. And what was your reaction at the time?
14 DR. BAKER:
15 A. It seems that we have a problem.
16 COFFEY, Q.C.:
17 Q. Okay. And why did you come to that
18 conclusion?
19 DR. BAKER:
20 A. Because the scope of the retesting had
21 expanded, it had encompassed more people and
22 they obviously had identified a problem that
23 they wanted to find out the depth of.
24 COFFEY, Q.C.:
25 Q. Did Dr. Cook tell you anything, anything

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1 further at that time about what, if anything,
2 they had discovered up to that point?
3 DR. BAKER:
4 A. No, because they were in the very preliminary
5 stages of retesting' they were just in the
6 collection phase. And to my knowledge even
7 the first ones that we were ready to send in,
8 I don't think they had arrived to them at that
9 point in time, at the time of the second phone
10 call. So there was nothing that he relayed to
11 me that gave me an indication of what the
12 actual problem was or what stage they were at
13 in investigating any potential problems.
14 COFFEY, Q.C.:
15 Q. Doctor, what then, what's your next memory
16 then of what happened? This phone call would
17 have been sometime in July?
18 DR. BAKER:
19 A. Sometime in July.
20 COFFEY, Q.C.:
21 Q. 2005?
22 DR. BAKER:
23 A. Yeah, well, the same process took place with
24 the collection. We were in the middle of
25 summer then, too, there was, I think, probably

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1 different people in the lab at the time,
2 people on vacation and we were--we went and
3 gathered the reports in a similar fashion,
4 going through the files. It was a manual
5 process, it was labour intensive. We weren't
6 electronic, we didn't have electronic files
7 and so on. And we identified the ones that we
8 felt were the appropriate ones and we drew out
9 the blocks and slides. And I think that they
10 went in in a couple of different batches
11 because as we collected them, we tried to
12 group them in a couple of different batches to
13 send them in. There was some minor problem
14 with some of the specimens that we were
15 required to send in in that some of them had
16 been sent out previously to a research centre
17 her in St. John's. At times we are requested
18 to send blocks and slides in for research
19 purposes to research labs here in St. John's.
20 And we had just prior to Don's request sent in
21 a significant number of blocks to a research
22 laboratory here in St. John's of breast tissue
23 and some of them corresponded to the ones that
24 were identified as having to be retested. So
25 they were probably the last ones to go in

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1 because we had to request on several occasions
2 to get them back from the research centre
3 where they were doing--they wanted to finish
4 off their work and they just asked us for a
5 little bit more time, so we allowed them. We
6 told them the reason why we wanted them back,
7 but we allowed them to do the work that was
8 necessary on them. And they forwarded on back
9 to us, but they were included in a batch that
10 probably went in, was one of the last batches,
11 which was probably in October, late September,
12 early October.
13 COFFEY, Q.C.:
14 Q. And again, in relation to the July phone call
15 or conversation with Dr. Cook, was again there
16 any sense of urgency communicated to you?
17 DR. BAKER:
18 A. Just to get them together as soon as possible
19 and get them in to me. We'd like to get the
20 retesting done as soon as possible.
21 COFFEY, Q.C.:
22 Q. Did you have--okay, what then happened?
23 DR. BAKER:
24 A. That was pretty well it. We got everything
25 together and sent it in, as I said, in several

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1 batches. And I didn't hear anything over the
2 course of the fall.
3 COFFEY, Q.C.:
4 Q. Okay. I'm going to be referring to some
5 documents, too, in regard to this. If I
6 could, Exhibit P-0534? Doctor, this is a memo
7 to all pathologists in Eastern Health and
8 other lab directors, including yourself,
9 you're up there.
10 DR. BAKER:
11 A. Um-hm, yes.
12 COFFEY, Q.C.:
13 Q. And it's from Dr. Cook as the clinical chief
14 of the lab medicine program, Eastern Health.
15 And it's about, the memo concerns HER2/neu, as
16 you can see.
17 DR. BAKER:
18 A. Correct.
19 COFFEY, Q.C.:
20 Q. July 20th, 2005. But he concludes by saying,
21 "As a reminder when choosing blocks to send
22 for both hormone receptor testing and HER2/neu
23 testing, please select a section that contains
24 both tumour and normal or benign epithelium.
25 The normal and/or benign epithelium acts as an

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1 internal control for immunohistochemical
2 staining. If you have any questions, please
3 call Dr. Beverley Carter." Do you recall
4 receiving this?
5 DR. BAKER:
6 A. Yes, I think I did, yes.
7 COFFEY, Q.C.:
8 Q. Now, the idea of utilizing normal or benign
9 epithelium as well as tumour in the block
10 selection for even with the hormone receptor
11 testing would be ER/PR?
12 DR. BAKER:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. I take it that at this point in time this
16 wasn't new to you?
17 DR. BAKER:
18 A. It wasn't new, no, because it was reflected in
19 the memo from Dr. Ejeckam.
20 COFFEY, Q.C.:
21 Q. Ejeckam. Did you know who Dr. Beverley Carter
22 was?
23 DR. BAKER:
24 A. Yes, I knew she was a breast pathologist in
25 St. John's. I hadn't met her at that point in

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1 time or even had a conversation with her, but
2 I got to know her over the course of the next
3 year or so in the form of telephone
4 conversations mainly, with consultations that
5 I sent in to her.
6 COFFEY, Q.C.:
7 Q. Exhibit P-0581? Doctor, these are handwritten
8 notes of Dr. Cook, okay.
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Just identify them for you. But the second
13 note here says "Spoke to Gary Baker August 24,
14 2005, 11:05 a.m. Advised him to send current
15 ER and PRs directly to Mount Sinai as opposed
16 to sending cases to St. John's. Send copy of
17 control"--I'm sorry, "of contact individual at
18 Mount Sinai--sent copy of contact individual
19 at Mount Sinai." I was going to ask you about
20 this. The current cases for ER/PR, when did
21 you first become aware that St. John's was not
22 going to be doing them? Would this be -
23 DR. BAKER:
24 A. That was around the time that I learned that
25 they had suspended doing them. I think it was

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1 around July, August of that year.
2 COFFEY, Q.C.:
3 Q. And having been told, do you recall the phone
4 call with Dr. Cook, him telling you, look,
5 we're not going to be doing them in the
6 future, you might want to -
7 DR. BAKER:
8 A. Yes, I do. And -
9 COFFEY, Q.C.:
10 Q. Deal with Mount Sinai?
11 DR. BAKER:
12 A. And he indicated that they would be sent from
13 that point on to Mount Sinai, yes.
14 COFFEY, Q.C.:
15 Q. And what did you do in that regard then
16 yourself?
17 DR. BAKER:
18 A. Any subsequent cases that came up in the
19 subsequent week or months and so on, I just
20 forwarded them on, after getting the contact
21 information, I forwarded them on to Mount
22 Sinai.
23 COFFEY, Q.C.:
24 Q. And what was your experience then with respect
25 to--I take it Mount Sinai was doing ER/PR and

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1 HER2/neu?
2 DR. BAKER:
3 A. Correct, yes.
4 COFFEY, Q.C.:
5 Q. What has been your experience in that regard?
6 DR. BAKER:
7 A. Excellent, the response has been good, the
8 turn-around time is good, the reports are
9 excellent.
10 THE COMMISSIONER:
11 Q. Dr. Baker, what would be the difference in the
12 turn-around time in sending them as far as
13 Mount Sinai and the turn-around time in
14 sending them as far as St. John's?
15 DR. BAKER:
16 A. In that respect, Commissioner, I found it very
17 similar, actually. In St. John's over the
18 years there was a week to ten day turn-around
19 time, most times, for myself. And in Mount
20 Sinai it would be very similar, at the maximum
21 it would be two weeks. And we would always
22 get a faxed report first from Mount Sinai's
23 labs to our fax machine in pathology and that
24 would be followed up by an actual, an
25 electronically produced copy of the report, as

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1 well, and that may not come for another week
2 later.
3 COFFEY, Q.C.:
4 Q. Thank you. Exhibit P-1778? Doctor, while I'm
5 on the topic of dealing with Mount Sinai, this
6 is a letter of September 26th, 2005, it's to
7 yourself, it's from Dr. Brendan Mullen, copied
8 to Dr. Cook.
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. I take it that this is a letter setting up the
13 process that you've utilized since with Mount
14 Sinai?
15 DR. BAKER:
16 A. Correct, yes.
17 COFFEY, Q.C.:
18 Q. Okay.
19 DR. BAKER:
20 A. We devised our own form just as a standard
21 format to request ER/PR, ER/PR and HER2/neu
22 that would require my signature when they were
23 sent off and basically it would contain the
24 information on the patient and so on.
25 COFFEY, Q.C.:

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1 Q. Now, Doctor, if I could, please, Commissioner,
2 bring up Exhibit, please, P-0590? Doctor,
3 this is a memo again to--from Dr. Cook. It's
4 dated September 6th, 2005, Dr. Cook, again to
5 a number of physicians, including yourself.
6 Subject is "Estrogen and Progesterone
7 Receptors, ERs and PRs." And did you receive
8 a copy of this?
9 DR. BAKER:
10 A. I did, yes.
11 COFFEY, Q.C.:
12 Q. Indicates, begins, "I wish to advise you we
13 are doing a review of our estrogen and
14 progesterone receptors. I expect to have more
15 information within the next few weeks and will
16 keep you updated. Please note the following
17 points." And then there are a number of
18 bullets. And here, Doctor, it says, "Further
19 to my memo dated June 13th, 2005," in fact,
20 the memo we just looked at awhile back, it's
21 June 14th. "I am requesting you forward all
22 ER negative cases on primary breast lesions
23 independent of PR status from May, 1997 to
24 March 31, 2004 to Barry Dyer at the General
25 Hospital site."

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1 DR. BAKER:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. Now, Doctor, here it indicates independent of
5 PR status, okay. So did that make any
6 difference in your approach?
7 DR. BAKER:
8 A. No, no. I just relayed the information to my
9 people who did the collection and they went
10 ahead and selected these from the files.
11 COFFEY, Q.C.:
12 Q. So and as--and why I ask that is this, is when
13 you first--you got the memo, you had the
14 conversation back in late May, early June with
15 Dr. Cook?
16 DR. BAKER:
17 A. Um-hm.
18 COFFEY, Q.C.:
19 Q. And then you got that June 14th memo?
20 DR. BAKER:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. You've indicated to the Commissioner that in
24 the first pass through in collecting the 2002
25 cases if a case was ER positive but PR

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1 negative, it still fell into the category, it
2 should be sent to St. John's?
3 DR. BAKER:
4 A. Correct, yes.
5 COFFEY, Q.C.:
6 Q. That was your approach?
7 DR. BAKER:
8 A. That was my understanding of the memo.
9 COFFEY, Q.C.:
10 Q. But under this approach those sorts of cases
11 would not be sent to St. John's, would they?
12 DR. BAKER:
13 A. No, correct.
14 COFFEY, Q.C.:
15 Q. So do you recall if that made any -
16 DR. BAKER:
17 A. I didn't, I don't remember any specific thing
18 that--I don't, no.
19 COFFEY, Q.C.:
20 Q. Any adjustment in that regard. In any case, I
21 take it that by the time you got the September
22 6th memo anything that was--anything ER
23 negative was to go in to St. John's?
24 DR. BAKER:
25 A. Yes. And they were all--by this time I was--

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1 by the time I received this memo a large
2 proportion of ours had already been collected
3 and some of them had already gone.
4 COFFEY, Q.C.:
5 Q. Here, Doctor, in the second bullet, it says,
6 "From January 1, 2001 ER negative is defined
7 as 10 percent or less."
8 DR. BAKER:
9 A. Um-hm.
10 COFFEY, Q.C.:
11 Q. "From May, 1997 to December, 2000 ER negative
12 is defined as 30 percent or less."
13 DR. BAKER:
14 A. Um-hm.
15 COFFEY, Q.C.:
16 Q. And again, looking back at the June situation,
17 June of 2005, you had been defining yourself,
18 dealing with your staff, as negative if the
19 word "negative" is there, it's to go in?
20 DR. BAKER:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. But your practice had been in dictating, you
24 would describe everything as positive that was
25 one percent or more?

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1 DR. BAKER:
2 A. Correct.
3 COFFEY, Q.C.:
4 Q. The word "negative" wouldn't be there?
5 DR. BAKER:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. So what, if anything, in the approach taken in
9 Carbonear, what if anything was the effect of
10 this definition of negative?
11 DR. BAKER:
12 A. I can recollect relaying the information and I
13 just assumed that things had been retrieved
14 appropriate to the memo.
15 COFFEY, Q.C.:
16 Q. Okay. Following this memo?
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. If something in the meantime had been
21 collected for a particular year, I'll just
22 pick a year, 2001, for example, or -
23 DR. BAKER:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. And certainly 2002?
2 DR. BAKER:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. They had already been collected and sent to
6 St. John's?
7 DR. BAKER:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. If the word "negative" did not appear in the
11 report, it wouldn't go to St. John's?
12 DR. BAKER:
13 A. Well, now that you mention it, yeah, the
14 potential is there, yes.
15 COFFEY, Q.C.:
16 Q. Because your staff would have understood in
17 June and that's what you were asked to do?
18 DR. BAKER:
19 A. Um-hm.
20 COFFEY, Q.C.:
21 Q. Because negative is not defined in June, it
22 just says negative?
23 DR. BAKER:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. And your practice was if it was zero, it was
2 negative, you'd use the word "negative" and
3 your staff would be looking for the word
4 "negative"?
5 DR. BAKER:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. After this memo came in September 6th, 2005, I
9 take it in the intervening time frame had any
10 effort been made to collect these '97 through
11 2004, between July and September now?
12 DR. BAKER:
13 A. Before the time I received this memo?
14 COFFEY, Q.C.:
15 Q. Yeah.
16 DR. BAKER:
17 A. Yes, they had been. Yeah, there was
18 collection process ongoing.
19 COFFEY, Q.C.:
20 Q. Yeah.
21 DR. BAKER:
22 A. Because we had to go through a large number of
23 files and so on to retrieve reports and so on.
24 COFFEY, Q.C.:
25 Q. And utilizing your own definition of negative,

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1 the way you used it in the report?
2 DR. BAKER:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. So that do you know after this memo came out,
6 because you see where I'm going with this?
7 DR. BAKER:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. What I'm concentrating on here is is that your
11 own--you weren't given to understand back in
12 July we're using 30 and 10 as cut offs?
13 DR. BAKER:
14 A. No, not in that particular memo, no, no.
15 COFFEY, Q.C.:
16 Q. No. Having gotten the 30/10 cut off memo,
17 which is what this is, do you know if in
18 Carbonear there was any reassessment of how
19 we've approached this?
20 DR. BAKER:
21 A. Not to my knowledge, no.
22 COFFEY, Q.C.:
23 Q. So whatever had already been collected to be
24 sent to St. John's for a particular year had
25 already gone and there was no re, at that

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1 point, reassessment or reexamination?
2 DR. BAKER:
3 A. No, not to my recollection.
4 COFFEY, Q.C.:
5 Q. Doctor, at the time in September of 2005 when
6 you got this memo, the idea of this cutoff or
7 utilizing this cutoff, of these two cutoffs as
8 the definition of negative, did that actually
9 come to your attention at the time, were you
10 actually aware of the -
11 DR. BAKER:
12 A. Before this memo?
13 COFFEY, Q.C.:
14 Q. Yes. Now, before the memo I take it you
15 wouldn't have even heard of this?
16 DR. BAKER:
17 A. No.
18 COFFEY, Q.C.:
19 Q. After you got the memo, though, is what I'm
20 asking about?
21 DR. BAKER:
22 A. No, I wasn't, I wasn't aware. No, I wasn't
23 aware, I wasn't aware that the parameters of
24 the definition of negative and positive had
25 changed in St. John's.

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1 COFFEY, Q.C.:
2 Q. And they were asking you to actually change or
3 adjuster your search pattern, your stat search
4 pattern?
5 DR. BAKER:
6 A. Yes. In this memo they were, yes.
7 COFFEY, Q.C.:
8 Q. But what I'm getting at is this second bullet
9 didn't jump out to you at all?
10 DR. BAKER:
11 A. No, it didn't.
12 COFFEY, Q.C.:
13 Q. Did you pass the memo itself on to your staff?
14 DR. BAKER:
15 A. No, I don't remember doing that. It was in a
16 verbal form.
17 COFFEY, Q.C.:
18 Q. Do you know if you told your staff about the
19 10 and 30 percent cutoffs?
20 DR. BAKER:
21 A. My recollection is that I did, but I can't be
22 100 percent certain.
23 COFFEY, Q.C.:
24 Q. Do you know if they used the 10 and 30 percent
25 cutoff in their own search, are you aware

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1 today?
2 DR. BAKER:
3 A. Am I aware today if they used it? Well, in
4 subsequent--we'll be coming to it, I'm sure.
5 COFFEY, Q.C.:
6 Q. Yes.
7 DR. BAKER:
8 A. In subsequent review of reports further down
9 the road, actually, a couple of years down the
10 road I did pick up some samples that were
11 missed.
12 COFFEY, Q.C.:
13 Q. Okay. And the third bullet here requests
14 pathology report, original ER/PR slides,
15 controls, H & E slide and paraffin block,
16 that's very--that's, in fact, identical -
17 DR. BAKER:
18 A. Standard, yes.
19 COFFEY, Q.C.:
20 Q. Had happened before. And, Doctor, the
21 reference here in the fourth bullet, "All ER
22 and PR performed on the Ventana System from
23 April 1, 2004, to August 9, 2005, will be
24 referred to Mount Sinai for retesting".
25 DR. BAKER:

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1 A. Uh-hm.
2 COFFEY, Q.C.:
3 Q. "You can also forward these cases to Barry
4 Dyer".
5 DR. BAKER:
6 A. Uh-hm.
7 COFFEY, Q.C.:
8 Q. What, if anything, did you understand about
9 that, or the idea, first of all, that they
10 were going to retest the current--I'm sorry,
11 the Ventana tested cases? When did you first
12 become aware that that was going to happen?
13 DR. BAKER:
14 A. That was also mentioned in a conversation with
15 Don Cook too, I think as well, back when--in
16 his second call to me, that they were going to
17 do some retesting of some of the ER/PR tests
18 that went on the Ventana System during that
19 period of time, and that would you kindly send
20 them in as well.
21 COFFEY, Q.C.:
22 Q. Did he explain to you why that was?
23 DR. BAKER:
24 A. Nothing in detail, no. He just requested that
25 we send them in and they were going to do some

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1 verification on them, that's all.
2 COFFEY, Q.C.:
3 Q. Doctor, the next bullet, he sets out, Dr. Cook
4 does, a suggested approach to concentrating on
5 particular years.
6 DR. BAKER:
7 A. Uh-hm.
8 COFFEY, Q.C.:
9 Q. Do you know if that was followed in Carbonear
10 or had you been -
11 DR. BAKER:
12 A. Yes, I think that we concentrated on the
13 sequence there, 1999 to 2004 first, and the--
14 in that sequence, yes, although as I mentioned
15 previously, there were some that we didn't
16 have in our possession because they were at
17 the laboratory in St. John's.
18 COFFEY, Q.C.:
19 Q. Yes.
20 DR. BAKER:
21 A. So they may have put some things out of
22 sequence here.
23 COFFEY, Q.C.:
24 Q. The reference here, Doctor, to laboratory
25 medicine program for St. John's hospitals is

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1 currently undergoing a quality review process.
2 DR. BAKER:
3 A. Uh-hm.
4 COFFEY, Q.C.:
5 Q. "Please note the following changes", and he
6 talks about the hold on reporting, and you had
7 already been aware of that from certainly a
8 phone call that we just looked at in August,
9 late August?
10 DR. BAKER:
11 A. Correct.
12 COFFEY, Q.C.:
13 Q. And the second bullet here advises you that
14 St. John's is going to be using Mount Sinai
15 for current cases, and that you can elect to
16 do so, and, in fact, you've told us you did?
17 DR. BAKER:
18 A. Uh-hm, yes.
19 COFFEY, Q.C.:
20 Q. "And the status of the Ventana System will be
21 determined when we review correlations of
22 ER/PR results from Mount Sinai and Montreal
23 General labs", and they're "awaiting reports
24 from medical and technical consultants before
25 we operationalize the Ventana System".

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1 Doctor, what was your understanding of what
2 sorts of test the Ventana System was used for?
3 DR. BAKER:
4 A. For all immunohistochemical testing.
5 COFFEY, Q.C.:
6 Q. But in your own practise, the only IHC tests
7 being done were the ER/PR?
8 DR. BAKER:
9 A. Correct.
10 COFFEY, Q.C.:
11 Q. That you were ordering yourself?
12 DR. BAKER:
13 A. Yes. I just viewed it as a newer piece of
14 machinery that was capable of doing all the
15 IHC.
16 COFFEY, Q.C.:
17 Q. Doctor, while we're on the topic now around
18 this time, this is addressed to--well, it's on
19 Health Care Corporation of St. John's
20 letterhead?
21 DR. BAKER:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. Of course, the Health Care Corporation was no
25 more at that point, but--because Eastern

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1 Health had come into being effective April 1,
2 2005?
3 DR. BAKER:
4 A. That's correct.
5 COFFEY, Q.C.:
6 Q. While we're on it, what if anything were the
7 changes at that time, April 1, and since then
8 in your own position and in your work?
9 DR. BAKER:
10 A. Well, as of April, I had a different reporting
11 mechanism. Dr. Bob Williams was coming into
12 being as the VP of Medical Services around
13 that time, or very shortly after, so I was
14 responsible to him as Clinical Chief for
15 medical services for the rural avalon area. I
16 was no longer the Medical Director, I was no
17 longer the ACEO in charge of--although over
18 that period, I was no longer the ACEO
19 responsible for pharmacy and diagnostic
20 imaging and laboratory services, but as I
21 said, there was an overlap period that may
22 have lasted probably over the summer before
23 some of those things started petering out. So
24 I was essentially responsible to Dr. Bob
25 Williams for the clinical side on the

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1 laboratory--and for the laboratory side, there
2 was beginning a reorganization there with--
3 Mr. Terry Gulliver was taking over as the
4 Regional Director of Laboratory Medicine for
5 Eastern Health, and he was in that position, I
6 can't give you a specific time, but it was
7 over the summer, I think probably, or early
8 fall. Then in the fall, there was also
9 regional managers selected for the various
10 levels of laboratory, biochemistry,
11 hematology, pathology. Barry Dyer took on that
12 responsibility. So my jurisdiction over the
13 lab was limited at that particular point in
14 time because I had a regional director by the
15 name of Terry Gulliver, and also regional
16 managers for each of the sections, so
17 everything was fragmented.
18 COFFEY, Q.C.:
19 Q. I'm going to ask you about that in terms of
20 that, so--and that changed?
21 DR. BAKER:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. Began April 1st, 2005?
25 DR. BAKER:

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1 A. Not immediately, but over the course of a few
2 months, yes.
3 COFFEY, Q.C.:
4 Q. So Doctor, before that then, as the Assistant
5 CEO, up until the creation of Eastern Health,
6 had your responsibilities changed?
7 DR. BAKER:
8 A. Yes, well, I was no longer in charge of the
9 pharmacy and diagnostic imaging.
10 COFFEY, Q.C.:
11 Q. I was going to ask you when did that occur,
12 that no longer --
13 DR. BAKER:
14 A. Well, there was a period of time, as I said,
15 there was a divulging of responsibilities, I
16 suppose, but that overlapped well into the
17 fall probably.
18 COFFEY, Q.C.:
19 Q. This is after April 1 of '05.
20 DR. BAKER:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Before April 1 '05, first of all, I'm going to
24 ask you about that.
25 DR. BAKER:

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1 A. Sorry.
2 COFFEY, Q.C.:
3 Q. Before Eastern Health came into being, had
4 your responsibilities changed any as the
5 Assistant CEO?
6 DR. BAKER:
7 A. No, I was still carrying all those
8 responsibilities.
9 COFFEY, Q.C.:
10 Q. And so as Assistant CEO then, you were
11 reporting to the CEO?
12 DR. BAKER:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. And the clinical part of the lab was your
16 responsibility, the technologists reported to
17 you?
18 DR. BAKER:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. And you were responsible for diagnostic
22 imaging?
23 DR. BAKER:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. And the pharmacy?
2 DR. BAKER:
3 A. And pharmacy, yes.
4 COFFEY, Q.C.:
5 Q. Anything else?
6 DR. BAKER:
7 A. Medical services.
8 COFFEY, Q.C.:
9 Q. Medical services, and medical services, I
10 wanted to expand upon that at the time you
11 first mentioned it. So medical services
12 involved all medical services in the hospital?
13 DR. BAKER:
14 A. All medical services in Carbonear Hospital, in
15 the long term care facilities in Carbonear,
16 Interfaith and Harbour Lodge, the Old Perlican
17 Hospital, the Placentia Hospital, and the
18 Whitbourne Clinic.
19 COFFEY, Q.C.:
20 Q. So, in effect, all the physicians working in
21 those institutions in that regard reported to
22 you?
23 DR. BAKER:
24 A. Yes, we were a total of about 60 physicians.
25 COFFEY, Q.C.:

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1 Q. So since the creation then of Eastern Health,
2 what's your current responsibility, what are
3 your current responsibilities, who do you
4 report to, and who reports to you?
5 DR. BAKER:
6 A. Well, at the present time, I still have a dual
7 role, I'm clinical chief responsible for
8 medical services, so my scope of
9 responsibility of medical services hasn't
10 changed a lot as far as my own jurisdiction in
11 rural avalon. I'm still responsible for all
12 the medical services for all the sites I've
13 just mentioned; recruitment, retention,
14 administrative things with physicians,
15 meetings, all that sort of thing. As far as
16 the laboratory, I still was--the pathologists
17 there, and the most recent--and up until April
18 of this year, I still was responsible for
19 clinical activity there, even though
20 administratively Terry Gulliver had
21 jurisdiction over all the laboratories in
22 Eastern Health. I still was on a day to day
23 basis working with the manager on site in
24 dealing with any minor administrative issues
25 or any clinical issues that arose on a daily

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1 basis. If there were issues that were of
2 larger significance, then they would be
3 brought to the attention of Terry Gulliver or
4 the actual regional managers of each of the
5 sections. So my role had been somewhat
6 diminished.
7 COFFEY, Q.C.:
8 Q. In your continuing role as Clinical Chief --
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Do you have any relationship with the
13 pathologist or pathologists in Clarenvile?
14 DR. BAKER:
15 A. No, I don't.
16 COFFEY, Q.C.:
17 Q. Who do they report to?
18 DR. BAKER:
19 A. They report--they report to their Medical
20 Director out there or their Clinical Chief out
21 there.
22 COFFEY, Q.C.:
23 Q. So there are no pathologists that report to
24 you?
25 DR. BAKER:

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1 A. No.
2 COFFEY, Q.C.:
3 Q. And the doctors in medical services that
4 you're responsible for are the ones you've
5 outlined?
6 DR. BAKER:
7 A. Yes.
8 THE COMMISSIONER:
9 Q. Which was Carbonear?
10 DR. BAKER:
11 A. No, Carbonear and all the rural avalon.
12 THE COMMISSIONER:
13 Q. What used to be --
14 DR. BAKER:
15 A. The old Avalon Health Care Institutions Board.
16 THE COMMISSIONER:
17 Q. They still remained with you?
18 DR. BAKER:
19 A. Yes.
20 THE COMMISSIONER:
21 Q. Approximately 60?
22 DR. BAKER:
23 A. Approximately 60 physicians. That would be
24 community physicians, specialists, and
25 physicians salaried within the facilities.

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1 COFFEY, Q.C.:
2 Q. And currently, Doctor, how much of your work
3 day--your employment time or work time does
4 that take up?
5 DR. BAKER:
6 A. About a quarter.
7 COFFEY, Q.C.:
8 Q. A quarter.
9 DR. BAKER:
10 A. Percentage-wise on paper, but in reality
11 sometimes a lot more.
12 COFFEY, Q.C.:
13 Q. Exhibit P-1287, please. Doctor, this is a fax
14 on Avalon Health Care Institutions Board
15 letterhead now indicated to be now part of
16 Eastern Health. It comes from Carbonear.
17 It's to--fax coversheet to Dr. R. Williams,
18 and it's from yourself as ACEO Medical
19 Services, September 16, 2005. The number of
20 pages being transmitted is seven, and it's
21 typed here "As per your request". If we look
22 at the next page, page two, it's a memorandum-
23 -a February 16th, 1998 memorandum from Dr.
24 Khalifa you looked at earlier today.
25 DR. BAKER:

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1 A. Uh-hm.
2 COFFEY, Q.C.:
3 Q. And as well on the fifth page of this exhibit
4 is a copy of the May 2nd, 2003, memorandum
5 from Dr. Ejeckam?
6 DR. BAKER:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. Which we looked at earlier. Doctor, how is it
10 that you came to be faxing those two documents
11 to Dr. Williams?
12 DR. BAKER:
13 A. I think it was probably the same day or the
14 day prior I was having a conversation with Dr.
15 Williams who then was my superior about some
16 other issues that I--the issue escapes me, and
17 the issue of the ER/PR came up just in
18 conversation in a casual way, and I just
19 indicated to him about having the memos that
20 were sent out in those two particular time
21 frames. It seemed that he didn't have them in
22 his possession, and I said, Dr. Williams, do
23 you want me to send the copies in to you and
24 he said, yes, I would be grateful if you
25 would, and I just got my secretary to fax them

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1 in to him just for his information.
2 COFFEY, Q.C.:
3 Q. Doctor, did you have any further contact with
4 Dr. Williams about this in September of 2005?
5 DR. BAKER:
6 A. No, not that I'm--no, not about this
7 particular issue, no, not that I can
8 recollect, no.
9 COFFEY, Q.C.:
10 Q. Exhibit P-0087, please. Doctor, these are
11 some notes--well, it's a typed version of
12 notes that Dr. Williams had made concerning a
13 phone call or a conference call, October 4,
14 2005. It says, "This refers to a conference
15 call with other regional boards; Central,
16 Western", and the personnel are described,
17 "Labrador, Carbonear", yourself.
18 DR. BAKER:
19 A. Uh-hm.
20 COFFEY, Q.C.:
21 Q. Dr. Gary Baker.
22 DR. BAKER:
23 A. Uh-hm.
24 COFFEY, Q.C.:
25 Q. St. John's, George Tilley and Susan Bonnell,

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1 and certain people at the General Hospital
2 site. It's noted here when you go through,
3 the thorough review of background, RW, which
4 would be Robert Williams; a specific issues
5 review, DC, Donald Cook, and questions whether
6 we should notify all patients who are being
7 retested.
8 DR. BAKER:
9 A. Uh-hm.
10 COFFEY, Q.C.:
11 Q. Doctor, do you recall how it was you came to
12 participate in this conference call?
13 DR. BAKER:
14 A. Actually, Mr. Coffey, I don't even remember
15 participating in this conference call.
16 COFFEY, Q.C.:
17 Q. Okay.
18 DR. BAKER:
19 A. My name may be there as the representative
20 from Carbonear, but my recollection is that I
21 never participated in this conference call.
22 COFFEY, Q.C.:
23 Q. Okay, I appreciate that these are his notes,
24 they're not yours.
25 DR. BAKER:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Do you think, Doctor, that if you did actually
4 participate, you'd remember this?
5 DR. BAKER:
6 A. Oh, for sure, yes. There was a period of time
7 when--I'm not sure if I mentioned earlier,
8 there was a period of time when I was getting
9 faxes of meetings, particularly from the
10 Newfoundland and Labrador Medical Association
11 and other areas, faxed to another fax machine
12 within the hospital. How they got that
13 number, I don't know, and I had the occasion
14 on at least two or three occasions of finding
15 the fax in another area of the hospital the
16 day after the actual teleconference. So there
17 were two or three teleconferences that I
18 missed.
19 COFFEY, Q.C.:
20 Q. And so if this conference call occurred,
21 you're saying, Mr. Coffey, I didn't
22 participate in it?
23 DR. BAKER:
24 A. No, I have no recollection of it.
25 COFFEY, Q.C.:

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1 Q. Doctor, one of the topics here is--the last
2 one here is questions of whether we should
3 notify all patients who are being retested.
4 DR. BAKER:
5 A. Uh-hm.
6 COFFEY, Q.C.:
7 Q. I want to ask you about that. By this point
8 in time, early October, approximately 20
9 patients, breast cancer patients a year, do
10 you have any sense of how many were ER
11 negatives now, I mean, in the sense of --
12 DR. BAKER:
13 A. No, I don't.
14 COFFEY, Q.C.:
15 Q. In terms of the review identified --
16 DR. BAKER:
17 A. I didn't do a review of the actual numbers,
18 no.
19 COFFEY, Q.C.:
20 Q. Doctor, did you ever have in the summer of
21 2005 or the early fall of 2005 any
22 conversations with anybody about the idea of
23 whether or not--the issue of whether or not
24 patients should be told that their tissue is
25 being retested?

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1 DR. BAKER:
2 A. No, I had no conversations with anybody about
3 that issue.
4 COFFEY, Q.C.:
5 Q. Did it cross your mind at the time?
6 DR. BAKER:
7 A. It did on one occasion cross my mind. I was
8 just wondering whether or not there was going
9 to be contact of patients, but I didn't have
10 specific conversations with anybody expressing
11 my views.
12 COFFEY, Q.C.:
13 Q. And do you recall the context in which that
14 occurred?
15 DR. BAKER:
16 A. It was just thinking about the issue in
17 general probably in my office one day after,
18 you know, just--it was an ongoing issue over
19 that summer of collecting of specimens and so
20 on. It was on your mind and wondering what
21 was going on, and that thought just crossed my
22 mind about the patients, concern for the
23 patients.
24 COFFEY, Q.C.:
25 Q. Doctor, as the summer goes on into the fall,

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1 you would have understood that St. John's was
2 making inquiries, doing some kind of an
3 investigation trying to ascertain what had
4 happened?
5 DR. BAKER:
6 A. I heard through the grapevine that there was
7 going to be a review done of these--I think it
8 was referenced in one of the exhibits you gave
9 me.
10 COFFEY, Q.C.:
11 Q. September 6th memo, I believe.
12 DR. BAKER:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. And what did you understand they were doing in
16 that regard?
17 DR. BAKER:
18 A. Just that they had brought some external
19 consultants in to review the processes that
20 were ongoing in St. John's that related to
21 ER/PR testing and the machinery.
22 COFFEY, Q.C.:
23 Q. Doctor, were you ever told what the results of
24 all those investigations were?
25 DR. BAKER:

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1 A. No, never.
2 COFFEY, Q.C.:
3 Q. Did you ever inquire as to what they were?
4 DR. BAKER:
5 A. I had a brief conversation, and I don't
6 remember the specific time, with Oscar Howell
7 after Oscar Howell had taken over. This was
8 probably a year and a half later, as to, you
9 know, what were the areas of concern in the
10 reviews that were done, particularly with
11 reference to the peer review of physicians,
12 and the comments were very non-specific, there
13 was just nothing of--I didn't get any
14 particular useful information. There was
15 nothing that was said that was of any
16 importance to me as such, no.
17 COFFEY, Q.C.:
18 Q. So he, in effect, didn't tell you what --
19 DR. BAKER:
20 A. What was in the reports. I never saw a copy
21 of the report, I never requested a copy of the
22 report, and I didn't know what the content
23 was.
24 COFFEY, Q.C.:
25 Q. Is there any reason you didn't request a copy

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1 of it?
2 DR. BAKER:
3 A. No, no particular reason, no.
4 COFFEY, Q.C.:
5 Q. Did you understand--did you have any
6 understanding at the time that it was somehow
7 confidential or protected in any manner?
8 DR. BAKER:
9 A. No, no one relayed that to me, no. I thought
10 that the report was part of the process in St.
11 John's and that in due course it would
12 probably be given to me, or some results or
13 recommendations in that report, you know,
14 highlighted to me.
15 COFFEY, Q.C.:
16 Q. Doctor, we know in the sense of the documents
17 from witnesses here that the reports,
18 certainly the first two reports, were done--
19 examinations occurred or the investigations
20 occurred in September of 2005.
21 DR. BAKER:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. And the reports followed in October/November,
25 2005?

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1 DR. BAKER:
2 A. Uh-hm.
3 COFFEY, Q.C.:
4 Q. Have you had a chance--since the Commission
5 and these proceedings have begun, have you
6 actually seen Dr. Banerjee's or Trish
7 Wegrynowski's reports?
8 DR. BAKER:
9 A. No, I haven't seen the reports in total. I've
10 just seen some of the recommendations or some
11 of the recommendations they made.
12 COFFEY, Q.C.:
13 Q. Doctor, so to this day no one within Eastern
14 Health has actually distributed those reports
15 to you?
16 DR. BAKER:
17 A. No.
18 COFFEY, Q.C.:
19 Q. Doctor, you're aware that Ms. Wegrynowski and
20 Dr. Banerjee returned to St. John's in early
21 2006, March?
22 DR. BAKER:
23 A. I only became aware of that recently, since
24 the start of the inquiry.
25 COFFEY, Q.C.:

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1 Q. And if they produced reports at that time, you
2 haven't seen those reports either?
3 DR. BAKER:
4 A. No, I haven't.
5 COFFEY, Q.C.:
6 Q. Exhibit P-0630, please. Doctor, this is a
7 series of e-mails of October 7, 2005. The
8 first of them, just to put it in context for
9 you, is from Diane Smith to a number of
10 individuals. You're not listed in the e-mail
11 grouping here, but it's a communique regarding
12 ER/PR testing and it says, "Please see
13 attached communique from Dr. Paul Gardiner,
14 Medical Director, Dr. H. Bliss Murphy Cancer
15 Centre, regarding ER/PR testing issue. We ask
16 that you ensure surgeons in your area who
17 perform breast surgery receive a copy of this
18 communique", and then the next e-mail at 5:27
19 that day from Diane Smith is to yourself, and
20 the same topic, and it says, "Dr. Baker, Dr.
21 Gardiner asked if you would ensure surgeons in
22 the covering area are aware of the attached
23 communique. Thank you, Diane".
24 DR. BAKER:
25 A. Uh-hm.

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1 COFFEY, Q.C.:
2 Q. And as well Diane Smith forwards the series of
3 e-mails to Patricia Pilgrim and concludes her
4 comment to Ms. Pilgrim by saying, "Dr.
5 Williams suggested we forward to Dr. Baker
6 also".
7 DR. BAKER:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. Did you receive this e-mail, this second e-
11 mail here?
12 DR. BAKER:
13 A. Yes, I think I did, yes.
14 COFFEY, Q.C.:
15 Q. And the letter from Dr. Gardiner addressed to
16 surgeons?
17 DR. BAKER:
18 A. Yes, I did.
19 COFFEY, Q.C.:
20 Q. Did you distribute that letter?
21 DR. BAKER:
22 A. I did. I personally delivered it to both the
23 surgeons in our facility.
24 COFFEY, Q.C.:
25 Q. Did the surgeons at the time or subsequently

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1 have any questions for you?
2 DR. BAKER:
3 A. No, they were aware of the testing that was
4 ongoing because they were familiar with--
5 well, they indicated to me that they were
6 aware of the situation in St. John's. They
7 didn't request any more information other than
8 that, and I gave them a copy of the letter,
9 and they took it.
10 COFFEY, Q.C.:
11 Q. Have you ever, in fact, discussed the matter
12 with the surgeons in any kind of detailed way?
13 DR. BAKER:
14 A. Not in detail, they seemed to--from comments
15 that they have made as to "I know what's going
16 on in St. John's, I know that there's
17 retesting going on, you know, and I know about
18 the issues and so on", that gave me an
19 indication that they were aware of what was
20 happening.
21 COFFEY, Q.C.:
22 Q. Doctor, we've heard through evidence that The
23 Independent newspaper on October 3rd, 2005,
24 published a story making this public.
25 DR. BAKER:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Doctor, after the letter became public, did
4 you receive any kind of contacts, were you
5 ever contacted by any patients or people on
6 behalf of patients?
7 DR. BAKER:
8 A. No.
9 COFFEY, Q.C.:
10 Q. Making inquiries about the status of --
11 DR. BAKER:
12 A. Nothing came my way, no.
13 COFFEY, Q.C.:
14 Q. If we could look at, please, Exhibit P-1328.
15 Doctor, just here--go to page 16, please, and
16 just so the Commissioner has some sense of
17 what else was going on in your work world,
18 this is a memo of July 19th, 2005, on Avalon
19 Health Care Institutions Board letterhead.
20 It's to members of regional and medical staff
21 from the President of the Regional Medical
22 Staff, referral of a meeting, and then,
23 Doctor, there are here a series of memorandums
24 if we go back through the exhibit, and then at
25 page 13 of the minutes of a meeting of the

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1 Regional Medical Advisory Committee and Dr.
2 Williams.
3 DR. BAKER:
4 A. Uh-hm.
5 COFFEY, Q.C.:
6 Q. And you're listed as present as are a number
7 of others. Doctor, there's another one,
8 Regional Medical Staff meeting, minutes of 14
9 September, 2005, and then a letter of
10 September 30th, 2005, advising Dr. Williams
11 about a discussion that had taken place about
12 his proposed structure of the medical staff
13 under Eastern Health. There are a number of
14 issues the medical staff have concerns about
15 and they are included in that attached
16 document.
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Doctor, page seven, there's an e-mail from
21 Faye Matthews to Dr. Williams indicating there
22 had been an MAC meeting the night before, and
23 finally, Doctor, at page one of the exhibit, a
24 letter of November 22nd, 2005, to yourself
25 from Dr. Williams, copied to a number of

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1 individuals dealing with following up on your
2 correspondence of September 30th, relating to
3 the proposed medical staff structure for
4 Eastern Health in the area--in rural avalon.
5 DR. BAKER:
6 A. Avalon, yes.
7 COFFEY, Q.C.:
8 Q. So, Doctor, I refer you to this because I want
9 to ask you what has happened with respect to
10 the MAC in Carbonear since April, 2005, how
11 has that worked?
12 DR. BAKER:
13 A. It remains the same as it was before 2005.
14 There's been essentially no change. The MAC of
15 rural Avalon is still functioning in the same
16 manner with the same representatives from the
17 various disciplines within the hospital,
18 specialists and GPs. It still functions as it
19 had before 2005. The actual Eastern Health
20 regional structure, as was discussed in these
21 communications here, has not come into effect
22 yet.
23 COFFEY, Q.C.:
24 Q. And what are the plans in that regard, if any,
25 have they been --

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1 DR. BAKER:
2 A. The plans are still ongoing. There were
3 meetings planned and meetings cancelled. They
4 hired a new Director of Medical Services, Dr.
5 John Guy, approximately a year ago and he was
6 tasked to developing a new set of medical
7 staff bylaws for Eastern Health. That process
8 is still ongoing. And the actual structure of
9 the medical staff structure for Eastern Health
10 is still ongoing with no final draft or final
11 structure in place at the present time.
12 COFFEY, Q.C.:
13 Q. It's a work in progress, I take it?
14 DR. BAKER:
15 A. It is, yes.
16 COFFEY, Q.C.:
17 Q. Doctor, I'm just going--first, perhaps,
18 Registrar, Exhibit P-2201. This is a memo of
19 December 2nd, 2005, it's to a number of
20 individuals, pathologists outside St. John's,
21 really. You're listed as the second one.
22 It's from Barry Dyer. The subject is "ER/PR
23 Retesting." He writes, "Please forward me a
24 complete list of all patient specimens that
25 have been sent in for ER/PR retesting. The

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1 purpose is to cross reference to ensure that
2 all specimens shipped have been received by
3 our laboratory." Now, Doctor, did you send in
4 or respond to this, do you know, did you or
5 your staff?
6 DR. BAKER:
7 A. I passed it along to my staff. I assume that
8 it was sent.
9 COFFEY, Q.C.:
10 Q. Did you hear anything further about it that
11 you recall?
12 DR. BAKER:
13 A. No, nothing at all.
14 COFFEY, Q.C.:
15 Q. So, Doctor, by then the beginning of December
16 of 2005 from your perspective in relation to
17 Carbonear what was the status of identifying
18 patients who were affected by this in terms of
19 to be retested?
20 DR. BAKER:
21 A. In terms of completion?
22 COFFEY, Q.C.:
23 Q. Yes.
24 DR. BAKER:
25 A. In my view the completion had--the process was

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1 complete, that all the patients had been
2 identified and that they had been sent in.
3 COFFEY, Q.C.:
4 Q. So I take it then you would be awaiting the
5 return of the results?
6 DR. BAKER:
7 A. Yes, of results, yes. To the end of 2005 we
8 hadn't received any results back.
9 COFFEY, Q.C.:
10 Q. Exhibit P-0670? And, Doctor, again these are
11 handwritten notes of Dr. Cook. Okay, I
12 appreciate you wouldn't have seen these
13 before. But, there's a note here midway down
14 the page, October 31st, 2005, 11:30 a.m. Dr.
15 Cook writes, "Spoke to Gary Baker. Will send
16 out addendum reports from Mount Sinai
17 Hospital," "MSH" Mount Sinai Hospital, "to Dr.
18 Baker. Dr. Baker will have to enter into his
19 own system and follow up with administration
20 on how to handle them. Gave him Kara Laing's
21 name, Heather Predham and Bob Williams." See
22 that?
23 DR. BAKER:
24 A. Yes, I see that.
25 COFFEY, Q.C.:

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1 Q. Okay. Do you recall that conversation with
2 Dr. Cook?
3 DR. BAKER:
4 A. I recall the conversation, the first part of
5 the conversation, I recall him indicating to
6 me that he would be sending addendum reports
7 and then I would have to incorporate them into
8 my own system. And that is what we did when
9 we did eventually receive them. I don't
10 remember the portion about Kara Laing, Heather
11 Predham, Bob Williams. Maybe he did say it, I
12 just don't remember.
13 COFFEY, Q.C.:
14 Q. Doctor, so then, you know, having done the
15 searches at the time in 2005, identify the
16 patients and the material, send it off and
17 you're awaiting results?
18 DR. BAKER:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. You understood that you'd be getting reports?
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. A report or reports on the retests?

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1 DR. BAKER:
2 A. Correct.
3 COFFEY, Q.C.:
4 Q. And would have to enter them in your own
5 system?
6 DR. BAKER:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. How about the notification of patients?
10 DR. BAKER:
11 A. I wasn't involved in notification of patients.
12 COFFEY, Q.C.:
13 Q. Who was to be involved in that in your
14 hospital?
15 DR. BAKER:
16 A. There was no one--at this point in time we
17 were part of the Eastern Health overall and it
18 was my understanding that it was part of the
19 process in St. John's that patients would be
20 notified.
21 COFFEY, Q.C.:
22 Q. Was that ever -
23 DR. BAKER:
24 A. By the quality assurance people, you know -
25 COFFEY, Q.C.:

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1 Q. Was that ever talked about, actually
2 explicitly talked about?
3 DR. BAKER:
4 A. No, it wasn't explicitly talked about, but it
5 was just my understanding.
6 COFFEY, Q.C.:
7 Q. That the quality assurance, Heather Predham?
8 DR. BAKER:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. And the group she was with would be attending
12 to the patient notification?
13 DR. BAKER:
14 A. Yeah, because we were all part of Eastern
15 Health region an any patients from Eastern
16 Health would be contacted to that area.
17 COFFEY, Q.C.:
18 Q. Were you given any understanding about, well,
19 first of all, patients whose tests, retest
20 results didn't change?
21 DR. BAKER:
22 A. No.
23 COFFEY, Q.C.:
24 Q. As to how that was to be handled, you -
25 DR. BAKER:

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1 A. No, I wasn't. I didn't receive any results
2 from the retesting until February, probably
3 sometime February or the following year, 2006.
4 My process for handling them was I would
5 receive the report back from primarily in the
6 beginning it was Don Cook. He was doing an
7 addendum report on his system in there based
8 on the reports that he was getting back from
9 Mount Sinai. They would include the retesting
10 status of the patient as far as ER/PR status.
11 I would take that report, incorporate it into
12 my own original report as an addendum and make
13 sure that copies of that were sent to the
14 attending surgeon who was involved with the
15 patient originally and also to the cancer
16 clinic for the file, for the patient on the
17 file.
18 COFFEY, Q.C.:
19 Q. So you, beginning in February, 2006 on the
20 retested patients, you would get for each
21 individual patient who was retested, you'd get
22 a report from Don Cook?
23 DR. BAKER:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. And what form, what sort of a form was it?
2 DR. BAKER:
3 A. It was a Meditech form, eight and a half by
4 eleven form with the patient's information
5 and, you know, and just the retest information
6 ER/PR results, you know, positive, so much
7 percentage, negative, you know.
8 COFFEY, Q.C.:
9 Q. So you would take that yourself, then you took
10 each of those reports?
11 DR. BAKER:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And into the -
15 DR. BAKER:
16 A. And I passed it along to my secretary. She
17 would transcribe it into our own system under
18 the previous--the original report as an
19 addendum and I would sign them out and then
20 the reports, as addended, would be sent on to
21 the attending surgeon and also a copy would be
22 sent immediately to the cancer clinic for
23 inclusion in the patient's file.
24 COFFEY, Q.C.:
25 Q. Now Doctor, we have heard evidence about a

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1 tumour panel, physician review panel. It's
2 been called different names.
3 DR. BAKER:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. When did you first become aware of that, the
7 existence of such a panel?
8 DR. BAKER:
9 A. In the spring of 2006, I became aware that
10 there was a tumour panel that were reviewing
11 the conversions and seeing what impact those
12 conversions would have on the patient's
13 further treatment.
14 COFFEY, Q.C.:
15 Q. How did that come to your attention, Doctor?
16 DR. BAKER:
17 A. That came to my attention, it was one day that
18 a secretary from St. Clare's, Dr. Don Cook's
19 secretary, had a conversation with my
20 secretary and asked for original reports on a
21 number of patients who had been retested and
22 they wanted them for the tumour panel, and
23 then I knew the existence of the tumour panel.
24 COFFEY, Q.C.:
25 Q. So did you make any inquiries about -

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1 DR. BAKER:
2 A. The panel afterwards?
3 COFFEY, Q.C.:
4 Q. Yes.
5 DR. BAKER:
6 A. No, I just understood it to be a review
7 process of each of the individual patients to
8 determine, you know, what if any change in
9 treatment there would be for each individual
10 patient.
11 COFFEY, Q.C.:
12 Q. Now there are tumour panel letters. We've
13 seen some of those, okay. Have you ever seen
14 or received letters from the tumour panel?
15 DR. BAKER:
16 A. Not to my recollection, no.
17 COFFEY, Q.C.:
18 Q. Exhibit P-1091. Doctor, this is a memo dated
19 February 1st, 2006. It's from Dr. Cook. It's
20 addressed to a number of individuals,
21 including yourself here, there in the middle,
22 right here.
23 DR. BAKER:
24 A. Yes, yes.
25 COFFEY, Q.C.:

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1 Q. And did you receive a copy of this?
2 DR. BAKER:
3 A. I did, yes.
4 COFFEY, Q.C.:
5 Q. And it indicates "we have received most of the
6 results from Mount Sinai regarding ER/PR
7 review process. The results from Mount Sinai
8 were issued on Excel spreadsheets. I will be
9 issuing individual reports on patients and
10 submitting these to you at your respective
11 sites. When you receive these reports, please
12 ensure they are incorporated in your hospital
13 information and the laboratory information
14 systems. I expect you will be receiving the
15 first of these reports within the next two
16 weeks."
17 If we could look, please, at Exhibit P-
18 1976? This is an unsigned copy, but check
19 marked copy of that same memo, and here, in
20 the right-hand side, there's a handwritten
21 note by Dr. Cook. "Spoke to Gary Baker,
22 February 9th" and it's probably "Paul Neil,
23 Wednesday, February 10th, ensuring they got my
24 memo." So Dr. Cook, apparently took the
25 trouble--do you recall him taking the trouble

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1 to ensure that you had received his memo?
2 DR. BAKER:
3 A. That I got the memo, yes.
4 COFFEY, Q.C.:
5 Q. Doctor, in the meantime, you'd been utilizing
6 Mount Sinai?
7 DR. BAKER:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. How are the results from Mount Sinai handled?
11 Did they come by fax and then -
12 DR. BAKER:
13 A. They come back in the standard format that
14 Mount Sinai is using. They're faxed--the
15 report is first faxed to my fax machine in
16 pathology, and that fax copy is taken and
17 incorporated into the report, same as these
18 would have been, as an addendum to the
19 original pathology report, and entered word
20 for word, no changes at all, and we provide a
21 copy to the surgeon, attending surgeon, and
22 also we provide the actual original report
23 from Mount Sinai to the Cancer Clinic, because
24 at one point, there were some problems with
25 transcription that we received a letter about

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1 from Dr. Laing, I think it was, and she asked
2 us to--but we had been doing that previous to
3 that point in time. So there was no issue
4 with us.
5 COFFEY, Q.C.:
6 Q. Exhibit P-1591. Doctor, this is an e-mail of-
7 -well, it's actually--there are two e-mails,
8 but the first of them, March 29th, 2006, from
9 Nash Denic to a number of individuals. I
10 believe you're -
11 DR. BAKER:
12 A. I'm there, yes.
13 COFFEY, Q.C.:
14 Q. Your name's buried in there somewhere.
15 DR. BAKER:
16 A. On top.
17 COFFEY, Q.C.:
18 Q. Yes, actually, you're the third one in. It
19 reads, "there has been some confusion from the
20 Cancer Clinic who the reports from Mount Sinai
21 Hospital should go to. Therefore, the Cancer
22 Clinic will be sending a letter to all
23 pathology lab directors outlining the
24 directions how the ER/PR and HER2/neu reports
25 from the Mount Sinai Hospital should be

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1 handled. In the meantime, if you have
2 questions, you can call Dr. Joy McCarthy," at
3 a particular phone number. Signed Nash Denic.
4 Bring up, please, Exhibit P-2335. This
5 is a letter of April 5th, 2006 to directors of
6 pathology. You're listed there, the last one.
7 DR. BAKER:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. You received a copy of this, Doctor?
11 DR. BAKER:
12 A. I did, yes.
13 COFFEY, Q.C.:
14 Q. And I take it this is the letter from Dr.
15 Laing you just alluded to, referred to just a
16 moment ago?
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. And she writes, "this is a letter to request
21 that all ER/PR and HER2/neu reports from Mount
22 Sinai Hospital in Toronto be faxed to the
23 Cancer Clinic. We realize that you are not
24 necessarily aware if a patient has been
25 referred to the Cancer Clinic or not. Reports

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1 on patients that are not referred will be
2 destroyed by our new patient referral booking
3 clerks. We will not be sending back reports
4 to you. Having the faxed original Mount Sinai
5 ER/PR and HER2/neu reports ensures there is no
6 discrepancy between the Newfoundland
7 pathologist's report and the original Mount
8 Sinai report. Sometimes there may be typos or
9 clerical errors in these reports that are
10 inconsistent with the original Mount Sinai
11 report. We have discovered three such cases
12 to date in the HER2/neu reports. We have
13 informed our new patient booking clerks that
14 all reports will be faxed to them. They will
15 shred any reports that are not Cancer Clinic
16 patients and will distribute the other reports
17 to the appropriate oncologist when they
18 arrive," and she talks about contact people.
19 Doctor, the reference here to typos or
20 clerical errors, are you aware of any
21 involving Carbonear? I'm not suggesting there
22 have been.
23 DR. BAKER:
24 A. Not that I'm aware of. The process that I
25 would take when these were being--well,

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1 transcribed by my secretary, she would use the
2 original from Mount Sinai and transcript word
3 for word into the system as addendum on the
4 original report. She would pass the Mount
5 Sinai report back to me when I was signing out
6 the addended report and I would verify on the
7 screen the content of the addendum with the
8 original report before signing out.
9 THE COMMISSIONER:
10 Q. Mr. Coffey, wherever you can find a spot.
11 COFFEY, Q.C.:
12 Q. Okay, yes, Commissioner. Doctor, in terms of
13 dealing with then the grouping of or group of
14 reports, the reports that came back from Mount
15 Sinai in February 2006, first group you
16 received, after you'd addressed them, get them
17 from Don Cook and you'd do what you've
18 indicated you did with them, how long did that
19 process take?
20 DR. BAKER:
21 A. From beginning to end?
22 COFFEY, Q.C.:
23 Q. Yes, in terms of that, after--from February
24 '06, when did that end or when did they -
25 DR. BAKER:

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1 A. I can recollect still receiving reports up
2 until April, maybe April, May, odd ones, yeah.
3 COFFEY, Q.C.:
4 Q. Of 2006?
5 DR. BAKER:
6 A. Yeah. Most of them came in the time frame
7 around February, March and so on, but there
8 was the occasional one that came later.
9 COFFEY, Q.C.:
10 Q. And Doctor, your handling of those reports,
11 would you have been aware of whether or not
12 any particular patient was or wasn't being
13 panelled?
14 DR. BAKER:
15 A. No, I wouldn't. I wouldn't be given any
16 indication at all.
17 COFFEY, Q.C.:
18 Q. So as long as you got a report from Donald
19 Cook -
20 DR. BAKER:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. - about the Mount Sinai retest results, you
24 did -
25 DR. BAKER:

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1 A. I made sure it was incorporated into my system
2 and the appropriate people in my system
3 notified.
4 COFFEY, Q.C.:
5 Q. And the panelling process and panel letters
6 was something separate?
7 DR. BAKER:
8 A. They were separate. They were distinct to the
9 St. John's area. It was being done on, I
10 suppose, a province wide basis on all the
11 ER/PRs that were being retested and I felt
12 that obviously it was being handled
13 appropriately in there.
14 COFFEY, Q.C.:
15 Q. And Doctor, in terms of the ER/PR issue, in
16 the sense of the retesting issue, what's your
17 next recollection of anything involving
18 yourself?
19 DR. BAKER:
20 A. ER/PR issue, in reference to finding more
21 report?
22 COFFEY, Q.C.:
23 Q. And that came up eventually?
24 DR. BAKER:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. But in particular, we understand that there
3 was a presentation in the fall of 2006. Do
4 you recall that?
5 DR. BAKER:
6 A. Yes. There was a presentation that I was
7 invited to whereby -
8 COFFEY, Q.C.:
9 Q. Okay. What I'm going to do then, if we could
10 take that up right after lunch then.
11 DR. BAKER:
12 A. Sure, okay.
13 COFFEY, Q.C.:
14 Q. That's where we'll begin and then continue on
15 to the conclusion.
16 DR. BAKER:
17 A. Great, yes.
18 COFFEY, Q.C.:
19 Q. Thank you.
20 DR. BAKER:
21 A. Thank you.
22 THE COMMISSIONER:
23 Q. We'll meet at 2:05.
24 COFFEY, Q.C.:
25 Q. Thank you, Commissioner.

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1 (LUNCH BREAK)
2 THE COMMISSIONER:
3 Q. Please be seated. Mr. Coffey.
4 COFFEY, Q.C.:
5 Q. Thank you, Commissioner. Doctor, just before
6 the lunch break, we touched on the
7 presentation in November 2006.
8 DR. BAKER:
9 A. Correct, yes.
10 COFFEY, Q.C.:
11 Q. Doctor, what do you recall about how you
12 became aware of it and did you participate and
13 what happened generally?
14 DR. BAKER:
15 A. I can remember a phone call, and probably an
16 e-mail as well, coming from Dr. Nash Denic's
17 office, regarding a meeting that was scheduled
18 for November to give an overview and update of
19 the progress that was made in relation to
20 ER/PR testing and the improvement that they
21 made in the system, and just to give some
22 background as to where they were at that
23 particular point in time.
24 COFFEY, Q.C.:
25 Q. And did you participate in that?

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1 DR. BAKER:
2 A. Yes, I drove to St. John's and participated in
3 person at the Health Science Centre, in the
4 auditorium.
5 COFFEY, Q.C.:
6 Q. Okay, so rather than use the video
7 conferencing route, you just drove into St.
8 John's?
9 DR. BAKER:
10 A. And participated, yes.
11 COFFEY, Q.C.:
12 Q. And where was it held, do you recall?
13 DR. BAKER:
14 A. At the Health Science Centre auditorium,
15 General Hospital.
16 COFFEY, Q.C.:
17 Q. And the attendance, how many?
18 DR. BAKER:
19 A. I'd say 30 people.
20 COFFEY, Q.C.:
21 Q. Okay, and generally physicians?
22 DR. BAKER:
23 A. Physicians, some administrative people,
24 laboratory administrative people, senior
25 administration. There was a lawyer there too,

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1 as well, but I don't know the name.
2 COFFEY, Q.C.:
3 Q. And Doctor, did anyone come in from Carbonear
4 Hospital with you, anyone else?
5 DR. BAKER:
6 A. No, just myself.
7 COFFEY, Q.C.:
8 Q. Doctor, what do you recall about it? What
9 format did it take? Who presented?
10 DR. BAKER:
11 A. It was just a general format, overview of--
12 first of all, Dr. Ford Elms, I think was the
13 first speaker and he gave just a general
14 overview of immunohistochemistry, the
15 principles behind it. Dr. Cook spoke about
16 the presentation of the first case, the index
17 case, and how it came to light, and the
18 testing that was undertaken and the retesting
19 at Mount Sinai, not in great detail, but just
20 an overview of things. Kara Laing, I think,
21 spoke about some issues as well, and I really
22 can't remember the issues that she spoke
23 about. Nash Denic spoke as well, I think, but
24 it was just a general overview of things and
25 where they were to this date, what

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1 improvements they've made in the lab, what
2 quality control things they've instituted.
3 They referenced the external reviews, but
4 didn't give any detail about them, to my
5 recollection, but just and then they just
6 highlighted improvement that they made into
7 the lab in the immunohistochemistry section up
8 to that point in time.
9 COFFEY, Q.C.:
10 Q. Doctor, did you ask any questions at the time,
11 do you recall?
12 DR. BAKER:
13 A. No, there was--no, I don't think there was any
14 questions asked at all. The presentation went
15 on as scheduled and I don't remember anybody
16 asking any questions at the end, tell you the
17 truth.
18 COFFEY, Q.C.:
19 Q. Okay. Doctor, the Commissioner at times has
20 heard references to, of course, false
21 negatives, many references to that.
22 Occasionally references to false positives.
23 DR. BAKER:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Do you know if there were any cases from your
2 area that involved false -
3 DR. BAKER:
4 A. I've been shown an exhibit and I was shown it
5 actually in my examination back last November
6 as well by yourself, Mr. Coffey.
7 COFFEY, Q.C.:
8 Q. When we were interviewing you?
9 DR. BAKER:
10 A. Yes, that's right. You showed me an example.
11 It was the first time I had seen that one.
12 COFFEY, Q.C.:
13 Q. While we're on it, Exhibit C-0224. Doctor,
14 this is a laboratory report, well, a pathology
15 report of a particular patient. The
16 information is redacted, the patient's
17 personal information.
18 DR. BAKER:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. But at the bottom of the page, the reference,
22 it says "Dr. Baker's case. False positive on"
23 a particular surgical number or specimen
24 number, and it goes on from there talking
25 about "ER and PR negative on original and

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1 repeat from Mount Sinai however, on met to the
2 node, Baker reports 70 percent ER/PR, 70
3 percent on Ventana. Cook and Carter reviewed
4 and found ER less than five percent."
5 DR. BAKER:
6 A. Um-hm.
7 COFFEY, Q.C.:
8 Q. So the first time you became aware of this
9 yourself was when you were interviewed by
10 myself and Ms. Chaytor in November of 2007?
11 DR. BAKER:
12 A. That's correct.
13 COFFEY, Q.C.:
14 Q. Did you make any inquiries about it afterward?
15 DR. BAKER:
16 A. No, I didn't. No, I didn't.
17 COFFEY, Q.C.:
18 Q. So if there was something involving a patient
19 that at one point you had done a report for
20 and Dr. Cook, and I believe that's probably
21 his handwriting, and/or Dr. Carter arrived at
22 some conclusions about them having been a
23 false positive involved here, it wasn't
24 brought to your attention?
25 DR. BAKER:

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1 A. No, it wasn't. Could I make a point about the
2 report?
3 COFFEY, Q.C.:
4 Q. Sure, you certainly can, Doctor.
5 DR. BAKER:
6 A. On the bottom, in the handwriting, which I
7 assume you indicated was Dr. Cook's, he's
8 referencing there, in the second line,
9 "primary breast lesion, ER and PR negative on
10 original," which to me, the original would be
11 my original report.
12 COFFEY, Q.C.:
13 Q. Yes.
14 DR. BAKER:
15 A. And repeat from Mount Sinai was also, I'm
16 assuming from the same sentence, would be have
17 been reported as ER/PR negative. I think that
18 would become apparent if he saw the actual
19 report from Mount Sinai. The actual
20 information regarding a false positive was in
21 reference to a totally different specimen. It
22 was lymph node from this lady that was
23 removed, I think, probably several months
24 later and we don't usually do ER/PR on lymph
25 nodes unless specifically requested. I don't

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1 know why this was done, but the actual ER/PR,
2 the original ER/PR was on the primary lesion
3 and it actually was verified by the repeat at
4 Mount Sinai as being the same.
5 COFFEY, Q.C.:
6 Q. Yes, and so that information, have you--you've
7 learned that, what, since, what you just told
8 -
9 DR. BAKER:
10 A. Well, I was shown this again in my preparation
11 for coming here.
12 COFFEY, Q.C.:
13 Q. Okay, and you made inquiries?
14 DR. BAKER:
15 A. I hadn't seen it since last November, and so I
16 went to my office and researched the actual
17 tissue and the actual reports.
18 COFFEY, Q.C.:
19 Q. In relation to this particular patient?
20 DR. BAKER:
21 A. Yes, correct.
22 COFFEY, Q.C.:
23 Q. And you're telling the Commissioner about this
24 note, the initial note here, there's a
25 reference, the words are handwritten here

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1 "false positive." Your understanding, that
2 relates to the primary breast lesion sample?
3 DR. BAKER:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. And however, the node specimen, a different
7 one?
8 DR. BAKER:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. You had, in checking now, you've ascertained
12 that yes, you had reported that as ER 70
13 percent positive?
14 DR. BAKER:
15 A. Um-hm.
16 COFFEY, Q.C.:
17 Q. And -
18 DR. BAKER:
19 A. And a repeat indicated--or a reassessment by
20 Dr. Cook and, I think, Dr. Carter indicated
21 that it was less than one or something, less
22 than five.
23 THE COMMISSIONER:
24 Q. Now, just make sure I understand.
25 COFFEY, Q.C.:

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1 Q. Yes.
2 THE COMMISSIONER:
3 Q. I understood your explanation to be that in
4 the case of this particular patient, there
5 were ER/PR tests done on two different
6 specimens?
7 DR. BAKER:
8 A. Correct.
9 THE COMMISSIONER:
10 Q. The second being the lymph nodes?
11 DR. BAKER:
12 A. Correct.
13 THE COMMISSIONER:
14 Q. And the reference to false positive relates to
15 the test done on the lymph nodes, not on the
16 first test?
17 DR. BAKER:
18 A. Correct.
19 THE COMMISSIONER:
20 Q. And on the first test, your opinion was
21 confirmed by Mount Sinai?
22 DR. BAKER:
23 A. Correct.
24 COFFEY, Q.C.:
25 Q. The primary breast lesion, yes.

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1 THE COMMISSIONER:
2 Q. Yes.
3 COFFEY, Q.C.:
4 Q. And the lymph node is the one that it would be
5 classified as a false positive?
6 DR. BAKER:
7 A. Yes, but the treatment of the patient would
8 have been assessed on the primary breast
9 lesion.
10 COFFEY, Q.C.:
11 Q. Primary breast. But even in relation to that,
12 that particular aspect of the matter, the fact
13 that Doctors Cook and Carter had apparently
14 come to this conclusion about the lymph node -
15 DR. BAKER:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. - specimen being a false positive, was not
19 brought to your attention by anyone until -
20 DR. BAKER:
21 A. No.
22 COFFEY, Q.C.:
23 Q. - you had cause, as a result of your
24 interaction with us, to investigate that?
25 DR. BAKER:

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1 A. That's right.
2 COFFEY, Q.C.:
3 Q. Okay.
4 DR. BAKER:
5 A. I would assume that this came to light only
6 because it created some confusion in the
7 patient's chart as one being positive and one
8 being negative.
9 COFFEY, Q.C.:
10 Q. Sure. Now, Doctor, if I could, bring up,
11 please, Exhibit P-2272, and Doctor, that's
12 2270. 2272, please. Thank you, Registrar.
13 Thank you very much. Now Doctor, page two of
14 this is an e-mail from Dr. Denic, Nash Denic,
15 May 31st, 2007 to Judy Thomas, but there are a
16 number of attachments here. You can see them
17 described.
18 DR. BAKER:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. See them there in this. Now Doctor, I'll use
22 this as a basis then for my next question.
23 After the presentation in November 2006, what
24 was your next involvement in ER/PR? And in
25 particular, perhaps to assist you, we

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1 understand that in late 2006, there were plans
2 to reinstitute ER/PR testing in St. John's,
3 beginning early in 2007.
4 DR. BAKER:
5 A. That's correct, yes.
6 COFFEY, Q.C.:
7 Q. And then happened, we gather, in February
8 2007. Were you consulted about that?
9 DR. BAKER:
10 A. No, I came to know, from the November meeting,
11 that there were plans to reinstitute the ER/PR
12 testing in St. John's with a target date
13 somewhere in early 2007. I gathered from the
14 conversation that it was going to restricted
15 to St. John's initially, to the St. John's
16 hospitals, and not initially offered to
17 outside hospitals, even though Carbonear and
18 Clarenville were part of Eastern Health at the
19 time. So we weren't offered any--we continued
20 to send out ER/PRs to Mount Sinai.
21 COFFEY, Q.C.:
22 Q. And then what happened?
23 DR. BAKER:
24 A. There was no offer to have ER/PRs from our
25 area sent in until, it was December of 2007.

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1 COFFEY, Q.C.:
2 Q. Okay, and I'll come to that in a moment. So
3 in terms of the next--having left the meeting
4 or the presentation in November, you
5 understood they would reinstitute the testing
6 in St. John's?
7 DR. BAKER:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. But it wouldn't involve Carbonear, at least
11 initially?
12 DR. BAKER:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. And ER/PR testing in Carbonear continued on
16 through Mount Sinai?
17 DR. BAKER:
18 A. Correct, yes.
19 COFFEY, Q.C.:
20 Q. We understand that, in terms of the ER/PR
21 matter, of course, it became a matter of some
22 public notoriety in May of 2007.
23 DR. BAKER:
24 A. Correct.
25 COFFEY, Q.C.:

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1 Q. And at that time, up to that point, what was
2 the status of ER/PR matter in Carbonear, from
3 your perspective as the pathologist there?
4 What did you understand the status of it was
5 overall?
6 DR. BAKER:
7 A. We just continued to send our samples to Mount
8 Sinai.
9 COFFEY, Q.C.:
10 Q. And any investigation of it?
11 DR. BAKER:
12 A. No, in what respect?
13 COFFEY, Q.C.:
14 Q. In the sense of what might have caused the
15 problem or causes of the problem?
16 DR. BAKER:
17 A. No, not to my recollection, no.
18 COFFEY, Q.C.:
19 Q. Doctor, the results for Carbonear, okay, you'd
20 been provided with them, I take it on an
21 individual case?
22 DR. BAKER:
23 A. Yes, they would come back individually, yeah,
24 as an addended report, yes.
25 COFFEY, Q.C.:

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1 Q. Up to then May of 2007, had anyone offered to
2 provide you with kind of an overall summary
3 for Carbonear?
4 DR. BAKER:
5 A. No, I never received a summary.
6 COFFEY, Q.C.:
7 Q. Okay. Did you prepare one yourself?
8 DR. BAKER:
9 A. No, I didn't.
10 COFFEY, Q.C.:
11 Q. Up to May of 2007, had anyone ever asked you
12 "are you certain that that's all of the
13 patients? You, in Carbonear, have captured all
14 the patients?"
15 DR. BAKER:
16 A. No, I don't remember that comment coming my
17 way.
18 COFFEY, Q.C.:
19 Q. I'm not suggesting anyone did, I'm just asking
20 you if anyone asked you that.
21 DR. BAKER:
22 A. No, I don't remember any comment coming my way
23 in that regards.
24 COFFEY, Q.C.:
25 Q. Doctor, when we look here on the screen -

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1 DR. BAKER:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. - you'll see this is a--the memorandum below
5 it, it's to pathologists in Newfoundland.
6 It's from Dr. Denic and Dr. Carter, and it's
7 re: breast pathology and he begins by saying
8 "please find enclosed a number of evidence
9 based policies in current use at the St.
10 John's hospitals of Eastern Health. These
11 policies refer to the grossing and reporting
12 of breast specimens. These policies directly
13 address items that were identified in the
14 recent ER review as possible contributing
15 factors" and then it goes on from there, okay?
16 DR. BAKER:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. Did you ever receive this e-mail?
20 DR. BAKER:
21 A. I did, yes.
22 COFFEY, Q.C.:
23 Q. And we understand that, from some evidence
24 we've heard already, that about a week before
25 this, there was a conference call involving

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1 some senior officials throughout Newfoundland
2 from various health authorities. Did you
3 participate in that?
4 DR. BAKER:
5 A. No, I wasn't involved in that.
6 COFFEY, Q.C.:
7 Q. How is it that you came to get the e-mail?
8 DR. BAKER:
9 A. It was sent through, I believe, through Dr.
10 Nash Denic's office, through his secretary,
11 and I subsequently asked for a hard copy as
12 well, and it was forwarded to me from his
13 office.
14 COFFEY, Q.C.:
15 Q. And you received, there are a number here of--
16 he refers there to evidence based policies, a
17 number of them.
18 DR. BAKER:
19 A. Um-hm.
20 COFFEY, Q.C.:
21 Q. And I gather that these attachments are those?
22 DR. BAKER:
23 A. Yes, it was a fairly large document of 20-25
24 pages probably.
25 COFFEY, Q.C.:

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1 Q. And those particular policies and documents,
2 did you--I take it you reviewed them when you
3 received them?
4 DR. BAKER:
5 A. I reviewed them and if there were any changes
6 needed within my own procedures within the
7 lab, I instituted them immediately.
8 COFFEY, Q.C.:
9 Q. Do you recall what, if any, changes had to be
10 made at the time?
11 DR. BAKER:
12 A. I'm sure these--probably the -
13 COFFEY, Q.C.:
14 Q. And Doctor, if I could, because you don't have
15 the actual documents themselves in front of
16 you, if we could bring up, please, Exhibit P-
17 2195? Doctor, this is a copy of what was sent
18 to Dr. Neil, but -
19 DR. BAKER:
20 A. Yes, okay.
21 COFFEY, Q.C.:
22 Q. - there's a ductal carcinoma in situ reporting
23 document.
24 DR. BAKER:
25 A. Yes, it was mainly in relation to the way that

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1 things were reported, in my recollection. The
2 so-called synoptic reporting and so on, the
3 way that they would like to see the reports
4 issued, although over the course of the past
5 12 to 15 years, I had been using a form of
6 synoptic reporting, but not exactly similar to
7 this one. I received back in 1998 from Dr.
8 Khalifa at one point, a number of synoptic
9 check off form type lists. I don't know if
10 you've seen them or not.
11 COFFEY, Q.C.:
12 Q. We certainly had references to them, yes.
13 DR. BAKER:
14 A. Yes, and they were a form of synoptic
15 reporting and check offs for major malignancy
16 such as breast and ovary and uterus and kidney
17 and all those types of things, and I
18 instituted those at the time and was
19 essentially producing synoptic reports from
20 that point on, from '98 on.
21 COFFEY, Q.C.:
22 Q. And so if here there were changes in the
23 format or what the contents of what was
24 requested here, you implemented those?
25 DR. BAKER:

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1 A. I adjusted those, yes, implemented those.
2 COFFEY, Q.C.:
3 Q. And anything else, Doctor, in particular that
4 stands out in your mind?
5 DR. BAKER:
6 A. No, not essentially, no.
7 COFFEY, Q.C.:
8 Q. In an operational way, in terms of fixation or
9 grossing?
10 DR. BAKER:
11 A. No, because my standard procedure was
12 essentially basically the same. The issue
13 with fixation and making sure that tissue was
14 in fixative in a very short period of time was
15 always part of our course in Carbonear. There
16 wasn't an issue.
17 COFFEY, Q.C.:
18 Q. Doctor, while I'm on the topic, okay, of
19 written policies and procedures, if we could
20 bring up, I believe, Registrar, you've already
21 opened P-2157? I'm sorry. Yes, 2157.
22 Doctor, this is a document, it's very long,
23 it's 300 and some odd pages long.
24 DR. BAKER:
25 A. Um-hm.

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1 COFFEY, Q.C.:
2 Q. "Pathology Policies and Procedures Manual,
3 Table of Contents" and it goes on from there.
4 Have you seen this before, Doctor?
5 DR. BAKER:
6 A. Yeah, actually, I've seen portions of it.
7 Some of them were issued to us, singly and
8 have come to my attention to Carbonear in
9 single versions, several of these. I was just
10 recently supplied with a document and I
11 haven't reviewed it completely, which looks
12 very similar to this document, just supplied
13 to me recently, within the past month, that
14 contains, I would think, most of these things.
15 COFFEY, Q.C.:
16 Q. Yeah. In fact, it's here electronically it's
17 382 pages.
18 DR. BAKER:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. This particular one, so -
22 DR. BAKER:
23 A. Yeah, it's a fairly large binder that I
24 received.
25 COFFEY, Q.C.:

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1 Q. So the individual ones, when you began to
2 receive those, when would that have been?
3 DR. BAKER:
4 A. That was probably during--after Christmas of
5 this year, so probably January, February this
6 year, fixation policies. Some of them came in
7 draft form initially, then they came in final
8 form. Ones relating to tissue grossing and so
9 on, examination came again sometimes in draft
10 form and then in final form.
11 COFFEY, Q.C.:
12 Q. And what has your hospital done in relation to
13 those as they've been issued?
14 DR. BAKER:
15 A. We've implemented them as they've been issued,
16 yeah.
17 COFFEY, Q.C.:
18 Q. And the most recent large one, you're still in
19 the process of -
20 DR. BAKER:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. - having to go through it?
24 DR. BAKER:
25 A. Well, going through it and making sure that

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1 we're in compliance.
2 THE COMMISSIONER:
3 Q. Just a small technical point.
4 DR. BAKER:
5 A. Yes.
6 THE COMMISSIONER:
7 Q. If they're adopted when you receive them, do
8 they apply to you anyway because you're part
9 of Eastern Health?
10 DR. BAKER:
11 A. Oh, yes, that's correct, yes. They would be
12 just brought into our system and made sure
13 that they were put in place appropriately.
14 THE COMMISSIONER:
15 Q. Okay. So you don't actually have to go
16 through a separate procedure within your
17 institution?
18 DR. BAKER:
19 A. Oh, no, no, no. We're a part of Eastern
20 Health and we adopt them automatically.
21 THE COMMISSIONER:
22 Q. All right, thank you.
23 COFFEY, Q.C.:
24 Q. Now, Doctor, has anyone ever approached you
25 about having Carbonear resume ER/PR testing in

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1 St. John's?
2 DR. BAKER:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Okay. When did that happen?
6 DR. BAKER:
7 A. That happened in January of this year. I
8 received a call from Dr. Nash Denic indicating
9 that the service was available in St. John's
10 now and that I should send all samples from
11 Carbonear site to St. John's for ER/PR testing
12 as of that time.
13 COFFEY, Q.C.:
14 Q. And did you do so?
15 DR. BAKER:
16 A. I did do so, yes. And that applied up until
17 April of this year when testing was suspended
18 again.
19 COFFEY, Q.C.:
20 Q. And what then happened in April? Since April
21 what's been going on?
22 DR. BAKER:
23 A. Since April, I have been sending them back to
24 Mount Sinai Hospital. I was told in April,
25 with a telephone call from Dr. Denic, that

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1 they had to suspend testing because of the,
2 well, the reduction in the number of
3 pathologists there and the amiability to
4 correct interpretation and that he was making
5 arrangement with Mount Sinai to resume testing
6 for them.
7 COFFEY, Q.C.:
8 Q. So since April of 2008?
9 DR. BAKER:
10 A. 2008, yes.
11 COFFEY, Q.C.:
12 Q. Doctor, have you been dealing directly then
13 with Mount Sinai again or -
14 DR. BAKER:
15 A. Yes, again, in a similar fashion as I was
16 before, yeah, sending off the--selecting the
17 blocks and sending them off with a copy of the
18 patient report and the request form for ER/PR
19 and HER2/neu.
20 COFFEY, Q.C.:
21 Q. And what's the current status of that
22 arrangement, have you been advised of anything
23 any different?
24 DR. BAKER:
25 A. No. It's still ongoing the same way.

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1 COFFEY, Q.C.:
2 Q. Have you been advised of any plans?
3 DR. BAKER:
4 A. No.
5 COFFEY, Q.C.:
6 Q. To change in that regard?
7 DR. BAKER:
8 A. No, nothing, no, nothing at all.
9 COFFEY, Q.C.:
10 Q. Doctor, could, Doctor, Exhibit P-2524?
11 Doctor, this is some handwritten notes,
12 they've been identified to us as being of, I
13 think, Dr. Denic.
14 DR. BAKER:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. There's a note here June 13th, '08. Dr. Gary
18 Baker. And do you recall this evidence is
19 apparently a phone calls. It says told "he
20 must do CME activities as per Royal College
21 requirements."
22 DR. BAKER:
23 A. Um-hm.
24 COFFEY, Q.C.:
25 Q. "Encourage to attend the meetings and

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1 workshop. Asked to contact Dr." somebody in
2 Clarenville.
3 DR. BAKER:
4 A. Dr. Khan in Clarenville.
5 COFFEY, Q.C.:
6 Q. Khan, in Clarenville, to do QC, presumably
7 that's QA in pathology?
8 DR. BAKER:
9 A. That's in--will I explain?
10 COFFEY, Q.C.:
11 Q. If you would, please?
12 DR. BAKER:
13 A. That's in relation to a similar type situation
14 that as instituted in St. John's within the
15 past year where there would be auditing of
16 patients' slides. There would be a selection
17 of patients' slides taken from recently
18 reported cases, a selection of them, probably
19 a dozen a month or so and reviewed by external
20 pathologists. So in St. John's they would be
21 reviewing them between themselves in there,
22 because there are a certain--a large number of
23 pathologists.
24 COFFEY, Q.C.:
25 Q. Um-hm.

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1 DR. BAKER:
2 A. In Carbonear there was an agreement made that
3 I would send my slides to Clarenville and
4 Clarenville would send their slides to me, and
5 that has been instituted for external review.
6 And a report would be issued by each of the
7 pathologists upon review to the pathologist
8 indicating if there was any discrepancies.
9 COFFEY, Q.C.:
10 Q. And the choice of cases to -
11 DR. BAKER:
12 A. Would be random.
13 COFFEY, Q.C.:
14 Q. Random. And who is the random number
15 generator?
16 DR. BAKER:
17 A. The random number generator would be the
18 secretary.
19 COFFEY, Q.C.:
20 Q. The secretary, okay. And that happened, that
21 was instituted when, Doctor, I'm sorry?
22 DR. BAKER:
23 A. Within the past three months.
24 COFFEY, Q.C.:
25 Q. Okay. Doctor, has there been any written

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1 direction in this regard? I appreciate that
2 this is a note about the conversation, but -
3 DR. BAKER:
4 A. No, there's been no written direction. Dr.
5 Denic visited me just a couple of weeks ago
6 and indicated, I indicated to him that it has
7 been instituted. He asked if there were
8 reports issued. I indicated, yes, from the
9 reviewing pathologist in Clarenville. And
10 just before I came out here today, actually, I
11 received slides from Clarenville to review for
12 them, as well, so the thing is instituted and
13 is working.
14 COFFEY, Q.C.:
15 Q. Doctor, is this just--when I say just, I don't
16 mean to minimize it in any way.
17 DR. BAKER:
18 A. No.
19 COFFEY, Q.C.:
20 Q. But does this just involve slides or is it
21 kind of a case review overall?
22 DR. BAKER:
23 A. No, it just involves slides. What we would do
24 would be select the actual surgical slides and
25 a copy of the report that was issued by

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1 myself, send them to the reviewing pathologist
2 and he would review and either agree or
3 disagree. If he disagreed, then he would
4 highlight his disagreement.
5 COFFEY, Q.C.:
6 Q. Okay. So -
7 DR. BAKER:
8 A. And that would come back to me for either an
9 addendum to the report if necessary, if it was
10 a significant disagreement, or--and for
11 education purposes, as well. So for
12 discussion with him.
13 COFFEY, Q.C.:
14 Q. In reviewing these slides now, for example,
15 the ones that just arrived in your
16 institution, you'd have the reports and the
17 related slides?
18 DR. BAKER:
19 A. Correct.
20 COFFEY, Q.C.:
21 Q. Related to his reports?
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And you'd go through the slides, make your

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1 own--come to your own conclusions and look at
2 his report and see if you agreed, disagreed or
3 what you agreed or disagreed on?
4 DR. BAKER:
5 A. That's right.
6 COFFEY, Q.C.:
7 Q. And report accordingly?
8 DR. BAKER:
9 A. And actually, when I send mine out there, I
10 always send blocks along, as well if he wanted
11 to re-cut slides to make sure.
12 COFFEY, Q.C.:
13 Q. Okay. Doctor, the matter of identifying
14 patients in the Carbonear area, were there
15 some patients who were missed in the first
16 time through?
17 DR. BAKER:
18 A. Yes, there were.
19 COFFEY, Q.C.:
20 Q. And when did you first become aware of that
21 and the circumstances? Perhaps you could tell
22 the Commissioner about that?
23 DR. BAKER:
24 A. I became aware of a number of missed patients
25 in September of 2007. There had been--it was

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1 in between holidays that I was taking. I'd
2 just come back from holidays in July and--or
3 sorry, August, and there was a request on my
4 desk from Terry Gulliver to bring together all
5 the reports, both negative and positive, for
6 ER/PR and compile them for Dr. Reza because he
7 was doing a database. So I instructed my
8 secretary at the time, who wasn't my regular
9 secretary, she was a casual that was in place,
10 to gather together all those reports again
11 because originally it was just the negatives,
12 so we had go looking for the positive again.
13 And we got all those together, compiled them,
14 and I think she just finished the task just
15 before I went away on holidays for another
16 week or so again. And she divided them into
17 negative and positive and to years and
18 submitted them to Terry Gulliver in St. John's
19 for use by Dr. Reza for his compilation of a
20 database. And I asked her before I left on
21 holidays to make sure that she did a xerox
22 copy of all the reports that she had compiled
23 and put them in the filing cabinet so I could
24 review them when I got back from my holidays.
25 When I got back from my holidays, that was

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1 early September, I did take out the folder of
2 reports, both the positive and the negative.
3 I reviewed the negatives and everything seemed
4 fine. I reviewed the positive and as I was
5 going through, I noted, came across one that
6 was--and it's my way of reporting, I reported
7 positive as anything above zero. And I noted
8 one there that in one year, I think it was
9 '98, I don't remember the name, that was
10 reported as positive, you know, 15 to 20
11 percent and so on. And I just, something just
12 tweaked in me, something just--and said, well,
13 if this is in the positive pile, I wonder if
14 these were actually, actually retested. So I
15 went and checked the actual ones that we had
16 sent in and it wasn't.
17 COFFEY, Q.C.:
18 Q. For retesting, yeah.
19 DR. BAKER:
20 A. For retesting, hadn't been sent in for
21 retesting. So then I said, well, you know, if
22 there's one, there may be others. So I went
23 down and went through the whole list of the
24 positive that was there and I detected ten of
25 the positive that hadn't been sent in for

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1 retesting that really should have fallen into
2 the category of negative that were below the
3 30 percent.
4 COFFEY, Q.C.:
5 Q. This cutoff point, this 10, 30 percent cutoff?
6 DR. BAKER:
7 A. That's right, yes.
8 COFFEY, Q.C.:
9 Q. Which I -
10 DR. BAKER:
11 A. Yes, alluded to earlier.
12 COFFEY, Q.C.:
13 Q. Alluded to earlier.
14 DR. BAKER:
15 A. Yes. So I immediately took those out. I had
16 a conversation with Dr. Oscar Howell about the
17 discovery of these cases and after that I
18 indicated to him that I had discovered the ten
19 cases and he said he would get Terry Gulliver
20 to call me. Terry did call me that afternoon
21 and we were just in the process of trying to
22 get together the slides and the blocks and all
23 the reports to be sent in. So the following
24 day we sent all the cases in to Terry Gulliver
25 for retesting. He received them and the

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1 testing was done but it was done over a period
2 of time because we were given the indication
3 from Mount Sinai that they were backlogged
4 with work so some of their reports didn't come
5 back from those retests, those delayed retests
6 until well into the fall, probably before
7 Christmas and some maybe even after Christmas.
8 COFFEY, Q.C.:
9 Q. And what then happened with those reports when
10 they came back?
11 DR. BAKER:
12 A. Those reports were handled in the same way.
13 They were included into, as an addendum into
14 the original patients' report. They were
15 signed out by myself after verification and
16 sent to the surgeon involved and also to the
17 oncologist or to the oncology clinics, cancer
18 clinic in St. John's. And I assume that they
19 would have been handled in the same, a similar
20 fashion as all the rest of the ones would have
21 been handled in town, they would have been
22 vetted through the tumour panel, if necessary
23 if there were conversions and the people
24 notified through the appropriate avenues in
25 there.

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1 COFFEY, Q.C.:
2 Q. Do you know if, in fact, they did end up going
3 through a tumour panel? You assume so, yes.
4 DR. BAKER:
5 A. I'm not sure, I'm not sure, I have no idea.
6 There were some conversions.
7 COFFEY, Q.C.:
8 Q. And but in terms of the information you got
9 back, the reports on individual patients, the
10 ten patients, you followed the same process
11 you had before in terms of -
12 DR. BAKER:
13 A. Correct.
14 COFFEY, Q.C.:
15 Q. Make sure it was on their chart, make sure the
16 cancer clinic had it and the attending
17 physician?
18 DR. BAKER:
19 A. Yes. I tried to cover all bases.
20 COFFEY, Q.C.:
21 Q. Doctor, the matter of the deceased patients.
22 DR. BAKER:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. How did Carbonear handle that?

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1 DR. BAKER:
2 A. The deceased patients, and that brings a
3 comment to mind, back in the very beginning, I
4 think it was probably in July, in one of the
5 conversations I had with Don Cook, it was
6 probably the second conversation about the
7 broader scope of the examination, I did ask
8 about deceased patients and the comment was
9 made that, no, we haven't decided to do
10 deceased patients yet, we will let you know
11 when we're going to to do them or if and when
12 we're going to do them. So I said, okay,
13 fine, we'll just concentrate on the living
14 patients right now and we'll get all those
15 together. I heard no word about deceased
16 patients until the conversation I had with
17 Terry Gulliver on the day that I had, those
18 two days I had discovered those ten reports.
19 COFFEY, Q.C.:
20 Q. Yes.
21 DR. BAKER:
22 A. And he just off the cuff had made a comment,
23 well, I'll send them off with the deceased
24 patients that I'm sending off now. And I
25 said, Terry, you're sending off deceased

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1 patients now? I said, no one notified me. So
2 we went through our files again and found, I
3 think it was three or four deceased patients
4 that we also included in the bundle that we
5 sent in with the ones that I had found. Other
6 than that, I wouldn't have known.
7 COFFEY, Q.C.:
8 Q. And the deceased patients, those three or four
9 patients, their tissue samples, have they been
10 retested?
11 DR. BAKER:
12 A. Yes, they have.
13 COFFEY, Q.C.:
14 Q. And how about their reports, what's the status
15 on that?
16 DR. BAKER:
17 A. They were forwarded back to me, as well and
18 they've been included.
19 COFFEY, Q.C.:
20 Q. In the same way?
21 DR. BAKER:
22 A. Same way.
23 COFFEY, Q.C.:
24 Q. Same way that -
25 DR. BAKER:

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1 A. To my knowledge they have been, yes.
2 COFFEY, Q.C.:
3 Q. You've put them through the same--your own
4 same process?
5 DR. BAKER:
6 A. Same process, yes.
7 COFFEY, Q.C.:
8 Q. Dictated to the chart and notifying the
9 physician, the attending physician?
10 DR. BAKER:
11 A. Physician and the cancer clinic, yes.
12 COFFEY, Q.C.:
13 Q. And if their families are to be notified about
14 the existence of those results and what those
15 results were, I take it that whose, from your
16 perspective, whose responsibility is that
17 decision?
18 DR. BAKER:
19 A. Through the quality assurance people in St.
20 John's. I assume that that was the process
21 that was going to take place. I haven't been
22 notified anything different.
23 COFFEY, Q.C.:
24 Q. And, Doctor, in terms of the patients, the
25 ten, group of ten, their retest results, the

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1 actual patients being notified of that, your
2 understanding is that who was handling that?
3 DR. BAKER:
4 A. The quality assurance people, information
5 people in St. John's.
6 COFFEY, Q.C.:
7 Q. If we could, please, Doctor, give the
8 Commissioner some sense of this, if we could
9 bring up, please Exhibit C-0026, please?
10 Doctor, this is the report, department of
11 laboratory medicine, Carbonear General
12 Hospital report, for Elizabeth White?
13 DR. BAKER:
14 A. Yeah.
15 MR. SIMMONS:
16 Q. She's testified here and this is a report that
17 would have been prepared, if we go to the
18 second page, would have been prepared by
19 yourself?
20 DR. BAKER:
21 A. Correct.
22 COFFEY, Q.C.:
23 Q. I take it. And this would be, now the first
24 diagnostic report, I take it?
25 DR. BAKER:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. This is the sort of report this would be. We
4 look at the date here, October 25th, 1999?
5 DR. BAKER:
6 A. Correct, yeah.
7 COFFEY, Q.C.:
8 Q. Okay, so. And, Doctor, you've indicated that
9 you'd make the initial report and then order
10 an ER/PR test and wait for the slides to come
11 in in order to do the report relating to ER/PR
12 status?
13 DR. BAKER:
14 A. Correct.
15 COFFEY, Q.C.:
16 Q. Exhibit, the same exhibit, page 3. I
17 apologize. Yeah, page 3. Doctor, this is
18 again it's for Ms. White. And here is your
19 report, it's November 4th, 1999 and it's
20 styled addendum report. And it says,
21 "Estrogen receptors-positive (20-30 percent of
22 cells) and progesterone receptors-positive-(10
23 percent of cells)."
24 DR. BAKER:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. So, Doctor, that's the reporting style, I take
3 it, that you described to us earlier today?
4 DR. BAKER:
5 A. Correct.
6 COFFEY, Q.C.:
7 Q. If it was--if the number inside the brackets
8 was anything other than zero?
9 DR. BAKER:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. It was positive, you used the word "positive"?
13 DR. BAKER:
14 A. Yes, I did.
15 COFFEY, Q.C.:
16 Q. Inside the brackets. And if, however, it was
17 zero inside the brackets, zero percent of
18 cells, then you would describe it as negative?
19 DR. BAKER:
20 A. Correct.
21 COFFEY, Q.C.:
22 Q. And, Doctor, then the--this particular patient
23 as an example, okay, potentially, here,
24 looking at this, Doctor, would this have been
25 picked up in the first search for retesting,

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1 would this have been identified as one to be
2 retested?
3 DR. BAKER:
4 A. No, no, it wasn't. This was picked up by
5 myself in those ten that I discovered in
6 September. And when I went back to check
7 whether or not it had been sent in, this
8 specimen had already been requested in August,
9 it had been sent in in August, so I discovered
10 after the fact that it had already been sent
11 in, requested in August of 2007.
12 COFFEY, Q.C.:
13 Q. Did you make any -
14 DR. BAKER:
15 A. So she was part of the ten that I had
16 discovered.
17 COFFEY, Q.C.:
18 Q. She was part of the ten?
19 DR. BAKER:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. And when you actually went to get her material
23 -
24 DR. BAKER:
25 A. It was gone.

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1 COFFEY, Q.C.:
2 Q. It was gone. And did you make any inquiries
3 about what had happened in the--to cause it to
4 go before you ever got around to identifying
5 it?
6 DR. BAKER:
7 A. There was a request that came in from St.
8 John's for us just to send the blocks in to
9 St. John's for, it didn't say for anything, it
10 just said--usually the request will come out
11 and say we require the blocks of such and
12 such, please send them in immediately.
13 COFFEY, Q.C.:
14 Q. And had you been aware that, in fact, that it
15 happened in respect to this particular
16 patient?
17 DR. BAKER:
18 A. Was I made aware?
19 COFFEY, Q.C.:
20 Q. Were you aware of it in August that this had
21 happened?
22 DR. BAKER:
23 A. Not to my recollection, I can't.
24 COFFEY, Q.C.:
25 Q. It could have happened, for example, while you

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1 were on vacation?
2 DR. BAKER:
3 A. Could have very well, yes.
4 COFFEY, Q.C.:
5 Q. But you then -- she was amongst the ten?
6 DR. BAKER:
7 A. Yes, she was amongst the ten when I discovered
8 the ten in September.
9 COFFEY, Q.C.:
10 Q. Doctor, one of the things I did want to ask
11 you about in relation to this, if we could
12 look at Exhibit C-0027, please. Now, Doctor,
13 this is the -- again a copy of your pathology
14 report from Ms. White.
15 DR. BAKER:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And it's the same, in fact -- a different
19 photocopy size of the same page we looked at
20 before.
21 DR. BAKER:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. C-0026, but when we look at page three of
25 this, which is the addendum page.

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1 DR. BAKER:
2 A. Uh-hm.
3 COFFEY, Q.C.:
4 Q. In the report --
5 DR. BAKER:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Again the typed account here is the same as
9 the one we just looked at.
10 DR. BAKER:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. But here someone has scratched out the words
14 "positive" and written over the first one for
15 estrogen negative, and below the second one
16 for progesterone "negative".
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Did you make that alteration?
21 DR. BAKER:
22 A. No, that's not my writing.
23 COFFEY, Q.C.:
24 Q. Do you know whose it is, Doctor?
25 DR. BAKER:

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1 A. No, I don't.
2 COFFEY, Q.C.:
3 Q. I would point out, Commissioner, that that
4 particular copy may not have come from
5 Carbonear itself as we have received records
6 from elsewhere than actual Carbonear --
7 DR. BAKER:
8 A. It could have -- I mean, it could have been a
9 copy of the report from the oncology files,
10 you know.
11 COFFEY, Q.C.:
12 Q. Yes. So, Doctor, just a couple of other
13 questions. You've referred to -- of course,
14 you've had a long term working relationship
15 with this technologist in pathology there at
16 your hospital for many years.
17 DR. BAKER:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. What's the nature of your interaction over the
21 years with your pathology technologist in the
22 sense of how frequent is it?
23 DR. BAKER:
24 A. The interaction?
25 COFFEY, Q.C.:

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1 Q. Yes.
2 DR. BAKER:
3 A. It's on a daily basis consistent -- my office
4 is within the actual pathology section. Every
5 time I come outside my office door, my
6 technologist is there on the bench. We're
7 talking constantly on a daily basis.
8 COFFEY, Q.C.:
9 Q. So that if there were any problems that --
10 it's a he?
11 DR. BAKER:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. He could raise it with you -- he's raised them
15 with you?
16 DR. BAKER:
17 A. He has raised any issues with me over the
18 years, yes.
19 COFFEY, Q.C.:
20 Q. And if you had any concerns at all, you --
21 DR. BAKER:
22 A. Would raise them with him, yes.
23 COFFEY, Q.C.:
24 Q. Doctor, on one point, practising pathology as
25 a sole practitioner, and you've been doing it

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1 for a while --
2 DR. BAKER:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Twenty-five years. Doctor, what challenges
6 does that present, has it presented to you, if
7 any? Are there advantages; if so, what are
8 they; if there are any disadvantages, what are
9 they?
10 DR. BAKER:
11 A. It's difficult at times because you're -- the
12 disadvantage, I suppose, is that you're the
13 only individual there. You're on call
14 consistently throughout the day and the
15 weekends and so on for any issues that arise,
16 so the work commitment is heavy. I've made
17 myself accustomed to it. You know, I enjoy --
18 the commitment is there and I devote my time
19 to it. Another drawback would be that at times
20 it's nice to have a companion to slip a slide
21 to and say what do you think of that. There
22 are difficult cases, but I've always -- I know
23 my limitations and I've always utilized the
24 service in St. John's, my colleagues in there;
25 Dr. Denic, Dr. Cook, Dr. Elms, and so on over

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1 the years. I'd send in a consultation and
2 say, you know, this is my interpretation, what
3 do you think, and they always obliged me and
4 given me their opinion and so on. If they
5 can't give me their opinion, they'll send it
6 off somewhere else to get an opinion.
7 COFFEY, Q.C.:
8 Q. Doctor, is there an opportunity available for
9 you to take part via video-conferencing, for
10 example, in any kind of rounds in St. John's?
11 DR. BAKER:
12 A. There may be, but I haven't investigated that.
13 There may possibly be. We don't have a video-
14 conferencing centre in Carbonear. The closest
15 place for me to probably avail of video-
16 conferencing would be in the College of the
17 North Atlantic in Carbonear. So it's kind of
18 an inconvenient type of situation. We have
19 some teleconferencing facilities. Over the
20 years, I have been involved in a fair number
21 of teleconferencing of Telemedicine seminars
22 and conferencing related to pathology and so
23 on, and I've availed of those. I've availed of
24 -- as I said before previously in testimony,
25 you know, visiting speakers and so on, I avail

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1 of those, but being a sole practitioner, it's
2 difficult sometimes to break away from your
3 practice and go in town and attend rounds and
4 then drive back home again.
5 COFFEY, Q.C.:
6 Q. Oh, yes.
7 DR. BAKER:
8 A. It would certainly interrupt your work day and
9 interrupt your commitment to the work you had
10 to do.
11 COFFEY, Q.C.:
12 Q. Doctor, the ability to participate in
13 continuing medical education that does not
14 occur in St. John's, like, it occurs outside
15 the province, what has been that --
16 DR. BAKER:
17 A. It's been sporadic. It's difficult to get
18 locums at times to fill in to allow you to
19 travel to outside conferences.
20 COFFEY, Q.C.:
21 Q. Who's responsible for getting locums?
22 DR. BAKER:
23 A. For getting locums, myself, and it's difficult
24 to get locums for a vacation for a few weeks,
25 let alone to have them come on the spur of the

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1 moment for a three or four day conference. So
2 it's been sporadic over the years, and the
3 funding has been also not very great for that
4 type of activity. In our present old avalon
5 board and presently it still exists, there's a
6 great deal of variability in funding
7 throughout the various boards. Right now -- we
8 got a maximum of $500.00 a year for CME
9 funding for travelling to conferences.
10 COFFEY, Q.C.:
11 Q. You say "we". Is it -
12 DR. BAKER:
13 A. We did. Now it's $5,000.00.
14 COFFEY, Q.C.:
15 Q. Okay.
16 DR. BAKER:
17 A. But we did.
18 COFFEY, Q.C.:
19 Q. Up until recently it's was?
20 DR. BAKER:
21 A. $500.00.
22 COFFEY, Q.C.:
23 Q. $500.00, and it was $500.00 what, for you?
24 DR. BAKER:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. Individual doctors, it was $500.00?
3 DR. BAKER:
4 A. $500.00.
5 COFFEY, Q.C.:
6 Q. Per year?
7 DR. BAKER:
8 A. Yes, that's correct.
9 COFFEY, Q.C.:
10 Q. Commissioner, those are the questions I have
11 for the doctor. Thank you.
12 THE COMMISSIONER:
13 Q. Thank you.
14 MS. BRAZIL:
15 Q. No questions, Commissioner.
16 THE COMMISSIONER:
17 Q. Mr. Simmons.
18 COFFEY, Q.C.:
19 Q. Actually, if I could, Mr. Simmons, just one --
20 I apologize, Commissioner, just one thing, if
21 I could. Doctor, just on the -- I had meant to
22 ask you this. On this effort to identify
23 these ten patients, has there been any efforts
24 since to kind of go back through everything
25 again?

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1 DR. BAKER:
2 A. No.
3 COFFEY, Q.C.:
4 Q. Like, that effort at the time, was that the
5 last effort in Carbonear to identify patients,
6 last search?
7 DR. BAKER:
8 A. Yes, it was.
9 COFFEY, Q.C.:
10 Q. That was it?
11 DR. BAKER:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Doctor, I'm sorry, I just wanted to clarify
15 that, Commissioner. Thank you.
16 THE COMMISSIONER:
17 Q. Nothing arising out of that was there, Ms.
18 Brazil?
19 MS. BRAZIL:
20 Q. No.
21 THE COMMISSIONER:
22 Q. Okay, Mr. Simmons.
23 DR. GARY BAKER - EXAMINATION BY MR. DAN SIMMONS
24 MR. SIMMONS:
25 Q. Thank you, Commissioner, only one question,

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1 one point, Dr. Baker. Exhibit C-0224, please.
2 This is a pathology report that you commented
3 on earlier?
4 DR. BAKER:
5 A. Yes.
6 MR. SIMMONS:
7 Q. And it's the one where you described how there
8 was a primary sample, primary breast lesion
9 sample that had originally been tested as ER
10 negative PR negative, it was retested at Mount
11 Sinai and continued to be negative and
12 negative?
13 DR. BAKER:
14 A. Yes.
15 MR. SIMMONS:
16 Q. And there was also a subsequent -- well, there
17 had been an ER/PR test done on a lymph node?
18 DR. BAKER:
19 A. Yes.
20 MR. SIMMONS:
21 Q. Was the lymph node also retested at Mount
22 Sinai or not?
23 DR. BAKER:
24 A. No, the lymph node was -- I can't answer that
25 question, I'm not sure. I assume that it was

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1 retested in St. John's, but I'm not sure.
2 MR. SIMMONS:
3 Q. Okay.
4 DR. BAKER:
5 A. I don't have a copy of that report.
6 MR. SIMMONS:
7 Q. The note here says that, "Baker reports ER 70
8 percent on Ventana. Cook and Carter reviewed
9 and found ER less than 5 percent". So --
10 MR. SIMMONS:
11 Q. From that I infer that they reviewed the -- my
12 slides.
13 MR. SIMMONS:
14 Q. Your slides.
15 DR. BAKER:
16 A. And gave a different interpretation.
17 MR. SIMMONS:
18 Q. Right, so the reference to their being false
19 positive here refers to the lymph node and
20 appears to be based on a reinterpretation of
21 the original slide, not the preparation of a
22 new slide, is that fair?
23 DR. BAKER:
24 A. Yes.
25 MR. SIMMONS:

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1 Q. Okay, thank you.
2 THE COMMISSIONER:
3 Q. Mr. Pritchett?
4 MR. PRITCHETT:
5 Q. No questions, Commissioner.
6 THE COMMISSIONER:
7 Q. Ms. Newbury.
8 DR. GARY BAKER - EXAMINATION BY MS. JENNIFER NEWBURY
9 MS. NEWBURY:
10 Q. Good afternoon, Dr. Baker. My name is
11 Jennifer Newbury and I represent the Canadian
12 Cancer Society, Newfoundland and Labrador
13 Division. I just have a couple of questions
14 for you. First of all, could you advise what
15 our practise is at Carbonear Hospital in terms
16 of using the Cancer Registry reporting any
17 tumours, for example, to the Cancer Registry?
18 DR. BAKER:
19 A. We have always over the years provided hard
20 copies of all tumours diagnosed in Carbonear
21 to the Cancer Registry. We are linked within
22 the past, I think probably two years, two and
23 a half years, via computer terminal, and
24 everything that's diagnosed as a carcinoma in
25 any organ is automatically transmitted to the

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1 Cancer Registry.
2 MS. NEWBURY:
3 Q. Okay, and so over the last couple of years,
4 it's electronically; before that, hard copies?
5 DR. BAKER:
6 A. Yes.
7 MS. NEWBURY:
8 Q. And that was consistent since you were there
9 in 1983?
10 DR. BAKER:
11 A. Correct, yes.
12 MS. NEWBURY:
13 Q. And what types of information would be
14 included in that?
15 DR. BAKER:
16 A. It would be a full copy of the report issued
17 by myself on a patient tissue.
18 MS. NEWBURY:
19 Q. And who at the Carbonear Hospital is
20 responsible for this function?
21 DR. BAKER:
22 A. Well, the electronic form now is automatically
23 transported via the computer terminal once
24 it's been typed into the system by my
25 secretary. Previous to that, she would also

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1 take xerox copies of the original report and
2 send them to the Tumour Registry.
3 MS. NEWBURY:
4 Q. And do you ever use information or look to a
5 Cancer Registry for information for any
6 reason, for any part of your practice?
7 DR. BAKER:
8 A. I haven't, no.
9 MS. NEWBURY:
10 Q. And did you contact the Cancer Registry to
11 assist you when the ER/PR problem arose in
12 identifying patients whose specimens needed to
13 be retested?
14 DR. BAKER:
15 A. No, I didn't.
16 MS. NEWBURY:
17 Q. And is there any reason why you didn't do
18 that?
19 DR. BAKER:
20 A. I just didn't think of it at the time,
21 actually, to be honest.
22 MS. NEWBURY:
23 Q. Okay. You were discussing a little earlier
24 today about the recent procedure that's been
25 adopted for auditing slides.

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1 DR. BAKER:
2 A. Yes.
3 MS. NEWBURY:
4 Q. You've indicated that's been done for the last
5 three or four months, I believe?
6 DR. BAKER:
7 A. Yes.
8 MS. NEWBURY:
9 Q. And are the results of these reviews recorded
10 in individual patient files?
11 DR. BAKER:
12 A. No -- well, if there are any variations in
13 opinions, they would be issued as an addendum
14 to the patient's report. If there are no
15 changes in the diagnosis or any variation in
16 some characteristics of the diagnosis that was
17 made, then they would not be entered into the
18 patient report, no.
19 MS. NEWBURY:
20 Q. And in the example or situation where there
21 has been a different opinion, I assume that
22 it's added in as an addendum to the report?
23 DR. BAKER:
24 A. Yes.
25 MS. NEWBURY:

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1 Q. And then the referring physician would --
2 DR. BAKER:
3 A. Would get a copy of it, yes.
4 MS. NEWBURY:
5 Q. Would take that into account --
6 DR. BAKER:
7 A. Yes.
8 MS. NEWBURY:
9 Q. And proceed accordingly. Are there any
10 overall reports generated to, I guess, analyze
11 or to track trends for any discrepancies that
12 might happen over a period of time?
13 DR. BAKER:
14 A. Not at the present time there isn't, no.
15 MS. NEWBURY:
16 Q. And do you know of any plans for that to take
17 place?
18 DR. BAKER:
19 A. Not that I'm aware of, unless there's some
20 plans that will be coming down through Dr.
21 Denic and so on (unintelligible).
22 MS. NEWBURY:
23 Q. Okay, and this was initiated by Dr. Denic, was
24 it?
25 DR. BAKER:

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1 A. Well, it was originally initiated in St.
2 John's back, I think, last fall, and then it
3 was just fanned out to the rest of the region
4 this spring and summer.
5 MS. NEWBURY:
6 Q. And are you required to provide any
7 information whatsoever about the results, the
8 numbers of tests, the types of tests, and what
9 the results are?
10 DR. BAKER:
11 A. In relation to the auditing?
12 MS. NEWBURY:
13 Q. Yes.
14 DR. BAKER:
15 A. Yes, the reports that I receive back from the
16 auditing pathologist are available and will be
17 made available to Dr. Denic.
18 MS. NEWBURY:
19 Q. Thank you, and in selecting the random cases,
20 you indicated that your secretary is involved
21 in doing that?
22 DR. BAKER:
23 A. Uh-hm.
24 MS. NEWBURY:
25 Q. Does she have any direction to cover a cross-

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1 section of cases within the laboratory, for
2 example, different tumour sites or different
3 tests that might be done for tumour sites?
4 DR. BAKER:
5 A. Not really, no, just a broad selection and so
6 on, she would -- nothing specific, no.
7 MS. NEWBURY:
8 Q. And do you know if there are any plans to
9 analyze the data that might be collected, for
10 example, over the course of a year or two just
11 to ensure that there is a representative
12 sample?
13 DR. BAKER:
14 A. That is the intent, I think, yes.
15 MS. NEWBURY:
16 Q. Okay, and where did you learn that information
17 that that was --
18 DR. BAKER:
19 A. That would have come from Dr. Denic as well.
20 MS. NEWBURY:
21 Q. And when you're reviewing slides that come to
22 you from Clarenville, what types of issues
23 would you expect to detect in your view, and I
24 guess I'm referring to the different phases of
25 a laboratory test, and more particularly, are

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1 you looking at interpretation issues only or
2 could you be able to detect issues with the
3 technical preparation of the slides, any pre-
4 analytical fixation issues, as an example?
5 DR. BAKER:
6 A. Well, if there was anything there that I
7 detected and I felt should be drawn to the
8 attention of the pathologist concerned, then I
9 would do so. I'm mainly looking at diagnosis,
10 appropriate diagnosis being -- you know, my
11 interpretation being consistent with him, the
12 grading of the tumours and so on, that type of
13 thing.
14 MS. NEWBURY:
15 Q. And would you comment on the general quality
16 of the slide? I understand that there might
17 be some cases where the quality may not be
18 great, but a pathologist might be comfortable
19 in making an interpretation and making a
20 diagnosis --
21 DR. BAKER:
22 A. Uh-hm.
23 MS. NEWBURY:
24 Q. But would you, just in a view to looking at
25 the overall quality of what's being produced,

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1 would you comment even if you can make an
2 interpretation on the quality of the slides?
3 DR. BAKER:
4 A. Yes, I would, I would.
5 MS. NEWBURY:
6 Q. Thank you, Dr. Baker, those are the questions
7 I have.
8 THE COMMISSIONER:
9 Q. Thank you. Ms Brocklehurst.
10 MS. BROCKLEHURST:
11 Q. No, Commissioner, thank you.
12 THE COMMISSIONER:
13 Q. Mr. Pike.
14 MR. PIKE:
15 Q. No questions, thank you.
16 THE COMMISSIONER:
17 Q. Mr. Browne.
18 DR. GARY BAKER - EXAMINATION BY MR. PETER BROWNE
19 MR. BROWNE:
20 Q. Dr. Baker, good afternoon. Just one question
21 I want to canvas with you, a very short one.
22 Carbonear was very late in the game getting
23 Meditech, is that correct? I think it was
24 2004.
25 DR. BAKER:

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1 A. Yes, late 2003/2004, yes.
2 MR. BROWNE:
3 Q. And the system it has in place now that you're
4 part of Eastern Health, are you able to link
5 into other sites within Eastern Health, I
6 guess, geographic area, for instance? Can
7 Meditech at Carbonear link into the Cancer
8 Clinic or Health Sciences Centre?
9 DR. BAKER:
10 A. No, it can't.
11 MR. BROWNE:
12 Q. So there's no interfacing capabilities with
13 the Meditech System?
14 DR. BAKER:
15 A. Not at the present time, no.
16 MR. BROWNE:
17 Q. Are you aware of any intentions in the future
18 to sort of make that linking available?
19 DR. BAKER:
20 A. No, I'm not.
21 MR. BROWNE:
22 Q. Finally, Doctor, the Commissioner invites
23 anybody who sits in that chair to make any
24 comments, observations, or recommendations,
25 and this would be your opportunity if you wish

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1 to do so.
2 DR. BAKER:
3 A. I have no specific comments, but I'd just like
4 to thank -- take the opportunity to thank the
5 Commission for having me here and providing
6 the information, and I wish them well in their
7 deliberations and hopefully what comes out of
8 the Commission will benefit all in the health
9 care system.
10 THE COMMISSIONER:
11 Q. There's one small point perhaps you can
12 clarify for me out of your evidence earlier
13 today. Would you bring up Exhibit 2525,
14 please, P-2525. This was providing you with
15 information in June of 2005.
16 DR. BAKER:
17 A. Yes.
18 THE COMMISSIONER:
19 Q. And this was shown to you by Mr. Coffey in the
20 examination this morning.
21 DR. BAKER:
22 A. Yes.
23 THE COMMISSIONER:
24 Q. And you said in answer to his question this
25 morning that on reading this, your -- what you

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1 said was that you tended to the view. I'm
2 presuming your interpretation of what had been
3 provided to you was that it was a technical
4 problem in their staining system?
5 DR. BAKER:
6 A. Yes, I'd just inferred from that that they
7 were referencing the two systems there and so
8 on, and I just inferred from that that there
9 may have been some technical problem that they
10 were trying to resolve.
11 THE COMMISSIONER:
12 Q. My question is, what do you mean by technical
13 problem?
14 DR. BAKER:
15 A. Just some problem with the actual systems and
16 staining of the slides.
17 THE COMMISSIONER:
18 Q. Does that mean with the operation of the
19 machinery, does that mean with --
20 DR. BAKER:
21 A. Could be a whole broad spectrum of -- I'm
22 using a general term.
23 THE COMMISSIONER:
24 Q. But when you say it's just a technical
25 problem, that's in contrast to what?

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1 DR. BAKER:
2 A. Interpretation problem, I suppose.
3 THE COMMISSIONER:
4 Q. So you were looking at it in terms of whether
5 or not the problems that were arising were
6 interpretation problems by pathologists versus
7 something in the system before you get to look
8 at the slide, is that it?
9 DR. BAKER:
10 A. That's correct, yes.
11 THE COMMISSIONER:
12 Q. And when you say technical problem, it's sort
13 of before it gets to your desk for
14 interpretation?
15 DR. BAKER:
16 A. Yes, that's correct.
17 MR. BROWNE:
18 Q. Commissioner, if I may just follow up on that.
19 THE COMMISSIONER:
20 Q. Sure.
21 MR. BROWNE:
22 Q. Doctor, would that come from -- if you look at
23 the third line there, and I'll just read it
24 out, "This new Ventana System is fully
25 automated. It's much more sensitive than the

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1 immunoperoxidase technique under the previous
2 DAKO machine". Is that what you would be
3 referring to as the technical --
4 DR. BAKER:
5 A. Yes, that's what I would be, yes.
6 THE COMMISSIONER:
7 Q. Anything arising, Mr. Coffey?
8 COFFEY, Q.C.:
9 Q. No, Commissioner, thank you.
10 THE COMMISSIONER:
11 Q. Thank you, Dr. Baker, I very much appreciate
12 your having come around the bay to assist us.
13 DR. BAKER:
14 A. Thank you.
15 THE COMMISSIONER:
16 Q. Counsel, would you like to take the afternoon
17 break so we can switch over to the next
18 witness.
19 COFFEY, Q.C.:
20 Q. Yes, please.
21 (RECESS)
22 THE COMMISSIONER:
23 Q. Mr. Chaytor.
24 CHAYTOR, Q.C.:
25 Q. Good afternoon, Commissioner. The next witness

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1 is Dr. Jehan Siddiqui.
2 DR. JEHAN SIDDIQUI (AFFIRMED) EXAMINATION BY MS. SANDRA
3 CHAYTOR, Q.C.
4 REGISTRAR:
5 Q. Would you please state and spell your complete
6 name for the Commission.
7 DR. JEHAN SIDDIQUI:
8 A. Jehan Zaid Siddiqui, J-E-H-A-N Z-A-I-D S-I-
9 D-D-I-Q-U-I.
10 CHAYTOR, Q.C.:
11 Q. Commissioner, we have a few new exhibits this
12 afternoon. It's P-2545 through to P-2549
13 inclusive, which I would ask, please, to have
14 entered.
15 THE COMMISSIONER:
16 Q. Entered.
17 EXHIBITS P-2545 THROUGH TO P-2549 ENTERED
18 CHAYTOR, Q.C.:
19 Q. Thank you. Good afternoon, Dr. Siddiqui.
20 DR. SIDDIQUI:
21 A. Good afternoon.
22 CHAYTOR, Q.C.:
23 Q. Dr. Siddiqui, perhaps you could begin by just
24 briefly summarizing for us your educational
25 and professional background, and for your

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1 assistance perhaps we could bring up P-2549,
2 please, Registrar. This, I understand, is a
3 copy of your current CV, is that correct? So
4 perhaps you could just take us through then
5 and highlight your educational and
6 professional background.
7 DR. SIDDIQUI:
8 A. Okay. I did my medicine degree from Pakistan,
9 and after that I came to US in 1993. I did a
10 residency in internal medicine from State
11 University of Detroit, and that was from 1994
12 to 1997. I finished that in June of 1997. In
13 July, I joined State University of New York,
14 their East Meadow Complex, and that was a
15 fellowship in hematology and medical oncology.
16 I completed that fellowship in end of June,
17 2000, and at that point I started a fellowship
18 in bone marrow transplant, and that was at
19 State University of Florida in Tampa. I did
20 not complete that fellowship. I left that
21 fellowship in 2001 and I came to Newfoundland.
22 I have passed my US diploma boards in internal
23 medicine, medical oncology, and hematology,
24 and I've also passed Canadian Royal College
25 Boards in internal medicine and medical

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1 oncology. I joined here as a medical
2 oncologist in 2001 in January. I worked in
3 that capacity and then April of 2006, I was
4 offered the position of divisional chief in
5 Division of Medical oncology and that's what I
6 am working as right now.
7 CHAYTOR, Q.C.:
8 Q. Okay. Doctor, if I just may look at the
9 second page of your CV, there are a number of
10 research/presentations mentioned. The first
11 one indicates, "Elevated Von Willebrand
12 antigen levels and patients receiving
13 Tamoxifen as adjuvant therapy for primary
14 breast carcinoma". Could you tell us what was
15 that about? It looks like it's research you
16 did in conjunction with others in 2000?
17 DR. SIDDIQUI:
18 A. Dr. Stephen Feffer, he was our chief of
19 oncology at that facility, and Ms. Robin Fox
20 was our special technician for the coagulation
21 lab. These were the two other individuals
22 mentioned in that, and this was kind of a
23 retrospective study and they just looked at in
24 those patients who had -- I'm trying to
25 remember. I have not looked at that recently,

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1 but I think what it was looking
2 retrospectively at those patients who were on
3 Tamoxifen and they developed a blood clot, to
4 see if they had elevated levels of Von
5 Willebrand factor.
6 CHAYTOR, Q.C.:
7 Q. Okay. You say that your current position
8 you're a divisional chief and you've been
9 divisional chief of medical oncology since
10 April, 2006?
11 DR. SIDDIQUI:
12 A. That's correct.
13 CHAYTOR, Q.C.:
14 Q. What are your duties as divisional chief, what
15 does it mean to be the divisional chief?
16 DR. SIDDIQUI:
17 A. I think with the recent changes in the
18 hierarchy, it probably hasn't been revised
19 recently, but what I can tell you is basically
20 it is to carry out the day to day functioning
21 of the division of medical oncology, and what
22 that includes is that includes that I make
23 sure that all the patients which are referred
24 to us are seen, whether it would be at our
25 centre in St. John's, and that means to

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1 arrange for clinics for other doctors to
2 facilitate and to collaborate with the nursing
3 to make sure that they have nurses available
4 for that. I also make call schedules, who is
5 doing floor, who is doing consults. I also
6 arrange for physicians to go out to peripheral
7 clinics and by that, I mean, Gander, Grand
8 Falls, and Corner Brook. We go there on a
9 monthly basis to make sure that somebody is
10 going there, to make the schedule for that for
11 the whole year. In addition to that, I'm part
12 of several teams and committees. One example
13 is the leadership meeting. Then there are
14 several others, clinic management meetings. So
15 there are several of those that I am part of.
16 CHAYTOR, Q.C.:
17 Q. Okay. So how much time would you dedicate to
18 those -- I will call them administrative
19 duties. How much time would be dedicated to
20 those in terms of percentage of your day or
21 percentage of your week?
22 DR. SIDDIQUI:
23 A. Since April of 2007, it has been accepted as
24 30 percent.
25 CHAYTOR, Q.C.:

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1 Q. And that's since April of 2007. So you were in
2 the position for a year before that?
3 DR. SIDDIQUI:
4 A. That's right.
5 CHAYTOR, Q.C.:
6 Q. And was your division in terms of how much
7 time you spent any different prior to April of
8 2007?
9 DR. SIDDIQUI:
10 A. No, it wasn't, but the only difference was
11 that you were asking about that, and it was in
12 April of 2007 that an agreement was reached.
13 CHAYTOR, Q.C.:
14 Q. Okay.
15 DR. SIDDIQUI:
16 A. And they accepted that much, so what that
17 meant was that they decrease the number of
18 patients that myself, as divisional chief of
19 medical oncology, and Dr. Ganguly, as
20 divisional chief of radiation oncology, had to
21 see, and that was to take care of that 30
22 percent of the time.
23 CHAYTOR, Q.C.:
24 Q. And who was this agreement reached with?
25 DR. SIDDIQUI:

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1 A. This was with MCP.
2 CHAYTOR, Q.C.:
3 Q. Okay, and I think we'll see some --
4 DR. SIDDIQUI:
5 A. And our hospital as well, of course.
6 CHAYTOR, Q.C.:
7 Q. Your own administration as well.
8 DR. SIDDIQUI:
9 A. Our administration and the Eastern Health
10 administration.
11 CHAYTOR, Q.C.:
12 Q. Yes, and I think we'll see some correspondence
13 that I'll ask you about that in a little bit.
14 So it's always been -- about 30 percent of
15 your time has been dedicated to those duties,
16 but it was formally recognized and compensated
17 for as being 30 percent in April of 2007, is
18 that accurate?
19 DR. SIDDIQUI:
20 A. That's correct.
21 CHAYTOR, Q.C.:
22 Q. Okay. As divisional chief, does anybody
23 report to you?
24 DR. SIDDIQUI:
25 A. My group of oncologists.

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1 CHAYTOR, Q.C.:
2 Q. So all of the medical oncologists?
3 DR. SIDDIQUI:
4 A. Not all. Dr. Laing is a medical oncologist as
5 well as is Dr. Saltman too, but they are my
6 superiors, so the remaining ones.
7 CHAYTOR, Q.C.:
8 Q. Yes, and Dr. Laing, we understand, is the
9 clinical chief?
10 DR. SIDDIQUI:
11 A. That is correct.
12 CHAYTOR, Q.C.:
13 Q. So you would report to Dr. Laing, is that
14 right?
15 DR. SIDDIQUI:
16 A. I would.
17 CHAYTOR, Q.C.:
18 Q. And what's the difference, what is it that the
19 clinical chief does that's different from the
20 divisional chief?
21 DR. SIDDIQUI:
22 A. The current hierarchy is that we have two
23 divisional chiefs. One is for medical oncology
24 and the other one is for radiation oncology,
25 and what I do for my division, similar to

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1 radiation division and the radiation chief
2 would do, and these are for individual
3 departments, and then both of us, we report to
4 the clinical chief and we have program
5 director as well, two of them we report. Dr.
6 Laing is the clinical phase of our discipline
7 and in the current hierarchy, and Dr. Saltman
8 is academic phase of discipline, and Sharon
9 Smith is our administrative program director.
10 CHAYTOR, Q.C.:
11 Q. So she's your program director?
12 DR. SIDDIQUI:
13 A. That's correct.
14 CHAYTOR, Q.C.:
15 Q. And on what matters would you report to Mrs.
16 Smith?
17 DR. SIDDIQUI:
18 A. Most of the meetings, we sit together. I'm
19 part of the leadership team, so we go through
20 that, many of the patient matters, all the
21 other services that are related to patient
22 care like nursing, pharmacy, they all report
23 to her in my understanding. So I can talk to
24 them or if I have something about that, I can
25 talk to Ms. Smith as well.

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1 CHAYTOR, Q.C.:
2 Q. Okay. And we've heard some discussion about
3 how the program management style works or not,
4 I guess, for the laboratory medicine program
5 and there's recently been some changes in that
6 regard. From your perspective as an
7 oncologist in a program management where
8 there's two tiers with a program director and
9 clinical or medical director, has there been
10 that kind of a tension or any tension in the
11 oncology service?
12 DR. SIDDIQUI:
13 A. I don't think so. I think that for the
14 academic phase, which is Dr. Saltman, that is
15 evolving a bit since we were recently changed
16 to a separate discipline of medicine -- sorry,
17 a discipline of oncology. We were part of
18 discipline of medicine, and we are a
19 discipline of oncology, so that is evolving.
20 That will be more of academic part of it and
21 to develop research part of it. I never had
22 any problems in terms of reporting or to get
23 hold of any one of these three guys.
24 CHAYTOR, Q.C.:
25 Q. So from your perspective, it has worked well?

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1 DR. SIDDIQUI:
2 A. It has.
3 CHAYTOR, Q.C.:
4 Q. When was the change from it being a discipline
5 of medicine to discipline of oncology, when
6 did that come about?
7 DR. SIDDIQUI:
8 A. I remember when Dr. Saltman came in, I don't
9 know is that exactly the date that this
10 happened. That would be sometime in April, but
11 I could be wrong.
12 CHAYTOR, Q.C.:
13 Q. This year, this calendar year?
14 DR. SIDDIQUI:
15 A. This year, but I could be wrong this way or
16 that way. I think it may be a bit earlier,
17 but I think it joined somewhere in April of
18 2008.
19 CHAYTOR, Q.C.:
20 Q. And so what difference then did that make with
21 Dr. Saltman coming on?
22 DR. SIDDIQUI:
23 A. In respect to?
24 CHAYTOR, Q.C.:
25 Q. In respect to how the oncology service

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1 actually operates or in terms of reporting
2 structures?
3 DR. SIDDIQUI:
4 A. It hasn't made any big difference yet. He is
5 pretty much doing -- working as a full-fledged
6 medical oncologist. Right now he's doing
7 clinics as well as -- in St. John's as well as
8 his peripheral clinics. He goes to Corner
9 Brook, he's doing all those things. In terms
10 of reporting, I haven't noticed any difference
11 yet. He's also part of some of the committees
12 that I go to, and I still report to Kara and
13 to Sharon.
14 CHAYTOR, Q.C.:
15 Q. Okay, and, Doctor, do you have any particular
16 subspecialty?
17 DR. SIDDIQUI:
18 A. I have been trained as first internist and
19 medical oncologist and hematologist. and in my
20 training which was combined, we dealt with all
21 kinds of patients. Usually what happens is
22 that after a certain time period when you're
23 in practice, individual doctors, and that
24 would happen in a lot of specialities, they
25 try to pick up one site as their preferred

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1 site and I did that when I was asked to do
2 when I came in 2001. When I first joined,
3 there were three of us and I saw pretty much
4 all kinds of cancers, but then other
5 individuals started to come in. Dr. McCarthy
6 came in in 2001. Dr. Rorke came around the
7 same time, that was in summer. Then Dr. Ahmad
8 came in 2002. So once we had more and more of
9 individuals, we tried to become a bit site
10 specific. The growth in oncology is so quick,
11 and it's so astounding that it is better if
12 you are looking at one site. In many of the
13 bigger centres, you will now find people who
14 won't even do a whole system, they would just
15 do a single organ. So these are
16 subspecializations, but they still see other
17 things as well.
18 CHAYTOR, Q.C.:
19 Q. And, of course, when you say "site", you mean
20 a disease site?
21 DR. SIDDIQUI:
22 A. A disease site, yes.
23 CHAYTOR, Q.C.:
24 Q. So when you joined in 2001, there were three
25 medical oncologists. You said the three of

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1 you. That means medical oncologists?
2 DR. SIDDIQUI:
3 A. Yes, Dr. Laing, shortly after I joined, she
4 went on maternity leave.
5 CHAYTOR, Q.C.:
6 Q. Okay.
7 DR. SIDDIQUI:
8 A. And Dr. Alidina, he left it was in April or
9 May of 2001, and Dr. McCarthy and Dr. Rorke
10 came in July or August of 2001, and Dr. Wasil
11 left in 2001. So in that year there was a bit
12 of shuffle.
13 CHAYTOR, Q.C.:
14 Q. So compared to your numbers when you joined in
15 2001 and where you are today in 2008, how many
16 medical oncologists would there be?
17 DR. SIDDIQUI:
18 A. Now there are a total of seven.
19 CHAYTOR, Q.C.:
20 Q. So that's allowed you more of a luxury to
21 specialize in certain disease sites, is that
22 right?
23 DR. SIDDIQUI:
24 A. Exactly.
25 CHAYTOR, Q.C.:

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1 Q. Yes, okay. So which particular area are you
2 more focused on now?
3 DR. SIDDIQUI:
4 A. My focus is more on gastroentronology, lung,
5 and genito-utinary.
6 CHAYTOR, Q.C.:
7 Q. And what percentage of your practice would
8 include breast cancer patients?
9 DR. SIDDIQUI:
10 A. If we talk about the new breast cancer
11 patients, in the last three and a half to
12 three quarter of a year, I have seen probably
13 less than 30 new patients of breast cancer.
14 CHAYTOR, Q.C.:
15 Q. Less than 30?
16 DR. SIDDIQUI:
17 A. Less than 30 new, but I have old patients that
18 I have been following, and among these 30,
19 about -- I would say more than 50 percent were
20 seen in Corner Brook, and those other patients
21 who do not want to, or for personal reason
22 cannot come to St. John's to be seen.
23 CHAYTOR, Q.C.:
24 Q. So how would that compare then, 30 new, how
25 many new patients overall would you see in a

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1 year?
2 DR. SIDDIQUI:
3 A. On an average, somewhere between 180 to 210.
4 CHAYTOR, Q.C.:
5 Q. Okay. Mr. Coffey has just pointed out to me
6 you, in fact, said 30 over three years, is
7 that correct?
8 DR. SIDDIQUI:
9 A. Three and a half to three quarter of a year.
10 CHAYTOR, Q.C.:
11 Q. So you're only -- yes, you're only seeing
12 about ten new breast cancer patients per year,
13 is that right?
14 DR. SIDDIQUI:
15 A. On an average.
16 CHAYTOR, Q.C.:
17 Q. On an average, whereas overall you see 180 to
18 200 new patients a year?
19 DR. SIDDIQUI:
20 A. Right, but when I first came in 2001, and as I
21 said earlier, at that point we were seeing all
22 the patients. Once Dr. McCarthy came in, then
23 sort of -- and Dr. Zulfiqar, he came in 2003.
24 They were seeing more of breast, and was
25 slowly shifted. However, there were ups and

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1 downs when one of them was off. One of them
2 went on maternity, so those patients were
3 spread around.
4 CHAYTOR, Q.C.:
5 Q. Okay.
6 DR. SIDDIQUI:
7 A. So a bit more there may be ups and downs.
8 CHAYTOR, Q.C.:
9 Q. So overall then the trend has been for you
10 that you're seeing less and less breast cancer
11 patients?
12 DR. SIDDIQUI:
13 A. That's correct.
14 CHAYTOR, Q.C.:
15 Q. And in terms of -- we've heard here about
16 pathologists that the Royal College doesn't
17 recognize subspecialty in pathology. Does the
18 Royal College recognize subspecialty in
19 oncology?
20 DR. SIDDIQUI:
21 A. Not that I know of.
22 CHAYTOR, Q.C.:
23 Q. And --
24 DR. SIDDIQUI:
25 A. Sorry, if the question is do they have another

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1 exam that you take to get subspecialized?
2 CHAYTOR, Q.C.:
3 Q. Yes.
4 DR. SIDDIQUI:
5 A. I don't think so, but I'm not 100 percent sure
6 on that.
7 CHAYTOR, Q.C.:
8 Q. How do you, yourself, keep yourself apprised
9 of new developments? As you say, things are
10 changing very quickly in medicine, so it's a
11 benefit to be able to concentrate on a given
12 area. How do you keep yourself up to date on
13 the changes and on the new research and
14 literature?
15 DR. SIDDIQUI:
16 A. There are several ways to do that. The first
17 one is that the Royal College itself, they
18 want us to have a certain number of hours
19 every year of continued medical education, and
20 they have specified what could count as one,
21 and that includes going to meetings, boards,
22 and that kind of stuff. Then we also
23 personally go to meetings. Then there is
24 internet, which I think is the biggest
25 resource. There are a number of websites which

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1 are available which are routinely used by us.
2 So a combination of these are required. The
3 Royal College wants us to have at least 40
4 hours each year, and 400 hours over a five
5 year time period of recognized continued
6 medical education to be submitted, and most of
7 the time we stay above what the requirements
8 are.
9 CHAYTOR, Q.C.:
10 Q. Okay, and you said that your clinical meetings
11 can count towards your hours that are
12 required. Would that include, for example,
13 internal hospital rounds?
14 DR. SIDDIQUI:
15 A. There are some that are recognized by Royal
16 College, and -- just like our tumour board,
17 our grand rounds, our oncology rounds. These
18 are the ones which are recognized, and those
19 are the ones for which a record is kept, and
20 at the end of the year Dr. McCarthy takes care
21 of one of those, and those records are given
22 to us, and we calculate our numbers and we
23 submit those.
24 CHAYTOR, Q.C.:
25 Q. Okay.

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1 DR. SIDDIQUI:
2 A. And those could be audited.
3 CHAYTOR, Q.C.:
4 Q. So your grand rounds count, and how often
5 would your grand rounds -- how often did those
6 take place?
7 DR. SIDDIQUI:
8 A. Grand rounds are every week, but they may not
9 be oncology every week.
10 CHAYTOR, Q.C.:
11 Q. And do you only get credit then for the ones
12 that are oncology?
13 DR. SIDDIQUI:
14 A. No.
15 CHAYTOR, Q.C.:
16 Q. You get credit for whatever, okay, and Dr.
17 McCarthy keeps track of that and submits it at
18 the end of the --
19 DR. SIDDIQUI:
20 A. No, only the tumour board, which also counts,
21 and I'm not sure, probably the other ones as
22 well, but tumour board, keep very meticulous
23 track of that, and we are given assigned
24 number of hours at the end of the year.
25 CHAYTOR, Q.C.:

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1 Q. Okay. So perhaps you could tell us then the
2 difference between your grand rounds and your
3 tumour board?
4 DR. SIDDIQUI:
5 A. Grand round, as I said earlier, may not be
6 oncology and grand round is more like a
7 lecture on a particular topic, at the end of
8 which you're allowed to ask questions. Tumour
9 board, on the other hand, is basically
10 discussion about individual patients. We
11 carry those rounds -- there are more than one
12 kind of tumour boards, the most common one
13 that we do every Wednesday morning. Those
14 tumour boards, we pick up interesting are
15 those patients which require some special
16 decisions to be made. We pick up those
17 patients, and the tumour board consists of --
18 there are as many oncologists as could come.
19 Sometimes there are all of us, then the
20 radiation oncologists, then the pathologists,
21 the radiologists, and the surgeons, and they
22 are available in that round. The need for
23 those rounds is to make some difficult
24 decisions on individual patients, or if you
25 need multi-modality treatment for some patient

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1 or multi-speciality input, that could be
2 gained at the same time. So that is tumour
3 board as opposed to the grand rounds which is
4 more like a lecture.
5 CHAYTOR, Q.C.:
6 Q. More like a lecture, and who would attend the
7 grand rounds?
8 DR. SIDDIQUI:
9 A. We are all supposed to attend that.
10 CHAYTOR, Q.C.:
11 Q. And is it just oncologists or it could be
12 every --
13 DR. SIDDIQUI:
14 A. It could be every field of medicine.
15 CHAYTOR, Q.C.:
16 Q. Every discipline, okay, and both happen once a
17 week?
18 DR. SIDDIQUI:
19 A. That's right, and then we have --
20 CHAYTOR, Q.C.:
21 Q. Sorry, Wednesday mornings you said for your
22 tumour board?
23 DR. SIDDIQUI:
24 A. That's right.
25 CHAYTOR, Q.C.:

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1 Q. How long has that been the case, has that been
2 in place since 2001 when you joined?
3 DR. SIDDIQUI:
4 A. You mean the tumour board?
5 CHAYTOR, Q.C.:
6 Q. The tumour board, yes.
7 DR. SIDDIQUI:
8 A. Dr. McCarthy was the force behind it, and I'm
9 not sure about the exact date, but it started
10 shortly after she came in.
11 CHAYTOR, Q.C.:
12 Q. So when you arrived in January, 2001, there
13 wasn't tumour board?
14 DR. SIDDIQUI:
15 A. No at that time.
16 CHAYTOR, Q.C.:
17 Q. But Dr. McCarthy came later in the year, in
18 the summer of 2001, and she was instrumental
19 in getting tumour boards happening?
20 DR. SIDDIQUI:
21 A. That's right.
22 CHAYTOR, Q.C.:
23 Q. And that's been consistent ever since then?
24 DR. SIDDIQUI:
25 A. It has been very regular, very consistent, and

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1 very helpful.
2 CHAYTOR, Q.C.:
3 Q. And you say in your tumour boards difficult
4 cases would be assessed. Would you have any
5 documentation or any knowledge about the
6 patients that are to be assessed before you
7 attend the tumour board?
8 DR. SIDDIQUI:
9 A. You would. A list is prepared by our secretary
10 and that list is sent -- if there are any
11 particular questions, for example, if somebody
12 has a question about radiology, the
13 secretaries will let them know beforehand that
14 we need to discuss about certain scans, and
15 whatever the question is for, if it is for
16 pathology, they would be informed beforehand,
17 so that they can look at those slides and they
18 can talk about that particular case.
19 CHAYTOR, Q.C.:
20 Q. Okay, and when you did your residency in the
21 late 1990s in New York, were tumour boards a
22 regular part of the hospital you trained in?
23 DR. SIDDIQUI:
24 A. What I can remember is in the late part of my
25 residency I can remember going to several of

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1 those. Were they happening very regularly,
2 I'm not 100 percent sure on that, but I can
3 remember going to several of those in my third
4 year of fellowship.
5 CHAYTOR, Q.C.:
6 Q. And do your -- so in your third year would be,
7 I guess, 1999?
8 DR. SIDDIQUI:
9 A. That would be -- that's right, from July,
10 1999, to end of June, 2000.
11 CHAYTOR, Q.C.:
12 Q. And at Eastern Health, do the residents here
13 also take part in tumour boards?
14 DR. SIDDIQUI:
15 A. They are welcome, and those residents which
16 are working with us -- most of the time there
17 is some resident who is working with us. They
18 are welcome. Lots of time radiology residents
19 do come in, they present their cases along
20 with their attending. Lots of times pathology
21 residents also come in. If there is some
22 resident who is spending time with us, be it
23 internal medicine or surgery, they are welcome
24 and many of the times they do come.
25 CHAYTOR, Q.C.:

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1 Q. And in your tumour board rounds prior to 2005,
2 do you recall anybody ever bringing a case to
3 the tumour board rounds involving a patient
4 which seemed to have an ER or PR result which
5 seemed inconsistent with the diagnosis?
6 DR. SIDDIQUI:
7 A. I don't remember any.
8 CHAYTOR, Q.C.:
9 Q. Now, Doctor, I noticed on your CV that you're
10 also an Assistant Professor at Memorial
11 University, and what does that mean and how
12 much time do you have to devote to that
13 position?
14 DR. SIDDIQUI:
15 A. I'm what they call Clinical Assistant
16 Professor as opposed to a full time Assistant
17 Professor. The requisition from my part would
18 be that I have to take at least four teaching
19 sessions, plus I contribute towards teaching
20 when I'm doing floor, plus I also contribute
21 towards the different OSCE exams that they
22 take.
23 CHAYTOR, Q.C.:
24 Q. Okay, and if we could have then, please, P-
25 1681. This is a letter, June 28th, 2006, it's

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1 stamped, from the Government of Newfoundland
2 and Labrador, and it's actually from the
3 minister of the day, Minister of Health and
4 Community Services, Minister Osborne, and it's
5 written to yourself, along with Drs. Laing,
6 Ganguly, and Mr. Ritter. And Minister Osborne
7 is writing in response to "your correspondence
8 dated May 12th, 2006, which outlined and
9 summarized the various points of contention
10 that your group has with the current alternate
11 payment plan in place for radiation oncology
12 and other administrative issues. And as a
13 follow-up to my telephone conversation with
14 Dr. Ganguly on June 22nd, 2006." And then the
15 letter goes on to identify really three
16 issues: Issue one being workload thresholds;
17 issue two, interpretation of agreement; and
18 issue three, recognition of administrative and
19 teaching responsibilities. And, Doctor,
20 perhaps you could just tell us about this?
21 And again, the letter is written in response
22 to a letter that originated with you and the
23 others in May of 2006. What do you recall
24 about this?
25 DR. SIDDIQUI:

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1 A. I'm not sure if it was is response to a letter
2 that I had wrote or Dr. Laing wrote, I'm not
3 sure about that. This is 2006. It was in
4 2007 I think we did write a letter. In 2006
5 I'm not sure if I did write one or I might
6 have. But I think as I had said earlier, this
7 was the discussion about recognition of a time
8 for administrative duties.
9 CHAYTOR, Q.C.:
10 Q. Okay. And if we look at issue three, which is
11 the recognition of administrative and teaching
12 responsibilities, Minister Osborne writes,
13 "Based on Eastern Health's input we are
14 prepared to adjust the FTE of the clinical
15 chief from the current point, 0.8 FTE to 0. 6
16 FTE as of April 1st, 2006 following successful
17 closures of our discussions. The department
18 has confirmed with Eastern Health that no
19 physician within its organization who accepts
20 the position of divisional chief receives
21 additional compensation for these services.
22 As such, I do not support adjusting the FTE
23 for the two divisional chiefs within your
24 program due to the precedent setting nature
25 this would create at Eastern Health." So I

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1 take it at this point in time that would have
2 been your position and Dr. Ganguly's position
3 and at this point in time the government
4 wasn't prepared, after consulting with Eastern
5 Health, to entertain any compensation for your
6 administrative services?
7 DR. SIDDIQUI:
8 A. It looks like that, yeah.
9 CHAYTOR, Q.C.:
10 Q. Okay. And if we could have, please, P-0166?
11 And this is about six months or so later. And
12 it's an e-mail exchange, Doctor. I'll just
13 bring it to your attention. It seems to be on
14 the same subject, but you're not a recipient
15 or a sender. The first, the main part of the
16 e-mail exchange is from Mr. Tilley to Minister
17 Osborne, copied to Dr. Howell and John Abbott,
18 and it's January 17th, 2007. And Mr. Tilley
19 writes, "Minister, I was speaking to John
20 Abbott to learn that Dr. Ganguly has been in
21 touch with you about his resignation from his
22 administrative duties in our cancer care
23 program. During the fall representatives from
24 the NLMA met with Dr. Howell et al to say that
25 they were going to take on the issue of

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1 compensation for the administrative work that
2 three of our oncologists were providing to our
3 cancer care program: Laing, Clinical Chief;
4 Ganguly, Division Chief of Radiation Oncology;
5 and Siddiqui, Division Chief of Medical
6 Oncology." And then it goes on to say, "Back
7 in November with issues around ER/PR about to
8 be dealt with in the media I asked Oscar
9 Howell to resolve the compensation issue for
10 Kara Laing as it was different from the
11 others, retroactivity, and we needed her full
12 support when we moved forward on the ER/PR
13 discussions. That left the division chiefs
14 outstanding. There have been several meetings
15 with the individuals involved to find
16 resolution to this and like most things in
17 this field, things are complex. We looked
18 through the country to see what was reasonable
19 with regards to time commitment from
20 administrative perspective and ended up saying
21 30 percent of their time would be reasonable.
22 We then drafted up job descriptions for review
23 with them to ensure that the expectations were
24 clear. The compensation we pay them for their
25 administrative does not appear to be the

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1 issue. The physicians are paid through an
2 alternative payment plan with thresholds above
3 which they receive additional compensation for
4 new patients seen and there was some dispute
5 over where these thresholds should be,
6 particularly when one considers their
7 administrative responsibilities." And then
8 I'll just, it concludes with saying, "While we
9 have received their resignations for January
10 1, they did give us a two week extension to
11 January 15th. Since meetings are still
12 ongoing Dr. Siddiqui has indicated to us that
13 nothing will change in terms of his work until
14 all opportunities to find a resolution have
15 been explored." So I take it at this point in
16 time, Doctor Siddiqui, your issues six months
17 later had not been resolved and that there was
18 some issue as to some job action that may take
19 place as a result of that?
20 DR. SIDDIQUI:
21 A. That was basically from the position of
22 divisional chief.
23 CHAYTOR, Q.C.:
24 Q. Yes. For the divisional chief?
25 DR. SIDDIQUI:

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1 A. Divisional chief position only.
2 CHAYTOR, Q.C.:
3 Q. Okay. The issues around Dr. Laing were
4 resolved, it indicates, earlier, but yourself
5 and Dr. Ganguly's issues remained outstanding?
6 DR. SIDDIQUI:
7 A. That's right.
8 CHAYTOR, Q.C.:
9 Q. Okay. And then in April, 2007, so about four
10 months after this, it was resolved and a 30
11 percent recognition was given to your
12 administrative duties?
13 DR. SIDDIQUI:
14 A. That is correct.
15 CHAYTOR, Q.C.:
16 Q. And the issue being then in terms of perhaps
17 you could explain to us, what was the concern
18 about being paid on an alternate payment plan
19 and with thresholds, how was that impacting on
20 your ability to be able to do your
21 administrative duties?
22 DR. SIDDIQUI:
23 A. There are certain standards set in terms of
24 the number of patients that you are supposed
25 to see as a medical oncologist and as a

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1 radiation oncologist. And the numbers, they
2 come from CAMO and CARO which is the Canadian
3 Association of Medical Oncologists and
4 Radiation Oncologists and different provinces
5 have accepted them, the levels may be slightly
6 different. In our province MCP had accepted
7 that 140 patients, new patients need to be
8 seen every year just to justify your main
9 salary, and that was considered as the
10 threshold. And what we were mentioning in
11 there is that one way to pay for the division
12 chief would be to cut down that threshold by
13 30 percent. So whatever is that 30 percent,
14 cut it down of 140, so that would be in
15 recognition of the time by cutting down the
16 threshold.
17 CHAYTOR, Q.C.:
18 Q. Okay. So the number you gave me earlier, 180
19 to 200 new patients that you see each year is
20 well above the 140?
21 DR. SIDDIQUI:
22 A. It is.
23 CHAYTOR, Q.C.:
24 Q. And you should be 140 less 30 percent?
25 DR. SIDDIQUI:

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1 A. That is correct.
2 CHAYTOR, Q.C.:
3 Q. Okay. So you are working well above what the
4 threshold would indicate?
5 DR. SIDDIQUI:
6 A. That is right.
7 CHAYTOR, Q.C.:
8 Q. And is that true for your counterparts, as
9 well?
10 DR. SIDDIQUI:
11 A. In the radiation oncology?
12 CHAYTOR, Q.C.:
13 Q. Well, medical oncology?
14 DR. SIDDIQUI:
15 A. It is. And actually, I am not the one who is
16 seeing the highest number. My other
17 colleagues are seeing more than that.
18 CHAYTOR, Q.C.:
19 Q. Okay. So even though you now have seven,
20 seven medical oncologists on staff, you're all
21 still carrying significant workloads?
22 DR. SIDDIQUI:
23 A. The case load for the new patients is going up
24 on a steady pace and that needs more consults
25 which are sent. There are new indications

1 added for the treatment of cancers, so that
2 result in more consults, more new patients
3 that are referred to us. So even though we are
4 seven, but in the last several years the
5 percentage of new patients is increasing
6 steadily.
7 CHAYTOR, Q.C.:
8 Q. Okay.
9 DR. SIDDIQUI:
10 A. So we still ended up seeing that many
11 patients.
12 CHAYTOR, Q.C.:
13 Q. What does a new patient mean, is it a patient
14 that is new to you or newly diagnosed, what
15 does it mean?
16 DR. SIDDIQUI:
17 A. If I have never seen a patient before that is
18 diagnosed with colon or breast cancer and it
19 is sent to me, that's a new patient for me and
20 that will be counted as one in that threshold
21 of 140.
22 CHAYTOR, Q.C.:
23 Q. Okay, so someone new to you. So, for example,
24 if that person had been seen by another
25 oncologist previously, it's still a new

1 patient to you?
2 DR. SIDDIQUI:
3 A. No.
4 CHAYTOR, Q.C.:
5 Q. No? It would have to be the first time the
6 person was seen by any -
7 DR. SIDDIQUI:
8 A. That's right.
9 CHAYTOR, Q.C.:
10 Q. - oncologist in your service?
11 DR. SIDDIQUI:
12 A. That is right.
13 CHAYTOR, Q.C.:
14 Q. Okay.
15 DR. SIDDIQUI:
16 A. Whoever sees that patient first time and does
17 a consult or a first assessment similarly on
18 that patient, that patient is counted, that
19 patient is counted for that person.
20 CHAYTOR, Q.C.:
21 Q. And what if a number of years passed and the
22 patient has a recurrence of their disease?
23 DR. SIDDIQUI:
24 A. That is just counted as once. If I see a
25 patient eight years ago and it comes back to

1 me with the same cancer afterwards, it is not
2 recounted.
3 CHAYTOR, Q.C.:
4 Q. Okay. So that's not considered a new patient?
5 DR. SIDDIQUI:
6 A. No.
7 CHAYTOR, Q.C.:
8 Q. And what if it were a new disease site?
9 DR. SIDDIQUI:
10 A. If it's a different cancer, then it counts as
11 new. Somebody had a colon cancer before and
12 now they are coming in with lung cancer, then
13 it's a different cancer.
14 CHAYTOR, Q.C.:
15 Q. Okay.
16 DR. SIDDIQUI:
17 A. It doesn't need to be seen by the same
18 oncologist, like if it initially was seen by
19 an oncologist who does not do lung, then it
20 may go to another oncologist who does lung.
21 CHAYTOR, Q.C.:
22 Q. Okay. And if it's a metastases from the
23 original cancer is it still considered a -
24 DR. SIDDIQUI:
25 A. No. It will be still counted as the same one

1 the first time around and -
2 CHAYTOR, Q.C.:
3 Q. Not a new patient?
4 DR. SIDDIQUI:
5 A. - would not be recounted, it won't be a new
6 patient.
7 CHAYTOR, Q.C.:
8 Q. Okay.
9 DR. SIDDIQUI:
10 A. So we see a patient one time and for the life
11 of it from then onwards it is not recounted.
12 CHAYTOR, Q.C.:
13 Q. Okay.
14 DR. SIDDIQUI:
15 A. For one division. If I have to send this
16 patient to radiation oncology, they have never
17 seen that patient before, it would be new for
18 them and vice versa, as well.
19 CHAYTOR, Q.C.:
20 Q. So these are significant levels of new
21 patients which are coming through your doors?
22 DR. SIDDIQUI:
23 A. That is correct.
24 CHAYTOR, Q.C.:
25 Q. Yes, okay. Is there any, do you know is there

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1 any plans to continue to recruit more medical
2 oncologists?
3 DR. SIDDIQUI:
4 A. We are hoping and we are trying. There are
5 two residents from Newfoundland which are in
6 the process of training and we are hoping that
7 they will come back. Right now we have, it
8 looks like they have every intention to.
9 CHAYTOR, Q.C.:
10 Q. And do you have two openings?
11 DR. SIDDIQUI:
12 A. I think Dr. Laing is working on that and by
13 the time they are done in their fellowship
14 there will be openings available.
15 CHAYTOR, Q.C.:
16 Q. Okay. And I'll get an opportunity, perhaps
17 I'll ask Dr. Laing some more about that. I
18 just wanted to ask you a little bit, too,
19 about the peripheral clinics that you referred
20 to. You said that those are monthly, so every
21 month. Does that mean somebody goes to Corner
22 Brook every month, Gander every month and
23 Grand Falls every month, all three locations?
24 DR. SIDDIQUI:
25 A. That is correct.

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1 CHAYTOR, Q.C.:
2 Q. Okay.
3 DR. SIDDIQUI:
4 A. Among the seven of us we have divided
5 ourselves in two groups. Three of us go to
6 Corner Brook and means that one person would
7 go there every month. And we go there four to
8 five days every month and that's in a
9 straight, usually a Tuesday to Friday or a
10 Monday to Friday and so three of us go for
11 that. And the other four, they go to Gander
12 and Grand Falls and they again go there every
13 month and they go there for a week, but that
14 week is divided between Gander and Grand
15 Falls.
16 CHAYTOR, Q.C.:
17 Q. Okay. And in terms of your caseload in the
18 other regions of the province, is it growing
19 at about the same rate outside of Eastern
20 Health?
21 DR. SIDDIQUI:
22 A. I would think so.
23 CHAYTOR, Q.C.:
24 Q. So those clinics are becoming busier all the
25 time, as well?

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1 DR. SIDDIQUI:
2 A. They are.
3 CHAYTOR, Q.C.:
4 Q. So I think we have some sense then of what you
5 do. But perhaps you could just give us an
6 idea of a typical week, then, for you, other
7 than a week that would involve going out to
8 peripheral clinic, but a week here in St.
9 John's, perhaps you could just tell us how you
10 divide your time and the duties that you have?
11 DR. SIDDIQUI:
12 A. Okay. I'll tell you about a typical week and
13 then there are two variables in that, as well.
14 I can talk about those as well.
15 CHAYTOR, Q.C.:
16 Q. Sure.
17 DR. SIDDIQUI:
18 A. Each one of us except Dr. Saltman and Dr.
19 Laing, we are supposed to do four half days
20 clinic each week. Myself, I do a clinic on
21 Monday morning which is supposed to go from
22 nine to twelve, but usually it doesn't end
23 until about 2:00. Then I do another clinic
24 which is Wednesday morning and that is for new
25 patients. Then I do another half day clinic

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1 on Thursday morning and that is for usually
2 supposed to be for non-chemo follow-up
3 patients. And then I do a clinic on Thursday
4 afternoon, which is called lung clinic but can
5 include other patients, as well. However,
6 what's happening right now is that most of the
7 times or most of the weeks I would say three
8 out of four weeks or at least two out of four
9 weeks in a month I end up doing one or two
10 extra clinics, as well because there are so
11 many patients to follow that I have to
12 accommodate them somewhere else. Now, this is
13 a usual week. The two variables that I was
14 talking about was that when you are on the
15 floor, which you are on one in seven, there
16 are seven of us, and -
17 CHAYTOR, Q.C.:
18 Q. And does that mean on call, is that what--is
19 that the same as on call?
20 DR. SIDDIQUI:
21 A. Slight difference. When you're on the floor,
22 you are taking care of patients on the floor
23 as well as you are covering the emergency
24 room, as well.
25 CHAYTOR, Q.C.:

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1 Q. Okay, but they're in-hospital patients?
2 DR. SIDDIQUI:
3 A. Exactly.
4 CHAYTOR, Q.C.:
5 Q. Okay.
6 DR. SIDDIQUI:
7 A. And then there's another person who is on
8 consults at the same time and those consults
9 could be in-house consults as well, other than
10 the emergency room. So if there are in-house
11 consults, they go to that person who is doing
12 consults and he will also accept consults who
13 are urgent from other physicians, as well. So
14 these were the two variables that I said that
15 it may change slightly if you are on the
16 floor. Some of us would like to hold one of
17 their four clinics when they are on the floor
18 and some of us don't, so this would have been
19 the variable. I usually don't.
20 CHAYTOR, Q.C.:
21 Q. Okay. So you usually then would be on the
22 floor on Tuesdays or Fridays?
23 DR. SIDDIQUI:
24 A. No, I said it's one in seven, it means there
25 are seven of us.

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1 CHAYTOR, Q.C.:
2 Q. Okay.
3 DR. SIDDIQUI:
4 A. And we do floors for two weeks straight.
5 CHAYTOR, Q.C.:
6 Q. Okay.
7 DR. SIDDIQUI:
8 A. And so it would be every seventh in two weeks
9 quotas that your turn would come.
10 CHAYTOR, Q.C.:
11 Q. So you do it in two week blocks?
12 DR. SIDDIQUI:
13 A. That is right.
14 CHAYTOR, Q.C.:
15 Q. Okay. I'm sorry, I missed that part. Okay.
16 And so what then normally would happen on
17 Tuesdays and Fridays in your practice?
18 DR. SIDDIQUI:
19 A. This is for the administrative part and plus
20 on Tuesdays, on Tuesdays we do a round on the
21 floor, as well, every Tuesday morning. That
22 is a kind of a teaching and clinical round.
23 And what that includes is that all of us from
24 medical oncology, we go upstairs, we go
25 through all of our patients that are admitted

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1 on the floor at that time. The residents are
2 with us and mostly the pharmacists who work
3 with us, as well as the palliative care
4 physician, or if there are any residents, they
5 also go with us on that round, and that is
6 every Tuesday morning. Then on Tuesday
7 afternoons usually we have sort of meetings
8 with medical reps or we have our divisional
9 meeting as well on every first Tuesday of the
10 month. So on Tuesday we sort of put on a few
11 of the meetings. And as I said, that I end up
12 doing an extra clinic and that I usually put
13 for Friday.
14 CHAYTOR, Q.C.:
15 Q. Okay. Doctor, I'd like to ask you now then
16 turn to the issue of ER/PR testing and your
17 background knowledge that you would have in
18 that. So at the time that you completed your
19 medical and hematology oncology residency,
20 1997, I believe you said, through 2000, at the
21 time you completed that in New York, were you
22 exposed then to ER/PR testing?
23 DR. SIDDIQUI:
24 A. Our role was basically interpretation of the
25 results.

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1 CHAYTOR, Q.C.:
2 Q. Okay. And at that time in New York was it a
3 biochemical method for the test or was it
4 being done through IHC?
5 DR. SIDDIQUI:
6 A. They had the Ligand binding assay and the
7 results used to come in femto-moles milligram.
8 CHAYTOR, Q.C.:
9 Q. Okay.
10 DR. SIDDIQUI:
11 A. That was the other method, not the IHC.
12 CHAYTOR, Q.C.:
13 Q. Okay. And was that -
14 DR. SIDDIQUI:
15 A. That's what my remembrance from the last year
16 is. If it changed towards the end of it, I
17 cannot be 100 percent sure. And again, from
18 New York I had done a little bit of, six,
19 seven months of bone marrow transplant
20 fellowship, as well.
21 CHAYTOR, Q.C.:
22 Q. Okay.
23 DR. SIDDIQUI:
24 A. If they changed around that time, I'm not
25 sure.

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1 CHAYTOR, Q.C.:
2 Q. Okay. So your recollection is that up until
3 at least close to 2000 they were still using
4 the biochemical method?
5 DR. SIDDIQUI:
6 A. Ligand binding assay, yeah.
7 CHAYTOR, Q.C.:
8 Q. Ligand binding, yes, okay. What were you
9 taught in terms of the significance or purpose
10 of the ER and PR test?
11 DR. SIDDIQUI:
12 A. The interpretation part is the one that I
13 could talk about.
14 CHAYTOR, Q.C.:
15 Q. Yes, sure.
16 DR. SIDDIQUI:
17 A. That tells us about the use of an additional
18 drug, which is hormone manipulation for the
19 treatment of those patients.
20 CHAYTOR, Q.C.:
21 Q. Yes. And what stage of treatment would
22 hormone manipulation be considered as a
23 treatment option?
24 DR. SIDDIQUI:
25 A. Hormone manipulation could be used both in the

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1 adjuvant as well as in the metastatic setting.
2 CHAYTOR, Q.C.:
3 Q. And is there any particular criteria or how
4 would you decide whether or not it's an
5 appropriate treatment?
6 DR. SIDDIQUI:
7 A. They had certain cutoffs, that's what our
8 teachers taught us at that time, with their
9 method, and we used to use those cutoffs for
10 deciding whether a patient should be a
11 candidate or not. Were those followed 100
12 percent, I'm not sure, but we had cutoffs
13 there at that time.
14 CHAYTOR, Q.C.:
15 Q. Okay. And would you have been taught anything
16 in terms of certain types of cancers which
17 would be expected to be ER positive?
18 DR. SIDDIQUI:
19 A. There was some general knowledge about that,
20 that some cancers are more likely to be ER
21 positive than others.
22 CHAYTOR, Q.C.:
23 Q. Okay. And what would those have been?
24 DR. SIDDIQUI:
25 A. Lobular cancer is one which could be more

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1 likely to be ER positive.
2 CHAYTOR, Q.C.:
3 Q. Okay.
4 DR. SIDDIQUI:
5 A. And others could be tubular could be positive.
6 Mucinous could be. So those are other
7 cancers.
8 CHAYTOR, Q.C.:
9 Q. Okay. And when you say more likely, were you
10 taught in terms, anything in term of how
11 likely or whether it would be rare for certain
12 types of cancers to, in fact, be hormone
13 receptor negative?
14 DR. SIDDIQUI:
15 A. Like for lobular it has to be a very high
16 number, the majority and a great majority of
17 them would be ER positive.
18 CHAYTOR, Q.C.:
19 Q. Okay. And you would have been aware of that
20 during your training days?
21 DR. SIDDIQUI:
22 A. I would think so.
23 CHAYTOR, Q.C.:
24 Q. Yes. And were you taught anything in terms of
25 any correlation between ER positivity and PR

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1 positivity?
2 DR. SIDDIQUI:
3 A. Again, what the teaching was that a positive
4 PR usually means a functional ER
5 (unintelligible). So majority of patients if
6 they are ER positive, they would be PR
7 positive, as well. But we did find patients
8 which were either/or, negative ER and positive
9 PR and vice versa.
10 CHAYTOR, Q.C.:
11 Q. Okay. And do you know what the literature
12 would say in terms of the percentage that that
13 would normally happen in?
14 DR. SIDDIQUI:
15 A. I think the great majority would be ER/PR
16 positive. To put the exact number, I'm not
17 sure, I would say probably 60 percent or so.
18 Less, about five percent or so would be ER
19 negative, PR positive, and then about a
20 similar number ER positive, PR negative.
21 CHAYTOR, Q.C.:
22 Q. Okay.
23 DR. SIDDIQUI:
24 A. And these numbers I'm not 100 percent sure,
25 though.

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1 CHAYTOR, Q.C.:
2 Q. Okay, Doctor, and forgive me because we're
3 trying to learn a lot of this as we're going,
4 too, but you used the word "functional" ER
5 positivity, if it was PR positive. And what
6 does that mean?
7 DR. SIDDIQUI:
8 A. The teaching was that if somebody has a
9 functional ER receptor, then usually the PR
10 would be positive, as well.
11 CHAYTOR, Q.C.:
12 Q. Okay. And I guess I'm just--I don't know what
13 the word "functional" means in that context.
14 DR. SIDDIQUI:
15 A. I think it would probably refer to the way
16 that these receptors work, that a PR
17 positivity would depend on a functional ER.
18 CHAYTOR, Q.C.:
19 Q. Okay.
20 DR. SIDDIQUI:
21 A. I don't know really how to explain that.
22 CHAYTOR, Q.C.:
23 Q. Okay. So is it--would it be the thinking then
24 if a patient is PR positive and ER negative,
25 they nonetheless may be still a candidate that

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1 would be receptive and respond to hormone
2 manipulation?
3 DR. SIDDIQUI:
4 A. They would. And for all clinical and
5 practical purposes we used to take either/or.
6 CHAYTOR, Q.C.:
7 Q. Either/or, okay, and is that still the case
8 today?
9 DR. SIDDIQUI:
10 A. I think so.
11 CHAYTOR, Q.C.:
12 Q. Yes, I realize you're not doing too many new
13 breast cases now, okay. And at the time of
14 your training, what were you taught in terms
15 of reliance that could be placed on the
16 results from the lab? Were you given any
17 cautions or anything in terms of--and in
18 particular with respect to ER/PR tests?
19 DR. SIDDIQUI:
20 A. In my residency and in my fellowship, I don't
21 remember every challenging that.
22 CHAYTOR, Q.C.:
23 Q. Okay.
24 DR. SIDDIQUI:
25 A. And the reports, when they used to come to us,

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1 they used to go to our attendings as well. We
2 were fellows at that time and resident. On
3 the top of my head, I don't remember ever
4 challenging those reports.
5 CHAYTOR, Q.C.:
6 Q. Okay, and no issue of if you got a result that
7 didn't seem to fit or be in keeping with your
8 diagnosis to challenge the report or go back
9 and ask for a retest of the original test?
10 DR. SIDDIQUI:
11 A. I don't remember of any case on top of my head
12 that we did that.
13 CHAYTOR, Q.C.:
14 Q. Okay, and you also did a fellowship, or in
15 your fellowship, you also did hematology?
16 DR. SIDDIQUI:
17 A. I did.
18 CHAYTOR, Q.C.:
19 Q. So would you have been exposed to laboratory
20 medicine through your residency?
21 DR. SIDDIQUI:
22 A. I was, but that was in that part of it. I did
23 some blood banking and I spent some time with
24 the coagulation lab.
25 CHAYTOR, Q.C.:

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1 Q. And that then again is because you did a
2 fellowship in hematology, so a medical
3 oncologist not doing the hematology portion
4 would not normally have exposure, I take it
5 then, to the lab or to laboratory medicine?
6 DR. SIDDIQUI:
7 A. In U.S., most of the fellowships were both and
8 most of the individuals that I know, they did
9 both, so I'm not sure what the structure would
10 be if it was only medical oncology, because in
11 medical oncology exam, you still have to
12 answer quite a bit of hematology as well. So
13 I would not know that structure.
14 CHAYTOR, Q.C.:
15 Q. Okay. So Doctor, and I want you to think
16 prior to obviously 2005, because there's
17 probably been some changes that have come
18 about since this issue arose, but if the
19 result, prior to 2005, if the result of an
20 ER/PR test that you received on a patient
21 didn't meet your expectations of was something
22 other than what you would have expected,
23 either because of the type of cancer or
24 because of the PR positivity or some other
25 factor, did you ever have reason to question

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1 that and ask that the test be repeated?
2 DR. SIDDIQUI:
3 A. I don't remember ever doing that.
4 CHAYTOR, Q.C.:
5 Q. Okay, and do you ever recall that being a
6 subject of discussion within the oncology
7 service at the Cancer Centre?
8 DR. SIDDIQUI:
9 A. No.
10 CHAYTOR, Q.C.:
11 Q. So if anyone else had actually, any of your
12 medical oncology colleagues had asked for that
13 to happen and to have a retest, that was never
14 brought to your attention?
15 DR. SIDDIQUI:
16 A. Again, I've heard so many things in the last
17 few months. There may be some orders done,
18 but when exactly were they done, did I know
19 about those at that time, I doubt, because
20 personally, I don't remember that I put in a
21 consult to repeat those.
22 CHAYTOR, Q.C.:
23 Q. You personally didn't?
24 DR. SIDDIQUI:
25 A. I did not. I don't remember.

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1 CHAYTOR, Q.C.:
2 Q. Okay.
3 DR. SIDDIQUI:
4 A. I remember putting in a few consults for ER/PR
5 after this started, especially when I was in
6 Corner Brook. When I went in to see those
7 patients, they were not in the chart, so I
8 just put in consults for those, and I remember
9 putting in some consults initially when we
10 were seeing patients and the ER/PRs were not
11 in the chart. They didn't come in the recent
12 month. So I remember putting in or probably
13 calling as well, just to get the ER/PRs done.
14 CHAYTOR, Q.C.:
15 Q. Okay.
16 DR. SIDDIQUI:
17 A. That would be in the early part, when I joined
18 here.
19 CHAYTOR, Q.C.:
20 Q. And Doctor, when would that have been?
21 DR. SIDDIQUI:
22 A. You mean calling reporting consults?
23 CHAYTOR, Q.C.:
24 Q. Yes.
25 DR. SIDDIQUI:

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1 A. I would think when I went to Corner Brook, I
2 would think it would be probably somewhere in
3 2006.
4 CHAYTOR, Q.C.:
5 Q. Okay.
6 DR. SIDDIQUI:
7 A. And the patients, we saw the patients, and if
8 there was no report in the chart, 2006 or '07,
9 I cannot be 100 percent sure on that. But if
10 we see the patient and if the repeat was not
11 done, most of the time they were in the
12 pipeline, but my nurse in Corner Brook would
13 not know, so many of the times when I put in
14 the consult, they--but there were not a whole
15 lot of those times, though, but they were in
16 the pipeline somewhere.
17 CHAYTOR, Q.C.:
18 Q. So those were people, if it's 2006-2007, those
19 were people that either weren't identified in
20 the initial identification of patients or
21 there was some delay in having their tests
22 repeated?
23 DR. SIDDIQUI:
24 A. Some delayed, or many of the times, they were
25 actually done and I think in Corner Brook,

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1 they haven't made it yet there.
2 CHAYTOR, Q.C.:
3 Q. So the results actually hadn't arrived back
4 onto the patient's chart?
5 DR. SIDDIQUI:
6 A. I think that probably in one or two, that was
7 the situation.
8 CHAYTOR, Q.C.:
9 Q. And if that were the situation then, had the
10 patient also not yet been advised of the
11 results and if any treatment was necessary,
12 the treatment had yet to be commenced?
13 DR. SIDDIQUI:
14 A. This was a general thing. I cannot put a
15 finger on which patient was that, but if a
16 result is not there, then of course.
17 CHAYTOR, Q.C.:
18 Q. And Doctor, do you still, in your--do you
19 still check people's charts when they come in
20 to make sure that their retest was actually
21 done?
22 DR. SIDDIQUI:
23 A. In three hours clinic, sometimes 15 or 18
24 patients are booked. Some patients have
25 charts which are several hundred pages. If

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1 you know that you're looking for something,
2 you would probably find that. Otherwise, you
3 have to rely on the system that if there is a
4 new report that you ordered, it should come
5 back to you in your mail box.
6 CHAYTOR, Q.C.:
7 Q. Okay. So I take it, you--and I hear what
8 you're saying in terms of your time
9 constraints, so you wouldn't, every time a
10 patient comes before you now today, be
11 thumbing through the chart to see if the
12 retest is actually done?
13 DR. SIDDIQUI:
14 A. Not every time. When I start seeing a patient
15 the first time or two, I do that, probably a
16 couple of times, just to make sure that I am
17 not missing anything. But when they are in
18 the system and when they are in follow ups, so
19 not until a report comes to you specifically.
20 CHAYTOR, Q.C.:
21 Q. Okay. But back when this was fresher and
22 still going through the process, 2006 and into
23 2007, that was your practice? You would look
24 through to make sure that the retest had been
25 done on the patient?

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1 DR. SIDDIQUI:
2 A. Most of the time, I would rely on the report
3 that it would come to my mail box, because
4 again, you would not know which patient is
5 done when, because I think some of the
6 patients were even done in December of 2007.
7 So I would not have a way to know whether this
8 is being done or is in the pipeline.
9 CHAYTOR, Q.C.:
10 Q. Okay, and Doctor, I will ask you some more
11 questions in a little while about the
12 identification of patients and any involvement
13 you may have had in that. I just want to go
14 back to the communication between oncologists
15 and other than your tumour board rounds, what
16 interaction would you have, on a day-to-day
17 basis, with your colleagues?
18 DR. SIDDIQUI:
19 A. Our offices are next to each other, in the
20 same place. We see each other probably
21 several times a day.
22 CHAYTOR, Q.C.:
23 Q. Okay, and is there -
24 DR. SIDDIQUI:
25 A. And we do clinics. Our clinics are--they're

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1 not huge spaces and there are six rooms in
2 each clinic and we all share those rooms. So
3 when we're in the clinic, we are all there.
4 CHAYTOR, Q.C.:
5 Q. Okay, and so would there be ample opportunity
6 to discuss with your colleagues if you had any
7 issue with respect to any given patient or
8 needed to really speak to someone to get
9 someone else's perspective on a particular
10 issue, that there'd be ample opportunity to do
11 that?
12 DR. SIDDIQUI:
13 A. There would be ample opportunity if it's a
14 quick question and you think just one person
15 can answer that, then you can do that there.
16 Otherwise, tumour board is the place for that
17 patient.
18 CHAYTOR, Q.C.:
19 Q. Yes, if it's something complicated?
20 DR. SIDDIQUI:
21 A. Something complicated and more input is
22 needed.
23 CHAYTOR, Q.C.:
24 Q. And in terms though of informal discussions or
25 conversation during the day, would there be a

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1 lot of that between your colleagues?
2 DR. SIDDIQUI:
3 A. I mean, I don't know a lot, but we will chat
4 here and there.
5 CHAYTOR, Q.C.:
6 Q. Yes.
7 DR. SIDDIQUI:
8 A. We'll see each other. Crossing somebody
9 office, you'll say "hello, hi" and when you're
10 in the clinic, we all have very busy
11 schedules, so as much as we could.
12 CHAYTOR, Q.C.:
13 Q. Yes, okay, and whose office is next to yours?
14 DR. SIDDIQUI:
15 A. To my left side is Dr. McCarthy's office. To
16 the front of me is Dr. Greenland, and then Dr.
17 Rorke and next to it is Dr. Ahmad, and after
18 that is Dr. Tompkins.
19 CHAYTOR, Q.C.:
20 Q. Okay.
21 DR. SIDDIQUI:
22 A. My right side is just the hallway.
23 CHAYTOR, Q.C.:
24 Q. Okay, and Dr. Laing is on a different floor, I
25 take it, or a different -

1 DR. SIDDIQUI:
2 A. That's right. She's on the other floor.
3 CHAYTOR, Q.C.:
4 Q. Okay. When you first arrived in St. John's in
5 2001, what--and at that point in time, there
6 wasn't tumour boards happening until later in
7 the year when Dr. McCarthy arrived, what
8 opportunity did you have for liaising with
9 pathologists?
10 DR. SIDDIQUI:
11 A. I think that would depend on some individual
12 case, if I need to talk to them. We could
13 call them or we could put in a consult to
14 them.
15 CHAYTOR, Q.C.:
16 Q. Okay. Was there any other formal
17 communication or formal means for you to sit
18 down on a regular basis and discuss cases with
19 pathologists?
20 DR. SIDDIQUI:
21 A. I'm just trying to remember. The only other
22 thing came to my mind is that one time, there
23 used to be urology board at that time as well,
24 I went to once with Dr. Alidina in that board
25 and I'm not sure if there was any pathologist

1 in that or not, but otherwise, consults and
2 phone if you need to talk to one.
3 CHAYTOR, Q.C.:
4 Q. Okay, and today, in terms of the tumour
5 rounds, do pathologists attend those on a
6 regular and consistent basis?
7 DR. SIDDIQUI:
8 A. They do. There may be a different
9 pathologist, but when the list of patients
10 goes to them, then I think if some of them saw
11 it, they decide who to come.
12 CHAYTOR, Q.C.:
13 Q. Okay, and did you ever have any difficulty
14 when you would need to consult with a
15 pathologist or ask any questions of the
16 pathologists, did you ever have any difficulty
17 reaching anyone or getting an answer to your
18 question?
19 DR. SIDDIQUI:
20 A. I don't think so.
21 CHAYTOR, Q.C.:
22 Q. Okay, and so basically, they were accessible,
23 if you needed to talk to them about anything?
24 DR. SIDDIQUI:
25 A. Um-hm.

1 CHAYTOR, Q.C.:
2 Q. Okay, and when you first arrived here in 2001,
3 how were they repeating or, sorry, reporting
4 the ER/PR tests?
5 DR. SIDDIQUI:
6 A. That was immunohistochemistry and they were
7 putting--there were two kinds of reports that
8 I can remember. In some reports, they will
9 put in a percentage and in some reports, they
10 will just write negative and positive.
11 CHAYTOR, Q.C.:
12 Q. Okay. So it varied from pathologist to
13 pathologist, I take it?
14 DR. SIDDIQUI:
15 A. And from centre to centre.
16 CHAYTOR, Q.C.:
17 Q. And from centre to centre, and so some would
18 just say negative, some would say positive?
19 DR. SIDDIQUI:
20 A. That's right.
21 CHAYTOR, Q.C.:
22 Q. And what did you--how would you know what any
23 given individual might mean by negative or
24 positive?
25 DR. SIDDIQUI:

1 A. When I started in 2001, there were other
2 oncologists who had recently left before that.
3 I inherited patients from them as well, plus
4 sort of informal discussions with my other
5 colleagues and that sort of helped me know
6 what is the current standard that my peers are
7 using.
8 CHAYTOR, Q.C.:
9 Q. And what did you understand the current
10 standard was?
11 DR. SIDDIQUI:
12 A. At that point, it was 30 percent, and many
13 pathology reports were reflective of that.
14 CHAYTOR, Q.C.:
15 Q. Okay. So in January 2001, when you started,
16 it was 30 percent?
17 DR. SIDDIQUI:
18 A. That's right, to my understanding.
19 CHAYTOR, Q.C.:
20 Q. Okay, and you learned that from your review of
21 the patients charts that you inherited from
22 others and also from informal discussions with
23 your colleagues?
24 DR. SIDDIQUI:
25 A. That's right.

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1 CHAYTOR, Q.C.:
2 Q. Okay, and at any point in time, did that
3 change, from the 30 percent?
4 DR. SIDDIQUI:
5 A. We started treating patients with much lower
6 numbers. If I have to put exactly a finger on
7 which time it happened, it's hard to put an
8 exact finger, but we started treating patients
9 with low numbers. I have personally treated
10 patients with low numbers. No two patients
11 are alike, as you know. So sometimes for
12 patients who are elderly, who have no other
13 choice or cannot tolerate chemo, sometimes we
14 do treat them with a low number as well, and I
15 did treat patients with low number. If I'd go
16 back, I think in the last four or five years,
17 I'm sure that we have used that and it goes
18 before that, I cannot put a finger on exactly
19 when. We just switched from 30 to 10.
20 CHAYTOR, Q.C.:
21 Q. Okay, and would it be though, if you came in
22 January 2001 and it was 30 percent then, would
23 it have been sometime in 2001 or was it about
24 a year after you were in practice?
25 DR. SIDDIQUI:

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1 A. Again, it would be difficult for me to put an
2 exact finger on the exact date. It would be--
3 could be in 2001. Could be in 2002, somewhere
4 around that time.
5 CHAYTOR, Q.C.:
6 Q. Okay. So your sense of it or your
7 recollection of it is that it was certainly a
8 period of months after you were already in
9 your job?
10 DR. SIDDIQUI:
11 A. I joined in January of 2001, that was very
12 early, so if it was towards the end of 2001 or
13 somewhere in 2002, somewhere around that time.
14 CHAYTOR, Q.C.:
15 Q. Okay, and how did you learn that there was now
16 going to be a formal shift to a lower
17 percentage? How was that communicated?
18 DR. SIDDIQUI:
19 A. I think this was, again, with our peer
20 discussions.
21 CHAYTOR, Q.C.:
22 Q. Okay, and so your discussions amongst your
23 fellow medical oncologists?
24 DR. SIDDIQUI:
25 A. That's right.

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1 CHAYTOR, Q.C.:
2 Q. And was there any kind of memo or any
3 documentation that was sent to advise of that?
4 DR. SIDDIQUI:
5 A. I don't remember one, if there was one.
6 CHAYTOR, Q.C.:
7 Q. Okay, and do you know how that--whether or not
8 that was communicated to the pathologists?
9 DR. SIDDIQUI:
10 A. I don't know if it was.
11 CHAYTOR, Q.C.:
12 Q. Okay.
13 THE COMMISSIONER:
14 Q. How can we find out whose decision it is?
15 CHAYTOR, Q.C.:
16 Q. Do you know whose decision it would be to
17 change the cut off or accepted cut off for
18 positivity?
19 DR. SIDDIQUI:
20 A. I don't know if it was a single person's
21 decision or the whole group thought it that
22 way.
23 CHAYTOR, Q.C.:
24 Q. Do you recall was it discussed in--by the
25 summer of 2001 and Dr. McCarthy arrived, you

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1 now have your tumour rounds. Do you recall it
2 being the subject of discussion in tumour
3 rounds?
4 DR. SIDDIQUI:
5 A. I don't remember. There may be one, but I
6 don't remember one.
7 CHAYTOR, Q.C.:
8 Q. Okay.
9 THE COMMISSIONER:
10 Q. And when you talk about the whole group, you
11 mean the group of oncologists?
12 DR. SIDDIQUI:
13 A. That's correct.
14 THE COMMISSIONER:
15 Q. So it is an oncology decision?
16 DR. SIDDIQUI:
17 A. Interpretation part would be.
18 THE COMMISSIONER:
19 Q. Well, in the sense of the cut off, that's a
20 decision for an oncologist? You're
21 determining whether or not to give a
22 particular treatment.
23 DR. SIDDIQUI:
24 A. I would think so.
25 THE COMMISSIONER:

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1 Q. Okay, and at the time the switch came from 30
2 to 10, I'm getting the impression you're a
3 little uncertain about whether or not you sort
4 of gradually did it or you had a group meeting
5 and decided, let's do the switch. Is that -
6 DR. SIDDIQUI:
7 A. I don't remember of a particular group
8 meeting. The change, I think, would be
9 probably a little bit gradual.
10 THE COMMISSIONER:
11 Q. Okay.
12 CHAYTOR, Q.C.:
13 Q. Okay, and you think that was so a gradual
14 switch then to the ten percent, okay. Doctor,
15 did you then continue to receive pathology
16 reports from pathologists that said just
17 positive or negative?
18 DR. SIDDIQUI:
19 A. I think, I really am not sure about that. I
20 remember a few reports from 2001 which said
21 just negative or positive. In 2003, there may
22 be some pathology reports that will say 20 to
23 30 percent, but in the brackets, they would
24 say that--I remember one that in the bracket
25 it would say that "to my interpretation, it is

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1 considered negative."
2 CHAYTOR, Q.C.:
3 Q. Okay.
4 DR. SIDDIQUI:
5 A. So in 2003.
6 CHAYTOR, Q.C.:
7 Q. And that was in 2003?
8 DR. SIDDIQUI:
9 A. Yeah.
10 CHAYTOR, Q.C.:
11 Q. Okay, and the percentage given was 20 to 30
12 percent?
13 DR. SIDDIQUI:
14 A. 20 to 30 percent, but they would also quote
15 some study from 1990 and some publication and
16 that would say that "to my interpretation,
17 this is negative."
18 CHAYTOR, Q.C.:
19 Q. And in that, in such a situation then, Dr.
20 Siddiqui, how would you treat the patient?
21 Would that patient be a candidate for hormone
22 manipulation?
23 DR. SIDDIQUI:
24 A. I think that's again really individualized.
25 That particular patient, I have to look at

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1 that patient to say whether if she was or not.
2 CHAYTOR, Q.C.:
3 Q. But would it be--would that be in--regardless
4 of the--I guess I'm asking you, regardless of
5 the interpretation that a pathologist may give
6 or the definition of positivity that a
7 pathologist may give, whose call ultimately is
8 it?
9 DR. SIDDIQUI:
10 A. In those cases, you'd think again, because
11 pathologists are still considering that as
12 negative in their interpretation, but I think
13 if it was that number, we mostly treated them.
14 CHAYTOR, Q.C.:
15 Q. Doctor, did you ever have the occasion to call
16 or pick up the phone and ask a--contact the
17 pathologist and ask "what do you mean by
18 positive? What do you mean by negative?"
19 DR. SIDDIQUI:
20 A. No.
21 CHAYTOR, Q.C.:
22 Q. And why not?
23 DR. SIDDIQUI:
24 A. There were very few of those cases which were
25 in that area, and I think we sort of discussed

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1 among ourselves the treatment of those.
2 CHAYTOR, Q.C.:
3 Q. Okay. So you never went back looking for any
4 clarification as to what those terms may mean
5 for any given pathologist?
6 DR. SIDDIQUI:
7 A. I don't remember calling them back.
8 CHAYTOR, Q.C.:
9 Q. Okay, and in terms of the decision to move to
10 the ten percent, and I hear you saying that
11 was probably a consensus amongst the
12 oncologists and would that just be the medical
13 oncologists or would that include radiation
14 oncologists?
15 DR. SIDDIQUI:
16 A. Would they know about that? I think they
17 would, but usually that would be the talk
18 among the medical oncologists.
19 CHAYTOR, Q.C.:
20 Q. And do you know whether or not it originated
21 with any of the oncologists that would have
22 been seen more as primarily interested in
23 breast oncology, such as Dr. McCarthy, Dr.
24 Laing? Would it have originated with one of
25 those oncologists?

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1 DR. SIDDIQUI:
2 A. I'm not sure, but possibly.
3 CHAYTOR, Q.C.:
4 Q. And you say that Dr. Laing was on maternity
5 leave for part of 2001?
6 DR. SIDDIQUI:
7 A. That is correct.
8 CHAYTOR, Q.C.:
9 Q. And Dr. McCarthy arrived in the summer of
10 2001?
11 DR. SIDDIQUI:
12 A. That's correct.
13 CHAYTOR, Q.C.:
14 Q. When you originally began in 2001, was ER/PR
15 coming to your--the pathology report that you
16 would get, would it come with the ER/PR test
17 or would it often be that the ER/PR test would
18 be sent along later as an addendum to the
19 report?
20 DR. SIDDIQUI:
21 A. I think not every report was coming with an
22 ER/PR.
23 CHAYTOR, Q.C.:
24 Q. They weren't all getting an ER/PR?
25 DR. SIDDIQUI:

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1 A. No, not every report, when I first see the
2 patient. I think not every report was coming
3 with an ER/PR because there's a time when I
4 remember putting in a few consults, just to
5 get the ER/PR done.
6 CHAYTOR, Q.C.:
7 Q. Okay. So that you would actually have to
8 request the ER/PR test yourself?
9 DR. SIDDIQUI:
10 A. That is correct.
11 CHAYTOR, Q.C.:
12 Q. It wouldn't automatically come, okay, and was
13 that a subject of discussion in the tumour
14 rounds, to ask that pathologists be sure to
15 always have the ER/PR test carried out?
16 DR. SIDDIQUI:
17 A. It may be, but I don't remember that.
18 CHAYTOR, Q.C.:
19 Q. Okay, and if the ER/PR test is done as an
20 addendum afterwards, how was that brought to
21 your attention?
22 DR. SIDDIQUI:
23 A. Again, the pathology would add an addendum to
24 that and a report would be printed and that
25 would come to your mail box.

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1 CHAYTOR, Q.C.:
2 Q. Okay, and your mail box, so then you get a
3 hard copy, I take it, of the report?
4 DR. SIDDIQUI:
5 A. That is correct.
6 CHAYTOR, Q.C.:
7 Q. Okay, so you would get the hard copy of the
8 original report and then sometime later, you'd
9 get another hard copy and it would have the
10 addendum included in it?
11 DR. SIDDIQUI:
12 A. That's right. When you see the patient the
13 first time, the first report is usually in the
14 chart, and the addendum, if you have seen the
15 patient, then the addendum would come to you
16 afterwards.
17 CHAYTOR, Q.C.:
18 Q. Okay.
19 DR. SIDDIQUI:
20 A. Most of the times.
21 CHAYTOR, Q.C.:
22 Q. And would there be anything to highlight the
23 changes to the report?
24 DR. SIDDIQUI:
25 A. It would just say addendum. Sometimes it

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1 actually went to the surgeons as well.
2 CHAYTOR, Q.C.:
3 Q. So the original pathology report would be on
4 the patient's chart?
5 DR. SIDDIQUI:
6 A. That's right.
7 CHAYTOR, Q.C.:
8 Q. And then if you get something in your mail
9 box, you would know well, that must be an
10 addendum to the original report?
11 DR. SIDDIQUI:
12 A. Right, and many of the times, if the ER/PR
13 were not back and the patient is going on a
14 chemotherapy, then you know that you're
15 waiting for that test and when the patient
16 comes in, then you can look for that.
17 CHAYTOR, Q.C.:
18 Q. Okay, and Doctor, I asked you already whether
19 or not you were aware prior to 2005 whether
20 any of your colleagues, any of your colleagues
21 had repeated or had a ER/PR test repeated, had
22 reason to have that done and did you ever
23 hear, prior to 2005, of an instance where that
24 happened and it resulted in a different
25 outcome?

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1 DR. SIDDIQUI:
2 A. I don't remember one.
3 CHAYTOR, Q.C.:
4 Q. Okay, and given your close physical proximity
5 and your working relationship with your
6 colleagues, would you have expected if that
7 had happened that that would be the subject of
8 discussion, something that would be discussed
9 amongst you?
10 DR. SIDDIQUI:
11 A. It may be, it maybe not. It depends what kind
12 of a day is that, I would think. If you're
13 really busy, you may not. If you're not, you
14 may be able to discuss it with your
15 colleagues.
16 CHAYTOR, Q.C.:
17 Q. Okay, and in any event, you have no
18 recollection of that having been the subject
19 of discussion with you?
20 DR. SIDDIQUI:
21 A. I don't remember one.
22 CHAYTOR, Q.C.:
23 Q. And you think if that had happened, is that
24 something that would stick out in your mind?
25 DR. SIDDIQUI:

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1 A. I would think so, but the other thing is that
2 in the last seven and a half years that I have
3 been here, I've seen about 200 new patients
4 each year and about 12 to 1400 follow ups. So
5 a lot of discussions, even if you had them,
6 it's hard to remember about 10,000 follow ups
7 and some discussions among colleagues. But it
8 doesn't come on top of my head that I had one.
9 CHAYTOR, Q.C.:
10 Q. And certainly, if there had been any concern
11 expressed along with it, if it were discussed
12 in the manner of any concern then about the
13 lab results, would that be something you think
14 that you would remember?
15 DR. SIDDIQUI:
16 A. Sometimes you would, sometimes you won't.
17 CHAYTOR, Q.C.:
18 Q. So that could happen and you might not
19 remember it?
20 DR. SIDDIQUI:
21 A. It's possible.
22 CHAYTOR, Q.C.:
23 Q. And do you recall any discussions along those
24 lines, anybody having any concerns about the
25 results they were getting from the lab?

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1 DR. SIDDIQUI:
2 A. I remember one or two of my own patients that
3 I had. They were not ER/PR though. They were
4 otherwise that I had to talk to the
5 pathologist, but those are the ones that come
6 to mind.
7 CHAYTOR, Q.C.:
8 Q. Okay, and was it because what you were seeing
9 in the pathology report didn't seem to be
10 consistent with your view of what you were
11 expecting?
12 DR. SIDDIQUI:
13 A. No, it was more of a change in a pathology
14 report and that would have affected the
15 treatment. This was one of--want me to talk
16 about those?
17 CHAYTOR, Q.C.:
18 Q. Sure, okay.
19 DR. SIDDIQUI:
20 A. One, I think, was a colon patient in whom
21 there is that T & M staging and the T part was
22 changed from T3 to T4 and then back again, and
23 that was one thing I needed to sort out, that
24 comes to mind, because that would have an
25 impact on treatment. And there was another

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1 lung patient in whom the diagnosis pathology
2 was different afterwards.
3 CHAYTOR, Q.C.:
4 Q. Okay. So how, in those two cases, would there
5 have been--well, for example, your first case,
6 how would that difference have come about?
7 Would there have been a repeat test or what
8 happened there?
9 DR. SIDDIQUI:
10 A. It was the same specimen that they had and I
11 think it was--again, I don't remember the
12 exact thing, but what comes to mind is that
13 there may be some difference of opinion among
14 the pathologists. So they said it was T3 at
15 one time and then T4 at the other.
16 CHAYTOR, Q.C.:
17 Q. Okay.
18 DR. SIDDIQUI:
19 A. And the second one was the immediate report
20 after the biopsy, but I think the second one
21 was a detailed report. The first one, the
22 report that was given to me was of a different
23 kind of lung cancer, and to me, it looked okay
24 clinically, but then they called the person
25 who was covering me and the detailed report

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1 was given to him.
2 CHAYTOR, Q.C.:
3 Q. Okay, and I think there's some minutes that
4 I'll bring you to in a little while where you
5 actually then brought those issues up at the
6 surgical pathology review committee.
7 DR. SIDDIQUI:
8 A. Okay.
9 CHAYTOR, Q.C.:
10 Q. Okay, and Doctor, so in those instances, when
11 you had changes and changes which would--in
12 pathology, which would affect the patient's
13 treatment, in those cases, you contacted the
14 pathologists involved and discussed the case?
15 DR. SIDDIQUI:
16 A. In the first one, I did. Second one, they
17 called.
18 CHAYTOR, Q.C.:
19 Q. The second one, they called to alert you to
20 it?
21 DR. SIDDIQUI:
22 A. They called Dr. Rorke who was covering for me
23 and the patient was on the floor and they
24 called him.
25 CHAYTOR, Q.C.:

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1 Q. Okay, and then also, as I said, we'll see here
2 that you also then brought that up in the
3 surgical pathology review committee.
4 DR. SIDDIQUI:
5 A. I did.
6 CHAYTOR, Q.C.:
7 Q. So those were issues that you followed up on
8 when you had a change in result which could
9 affect your patient's treatment. You saw that
10 as issues that you needed to talk to the
11 pathologist about and also bring it to a wider
12 group?
13 DR. SIDDIQUI:
14 A. That's right.
15 CHAYTOR, Q.C.:
16 Q. Okay, maybe we'll talk then about the Surgical
17 Pathology Review Committee. How did you get
18 involved in that committee and what was the
19 mandate of that committee?
20 DR. SIDDIQUI:
21 A. I was asked by Dr. Laing to go to that
22 committee, and that's how I joined that, and
23 the goal or the mandate of the committee was
24 things which were of interest for me in that
25 they had mentioned they were looking for a

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1 standardized reporting system, which would
2 have been a very helpful thing, and discussion
3 about important or interesting cases. Plus
4 there were several other things, the structure
5 and whom they would report, and the reports
6 that they would come up with.
7 CHAYTOR, Q.C.:
8 Q. Okay, and do you know why the committee was
9 formed, and what time period is this that this
10 committee came on?
11 DR. SIDDIQUI:
12 A. The committee meetings per se, I don't have a
13 whole lot of recollection of those. I have to
14 go by the dates that are on different
15 committee meetings.
16 CHAYTOR, Q.C.:
17 Q. I think your first meeting may have been April
18 15th, 2003.
19 DR. SIDDIQUI:
20 A. 2003.
21 CHAYTOR, Q.C.:
22 Q. Yes.
23 DR. SIDDIQUI:
24 A. So I don't know exactly when Dr. Laing asked
25 me to do that, but it would be, I guess, a few

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1 weeks before that.
2 CHAYTOR, Q.C.:
3 Q. Okay, and do you know why, at that point in
4 time, this committee was being formed?
5 DR. SIDDIQUI:
6 A. I can tell you what it says on the mandate of
7 the committee, what they wanted to achieve, so
8 I would think that those were those goals.
9 CHAYTOR, Q.C.:
10 Q. Okay, and you don't know why, in particular,
11 at that point it was felt necessary to have
12 this committee, as opposed to any other point
13 in time?
14 DR. SIDDIQUI:
15 A. No.
16 CHAYTOR, Q.C.:
17 Q. Or whether there was any significance to that,
18 in fact, okay, and what types of disciplines
19 would have sat on this committee, other than--
20 you're there as a medical oncologist?
21 DR. SIDDIQUI:
22 A. That is correct.
23 CHAYTOR, Q.C.:
24 Q. And what other -
25 DR. SIDDIQUI:

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1 A. And it was headed by a pathologist, Dr.
2 Ejeckam was a pathologist who headed that. We
3 had gynecologic oncology in that represented.
4 We had radiologists. We had surgeons. I
5 think there were two surgeons who were
6 initially part of this committee, and we had
7 other pathologists as well, other than Dr.
8 Ejeckam.
9 CHAYTOR, Q.C.:
10 Q. Okay, and this group would, or a group of
11 those disciplines would get together in any
12 event on a weekly basis to discuss cases, so
13 this was, this committee was for something
14 other than that. This wasn't to discuss -
15 DR. SIDDIQUI:
16 A. These were different doctors, because Dr.
17 Ejeckam, I don't remember if he ever came to
18 our tumour board. One of the radiologists was
19 from St. Clare's, if I'm not mistaken, Dr.
20 Thava, I don't remember how he came to the
21 tumour board.
22 CHAYTOR, Q.C.:
23 Q. Okay.
24 DR. SIDDIQUI:
25 A. Dr. Kwan was a member and Dr. Dawson was a

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1 member, I think. They did come to the tumour
2 board, but the discussions would be different.
3 The tumour board was weekly and this was, I
4 think, initially supposed to be every two
5 months.
6 CHAYTOR, Q.C.:
7 Q. Okay, and perhaps then we'll look at your
8 minutes from that. If I could have, please,
9 P-1572? Doctor, I understand this is the
10 first meeting of the committee, and you'll see
11 it's April 15th, 2003, Dr. Ejeckam is the
12 chairman and Dr. Battcock and what kind of
13 physician would Dr. Battcock be?
14 DR. SIDDIQUI:
15 A. He's a radiologist.
16 CHAYTOR, Q.C.:
17 Q. Radiologist, and -
18 DR. SIDDIQUI:
19 A. And he's from St. Clare's, I believe.
20 CHAYTOR, Q.C.:
21 Q. I'm sorry?
22 DR. SIDDIQUI:
23 A. From St. Clare's.
24 CHAYTOR, Q.C.:
25 Q. From St. Clare's, okay, and Dr. Lisa Dawson?

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1 DR. SIDDIQUI:
2 A. She's a gynecologic oncologist. Dr. Parai is
3 a pathologist.
4 CHAYTOR, Q.C.:
5 Q. And yourself, and then Theresa Curtis is the
6 secretary, and we have two apologies, from Dr.
7 -
8 DR. SIDDIQUI:
9 A. Those are both surgeons.
10 CHAYTOR, Q.C.:
11 Q. They're both surgeons, okay.
12 DR. SIDDIQUI:
13 A. The first one is Dr. Thava which is from St.
14 Clare's mostly, and Dr. Kwan mostly from
15 General Hospital Health Science.
16 CHAYTOR, Q.C.:
17 Q. Okay, and your first meeting, the terms of
18 reference is set out, and your terms of
19 reference indicated to be standardized
20 reporting of pathology specimens. "Dr.
21 Ejeckam asked the members for input for
22 standardized reporting of pathology specimens.
23 After much discussion, it was agreed that ER
24 and PR receptors be done automatically on
25 breast surgery cases. Since HER2/neu testing

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1 is expensive and only done when requested, it
2 was suggested it should be performed
3 automatically on patients with a past history
4 of carcinoma of the breast." And Doctor, you
5 stated earlier that when you first arrived
6 that ER/PR cases or ER/PR tests weren't
7 automatically happening, and I take it as of
8 April, 2003, there was still some issue around
9 that, that ER/PR receptors weren't being done
10 automatically?
11 DR. SIDDIQUI:
12 A. I think so, and again, I don't have a full
13 recollection of that meeting, so I would go
14 with the minutes that are here. It looks like
15 that way.
16 CHAYTOR, Q.C.:
17 Q. Okay, and is there anything else other than
18 what's written here? Do you have any other
19 recollection then of what was discussed at
20 that meeting?
21 DR. SIDDIQUI:
22 A. No.
23 CHAYTOR, Q.C.:
24 Q. Okay, and then the second item under terms of
25 reference is clinical information. "Dr. G.

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1 Ejeckam circulated a form listing ten
2 requirements a properly completed specimen
3 requisition form should include. All members
4 agreed these requirements would benefit the
5 clinician and pathologist for improved patient
6 care." And again, other than what's written
7 there, would you have any independent
8 recollection of what was discussed?
9 DR. SIDDIQUI:
10 A. No.
11 CHAYTOR, Q.C.:
12 Q. And the terms of reference continue with
13 "tissue audits on surgical specimens" and it
14 was stated that "requests are received which
15 are inappropriate. It was noted there are
16 guidelines which have to be followed and this
17 information will be forwarded to the
18 clinicians. Reporting mechanism, it was
19 agreed a memo should be sent to the medical
20 staff through the medical director stating the
21 requirements for a properly completed specimen
22 requisition. If these requirements are not
23 met, the committee would make recommendations
24 on individual cases to Dr. Williams and Dr.
25 Cook," and is there anything you have any

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1 independent recollection on either of those
2 items?
3 DR. SIDDIQUI:
4 A. No.
5 CHAYTOR, Q.C.:
6 Q. Okay, and then under new business, item 3.1 is
7 "ER and PR receptors. Dr. G. Ejeckam stated
8 that ER and PR receptors are not being
9 performed for the next six weeks, due to a
10 technical problem. If a solution cannot be
11 found, these tests will be sent outside St.
12 John's. He stated it is being considered to
13 send one or two technologists to Halifax or
14 Toronto for training," and Doctor, other than
15 what's written there, do you have any
16 independent recollection of what was stated by
17 Dr. Ejeckam on this issue, ER/PR receptors?
18 DR. SIDDIQUI:
19 A. No.
20 CHAYTOR, Q.C.:
21 Q. No, okay, and if we could have then, please,
22 P-0113? And this is just, I guess, 11 days
23 before your first meeting, and it's the memo
24 that--the first of three memos that Dr.
25 Ejeckam wrote in this time period. It's dated

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1 April 4th, 2003, and he wrote it to all the
2 pathologists of the Health Sciences, St.
3 Clare's, and out-of-town hospitals, and he
4 wrote "kindly note that immunohistochemical
5 stains with the following antibodies" and
6 there's a list, including ER and PR, "have
7 remained unreliable, erratic and therefore
8 unhelpful for diagnostic purposes. Consequent
9 on the above, staining with these antibodies
10 shall stop forthwith until we can solve the
11 reliability, sensitivity and specificity
12 problems. Efforts are underway and hopefully
13 a solution will be found in the next four to
14 six weeks." Is that the type of thing then
15 that perhaps was discussed at the meeting,
16 that this is what Dr. Ejeckam conveyed to the
17 surgical pathology review committee?
18 DR. SIDDIQUI:
19 A. I would think so, looking at the dates and
20 similar content.
21 CHAYTOR, Q.C.:
22 Q. Okay, and the idea of those stains being
23 "unreliable, erratic and unhelpful for
24 diagnostic purposes," would that have caused
25 you concern at the time, in terms of your

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1 ongoing treatment and care of your patients?
2 DR. SIDDIQUI:
3 A. I would be concerned, but I would also know at
4 the same time that the appropriate person who
5 is going to take care of that is aware of the
6 problem, is looking into that and is taking
7 care of that.
8 CHAYTOR, Q.C.:
9 Q. And would it have caused you any pause to
10 reflect or think about "well, how long has
11 this been going on? Could it--is it just
12 being detected now? Could it potentially
13 affect any of my patients who've recently been
14 tested with those stains?"
15 DR. SIDDIQUI:
16 A. Again, looking at these minutes, what my
17 thoughts would have been, that they're aware
18 of the problem. If they're sending me a
19 report, they have considered all those
20 variables before they sent it to me.
21 CHAYTOR, Q.C.:
22 Q. So at that point in time, in 2003, it didn't
23 cause you, yourself, to go back or ask any
24 more questions or go back and ask whether or
25 not it's any need to have any of your

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1 patients' tests reviewed at that point in
2 time?
3 DR. SIDDIQUI:
4 A. I don't remember, no.
5 CHAYTOR, Q.C.:
6 Q. Okay, and if you had done that, is that
7 something, Doctor, that you would remember?
8 If you had actually--this has registered with
9 you to the point that "this sounds serious. I
10 should be looking at my patients. I wonder is
11 there any concern for the period of time
12 immediately before this having been
13 discovered?"
14 DR. SIDDIQUI:
15 A. If I had asked that, I might have remembered
16 that, but again, cannot be 100 percent sure,
17 but again, the main thing in my mind would be
18 that we get technical--I'm divisional chief, I
19 do make call schedules and I do get technical
20 difficulties at time. It doesn't mean that
21 the things get done, the things would get
22 done, and will be get done in the right way,
23 so I would expect the same thing, that they
24 know the problem, the appropriate person knows
25 the problem, they're looking at that, and if

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1 they are sending me a report, it's not like a
2 preliminary report and they say it's going to
3 change in two weeks. They have looked into
4 those things before they send it to us.
5 CHAYTOR, Q.C.:
6 Q. Okay, and if then afterwards they've detected
7 some issue and the wording here that's used is
8 "remained unreliable, erratic and therefore
9 unhelpful for diagnostic purposes," so if that
10 caused you any concern at the time, it wasn't
11 to the extent that you asked any further
12 questions as to whether or not you should have
13 any patients reviewed or any charts, any tests
14 actually retested?
15 DR. SIDDIQUI:
16 A. Then I would think that if they know what the
17 problem is, they would figure out when it
18 started, and if this had remained, they can
19 look back when it started. They'd look at
20 those things and get back to us.
21 CHAYTOR, Q.C.:
22 Q. So you would rely on them to notify you if
23 that were a concern?
24 DR. SIDDIQUI:
25 A. I would rely on pathologist, yeah.

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1 CHAYTOR, Q.C.:
2 Q. And your role on the committee, on the
3 surgical pathology review committee, Dr. Laing
4 appointed you to that or asked you to sit on
5 that committee, and you're the only medical
6 oncologist on the committee. Would you have
7 gone back to Dr. Laing and/or colleagues and
8 relayed this issue to them and told them that
9 an issue has arisen with those stains and Dr.
10 Ejeckam is concerned to the point that he's
11 stopping the testing for a period of time?
12 DR. SIDDIQUI:
13 A. Not until if he asked me to do. I'm part of a
14 committee and I just can't go out and start
15 saying things. If he thinks that it is that
16 big of thing, that it would have clinical
17 implications, there's a way to do that. He
18 would send a letter to my division chief or
19 clinical chief at that time, and they would
20 send us letters to let us know that these
21 should not be used for treatment purposes.
22 CHAYTOR, Q.C.:
23 Q. So you didn't see--your role on the committee
24 wasn't intended to be a liaison for, or a
25 conduit for information flow to the other

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1 oncologists?
2 DR. SIDDIQUI:
3 A. I think it could be, depending upon the type
4 of information. If they had asked me to do
5 that, I would probably do that.
6 CHAYTOR, Q.C.:
7 Q. So in this particular situation, you did not
8 go back and tell Dr. Laing or your colleagues
9 about this issue?
10 DR. SIDDIQUI:
11 A. I don't remember talking to any of them about
12 that.
13 CHAYTOR, Q.C.:
14 Q. Okay, and unless Dr. Ejeckam had specifically
15 said you should do that, you would not have
16 done that?
17 DR. SIDDIQUI:
18 A. That's right, and plus, I would think that the
19 best way to do that would be to send an
20 official letter to our department and tell us
21 that from this date to this date and that's
22 how to follow up, either to repeat those tests
23 or whatever they would suggest.
24 CHAYTOR, Q.C.:
25 Q. And if we look then, Doctor, at page two of

1 this same exhibit, this is then a second memo
2 written by Dr. Ejeckam, and again it's to all
3 pathologists. So no indication that this
4 would have gone to the oncologists, and it's
5 May 2nd, 2003, and when did you first see this
6 memo, Doctor?
7 DR. SIDDIQUI:
8 A. I saw that the first time when I was
9 interviewed. I think that was in March of
10 this year.
11 CHAYTOR, Q.C.:
12 Q. Okay, during your interview for the Inquiry?
13 DR. SIDDIQUI:
14 A. That's right.
15 CHAYTOR, Q.C.:
16 Q. And is that also true of the one I just showed
17 you?
18 DR. SIDDIQUI:
19 A. That is right.
20 CHAYTOR, Q.C.:
21 Q. Okay. So prior to coming for your interview
22 at the Inquiry, you weren't aware of the
23 existence of those memos?
24 DR. SIDDIQUI:
25 A. There was another one that I think you'll

1 probably show me that. I had heard about that
2 over the CBC Radio.
3 CHAYTOR, Q.C.:
4 Q. The June one?
5 DR. SIDDIQUI:
6 A. That's one.
7 CHAYTOR, Q.C.:
8 Q. This one further along, this June 19th one?
9 DR. SIDDIQUI:
10 A. That is right.
11 CHAYTOR, Q.C.:
12 Q. Okay, but those two memos, you weren't aware
13 of?
14 DR. SIDDIQUI:
15 A. I don't remember seeing them before that March
16 interview.
17 CHAYTOR, Q.C.:
18 Q. Okay, and Doctor, I just want to take you down
19 to page two of this memo, and at this point in
20 time, I should point out to you first that
21 he's "glad to inform that we have rectified
22 the difficulties related to the immunostain of
23 ER/PR. Therefore, we can now resume regular
24 requests for these antibody stains. I will,
25 however, like to bring the following

1 information to your attention," and then
2 there's a number of things which we've been
3 through several times here at the Commission,
4 including fixation, but paragraph five on the
5 reporting of ER/PR, and again, I appreciate
6 this is written to pathologists, but "several
7 formulae are in the literature for positive
8 results. ER positive greater or equal to five
9 percent nuclear staining, ER positive ten
10 percent of tumour staining, ER positive one
11 percent, shown to benefit from endocrine," is
12 it, "endocrine treatment"?
13 DR. SIDDIQUI:
14 A. Endocrine treatment, yes.
15 CHAYTOR, Q.C.:
16 Q. Thank you, and then there's a consensus
17 statement referred to, November 1st to 3rd,
18 2000, National Institute of Health, "any
19 positive nuclear ER immunostaining is
20 considered to be a positive result and should
21 be a definitive reason for instituting anti-
22 estrogen therapy for a patient. The medical
23 oncologists may require percentage of tumour
24 positivity." Were you aware of this consensus
25 statement? Had you ever heard of that as a

1 medical oncologist?
2 DR. SIDDIQUI:
3 A. I might have heard of the contents of it, but
4 exactly was it from this statement, I'm not
5 sure if I was at that time.
6 CHAYTOR, Q.C.:
7 Q. Okay. So this is now being written in 2003,
8 that memo, but the consensus statement is said
9 to be 2000, so whether or not--you are not
10 able to say whether or not, in 2000, you would
11 have been aware of that?
12 DR. SIDDIQUI:
13 A. What comes to mind is that again, they're
14 pointing towards the percentage. We were
15 using, I think, ten percent at that time, and
16 that has been the case for most of the places.
17 CHAYTOR, Q.C.:
18 Q. Okay, and then it continues on in paragraph
19 seven and it refers to or he lists a number of
20 ER positive tumours, and Dr. Ejeckam has told
21 us that he -
22 DR. SIDDIQUI:
23 A. He missed lobular.
24 CHAYTOR, Q.C.:
25 Q. Yes, he missed lobular. He meant to have

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1 lobular there as well, but it's missing from
2 the list. Those you've--tubular and mucinous,
3 you've certainly referred to, and would you
4 also have been aware that papillary and ductal
5 low nuclear grade tend to be ER positive as
6 well?
7 DR. SIDDIQUI:
8 A. That's correct.
9 CHAYTOR, Q.C.:
10 Q. Okay, and you would have been aware of that
11 back in your training days or your residency
12 days. Is that right?
13 DR. SIDDIQUI:
14 A. I would think so, this information, yes, in
15 the back to somewhere, what exactly you called
16 that.
17 CHAYTOR, Q.C.:
18 Q. Yes, okay.
19 THE COMMISSIONER:
20 Q. Ms. Chaytor, whenever you can find a
21 convenient spot.
22 CHAYTOR, Q.C.:
23 Q. Okay, thank you. Doctor, and what was your
24 practice then in terms of if you had a patient
25 who had one of those types of cancers or

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1 lobular and you were to have an ER negative?
2 What was your practice in the event that
3 happened? Do you recall, first of all, did
4 that happen in your practice, and if so, what,
5 if anything, did you do about that?
6 DR. SIDDIQUI:
7 A. Lobular cancers, a great majority of them are
8 ER positive, as we know, but they could be ER
9 negative. It's not unheard of. Again, I
10 don't remember the particular instant. What I
11 can think that I might have done is that if
12 you find a lobular and it is ER negative, you
13 would think that that could be the one which
14 could be ER negative. If we are seeing breast
15 cancer on every single day and only then you
16 could probably pick up a trend that you are
17 having lobular, multiple lobulars. As you
18 know, lobular cancers are only about five to
19 ten percent of all breast cancers, so that
20 would mean that probably one out of 15 or 20
21 is a lobular, and if you are seeing 40, even
22 40 breast cancers in a year, so you saw
23 probably two lobular in a year, and they may
24 be seven months apart or 11 months apart. So
25 you would not be able to pick up a trend, and

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1 if it was just a single lobular which was ER
2 negative, which there could be at times,
3 especially the poorly differentiated one, you
4 could think that they may be the negative one.
5 CHAYTOR, Q.C.:
6 Q. Okay, and in terms of trends, were you or are
7 you now keeping track of any trends or any
8 metrics?
9 DR. SIDDIQUI:
10 A. You mean keeping track of my own patients?
11 CHAYTOR, Q.C.:
12 Q. Yes, or has it been, not just you personally,
13 is there any coordinated effort for that to
14 happen within the oncology service?
15 DR. SIDDIQUI:
16 A. There's a tumour registry which keeps track of
17 patients, but I don't know if they pick up on
18 things like that or not.
19 CHAYTOR, Q.C.:
20 Q. Okay, and so to this day, whether or not
21 anyone is tracking types of tumour and having
22 that correlated with their hormone receptor
23 positivity, you don't know if that's
24 happening?
25 DR. SIDDIQUI:

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1 A. If they are, I am not aware of it.
2 CHAYTOR, Q.C.:
3 Q. You're not aware of it, okay, and you
4 personally, in your own practice, aren't
5 tracking things like that?
6 DR. SIDDIQUI:
7 A. We can't.
8 CHAYTOR, Q.C.:
9 Q. And why, Doctor, why is it--is it the time
10 constraints that you have and the patient
11 loads?
12 DR. SIDDIQUI:
13 A. No, as I said, if we are seeing two lobular
14 patients in the whole year or three in the
15 whole year, they would be so far apart. If
16 you are lucky and it happens to be that you
17 saw two patients on the same day and they're
18 both ER/PR negative, then you could be--that
19 could come to your mind. But if they're a
20 long time apart, you would not remember the
21 first one, if they're six months or eight
22 months or a year apart.
23 CHAYTOR, Q.C.:
24 Q. Yes, and that's why I was wondering if you
25 were to keep track though and have a record of

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1 it and not have to rely on your memory, but
2 that's not happening?
3 DR. SIDDIQUI:
4 A. No, I did not. I don't know about my other
5 colleagues, if they did. I do not such track.
6 CHAYTOR, Q.C.:
7 Q. Okay, and you're not aware of anything
8 currently within the oncology service that
9 people are pooling their results as such and
10 keeping track of issues such as that? And I
11 just use that one as an example.
12 DR. SIDDIQUI:
13 A. As I said, tumour registry, they keep a track
14 of the patients and they'd keep a track of the
15 number of cancers each year, and the
16 percentage changes. Are they keeping a track
17 of ER/PR negative on a particular type of
18 cancer, I'm not sure.
19 CHAYTOR, Q.C.:
20 Q. Okay. Thank you, Doctor. Thank you,
21 Commissioner. This is a good point then.
22 THE COMMISSIONER:
23 Q. All right then. We'll adjourn until Monday
24 morning at 9:30. Thank you.
25

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1 CERTIFICATE
2 I, Judy Moss, hereby certify that the foregoing is
3 a true and correct transcript in the matter of the
4 Commission of Inquiry on Hormone Receptor Testing,
5 heard on the 5th 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 5th day of September, A.D., 2008
13 Judy Moss

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