

<p>COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p>BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p>July 11, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. . . . . Commission Co-counsel Sandra Chaytor, Q.C./Mandy Woodland . . . . Commission Co-counsel</p> <p>Jackie Brazil . . . . . Her Majesty in Right of NL</p> <p>Peter Browne . . . . . Doctors Kara Laing et al</p> <p>Daniel Simmons . . . . . Eastern Regional Integrated . . . . . Health Authority</p> <p>Darlene Russell. . . . . Members of the Breast Cancer . . . . . Testing Class Action</p> <p>Mark Pike . . . . . NL Medical Association Jennifer Newbury . . . . . Canadian Cancer Society (NL Division) Blair Pritchett. . . . . Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p>LIST OF EXHIBITS</p> <p>EXHIBIT P-2195 . . . . . Pg. 4</p> <p>EXHIBIT P-2272 . . . . . Pg. 4</p> <p>EXHIBIT P-2299 . . . . . Pg. 4</p> <p>EXHIBIT P-1849 . . . . . Pg. 4</p> <p>EXHIBITS P-2196 THROUGH P-2223 . . . . . Pg. 122</p>
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Page 5

1 know?  
 2 MR. BROWNE:  
 3 Q. I will, Commissioner.  
 4 COFFEY, Q.C.:  
 5 Q. That's, I take it, Doctor, a subtle way of  
 6 asking you to speak up.  
 7 DR. NEIL:  
 8 A. Okay, no problem.  
 9 COFFEY, Q.C.:  
 10 Q. Thanks, Doctor. Doctor, here on the screen,  
 11 this exhibit is entitled Association of  
 12 Directors of Anatomical and Surgical  
 13 Pathology.  
 14 DR. NEIL:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. And you provided us, thank you, yesterday with  
 18 this document. What is this, Doctor?  
 19 DR. NEIL:  
 20 A. This is a document that I retrieved from a  
 21 U.S. source recommending quality assurance and  
 22 improvements in surgical and autopsy  
 23 pathology, which I've perused on various  
 24 occasions, and I think it's a very good  
 25 document.

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1 COFFEY, Q.C.:  
 2 Q. This is the document, I take it, that you  
 3 referred to yesterday as you were looking at  
 4 as a possible template?  
 5 DR. NEIL:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. For quality assurance and quality improvement?  
 9 DR. NEIL:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. Okay. I'm not going to take you actually  
 13 through it, Doctor, you know, in detail, but  
 14 this is it and the Commissioner can read it,  
 15 and this is certainly what you had in mind?  
 16 DR. NEIL:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. Registrar, could we bring up, please, Exhibit  
 20 P-1849? Now Doctor, these are your  
 21 handwritten notes?  
 22 DR. NEIL:  
 23 A. That's correct.  
 24 COFFEY, Q.C.:  
 25 Q. Okay, and there are four pages of them.

Page 7

1 Looking at the first page now which begins  
 2 "letter September 6th, 2005" and there are a  
 3 number of bullets below it, and then the  
 4 second page begins "results ER/PR" and then  
 5 there are notes that follow that, ending with  
 6 a page entitled "results 939 patients."  
 7 DR. NEIL:  
 8 A. Yes.  
 9 COFFEY, Q.C.:  
 10 Q. Okay. Doctor, these four pages of notes, do  
 11 they actually relate to the same day?  
 12 DR. NEIL:  
 13 A. No.  
 14 COFFEY, Q.C.:  
 15 Q. Okay, could you--then looking back at it, I  
 16 understand from a comment Mr. Browne made to  
 17 me yesterday that the first page stands on its  
 18 own?  
 19 DR. NEIL:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. Okay, and if you could, perhaps you could  
 23 indicate to the Commissioner what this is and  
 24 just take us through it?  
 25 DR. NEIL:

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1 A. This is just a time line for my own benefit,  
 2 for the preparation for the Commission of  
 3 Inquiry. It outlines that I have a letter of  
 4 September 6th, which we talked about, and I  
 5 reviewed that letter and the next three points  
 6 actually are how I actually arrived at the  
 7 list of patients for the recall.  
 8 COFFEY, Q.C.:  
 9 Q. Which you described to the Commissioner  
 10 yesterday?  
 11 DR. NEIL:  
 12 A. Yes, which we described yesterday.  
 13 COFFEY, Q.C.:  
 14 Q. And go ahead, Doctor, then there's another  
 15 bullet, I believe, below that, generated -  
 16 DR. NEIL:  
 17 A. Generated a yearly list based on the previous  
 18 three bullets and when the reports would come  
 19 back, the pathologist would review their cases  
 20 and I just listed the names of the  
 21 pathologists that are there at the time.  
 22 COFFEY, Q.C.:  
 23 Q. Doctor, on the last point, and I understand  
 24 from your evidence yesterday that when the  
 25 reports of the Mount Sinai results would come

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1 back individually, you know, for each patient  
 2 from Dr. Cook -  
 3 DR. NEIL:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. - that you attended to having them entered in  
 7 Meditec?  
 8 DR. NEIL:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. Were the reports, if a pathologist was still  
 12 on staff related to that patient, were those  
 13 individual reports then referred to a  
 14 particular pathologist?  
 15 DR. NEIL:  
 16 A. If the pathologist on staff was still there,  
 17 he got those reports. All other reports came  
 18 to me.  
 19 COFFEY, Q.C.:  
 20 Q. Okay, so I had understood that yesterday, in  
 21 bulk they came to you?  
 22 DR. NEIL:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. They were funnelled through you?

Page 10

1 DR. NEIL:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. You ensured that they were entered in Meditec?  
 5 DR. NEIL:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. And for those doctors--for those patients for  
 9 whom the pathologist who had dealt with the  
 10 original ER/PR was still on staff, he or she  
 11 got the copies?  
 12 DR. NEIL:  
 13 A. Yes, he got those.  
 14 COFFEY, Q.C.:  
 15 Q. And the purpose of giving him, I take it in  
 16 the main it was his, was what? What was the  
 17 purpose?  
 18 DR. NEIL:  
 19 A. The purpose was to sign the report, verify  
 20 that what was typed was actually what was on  
 21 the report from Dr. Cook and sign it.  
 22 COFFEY, Q.C.:  
 23 Q. Okay, so the actual entry then of--for  
 24 example, if it wasn't your patient, if it was  
 25 Dr. Luer, for example, the report--Dr. Cook's

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1 report would at some point, after you received  
 2 it, end up in Dr. Luer's hands?  
 3 DR. NEIL:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. And after the data was entered into Meditec,  
 7 Dr. Luer was responsible, because it was  
 8 originally his patient, to go in and satisfy  
 9 himself that it's appropriate to sign it?  
 10 DR. NEIL:  
 11 A. Yes, correct.  
 12 COFFEY, Q.C.:  
 13 Q. Okay, and for those doctors that were no  
 14 longer on staff, who did that signing?  
 15 DR. NEIL:  
 16 A. I did.  
 17 COFFEY, Q.C.:  
 18 Q. Doctor, if we could, please, apologize, page  
 19 two, three and four of this exhibit, what do  
 20 they relate to?  
 21 DR. NEIL:  
 22 A. Page two, three and four go together. These  
 23 are my handwritten notes of a teleconference  
 24 that occurred later when the results of the  
 25 ER/PR testing came back and it was an

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1 explanation from Dr. Denic as to really what  
 2 the time lines were and what the results were  
 3 and what the recommendations were of all the  
 4 investigations that occurred up to that point.  
 5 So these were notes that I took and for my own  
 6 interest and I put them in my file.  
 7 COFFEY, Q.C.:  
 8 Q. Now Doctor, here, are you able to recall which  
 9 particular teleconference or video conference  
 10 this was?  
 11 DR. NEIL:  
 12 A. As we discussed yesterday, I think this was  
 13 the case, the only teleconference that I  
 14 really remember attending, it was the video  
 15 conference that Dr. Elms, Ford Elms was there  
 16 as well. I didn't make notes of Dr. Elms'  
 17 presentation. I just made notes of the  
 18 presentation from Dr. Denic.  
 19 COFFEY, Q.C.:  
 20 Q. And Doctor, here, on the third page, and  
 21 because you've written "problem was, question"  
 22 and then you've got written "reporting varied."  
 23 Different technology, DAKO etcetera, Ventana,  
 24 antibody and antigen."  
 25 DR. NEIL:

Page 13

1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. "No national lab accreditation process"--I'm  
 4 sorry, can you read that?  
 5 DR. NEIL:  
 6 A. "No national lab accreditation process, but  
 7 now started."  
 8 COFFEY, Q.C.:  
 9 Q. "But now started. Staining complex."  
 10 DR. NEIL:  
 11 A. Yes.  
 12 COFFEY, Q.C.:  
 13 Q. "From tissue procurement to reporting"  
 14 DR. NEIL:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. The staining is complex, I take it, the  
 18 process?  
 19 DR. NEIL:  
 20 A. Yes, that's correct.  
 21 COFFEY, Q.C.:  
 22 Q. Then you've got written out here, "needs  
 23 direction" in capital letters and an asterisk.  
 24 DR. NEIL:  
 25 A. Yes.

Page 14

1 COFFEY, Q.C.:  
 2 Q. "Variation in other labs. Limited resources,  
 3 lack of QA."  
 4 DR. NEIL:  
 5 A. Correct.  
 6 COFFEY, Q.C.:  
 7 Q. "Turnover of pathologists/oncologists."  
 8 DR. NEIL:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And then "external reviewers recommended  
 12 reinstatement."  
 13 DR. NEIL:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. Doctor, during this presentation or talk by  
 17 Dr. Denic, do you recall if Dr. Denic referred  
 18 at any time to the observations of the  
 19 external reviewers in relation to--external  
 20 reviewer, Dr. Banerjee, in relation to the  
 21 usage or non usage of internal controls by the  
 22 pathologists? Did the subject of internal  
 23 controls and their utilization come up?  
 24 DR. NEIL:  
 25 A. I would have written that down, I think.

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1 COFFEY, Q.C.:  
 2 Q. Yes, and it's not there, so -  
 3 DR. NEIL:  
 4 A. It's not there.  
 5 COFFEY, Q.C.:  
 6 Q. - it's not. And because I take it, that kind  
 7 of a remark in that context would have been  
 8 directed at the pathologists?  
 9 DR. NEIL:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. And you'd be certain to write that down.  
 13 DR. NEIL:  
 14 A. I would have. I wrote what I think are good  
 15 notes. It wasn't there.  
 16 COFFEY, Q.C.:  
 17 Q. Now Doctor, if I could, Registrar, please,  
 18 Exhibit 2195, please? Now Doctor, these are  
 19 two exhibits, you provided these actual copies  
 20 to us yesterday. Thank you for that. This is  
 21 a fax transmission to yourself from Judy at  
 22 Eastern Health and it just says "as requested"  
 23 the first page. Then the pages that follow,  
 24 page two is entitled "procedure, ductal  
 25 carcinoma in situ reporting." Goes on to the

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1 third page and then there's a "pathology  
 2 procedures manual, anatomic pathology/grossing  
 3 protocols." The title is "breast needle core  
 4 biopsy, standardized grossing" and then  
 5 there's a pathology procedures manual titled  
 6 "breast sentinel node lymph node" then there's  
 7 following page, "Pathology Procedures Manual"  
 8 title "cancer lumpectomy specimen, breast  
 9 conserving surgery." Continues on to page  
 10 seven. Page eight has a canned text needle  
 11 core biopsy reporting, BCBR, and page nine is  
 12 the same thing.  
 13 Now Doctor, I'm going to show you those  
 14 and I want to bring up, please, if I could,  
 15 Exhibit, Registrar, 2272? Doctor, this is a--  
 16 it begins on page one, again it's a fax  
 17 transmission from Eastern Health, a cover  
 18 sheet to yourself, May 31st 2007, from Judy.  
 19 It's written "as requested, including one path  
 20 procedure sheet I had left out." And then  
 21 page two of this exhibit is an e-mail, Nash  
 22 Denic, May 31st, 2007 to Judy Thomas,  
 23 forwarding a memorandum with a number of  
 24 attachments and they are synoptic DCIS.bb.doc,  
 25 breast needle core biopsies, standardized

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1 grossing and if one wants to look, they match  
 2 the documents that we just looked at.  
 3 DR. NEIL:  
 4 A. Yes, they do.  
 5 COFFEY, Q.C.:  
 6 Q. And there's a memorandum below it to  
 7 pathologists in Newfoundland, I'm going to  
 8 take you to in a moment, and then the fourth  
 9 page of this exhibit is the Pathology  
 10 Procedures Manual, title breast needle core  
 11 biopsy, standardized reporting. So I take it,  
 12 Doctor, would I be correct in surmising that  
 13 in Exhibit 2195, Judy had faxed you a number  
 14 of documents, those attachments?  
 15 DR. NEIL:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. And then one was missing?  
 19 DR. NEIL:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. And she sent the final one with that note?  
 23 DR. NEIL:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

Page 18

1 Q. Now Doctor, looking at this e-mail, Doctor, do  
 2 you recall--do you recall, Doctor, how this  
 3 came about? I mean, this transmission of  
 4 these documents to yourself, what led to this,  
 5 in May of 2007?  
 6 DR. NEIL:  
 7 A. We wanted to have standardized protocols for  
 8 examination of breast tissues, standard  
 9 protocols for fixation. This e-mail came from  
 10 Dr. Denic to all pathologists in Newfoundland.  
 11 Unfortunately, the e-mail didn't come through  
 12 to me. That's the reason for the faxes.  
 13 COFFEY, Q.C.:  
 14 Q. Okay.  
 15 DR. NEIL:  
 16 A. So I called Judy and said "I didn't get the  
 17 attachments. Please send it over to me right  
 18 away," which she did.  
 19 COFFEY, Q.C.:  
 20 Q. So you got the e-mail without the attachments?  
 21 DR. NEIL:  
 22 A. I got--I didn't get the attachments.  
 23 COFFEY, Q.C.:  
 24 Q. Okay.  
 25 DR. NEIL:

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1 A. That's why the faxes are there. I went  
 2 looking for the fax, looking for that  
 3 attachment and got it through a fax instead.  
 4 In any event, I did get it.  
 5 COFFEY, Q.C.:  
 6 Q. Now, Doctor, if we could, please -- could the  
 7 Registrar please bring up P-0854. Doctor,  
 8 this is an e-mail from John Abbott who was  
 9 then the Deputy Minister to Oscar Howell, the  
 10 VP Medical of Eastern Health, May 23rd, 2007,  
 11 and it says -- after asking Dr. Howell to  
 12 call, Mr. Abbott says, "I also need for you to  
 13 arrange a conference call tomorrow a.m. with  
 14 other VPs of Medical Service in province on  
 15 the ER/PR issue, and current testing  
 16 processes. Please include Cathi Bradbury and  
 17 Moira Hennessey in call".  
 18 DR. NEIL:  
 19 A. Uh-hm.  
 20 COFFEY, Q.C.:  
 21 Q. And then the Commissioner has heard that there  
 22 was, in fact, a teleconference the next day  
 23 across the province involving a number of VP  
 24 medicals from the health authorities.  
 25 DR. NEIL:

Page 20

1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. Did you participate in that teleconference, do  
 4 you recall?  
 5 DR. NEIL:  
 6 A. Not that I recall, no.  
 7 COFFEY, Q.C.:  
 8 Q. Doctor, this memo -- if we could look back  
 9 please at Exhibit P-2272, and before I leave  
 10 the topic of that May 24th teleconference, do  
 11 you ever recall being told by Dr. Jenkins  
 12 about what went on during it or what it was  
 13 about?  
 14 DR. NEIL:  
 15 A. No.  
 16 COFFEY, Q.C.:  
 17 Q. Okay, and again --  
 18 DR. NEIL:  
 19 A. I've had a lot of conversations with Dr.  
 20 Jenkins, so --  
 21 COFFEY, Q.C.:  
 22 Q. I appreciate that. This particular thing  
 23 would have involved the issue of the other  
 24 three health authorities as at that point not  
 25 utilizing Eastern Health for ER/PR testing.

Page 21

1 DR. NEIL:  
 2 A. Okay, okay.  
 3 COFFEY, Q.C.:  
 4 Q. Do you recall that being --  
 5 DR. NEIL:  
 6 A. Yes, yes.  
 7 COFFEY, Q.C.:  
 8 Q. What do you recall about being told about  
 9 that?  
 10 DR. NEIL:  
 11 A. Well, I was asking were we, in fact, sending  
 12 back to Eastern Health, and if we weren't,  
 13 why, and we have discussed that already.  
 14 COFFEY, Q.C.:  
 15 Q. So you told Dr. Jenkins what you told the  
 16 Commissioner?  
 17 DR. NEIL:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. Now looking at this, Doctor, this particular  
 21 memorandum by e-mail, did you have any heads  
 22 up that this was coming to you?  
 23 DR. NEIL:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

Page 22

1 Q. And you understood, I take it at the time --  
 2 you pointed out that there was some thought in  
 3 the pathology community that this should be  
 4 somehow standardized?  
 5 DR. NEIL:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. The approach in the province. What then  
 9 happened? You received this -- you received  
 10 the e-mail and then the fax. What then  
 11 happened, Doctor?  
 12 DR. NEIL:  
 13 A. This got circulated to all our pathologists  
 14 and, in effect, this is what we adopted,  
 15 mostly notably the fixation protocols.  
 16 COFFEY, Q.C.:  
 17 Q. And in relation to that, if you could bring  
 18 up, please, Exhibit P-2195, page 10, please,  
 19 Registrar. This is the fixation protocol  
 20 you're speaking of?  
 21 DR. NEIL:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. Now, Doctor, have you received any -- since  
 25 that time, since May 31st, 2007, have you

Page 23

1 received anything further in relation to  
 2 pathology procedures manuals, policy manuals  
 3 generally, anything else since?  
 4 DR. NEIL:  
 5 A. No.  
 6 COFFEY, Q.C.:  
 7 Q. And so when you said yesterday to the  
 8 Commissioner that you had received a procedure  
 9 -- written procedure from Eastern Health  
 10 relating to fixation and Western Memorial is  
 11 now following that --  
 12 DR. NEIL:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. This is the document you're talking about?  
 16 DR. NEIL:  
 17 A. This is it.  
 18 COFFEY, Q.C.:  
 19 Q. If we could, please, as well -- I'm just going  
 20 to go to page 11. Now this is a document --  
 21 it came separately when we look back at the  
 22 attachments.  
 23 DR. NEIL:  
 24 A. Okay.  
 25 COFFEY, Q.C.:

Page 24

1 Q. This is a separate attachment. It says, "For  
 2 optimal tissue selection for  
 3 immunohistochemical testing of breast cancer  
 4 specimens, the following steps are suggested",  
 5 and it goes through bread loafing, placing in  
 6 10 percent buffer formalin and so on. Is this  
 7 being followed in Western Memorial?  
 8 DR. NEIL:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And it has been since that time?  
 12 DR. NEIL:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. If we could, please -- I'm just going to go  
 16 back one page. Looking at this particular SP  
 17 number here on the top right hand side is  
 18 09SP105, and there's a policy and a procedure  
 19 and the procedure has six steps. If we could  
 20 look, please, at Exhibit P-2157. This is a  
 21 document entitled -- the first page of it is  
 22 entitled "Pathology Policy and Procedures  
 23 Manual, Table of Contents", and pathology  
 24 policies are listed there. If we could,  
 25 please, Registrar, page 42. Now, Doctor, this

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1 is a document headed "Pathology Division", and  
 2 pathology/specimen collection and handling,  
 3 the number is PRC-PAT-102. It's two pages  
 4 long. The title is "Fixation procedure for  
 5 pathology specimens". The issuing authority  
 6 is Dr. Nash Denic and Terry Gulliver. The  
 7 signatures are indicated to be March 17, 2008,  
 8 the issue date is March 19, 2008; the date  
 9 effective, March 19th, 2008. It has headings;  
 10 overview, safety precautions, and procedure.  
 11 There are four procedures and there are  
 12 references below. Now if we could go back --  
 13 have you seen this before or received a copy  
 14 of it?  
 15 DR. NEIL:  
 16 A. No, I haven't.  
 17 COFFEY, Q.C.:  
 18 Q. If we could look, please, back at page nine,  
 19 the same exhibit. Now, Doctor, this is a  
 20 document on Eastern Health letterhead. It's  
 21 called "Fixation policy". The policy name is  
 22 fixation policy, the laboratory 410J-PCO-010.  
 23 The issuing authority signed and dated, Nash  
 24 Denic, February 4th, 2008, Terry Gulliver,  
 25 February 5th, 2008, and it's a level four

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1 document apparently. The original approval  
 2 date is February 4th, as I've said, and review  
 3 date is said to be February 4th, 2009, and the  
 4 document itself has headings; overview,  
 5 policy, scope, purpose, and a procedure with  
 6 five steps noted. Doctor -- and I should go  
 7 on with this particular one. As well there  
 8 are supporting documents noted and linkages  
 9 to, I take it, what I understand are other  
 10 policies and procedures. Doctor, have you  
 11 received a copy of the document at page nine?  
 12 DR. NEIL:  
 13 A. No.  
 14 COFFEY, Q.C.:  
 15 Q. Doctor, at the time back in May 31st, 2007,  
 16 when you received Dr. Denic's memo to all  
 17 pathologists in Newfoundland, and then you got  
 18 the --  
 19 DR. NEIL:  
 20 A. Uh-hm.  
 21 COFFEY, Q.C.:  
 22 Q. Policies such as you did or procedures such as  
 23 you did at the time.  
 24 DR. NEIL:  
 25 A. Uh-hm.

Page 27

1 COFFEY, Q.C.:  
 2 Q. Did you have any understanding about what you  
 3 might or might not receive from Eastern Health  
 4 if they changed or added to their policies and  
 5 procedures? What is the expectation?  
 6 DR. NEIL:  
 7 A. Dr. Denic did say that they were going to do  
 8 policies and procedure manuals.  
 9 COFFEY, Q.C.:  
 10 Q. Yes.  
 11 DR. NEIL:  
 12 A. It was my understanding that some of these  
 13 would be shared, and it's still my  
 14 understanding that some of these would be  
 15 shared. It looks like they've got a lot of  
 16 work done.  
 17 COFFEY, Q.C.:  
 18 Q. Yes. Well, in fact, that document that took  
 19 all that time to load --  
 20 DR. NEIL:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. Exhibit P-2157.  
 24 DR. NEIL:  
 25 A. Yes.

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1 COFFEY, Q.C.:  
 2 Q. I'll just let you know, Doctor, that after you  
 3 leave here today, if you want to see --  
 4 DR. NEIL:  
 5 A. I would like to have a copy of that.  
 6 COFFEY, Q.C.:  
 7 Q. What the Commission has received -- it's on  
 8 the website. Actually now it's on the  
 9 website.  
 10 DR. NEIL:  
 11 A. Okay.  
 12 COFFEY, Q.C.:  
 13 Q. As of the past week or so.  
 14 DR. NEIL:  
 15 A. Uh-hm.  
 16 COFFEY, Q.C.:  
 17 Q. It's on the Commission's website, that is.  
 18 DR. NEIL:  
 19 A. Uh-hm, okay.  
 20 COFFEY, Q.C.:  
 21 Q. So, Doctor, in particular because you did --  
 22 as you pointed out to the Commissioner, if we  
 23 look back at Exhibit P-2195, at page 10, they  
 24 fixation policy that you received a copy of as  
 25 it was.

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1 DR. NEIL:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. In May of 2007, the comparable fixation  
 5 procedures or policies that I just showed you.  
 6 DR. NEIL:  
 7 A. Should be the same.  
 8 COFFEY, Q.C.:  
 9 Q. Should be the same, and if they are different,  
 10 I take it you'd like to see the differences  
 11 and nuances or possible differences?  
 12 DR. NEIL:  
 13 A. Certainly.  
 14 COFFEY, Q.C.:  
 15 Q. Okay. I'm not going to take you to -- there  
 16 are some particular -- if we could, please,  
 17 Exhibit P-2157, page 10. In particular,  
 18 Doctor, I'm going to take you to -- this is  
 19 the fixation policy generally, okay.  
 20 DR. NEIL:  
 21 A. Uh-hm.  
 22 COFFEY, Q.C.:  
 23 Q. Go back to see -- fixation policy, and this  
 24 refers to really all tissues, okay.  
 25 DR. NEIL:

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. Requiring formalin fixation. There's, for  
 4 example, number five here in procedure, the  
 5 date and time of fixation must be documented  
 6 on the requisition.  
 7 DR. NEIL:  
 8 A. Uh-hm.  
 9 COFFEY, Q.C.:  
 10 Q. When you look back at the one that you were  
 11 given back in May of 2007, that's not referred  
 12 to, is it?  
 13 DR. NEIL:  
 14 A. No.  
 15 COFFEY, Q.C.:  
 16 Q. And again I'm not going to take you through --  
 17 they can be compared and there are differences  
 18 between them?  
 19 DR. NEIL:  
 20 A. Yes, there are.  
 21 COFFEY, Q.C.:  
 22 Q. Looking at Exhibit P-2195, please, Doctor,  
 23 this is the one that you received in May and  
 24 you've indicated to the Commissioner that  
 25 Western has been following since. Doctor, the

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1 procedures here, was there a written -- a  
 2 comparable written procedure in existence in  
 3 Western Memorial or Western Health prior to  
 4 May, 2007? Did you have a fixation policy for  
 5 Western Memorial or Western Health?  
 6 DR. NEIL:  
 7 A. Not that I'm aware of. I'm not saying it's  
 8 not there, but I'm not aware of it.  
 9 COFFEY, Q.C.:  
 10 Q. And now this procedure that's outlined here, I  
 11 understand this is a general procedure, it's  
 12 not applicable to any one particular type of -  
 13 -  
 14 DR. NEIL:  
 15 A. No, but I do have to make a point about  
 16 procedures. Standard pathology textbooks,  
 17 Ackerman being one of them, has standard  
 18 grossing procedures back in the back part of  
 19 the textbook which we refer to quite  
 20 frequently. This fixation issue is probably  
 21 there.  
 22 COFFEY, Q.C.:  
 23 Q. Included in that?  
 24 DR. NEIL:  
 25 A. Included in the --

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1 COFFEY, Q.C.:  
 2 Q. In a standard text?  
 3 DR. NEIL:  
 4 A. Yes, in a standard text.  
 5 COFFEY, Q.C.:  
 6 Q. And now in terms of Western Memorial or  
 7 Western Health's practises, including that in  
 8 Stephenville, okay --  
 9 DR. NEIL:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. Because this would begin, in effect, at the  
 13 surgery.  
 14 DR. NEIL:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. In the OR. Do you know if Western Memorial or  
 18 Western Health was following this procedure  
 19 set out here in this exhibit, the one of May,  
 20 2007, or that you received May, 2007, before  
 21 that? Was this being done?  
 22 DR. NEIL:  
 23 A. For the most part. Number four being one that  
 24 comes to mind in that these are thin slices.  
 25 COFFEY, Q.C.:



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1 Q. Three to five millimetres.  
 2 DR. NEIL:  
 3 A. Three to five are pretty thin slices. So  
 4 prior to this coming, our slices may not have  
 5 been as thin as three to five millimetres.  
 6 COFFEY, Q.C.:  
 7 Q. How about number five?  
 8 DR. NEIL:  
 9 A. Generally speaking, larger specimens are fixed  
 10 overnight, at least overnight, and they are  
 11 placed in large containers. Often, in fact,  
 12 we remove them from the container that they're  
 13 in and put in a larger container with more  
 14 formalin, and that's been the practice for  
 15 quite a while.  
 16 COFFEY, Q.C.:  
 17 Q. In terms of the idea of having larger  
 18 specimens fixed for no shorter than 24 hours,  
 19 if a specimen, for example, arrives early in  
 20 the afternoon from the OR, and is bread  
 21 loafed, say, by two o'clock --  
 22 DR. NEIL:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. When would -- in the routine or normal course

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1 of business at Western Memorial, when would  
 2 that specimen did come out of the formalin and  
 3 be put into the processor?  
 4 DR. NEIL:  
 5 A. Sometime the next day.  
 6 COFFEY, Q.C.:  
 7 Q. Which would be when the next day, generally?  
 8 DR. NEIL:  
 9 A. It could be --  
 10 COFFEY, Q.C.:  
 11 Q. Early the next morning, generally?  
 12 DR. NEIL:  
 13 A. It could be early the next morning. It could  
 14 be later on in the day, but remember when it  
 15 comes out of the formalin after it's been  
 16 bread loafed --  
 17 COFFEY, Q.C.:  
 18 Q. Yes.  
 19 DR. NEIL:  
 20 A. The tissue, the tumour tissue being blocked  
 21 and put in a cassette, still remains in  
 22 formalin.  
 23 COFFEY, Q.C.:  
 24 Q. When it goes into the --  
 25 DR. NEIL:

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1 A. When it goes into the tissue processor, which  
 2 starts processing about 5:30 or so, and it's  
 3 still in formalin in the first station. So it  
 4 is still fixing for that whole day no matter  
 5 when it's looked at.  
 6 COFFEY, Q.C.:  
 7 Q. Because the processor doesn't start until  
 8 after hours the second day?  
 9 DR. NEIL:  
 10 A. The processor starts after hours and it's  
 11 sitting in formalin before it actually starts  
 12 and in the first station after it starts. So  
 13 there is more than adequate fixation after  
 14 it's bread loafed and examined.  
 15 COFFEY, Q.C.:  
 16 Q. And, Doctor, with respect to written  
 17 procedures and written policies, for example  
 18 in the Laboratory Medicine Program, Western  
 19 Health now, Doctor, what kind of resources  
 20 have you had and in fact, do you have now  
 21 available to you to actually, from scratch, as  
 22 it were, create such documentation?  
 23 DR. NEIL:  
 24 A. I have to understand your question, the -  
 25 COFFEY, Q.C.:

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1 Q. If you set out to create what you're going to  
 2 see now in Exhibit P-2157, okay?  
 3 DR. NEIL:  
 4 A. Okay.  
 5 COFFEY, Q.C.:  
 6 Q. If you set out to create that, that sort of a  
 7 kind of, for the whole Laboratory Medicine  
 8 Program, I'm not saying that all relates to  
 9 it, but if it does, okay.  
 10 DR. NEIL:  
 11 A. Yes.  
 12 COFFEY, Q.C.:  
 13 Q. For the whole of the Laboratory Medicine  
 14 Program, the pathology end of it that you're  
 15 involved in.  
 16 DR. NEIL:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. Do you have the resources available to you  
 20 right now to -  
 21 DR. NEIL:  
 22 A. No.  
 23 COFFEY, Q.C.:  
 24 Q. What would you have to do in order to actually  
 25 accomplish that, if you set out to do it?

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1 Would you have to, in effect, use someone  
 2 else's and modify it to your own situation?  
 3 DR. NEIL:  
 4 A. I would like to have that, that would  
 5 certainly make my job very much easier. I  
 6 need resources--I need, personally, I need the  
 7 time to go through that, to adopt the  
 8 procedures from that document and other  
 9 documents and customize those to Western  
 10 Health. I look at some of the stuff as my  
 11 responsibility as laboratory director, in  
 12 consultation with our laboratory manager. Now  
 13 our laboratory manager does have procedure  
 14 manuals, procedure and policy manuals for  
 15 technologists and general lab procedures which  
 16 are constantly updated, so there are policies  
 17 and procedure manuals for technologists.  
 18 COFFEY, Q.C.:  
 19 Q. On that end of the -  
 20 DR. NEIL:  
 21 A. On that end of it. Some of the things that  
 22 I'm talking about are policies and procedures  
 23 that apply to pathologists, per se.  
 24 COFFEY, Q.C.:  
 25 Q. Yes.

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1 DR. NEIL:  
 2 A. And we have a fair number of them, as I  
 3 mentioned, in the standard pathology  
 4 textbooks; Ackerman being one of them. But  
 5 things need to be fine tuned and we need to  
 6 have a lot more policies and procedure manuals  
 7 that apply directly to the work that we do.  
 8 For me to do that, in the situation that we're  
 9 in today and the situation has been like that  
 10 for awhile, the amount of work that I have on  
 11 an administrative side, verses the service  
 12 work that I'm doing today, doesn't balance  
 13 out. The service work comes first and when I  
 14 have a pile of slides on the side of my desk  
 15 and a surgeon phones me and says, what's the  
 16 result on Mrs. so and so or Mr. so and so, and  
 17 they've done it, and I haven't gotten to it  
 18 because I'm doing administrative work, well  
 19 that can't happen. And to pass it along to my  
 20 colleagues, they're just as overworked as I  
 21 am. So the resources that I would like to  
 22 have six months or so dedicated solely to  
 23 policies and procedures and six months is just  
 24 off the top of my head.  
 25 COFFEY, Q.C.:

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1 Q. To actually get the breathing space, as it  
 2 were, to actually -  
 3 DR. NEIL:  
 4 A. I need some breathing time, exactly, and I've  
 5 actually said that to our administration and  
 6 they've been considering that. Hopefully by  
 7 the end of this month, I'll have another  
 8 pathologist; maybe by the fall, I'll have a  
 9 pathology assistant, but I'm not hopeful  
 10 because those people are rare. We have been  
 11 told that we have additional technology staff  
 12 available to us or will be having additional  
 13 technology staff available to us.  
 14 COFFEY, Q.C.:  
 15 Q. When were you told that?  
 16 DR. NEIL:  
 17 A. In the last week.  
 18 COFFEY, Q.C.:  
 19 Q. And who told you that? Who did you get the  
 20 news from?  
 21 DR. NEIL:  
 22 A. It came from Dr. Jenkins. Actually there's  
 23 seven staff in total, but that doesn't really  
 24 alleviate my concern about policies and  
 25 procedures for pathologists. And in that

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1 policies and procedures for pathologists, is a  
 2 document you brought up earlier, the QA  
 3 document, which is what I need to refine and  
 4 produce for, not only us, but I think that  
 5 should be for the whole province. You need  
 6 time to do those things. I don't have it.  
 7 COFFEY, Q.C.:  
 8 Q. Doctor, if we could, please, ask you to,  
 9 Registrar, bring up Exhibit P-2287? Doctor,  
 10 this is a series of e-mails but they go back  
 11 to November 30th, 2007 and there's an e-mail  
 12 from Patricia Pilgrim to Dr. Jenkins involving  
 13 communication of test results, ER/PR and  
 14 there's various headings in that, for the  
 15 living patients whose results have not  
 16 changed; for the living patients whose results  
 17 have changed; for deceased patients within  
 18 Eastern Health region; and finally for  
 19 deceased patients from other regions. Now,  
 20 then that e-mail was forwarded by Dr. Jenkins  
 21 on December 17th to yourself, saying, "Please  
 22 provide your feedback on the proposed process"  
 23 and it was sent to you and Hedy Dalton Kenny?  
 24 DR. NEIL:  
 25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. And who is that?

3 DR. NEIL:

4 A. Hedy is the regional director of laboratory

5 services.

6 COFFEY, Q.C.:

7 Q. And it notes, she's written back saying, "Paul

8 is not in the office today, I will consult

9 with him when he returns." And she goes on to

10 suggest that "notification of next of kin of

11 those deceased patients whose results were

12 changed be done by Eastern Health personnel,

13 not by the co-ordinator at Western. Western

14 Health will provide the required contact

15 information of the next of kin." Doctor, from

16 the perspective of the deceased patients, I

17 take it that in 2007 you were asked to

18 provide, you referred to that yesterday I

19 believe, the blocks, the appropriate blocks

20 and slides if necessary for retesting.

21 DR. NEIL:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. The results came back.

25 DR. NEIL:

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1 A. Yes.

2 COFFEY, Q.C.:

3 Q. And they've been entered into the Meditec

4 system appropriately, in Western.

5 DR. NEIL:

6 A. Yes.

7 COFFEY, Q.C.:

8 Q. In terms of that process, when did that

9 conclude, your end of it, your involvement in

10 terms of entering the data? Do you remember

11 when?

12 DR. NEIL:

13 A. The process of deceased patients, finding out

14 who they were and getting the work done

15 occurred over a period of several weeks, maybe

16 even a month or more. We did get several

17 letters from Robert Thompson and they came

18 through Susan Gillam, our CEO, and as she got

19 those letters, we did what we needed to do in

20 finding the patients and sending them off

21 appropriately. So a timeframe is probably

22 weeks to maybe a month or more.

23 COFFEY, Q.C.:

24 Q. And that concluded approximately when, do you

25 remember?

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1 DR. NEIL:

2 A. It's been several months now or more. I can't

3 give you an exact date because I don't know

4 it.

5 THE COMMISSIONER:

6 Q. I'm sorry?

7 DR. NEIL:

8 A. I said I can't give him an exact date because

9 I don't know the exact date. If I had my

10 material, I could.

11 COFFEY, Q.C.:

12 Q. Yes, and again, the point is, Doctor, you've

13 been through it -

14 DR. NEIL:

15 A. Yes, it's done.

16 COFFEY, Q.C.:

17 Q. - and it's done. I just wanted to have that.

18 And I take it that you entered into that

19 process of retesting the deceased tissue

20 samples when you were asked to do so by

21 Eastern Health?

22 DR. NEIL:

23 A. Yes.

24 COFFEY, Q.C.:

25 Q. Provide the material and -

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1 DR. NEIL:

2 A. Yes.

3 COFFEY, Q.C.:

4 Q. Okay. If we could, please, Exhibit P-2290?

5 And, Doctor, this is a letter, it's from

6 yourself April 1st, 2008. It's to a

7 particular doctor, which the name is redacted

8 and I'll just have you have a look at that for

9 a moment, okay, and read it to yourself. And

10 then if I could, please, bring up Exhibit P-

11 2291? And this, again, would you have a look

12 at that, Doctor? Again, it's to a doctor,

13 it's a letter from yourself, I understand, and

14 both of the letters refer to, "Please find

15 enclosed reports on the above-mentioned

16 patient", whose name is redacted. And in

17 particular, Doctor, the surgical number here

18 on this page, 291, you'll see is a 1997

19 number?

20 DR. NEIL:

21 A. Yes.

22 COFFEY, Q.C.:

23 Q. And the SU signifies what?

24 DR. NEIL:

25 A. It's surgical.

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1 COFFEY, Q.C.:

2 Q. That's the utilization by Western Memorial?

3 DR. NEIL:

4 A. Yes.

5 COFFEY, Q.C.:

6 Q. If we could bring up again, please, Exhibit P-

7 0290? And, Doctor, you'll see here the

8 surgical number here is a 1997 case too?

9 DR. NEIL:

10 A. Uh-hm.

11 COFFEY, Q.C.:

12 Q. It's a different number, but--do you recall

13 what this was about generally, Doctor, these

14 particular cases? Like why in April of 2008

15 they were being dealt with?

16 DR. NEIL:

17 A. There may have been some discrepancies in the

18 diagnosis and if I knew the names of those

19 patients, it would certainly jog my memory a

20 bit more, but I don't know the names of those

21 patients because they're obviously not on the

22 screen.

23 COFFEY, Q.C.:

24 Q. Yes. And if I could here, this particular

25 one, this is 2290, I believe, yes, in the text

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1 you refer to being unclear as to the patient's

2 clinical situation at that point and yourself

3 and Dr. Jenkins discuss the appropriate course

4 of action with Dr. Laing and you're saying to

5 this physician, you're addressing this letter

6 to, "as you are the physician in this case, it

7 was recommended that you discuss her clinical

8 situation with Dr. Ganguly, who is following

9 the patient and subsequently discuss her

10 clinical situation and enclose reports." So,

11 Doctor, do you know if there were any people

12 from 1997 missed, as it were? Do you know if

13 that -

14 DR. NEIL:

15 A. Not that I'm aware of.

16 COFFEY, Q.C.:

17 Q. Not that you're aware of, okay, so this

18 wouldn't relate to that -

19 DR. NEIL:

20 A. And this was my concern all along, not to miss

21 patients.

22 COFFEY, Q.C.:

23 Q. So this doesn't relate to that.

24 DR. NEIL:

25 A. No, there are no missed patients to my

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1 knowledge.

2 COFFEY, Q.C.:

3 Q. And as well, if we could, Exhibit P-2292

4 please? Again, this is a letter of April 1,

5 2008, there are three of them on the same date

6 and this relates to, I take it this is

7 addressed to a doctor whose name is redacted,

8 and again -

9 DR. NEIL:

10 A. I can tell you in general what these cases

11 mean.

12 COFFEY, Q.C.:

13 Q. Yes, in the early '08, that's what -

14 DR. NEIL:

15 A. In general what these cases mean, and

16 discrepancy is not really the right word

17 because they're not really a discrepancy per

18 se. As we discussed earlier, we have DCIS

19 patients and DCIS patients with microinvasion.

20 To reconcile the diagnosis, the Mount Sinai

21 diagnosis and the Western diagnosis on our

22 spreadsheets, sometimes we would have a

23 difference.

24 COFFEY, Q.C.:

25 Q. Yes.

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1 DR. NEIL:

2 A. Simply because of a sampling those particular

3 blocks and at some time you may see DCIS, you

4 cut another sample from that particular block,

5 you may see three or four more cells outside

6 that duct which now become microinvasive which

7 requires ER/PR testing. But by sampling these

8 particular tissues further -

9 COFFEY, Q.C.:

10 Q. You'd have to go through more blocks.

11 DR. NEIL:

12 A. You would have to go through more blocks.

13 That's why a so-called discrepancy may come

14 up. It's a sampling thing, so to reconcile

15 those sampling issues, I wrote physicians, I

16 further got further consultations to make sure

17 that these particular patients had ER/PR

18 results, if needed.

19 COFFEY, Q.C.:

20 Q. If there was an invasive component, they

21 needed it.

22 DR. NEIL:

23 A. If there was an invasive component, they

24 needed it.

25 COFFEY, Q.C.:

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1 Q. Doctor, I had understood yesterday you told  
 2 the Commissioner that, in fact, that process  
 3 had begun really in the middle of 2007, in the  
 4 summer.  
 5 DR. NEIL:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. In fact there's correspondence there about it.  
 9 DR. NEIL:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. That's why in 2008 then, for some patients  
 13 anyway, that was still being pursued?  
 14 DR. NEIL:  
 15 A. It was still being pursued.  
 16 COFFEY, Q.C.:  
 17 Q. Okay, that was what--Doctor, before I leave  
 18 it, you did, in answering an earlier question,  
 19 refer to the fact that on the technologist end  
 20 or side of the lab there are written policies  
 21 and procedures that are constantly being  
 22 updated?  
 23 DR. NEIL:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. How long have they been in existence?  
 2 DR. NEIL:  
 3 A. Years and years.  
 4 COFFEY, Q.C.:  
 5 Q. And who is responsible for them, actually  
 6 maintaining them?  
 7 DR. NEIL:  
 8 A. Ultimately responsible would be the regional  
 9 director of Laboratory Services.  
 10 COFFEY, Q.C.:  
 11 Q. Who is currently?  
 12 DR. NEIL:  
 13 A. Who is Hedy Dalton Kenny and her predecessors,  
 14 of course.  
 15 COFFEY, Q.C.:  
 16 Q. Would you anticipate that some of those  
 17 written policies and procedures would relate  
 18 to breast tissue?  
 19 DR. NEIL:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. In particular, and in some perhaps in a more  
 23 general way, a fixation wouldn't cover -  
 24 DR. NEIL:  
 25 A. The fixation may not be there, I don't know.

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1 COFFEY, Q.C.:  
 2 Q. But in terms of procedures involving the, for  
 3 example, the tissue processor?  
 4 DR. NEIL:  
 5 A. Anything that would involve the work of a  
 6 technologist, what they do on a daily basis  
 7 would be in that manual.  
 8 COFFEY, Q.C.:  
 9 Q. Okay, and I'll take that up then with--do you  
 10 now, like how big the manual is, like volume  
 11 wise? It's about three, four inches.  
 12 DR. NEIL:  
 13 A. Three or four inches thick.  
 14 COFFEY, Q.C.:  
 15 Q. And we will be looking for a copy of that, but  
 16 I'll get that through counsel for the Health  
 17 Authority. Doctor, if we could, please,  
 18 Exhibit P-2293 please? Doctor, this is a  
 19 series of e-mails between Moira Hennessey,  
 20 well it involves Moira Hennessey and Dr.  
 21 Jenkins. These occurred in April, 2008 and  
 22 the one at the bottom of the page, you'll see  
 23 April 2nd, it's from, actually Dr. Jenkins to  
 24 yourself. It says, "I had a call from Moira,  
 25 she has a few questions, please give me a call

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1 to discuss." And then Dr. Jenkins goes back  
 2 to Moira Hennessey later that day saying  
 3 "Further to our phone call a short while ago,  
 4 I have confirmed with Dr. Neil that our ER/PR  
 5 specimens are still going to Mount Sinai. As  
 6 well, regarding the tissue fixation standards  
 7 circulated by Dr. Denic, Dr. Neil confirms  
 8 that we are following that standard." And  
 9 you've told the Commissioner about that  
 10 earlier.  
 11 DR. NEIL:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. If I could, please, on this, if we could bring  
 15 up finally Exhibit P-2294 please? Now,  
 16 Doctor, these would be Dr. Jenkins' notes, I  
 17 take it.  
 18 DR. NEIL:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. You recognize his handwriting?  
 22 DR. NEIL:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. And it's about the telephone call with Moira

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1 Hennessey, but number two, he says, "we are  
 2 following the fixation standard as best we  
 3 can" and he is quoting, in effect, from you.  
 4 DR. NEIL:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. "Occasionally specimen comes in on Thursday,  
 8 we are meeting the standard, some controversy  
 9 around this in the literature. We have met  
 10 the standard in all cases to the best of  
 11 Paul's knowledge." So that in April 2008,  
 12 apparently Ms. Hennessey, on behalf of the  
 13 Department was requiring of Western Memorial  
 14 as to the fixation policy in place and whether  
 15 it was being followed.  
 16 DR. NEIL:  
 17 A. Uh-hm.  
 18 COFFEY, Q.C.:  
 19 Q. Now if we could, P-2296 please? Doctor, this  
 20 is two e-mails of May 6th involving, well the  
 21 first of them is from yourself, to J. Grabka.  
 22 And you say, "Jeanette, please have Sharon  
 23 distribute this memo to the appropriate  
 24 people, I do not know to send it to in the OR.  
 25 I spoke to Shirley Butt's replacement. Maybe

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1 you or Hedy could address properly. I have  
 2 discussed this with Ken." And then apparently  
 3 it was forwarded at some point to Ken Jenkins  
 4 because he asked somebody to file it. Doctor,  
 5 this May 5th memo, 2008, it's to surgeons in  
 6 the OR and to Dr. Jenkins and Dr. Mercer. And  
 7 you raise here a misunderstanding that "breast  
 8 surgery would not be performed in this or any  
 9 other institution" and I think we looked at  
 10 this earlier, and if we haven't, it's here.  
 11 Doctor, you've noted here "It is imperative  
 12 the pathologists receive all breast specimens  
 13 removed from malignancy in a timely manner in  
 14 order to process properly for ER/PR analysis.  
 15 No cases should be done on Friday afternoon as  
 16 they cannot be dealt with properly." What I  
 17 wanted to ask you about, and you go on and set  
 18 out here or requesting a surgery being done  
 19 Monday through Wednesday. In the e-mail,  
 20 because this is what I wanted to ask you  
 21 about, in your e-mail you say, "I do not know  
 22 who to send it to in the OR", because, of  
 23 course, fixation policies and scheduling of  
 24 surgery, bearing in mind fixation policies,  
 25 involves interaction with the operating room.

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1 DR. NEIL:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. - their personnel. In Western Memorial and  
 5 now Western Health, is there any particular  
 6 formal linkage between them? Like, who has  
 7 to, in effect, convey your request/demand as  
 8 it were to the OR and an OR personnel and have  
 9 it imposed, as it were, if necessary, imposed  
 10 on them or have them accommodate your  
 11 concerns? I'm trying to get some sense for  
 12 the Commissioner, in Western as to the  
 13 interface between the operating room personnel  
 14 and the laboratory medicine personnel in  
 15 relation to policies or procedures that they  
 16 might carry out that impact you or vice versa.  
 17 So, could you tell the Commissioner how that's  
 18 -  
 19 DR. NEIL:  
 20 A. When I said I do not know who to send it to in  
 21 the OR, I just didn't know the name of the  
 22 person.  
 23 COFFEY, Q.C.:  
 24 Q. Even that, that's, even that I'm getting at,  
 25 okay.

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1 DR. NEIL:  
 2 A. I didn't know the name of the person. Heads  
 3 of department change frequently and  
 4 unfortunately, I don't always keep up on the  
 5 changes. So, when I said, send it to the OR,  
 6 I meant, send it to the person who is in  
 7 charge, the nurse, co-ordinator, whatever you  
 8 want to call him or her. Hedy or Jeanette  
 9 would know this; if they didn't know it, they  
 10 would find out. It's the person in charge  
 11 that I wanted it sent to.  
 12 COFFEY, Q.C.:  
 13 Q. But in relation to that then, here's what I'm  
 14 getting at, is having sent it to the person in  
 15 charge -  
 16 DR. NEIL:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. - do you have the ability in your position to  
 20 impose it upon them or what happens, if -  
 21 DR. NEIL:  
 22 A. I hope I do.  
 23 COFFEY, Q.C.:  
 24 Q. Okay. That's what I'm asking in terms of that  
 25 because the Commissioner has heard about

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1 Eastern Health, at least, seen some  
 2 documentation involving Eastern Health,  
 3 request of a similar nature.  
 4 DR. NEIL:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. Okay. In terms of scheduling of surgery  
 8 throughout the day, in their case. So, from  
 9 your perspective, in your position, when you  
 10 sent that memo -  
 11 DR. NEIL:  
 12 A. I expected it to be acted on.  
 13 COFFEY, Q.C.:  
 14 Q. Acted upon. And if not, to enter into a  
 15 dialogue as to why it couldn't have and  
 16 discuss it further.  
 17 DR. NEIL:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. So, from your perspective in terms of your own  
 21 view of your own sphere of authority, having  
 22 sent it, unless you heard to the contrary, you  
 23 expected -  
 24 DR. NEIL:  
 25 A. I expected it to be done. To me it's a

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1 serious issue. It is a serious issue, period.  
 2 So, it should be acted upon. As I've said in  
 3 an e-mail, I did discuss it with Dr. Jenkins,  
 4 he was aware of it, should be done.  
 5 COFFEY, Q.C.:  
 6 Q. Commissioner, thank you. Thank you, Dr. Neil.  
 7 I've gone a little bit longer than what I  
 8 thought, but -  
 9 DR. NEIL:  
 10 A. Thank you  
 11 THE COMMISSIONER:  
 12 Q. Do you have any questions, Ms. Brazil?  
 13 MS. BRAZIL:  
 14 Q. I have no questions for this witness,  
 15 Commissioner, thank you.  
 16 THE COMMISSIONER:  
 17 Q. Thank you. Mr. Simmons?  
 18 DR. PAUL NEIL, EXAMINATION BY MR. DANIEL SIMMONS  
 19 MR. SIMMONS:  
 20 Q. Thank you, Commissioner. Commissioner, I can  
 21 see there's an advantage now to being on this  
 22 side of the room because the air is cooler,  
 23 closer to the air conditioners. Dr. Neil -  
 24 THE COMMISSIONER:  
 25 Q. Well, you blew it on the first day apparently

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1 when you went on the other side.  
 2 MR. SIMMONS:  
 3 Q. I did.  
 4 THE COMMISSIONER:  
 5 Q. I'm sure there are advantages to being on that  
 6 side or the room, as well.  
 7 MR. SIMMONS:  
 8 Q. There are. Dr. Neil, I'm Dan Simmons, I'm the  
 9 lawyer for Eastern Health. I've got a few  
 10 questions for you. I won't be too long.  
 11 First, can I bring up Exhibit P-2297 please?  
 12 Mr. Coffey showed you earlier these pathology  
 13 reports here. This particular one from  
 14 Western Memorial and this is from 2003 and  
 15 it's one that was--there's an addendum on this  
 16 one completed by Dr. Luer. It's the one that  
 17 referred to poor quality of sections in  
 18 staining precluding assessment for estrogen  
 19 receptor on this particular sample.  
 20 DR. NEIL:  
 21 A. Yes.  
 22 MR. SIMMONS:  
 23 Q. Can you tell from these pathology reports  
 24 where the sample originated, whether it was at  
 25 Western Memorial Hospital itself or whether at

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1 Sir Thomas Roddick Hospital in Stephenville.  
 2 DR. NEIL:  
 3 A. This originated at Western Memorial,  
 4 MR. SIMMONS:  
 5 Q. This one originated at Western, and you can  
 6 tell from the pathology report?  
 7 DR. NEIL:  
 8 A. I can tell -- yes, I can tell by looking at  
 9 that.  
 10 MR. SIMMONS:  
 11 Q. Okay, by the surgical number or --  
 12 DR. NEIL:  
 13 A. No, by the physician name.  
 14 MR. SIMMONS:  
 15 Q. I see, okay, and that's the way you can do  
 16 that, and you told us, I think, that you  
 17 recall there being one occasion when Dr. Luer  
 18 had raised an issue like this with you  
 19 verbally?  
 20 DR. NEIL:  
 21 A. Yes.  
 22 MR. SIMMONS:  
 23 Q. And one occasion when -- was it, Dr. Curren  
 24 (phonetic).  
 25 DR. NEIL:

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1 A. Correct.  
 2 MR. SIMMONS:  
 3 Q. Had raised a similar issue?  
 4 DR. NEIL:  
 5 A. Correct.  
 6 MR. SIMMONS:  
 7 Q. You gave us also a very helpful chart which  
 8 shows the different pathologists that had been  
 9 at Western Memorial at different times.  
 10 DR. NEIL:  
 11 A. Uh-hm.  
 12 MR. SIMMONS:  
 13 Q. How they changed relatively frequently over  
 14 the years, I guess.  
 15 DR. NEIL:  
 16 A. Yes.  
 17 MR. SIMMONS:  
 18 Q. Prior to 2005, had you had any other comments  
 19 or complaints from any of those other  
 20 pathologists about the quality of the ER or PR  
 21 slides that had been returned?  
 22 DR. NEIL:  
 23 A. No, not that I recall.  
 24 MR. SIMMONS:  
 25 Q. And those pathologists generally, had they

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1 come to Corner Brook from other institutions  
 2 and other parts of Canada or the United  
 3 States?  
 4 DR. NEIL:  
 5 A. They generally came from other institutions in  
 6 the US.  
 7 MR. SIMMONS:  
 8 Q. Yes.  
 9 DR. NEIL:  
 10 A. Where their training occurred, not exclusively  
 11 --  
 12 MR. SIMMONS:  
 13 Q. So this --  
 14 DR. NEIL:  
 15 A. There were some people who were trained --  
 16 prior to 2005, there were people trained in  
 17 St. John's as well that worked for us.  
 18 MR. SIMMONS:  
 19 Q. So there were some that were trained in St.  
 20 John's, but there were pathologists who had  
 21 trained in various other locations and  
 22 institutions.  
 23 DR. NEIL:  
 24 A. Yes.  
 25 MR. SIMMONS:

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1 Q. In the United States?  
 2 DR. NEIL:  
 3 A. Yes.  
 4 MR. SIMMONS:  
 5 Q. And elsewhere in Canada as well?  
 6 DR. NEIL:  
 7 A. And else where in Canada.  
 8 MR. SIMMONS:  
 9 Q. So would you have expected them to have come  
 10 with some diversity of knowledge?  
 11 DR. NEIL:  
 12 A. Certainly.  
 13 MR. SIMMONS:  
 14 Q. You'd certainly like to expect when they were  
 15 looking at those slides?  
 16 DR. NEIL:  
 17 A. Certainly.  
 18 MR. SIMMONS:  
 19 Q. And none of those had raised any concerns?  
 20 DR. NEIL:  
 21 A. None of those had raised concerns.  
 22 MR. SIMMONS:  
 23 Q. Okay, and when a pathologist gets the end  
 24 result slide which has the estrogen receptor  
 25 stain or the progesterone receptor stain on

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1 it, do I understand correctly from what we've  
 2 heard that the quality of the end product  
 3 might be affected by any of the steps along  
 4 the way, beginning with the operating room and  
 5 the adequacy of fixation at the outset of the  
 6 process?  
 7 DR. NEIL:  
 8 A. Certainly.  
 9 MR. SIMMONS:  
 10 Q. And for this particular slide that Dr. Luer  
 11 commented on, the fixation and processing  
 12 portion would have happened at Western  
 13 Memorial?  
 14 DR. NEIL:  
 15 A. Yes.  
 16 MR. SIMMONS:  
 17 Q. And it's the block that would have gone to St.  
 18 John's to be processed into the stain slide  
 19 there?  
 20 DR. NEIL:  
 21 A. Correct.  
 22 MR. SIMMONS:  
 23 Q. A couple of questions for you about  
 24 identification of the patients whose samples  
 25 were to be retested once you were asked to do



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1 that in 2005, and you described for us how you  
 2 had Meditec records available from 1999  
 3 forward?  
 4 DR. NEIL:  
 5 A. Correct.  
 6 MR. SIMMONS:  
 7 Q. And prior to that you had an earlier system  
 8 which wasn't as user friendly, I guess, as the  
 9 lingo goes.  
 10 DR. NEIL:  
 11 A. Correct.  
 12 MR. SIMMONS:  
 13 Q. But in your Meditec system, were you able to  
 14 do a search of that system and identify the  
 15 results of the ER/PR testing or would it only  
 16 identify the fact that an ER or PR test had  
 17 been done?  
 18 DR. NEIL:  
 19 A. It would identify the fact that an ER/PR test  
 20 was done.  
 21 MR. SIMMONS:  
 22 Q. Yes.  
 23 DR. NEIL:  
 24 A. If you actually looked at the patient record  
 25 you could see the result.

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1 MR. SIMMONS:  
 2 Q. Okay. So, in order to determine which patient  
 3 results spell within or outside of the retest  
 4 criteria, there wasn't an automated way to do  
 5 that.  
 6 DR. NEIL:  
 7 A. No.  
 8 MR. SIMMONS:  
 9 Q. You had to read the text of the pathology  
 10 reports, did you?  
 11 MR. SIMMONS:  
 12 Q. Yes, you did.  
 13 DR. NEIL:  
 14 A. Yes.  
 15 MR. SIMMONS:  
 16 Q. Now, you also said that at a later point in  
 17 the process you wanted to identify those  
 18 patients who were deceased at that time and  
 19 that you used Meditec as a tool to assist you  
 20 in doing that?  
 21 DR. NEIL:  
 22 A. Yes.  
 23 MR. SIMMONS:  
 24 Q. Would you know how information about whether a  
 25 patient had died would find its way into your

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1 hospital Meditec system?  
 2 DR. NEIL:  
 3 A. Yes.  
 4 MR. SIMMONS:  
 5 Q. How would that happen?  
 6 DR. NEIL:  
 7 A. There was usually a death record.  
 8 MR. SIMMONS:  
 9 Q. Okay. If the patient had not died at the  
 10 institution or somehow affiliated with Western  
 11 Health, would those records find their way  
 12 into your Meditec system?  
 13 DR. NEIL:  
 14 A. If the patient had died outside -  
 15 MR. SIMMONS:  
 16 Q. If the patient had died in St. John's, for  
 17 example.  
 18 DR. NEIL:  
 19 A. I generally wouldn't know it.  
 20 MR. SIMMONS:  
 21 Q. You wouldn't know.  
 22 DR. NEIL:  
 23 A. Not from our record.  
 24 MR. SIMMONS:  
 25 Q. Right. So, your record would identify those

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1 patients who had died and a record of that was  
 2 generated at Western Memorial or some  
 3 affiliated institution.  
 4 DR. NEIL:  
 5 A. Yes.  
 6 MR. SIMMONS:  
 7 Q. So, by necessity, that wouldn't necessarily be  
 8 a complete list of the patients who were  
 9 deceased?  
 10 DR. NEIL:  
 11 A. No.  
 12 MR. SIMMONS:  
 13 Q. That was the best source that you were aware  
 14 of.  
 15 DR. NEIL:  
 16 A. The only source that I had.  
 17 MR. SIMMONS:  
 18 Q. You were asked some questions again a few  
 19 moments ago about your memo concerning the  
 20 scheduling of breast surgeries at Western  
 21 Memorial. And I believe you told us yesterday  
 22 that most of those surgeries are done by a  
 23 single surgeon, are they?  
 24 DR. NEIL:  
 25 A. On Thursday, yes.

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1 MR. SIMMONS:  
 2 Q. On Thursdays. And how many surgeons do you  
 3 have at Western Memorial, surgeons who would  
 4 perform breast surgery.  
 5 DR. NEIL:  
 6 A. Well, one surgeon is a breast surgeon and she  
 7 operates on Wednesday.  
 8 MR. SIMMONS:  
 9 Q. Yes. So, I suspect she would do most of the  
 10 cases.  
 11 DR. NEIL:  
 12 A. She does most of the cases, yes.  
 13 MR. SIMMONS:  
 14 Q. Okay. So, was it particularly difficult at  
 15 Western Memorial to be able to schedule things  
 16 so that surgeries didn't happen on Thursday or  
 17 Fridays? Were there any challenges to that at  
 18 your institution?  
 19 DR. NEIL:  
 20 A. Not really because it's a small institution  
 21 and I know people and, as I mentioned in my  
 22 testimony yesterday, I spoke to that  
 23 particular surgeon and her husband and got  
 24 them to switch their days.  
 25 MR. SIMMONS:

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1 Q. Right. And there wasn't much more involved to  
 2 it than that, I guess, was it?  
 3 DR. NEIL:  
 4 A. Well, a little bit of convincing and arm  
 5 twisting, but no, I got it done.  
 6 MR. SIMMONS:  
 7 Q. Okay. Now, if you hadn't been able to do  
 8 that, if you were stuck with breast surgeries  
 9 happening on Thursday or even Fridays, would  
 10 there have been other ways to tackle the issue  
 11 of ensuring that the specimens were placed in  
 12 formalin and sliced properly within an  
 13 appropriate time?  
 14 DR. NEIL:  
 15 A. It probably would have involved overtime, not  
 16 overtime, but would have involved people  
 17 working on a Saturday. So, there would have  
 18 been ways to tackle the problem.  
 19 DR. NEIL:  
 20 A. There are ways.  
 21 MR. SIMMONS:  
 22 Q. In your institution is there a standardized  
 23 method or regime or protocol for the  
 24 development and drafting and implementation of  
 25 policy and procedure throughout Western

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1 Health? Is there a framework?  
 2 DR. NEIL:  
 3 A. There is a framework?  
 4 MR. SIMMONS:  
 5 Q. Has that framework been applied in laboratory  
 6 medicine?  
 7 DR. NEIL:  
 8 A. We are in the process of doing that.  
 9 MR. SIMMONS:  
 10 Q. In the process -  
 11 DR. NEIL:  
 12 A. As I mentioned earlier, it's a time consuming  
 13 process and I have some work done, but I would  
 14 like more time to complete that work.  
 15 MR. SIMMONS:  
 16 Q. Yes, okay. And in order to implement a policy  
 17 or adopt a procedure, are there any occasions  
 18 when anyone that you're aware of in Western  
 19 Health has to go outside the organization for  
 20 approval or is the sign off on policy and  
 21 procedure always completely within your  
 22 organization?  
 23 DR. NEIL:  
 24 A. To my knowledge, we can sign off within the  
 25 organization.

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1 MR. SIMMONS:  
 2 Q. Right. And is there anything in place,  
 3 formally or informally in this province that  
 4 you're aware of that requires that any type of  
 5 policies be standardized across the different  
 6 regional health authorities? And you wouldn't  
 7 be aware of all areas, I know, but within the  
 8 areas that you're familiar with.  
 9 DR. NEIL:  
 10 A. Are there--I want to understand your question.  
 11 MR. SIMMONS:  
 12 Q. Is there any regime in this province to ensure  
 13 that, in specific, that the Western Health's  
 14 fixation policy is the same as the one at  
 15 Eastern Health, as that example?  
 16 DR. NEIL:  
 17 A. No.  
 18 MR. SIMMONS:  
 19 Q. No.  
 20 DR. NEIL:  
 21 A. I would like to ensure that it is because we  
 22 are treating the same tissues. It should be a  
 23 standard protocol across Canada.  
 24 MR. SIMMONS:  
 25 Q. Right, but one authority has no power to

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1 impose a policy or procedure on another?  
 2 DR. NEIL:  
 3 A. No.  
 4 MR. SIMMONS:  
 5 Q. No, but obviously co-operation and working  
 6 together is the way to go to see that happen.  
 7 DR. NEIL:  
 8 A. Co-operation is of upmost importance.  
 9 MR. SIMMONS:  
 10 Q. Yes, okay. Thank you very much, Dr. Neil,  
 11 that's all I have.  
 12 DR. NEIL:  
 13 A. You're welcome.  
 14 THE COMMISSIONER:  
 15 Q. Mr. Pritchett?  
 16 MR. PRITCHETT:  
 17 Q. We have no questions, Commissioner.  
 18 THE COMMISSIONER:  
 19 Q. Thank you. Ms. Newbury?  
 20 DR. PAUL NEIL, EXAMINATION BY MS. JENNIFER NEWBURY  
 21 MS. NEWBURY:  
 22 Q. Good morning, Dr. Neil.  
 23 DR. NEIL:  
 24 A. Good morning.  
 25 MS. NEWBURY:

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1 Q. Jennifer Newbury for the Canadian Cancer  
 2 Society, Newfoundland and Labrador Division.  
 3 I just have a few questions for you this  
 4 morning and I want to start with the topic of  
 5 disclosure. And I understood that it was your  
 6 evidence that you felt that you didn't  
 7 personally have any role to play in terms of  
 8 communicating with patients -  
 9 DR. NEIL:  
 10 A. That's correct.  
 11 MS. NEWBURY:  
 12 Q. - regarding that issue.  
 13 DR. NEIL:  
 14 A. I wasn't asked to participate.  
 15 MS. NEWBURY:  
 16 Q. You were -  
 17 DR. NEIL:  
 18 A. No.  
 19 MS. NEWBURY:  
 20 Q. Oh, you weren't asked to -  
 21 DR. NEIL:  
 22 A. I was not asked to participate in disclosure.  
 23 MS. NEWBURY:  
 24 Q. And I believe it was also your evidence that  
 25 you couldn't recall if you had advised Dr.

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1 Jenkins about the fact of retesting prior to  
 2 September 29, 2005? That was just before the  
 3 media reported the story.  
 4 DR. NEIL:  
 5 A. That's correct.  
 6 MS. NEWBURY:  
 7 Q. Okay. And by that time you'd received a  
 8 couple of memos; one dated June 14th, 2005 -  
 9 DR. NEIL:  
 10 A. Yes.  
 11 MS. NEWBURY:  
 12 Q. - and that dealt with retesting for 2002  
 13 samples. And then earlier in September you'd  
 14 received a memo which indicated that the scope  
 15 of retesting had broadened to include back to  
 16 May 1997 up to August of 2005.  
 17 DR. NEIL:  
 18 A. When the scope broadened, when we had more  
 19 years involved, I did discuss that with Dr.  
 20 Jenkins.  
 21 MS. NEWBURY:  
 22 Q. So, that would have been--the date of the  
 23 memo, I recall, is September 6th, 2005. So,  
 24 you think it was around that time.  
 25 DR. NEIL:

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1 A. Yes. With a memo of that magnitude, I would  
 2 have discussed that with senior management and  
 3 more specifically Dr. Jenkins.  
 4 MS. NEWBURY:  
 5 Q. Okay. And do you know if anyone in senior  
 6 management or in the quality department at  
 7 Western Memorial could have been alerted  
 8 through other means prior to September 6th,  
 9 2005?  
 10 DR. NEIL:  
 11 A. I don't know.  
 12 MS. NEWBURY:  
 13 Q. Okay. And when you received the first memo  
 14 back on June 14th, 2005 about the more limited  
 15 retesting, did you consider at that time  
 16 whether or not that particular information  
 17 should be disclosed to patients who were being  
 18 retested, even though it may not be your  
 19 responsibility.  
 20 DR. NEIL:  
 21 A. When I had that memo, I did what I was asked  
 22 to do.  
 23 MS. NEWBURY:  
 24 Q. Okay.  
 25 DR. NEIL:

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1 A. I'm sure it crossed my mind, but it wasn't--  
 2 I'm not in the business of talking to  
 3 patients.  
 4 MS. NEWBURY:  
 5 Q. Okay. Even if you weren't in the business of  
 6 talking to patients, did you consider whether  
 7 or not you should speak to that person at  
 8 Western Memorial who might be in the business  
 9 of doing that.  
 10 DR. NEIL:  
 11 A. Well, as I mentioned earlier, these things had  
 12 to be retested to tell a patient something and  
 13 I know there are varied opinions about this,  
 14 to tell a patient something that I didn't know  
 15 what the result was, if there was going to be  
 16 a change in the results or not, I didn't know.  
 17 To tell a patient something that I didn't know  
 18 the answer to is one thing; to tell a patient  
 19 I have an answer and it's changed is another  
 20 thing. That whole process, I didn't really  
 21 deal with. I did what I was asked to do, get  
 22 a result and carry on from there.  
 23 MS. NEWBURY:  
 24 Q. And you weren't thinking at that time, well, I  
 25 should let someone know -

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1 DR. NEIL:  
 2 A. No, I wasn't.  
 3 MS. NEWBURY:  
 4 Q. - whether or not that should be an issue to be  
 5 addressed.  
 6 DR. NEIL:  
 7 A. No I wasn't.  
 8 MS. NEWBURY:  
 9 Q. Regardless of what the outcome might be.  
 10 DR. NEIL:  
 11 A. No, I wasn't.  
 12 MS. NEWBURY:  
 13 Q. Okay.  
 14 DR. NEIL:  
 15 A. I knew it would arise.  
 16 MS. NEWBURY:  
 17 Q. Ultimately -  
 18 DR. NEIL:  
 19 A. Ultimately, it would arise.  
 20 MS. NEWBURY:  
 21 Q. Right, but you were thinking--was it your  
 22 opinion that more than likely the disclosure  
 23 would take place after the results had come  
 24 back?  
 25 DR. NEIL:

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1 A. Yes, that was my opinion.  
 2 MS. NEWBURY:  
 3 Q. And was that perhaps why you didn't alert  
 4 someone to it, that you were thinking this is  
 5 an issue for later when we have the results  
 6 back.  
 7 DR. NEIL:  
 8 A. I would like to see that we have proven that  
 9 we have a problem.  
 10 MS. NEWBURY:  
 11 Q. Okay. And at that time, as of June 14th,  
 12 2005, did you have any idea whatsoever what  
 13 the scope of the problem -  
 14 DR. NEIL:  
 15 A. No, no.  
 16 MS. NEWBURY:  
 17 Q. - that was being investigated.  
 18 DR. NEIL:  
 19 A. No, no, yes.  
 20 MS. NEWBURY:  
 21 Q. And if you had thought that there was a  
 22 greater chance that, you know, a fairly  
 23 significant number of the tests might change,  
 24 would you have been more inclined to delve  
 25 into that a bit earlier on?

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1 DR. NEIL:  
 2 A. Oh sure. I really didn't have an idea of the  
 3 magnitude of the problem that was occurring,  
 4 certainly in June.  
 5 MS. NEWBURY:  
 6 Q. And September, early September, September 6th,  
 7 2005 when you received the memo which  
 8 indicated that the scope had broadened for the  
 9 retesting, did you specifically address at  
 10 that time whether you should alert the person  
 11 within your organization responsible for  
 12 disclosure?  
 13 DR. NEIL:  
 14 A. I brought this issue to Dr. Jenkins to say, I  
 15 have a task in front of me that I need to do.  
 16 That was my sole focus. When the issue came  
 17 to senior management, senior management, to  
 18 me, were the people to deal with disclosure  
 19 and patients and that whole issue. My role  
 20 was solely to get the job done that was tasked  
 21 to do.  
 22 MS. NEWBURY:  
 23 Q. And if you had a less complicated situation  
 24 perhaps, a single patient result within your  
 25 organization that had been tested within your

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1 organization and there was some reason to be  
 2 concerned about the results, such that you  
 3 required a retest, as a pathologist, do you  
 4 feel that you have any responsibility in that  
 5 situation regarding disclosure.  
 6 DR. NEIL:  
 7 A. Most definitely.  
 8 MS. NEWBURY:  
 9 Q. And what would you be responsible for -  
 10 DR. NEIL:  
 11 A. If there is a situation in my hospital, my  
 12 lab, that patients need to have information,  
 13 if disclosure has to occur, my first move  
 14 would be to talk to senior management and the  
 15 appropriate people in the appropriate  
 16 department and I've done this, and say, we got  
 17 a problem and we need to deal with it.  
 18 MS. NEWBURY:  
 19 Q. And you would go directly to senior  
 20 management?  
 21 DR. NEIL:  
 22 A. Yes.  
 23 MS. NEWBURY:  
 24 Q. Would you include any treating physicians?  
 25 DR. NEIL:

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1 A. Senior management would be the first people I  
 2 would go to.  
 3 MS. NEWBURY:  
 4 Q. Okay. And whether they bring in treating  
 5 physicians, that would be -  
 6 DR. NEIL:  
 7 A. They are, I won't say trained, but they are  
 8 more experienced in disclosure than I am and I  
 9 totally rely on their abilities in disclosure,  
 10 but it was my responsibility to say, I have a  
 11 problem, which I've done.  
 12 MS. NEWBURY:  
 13 Q. Are there any written policies at Western  
 14 Memorial about -  
 15 DR. NEIL:  
 16 A. There is a disclosure policy at Western, yes.  
 17 MS. NEWBURY:  
 18 Q. Okay. And how long has that policy been in  
 19 place?  
 20 DR. NEIL:  
 21 A. I don't know the answer to that, but it's been  
 22 several years, I think.  
 23 MS. NEWBURY:  
 24 Q. And that's a general disclosure policy -  
 25 DR. NEIL:

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1 A. It's a general disclosure policy.  
 2 MS. NEWBURY:  
 3 Q. - applicable to everyone in the institution?  
 4 DR. NEIL:  
 5 A. Yes, yes. I know there has been a recent  
 6 change, a recent update in a disclosure policy  
 7 in the last several months. It may have been  
 8 several years before that one had changed. It  
 9 may have existed in our institution for quite  
 10 a long time. I just don't know the answer to  
 11 that, but I know it does exist.  
 12 MS. NEWBURY:  
 13 Q. Okay. I'm not sure if that's been provided.  
 14 UNKNOWN SPEAKER:  
 15 Q. (Inaudible).  
 16 MS. NEWBURY:  
 17 Q. It hasn't been provided. Perhaps Mr.  
 18 Pritchett can provide a copy of that.  
 19 DR. NEIL:  
 20 A. I know you're going to be interviewing Dr.  
 21 Jenkins, he can provide that.  
 22 MS. NEWBURY:  
 23 Q. Okay. And just on the issue then of thinking  
 24 about, perhaps back in June or at whatever  
 25 stage you're involved in this, at what point

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1 do you go into the office of Dr. Jenkins,  
 2 senior management or someone else, -  
 3 DR. NEIL:  
 4 A. Yes.  
 5 DR. NEIL:  
 6 A. - was it clear in your mind, given your  
 7 interaction with Eastern Health here, which  
 8 organization would have the primary  
 9 responsibility to take the steps or to  
 10 consider when and how disclosure should take  
 11 place with regard to the patient. I'm just  
 12 wondering if that was a factor here, that  
 13 Eastern Health is involved in conducting the  
 14 retesting, you're involved in providing  
 15 information.  
 16 DR. NEIL:  
 17 A. Yes.  
 18 MS. NEWBURY:  
 19 Q. Did that, in any way, influence you in terms  
 20 of not taking the decision earlier to go to  
 21 senior management.  
 22 DR. NEIL:  
 23 A. This was an Eastern Health issue. Eastern  
 24 Health asked me to do several things which I  
 25 did. Obviously, Eastern Health has a role and

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1 still does have a role to play in this whole  
 2 issue. To answer your question, yes, I would  
 3 think because it was an Eastern Health issue,  
 4 I did what Eastern Health asked me to do,  
 5 disclosure to patients would be an Eastern  
 6 Health issue, primarily. Now, I'm sure that  
 7 Western would be involved with it, but  
 8 primarily it would be Eastern Health.  
 9 MS. NEWBURY:  
 10 Q. So, it's your sense that Eastern Health would  
 11 be primarily responsible for making those  
 12 decisions, but consultation would take place  
 13 with Western Health.  
 14 DR. NEIL:  
 15 A. Yes, yes. To put things in perspective, I  
 16 didn't really consider disclosure; it was not  
 17 in my focus.  
 18 MS. NEWBURY:  
 19 Q. It wasn't on your radar at all.  
 20 DR. NEIL:  
 21 A. It was not on my radar. I wanted to do what I  
 22 had to do.  
 23 MS. NEWBURY:  
 24 Q. And are there any written policies in place,  
 25 generally speaking, not just dealing with

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1 disclosure issues, but dealing generally with  
 2 interaction when using Eastern Health as a  
 3 tertiary care centre, just to deal with  
 4 communication issues and -  
 5 DR. NEIL:  
 6 A. Not that I'm aware of.  
 7 MS. NEWBURY:  
 8 Q. - allocating responsibilities.  
 9 DR. NEIL:  
 10 A. Not that I'm aware of.  
 11 MS. NEWBURY:  
 12 Q. Is there any, I guess, less formal means of  
 13 resolving conflicts or communication issues  
 14 that might arise between Western Memorial or  
 15 Western Regional Health Authority and Eastern  
 16 Health when you're using the services of  
 17 Eastern Health as a tertiary care centre?  
 18 DR. NEIL:  
 19 A. I have and still have a good working  
 20 relationship with many of the pathologists and  
 21 lab directors, managers, whatever their  
 22 positions may be called. I can pick up the  
 23 phone at any time.  
 24 MS. NEWBURY:  
 25 Q. Okay, and that's on a peer to peer basis?

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1 DR. NEIL:  
 2 A. On a peer to peer basis.  
 3 MS. NEWBURY:  
 4 Q. And you -- I think you indicated earlier that  
 5 you're -- the lab technologists might likewise  
 6 call lab technologists at Eastern Health?  
 7 DR. NEIL:  
 8 A. Yes, and I've instructed them to do that on  
 9 various occasion.  
 10 MS. NEWBURY:  
 11 Q. But when you get into sort of more complicated  
 12 organizational type issues, is there any  
 13 mechanism in place, not so much, you know,  
 14 dealing with the technicalities of a  
 15 particular patient's test?  
 16 DR. NEIL:  
 17 A. Not that I'm aware of.  
 18 MS. NEWBURY:  
 19 Q. Okay.  
 20 DR. NEIL:  
 21 A. Not that I'm aware of.  
 22 MS. NEWBURY:  
 23 Q. I think one example you gave yesterday of  
 24 some, I guess, question about whose  
 25 responsible for paying the costs of ER/PR

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1 testing --  
 2 DR. NEIL:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. Which, I think, was being sent along to  
 6 Western Memorial by Eastern Health, and you  
 7 had some doubts as to whether or not you ought  
 8 to be paying for those ER/PR tests.  
 9 DR. NEIL:  
 10 A. Yes.  
 11 MS. NEWBURY:  
 12 Q. If you had wanted to push that particular  
 13 issue, is there someone in Western Memorial  
 14 who is the point person responsible for  
 15 resolving those types of issues?  
 16 DR. NEIL:  
 17 A. That's an issue between lab managers, I  
 18 believe.  
 19 MS. NEWBURY:  
 20 Q. Is it?  
 21 DR. NEIL:  
 22 A. Yeah.  
 23 MS. NEWBURY:  
 24 Q. Okay. So there's no sort of catchall person  
 25 or department within Western Memorial

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1 responsible for that?

2 DR. NEIL:

3 A. Well, you know, not one person per se. If I

4 were to say today how would I approach that

5 problem, I would include three people in those

6 discussions from Western; lab manager, our

7 financial person, and myself.

8 MS. NEWBURY:

9 Q. Okay, and if it were something not relating to

10 cost issue, if it had to do with a

11 communication issue or allocating

12 responsibility when things get complicated,

13 because I take it here you have oncologists

14 coming from --

15 DR. NEIL:

16 A. Yes.

17 MS. NEWBURY:

18 Q. From Eastern Health to Western Memorial to the

19 Cancer Clinic here, so not only do you have

20 the lab results or the specimens going to

21 Eastern Health for some testing, you also have

22 oncologists coming out from Eastern Health --

23 DR. NEIL:

24 A. Yes.

25 MS. NEWBURY:

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1 Q. When things get complicated, is there anyone

2 you would look to in that situation, or does

3 it depend on the situation?

4 DR. NEIL:

5 A. It depends -- well, I would think that

6 anything to do with any of the health

7 authorities across the province that are

8 outside by area would be dealt with by VP of

9 Medical Services.

10 MS. NEWBURY:

11 Q. And is there anything in place that would

12 trigger involvement by that particular person

13 when things get complicated? Do you have any

14 criteria, you know, when you have this sort of

15 a problem, alert VP of Medical Services?

16 DR. NEIL:

17 A. If it's outside my area --

18 MS. NEWBURY:

19 Q. Uh-hm.

20 DR. NEIL:

21 A. And sometimes even within my area, if I have a

22 difficult problem, my next person up the line

23 is VP Medical Services.

24 MS. NEWBURY:

25 Q. Okay. So as soon as you can't resolve

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1 something, either because it's complicated or

2 because it's outside your area --

3 DR. NEIL:

4 A. If -- yes, he's my contact, and in his

5 absence, the CEO.

6 MS. NEWBURY:

7 Q. I think you had indicated in your evidence

8 yesterday that you don't keep track of trends

9 within your department regarding positivity

10 rates --

11 DR. NEIL:

12 A. Correct.

13 MS. NEWBURY:

14 Q. For ER/PR testing. Are there any other trends

15 that you monitor -- are there any trends that

16 you monitor within your department regarding

17 breast cancer generally?

18 DR. NEIL:

19 A. No.

20 MS. NEWBURY:

21 Q. Okay, and I understand from your evidence

22 yesterday that Western Memorial has regularly

23 supplied information to the Cancer Registry?

24 DR. NEIL:

25 A. Yes.

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1 MS. NEWBURY:

2 Q. Back from the entire time that you've been

3 working there?

4 DR. NEIL:

5 A. Yes.

6 MS. NEWBURY:

7 Q. And do you know how long before you commenced

8 work at Western Memorial that that practice

9 was in place?

10 DR. NEIL:

11 A. I would say that practice has occurred for

12 many years.

13 MS. NEWBURY:

14 Q. And that's a consistent practice with each and

15 every diagnosis?

16 DR. NEIL:

17 A. Any cancer diagnosis.

18 MS. NEWBURY:

19 Q. Any cancer diagnosis, okay, and what type of

20 information would be supplied to the Cancer

21 Registry?

22 DR. NEIL:

23 A. It's the tumour type, and all that goes along

24 with that.

25 MS. NEWBURY:

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1 Q. Okay, so the grade, stage?  
 2 DR. NEIL:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. Okay. Is there any follow up information ever  
 6 provided to the Cancer Registry regarding that  
 7 particular patient? Do you -- you know, if  
 8 there any additions or any changes in the  
 9 diagnosis, would that be provided to the  
 10 Cancer Registry?  
 11 DR. NEIL:  
 12 A. If there's a change in the patient's diagnosis  
 13 -- every time there's a cancer, we send those  
 14 results to the Cancer Clinic.  
 15 MS. NEWBURY:  
 16 Q. And on what format do the reports go? Do you  
 17 know that offhand?  
 18 DR. NEIL:  
 19 A. Offhand, I don't know. We've been having some  
 20 difficulty with transmission. We've done it  
 21 historically way back when through just mail.  
 22 MS. NEWBURY:  
 23 Q. Okay.  
 24 DR. NEIL:  
 25 A. But we've been trying to get systems in where

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1 we can do all that electronically.  
 2 MS. NEWBURY:  
 3 Q. Okay.  
 4 DR. NEIL:  
 5 A. It would be unfair for me to say one or the  
 6 other because I don't do that.  
 7 MS. NEWBURY:  
 8 Q. And who in Western Memorial would know that  
 9 information?  
 10 DR. NEIL:  
 11 A. Our lab manager.  
 12 MS. NEWBURY:  
 13 Q. Lab manager. Do you happen to know whether  
 14 the ER/PR test results would be provided to  
 15 the Cancer Registry?  
 16 DR. NEIL:  
 17 A. Yes, because they are part of the patient  
 18 record.  
 19 MS. NEWBURY:  
 20 Q. Okay. So it actually would give the rate of  
 21 positivity results?  
 22 DR. NEIL:  
 23 A. It would be one of the data fields in the  
 24 patient reports.  
 25 MS. NEWBURY:

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1 Q. And how long has the inclusion of ER/PR test  
 2 results been provided to the Cancer Registry?  
 3 DR. NEIL:  
 4 A. As long as I can remember.  
 5 MS. NEWBURY:  
 6 Q. And do you have --  
 7 DR. NEIL:  
 8 A. Because it's part of the patient report.  
 9 MS. NEWBURY:  
 10 Q. Okay.  
 11 DR. NEIL:  
 12 A. It's part of the patient report.  
 13 MS. NEWBURY:  
 14 Q. And do you have any understanding as to what  
 15 this information is used for by the Cancer  
 16 Registry, what is the whole purpose of doing  
 17 that exercise?  
 18 DR. NEIL:  
 19 A. It's a registry, it's a database.  
 20 MS. NEWBURY:  
 21 Q. Okay. Do you ever avail of the information,  
 22 aside from in this case you used it to help  
 23 you retrieve patient information?  
 24 DR. NEIL:  
 25 A. On a routine basis, no.

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1 MS. NEWBURY:  
 2 Q. Are you ever provided with any overall stats  
 3 or trends?  
 4 DR. NEIL:  
 5 A. If I want it, I can get it.  
 6 MS. NEWBURY:  
 7 Q. You could?  
 8 DR. NEIL:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. And do you know if anyone else in your  
 12 hospital ever uses that information for any  
 13 research?  
 14 DR. NEIL:  
 15 A. Not that I'm aware of.  
 16 MS. NEWBURY:  
 17 Q. Thank you, Dr. Neil. Those are all the  
 18 questions I have.  
 19 DR. NEIL:  
 20 A. Thank you.  
 21 COMMISSIONER:  
 22 Q. Ms. Russell.  
 23 DR. PAUL NEIL, EXAMINATION BY MS DARLENE RUSSELL  
 24 MS. RUSSELL:  
 25 Q. Hello, Dr. Neil. I'm Darlene Russell, co-



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1 counsel for the breast cancer testing class  
 2 action. I believe that you said yesterday  
 3 that you have 30 to 40 breast cancer cases at  
 4 Western Health per year?  
 5 DR. NEIL:  
 6 A. Yes.  
 7 MS. RUSSELL:  
 8 Q. Okay. So that would involve approximately 30  
 9 to 40, I guess, ER/PR tests as well?  
 10 DR. NEIL:  
 11 A. Yes.  
 12 MS. RUSSELL:  
 13 Q. Okay. Out of those, do you know how many are  
 14 negative per year?  
 15 DR. NEIL:  
 16 A. I don't have those statistics.  
 17 MS. RUSSELL:  
 18 Q. Okay. Do you know how many were negative  
 19 between '97 and 2005, the total number?  
 20 DR. NEIL:  
 21 A. I don't have those statistics.  
 22 MS. RUSSELL:  
 23 Q. Do you know how many you sent away for  
 24 retesting, how many ER/PR tests -- because you  
 25 would have sent all the negatives.

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1 DR. NEIL:  
 2 A. Yes.  
 3 MS. RUSSELL:  
 4 Q. Between '97 and 2005?  
 5 DR. NEIL:  
 6 A. We sent approximately 250.  
 7 MS. RUSSELL:  
 8 Q. About 250 total?  
 9 DR. NEIL:  
 10 A. Yes.  
 11 MS. RUSSELL:  
 12 Q. For '97 to 2005?  
 13 DR. NEIL:  
 14 A. Yes.  
 15 MS. RUSSELL:  
 16 Q. Okay, how many of these turned out to be false  
 17 negative?  
 18 DR. NEIL:  
 19 A. I don't have those statistics.  
 20 MS. RUSSELL:  
 21 Q. Okay. You have spreadsheets on all this  
 22 information, do you?  
 23 DR. NEIL:  
 24 A. Yes, but I didn't do a statistical analysis on  
 25 those.

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1 MS. RUSSELL:  
 2 Q. Okay, but that wouldn't be a difficult thing  
 3 to do?  
 4 DR. NEIL:  
 5 A. No, but it wasn't -- it wasn't my focus. This  
 6 data was being collected and collated by  
 7 Eastern Health, CIHI, I believe, and others.  
 8 MS. RUSSELL:  
 9 Q. You still have those spreadsheets?  
 10 DR. NEIL:  
 11 A. I have those -- I have spreadsheets, yes.  
 12 MS. RUSSELL:  
 13 Q. Could we get a copy of those with the  
 14 appropriate information redacted, obviously,  
 15 or the confidential information?  
 16 DR. NEIL:  
 17 A. I have no problem with that. I'm not --  
 18 COMMISSIONER:  
 19 Q. Is that information not in another form in  
 20 another exhibit?  
 21 MR. BROWNE:  
 22 Q. Commissioner, this information is not  
 23 something that we would have necessarily gone  
 24 back to, all of this (inaudible) gone back  
 25 with respect to -

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1 COMMISSIONER:  
 2 Q. I'm thinking about the NLCHI stuff.  
 3 COFFEY, Q.C.:  
 4 Q. I believe, Commissioner, what she's asking for  
 5 here is the spreadsheets that went -- the  
 6 listing that went with the -- the doctor had  
 7 spreadsheets with each year --  
 8 MS. RUSSELL:  
 9 Q. He had his own spreadsheets.  
 10 COFFEY, Q.C.:  
 11 Q. -- and on the way out, not the information  
 12 coming back. We've got that in another form.  
 13 I think you're asking here to --  
 14 DR. NEIL:  
 15 A. What went out?  
 16 MS. RUSSELL:  
 17 Q. Yes.  
 18 COMMISSIONER:  
 19 Q. Oh, as opposed to the information that came  
 20 back. Sorry.  
 21 COFFEY, Q.C.:  
 22 Q. Yes, oh, yes.  
 23 MR. BROWNE:  
 24 Q. I'm clear on that as well.  
 25 COMMISSIONER:

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1 Q. Okay, so we're --

2 DR. NEIL:

3 A. I have -- with the names gone, of course?

4 MS. RUSSELL:

5 Q. With the names gone, yes.

6 DR. NEIL:

7 A. I have no problem with that.

8 MS. RUSSELL:

9 Q. Okay, and we have specific identification that

10 tells how many negatives came back for Corner

11 Brook in other documents, and could we get

12 those numbers -- would you mind compiling

13 those numbers that I just requested?

14 COMMISSIONER:

15 Q. What you're asking the witness for is a copy

16 of a document that already exists with the

17 identifying names redacted?

18 MS. RUSSELL:

19 Q. Yes.

20 COMMISSIONER:

21 Q. And I think the witness has said he's prepared

22 to do that.

23 DR. NEIL:

24 A. I can certainly --

25 COMMISSIONER:

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1 Q. If he has a copy of it still.

2 DR. NEIL:

3 A. I can certainly provide that -- those are my

4 working documents that I spoke to Mr. Coffey

5 about yesterday.

6 MS. RUSSELL:

7 Q. Okay.

8 DR. NEIL:

9 A. And there are copies of that. I'm more than

10 prepared to give them to you.

11 MS. RUSSELL:

12 Q. Okay.

13 DR. NEIL:

14 A. With the names removed.

15 MS. RUSSELL:

16 Q. Thank you. No further questions.

17 COMMISSIONER:

18 Q. Thank you, Ms. Russell. Mr. Pike.

19 MR. PIKE:

20 Q. No questions, Commissioner. Thank you.

21 COMMISSIONER:

22 Q. Mr. Browne.

23 DR. PAUL NEIL, EXAMINATION BY MR. PETER BROWNE

24 MR. BROWNE:

25 Q. Good morning, Dr. Neil

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1 DR. NEIL:

2 A. Good morning.

3 MR. BROWNE:

4 Q. You'll be glad to know when I come up to the

5 podium, it means things are drawing hopefully

6 to an end.

7 DR. NEIL:

8 A. Good.

9 MR. BROWNE:

10 Q. Just a couple of areas to cover off. Firstly,

11 you were shown a couple of exhibits by Mr.

12 Coffey regarding the fixation policies for

13 both the copies you received in 2007 and

14 subsequently the new document that was dated

15 in 2008?

16 DR. NEIL:

17 A. Yes.

18 MR. BROWNE:

19 Q. Several of the references in that material

20 refer to Ackerman's. Is that the textbook

21 that you have at your institution?

22 DR. NEIL:

23 A. Yes, it is.

24 MR. BROWNE:

25 Q. Okay. As well, I had -- I had made a note to

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1 speak t you about your administrative and

2 clinical responsibility. I think Mr. Coffey

3 covered that off to some extent this morning.

4 Is there anything in addition to what he asked

5 that you want to add to that in terms of you

6 are a unique -- you carry a unique position in

7 that you have both clinical duties and

8 administrative duties.

9 DR. NEIL:

10 A. Yes.

11 MR. BROWNE:

12 Q. Are there any observations or comments that

13 you want to provide the Commissioner with

14 regard to that unique position that may be

15 relevant to this?

16 DR. NEIL:

17 A. Well, I think I covered most of it with Mr.

18 Coffey. You know, it's a role -- it's a role

19 that -- yes, it's a dual role, and I'm finding

20 that the service part of that role is more

21 time consuming than I want it to be. I think

22 I've made my point on that.

23 MR. BROWNE:

24 Q. We've heard from Dr. Cook, in particular,

25 about the -- he's clinical chief or was

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1 clinical chief for Eastern Health, about the  
 2 division of time and so on. Is there -- in  
 3 your institution is there expectation of how  
 4 much service time and administrative time  
 5 you're supposed to divide?  
 6 DR. NEIL:  
 7 A. The expectation is, from my position at least,  
 8 half time administrative. I'm finding it's  
 9 more.  
 10 MR. BROWNE:  
 11 Q. As well Mr. Coffey asked you yesterday, I  
 12 believe, about continuing medical education  
 13 and he asked you about the financial side and  
 14 the time side, and I think you indicated that  
 15 it was approximately one week in duration that  
 16 you have?  
 17 DR. NEIL:  
 18 A. One week is what has been historically in  
 19 Western for all physicians.  
 20 MR. BROWNE:  
 21 Q. And I just want to tie that back to your  
 22 responsibility as sort of an administrative --  
 23 your administrative responsibilities for the  
 24 department.  
 25 DR. NEIL:

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1 A. Uh-hm.  
 2 MR. BROWNE:  
 3 Q. And presumably for your colleagues. As your  
 4 capacity, should there be more time for  
 5 somebody who is in an administrative position  
 6 to, say, go to -- to have more continuing  
 7 medical education to bring back information  
 8 for the department and disseminate that to  
 9 your colleagues?  
 10 DR. NEIL:  
 11 A. I would like to have a lot more time.  
 12 MR. BROWNE:  
 13 Q. And we saw that this morning. I think you  
 14 indicated you wanted six months to work on --  
 15 DR. NEIL:  
 16 A. Six months would be wonderful. Probably a  
 17 little bit unrealistic, but --  
 18 MR. BROWNE:  
 19 Q. Sure, and I appreciate that that was sort of a  
 20 bit of a facetious comment, but nevertheless,  
 21 the point being that if individuals who are  
 22 charged with respective institutions, should  
 23 they have necessarily -- if they're bringing  
 24 back information or expectation, disseminating  
 25 information, additional time to do that?

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1 DR. NEIL:  
 2 A. Most definitely.  
 3 MR. BROWNE:  
 4 Q. And finally, Doctor, and you alluded to this  
 5 yesterday in some questioning from the  
 6 Commissioner, do you have any statements or  
 7 recommendations you would like to make to the  
 8 Commissioner?  
 9 DR. NEIL:  
 10 A. I'd like to add a couple of words, if you  
 11 didn't mind.  
 12 MR. BROWNE:  
 13 Q. Please do.  
 14 DR. NEIL:  
 15 A. First of all, I'd just like to thank the  
 16 Commissioner and Commission counsel for giving  
 17 me the opportunity to come here and express my  
 18 thoughts and my views. I'd like to first of  
 19 all speak to the people of Western  
 20 Newfoundland, and I'd like to ensure those  
 21 ladies particularly that we have done  
 22 everything possible to comply with the recall,  
 23 and ensure that what we have done, we have  
 24 done to the best of our ability because this  
 25 is a serious issue. I'd like to thank

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1 everybody in Western Health for assisting me.  
 2 It's not only me that has done a fair amount  
 3 of work, and I have, all of our staff have  
 4 done a tremendous amount of work; lab staff,  
 5 lab managers, senior administration, these  
 6 people have done a tremendous amount of work.  
 7 So I'd like to ensure the people of Western  
 8 Newfoundland that we've done all we can. On a  
 9 go forward basis, I'd also like to ensure them  
 10 that all procedures regarding tissue  
 11 preparation and processing are currently in  
 12 place to the best of our ability, and we are  
 13 sending our specimens to Mount Sinai, so rest  
 14 assured that the results in my opinion are the  
 15 proper results and they have no concerns.  
 16 Finally, I'd like to recommend to the  
 17 Commission that as laboratory directors, and  
 18 all labs across the province, continue our  
 19 dialogue and consultation in order to improve  
 20 and provide best quality laboratory service  
 21 that this province can offer. I've alluded to  
 22 some examples of how we can do that, and one  
 23 was the quality assurance document that came  
 24 up early this morning.  
 25 MR. BROWNE:

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1 Q. Yes.  
 2 DR. NEIL:  
 3 A. That and other things like that are things  
 4 that we should be, as a group of people, lab  
 5 directors, and others that need to be  
 6 involved, get together and make sure we have  
 7 the proper procedures in place, and we've done  
 8 a lot of work -- Eastern Health has done a lot  
 9 of work, but there's a lot more that needs to  
 10 be done. I've alluded to the time that I need  
 11 to do some of this work, and I just hope that  
 12 we can get it done because we need a quality  
 13 laboratory service in this province, and I  
 14 speak of this province because we're a small  
 15 province, 500,000 people. We need quality  
 16 work and we can do it together, not as  
 17 separate boards or separate health  
 18 authorities, we need to do it together. That  
 19 applies, I guess, in every aspect of medicine,  
 20 but I can only speak to my own, laboratory  
 21 medicine.  
 22 MR. BROWNE:  
 23 Q. You mentioned to me about some type of think  
 24 tank?  
 25 DR. NEIL:

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1 A. A think tank is what I'm recommending. It has  
 2 started to a certain extent, but it should be  
 3 a focused think tank of all people who can get  
 4 together and come up with quality laboratory  
 5 service in this province.  
 6 MR. BROWNE:  
 7 Q. Just so we're clear, that includes  
 8 pathologists and technicians, and all aspects?  
 9 DR. NEIL:  
 10 A. All aspects, all aspects, would be my  
 11 recommendation.  
 12 COMMISSIONER:  
 13 Q. Dr. Neil, you said yesterday that we wanted  
 14 standardized protocols.  
 15 DR. NEIL:  
 16 A. Yes.  
 17 COMMISSIONER:  
 18 Q. And who is that we? Were you speaking then  
 19 from the perspective of Western Health or were  
 20 you speaking in a larger context?  
 21 DR. NEIL:  
 22 A. We - when I say "we", a lot of times I mean  
 23 "me", but I also discuss a lot of what I do  
 24 with my colleagues. So my colleagues want the  
 25 same as I do. My colleagues being the other

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1 pathologists in our group.  
 2 COMMISSIONER:  
 3 Q. So that -- because primarily the witnesses  
 4 that we have had here thus far have come from  
 5 Eastern Health, and it's been sort of the  
 6 perspective of the largest single institution  
 7 in the province. I'm curious about whether or  
 8 not from the perspective of those outside of  
 9 this region, there are particular problems,  
 10 vis a vis your ability to deal, in particular,  
 11 with pathology related to breast, but perhaps  
 12 it might be a little wider than that, with the  
 13 issues that come up as pathologists. For  
 14 example, are your--you spoke about it in  
 15 reference really yesterday--your education  
 16 opportunities, you know, is that made more  
 17 difficult because you've got to get out of  
 18 Western Newfoundland as opposed to flying out  
 19 of St. John's, for example? Does it make it  
 20 more expensive? Is it more likely that a  
 21 pathologist who works in St. John's has  
 22 opportunities, because the university is here,  
 23 that are not available to you in Western  
 24 Newfoundland or not available to somebody who  
 25 works in St. Anthony, for example? Are there

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1 ways that--are there things that you need,  
 2 because of your particular place, physical or  
 3 otherwise, that are over and above what a  
 4 pathologist might need if they're working in  
 5 Eastern Health?  
 6 DR. NEIL:  
 7 A. Yes. I think there are.  
 8 THE COMMISSIONER:  
 9 Q. And what kind of things?  
 10 DR. NEIL:  
 11 A. A smaller place, and you'll speak to Dr.  
 12 Dankwa this afternoon, he's a sole  
 13 pathologist. Dr. Maurice Dalton in Grand  
 14 Falls has a two-person operation, but most of  
 15 the time, it's only one. Same applies to  
 16 Gander. For these people to leave for any  
 17 extended period of time, it's difficult  
 18 because the work needs to get done, and if  
 19 they're not there, it doesn't get done. It's  
 20 a little bit better for me because I have, you  
 21 know, five people and hopefully to have more.  
 22 But to leave your community and get continuing  
 23 medical education, work doesn't get done while  
 24 you're gone, and that's not a good thing.  
 25 We've tried recently to have local conferences

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1 here in St. John's. It has worked and it  
 2 should continue and I think the plan is for  
 3 that to continue. Bring speakers in, bring  
 4 people who can help us in our work. But that  
 5 doesn't mean that you can't go out. You need  
 6 national exposure, and for smaller communities  
 7 -  
 8 THE COMMISSIONER:  
 9 Q. And in your view, perhaps international?  
 10 DR. NEIL:  
 11 A. And international, yes.  
 12 THE COMMISSIONER:  
 13 Q. What about the use of--well, obviously you  
 14 already do it, because you're involved in that  
 15 CAP program.  
 16 DR. NEIL:  
 17 A. Yes.  
 18 THE COMMISSIONER:  
 19 Q. So that I'm just wondering are there, using  
 20 technology, ways of assisting you, and  
 21 secondly, whether or not because of the  
 22 numbers or lack of numbers that you see of  
 23 certain kinds of things -  
 24 DR. NEIL:  
 25 A. Yes.

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1 THE COMMISSIONER:  
 2 Q. - have you considered whether or not you can  
 3 or should be doing certain tests?  
 4 DR. NEIL:  
 5 A. I know what you're talking about. The  
 6 internet is good, but it's not--it can't  
 7 replace people and talking to your colleagues  
 8 one on one. For things we don't see often,  
 9 are you talking about centralizing some  
 10 services or centralizing breast services?  
 11 THE COMMISSIONER:  
 12 Q. Well, that's the question I'm raising, as to  
 13 whether or not--I think there's--it comes from  
 14 two perspectives. One is whether or not for  
 15 optimum service, you really have to have  
 16 sufficient numbers -  
 17 DR. NEIL:  
 18 A. Yes.  
 19 THE COMMISSIONER:  
 20 Q. - to enable you to keep your skills up as a  
 21 pathologist?  
 22 DR. NEIL:  
 23 A. Yes.  
 24 THE COMMISSIONER:  
 25 Q. And there may be an economic side of it as

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1 well, whether or not the, either equipment  
 2 required or the training required is out of  
 3 proportion with the number of cases that you  
 4 have to deal with for particular kinds of  
 5 pathology.  
 6 DR. NEIL:  
 7 A. Yes. I'll give you a good example. I had  
 8 mentioned a dermatologist has come to Corner  
 9 Brook. He's very good, very active. He's  
 10 giving us material that we very rarely see  
 11 sometimes. We have to recognize our  
 12 limitations. We're not trained  
 13 dermatopathologists, which is why I initiated  
 14 a consultation service with Gamma DynaCare.  
 15 You have to have the subspecialists that you  
 16 can rely on. I think Dr. Cook also mentioned  
 17 it in his remarks. Subspecialty training is  
 18 vitally important, but we're in a small  
 19 province. To think that we're going to get  
 20 subspecialty training in all areas is probably  
 21 unrealistic. But we can certainly strive for  
 22 that, and hopefully with what's happened  
 23 recently, we'll be able to better do that.  
 24 But when you look at a smaller population  
 25 outside--a smaller population of pathologists

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1 outside this province, outside St. John's, we  
 2 have to recognize that we have to have some  
 3 place to send our breast cases that are  
 4 difficult, send our prostate cases that are  
 5 difficult, discuss that, learn from that,  
 6 because these are very--they're very important  
 7 cases and they take up a lot of time if you  
 8 haven't got a subspecialist to help you out  
 9 with these. The pathologists on the periphery  
 10 are general pathologists. They deal with  
 11 routine stuff and very well, but we have to  
 12 recognize our limitations and subspecialists  
 13 are of vital importance.  
 14 So I guess, to answer your question, yes,  
 15 all the difficult breast cases, and this is  
 16 what, I think, Maurice has been doing in Grand  
 17 Falls, his difficult breast cases, he's been  
 18 sending to Bev Carter, and unfortunately,  
 19 Bev's not here any more. So what does he do?  
 20 I don't know the answer to that. Hopefully  
 21 we'll get someone to replace her. This is the  
 22 think tank I'm talking about, because all  
 23 these issues, we can't resolve these issues  
 24 here today, but I think a think tank can come  
 25 up with some sort of idea as to how we're

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1 going to provide the best solution in this  
 2 province for the limited number of patients  
 3 that we have and certainly the limited number  
 4 of pathologists that we have.  
 5 THE COMMISSIONER:  
 6 Q. Thank you.  
 7 DR. NEIL:  
 8 A. Thank you.  
 9 MR. BROWNE:  
 10 Q. Thank you, Commissioner.  
 11 THE COMMISSIONER:  
 12 Q. Thank you, Mr. Browne. Mr. Coffey, is there  
 13 anything arising?  
 14 DR. PAUL NEIL, RE-EXAMINATION BY BERNARD COFFEY, Q.C.  
 15 COFFEY, Q.C.:  
 16 Q. Yes, just one question, Commissioner. Doctor,  
 17 in answering a question for Ms. Newbury, you  
 18 said, you know, you made a comment "when we  
 19 have a problem, we deal with it" in relation  
 20 to -  
 21 DR. NEIL:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. And you, certainly, the documentation that  
 25 we've seen, I think I alluded to it yesterday

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1 and what I hope is a jocular fashion, that  
 2 you're, if nothing else, persistent.  
 3 DR. NEIL:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. Okay. Doctor, just on that point, because  
 7 certainly after your conversation with Dr.  
 8 Cook in August, late August and then his memo  
 9 of September 6th, we've seen that Western  
 10 provided the material, you know, kind of  
 11 almost day to day at one point.  
 12 DR. NEIL:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. In early October. And you'd received the June  
 16 14th memo and it wasn't until late August,  
 17 early September that, as you say "if there's a  
 18 problem, we addressed it."  
 19 DR. NEIL:  
 20 A. Yeah.  
 21 COFFEY, Q.C.:  
 22 Q. Can you offer a comment or explain to the  
 23 Commissioner, because it'll occur to somebody,  
 24 bearing in mind how diligently it was pursued  
 25 late summer, early fall -

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1 DR. NEIL:  
 2 A. In September and not June?  
 3 COFFEY, Q.C.:  
 4 Q. Yes, and in terms of--well, the initial one  
 5 was just one year in June?  
 6 DR. NEIL:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. And I appreciate you didn't have the benefit  
 10 of all the detailed memo and the conversation  
 11 with Dr. Cook.  
 12 DR. NEIL:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. So can you explain, but there's apparently a  
 16 difference in speed of approach anyway.  
 17 DR. NEIL:  
 18 A. Yes. There are several reasons for that.  
 19 Number one, in June, the middle of June, and  
 20 that's really the first memo that I had that I  
 21 had to do this. We took it as a serious  
 22 issue, but the workload in Western, and I'm  
 23 sure in every other institution, for, you  
 24 know, technologists and clerical staff and  
 25 ourselves, we tried to do the task that was

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1 presented to us in a regular working time. In  
 2 other words, do your own work and try to do  
 3 this as well, and it became a little bit  
 4 taxing, and I instructed our staff to do  
 5 exactly what was there. I was away for the  
 6 month of July or the better part of July, and  
 7 whether that had anything to do with it or  
 8 not, I don't know, but I was away, and when I  
 9 came back, it was a slow process, and in order  
 10 to do it at the level that we did it in  
 11 September, we had to dedicate our staff  
 12 totally to doing this, outside their regular  
 13 working hours.  
 14 COFFEY, Q.C.:  
 15 Q. So there was a lot of overtime?  
 16 DR. NEIL:  
 17 A. There was a lot of overtime and weekends, and  
 18 that's the real difference.  
 19 COFFEY, Q.C.:  
 20 Q. Okay, so in late August, early in September,  
 21 in particular, there were a lot of staff  
 22 called back -  
 23 DR. NEIL:  
 24 A. A lot of staff called back and not one person  
 25 or two people, but a lot of dedicated staff.

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1 When I made my remarks, I really mean that  
 2 these people worked hard.  
 3 COFFEY, Q.C.:  
 4 Q. So just again for the Commissioner, so she  
 5 understands, you know, kind of the difference  
 6 in -  
 7 DR. NEIL:  
 8 A. That's the difference. We pulled out all  
 9 stops in September.  
 10 COFFEY, Q.C.:  
 11 Q. Thank you, Commissioner, I just wanted -  
 12 THE COMMISSIONER:  
 13 Q. Thank you. Thank you very much, Dr. Neil, for  
 14 your contribution. It's been most interesting  
 15 hearing about the perspective of the West  
 16 coast.  
 17 DR. NEIL:  
 18 A. Thank you very much.  
 19 THE COMMISSIONER:  
 20 Q. I suggest we take the morning break and then  
 21 we can continue with the next witness.  
 22 (RECESS)  
 23 THE COMMISSIONER:  
 24 Q. Please be seated. Mr. Coffey.  
 25 COFFEY, Q.C.:

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1 Q. Thank you. The next witness is Dr. Dankwa.  
 2 DR. ESSANDOH KWEKU DANKWA, AFFIRMED, EXAMINATION BY  
 3 BERNARD COFFEY, Q.C.  
 4 REGISTRAR:  
 5 Q. Would you please state and spell your complete  
 6 name for the Commission?  
 7 DR. DANKWA:  
 8 A. My name is Essandoh Kweku Dankwa. Essandoh is  
 9 spelled E-S-S-A-N-D-O-H. Kweku is K-W-E-K-U,  
 10 and my surname, Dankwa, D-A-N-K-W-A.  
 11 REGISTRAR:  
 12 Q. Thank you.  
 13 COFFEY, Q.C.:  
 14 Q. Thank you, Doctor. Commissioner, there are  
 15 further exhibits I'm going to ask that be  
 16 entered, please. They are exhibit numbers P-  
 17 2196 -  
 18 THE COMMISSIONER:  
 19 Q. Sorry, would you give me that number again,  
 20 please?  
 21 COFFEY, Q.C.:  
 22 Q. P-2196 through P-2223 inclusive.  
 23 THE COMMISSIONER:  
 24 Q. Okay, entered.  
 25 EXHIBITS ENTERED AND MARKED P-2196 THROUGH P-2223

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1 COFFEY, Q.C.:  
 2 Q. Thank you, Registrar. If I could, please,  
 3 Exhibit P-2196? Now, Doctor, this is a  
 4 curriculum vitae, and I take it it's yours?  
 5 DR. DANKWA:  
 6 A. Yes, it is.  
 7 COFFEY, Q.C.:  
 8 Q. Doctor, if I could, please, I'm going to ask  
 9 you to outline for the Commissioner your  
 10 professional educational background and your  
 11 professional background, please?  
 12 DR. DANKWA:  
 13 A. I grew up in Ghana, West Africa, where I did  
 14 my basic medical training at the University of  
 15 Ghana Medical School located in Accra. I  
 16 completed my medical training in 1980.  
 17 Following that, I did my--started my post-  
 18 graduate training in pathology in Ghana, West  
 19 Africa. In 1984, I moved over to the United  
 20 Kingdom, to Bristol on a British Council  
 21 Scholarship by competition.  
 22 In Bristol, that was where I had my first  
 23 introduction to immunohistochemistry and I  
 24 stayed in Bristol until 1988, to complete my  
 25 training in pathology, culminating in me

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1 obtaining the membership of the Royal College  
 2 of Pathologists, by examination.  
 3 COFFEY, Q.C.:  
 4 Q. That's in the UK?  
 5 DR. DANKWA:  
 6 A. In the UK, yes, and following that, I worked  
 7 in the United Kingdom until 1993 when I moved  
 8 over to the United States, worked as a fellow  
 9 and staff pathologist at the Armed Forces  
 10 Institute of Pathology in Washington, and I  
 11 was there until 1995--1994. While I was  
 12 there, I saw the job opportunity in St.  
 13 Anthony. I applied for it, and I was  
 14 successful. I moved back to United Kingdom  
 15 for a couple of months, working in London,  
 16 before I resumed the job in St. Anthony, where  
 17 I have been until now.  
 18 COFFEY, Q.C.:  
 19 Q. And Doctor, in St. Anthony, what is your  
 20 position?  
 21 DR. DANKWA:  
 22 A. I'm the only pathologist there and also the  
 23 Director of Pathology over there. I have  
 24 other responsibilities too, outside of  
 25 pathology.

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1 COFFEY, Q.C.:

2 Q. Could you explain those to the Commissioner,

3 please?

4 DR. DANKWA:

5 A. Yes. I'm also the Associate VP of Medical

6 Service. So I have the responsibility of

7 looking at the medical service as a whole, in

8 addition to my directorship as pathologist and

9 the only pathologist there.

10 COFFEY, Q.C.:

11 Q. So you're the VP Medical Services.

12 DR. DANKWA:

13 A. Associate VP

14 COFFEY, Q.C.:

15 Q. Associate VP Medical Services. So there's

16 yourself and one other?

17 DR. DANKWA:

18 A. Right, the overall VP is Michael Jong, who is

19 in Goose Bay.

20 COFFEY, Q.C.:

21 Q. And we'll see Dr. Jong's name, I think, in

22 some of the materials.

23 DR. DANKWA:

24 A. Right.

25 COFFEY, Q.C.:

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1 Q. So Michael Jong is the VP Medical?

2 DR. DANKWA:

3 A. Medical Services, yes.

4 COFFEY, Q.C.:

5 Q. For the -

6 DR. DANKWA:

7 A. The entire region.

8 COFFEY, Q.C.:

9 Q. - in the region, and that's Labrador Grenfell?

10 DR. DANKWA:

11 A. Grenfell, correct.

12 COFFEY, Q.C.:

13 Q. You're the associate?

14 DR. DANKWA:

15 A. Yes.

16 COFFEY, Q.C.:

17 Q. You're also the Director of Pathology?

18 DR. DANKWA:

19 A. Yes.

20 COFFEY, Q.C.:

21 Q. And you are the pathologist?

22 DR. DANKWA:

23 A. The only pathologist, yes.

24 COFFEY, Q.C.:

25 Q. Doctor, and I'll refer to Labrador Grenfell

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1 generally in this context, perhaps I'll just

2 use the short--refer to it as St. Anthony.

3 DR. DANKWA:

4 A. Right, okay.

5 COFFEY, Q.C.:

6 Q. And when it involves Labrador, I'll

7 distinguish, okay?

8 DR. DANKWA:

9 A. Sure.

10 COFFEY, Q.C.:

11 Q. But Doctor, in St. Anthony, the technologists,

12 how are they organized and whom do they report

13 to?

14 DR. DANKWA:

15 A. The technologists, we have about 12--we have

16 12 of them, and then a secretary, and they

17 report directly to the Director of--Regional

18 Director of Diagnostic Services, but

19 indirectly to me. They report directly to the

20 Regional Director and then indirectly -

21 COFFEY, Q.C.:

22 Q. And then he reports to whom?

23 DR. DANKWA:

24 A. To the VP Medical Service, that is Dr. Michael

25 Jong.

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1 COFFEY, Q.C.:

2 Q. And then you say indirectly they report to

3 you? How does that work?

4 DR. DANKWA:

5 A. We have--even though their reporting lines is

6 to the Regional Director, there is always a

7 regular communication between me, the regional

8 director and then directly to the staff as

9 well.

10 COFFEY, Q.C.:

11 Q. So you, I take it, routinely deal with the

12 technologists directly yourself?

13 DR. DANKWA:

14 A. All the time.

15 COFFEY, Q.C.:

16 Q. All the time, and I'll be talking to you

17 further about that.

18 DR. DANKWA:

19 A. Sure, okay.

20 COFFEY, Q.C.:

21 Q. That's the structure?

22 DR. DANKWA:

23 A. Yes.

24 COFFEY, Q.C.:

25 Q. How long has that structure been in place?



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1 DR. DANKWA:  
 2 A. Those are altered to this particular  
 3 arrangement in 2005, when the new regional  
 4 board was instituted.  
 5 COFFEY, Q.C.:  
 6 Q. So before 2005, what was the structure?  
 7 DR. DANKWA:  
 8 A. Before 2005, we had a manager of the lab who  
 9 was restricted mainly to the laboratory  
 10 service, rather than radiology. When we say  
 11 the diagnostic services, we include the  
 12 radiology as well. But prior to 2005, we had  
 13 a manager who was restricted to the laboratory  
 14 services.  
 15 COFFEY, Q.C.:  
 16 Q. Laboratory services, and how about your own  
 17 role, before 2005?  
 18 DR. DANKWA:  
 19 A. Before 2005, it was virtually the same. I was  
 20 responsible for the laboratory and then I was  
 21 also the medical director at that time, so I  
 22 was responsible.  
 23 COFFEY, Q.C.:  
 24 Q. And your interaction with technologists in St.  
 25 Anthony -

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1 DR. DANKWA:  
 2 A. Was the same.  
 3 COFFEY, Q.C.:  
 4 Q. Was similar?  
 5 DR. DANKWA:  
 6 A. Yeah, similar.  
 7 COFFEY, Q.C.:  
 8 Q. Okay, Doctor, I'm going to go back then to--  
 9 because you made a reference--a comment to the  
 10 Commissioner about the fact that when you  
 11 arrived in Bristol, in the UK, and what year  
 12 was that?  
 13 DR. DANKWA:  
 14 A. This was in 1984.  
 15 COFFEY, Q.C.:  
 16 Q. '84, and in effect, I take it, you did a  
 17 residency there?  
 18 DR. DANKWA:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. You were--that was your first introduction to  
 22 or exposure to immunohistochemistry?  
 23 DR. DANKWA:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And IHC processes?  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. Could you tell the Commissioner about that,  
 6 what you found in Bristol at the time and what  
 7 your initial exposure was?  
 8 DR. DANKWA:  
 9 A. Right. Prior to coming to Bristol, we had  
 10 read a lot in the literature about the values  
 11 of immunohistochemistry and what it could do.  
 12 So to me, before I got to Bristol, it was  
 13 something in the literature, not actually in  
 14 practice. But when I got to Bristol, it was  
 15 actually in practice. Not only were they  
 16 producing the antibodies themselves, they were  
 17 also using it in diagnostic services and they  
 18 were evaluating the antibodies and applying it  
 19 to their diagnostic process in the area.  
 20 COFFEY, Q.C.:  
 21 Q. And the institution in Bristol at the time, do  
 22 you recall the actual name of the institution  
 23 that you were working for?  
 24 DR. DANKWA:  
 25 A. I was in the, what they call the Bristol Royal

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1 Infirmary, that was the main one I was in for  
 2 most of the time, but I rotated through the  
 3 other, the other centres as well.  
 4 COFFEY, Q.C.:  
 5 Q. Now this particular centre, the Bristol Royal  
 6 Infirmary, was that involved in particular--  
 7 did it have any particular involvement or  
 8 expertise in IHC?  
 9 DR. DANKWA:  
 10 A. The pathologists and the trainees there were  
 11 provided support for their site laboratories  
 12 that were there within the university and so  
 13 with almost every investigation, they would  
 14 involve some of us in their process.  
 15 COFFEY, Q.C.:  
 16 Q. And how much--I suppose what I'm trying to ask  
 17 you, Doctor, was there anything particular  
 18 about Bristol in terms of IHC generally in the  
 19 UK at that time, anything--were they more  
 20 involved in it than other spots?  
 21 DR. DANKWA:  
 22 A. They were certainly more involved than others,  
 23 I would say.  
 24 COFFEY, Q.C.:  
 25 Q. What do you recall about that? Can you tell

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1 the Commissioner about -  
 2 DR. DANKWA:  
 3 A. There were a lot of research projects that  
 4 were taking place and almost every division in  
 5 the hospital, not only pathology, but  
 6 surgical, internal medicine, were all pursuing  
 7 some aspects of immunohistochemistry and we,  
 8 as pathologists, were involved with the  
 9 microscopic aspect of review and things.  
 10 COFFEY, Q.C.:  
 11 Q. Now at that time, you know, in the period, you  
 12 said 1985 through '88?  
 13 DR. DANKWA:  
 14 A. 1984.  
 15 COFFEY, Q.C.:  
 16 Q. '84, I'm sorry, through '88. Were you exposed  
 17 to using the IHC process for detection of  
 18 estrogen receptors and progesterone receptors?  
 19 DR. DANKWA:  
 20 A. At that time the estrogen receptors or the  
 21 assays were being done as a biochemical assay.  
 22 But I was therefore to bring it into the  
 23 laboratory using immunohistochemical stains,  
 24 yes. When I started there.  
 25 COFFEY, Q.C.:

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1 Q. When you started, that was kind of the  
 2 beginning -  
 3 DR. DANKWA:  
 4 A. That was the beginning, yes.  
 5 COFFEY, Q.C.:  
 6 Q. And, Doctor, how far--well I'll just ask you,  
 7 did you ever do any, do you recall any ER or  
 8 PR IHC analysis before you left in 1998? Had  
 9 it advanced to the point where you were  
 10 involved in it?  
 11 DR. DANKWA:  
 12 A. I cannot recall exactly because there were so  
 13 many immunohistochemical antibodies that were  
 14 coming into the technical--coming into use  
 15 that I could not exactly recall when it came  
 16 into being.  
 17 COFFEY, Q.C.:  
 18 Q. And Doctor, after 1988 you moved to?  
 19 DR. DANKWA:  
 20 A. I worked around the United Kingdom as  
 21 consultant pathologist and then moved in 1993  
 22 to the USA, Armed Forces Institute of  
 23 Pathology.  
 24 COFFEY, Q.C.:  
 25 Q. Between '88 and '93, were you ever involved in

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1 ER/PR IHC testing?  
 2 DR. DANKWA:  
 3 A. It must have occurred between that period and  
 4 when I was in Washington, yes.  
 5 COFFEY, Q.C.:  
 6 Q. But it doesn't stand out particularly in your  
 7 mind?  
 8 DR. DANKWA:  
 9 A. It doesn't stand out particularly, no.  
 10 COFFEY, Q.C.:  
 11 Q. Okay, in the Armed Forces Institute in  
 12 Washington and the United States, you were  
 13 there for what purpose at that time?  
 14 DR. DANKWA:  
 15 A. In the other breast and gynecology pathology.  
 16 COFFEY, Q.C.:  
 17 Q. I'm sorry, at the?  
 18 DR. DANKWA:  
 19 A. Other breast and gynecologic pathology, I was  
 20 an x-raying pathologist, as a staff  
 21 pathologist, doing the fellowship.  
 22 COFFEY, Q.C.:  
 23 Q. Okay, I was just going to ask you about that,  
 24 so you decided to come and I presume you had  
 25 to apply for it.

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1 DR. DANKWA:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. In 1993 you arrived in the United States and  
 5 you were there for a year?  
 6 DR. DANKWA:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. And what exactly was it you were doing there  
 10 at the time?  
 11 DR. DANKWA:  
 12 A. Involved in reviewing referrals of cases,  
 13 diagnostically difficult cases in breast and  
 14 gynecologic pathology.  
 15 COFFEY, Q.C.:  
 16 Q. Breast, the two areas.  
 17 DR. DANKWA:  
 18 A. And gynecologic areas, yes.  
 19 COFFEY, Q.C.:  
 20 Q. Now in that particular institution, I'll ask  
 21 you first, that program or course, is that a  
 22 year-long course?  
 23 DR. DANKWA:  
 24 A. A year long program.  
 25 COFFEY, Q.C.:

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1 Q. Would that, in effect, have been some sort of  
 2 subspecialization?  
 3 DR. DANKWA:  
 4 A. Yes, it would have been, yes.  
 5 COFFEY, Q.C.:  
 6 Q. How much were you exposed to ER/PR IHC testing  
 7 there, at that time?  
 8 DR. DANKWA:  
 9 A. I cannot say exactly how much, but there were  
 10 a variety of immunohistochemical tests that  
 11 were coming through at the same time, so  
 12 whenever the problem posed itself as having to  
 13 use the immunohistochemical process, we did  
 14 use them.  
 15 COFFEY, Q.C.:  
 16 Q. In the course of this consult work -  
 17 DR. DANKWA:  
 18 A. Exactly.  
 19 COFFEY, Q.C.:  
 20 Q. - you needed it done.  
 21 DR. DANKWA:  
 22 A. We would have done it, yes.  
 23 COFFEY, Q.C.:  
 24 Q. Doctor, at that time how would you have  
 25 learned how to read an ER or PR slide, how did

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1 you -  
 2 DR. DANKWA:  
 3 A. What often happened then was you did what you  
 4 could in interpreting the case and then you  
 5 would share that, you read that in a  
 6 consultation fashion where you would have  
 7 people who are more experienced in  
 8 interpretation sitting behind the microscope  
 9 with you and others as well to interpret what  
 10 you have seen and how you can interpret them  
 11 and they will correct you accordingly.  
 12 COFFEY, Q.C.:  
 13 Q. Doctor, the method then you were taught to use  
 14 in terms of analyzing an ER slide and a PR  
 15 slide, IHC slides, could you tell the  
 16 Commissioner how you go about it?  
 17 DR. DANKWA:  
 18 A. Well, and this would have occurred anywhere  
 19 between my experience in Bristol and then in  
 20 the Armed Forces Institute of Pathology. Some  
 21 pathologists would have reported them just as  
 22 positive or negative, but with the  
 23 immunohistochemistry in general, there were  
 24 other pathologists who were particular in  
 25 trying to give an idea about how much the

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1 staining was and attempt also to quantify it,  
 2 so there were different approaches in the  
 3 interpretation of immunohistochemistry and for  
 4 that matter, ER/PR.  
 5 COFFEY, Q.C.:  
 6 Q. And in particular ER/PR, you say like positive  
 7 or negative?  
 8 DR. DANKWA:  
 9 A. Negative, yes.  
 10 COFFEY, Q.C.:  
 11 Q. What was your understanding of what was  
 12 positive or negative, at least in the view of  
 13 these people you were dealing with in the 90s?  
 14 DR. DANKWA:  
 15 A. If the staining was present, it was positive.  
 16 COFFEY, Q.C.:  
 17 Q. Okay, if there was any amount of nuclear  
 18 staining--I think it's nuclei staining.  
 19 DR. DANKWA:  
 20 A. It was nuclei staining, yes.  
 21 COFFEY, Q.C.:  
 22 Q. It was positive.  
 23 DR. DANKWA:  
 24 A. It was positive, yes.  
 25 COFFEY, Q.C.:

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1 Q. And it was on either/or?  
 2 DR. DANKWA:  
 3 A. Yes, exactly.  
 4 COFFEY, Q.C.:  
 5 Q. And you said other pathologists, though, you  
 6 found were attempting to quantify -  
 7 DR. DANKWA:  
 8 A. Quantify what they were seeing, yes.  
 9 COFFEY, Q.C.:  
 10 Q. As a percentage, I take it?  
 11 DR. DANKWA:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. So I take it then, Doctor, in terms of the  
 15 pathologists you were dealing with at that  
 16 time, the Armed Forces Institute, there was no  
 17 standard way of doing it?  
 18 DR. DANKWA:  
 19 A. No. And this would have occurred anywhere  
 20 from Bristol into the US.  
 21 COFFEY, Q.C.:  
 22 Q. All the way into the US.  
 23 DR. DANKWA:  
 24 A. Yes, exactly, yeah.  
 25 COFFEY, Q.C.:

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1 Q. Doctor, I'll ask you know, do you know a Dr.  
 2 Khalifa?  
 3 DR. DANKWA:  
 4 A. Yes, indeed I do, yes.  
 5 COFFEY, Q.C.:  
 6 Q. And where did you first meet Dr. Khalifa?  
 7 DR. DANKWA:  
 8 A. I met him when I was down in the United  
 9 States.  
 10 COFFEY, Q.C.:  
 11 Q. At the Armed Forces -  
 12 DR. DANKWA:  
 13 A. It wasn't in the Armed Forces Institute. When  
 14 I joined the Armed Forces Institute, they  
 15 automatically assumed that I knew him because  
 16 he had also come from Africa, but I didn't.  
 17 COFFEY, Q.C.:  
 18 Q. I appreciate the comment, Doctor.  
 19 DR. DANKWA:  
 20 A. So his contact information was given to me and  
 21 we met, I think around, in another setting, at  
 22 another hospital in Washington, D.C., yes.  
 23 COFFEY, Q.C.:  
 24 Q. But it was during your year at the Armed  
 25 Forces Institute while you were posted, or

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1 working in that institute.  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. You did come to meet Dr. Khalifa?  
 6 DR. DANKWA:  
 7 A. Exactly, yes.  
 8 COFFEY, Q.C.:  
 9 Q. Did you ever work with him in the United  
 10 States professionally, like in the same  
 11 institution?  
 12 DR. DANKWA:  
 13 A. No, I didn't.  
 14 COFFEY, Q.C.:  
 15 Q. Just while I'm on that topic, after you left  
 16 the United States and went to St. Anthony, did  
 17 you ever meet Dr. Khalifa again?  
 18 DR. DANKWA:  
 19 A. Yes, when I was in St. Anthony, I came down to  
 20 the Health Science Centre when I was preparing  
 21 to do my, take my membership, the Canadian  
 22 membership and during that time, I run into  
 23 Dr. Khalifa by accident in a corridor.  
 24 COFFEY, Q.C.:  
 25 Q. In the corridor of the General Hospital, I

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1 take it?  
 2 DR. DANKWA:  
 3 A. In the hospital, yeah.  
 4 COFFEY, Q.C.:  
 5 Q. Doctor, you mention it, the Canadian College,  
 6 did you take the test?  
 7 DR. DANKWA:  
 8 A. Yes, I did.  
 9 COFFEY, Q.C.:  
 10 Q. And were you successful?  
 11 DR. DANKWA:  
 12 A. Yes, I was.  
 13 COFFEY, Q.C.:  
 14 Q. And when was that, Doctor, when did you -  
 15 DR. DANKWA:  
 16 A. It's what I think, '97.  
 17 COFFEY, Q.C.:  
 18 Q. Okay, around that, it would be in your -  
 19 DR. DANKWA:  
 20 A. Yes, it will be in my C.V. yes.  
 21 COFFEY, Q.C.:  
 22 Q. So, Doctor, to go, to come back to your  
 23 accepting of a position in St. Anthony,  
 24 Newfoundland.  
 25 DR. DANKWA:

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. Doctor, had you ever worked--perhaps the  
 4 Commissioner to get some sense of it, how big  
 5 of an institution is the hospital in St.  
 6 Anthony? How many patients does it handle,  
 7 you know, what kind of approximate staff sizes  
 8 and so on, could you tell us?  
 9 DR. DANKWA:  
 10 A. It's a 52 bed hospital currently. It has  
 11 about 500 staff working there. For physicians  
 12 in total, it's roundabout 30 physicians. We  
 13 have surgeons, obstetricians, pediatricians  
 14 and I'm a pathologist and family physicians  
 15 around as well.  
 16 COFFEY, Q.C.:  
 17 Q. And the geographic area covered?  
 18 DR. DANKWA:  
 19 A. It covers south for the, when it comes to  
 20 pathology, it covers the northern Newfoundland  
 21 and the whole of Labrador.  
 22 COFFEY, Q.C.:  
 23 Q. Now, Doctor, how long have you been  
 24 responsible for the pathology in Labrador?  
 25 DR. DANKWA:

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1 A. The pathology in Labrador originating from  
 2 Goose Bay, I was responsible up until 2006 and  
 3 then Captain William Jackman, that is in  
 4 Labrador City, was prior to that sending their  
 5 cases on to, I think the St. Clare's Hospital.  
 6 COFFEY, Q.C.:  
 7 Q. Their pathology was -  
 8 DR. DANKWA:  
 9 A. Their pathology work was going there and since  
 10 2007, all the pathology from Labrador had also  
 11 been coming to St. Anthony.  
 12 COFFEY, Q.C.:  
 13 Q. So just so I understand it and so the  
 14 Commissioner does, when you arrived in 1995 in  
 15 St. Anthony, the hospital itself, you would be  
 16 responsible for the pathology there?  
 17 DR. DANKWA:  
 18 A. Pathology, yes.  
 19 COFFEY, Q.C.:  
 20 Q. And at that point in time Labrador City,  
 21 Wabush, that area, was sending its pathology  
 22 specimens to St. Clare's in St. John's.  
 23 DR. DANKWA:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And that changed in?  
 2 DR. DANKWA:  
 3 A. 2007.  
 4 COFFEY, Q.C.:  
 5 Q. Okay. And the other hospitals there, that  
 6 would generate the pathology specimens -  
 7 DR. DANKWA:  
 8 A. Continuity count, St. Anthony.  
 9 COFFEY, Q.C.:  
 10 Q. So when you arrived as well, so we have to go  
 11 back to the time you arrived in '95. When you  
 12 arrived at the hospital in Goose Bay, which is  
 13 the Happy Valley/Goose Bay medical facility,  
 14 any pathology specimens they generated from  
 15 the time you arrived in '95 would come to St.  
 16 Anthony, to you?  
 17 DR. DANKWA:  
 18 A. Correct, yes.  
 19 COFFEY, Q.C.:  
 20 Q. And that has continued up to what point?  
 21 DR. DANKWA:  
 22 A. Up to this day.  
 23 COFFEY, Q.C.:  
 24 Q. Okay, up to this point?  
 25 DR. DANKWA:

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1 A. Yes, up to this point, yes.  
 2 COFFEY, Q.C.:  
 3 Q. So you made a reference to 2006 -  
 4 DR. DANKWA:  
 5 A. Yes, because we were separate boards to begin  
 6 with and Goose Bay and Captain William Jackman  
 7 in Labrador City, was one board, a new one -  
 8 COFFEY, Q.C.:  
 9 Q. Yes.  
 10 DR. DANKWA:  
 11 A. But the Goose Bay work was coming on to St.  
 12 Anthony, but not the Captain William Jackman.  
 13 COFFEY, Q.C.:  
 14 Q. Okay, so in the days before the most recent  
 15 amalgamation of the boards -  
 16 DR. DANKWA:  
 17 A. Exactly.  
 18 COFFEY, Q.C.:  
 19 Q. Jackman sent its to St. Clare's.  
 20 DR. DANKWA:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. And the Happy Valley/Goose Bay -  
 24 DR. DANKWA:  
 25 A. Send this to St. Anthony.

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1 COFFEY, Q.C.:  
 2 Q. - which be sending it to yourself?  
 3 DR. DANKWA:  
 4 A. Yes, correct.  
 5 COFFEY, Q.C.:  
 6 Q. And that still continues?  
 7 DR. DANKWA:  
 8 A. That still continues, yes.  
 9 COFFEY, Q.C.:  
 10 Q. Okay. Doctor, in St. Anthony when you arrived  
 11 there in 1995, the whole time you had been in  
 12 St. Anthony, have you ever had another, at any  
 13 point, another pathologist there with you?  
 14 DR. DANKWA:  
 15 A. Yes, when I arrived in '95, there was another  
 16 pathologist, but his prime aim was being in  
 17 the public health, was working, so we co-  
 18 shared some responsibilities in pathology, but  
 19 I was the main pathologist.  
 20 COFFEY, Q.C.:  
 21 Q. And how long did -  
 22 DR. DANKWA:  
 23 A. He was there until '99, 2000.  
 24 COFFEY, Q.C.:  
 25 Q. Until 2000?

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1 DR. DANKWA:  
 2 A. 2000, yes.  
 3 COFFEY, Q.C.:  
 4 Q. Would he have done any ER/PR cases, do you  
 5 think?  
 6 DR. DANKWA:  
 7 A. From our records I didn't see his name on any  
 8 of them.  
 9 COFFEY, Q.C.:  
 10 Q. Doctor, when you arrived in St. Anthony in  
 11 1995, can you tell the Commissioner, please,  
 12 bearing in mind the administrative roles, the  
 13 hats you wear, and your clinical service  
 14 responsibilities, if there is such a thing,  
 15 can you describe for the Commissioner kind of  
 16 a typical day for a person, like a sole  
 17 practitioner like yourself in St. Anthony?  
 18 How does it work?  
 19 DR. DANKWA:  
 20 A. My day normally begins in the morning. I  
 21 would start off with reporting of the  
 22 histology slides and in between that time,  
 23 between, say 8:30 or 9:00 until about lunch  
 24 break, that would be one of my prime focus and  
 25 intermittently I would have a contacts from my

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1 clinical colleagues who may be interested in  
 2 discussing the various cases. While that is  
 3 happening, it doesn't preclude any medical  
 4 issues coming up with the involved physicians  
 5 administratively that I may have to be  
 6 involved in, so quite often I may have a lot  
 7 of interruption with my actual day-to-day work  
 8 in reporting the histology. Fully  
 9 (unintelligible) time, I mean that is assuming  
 10 that there was no urgent cases which would be  
 11 in the middle of an operation, they may just  
 12 stop it and want to get a diagnosis about a  
 13 case, that is a frozen section diagnosis. If  
 14 that happens, I have to drop everything that  
 15 I'm doing in order to respond to that. If we  
 16 don't get those sort of cases, then I may have  
 17 to continue with my afternoon work, and that  
 18 is when I concentrate mostly on dealing with  
 19 the grossing of a specimen and also  
 20 supervising the lab tech to make sure that  
 21 things were progressing as well as it should.  
 22 So I may end up in a day, and I also have  
 23 teaching responsibilities to students and  
 24 residents who may be there.  
 25 COFFEY, Q.C.:

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1 Q. Who may be passing through from Memorial's  
 2 Medical School?  
 3 DR. DANKWA:  
 4 A. Yes, exactly. And so quite often there will  
 5 be a number of interruptions going through the  
 6 day and with the reporting of histology  
 7 slides, you want to be a bit more focused when  
 8 you are doing that, so I end up actually  
 9 reporting most of my cases in the evening when  
 10 everybody is gone and it's quiet and on the  
 11 weekends as well.  
 12 COFFEY, Q.C.:  
 13 Q. Now, Doctor, in terms of--and reporting of  
 14 histology is, I take it, you're looking at the  
 15 slides, the H&E slides generally and making  
 16 diagnoses and dictating them and so on.  
 17 DR. DANKWA:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. The aspect of your job that involves grossing  
 21 -  
 22 DR. DANKWA:  
 23 A. Yes, indeed it does.  
 24 COFFEY, Q.C.:  
 25 Q. Could you explain to the Commissioner, please,

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1 the set up in St. Anthony for that? I mean,  
 2 how did the specimens come, in what form do  
 3 they come, who handles them?  
 4 DR. DANKWA:  
 5 A. Okay. I'll begin with St. Anthony, bearing in  
 6 mind that I'm the only one, so I have to  
 7 really co-ordinate the things. I handle not  
 8 only cases coming from St. Anthony, but cases  
 9 from Goose Bay and Lab City, so I'll start  
 10 with St. Anthony.  
 11 COFFEY, Q.C.:  
 12 Q. Yes, if you would please?  
 13 DR. DANKWA:  
 14 A. If a surgeon--when a surgeon is operating,  
 15 quite often they give me warnings if they  
 16 believe that a specimen may have to come down  
 17 to me as a frozen section, do it in the middle  
 18 of the operation. If that doesn't happen,  
 19 then what often happens, when the specimen is  
 20 removed, they give it to the nurse who is  
 21 assisting them to place it in formalin  
 22 immediately. I have encouraged them to, as  
 23 much as possible, if they could, to make a cut  
 24 into the tissue through to the tumour, if  
 25 there's a tumour, just as a precautionary

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1 measure. If I'm not there, like this, today,  
 2 that the specimen will at least get some  
 3 formalin into the tumour before I get to see  
 4 it. And once that is done, quite often we get  
 5 a nurse that is coming down to the laboratory  
 6 with the specimens, so they have a run in the  
 7 morning, but quite often it's in the afternoon  
 8 when they bring it in and most of the  
 9 operation would have been done, major  
 10 operation would have been done by about 2:00,  
 11 3:00, so we get most of the specimens by then.  
 12 And once it gets to the lab, all the big  
 13 specimens, let's take breast, for example,  
 14 because that's what we're talking about now,  
 15 if it's a lump, regardless of what it is, we  
 16 paint the margins, others may use the term  
 17 inking of the margins, but I paint them, I  
 18 prefer that approach to inking. And then we  
 19 slice them up and put paper towels in between  
 20 the slices to allow more penetration of  
 21 formalin and then leave it to fix, usually  
 22 overnight. If it's a small specimen, within  
 23 about a few hours it probably will be fixed  
 24 enough to process them, but with breasts,  
 25 because fixation can be tricky, I normally

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1 leave them overnight to let the penetration  
 2 occur. The formalin, if it's very bloody--  
 3 sorry for my words.  
 4 COFFEY, Q.C.:  
 5 Q. No, it is what it is.  
 6 DR. DANKWA:  
 7 A. All right, okay. We would have the formalin  
 8 changed by the end of the day so that it would  
 9 get fresh formalin on the breast specimen for  
 10 the following day.  
 11 COFFEY, Q.C.:  
 12 Q. So, Doctor, in terms of, for example, if  
 13 there's a breast operation in the morning or  
 14 it's concluded by, for example, 2:00 and the  
 15 specimen is down to yourself, it would come in  
 16 a container to you?  
 17 DR. DANKWA:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. Would it be immersed in formalin?  
 21 DR. DANKWA:  
 22 A. It would be immersed in formalin and the ratio  
 23 I've advised them is ten to one volume of  
 24 formalin to the specimen.  
 25 COFFEY, Q.C.:

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1 Q. Doctor, and you've indicated that you  
 2 encourage surgeons to, if they can, to excise,  
 3 at least put one cut into the tissue so that  
 4 in effect the tumour is exposed to formalin.  
 5 DR. DANKWA:  
 6 A. Yes, formalin.  
 7 COFFEY, Q.C.:  
 8 Q. Correctly.  
 9 DR. DANKWA:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. So you would get the breast tissue in  
 13 formalin, you would then--have we heard the  
 14 term "bread loafing" after your inking -  
 15 DR. DANKWA:  
 16 A. Yes, exactly, bread loafing.  
 17 COFFEY, Q.C.:  
 18 Q. Is the phrase that's used. Now, Doctor, is  
 19 there any particular procedure for bread  
 20 loafing breast tissue? Is there any  
 21 particular widths of the cutting slices that  
 22 you use or -  
 23 DR. DANKWA:  
 24 A. If it's a lump, I call it biopsy, but they may  
 25 use the term lumpectomy, there's a lump, small

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1 lump, I try to bisect the thickness about the  
 2 same thickness as a cassette that I am going  
 3 to place it in, that we are looking at roughly  
 4 around 3 millimetres wide. If it's a  
 5 mastectomy specimen, a bigger specimen, then  
 6 we're limited to about 5 to 10 millimetres  
 7 thickness.  
 8 COFFEY, Q.C.:  
 9 Q. It has to be a bit thicker because -  
 10 DR. DANKWA:  
 11 A. A bit thicker because of the size of the  
 12 specimen, yes.  
 13 COFFEY, Q.C.:  
 14 Q. And so that would be done, I take it, in St.  
 15 Anthony--if it's a St. Anthony operation, that  
 16 would be done the day of the operation?  
 17 DR. DANKWA:  
 18 A. The day of the operation, yes.  
 19 COFFEY, Q.C.:  
 20 Q. Are there any circumstances that you can--  
 21 well, first of all this procedure in terms of  
 22 the slicing of the tissue to those widths  
 23 you've described, how long have you been using  
 24 that process?  
 25 DR. DANKWA:

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<p>1 A. Ever since I started my training in Ghana and 2 then continued it in Bristol, there was a 3 breast unit attached to Bristol. 4 COFFEY, Q.C.: 5 Q. Okay, so that's the approach you've used all 6 your medical life. 7 DR. DANKWA: 8 A. All the time, yes. 9 COFFEY, Q.C.: 10 Q. So that's done, Doctor, are there any 11 circumstances where that wouldn't get done on 12 the same day as the operation in St. Anthony? 13 A St. Anthony operation? 14 DR. DANKWA: 15 A. I've trained my lab techs to do that if I am 16 not there, so that unless a trained lab tech 17 wasn't there, then that may happen, but 18 otherwise, they look out for it and then do 19 it. 20 COFFEY, Q.C.: 21 Q. And how long have the lab techs in St. Anthony 22 been doing this, you know, if you're not 23 there, how long ago did you train them? 24 DR. DANKWA: 25 A. I have been doing this for a long while.</p>	<p>1 technologists are supposed to do this bread 2 loafing? 3 DR. DANKWA: 4 A. Yes. 5 COFFEY, Q.C.: 6 Q. And how about, are they trained also to put in 7 the paper - 8 DR. DANKWA: 9 A. They could yes, without that, the fixation 10 wouldn't happen because the tissues would 11 collapse back into position again, yes. 12 COFFEY, Q.C.: 13 Q. So they're trained, in effect, to do the bread 14 loafing that you do? 15 DR. DANKWA: 16 A. Yes, exactly. 17 COFFEY, Q.C.: 18 Q. Is there any understanding that you have with 19 them that they are to do it that day? 20 DR. DANKWA: 21 A. Oh yes, they get that and then also make sure 22 they open any container just to make sure that 23 there's enough formalin, so as soon as they 24 open it and there isn't enough formalin, I 25 encourage them to cut through, yes.</p>
<p>Page 158</p> <p>1 Certainly, not the very time that I was around 2 because there were two of us and as soon as we 3 became, as soon as I happened to be the only 4 person. 5 COFFEY, Q.C.: 6 Q. So since around 2000? 7 DR. DANKWA: 8 A. Around 2000, I tried encouraging them to do 9 that and then change the formalin as well. 10 COFFEY, Q.C.: 11 Q. Toward the end of the day. 12 DR. DANKWA: 13 A. Yes, yes. 14 COFFEY, Q.C.: 15 Q. So the understanding I take it then you had 16 with your technologists is, if I'm there, I 17 will do it. 18 DR. DANKWA: 19 A. Yes. 20 COFFEY, Q.C.: 21 Q. You know, that day. 22 DR. DANKWA: 23 A. Yes. 24 COFFEY, Q.C.: 25 Q. And if I'm not there for some reason, then the</p>	<p>Page 160</p> <p>1 COFFEY, Q.C.: 2 Q. And, Doctor, I take it then it would be fixed 3 overnight? 4 DR. DANKWA: 5 A. Yes. 6 COFFEY, Q.C.: 7 Q. And when you come in the next day, what 8 happens then with the breast tissue? 9 DR. DANKWA: 10 A. I describe it and then take representative 11 blocks of the areas of interest, including the 12 tumour, the surrounding tissue, representative 13 areas of normal tissue and the nipple and part 14 of the skin above the tumour and then the 15 excision margins as well. 16 COFFEY, Q.C.: 17 Q. And they're, I take it, made of a proper size 18 to go in the cassettes? 19 DR. DANKWA: 20 A. Correct, yes. 21 COFFEY, Q.C.: 22 Q. And, Doctor, you've indicated, I believe, that 23 generally it's in the afternoons that you do 24 the grossing. 25 DR. DANKWA:</p>



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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. So I take it, on day one, surgery, Monday,  
 4 surgery on Monday. Monday afternoon the bread  
 5 loafing would occur?  
 6 DR. DANKWA:  
 7 A. Right.  
 8 COFFEY, Q.C.:  
 9 Q. Tuesday afternoon, I take it, would be the  
 10 grossing -  
 11 DR. DANKWA:  
 12 A. Yes, exactly.  
 13 COFFEY, Q.C.:  
 14 Q. And preparation for cassettes.  
 15 DR. DANKWA:  
 16 A. Correct.  
 17 COFFEY, Q.C.:  
 18 Q. And then when does the tissue processing?  
 19 DR. DANKWA:  
 20 A. The same night after I have taken the  
 21 representative blocks, they go onto the  
 22 processing slide.  
 23 COFFEY, Q.C.:  
 24 Q. Now you did indicate when you first alluded to  
 25 this earlier, that you would oversee or make

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1 sure the technologists were doing that end of  
 2 it properly?  
 3 DR. DANKWA:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. Like where does that occur within the lab,  
 7 like the tissue processor in comparison to  
 8 where you're doing a grossing?  
 9 DR. DANKWA:  
 10 A. Well the, with the grossing, the technicians  
 11 would be there when I'm doing the grossing.  
 12 COFFEY, Q.C.:  
 13 Q. Okay.  
 14 DR. DANKWA:  
 15 A. But when it comes to embedding, once the  
 16 tissue had gone through the processor, it is  
 17 then the technician's responsibility to take  
 18 on the next step, yes.  
 19 COFFEY, Q.C.:  
 20 Q. Okay, so before it goes into the tissue  
 21 processor, I take it, is that near the  
 22 grossing bench?  
 23 DR. DANKWA:  
 24 A. Yes, it is, yes.  
 25 COFFEY, Q.C.:

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1 Q. Who is responsible for operating in your  
 2 hospital the tissue processor unit?  
 3 DR. DANKWA:  
 4 A. There are two areas of responsibility, there  
 5 is the biomedics have a role in some regular  
 6 maintenance of the thing, and then we have the  
 7 companies themselves that we purchase the  
 8 processor from, also have some role in  
 9 maintaining it, but some of the daily  
 10 maintenance requirements are done by the  
 11 technicians.  
 12 COFFEY, Q.C.:  
 13 Q. The technologists.  
 14 DR. DANKWA:  
 15 A. Yes, the technologists, things like changing  
 16 the formalin, making sure that the various  
 17 reagents are in good condition.  
 18 COFFEY, Q.C.:  
 19 Q. Now, is there any--and in terms of that,  
 20 Doctor, are the people, the technologists who  
 21 are responsible for maintaining on a daily  
 22 basis the tissue processor unit, do they  
 23 report to you or do they report to the  
 24 technology side? In relation to the tissue  
 25 processor?

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1 DR. DANKWA:  
 2 A. In relation to the--technically they report to  
 3 the manager of diagnostic services, but in  
 4 practice, they make me aware of whatever is  
 5 happening, so--and I literally check every day  
 6 to see how things were processing, how things  
 7 were going, yes.  
 8 COFFEY, Q.C.:  
 9 Q. And have you, over the years, been ever made  
 10 aware of problems with the tissue processor?  
 11 I'm just asking, in terms of, you know,  
 12 there's a problem with the processor and -  
 13 DR. DANKWA:  
 14 A. Oh, you mean, by the technicians or whatever?  
 15 COFFEY, Q.C.:  
 16 Q. Yes.  
 17 DR. DANKWA:  
 18 A. They have, and quite often too, I may realize  
 19 something and go back to them. Bear in mind,  
 20 I'm the only one there, so I see everything  
 21 that is coming through, so I'm able to pick up  
 22 when things are going off and then have it  
 23 corrected before it gets out of hand.  
 24 COFFEY, Q.C.:  
 25 Q. Now Doctor, in the grossing of breast tissue,

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1 breast tumour, what are you looking for, in  
 2 terms of choosing tissue to go into the  
 3 cassettes? What are you looking--what sorts  
 4 of things do you look for as criteria, as to  
 5 whether or not the tissue ends up in a  
 6 cassette?  
 7 DR. DANKWA:  
 8 A. Well, if it's a case that you're suspecting a  
 9 tumour, then my main focus is making sure that  
 10 I can make the diagnosis or confirm it or  
 11 refute it. So I look for the suspicious areas  
 12 when I look at a specimen grossly, and then  
 13 select samples from there. But in addition to  
 14 that, I also look at--I want to see how the  
 15 tumour is behaving at the edge between the  
 16 tumour itself and then the normal tissue, and  
 17 then I would also like to be able to give  
 18 certain additional information to the surgeon,  
 19 like whether the tumour is completely removed  
 20 or not, and whether the nipple is involved or  
 21 not, because these have got prognostic  
 22 significance to the surgeon and I just want to  
 23 also assess the changes in the normal breast  
 24 tissue. By that, we also give a reflection as  
 25 to what may be happening in the other breast

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1 as well.  
 2 COFFEY, Q.C.:  
 3 Q. So the choice of the tissue to go into the  
 4 cassettes is yours?  
 5 DR. DANKWA:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. The tissue, then you, in effect, oversee the  
 9 tissue ending up in the tissue processor?  
 10 DR. DANKWA:  
 11 A. Right.  
 12 COFFEY, Q.C.:  
 13 Q. You described that, and that would--I take it  
 14 the tissue processor works overnight?  
 15 DR. DANKWA:  
 16 A. It does, yes, automated, yeah.  
 17 COFFEY, Q.C.:  
 18 Q. And then the next day then, what happens with  
 19 the tissue?  
 20 DR. DANKWA:  
 21 A. Hopefully by the next day, everything would  
 22 have come out to a stage where the specimen in  
 23 the cassette could now be blocked. What we  
 24 say blocked, it would then be placed in  
 25 paraffin wax.

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1 COFFEY, Q.C.:  
 2 Q. And who's responsible for doing that?  
 3 DR. DANKWA:  
 4 A. By the technician, yes.  
 5 COFFEY, Q.C.:  
 6 Q. And then what happens, for example, in breast  
 7 tissue?  
 8 DR. DANKWA:  
 9 A. Yes. Once it's placed in the paraffin wax,  
 10 it's allowed to set and then it's often--they  
 11 often use a frozen deck to help it to set and  
 12 following that, they take it off and then use  
 13 a microtome, a sharp blade, in making thin  
 14 sections of it and then use a glass slide to  
 15 pick them up from a warm water bath, have it  
 16 stick to the glass slide and then apply  
 17 various stains to it and normally the H & E to  
 18 begin with.  
 19 COFFEY, Q.C.:  
 20 Q. H & E to begin?  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. Okay, and so that would be routine? The H & E  
 25 -

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1 DR. DANKWA:  
 2 A. Routine, yes.  
 3 COFFEY, Q.C.:  
 4 Q. - they'd know to do certain -  
 5 DR. DANKWA:  
 6 A. Exactly, routine.  
 7 COFFEY, Q.C.:  
 8 Q. Do they prepare a H & E slide for each block?  
 9 DR. DANKWA:  
 10 A. Yes, they do, yes.  
 11 COFFEY, Q.C.:  
 12 Q. So then what happens to the H & E slides, the  
 13 blocks, where do they go?  
 14 DR. DANKWA:  
 15 A. They come to me, and then I read them and  
 16 report. If I'm happy with what I have seen, I  
 17 report them. If I need some more additional  
 18 blocks or whatever, I'd go back to the breast  
 19 and take some additional blocks.  
 20 COFFEY, Q.C.:  
 21 Q. In the meantime, where would the breast tissue  
 22 be?  
 23 DR. DANKWA:  
 24 A. It would be in formalin, put back in formalin.  
 25 COFFEY, Q.C.:

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1 Q. Okay, the breast tissue that did not--was not  
 2 chosen to go into the tissue processor  
 3 initially -  
 4 DR. DANKWA:  
 5 A. Yeah, it would stay in the formalin.  
 6 COFFEY, Q.C.:  
 7 Q. It would stay in the formalin?  
 8 DR. DANKWA:  
 9 A. In formalin, yes.  
 10 COFFEY, Q.C.:  
 11 Q. Doctor, I take it then, you would use the H &  
 12 E slides to make your diagnosis and your  
 13 microscopic interpretation. When does the  
 14 ER/PR testing come into this?  
 15 DR. DANKWA:  
 16 A. When in my interpretation I establish that  
 17 there is a case of malignancy, then that is  
 18 the time that I make a selection of a block, a  
 19 corresponding block to a glass slide that has  
 20 got a tumour in it that I'm satisfied with to  
 21 go--corresponding block to go for ER/PR  
 22 COFFEY, Q.C.:  
 23 Q. Is there any particular criteria that you  
 24 utilize as to which slide and therefore which  
 25 block?

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1 DR. DANKWA:  
 2 A. Right, I tend to look for a slide that shows a  
 3 representative size of the tumour and just  
 4 some normal tissue, so that there is a  
 5 transition from normal to the tumour, yes.  
 6 COFFEY, Q.C.:  
 7 Q. And why do you look for normal tissue?  
 8 DR. DANKWA:  
 9 A. That is where we get our internal control  
 10 from.  
 11 COFFEY, Q.C.:  
 12 Q. Now the idea of doing that, like if possible,  
 13 at all possible that's got representative  
 14 tumour and normal tissue, how long have you  
 15 known that that's the correct approach?  
 16 DR. DANKWA:  
 17 A. For as long as I've been doing  
 18 immunohistochemistry. It doesn't have to be  
 19 breast. Even with any other tumour of the  
 20 skin or whatever, if I'm going to do  
 21 immunohistochemistry, I choose an adjacent  
 22 area showing the reflective or normal tissue  
 23 changing onto the tumour, so that I can make  
 24 comparative change as to what is really  
 25 happening.

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1 COFFEY, Q.C.:  
 2 Q. So you choose a particular slide, and  
 3 therefore a particular block?  
 4 DR. DANKWA:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. Use the slide to specify a block?  
 8 DR. DANKWA:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. Order ER and PR?  
 12 DR. DANKWA:  
 13 A. Correct, yes.  
 14 COFFEY, Q.C.:  
 15 Q. And I take it this goes back to the time--  
 16 well, we'll come to when all this started in  
 17 St. Anthony, but from the time it started or  
 18 became available in St. Anthony, you would do  
 19 that. What then happens, Doctor, with ER/PR?  
 20 DR. DANKWA:  
 21 A. I send the block off. I mean, if we are  
 22 looking at when they were doing it here in St.  
 23 John's, we send the block off and fill in,  
 24 complete a form indicating what test I wanted  
 25 and usually I select the ER/PR and don't

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1 accompany it with a letter, but just the  
 2 request. To start off with, I started  
 3 accompanying it with a letter and then  
 4 eventually became just -  
 5 COFFEY, Q.C.:  
 6 Q. In the early days.  
 7 DR. DANKWA:  
 8 A. In the early days, yeah, and then it came to  
 9 just a form, to complete a form with a  
 10 representative block, and then the block would  
 11 go. Another slide, another H & E slide would  
 12 be made and then ER/PR stains would be done on  
 13 two other slides and separate controls would  
 14 also be made, and then sent-  
 15 COFFEY, Q.C.:  
 16 Q. In St. John's?  
 17 DR. DANKWA:  
 18 A. In St. John's, yes, and then sent back to me.  
 19 COFFEY, Q.C.:  
 20 Q. So what would you get back from St. John's?  
 21 DR. DANKWA:  
 22 A. I would get the H & E, the ER/PR glass slide,  
 23 two separate slides, and then the controls for  
 24 ER and then for PR, yes.  
 25 COFFEY, Q.C.:

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1 Q. Now Doctor, would you always get a control  
2 slide back?  
3 DR. DANKWA:  
4 A. As far as I can remember, yes, I would.  
5 COFFEY, Q.C.:  
6 Q. And would the requisition form come back to  
7 you?  
8 DR. DANKWA:  
9 A. Yes, it would also come back.  
10 COFFEY, Q.C.:  
11 Q. And then what would you do, Doctor? Okay, you  
12 -  
13 DR. DANKWA:  
14 A. Then I would interpret it, I would look  
15 through--look at the slide, interpret it, and  
16 then -  
17 COFFEY, Q.C.:  
18 Q. And what would you be looking for?  
19 DR. DANKWA:  
20 A. I would be looking for the staining of the  
21 tumour, but prior to that, I look--first I  
22 look at the H & E slide to make sure that it  
23 is the same block that I sent, the slide that  
24 come back, and then I look at the controls to  
25 make sure the controls have worked, because

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1 if they are -  
2 COFFEY, Q.C.:  
3 Q. External controls?  
4 DR. DANKWA:  
5 A. The St. John's controls, to make sure that  
6 they have worked. I mean, I never came across  
7 any situation where they didn't work, because  
8 I wouldn't report it otherwise. Following  
9 that, then I would look at the tumour itself  
10 or the (unintelligible) and normal tissue.  
11 COFFEY, Q.C.:  
12 Q. And what would you be looking for there,  
13 Doctor?  
14 DR. DANKWA:  
15 A. When I look down the microscope, my reflex  
16 action is to look at the internal control to  
17 see if that had worked.  
18 COFFEY, Q.C.:  
19 Q. And what does worked mean in this context?  
20 DR. DANKWA:  
21 A. That is if it's staining positively in the  
22 normal tissue, and then I compare it with the  
23 tumour component of the -  
24 COFFEY, Q.C.:  
25 Q. Now if the internal control, i.e. the normal

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1 tissue, you're looking for nuclear staining, I  
2 take it?  
3 DR. DANKWA:  
4 A. Nuclear staining, correct.  
5 COFFEY, Q.C.:  
6 Q. In this context. Doctor, if it stains, I take  
7 it, it stained, then you're prepared--you look  
8 at the tumour.  
9 DR. DANKWA:  
10 A. Yes, I'm prepared to go ahead and look at the  
11 tumour, yes.  
12 COFFEY, Q.C.:  
13 Q. If it doesn't stain, what do you -  
14 DR. DANKWA:  
15 A. If it doesn't stain, then I may have to  
16 request it again, but it depends on where the  
17 tumour is not staining. If it's the normal  
18 tissue is in close, so close proximity to the  
19 tumour itself, there are some of them that  
20 would not stain and it's a natural process.  
21 COFFEY, Q.C.:  
22 Q. That the--where at times, it's your  
23 understanding, that where there's normal  
24 tissue involved on the slide -  
25 DR. DANKWA:

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1 A. Yes.  
2 COFFEY, Q.C.:  
3 Q. - and it's in very close proximity to the  
4 tumour?  
5 DR. DANKWA:  
6 A. Yeah.  
7 COFFEY, Q.C.:  
8 Q. What is it--you might see what happen?  
9 DR. DANKWA:  
10 A. Sometimes they will not stain because the  
11 whole area is changing. It's becoming  
12 tumorous, but it looks normal. So that it  
13 would have characteristics of a tumour itself.  
14 COFFEY, Q.C.:  
15 Q. So what appears, at least, at first blush to  
16 you to be, as best you can tell, normal tissue  
17 -  
18 DR. DANKWA:  
19 A. Normal tissue, yes.  
20 COFFEY, Q.C.:  
21 Q. - is not staining, but you would normally  
22 expect it to stain?  
23 DR. DANKWA:  
24 A. Yes, yeah.  
25 COFFEY, Q.C.:

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1 Q. What do you do then, Doctor?  
 2 DR. DANKWA:  
 3 A. If I were to have a case like that, then I may  
 4 probably request a restrain, just to make sure.  
 5 COFFEY, Q.C.:  
 6 Q. Do you recall doing that?  
 7 DR. DANKWA:  
 8 A. No.  
 9 COFFEY, Q.C.:  
 10 Q. Do you recall ever doing it, in fact?  
 11 DR. DANKWA:  
 12 A. No, never doing that.  
 13 COFFEY, Q.C.:  
 14 Q. Do you recall, Doctor, in terms of ER/PR IHC  
 15 testing while you're in St. Anthony, have you  
 16 ever had occasion to request repeats of ER or  
 17 PR tests?  
 18 DR. DANKWA:  
 19 A. Yes, I have.  
 20 COFFEY, Q.C.:  
 21 Q. And why was that, do you recall?  
 22 DR. DANKWA:  
 23 A. In one case that I can remember clearly--I  
 24 can't remember that particular case, but I can  
 25 remember the circumstance. I didn't see the

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1 tumour in the slide, in the ER/PR slide that  
 2 I'm supposed to interpret.  
 3 COFFEY, Q.C.:  
 4 Q. So what did you do then?  
 5 DR. DANKWA:  
 6 A. I requested the test again, but I called the  
 7 lab in St. John's to let them know that I am  
 8 requesting it again, because I couldn't see  
 9 the tumour.  
 10 COFFEY, Q.C.:  
 11 Q. Doctor, if we could, please, Registrar,  
 12 Exhibit P-2197? Now Doctor, this is a letter  
 13 on, well, what is then Grenfell Regional  
 14 Health Services stationary, St. Anthony,  
 15 Newfoundland. You can see it right there.  
 16 DR. DANKWA:  
 17 A. Yeah.  
 18 COFFEY, Q.C.:  
 19 Q. This one is dated, I gather, November 4th,  
 20 1998.  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. It's addressed to Dr. Khalifa and the  
 25 patient's name and MCP number are redacted,

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1 but it says "I would appreciate it if the  
 2 usual estrogen and progesterone receptor  
 3 studies on the above lady's left breast lesion  
 4 could be performed. Thank you," signed by  
 5 yourself.  
 6 DR. DANKWA:  
 7 A. Yeah.  
 8 COFFEY, Q.C.:  
 9 Q. And you note, "NB, please return the block  
 10 when the case has been reviewed." And then  
 11 there's--when we look down here, that's the  
 12 text there, "received November 30th, '98. P.  
 13 Welsh" and then there's a December 4th '98,  
 14 and MB. Do you know who P. Welsh is or MB?  
 15 DR. DANKWA:  
 16 A. I have a feeling P. Welsh was a technician in  
 17 St. John's, yes.  
 18 COFFEY, Q.C.:  
 19 Q. You've got good instincts, yeah, good memory,  
 20 yeah, and MB?  
 21 DR. DANKWA:  
 22 A. I can't remember. I don't remember that one.  
 23 COFFEY, Q.C.:  
 24 Q. So this is a typical format of a letter that  
 25 you would, in the early stages, have sent to

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1 Dr. Khalifa?  
 2 DR. DANKWA:  
 3 A. Correct, yes.  
 4 COFFEY, Q.C.:  
 5 Q. Just a moment, please, Commissioner. If we  
 6 could, please, bring up Exhibit P-1287? Now  
 7 Doctor, looking at--I'm going to look at page  
 8 two of this, two, three and four of this  
 9 exhibit. Doctor, this is a memorandum on  
 10 Health Care Corporation of St. John's  
 11 letterhead from Dr. Khalifa to all  
 12 Newfoundland pathologists, February 16th,  
 13 1998. The reference is reporting of estrogen  
 14 and progesterone receptor, immunohistochemical  
 15 results, and it says "as you all know, it has  
 16 been suggested that assessment of estrogen and  
 17 progesterone receptor status in mammary  
 18 invasive carcinomas be performed  
 19 immunohistochemically on formalin fixed  
 20 paraffin embedded tissues" and it goes on at  
 21 some length from there and the doctor says "as  
 22 the technique was still in its introductory  
 23 phase, phase one, I have been reporting  
 24 results of the majority of cases to establish  
 25 consistency and reproducible techniques, and

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1 then there's phase two and phase three, and he  
 2 says "attached, please find a proposal for  
 3 uniform reporting of ER IHC staining" and he  
 4 refers to the proposal having been discussed  
 5 with many of his colleagues "who mostly agree  
 6 with its content and accept it as a policy,"  
 7 and then that's the proposal for uniform  
 8 reporting of ER/PR immunohistochemical  
 9 assessment, February 1998, 1-2-3, and then  
 10 some examples.  
 11 Now Doctor, going to try and put this now  
 12 in some context, from your perspective, okay,  
 13 in St. Anthony. When you arrived in St.  
 14 Anthony in 1995, ER/PR was being tested how?  
 15 DR. DANKWA:  
 16 A. We were sending the cases, the blocks on to  
 17 Halifax to be performed.  
 18 COFFEY, Q.C.:  
 19 Q. And what--so at that time, there was an IHC  
 20 process?  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. Being done in Halifax?  
 25 DR. DANKWA:

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1 A. In Halifax, correct.  
 2 COFFEY, Q.C.:  
 3 Q. In the hospital in Halifax?  
 4 DR. DANKWA:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. For St. Anthony?  
 8 DR. DANKWA:  
 9 A. Yes, right.  
 10 COFFEY, Q.C.:  
 11 Q. And they were reporting it as a percentage or  
 12 positive or negative or both?  
 13 DR. DANKWA:  
 14 A. They were reporting positive and negative.  
 15 COFFEY, Q.C.:  
 16 Q. That was just either or?  
 17 DR. DANKWA:  
 18 A. Yes, exactly.  
 19 COFFEY, Q.C.:  
 20 Q. Did you have any understanding at the time,  
 21 from them, as to what was meant by negative  
 22 and positive?  
 23 DR. DANKWA:  
 24 A. They didn't really qualify it with any  
 25 statement, but my understanding then would

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1 have been that when they see any positivity,  
 2 they would have called it as positive?  
 3 COFFEY, Q.C.:  
 4 Q. Any being any cells at all?  
 5 DR. DANKWA:  
 6 A. Yes, any cells at all.  
 7 COFFEY, Q.C.:  
 8 Q. Doctor, did you have any sense, when you  
 9 arrived, as to how long that process of  
 10 sending the blocks from St. Anthony to Halifax  
 11 for ER/PR IHC had been going on?  
 12 DR. DANKWA:  
 13 A. Not at that time, no.  
 14 COFFEY, Q.C.:  
 15 Q. Have you made any inquiries since?  
 16 DR. DANKWA:  
 17 A. No, I didn't make any inquiries.  
 18 COFFEY, Q.C.:  
 19 Q. So because the Commissioner has heard, for  
 20 example, in St. John's, here the testing was  
 21 being done by biochemical assay here in St.  
 22 John's.  
 23 DR. DANKWA:  
 24 A. All right.  
 25 COFFEY, Q.C.:

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1 Q. Back in '95, it was, okay?  
 2 DR. DANKWA:  
 3 A. Yes, yes.  
 4 COFFEY, Q.C.:  
 5 Q. So in St. Anthony, during your time there,  
 6 biochemical assays for ER/PR were not being  
 7 used?  
 8 DR. DANKWA:  
 9 A. No, they weren't being used, no.  
 10 COFFEY, Q.C.:  
 11 Q. Then what happened, Doctor, in terms of his--  
 12 okay, '95, it becomes '96, becomes '97.  
 13 DR. DANKWA:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. And we have this memo, February 1998.  
 17 DR. DANKWA:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. Now did you ever receive this memo?  
 21 DR. DANKWA:  
 22 A. Not as far as I can remember, no.  
 23 COFFEY, Q.C.:  
 24 Q. And though you have indicated that at some  
 25 point, you began--St. Anthony began to have

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1 ER/PR IHC testing done in St. John's?  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. How did that come about, do you recall?  
 6 DR. DANKWA:  
 7 A. I was sending my cases on to Khalifa, Dr.  
 8 Khalifa to report. When we met on one  
 9 occasion, he indicated that they were trying  
 10 to establish and have the tests done in St.  
 11 John's.  
 12 COFFEY, Q.C.:  
 13 Q. Okay, sorry, just back up a bit there. So  
 14 you're up there, doing your work in St.  
 15 Anthony in '95 and '96.  
 16 DR. DANKWA:  
 17 A. Right, yeah.  
 18 COFFEY, Q.C.:  
 19 Q. And any ER/PR that you order, the blocks being  
 20 packaged, with the appropriate request and  
 21 sent to Halifax?  
 22 DR. DANKWA:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. And the report comes back to you?

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1 DR. DANKWA:  
 2 A. Right.  
 3 COFFEY, Q.C.:  
 4 Q. At that time, you would dictate the report  
 5 into--or make a--create a report?  
 6 DR. DANKWA:  
 7 A. From the Halifax report, yes, we would  
 8 transcribe them into our own reporting  
 9 structure there, yes.  
 10 COFFEY, Q.C.:  
 11 Q. And I'll be talking to you more about the  
 12 systems that existed for that, but--and with  
 13 the understanding, I take it, that the surgeon  
 14 or the oncologist would deal appropriately  
 15 with the result from Halifax?  
 16 DR. DANKWA:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. So you ran into Dr. Khalifa?  
 20 DR. DANKWA:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. And the subject came up about ER/PR?  
 24 DR. DANKWA:  
 25 A. Yes.

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1 COFFEY, Q.C.:  
 2 Q. Could you tell the Commissioner about that?  
 3 DR. DANKWA:  
 4 A. Well, I mean, Khalifa was somebody, because of  
 5 the initial contact we had in the United  
 6 States, when we met again, it was like a  
 7 reunion and we were surprised to find  
 8 ourselves here in Newfoundland, in the same  
 9 area, and he was indicating that he was making  
 10 an effort to introduce the whole technique of  
 11 doing immunohistochemical stains on ER/PR and  
 12 wanted to know where I was sending my cases.  
 13 COFFEY, Q.C.:  
 14 Q. So you told him?  
 15 DR. DANKWA:  
 16 A. Yes, I told him it was going to Halifax, and  
 17 indicated that at the appropriate time, they  
 18 would probably let us know about sending our  
 19 cases onto them for them to do, and I used to--  
 20 we used to talk on the phone from time to  
 21 time, so he would give me a hint of what he  
 22 was doing well ahead of time, before it even  
 23 happened.  
 24 COFFEY, Q.C.:  
 25 Q. So did you ever send any cases then to him

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1 then to report?  
 2 DR. DANKWA:  
 3 A. Yes, yes.  
 4 COFFEY, Q.C.:  
 5 Q. So here he does refer, and if we look down  
 6 through this memo and -- it says, "As the  
 7 technique was still -- actually I'll go back  
 8 up a bit. In the second paragraph he writes  
 9 in February of '98, "The Division of Pathology  
 10 in St. John's has been employing this  
 11 technology for over a year. Recent audits  
 12 correlating IHC with biochemical results and  
 13 selected specimens where both techniques have  
 14 been run in parallel and high accuracy  
 15 introduced IHC detection. Results of these  
 16 audits have been discussed in several meetings  
 17 and are available for review. As the  
 18 technique was still in its introductory phase,  
 19 phase one, I have been reporting results in  
 20 the majority of cases to establish consistency  
 21 and reproducible results".  
 22 DR. DANKWA:  
 23 A. Techniques.  
 24 COFFEY, Q.C.:  
 25 Q. "As we have come to a more advanced stage of

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1 this pursue where this test could be done with  
 2 a relatively high efficiency and reliability,  
 3 I came to believe that we were probably ready  
 4 to move into the next two and final phases",  
 5 and phase two is described as each pathologist  
 6 will be asked to report results of his or her  
 7 own cases, as indicated by the brown staining  
 8 of nuclei of the invasive neoplastic cells.  
 9 This phase will start March 1, 1998, and it  
 10 goes on from there. Now, Doctor, when you'd  
 11 been utilizing Halifax, who had actually been  
 12 reporting the results?  
 13 DR. DANKWA:  
 14 A. It was in Halifax.  
 15 COFFEY, Q.C.:  
 16 Q. The actual reading of the slides?  
 17 DR. DANKWA:  
 18 A. Yes, they were reading it in Halifax, yes.  
 19 COFFEY, Q.C.:  
 20 Q. Did the slides that Halifax created, the ER/PR  
 21 slides, did they come to you?  
 22 DR. DANKWA:  
 23 A. No, they never did. They had a block and then  
 24 they would do their slides, and keep them.  
 25 COFFEY, Q.C.:

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1 Q. And so they would keep the block too?  
 2 DR. DANKWA:  
 3 A. They would keep the slides, but they would  
 4 send back the block.  
 5 COFFEY, Q.C.:  
 6 Q. Okay. Send the block out with a request?  
 7 DR. DANKWA:  
 8 A. Yes.  
 9 COFFEY, Q.C.:  
 10 Q. Get the paper report back.  
 11 DR. DANKWA:  
 12 A. Right.  
 13 COFFEY, Q.C.:  
 14 Q. With the block, and they keep their slides?  
 15 DR. DANKWA:  
 16 A. That's right, yes.  
 17 COFFEY, Q.C.:  
 18 Q. So what then happened with respect to Dr.  
 19 Khalifa in St. John's and ER/PR?  
 20 DR. DANKWA:  
 21 A. When he indicated to me that they were  
 22 prepared to now start interpreting ER/PRs for  
 23 us, I started sending him my cases.  
 24 COFFEY, Q.C.:  
 25 Q. And that, in effect, meant what? You would

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1 send that kind of covering letter with --  
 2 DR. DANKWA:  
 3 A. I would send -- yes, send a block to him, and  
 4 then he would interpret it. He would do the  
 5 stains and then interpret it and send a report  
 6 back to us.  
 7 COFFEY, Q.C.:  
 8 Q. And with his report on whether it was positive  
 9 or negative and percentage?  
 10 DR. DANKWA:  
 11 A. Yes, yes, exactly.  
 12 COFFEY, Q.C.:  
 13 Q. And that report, you would do what with that?  
 14 DR. DANKWA:  
 15 A. I would also do -- transcribe that into our  
 16 own system and then release that as a  
 17 supplementary report to the clinician.  
 18 COFFEY, Q.C.:  
 19 Q. Then what happened, Doctor, because he was  
 20 reporting initially?  
 21 DR. DANKWA:  
 22 A. Yes, he was reporting and then eventually he  
 23 indicated to me that they've established their  
 24 confidence in doing this reporting, and they  
 25 would like us to interpret it ourselves. I

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1 said that was fine. So they would do the  
 2 staining and send them back to us to  
 3 interpret.  
 4 COFFEY, Q.C.:  
 5 Q. Which, in effect, you'd send the blocks in  
 6 with the request.  
 7 DR. DANKWA:  
 8 A. Blocks in.  
 9 COFFEY, Q.C.:  
 10 Q. Either in a letter form or a requisition form?  
 11 DR. DANKWA:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. And the staining would be done?  
 15 DR. DANKWA:  
 16 A. Done, yeah.  
 17 COFFEY, Q.C.:  
 18 Q. The slides would come to you?  
 19 DR. DANKWA:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. You would read those slides.  
 23 DR. DANKWA:  
 24 A. Right.  
 25 COFFEY, Q.C.:



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1 Q. In the way you've described to the  
 2 Commissioner.  
 3 DR. DANKWA:  
 4 A. Exactly.  
 5 COFFEY, Q.C.:  
 6 Q. And report them yourself?  
 7 DR. DANKWA:  
 8 A. That's right.  
 9 COFFEY, Q.C.:  
 10 Q. Now, Doctor, when was it that started, do you  
 11 recall, when you ended up reporting your own  
 12 ER/PR?  
 13 DR. DANKWA:  
 14 A. It must have been somewhere in '98. I don't  
 15 have the exact date.  
 16 COFFEY, Q.C.:  
 17 Q. And, Doctor at that point when was the last  
 18 time that you had reported ER/PR IHC?  
 19 DR. DANKWA:  
 20 A. It must have been three years earlier.  
 21 COFFEY, Q.C.:  
 22 Q. In the United States?  
 23 DR. DANKWA:  
 24 A. In the United States. It must have been  
 25 somewhere around there, yeah.

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1 COFFEY, Q.C.:  
 2 Q. Again so the Commissioner can get some sense  
 3 of this --  
 4 DR. DANKWA:  
 5 A. Yes, okay.  
 6 COFFEY, Q.C.:  
 7 Q. You know, for example, from 1998 --  
 8 DR. DANKWA:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And really up to the present, how many breast  
 12 -- how many ER and PR cases would come out of  
 13 St. Anthony?  
 14 DR. DANKWA:  
 15 A. We were getting roughly about -- close to  
 16 about 15 to 20 cases, about 15 to 20 cases.  
 17 COFFEY, Q.C.:  
 18 Q. A year?  
 19 DR. DANKWA:  
 20 A. A year.  
 21 COFFEY, Q.C.:  
 22 Q. So, in effect, really somewhere between one to  
 23 two cases per month?  
 24 DR. DANKWA:  
 25 A. One to two per month, yes, that's correct.

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1 COFFEY, Q.C.:  
 2 Q. Doctor, over the years have you kept any  
 3 statistics in relation to the results?  
 4 DR. DANKWA:  
 5 A. No, I haven't.  
 6 COFFEY, Q.C.:  
 7 Q. I take it if you're only seeing one or two ER  
 8 and PR slides per month, would you really, in  
 9 effect, ever have been in a position to have  
 10 noticed any trend?  
 11 DR. DANKWA:  
 12 A. Probably not.  
 13 COFFEY, Q.C.:  
 14 Q. I take it, just because there were just so few  
 15 of them?  
 16 DR. DANKWA:  
 17 A. Yes, that's correct, yes.  
 18 COFFEY, Q.C.:  
 19 Q. What percentage of your overall work would the  
 20 ER and PR be?  
 21 DR. DANKWA:  
 22 A. For ER/PR per se, less than .5 percent.  
 23 COFFEY, Q.C.:  
 24 Q. Less than --  
 25 DR. DANKWA:

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1 A. .5 percent, yes.  
 2 COFFEY, Q.C.:  
 3 Q. And that's your clinical work, of course, I'm  
 4 talking about.  
 5 DR. DANKWA:  
 6 A. Yes, yeah, as pathology work, yeah.  
 7 COFFEY, Q.C.:  
 8 Q. Doctor, I'm going to be asking you about then  
 9 what happened in relation to the matter that  
 10 brings us here today, the retesting, but  
 11 before we get to that, you had started, and  
 12 you told the Commissioner about what would  
 13 happen or happens with surgical specimens that  
 14 are generated within the St. Anthony Hospital.  
 15 DR. DANKWA:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. And you did say, and you had a caveat, that's  
 19 that, the other hospitals are in a different  
 20 position.  
 21 DR. DANKWA:  
 22 A. Right, okay.  
 23 COFFEY, Q.C.:  
 24 Q. Can you tell the Commissioner, please, about  
 25 those?

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1 DR. DANKWA:  
 2 A. Right. How these -- how specimens are handled  
 3 in Goose Bay and Lab City are fairly similar.  
 4 The surgeon when they remove the specimen  
 5 would place them in formalin immediately.  
 6 Again I've also encouraged them to make an  
 7 incision through the tumour if they could. If  
 8 that is done, I mean, once it's in formalin,  
 9 it goes down to the lab. Now the specimens  
 10 are then packaged, cello taped to make sure  
 11 there are no leakages, whatever. I've also  
 12 encouraged the technicians to actually make  
 13 sure they open the containers and ensure  
 14 there's adequate formalin on it, the same  
 15 ratio, ten to one.  
 16 COFFEY, Q.C.:  
 17 Q. Which technologists were they?  
 18 DR. DANKWA:  
 19 A. These are the technologists in Goose Bay and  
 20 Lab City. These are packaged and normally  
 21 shipped every other day, and if possible, they  
 22 ship them on a daily basis. Quite often it  
 23 depends on the availability of flights and  
 24 when specimens come in. Once they are shipped  
 25 and they get in, we have technologists waiting

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1 to receive them, and they often fax us a list  
 2 of the cases that are coming down we have an  
 3 idea of what is coming through, and if it's a  
 4 breast or any live specimen, the technicians  
 5 in St. Anthony are ready to start bread  
 6 loafing -- painting it and then bread loafing  
 7 them if I'm not there physically.  
 8 COFFEY, Q.C.:  
 9 Q. And if you're there?  
 10 DR. DANKWA:  
 11 A. And if I'm there I'll do it myself.  
 12 COFFEY, Q.C.:  
 13 Q. I take it that that would be -- what kind of  
 14 then time delay can there be? I mean, if it  
 15 gets down kind of the quickest it could from  
 16 surgery in Labrador --  
 17 DR. DANKWA:  
 18 A. Yeah.  
 19 COFFEY, Q.C.:  
 20 Q. And we'll work our way from there, I mean,  
 21 what's the quickest it could get to you?  
 22 DR. DANKWA:  
 23 A. On the average -- on the average we are  
 24 looking at 48 hours.  
 25 COFFEY, Q.C.:

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1 Q. Before it would get to you?  
 2 DR. DANKWA:  
 3 A. Before it gets to me, yes.  
 4 COFFEY, Q.C.:  
 5 Q. And when it would get to you or your  
 6 technologist in St. Anthony, that's when the  
 7 bread loafing --  
 8 DR. DANKWA:  
 9 A. Bread loafing would occur.  
 10 COFFEY, Q.C.:  
 11 Q. And the process would pick up from there?  
 12 DR. DANKWA:  
 13 A. Yes, exactly.  
 14 COFFEY, Q.C.:  
 15 Q. What are the potential negative consequences  
 16 of that delay, Doctor?  
 17 DR. DANKWA:  
 18 A. That would be mainly delayed fixation. If a  
 19 specimen is large enough and there is not  
 20 adequate penetration of formalin, that delay -  
 21 - there will be a delayed fixation.  
 22 COFFEY, Q.C.:  
 23 Q. And with -- I take it that that can have  
 24 consequences for the cellular structure?  
 25 DR. DANKWA:

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1 A. Oh, yes, yes, it can.  
 2 COFFEY, Q.C.:  
 3 Q. Can it make -- first of all, can it make  
 4 diagnosis more difficult?  
 5 DR. DANKWA:  
 6 A. It can hinder diagnosis, but quite often the  
 7 formalin penetration is good enough for you to  
 8 interpret what you see.  
 9 COFFEY, Q.C.:  
 10 Q. What about its effects on IHC staining, in  
 11 particular, for example, ER/PR staining?  
 12 DR. DANKWA:  
 13 A. It potentially could have an effect, but  
 14 generally once the fixation had occurred, the  
 15 preservation -- once we can actually interpret  
 16 the tissue, then the next -- almost invariably  
 17 the antigen may have been preserved as well.  
 18 COFFEY, Q.C.:  
 19 Q. May have been preserved as well?  
 20 DR. DANKWA:  
 21 A. May have been preserved as well, yes, for it  
 22 to be interpreted, yes.  
 23 COFFEY, Q.C.:  
 24 Q. I take it then, Doctor, there's no tissue  
 25 processor in St. Anthony?

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1 DR. DANKWA:  
 2 A. In Goose Bay?  
 3 COFFEY, Q.C.:  
 4 Q. In Goose Bay.  
 5 DR. DANKWA:  
 6 A. No, there is not.  
 7 COFFEY, Q.C.:  
 8 Q. There's none in Labrador City?  
 9 DR. DANKWA:  
 10 A. No, no.  
 11 COFFEY, Q.C.:  
 12 Q. And during your tenure in St. Anthony, there  
 13 has never been a tissue processor in Lab City  
 14 --  
 15 DR. DANKWA:  
 16 A. Lab City.  
 17 COFFEY, Q.C.:  
 18 Q. Or St. Anthony -- sorry, or Goose Bay?  
 19 DR. DANKWA:  
 20 A. As far as I know, none. They would -- in  
 21 fact, to make use of it, you would have to  
 22 have a pathologist there. You'd have to have  
 23 a pathologist to make use of it.  
 24 COFFEY, Q.C.:  
 25 Q. Because you have to have the tissue grossed?

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1 DR. DANKWA:  
 2 A. Yes, exactly, to use it, yeah.  
 3 COFFEY, Q.C.:  
 4 Q. As that process that you described from Goose  
 5 Bay or -- well, now since, I take it, 2005 or  
 6 '06 involving Lab City, of transporting  
 7 specimens to St. Anthony, has that really  
 8 changed or is it, in effect, the same  
 9 throughout the years?  
 10 DR. DANKWA:  
 11 A. It's relatively stayed the same, but we have  
 12 been encouraging more frequent transportation  
 13 to gather cases across, but the limitation of  
 14 transportation has always been a major  
 15 challenge, and the staffing situation has been  
 16 another issue.  
 17 COFFEY, Q.C.:  
 18 Q. Now, Doctor, if the transportation issue was  
 19 to be addressed, at what level within your  
 20 organization would that have to be addressed?  
 21 DR. DANKWA:  
 22 A. It would be by the senior executive that would  
 23 have to -- the CEO and then --  
 24 COFFEY, Q.C.:  
 25 Q. And Dr. Jong?

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1 DR. DANKWA:  
 2 A. Jong, yes, and the finance money.  
 3 COFFEY, Q.C.:  
 4 Q. So, Doctor, really since -- I take it, since  
 5 1995, and certainly involving Goose Bay, in  
 6 effect, nothing really has changed in that  
 7 regard, you know, a day or two -- two days to  
 8 get down to your --  
 9 DR. DANKWA:  
 10 A. Yes, but the awareness has been heightened,  
 11 yeah.  
 12 COFFEY, Q.C.:  
 13 Q. And when did that awareness of, I take it, the  
 14 importance of fixation --  
 15 DR. DANKWA:  
 16 A. Oh, I have been on this topic for a long time,  
 17 since we've been dealing with cases because I  
 18 look -- I see all the cases that come through,  
 19 so I know the state of the tissues, and we try  
 20 to follow them up if there is any problem, and  
 21 part of the things I try to do to encourage a  
 22 proper fixation is to make sure that they get  
 23 adequate formalin and ship them early and let  
 24 us deal with them, so -- but this has been  
 25 heightened.

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1 COFFEY, Q.C.:  
 2 Q. I take it that you, looking at the -- through  
 3 the microscope at the slides, have to deal  
 4 with the end product if there's a problem?  
 5 DR. DANKWA:  
 6 A. Oh, yes.  
 7 COFFEY, Q.C.:  
 8 Q. And, therefore, if there is -- if there's  
 9 fixation problems apparent, you would have to  
 10 take it up with --  
 11 DR. DANKWA:  
 12 A. I would take it up, yes.  
 13 COFFEY, Q.C.:  
 14 Q. Doctor, over the years have you noticed such  
 15 problems?  
 16 DR. DANKWA:  
 17 A. We do get them, yes.  
 18 COFFEY, Q.C.:  
 19 Q. And how frequently would you see such problems  
 20 and how were they addressed?  
 21 DR. DANKWA:  
 22 A. It's infrequent, but once I see it, I start  
 23 working from the lab backwards looking at  
 24 things like the processor as the first thing I  
 25 look at to see if the change is actually

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1 uniform, if what looks like a fixation issue  
 2 is uniform because that would tell me that  
 3 it's probably something that is affecting all  
 4 the tissues at the same time. So that will  
 5 help me eliminate the processor, and then I'll  
 6 go back to the fixation, and then see where  
 7 the sample has been coming from and how it was  
 8 submitted, and then address it from there.  
 9 COFFEY, Q.C.:  
 10 Q. So you'd actually troubleshoot that particular  
 11 thing --  
 12 DR. DANKWA:  
 13 A. Oh, yes.  
 14 COFFEY, Q.C.:  
 15 Q. All the way back through the chain?  
 16 DR. DANKWA:  
 17 A. All the way back, yes, and having said that,  
 18 as specimens come in and they are opened -- if  
 19 I open them first and I see there is no  
 20 adequate formalin, I call back and I tell the  
 21 technician, the lead technician, to follow it  
 22 up or I call the tech, the appropriate tech to  
 23 deal with it.  
 24 COFFEY, Q.C.:  
 25 Q. And take it up with somebody --

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1 DR. DANKWA:  
 2 A. Somebody else, yes, exactly.  
 3 COFFEY, Q.C.:  
 4 Q. And to --  
 5 DR. DANKWA:  
 6 A. Address it.  
 7 COFFEY, Q.C.:  
 8 Q. And admonish them to get it right, in effect?  
 9 DR. DANKWA:  
 10 A. In a nice way.  
 11 COFFEY, Q.C.:  
 12 Q. Yes. Doctor, how many breast cancer cases  
 13 would come to St. Anthony out of Labrador?  
 14 You said 15 to 20 for St. Anthony in total.  
 15 How many would you get out of Labrador?  
 16 DR. DANKWA:  
 17 A. I would say probably about four or five.  
 18 COFFEY, Q.C.:  
 19 Q. So out of the 15 to 20 coming out of your  
 20 institution entirely, four or five of those  
 21 would originate in Labrador?  
 22 DR. DANKWA:  
 23 A. Four or five might come from there, yes.  
 24 COFFEY, Q.C.:  
 25 Q. Per year?

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1 DR. DANKWA:  
 2 A. Per year, yes. These are rough estimates, yes.  
 3 COFFEY, Q.C.:  
 4 Q. Doctor, if I could, please, I'm going to ask  
 5 the Registrar to bring up Exhibit P-1650.  
 6 Doctor, this is a letter from yourself as the  
 7 Assistant Executive Director, Medical  
 8 Services, Labrador Grenfell Regional  
 9 Integrated Health Authority. It's dated April  
 10 20th, 2005, to Susan King, as the immediate  
 11 past President of the NLMA, co-chair,  
 12 physician liaise, Services Liaison Committee,  
 13 and says, "Dear Ms. King, thank you for your  
 14 letter of March 24th, 2005, requesting  
 15 feedback on issues with respect to pathology  
 16 in this province. Indeed the presentation is  
 17 a good reflection of the realities on the  
 18 ground. The corrective measures suggested to  
 19 help prevent burnout and losses of  
 20 pathologists are valid and supported. In  
 21 addition to the compensation for permanent  
 22 pathology staff and other issues that need to  
 23 be closely examined, is the compensation for  
 24 locums. Currently it is extremely difficult  
 25 to attract locums to help relieve pathologists

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1 as locum pathologists are better paid  
 2 elsewhere. I'm pleased that these issues have  
 3 been brought to attention to address in the  
 4 coming MOU", which would be Memorandum of  
 5 Understanding. Doctor, what was this about?  
 6 DR. DANKWA:  
 7 A. I'm trying to remember now exactly what  
 8 prompted me to write this.  
 9 COFFEY, Q.C.:  
 10 Q. I take it this has something -- she is the --  
 11 DR. DANKWA:  
 12 A. She was the President of -- and past President  
 13 of the NLMA. I'm wondering if they came to  
 14 have a meeting with our staff and told us what  
 15 they had in context of what they are planning  
 16 to present to the Department of Health in  
 17 negotiating for the Memorandum of  
 18 Understanding. It must -- I'm not sure if it  
 19 was a response to a letter, but I think there  
 20 must have been some issues that were discussed  
 21 that led me to --  
 22 COFFEY, Q.C.:  
 23 Q. In particular, Doctor, I wanted to ask you  
 24 about in context of where you work and have  
 25 worked for many years now.

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1 DR. DANKWA:  
 2 A. Sure.  
 3 COFFEY, Q.C.:  
 4 Q. The idea of compensation for locums, extremely  
 5 difficult to attract locums to help relieve  
 6 pathologists, as you are the sole pathologist  
 7 for the past eight years --  
 8 DR. DANKWA:  
 9 A. Yes, correct.  
 10 COFFEY, Q.C.:  
 11 Q. Could you tell the Commissioner, please, about  
 12 that, what your experience has been, and as  
 13 well what it's like to work as a sole  
 14 pathologist?  
 15 DR. DANKWA:  
 16 A. I love working as a sole pathologist because  
 17 the quibbles or fighting with your colleagues  
 18 doesn't come into play, but one of the major  
 19 difficulties I'm currently facing is relief.  
 20 It takes a long time to find anybody who is  
 21 prepared to relieve you, and when you find  
 22 them, the compensation is not what attracts  
 23 them at all. That is enough for them to say  
 24 no. So this actually hinders my decision to  
 25 look for options -- to look for time off to go

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1 and do anything else. So I'm often stranded  
 2 literally because -- obviously, I love the  
 3 community I work in, I love the staff, and I  
 4 love the people I live with. That is my home  
 5 now. So as much as possible, I want to  
 6 maintain the service. I don't want it to fall  
 7 apart. So I do all I can to make sure that I  
 8 have a way of giving a continual service and a  
 9 quality service at that. So it's come to a  
 10 point -- I must say I'm very appreciative of  
 11 Western help in providing me support. In the  
 12 initial phase, they were very, very  
 13 supportive. Whenever I wanted to go away and  
 14 I was in that sort of difficulty, I contact  
 15 them and they were willing to take on my  
 16 tissues and deal with them. It has become  
 17 extremely difficult for them. For some  
 18 strange reason, workloads have gone up sky  
 19 high.  
 20 COFFEY, Q.C.:  
 21 Q. I'm sorry, what?  
 22 DR. DANKWA:  
 23 A. Workloads.  
 24 COFFEY, Q.C.:  
 25 Q. This particular type of procedure.

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1 DR. DANKWA:  
 2 A. We are getting a lot more work than we did get  
 3 before.  
 4 COFFEY, Q.C.:  
 5 Q. Workloads.  
 6 DR. DANKWA:  
 7 A. Workloads, yeah. So it has become extremely  
 8 difficult for them to provide the cover. So  
 9 what I have ended up doing now is gone out of  
 10 province, liaising with Gamma Dynacare. Coming  
 11 here, that was what I did. I contacted them to  
 12 see if they would be prepared to cover me for  
 13 the time that I will be away.  
 14 COFFEY, Q.C.:  
 15 Q. Like that you could be here now?  
 16 DR. DANKWA:  
 17 A. Yes, and they have, in effect, agreed to cover  
 18 for this. They made sure that -- they've  
 19 stated that it was for the five days.  
 20 COFFEY, Q.C.:  
 21 Q. Yes.  
 22 DR. DANKWA:  
 23 A. The hours are getting overwhelmed, and what  
 24 they want to get is early slides, not a white  
 25 tissue. So the white tissue will be piling up

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1 there. Those white tissue that the  
 2 technicians cannot handle are being left there  
 3 for me to go and do. So by Monday when I get  
 4 back, I'll have a stack of work to deal with.  
 5 So it's not making it easy to make any  
 6 alternatives either to take holidays or to go  
 7 and get continuing education or to do  
 8 something else.  
 9 COFFEY, Q.C.:  
 10 Q. Okay, and, Doctor, as you sit here now today,  
 11 in relation to the ability of yourself -- I  
 12 take it, finding a replacement for yourself, a  
 13 locum, so that you can get a month's holiday,  
 14 for example --  
 15 DR. DANKWA:  
 16 A. Right, yes.  
 17 COFFEY, Q.C.:  
 18 Q. Whose responsibility is it to find the person  
 19 to replace you?  
 20 DR. DANKWA:  
 21 A. Myself.  
 22 COFFEY, Q.C.:  
 23 Q. It's yourself, it's you.  
 24 DR. DANKWA:  
 25 A. Because I happen to also be the Associate VP

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1 of Medical Services.  
 2 COFFEY, Q.C.:  
 3 Q. Yes, that's what I was getting at.  
 4 DR. DANKWA:  
 5 A. That's right, yeah.  
 6 COFFEY, Q.C.:  
 7 Q. You can't just look to somebody else?  
 8 DR. DANKWA:  
 9 A. No.  
 10 COFFEY, Q.C.:  
 11 Q. And complain to them about the fact that he or  
 12 she hasn't gotten you a replacement.  
 13 DR. DANKWA:  
 14 A. That's right.  
 15 COFFEY, Q.C.:  
 16 Q. You have to do it yourself.  
 17 DR. DANKWA:  
 18 A. Yes, yeah.  
 19 COFFEY, Q.C.:  
 20 Q. Doctor --  
 21 DR. DANKWA:  
 22 A. But I must say, though, I do get help too from  
 23 Dr. Michael Jong, and I often contact -- if he  
 24 gets any word of any availability of somebody,  
 25 yes.

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1 COFFEY, Q.C.:  
 2 Q. Doctor, has anything changed even up to today  
 3 in terms of making a locum in St. Anthony any  
 4 more attractive for anyone? Has the  
 5 compensation changed in any way for locums?  
 6 Has the compensation for locums changed?  
 7 DR. DANKWA:  
 8 A. Compensation --  
 9 COFFEY, Q.C.:  
 10 Q. Compensation for locums?  
 11 DR. DANKWA:  
 12 A. Oh, for compensation, yes, it's improved with  
 13 a recent announcement by government about  
 14 locum rates has gone up, yes.  
 15 COFFEY, Q.C.:  
 16 Q. We understand, and the Commission has heard,  
 17 that there has been an increase in the  
 18 remuneration or income for pathologists.  
 19 DR. DANKWA:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. Generally within the province.  
 23 DR. DANKWA:  
 24 A. Exactly.  
 25 COFFEY, Q.C.:

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1 Q. I wanted to ask you, in particular, about  
 2 locums.  
 3 DR. DANKWA:  
 4 A. Yeah.  
 5 COFFEY, Q.C.:  
 6 Q. At the same time, did that change for locums?  
 7 DR. DANKWA:  
 8 A. Not very much, not very much. It's probably  
 9 gotten worse because the issue that is  
 10 happening now, it's making a lot of people  
 11 hesitant, what is going on now is making  
 12 people hesitant actually coming in at the  
 13 moment.  
 14 COFFEY, Q.C.:  
 15 Q. So in terms of the -- I think you just said  
 16 that the locum package has --  
 17 DR. DANKWA:  
 18 A. Has improved.  
 19 COFFEY, Q.C.:  
 20 Q. Improved?  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. But how much -- has it improved enough for you  
 25 to be able to get someone to come in and do a

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1 locum for you?  
 2 DR. DANKWA:  
 3 A. It's still not as competitive as elsewhere.  
 4 COFFEY, Q.C.:  
 5 Q. That's what I'm getting at.  
 6 DR. DANKWA:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. Okay, that's what I'm getting at. So it is  
 10 still not as -- even the current one today --  
 11 DR. DANKWA:  
 12 A. It's not good enough.  
 13 COFFEY, Q.C.:  
 14 Q. Is not as comparative as, for example, Ontario  
 15 or --  
 16 DR. DANKWA:  
 17 A. Correct, yes.  
 18 COFFEY, Q.C.:  
 19 Q. Or other spots.  
 20 DR. DANKWA:  
 21 A. That's right.  
 22 COFFEY, Q.C.:  
 23 Q. For locums?  
 24 DR. DANKWA:  
 25 A. For locums, yes, that's right.

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1 COMMISSIONER:  
 2 Q. Mr. Coffey, wherever you can find a  
 3 appropriate spot to take the luncheon break.  
 4 COFFEY, Q.C.:  
 5 Q. Actually, Commissioner this is a good point  
 6 because I'm going to go on really then to the  
 7 2003 and '05 situations, okay.  
 8 COMMISSIONER:  
 9 Q. Then we'll break until five after two.  
 10 COFFEY, Q.C.:  
 11 Q. Thank you, Commissioner.  
 12 (LUNCH BREAK)  
 13 COMMISSIONER:  
 14 Q. Mr. Coffey.  
 15 COFFEY, Q.C.:  
 16 Q. Thank you, Commissioner. Just one moment,  
 17 please, Commissioner, just to make sure here -  
 18 - Exhibit P-0113, please. Now, Doctor, after  
 19 Dr Khalifa approached you in 1998 about having  
 20 the cases sent to St. John's, the ER/PR, the  
 21 slides prepared there and sent back to you for  
 22 reporting, between then and April of 2003,  
 23 okay --  
 24 DR. DANKWA:  
 25 A. Yes.

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1 COFFEY, Q.C.:  
 2 Q. Did you ever have any reason to believe that  
 3 there was any problem with the ER/PR cases?  
 4 DR. DANKWA:  
 5 A. No.  
 6 COFFEY, Q.C.:  
 7 Q. Now this memo, it's page one of Exhibit P-  
 8 0113. It's to pathologists, HSC, St. Clare's  
 9 and out of town hospitals from Dr. G. Ejeckam,  
 10 and the subject is immunohistochemical stains  
 11 and the date is April 4, 2003. Doctor, did  
 12 you receive this?  
 13 DR. DANKWA:  
 14 A. No, I did not.  
 15 COFFEY, Q.C.:  
 16 Q. You didn't?  
 17 DR. DANKWA:  
 18 A. No, I didn't, no.  
 19 COFFEY, Q.C.:  
 20 Q. You've -- I take it -- well, I'll ask you,  
 21 when did you first become aware of this  
 22 particular memo's existence?  
 23 DR. DANKWA:  
 24 A. It was in the -- when I was invited to come --  
 25 COFFEY, Q.C.:

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1 Q. And be interviewed?  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. By the Commission counsel?  
 6 DR. DANKWA:  
 7 A. By the Commission counsel, yes.  
 8 COFFEY, Q.C.:  
 9 Q. Okay, Doctor, now you've had a chance, I take  
 10 it, since then, of course, to read it.  
 11 DR. DANKWA:  
 12 A. Yes, I have.  
 13 COFFEY, Q.C.:  
 14 Q. Which refers to these eight stains. Were you  
 15 aware back in 2003 that this had happened  
 16 even, back at that time?  
 17 DR. DANKWA:  
 18 A. No, I wasn't.  
 19 COFFEY, Q.C.:  
 20 Q. Doctor, at page two of that Exhibit P-0113,  
 21 there's a memo of May 2nd, 2003, from Dr  
 22 Ejeckam to pathologists, HSC, St. Clare's, and  
 23 out of town hospitals, and the subject is  
 24 ER/PR immunohistochemical stains, and it just  
 25 begins with, "I am glad to inform you we have

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1 rectified the difficulties related to the  
 2 immuno stain of ER/PR. Therefore, we can now  
 3 resume regular requests for these antibody  
 4 stains. I will, however, like to make the  
 5 following -- bring the following information  
 6 to your attention", and it goes on for three  
 7 pages. Now, Doctor, did you receive a copy of  
 8 this in 2003?  
 9 DR. DANKWA:  
 10 A. No, I didn't.  
 11 COFFEY, Q.C.:  
 12 Q. When did you first become aware of this?  
 13 DR. DANKWA:  
 14 A. It was before this -- before the initial  
 15 interview I had with you.  
 16 COFFEY, Q.C.:  
 17 Q. Was it just before that?  
 18 DR. DANKWA:  
 19 A. Yes, before that.  
 20 COFFEY, Q.C.:  
 21 Q. Before the time that myself and Ms. Chaytor --  
 22 DR. DANKWA:  
 23 A. In March, yes.  
 24 COFFEY, Q.C.:  
 25 Q. In March of this year?

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1 DR. DANKWA:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. You've had a chance to look at this since,  
 5 Doctor?  
 6 DR. DANKWA:  
 7 A. Yes, I have.  
 8 COFFEY, Q.C.:  
 9 Q. The contents of this, the first paragraph on  
 10 page one of the memo, "Results of the immuno  
 11 stains may be affected by", and he talks about  
 12 delayed fixation, over fixation, under  
 13 fixation, and so on, okay.  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. And the contents of this, was any of this --  
 18 when you saw this in --  
 19 DR. DANKWA:  
 20 A. March.  
 21 COFFEY, Q.C.:  
 22 Q. March of 2008, was any of this information new  
 23 to you as information?  
 24 DR. DANKWA:  
 25 A. No, it wasn't.

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1 COFFEY, Q.C.:  
 2 Q. You were already aware of this?  
 3 DR. DANKWA:  
 4 A. Aware of the information in it, yes.  
 5 COFFEY, Q.C.:  
 6 Q. And how long would you have been aware of this  
 7 sort of information?  
 8 DR. DANKWA:  
 9 A. From my training back in Bristol, and my  
 10 exposure down in Washington, DC, yes.  
 11 COFFEY, Q.C.:  
 12 Q. Now, Doctor, in St. Anthony --  
 13 DR. DANKWA:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. For example, between 1998 then and 2003, or  
 17 actually all the way up to 2005 for that  
 18 matter, in reporting ER/PR, you reported it  
 19 how? What format would you use?  
 20 DR. DANKWA:  
 21 A. Yes. I would state the intensity of staining  
 22 if there was any, and then I will qualify it  
 23 also by stating how much of the tumour is  
 24 actually -- by stating the percentage, how  
 25 much of the tumour is involved. So I will

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1 give the percentage, yes, it's staining, how  
 2 strongly it is staining, and what percentage  
 3 it is.  
 4 COFFEY, Q.C.:  
 5 Q. And, Doctor, what sort of terminology would  
 6 you use in a pathology report, the addendum is  
 7 what this would be --  
 8 DR. DANKWA:  
 9 A. Right, addendum.  
 10 COFFEY, Q.C.:  
 11 Q. To describe intensity, what sorts of  
 12 categorizations would you use?  
 13 DR. DANKWA:  
 14 A. I would use -- I would yes, weak, moderate,  
 15 and then marked.  
 16 COFFEY, Q.C.:  
 17 Q. Marked?  
 18 DR. DANKWA:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Meaning strong, I take it, or intense?  
 22 DR. DANKWA:  
 23 A. Strong, yes -- or sometimes strong, actually,  
 24 yes.  
 25 COFFEY, Q.C.:

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1 Q. And that sort of characterization you learned  
 2 to do back from your days in the UK and --  
 3 DR. DANKWA:  
 4 A. UK and --  
 5 COFFEY, Q.C.:  
 6 Q. And in the US?  
 7 DR. DANKWA:  
 8 A. Yes, yes.  
 9 COFFEY, Q.C.:  
 10 Q. And the fact that this memo had been sent out,  
 11 or a memo like this in May of 2003 by Dr.  
 12 Ejeckam, that fact that this had even  
 13 occurred, you first learned about when?  
 14 DR. DANKWA:  
 15 A. In March.  
 16 COFFEY, Q.C.:  
 17 Q. Of this year?  
 18 DR. DANKWA:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Doctor, in paragraph seven of this, for  
 22 example, there's a reference -- not for  
 23 example, it says here "ER positive tumours",  
 24 and it lists particular types of tumours.  
 25 DR. DANKWA:



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1 A. Sure.

2 COFFEY, Q.C.:

3 Q. I take it -- and we understand this is written

4 here to suggest that these particular types of

5 tumours, and as well Dr. Ejeckam has told the

6 Commissioner he should have included --

7 DR. DANKWA:

8 A. Lobular.

9 COFFEY, Q.C.:

10 Q. Lobular as well, "statistically they are more

11 likely to be positive".

12 DR. DANKWA:

13 A. Correct, yes.

14 COFFEY, Q.C.:

15 Q. Doctor, you would have been aware of that?

16 DR. DANKWA:

17 A. Yes, I would have been, yes.

18 COFFEY, Q.C.:

19 Q. From years ago?

20 DR. DANKWA:

21 A. From years back, yes.

22 COFFEY, Q.C.:

23 Q. Doctor, in examining patient slides in St.

24 Anthony, when you were checking the slides,

25 would you bring to bear your diagnosis as to

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1 the type of tumour in the sense that -- it's a

2 breast tumour, but a tubular versus a lobular

3 versus -- in terms of what you were looking at

4 on the slide, what you expected to see and --

5 DR. DANKWA:

6 A. Yes, if I get a tumour, and I make a diagnosis

7 of malignancy, I would have to quality what

8 type of malignancy it is and grade it as well,

9 yes.

10 COFFEY, Q.C.:

11 Q. And if, for example, you had called a tumour a

12 low nuclear grade ductal tumour --

13 DR. DANKWA:

14 A. Right, yes.

15 COFFEY, Q.C.:

16 Q. And then you sent off for ER/PR --

17 DR. DANKWA:

18 A. Right.

19 COFFEY, Q.C.:

20 Q. Testing, and the slides came back, when you

21 looked down through the scope at the H & E --

22 I'm sorry, the ER/PR slides, what would you be

23 expecting then to see?

24 DR. DANKWA:

25 A. I would naturally be expecting that to be

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1 positive. The way I look at it is whenever

2 any tumour is of low grade or well

3 differentiated, as you may say, it tends to

4 stain as a normal tissue that is in the

5 substance. So that will be my normal

6 expectation.

7 COFFEY, Q.C.:

8 Q. And if you come across a tumour that didn't

9 accord with your expectation in that regard?

10 DR. DANKWA:

11 A. If it didn't, okay, I'll critically look at

12 the controls again to make sure that there

13 isn't something that I've missed, and if the

14 controls are working, that's the external and

15 internal controls are working, I'll go ahead

16 and report it.

17 COFFEY, Q.C.:

18 Q. You'll report it as to what you'd seen?

19 DR. DANKWA:

20 A. As to what I've seen, yes.

21 COFFEY, Q.C.:

22 Q. Okay. Doctor, what has been referred to here

23 by various witnesses at times who have

24 testified here, ER/PR matter, issue, or

25 concern, when did you first become aware of

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1 it?

2 DR. DANKWA:

3 A. 2005, when I got a letter from Dr. Don Cook.

4 COFFEY, Q.C.:

5 Q. And if we could, please, Exhibit P-2199.

6 Doctor, this is a memo of June 14th, 2005.

7 It's to all laboratory directors, which you're

8 listed as the last in the order here, St.

9 Anthony.

10 DR. DANKWA:

11 A. Yes.

12 COFFEY, Q.C.:

13 Q. Dr. Dankwa, and it's from Dr. Cook, and it's -

14 - is this the memo you're referring to?

15 DR. DANKWA:

16 A. Yes, indeed.

17 COFFEY, Q.C.:

18 Q. So, Doctor -- the Commissioner has already

19 seen this a number of times and had it read

20 out to her. Doctor, when you first received

21 this, what, if anything, was your response in

22 the sense of -- what was your reaction?

23 DR. DANKWA:

24 A. I was a bit curious at that letter. I

25 wondered what was really behind it all. So I

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1 pondered a little around it because sometimes  
 2 you occasionally wonder whether the research  
 3 process that is coming through, but without  
 4 going through the research review process. So  
 5 after giving it some concentration, I called  
 6 Dr. Don Cook to find out exactly what it is  
 7 about, and then he explained the circumstances  
 8 surrounding it, and I took his word for it.  
 9 COFFEY, Q.C.:  
 10 Q. And what did he tell you about the  
 11 circumstances?  
 12 DR. DANKWA:  
 13 A. If I remember correctly, he mentioned about a  
 14 lady who was negative by their test, and the  
 15 oncologist, I think -- it looks like they must  
 16 have repeated and it was still negative. The  
 17 oncologist, the local oncologist here, was  
 18 concerned about the case and had a discussion  
 19 with a colleague of his in the United States,  
 20 who raised the comment that usually those  
 21 tumours tend to be positive, and based on  
 22 that, I think they had it retested and it was  
 23 retested as positive. That is what seemed to  
 24 have started this.  
 25 COFFEY, Q.C.:

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1 Q. So Dr. Cook explained that to you?  
 2 DR. DANKWA:  
 3 A. Yes, he did.  
 4 COFFEY, Q.C.:  
 5 Q. And did you discuss -- this memo does go on to  
 6 say that -- talks about the Ventana System  
 7 being fully automated.  
 8 DR. DANKWA:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. To be more sensitive than the previous DAKO  
 12 method. "Most of these false negatives have  
 13 occurred during the year 2002".  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. And they've already told you we're aware of a  
 18 number of negative ER and PR that have  
 19 converted.  
 20 DR. DANKWA:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. On retesting. So, Doctor, Dr. Cook had told  
 24 you about this one patient that had converted.  
 25 DR. DANKWA:

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. And, of course, you're being told here there's  
 4 a number of others?  
 5 DR. DANKWA:  
 6 A. A number of others, yes.  
 7 COFFEY, Q.C.:  
 8 Q. Did he discuss with you at the time, like,  
 9 what proportion of people that they had --  
 10 were finding were converting?  
 11 DR. DANKWA:  
 12 A. No, he didn't.  
 13 COFFEY, Q.C.:  
 14 Q. Okay. So you were satisfied after your  
 15 conversation with Dr. Cook that this was  
 16 something that you had to attend to?  
 17 DR. DANKWA:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. And what then happened? Would you explain to  
 21 the Commissioner then how you had to go about  
 22 searching for cases --  
 23 DR. DANKWA:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And in doing so, perhaps if I could, have you  
 2 begin with the information collection system  
 3 that existed for pathology reports when you  
 4 arrived in St. Anthony, take us up to the  
 5 present, and then you can fit then what you  
 6 did into that?  
 7 DR. DANKWA:  
 8 A. Into that, okay. The information system that  
 9 existed when I arrived was that they had a  
 10 computer, but they just basically typed the  
 11 results and then printed it out in hard copy  
 12 sheets. It wasn't filed in any electronic  
 13 file system. So there wasn't any electronic  
 14 information, it was all paper documentation  
 15 that was there. That continued until 2003,  
 16 July/August, when we moved onto the Meditec  
 17 System which is an electronic filing system,  
 18 and up to this day that is what we have.  
 19 COFFEY, Q.C.:  
 20 Q. Now the Meditec System, after it was  
 21 implemented in the middle of 2003, okay --  
 22 DR. DANKWA:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. The version of it that is in use in St.

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1 Anthony, is that able to be searched -- using  
 2 Meditec, are you able to search for and  
 3 identify every patient who has had an ER/PR  
 4 test done?  
 5 DR. DANKWA:  
 6 A. I can't say specifically for ER/PR, but I  
 7 could search for something like "breast".  
 8 COFFEY, Q.C.:  
 9 Q. Okay, breast.  
 10 DR. DANKWA:  
 11 A. Yes, yeah.  
 12 COFFEY, Q.C.:  
 13 Q. And from that, you'd get breast carcinoma?  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. And then ER/PR?  
 18 DR. DANKWA:  
 19 A. And then ER/PR, yes.  
 20 COFFEY, Q.C.:  
 21 Q. With that in mind then, Doctor, so this  
 22 request involving 2002 is before the Meditec?  
 23 DR. DANKWA:  
 24 A. Meditec, correct, yes.  
 25 COFFEY, Q.C.:

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1 Q. When you first got this then and after your  
 2 conversation with Dr. Cook--do you recall  
 3 approximately when your conversation with Dr.  
 4 Cook would have been?  
 5 DR. DANKWA:  
 6 A. I can't recall exactly what date that was.  
 7 COFFEY, Q.C.:  
 8 Q. And so if we could, before I get actually into  
 9 it further, Exhibit P-0590, please? Now Dr.  
 10 Dankwa, this is a letter from Dr. Donald Cook  
 11 as clinical chief to again, lab directors,  
 12 including yourself, there second from the last  
 13 addressee. It's September 6th, 2005, ER and  
 14 PRs, here in the title. "I wish to advise you  
 15 that we are doing a review of our estrogen and  
 16 progesterone receptors. I expect to have more  
 17 information within the next few weeks and will  
 18 keep you updated. Please note the following  
 19 points" and there's a number of them.  
 20 DR. DANKWA:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. Did you receive this memo?  
 24 DR. DANKWA:  
 25 A. Yes, I did.

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1 COFFEY, Q.C.:  
 2 Q. Okay, if we could, please, bring up Exhibit P-  
 3 1736? Doctor, these are handwritten notes  
 4 created by Dr. Cook, and the second entry  
 5 here, September 7th, 2005 at ten a.m., he says  
 6 "spoke to Dr. Dankwa from St. Anthony.  
 7 Updated him on situation and gave background  
 8 information before my memo went out," and that  
 9 memo is the September 6th one he's told us.  
 10 DR. DANKWA:  
 11 A. Right.  
 12 COFFEY, Q.C.:  
 13 Q. Do you recall Dr. Cook phoning you and giving  
 14 you a heads up about the September 6th memo?  
 15 DR. DANKWA:  
 16 A. I knew we had a talk about it sometime, yes,  
 17 but I can't recall the exact date.  
 18 COFFEY, Q.C.:  
 19 Q. Now Doctor, if we could, please, Registrar,  
 20 Exhibit P-0590 again? This September 6th,  
 21 2005 memo, Doctor, do you recall approximately  
 22 when it was you would have received that?  
 23 DR. DANKWA:  
 24 A. Not exactly, no.  
 25 COFFEY, Q.C.:

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1 Q. I take it, in the normal course, when it -  
 2 DR. DANKWA:  
 3 A. Yeah.  
 4 COFFEY, Q.C.:  
 5 Q. How far, if at all, had you gotten with  
 6 responding to the June 14th 2005 memo,  
 7 gathering the material he wanted in June, by  
 8 the time you got the September 6th memo?  
 9 DR. DANKWA:  
 10 A. By the time I got the September 6th memo, we  
 11 had already sent the requested information to  
 12 Don Cook's secretary.  
 13 COFFEY, Q.C.:  
 14 Q. If we could bring up again, please, Exhibit P-  
 15 2199? Doctor, this handwriting here, do you  
 16 recognize -  
 17 DR. DANKWA:  
 18 A. That's my secretary's handwriting, yes.  
 19 COFFEY, Q.C.:  
 20 Q. And this says "sent September 8th '05, names  
 21 at back. Please return ASAP when study  
 22 complete."  
 23 DR. DANKWA:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And if we could show the Commissioner, at  
 2 back, I take it, these are the -  
 3 DR. DANKWA:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. - well, the names and the MCP numbers are  
 7 redacted, but surgical numbers, 1-2-3-4-5,  
 8 perhaps 6.  
 9 DR. DANKWA:  
 10 A. Six, it was six, yeah.  
 11 COFFEY, Q.C.:  
 12 Q. Six patients?  
 13 DR. DANKWA:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. For 2002.  
 17 DR. DANKWA:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. That had negative?  
 21 DR. DANKWA:  
 22 A. Negatives, yes.  
 23 COFFEY, Q.C.:  
 24 Q. ER/PR?  
 25 DR. DANKWA:

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. And just looking at that, in this particular  
 4 memo or June 14th, you just requested to send-  
 5 -let me just get this here now. Yes, "I would  
 6 ask that you submit the reports, original  
 7 ER/PR slides, including controls, as well as H  
 8 & E slides and paraffin blocks of the tumours"  
 9 and they tell you they will repeat them on the  
 10 Ventana. Above that, he said "presently, we  
 11 are in the process of retesting all negative  
 12 ERs and PRs for that particular year."  
 13 DR. DANKWA:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. What did you interpret the negative ER and  
 17 negative PR to mean in this context in this  
 18 memo? What I'm getting at is in terms of how  
 19 did you identify--what criteria did you use to  
 20 identify those six patients?  
 21 DR. DANKWA:  
 22 A. In my reporting, I use negative or zero, zero  
 23 percentage staining, so all the negatives, all  
 24 the zero percentages were what I identified.  
 25 COFFEY, Q.C.:

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1 Q. And at the time, in responding to the June  
 2 memo, was that there were both the ER and PR  
 3 were zero or just one of them?  
 4 DR. DANKWA:  
 5 A. I focused on the--I think I used not that both  
 6 of them should be zero, but I focused on the  
 7 ER zeros, and collected all those cases, yes.  
 8 COFFEY, Q.C.:  
 9 Q. And that's in your initial gathering?  
 10 DR. DANKWA:  
 11 A. In the initial, yes.  
 12 COFFEY, Q.C.:  
 13 Q. And then when you received the--as you say, it  
 14 went out on September 8th -  
 15 DR. DANKWA:  
 16 A. September 8th, yes.  
 17 COFFEY, Q.C.:  
 18 Q. - and by that September 6th memo would have  
 19 arrived then sometime after that?  
 20 DR. DANKWA:  
 21 A. After that, yes, correct.  
 22 COFFEY, Q.C.:  
 23 Q. Now Doctor, if we could, please, then, how did  
 24 you go about identifying for the pre Meditec  
 25 patients, Meditec in St. Anthony patients, how

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1 did you go about identifying those patients?  
 2 DR. DANKWA:  
 3 A. At the end of each year, we go back to our  
 4 file and initially the files--we have a file  
 5 for current year in which we file the patients  
 6 records in alphabetical order. So at the end  
 7 of every year, these are all bound up in a  
 8 binder in alphabetical order and kept in our  
 9 archive system. So when these requests came,  
 10 we just went back to the archive for the  
 11 particular years that were concerned and then  
 12 just thumbed through, because we had no way of  
 13 doing it.  
 14 COFFEY, Q.C.:  
 15 Q. In terms, just so the Commissioner understands  
 16 this, okay. So you've got, for example, a  
 17 1998, a 1999 and 2000?  
 18 DR. DANKWA:  
 19 A. Yes, that's right.  
 20 COFFEY, Q.C.:  
 21 Q. Each year.  
 22 DR. DANKWA:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. At the beginning of 1999, you would start--

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1 we'd file away in binders all the '98 ones?  
 2 DR. DANKWA:  
 3 A. Exactly, yes.  
 4 COFFEY, Q.C.:  
 5 Q. And in '99 then, as a particular patient, you  
 6 say a file?  
 7 DR. DANKWA:  
 8 A. Right.  
 9 COFFEY, Q.C.:  
 10 Q. Is that a file just containing their pathology  
 11 report?  
 12 DR. DANKWA:  
 13 A. Yes, a file containing the pathology report,  
 14 yes.  
 15 COFFEY, Q.C.:  
 16 Q. And for a patient with a name beginning with  
 17 A, that would be first.  
 18 DR. DANKWA:  
 19 A. Yes, first, yeah.  
 20 COFFEY, Q.C.:  
 21 Q. And then B, C, Ds would follow and as the year  
 22 would go on, they'd be inserted in  
 23 alphabetical order?  
 24 DR. DANKWA:  
 25 A. Yes.

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1 COFFEY, Q.C.:  
 2 Q. As they're filed away.  
 3 DR. DANKWA:  
 4 A. Yes, so we would have one layer of one year.  
 5 So '98 will be on one level of the shelf.  
 6 Another shelf will be, say, '99. The next  
 7 would be 2000, just like that.  
 8 COFFEY, Q.C.:  
 9 Q. And every patient that you had done any  
 10 pathology work for -  
 11 DR. DANKWA:  
 12 A. Would be in that binder, yes.  
 13 COFFEY, Q.C.:  
 14 Q. And from A to Z literally.  
 15 DR. DANKWA:  
 16 A. A to Z, yes.  
 17 COFFEY, Q.C.:  
 18 Q. So that when you had--then, when you  
 19 requested, for example, initially for 2002,  
 20 what actually physically had to happen? For  
 21 example, how many reports would there be for  
 22 2002? How many -  
 23 DR. DANKWA:  
 24 A. You're looking at close to about over 2000,  
 25 getting close to 3,000.

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1 COFFEY, Q.C.:  
 2 Q. For that particular year?  
 3 DR. DANKWA:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. Reports?  
 7 DR. DANKWA:  
 8 A. Reports, yes.  
 9 COFFEY, Q.C.:  
 10 Q. For any one year?  
 11 DR. DANKWA:  
 12 A. Any one year. Initially, in '97, '96/97, it  
 13 was probably around about 2,000, but the  
 14 numbers kept increasing.  
 15 COFFEY, Q.C.:  
 16 Q. And by the time--well, for example, the last  
 17 full year would be 2002?  
 18 DR. DANKWA:  
 19 A. Yes, yeah.  
 20 COFFEY, Q.C.:  
 21 Q. How many would you be -  
 22 DR. DANKWA:  
 23 A. We would be getting close to 3,000, yeah, and  
 24 for--depending on what type of case it is, we  
 25 may have about three or two pages, so you are

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1 looking for every year, at least looking at  
 2 two to three thousand pages to sort through.  
 3 COFFEY, Q.C.:  
 4 Q. And the only order in which they are is  
 5 alphabetical by name?  
 6 DR. DANKWA:  
 7 A. Just alphabetical order, by names, yes.  
 8 COFFEY, Q.C.:  
 9 Q. In that, you would have biopsies for kidney -  
 10 DR. DANKWA:  
 11 A. Kidney, spleen -  
 12 COFFEY, Q.C.:  
 13 Q. - liver, lung, whatever?  
 14 DR. DANKWA:  
 15 A. - anything, yes, exactly.  
 16 COFFEY, Q.C.:  
 17 Q. Just all in -  
 18 DR. DANKWA:  
 19 A. All in the file, yes.  
 20 THE COMMISSIONER:  
 21 Q. So I understand--what was it five, six  
 22 patients that you actually came up with for  
 23 2002?  
 24 COFFEY, Q.C.:  
 25 Q. Six, Commissioner.

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1 DR. DANKWA:  
 2 A. Six cases.  
 3 THE COMMISSIONER:  
 4 Q. So somebody had to actually read 3,000  
 5 reports?  
 6 DR. DANKWA:  
 7 A. Exactly, go through the file, yes.  
 8 THE COMMISSIONER:  
 9 Q. Go through them to determine--to fine that six  
 10 patients?  
 11 DR. DANKWA:  
 12 A. Exactly.  
 13 COFFEY, Q.C.:  
 14 Q. And I'm going to take the witness through  
 15 that. So when you first got the June 14th  
 16 memo and then had your chat with Dr. Cook, and  
 17 I suppose, he's serious about this, this has  
 18 got to--and we got to get this done.  
 19 DR. DANKWA:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. So who--how did you go about having it done?  
 23 Like for all the pre Meditec time, because I  
 24 gather the same thing occurred then on  
 25 September 6th.

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1 DR. DANKWA:  
 2 A. Yeah (unintelligible) yes, exactly.  
 3 COFFEY, Q.C.:  
 4 Q. In the earlier years. Tell the Commissioner  
 5 how physically that was done, who did it, and  
 6 how it was done.  
 7 DR. DANKWA:  
 8 A. Eventually involved my secretary and then the  
 9 lead lab tech because we've got to weigh  
 10 confidentiality too in the concern here into  
 11 the situation. We cannot easily bring in  
 12 anybody to come in and help. So we focused on  
 13 trying to identify these cases. So we did  
 14 basically, we would do it during our work  
 15 period whenever we had any break, if possible,  
 16 and then after work we stayed on and then  
 17 thumbed through, yes.  
 18 COFFEY, Q.C.:  
 19 Q. And looking for what? They were told--your  
 20 secretary and eventually the technologist,  
 21 were told to identify which sorts of--what  
 22 were they looking for?  
 23 DR. DANKWA:  
 24 A. What we started looking for was breast, any  
 25 case that had any information about breast,

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1 and any case that had any supplemental report,  
 2 that had ER/PR on it. So all that was pulled  
 3 together and I would be looking through myself  
 4 as well.  
 5 COFFEY, Q.C.:  
 6 Q. Okay. So they would identify breast cases and  
 7 anything with ER or PR on it?  
 8 DR. DANKWA:  
 9 A. Breast cases and then ER/PR on it, yes,  
 10 exactly.  
 11 COFFEY, Q.C.:  
 12 Q. And they would bring those cases to your  
 13 attention?  
 14 DR. DANKWA:  
 15 A. Yes, and I'll look through it. I also thumbed  
 16 through some of them myself.  
 17 COFFEY, Q.C.:  
 18 Q. And then, Doctor, so those cases, I take it,  
 19 would involve some results that are ER/PR  
 20 positives?  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. As well as negatives?  
 25 DR. DANKWA:

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1 A. As negatives, yes.  
 2 COFFEY, Q.C.:  
 3 Q. So would you--you'd get all the ER/PR cases?  
 4 DR. DANKWA:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. Positive or negative?  
 8 DR. DANKWA:  
 9 A. Exactly, yes.  
 10 COFFEY, Q.C.:  
 11 Q. And then you would look through them for what?  
 12 DR. DANKWA:  
 13 A. Looking for those that were reading negative,  
 14 yes.  
 15 COFFEY, Q.C.:  
 16 Q. And then when the September 6th--if we could,  
 17 please, Exhibit P-0590? September 6th memo  
 18 came in, here what is positive and negative is  
 19 actually spelled out here?  
 20 DR. DANKWA:  
 21 A. Spelled out, yes.  
 22 COFFEY, Q.C.:  
 23 Q. And it's not necessarily exactly in accordance  
 24 with -  
 25 DR. DANKWA:

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1 A. Way I report, no.  
 2 COFFEY, Q.C.:  
 3 Q. - with yours, so what--for example, as an  
 4 example, would be, the second bullet here, for  
 5 the period covering the year 2002, ER negative  
 6 would be defined as ten percent or less?  
 7 DR. DANKWA:  
 8 A. Yes.  
 9 COFFEY, Q.C.:  
 10 Q. And you had originally gone through  
 11 identifying them anything that was five, for  
 12 example, was positive and you hadn't  
 13 identified it?  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. So did you--was that--your search the second  
 18 time through -  
 19 DR. DANKWA:  
 20 A. Yes, we had to go through it again, yes, yeah.  
 21 So basically, and bear in mind too that I had  
 22 one secretary, I was the only one, and then we  
 23 had a lead tech. We still had to do our  
 24 regular work as well as take on this. So when  
 25 I saw the second memo, I knew we had a

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1 problem. There is no way we could go through  
 2 over 15,000 pages and get that information.  
 3 So I requested my secretary to communicate  
 4 with Judy Thomas who was then working with, I  
 5 think, Don Cook as his secretary, also  
 6 coordinating the collection of these cases, to  
 7 see what other ways we could work on towards  
 8 helping us, assisting us to gather these  
 9 cases, and we know that nearly all our cases  
 10 that were malignant were referred on to St.  
 11 John's and we wondered if there was any way in  
 12 their system where they had electronic version  
 13 of information about our cases so that we can  
 14 use it, and that is where we started from. So  
 15 we -  
 16 COFFEY, Q.C.:  
 17 Q. So how did that--go ahead, Doctor.  
 18 DR. DANKWA:  
 19 A. Yeah, we continued thumbing through while I  
 20 was waiting for that information to come  
 21 through.  
 22 COFFEY, Q.C.:  
 23 Q. And what did you receive back from St. John's  
 24 then?  
 25 DR. DANKWA:

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1 A. We got--the print out was somewhere towards  
 2 the end of October 2005 when a print out was  
 3 made, but I think we got it around November  
 4 sometime.  
 5 COFFEY, Q.C.:  
 6 Q. And this was a print out from whom?  
 7 DR. DANKWA:  
 8 A. From--Judy Thomas printed it out, I think,  
 9 from the either St. Clare's electronic system  
 10 or St. John's Meditec system. Printing out  
 11 cases of all breast cancers that have gone  
 12 through the system here.  
 13 COFFEY, Q.C.:  
 14 Q. That had gone through their system but had  
 15 originated -  
 16 DR. DANKWA:  
 17 A. From us.  
 18 COFFEY, Q.C.:  
 19 Q. From St. Anthony?  
 20 DR. DANKWA:  
 21 A. From St. Anthony, yes.  
 22 COFFEY, Q.C.:  
 23 Q. And in the meantime, this thumbing through -  
 24 DR. DANKWA:  
 25 A. Was going on, yes.

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1 COFFEY, Q.C.:  
 2 Q. - manually, was still going on?  
 3 DR. DANKWA:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. Was the Meditec system ever, before '03, '04  
 7 and '05 at St. Anthony ever searched?  
 8 DR. DANKWA:  
 9 A. We use the Meditec to site the latter part of  
 10 '03 to '05, but we still had to thumb through  
 11 the 2003 because we weren't sure what the  
 12 Meditec was going to cover for us, yes.  
 13 COFFEY, Q.C.:  
 14 Q. Doctor, as you indicated, there's well over  
 15 10,000 pages of reports.  
 16 DR. DANKWA:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. Probably, as you say, I think 13 to 15,000 or  
 20 so.  
 21 DR. DANKWA:  
 22 A. Sure, yeah.  
 23 COFFEY, Q.C.:  
 24 Q. Doctor, to your knowledge, has anyone ever  
 25 actually thumbed through all of them?

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1 DR. DANKWA:  
 2 A. Now, yes.  
 3 COFFEY, Q.C.:  
 4 Q. Okay.  
 5 DR. DANKWA:  
 6 A. But at that time, no.  
 7 COFFEY, Q.C.:  
 8 Q. And when did the -  
 9 DR. DANKWA:  
 10 A. Thumbing through.  
 11 COFFEY, Q.C.:  
 12 Q. - when did the final thumbing through, when  
 13 did that occur?  
 14 DR. DANKWA:  
 15 A. That occurred last year when the Commission of  
 16 Inquiry was struck and then there was a  
 17 request for all our ER/PR cases.  
 18 COFFEY, Q.C.:  
 19 Q. And that has to do with the statistical -  
 20 DR. DANKWA:  
 21 A. The statistical, yes, gathering of  
 22 information, yes.  
 23 COFFEY, Q.C.:  
 24 Q. Okay, so that was in '07.  
 25 DR. DANKWA:

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1 A. In '07, I think. It was around June or July,  
 2 thereabouts, yes.  
 3 COFFEY, Q.C.:  
 4 Q. And I'll come to that then. So in the initial  
 5 identification of patients in 2005 for  
 6 retesting, do you know how many of the--like  
 7 were any particular years gone through? I  
 8 take it 2002 was probably gone through.  
 9 DR. DANKWA:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. At least using your criteria for negative.  
 13 DR. DANKWA:  
 14 A. Yes, exactly.  
 15 COFFEY, Q.C.:  
 16 Q. How about the other years, did anybody ever  
 17 actually go through all the paper at the time?  
 18 DR. DANKWA:  
 19 A. The paper, I think we might have done the  
 20 2003, 2002, and probably 2001, because we were  
 21 working backwards, yes.  
 22 COFFEY, Q.C.:  
 23 Q. And your Meditec system was checked for '03,  
 24 '04 and '05?  
 25 DR. DANKWA:

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1 A. Yes, exactly.  
 2 COFFEY, Q.C.:  
 3 Q. Then for the years prior to those years you've  
 4 just referred to, you would have been relying  
 5 upon the spreadsheet you received from St.  
 6 John's in -  
 7 DR. DANKWA:  
 8 A. Yes, exactly.  
 9 COFFEY, Q.C.:  
 10 Q. - in October of '05?  
 11 DR. DANKWA:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. To identify your patients for '97, '98 and '99  
 15 -  
 16 DR. DANKWA:  
 17 A. Correct.  
 18 COFFEY, Q.C.:  
 19 Q. - and 2000?  
 20 DR. DANKWA:  
 21 A. Right.  
 22 COFFEY, Q.C.:  
 23 Q. Doctor, the September 6th memo, as you  
 24 indicated, when you got it, you realized that  
 25 this is a much more arduous or monumental

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1 task?  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. You know, sitting in St. Anthony yourself.  
 6 Did you contact anyone about what was going on  
 7 here, in the sense of kind of what--why was  
 8 this all now necessary?  
 9 DR. DANKWA:  
 10 A. No, at that time, I didn't. We hadn't had any  
 11 results back. We didn't know exactly whether  
 12 there was any significant change in our  
 13 results or not. So I had nothing really to  
 14 work with.  
 15 COFFEY, Q.C.:  
 16 Q. To judge how many people this might involve,  
 17 in the sense of would have changed results,  
 18 you had no idea?  
 19 DR. DANKWA:  
 20 A. I had no idea. Had no idea then.  
 21 COFFEY, Q.C.:  
 22 Q. Did you have any sense, by September 2005, as  
 23 to how many conversions there had been in the  
 24 St. John's group that had been retested?  
 25 Anybody tell you?



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1 DR. DANKWA:  
 2 A. No.  
 3 COFFEY, Q.C.:  
 4 Q. Exhibit P-1779, please? Actually, if I could,  
 5 I apologize, if we could go back to 0590,  
 6 please, for a moment. This is that September  
 7 6th memo, Doctor. On the second page, Dr.  
 8 Cook advises "there is currently a hold on the  
 9 reporting of ER and PR by all pathologists in  
 10 the division of anatomical pathology" and he  
 11 says that "all current requests for ER/PR are  
 12 being forwarded to Mount Sinai. You," that's  
 13 yourself and the other lab directors, "may  
 14 elect to directly refer your ER/PRs to Mount  
 15 Sinai or to a laboratory of your choice." So  
 16 Doctor, in terms then of when you got the  
 17 September 6th memo, you were being told that  
 18 St. John's was no longer doing ER/PR, at least  
 19 for the time being?  
 20 DR. DANKWA:  
 21 A. That's true.  
 22 COFFEY, Q.C.:  
 23 Q. And the suggestion that you might use Mount  
 24 Sinai, did you take them up on that?  
 25 DR. DANKWA:

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1 A. I took that option, yes.  
 2 COFFEY, Q.C.:  
 3 Q. If we could go back then, please, to P-1779?  
 4 this is a letter of September 26th, 2005 to  
 5 yourself from Dr. Mullen?  
 6 DR. DANKWA:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. Brendan Mullen of Mount Sinai and I take it  
 10 then you were prepared to and did take up Dr.  
 11 Mullen's offer.  
 12 DR. DANKWA:  
 13 A. Offer, yes, I did.  
 14 COFFEY, Q.C.:  
 15 Q. So, Doctor, just while we're on this topic, I  
 16 take it from this point on, any ER/PR and  
 17 HER2/neu you wanted done -  
 18 DR. DANKWA:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Has been done at Mount Sinai?  
 22 DR. DANKWA:  
 23 A. Yes, adapt (phonetic).  
 24 COFFEY, Q.C.:  
 25 Q. And how does that arrangement work?

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1 DR. DANKWA:  
 2 A. Following the receipt of this letter, I mean,  
 3 I confirmed that they were quite happy to  
 4 continue with it, so what we do, if I identify  
 5 a case that needed a ER/PR, I'll select the  
 6 appropriate block, looking at the H&E slide,  
 7 and then write a cover letter, enclose a copy  
 8 of my report, and send it on requesting the  
 9 ER/PR and HER2/neu testing.  
 10 COFFEY, Q.C.:  
 11 Q. And what do you get back then?  
 12 DR. DANKWA:  
 13 A. I get a report back and eventually the block  
 14 would also follow. Usually they fax us the  
 15 report back to expedite it, which is good.  
 16 COFFEY, Q.C.:  
 17 Q. And what do you do then with the report?  
 18 DR. DANKWA:  
 19 A. We transcribe it into our system, that is you  
 20 are now looking at a go-forward cases, we  
 21 transcribe them into our system, file the  
 22 original in our system and then we leave the  
 23 transcribed one to the physician.  
 24 COFFEY, Q.C.:  
 25 Q. Doctor, and how has that service worked in

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1 terms of its timeliness?  
 2 DR. DANKWA:  
 3 A. Very good, yes.  
 4 COFFEY, Q.C.:  
 5 Q. Doctor, if we could, please, before I leave  
 6 the topic of the pre-2005 days, I've referred  
 7 you to Dr. Ejeckam's memos. Do you know who  
 8 Dr. Ejeckam was?  
 9 DR. DANKWA:  
 10 A. Yes, I do. I met him when he was here working  
 11 in the Health Sciences Centre, yes, but I  
 12 didn't know him before then.  
 13 COFFEY, Q.C.:  
 14 Q. Did you acquire any understanding as to how  
 15 involved or uninvolved he was in IHC? Did you  
 16 have any understanding of that?  
 17 DR. DANKWA:  
 18 A. I had no idea.  
 19 COFFEY, Q.C.:  
 20 Q. You just knew him as a fellow pathologist?  
 21 DR. DANKWA:  
 22 A. Yes, exactly.  
 23 COFFEY, Q.C.:  
 24 Q. Now, Doctor, if I could please, Exhibit P-  
 25 2202? And, Doctor, again, I apologize,

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1 Commissioner for doing this out of turn, but  
 2 while I'm, so I don't forget it, we spoke this  
 3 morning, Doctor, about the problems with you  
 4 getting the replacement. This is entitled  
 5 "Leave dates for 2002 through 2005"?  
 6 DR. DANKWA:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. And you prepared this at whose request?  
 10 DR. DANKWA:  
 11 A. You requested it at the last meeting.  
 12 COFFEY, Q.C.:  
 13 Q. During our interview?  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. And, Doctor, this then I take it is a summary  
 18 of the leave dates you've had during those  
 19 years?  
 20 DR. DANKWA:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. To give the Commissioner some sense of how  
 24 often you can get away and for the periods in  
 25 question.

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1 DR. DANKWA:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. Doctor, while I'm thinking about this now, as  
 5 the sole pathologist in St. Anthony, I take it  
 6 then, Doctor, that your normal work week is  
 7 Monday to Friday in the sense of you're  
 8 scheduled to be in at work.  
 9 DR. DANKWA:  
 10 A. Yes, correct.  
 11 COFFEY, Q.C.:  
 12 Q. They expect to find out at the office Monday  
 13 to Friday.  
 14 DR. DANKWA:  
 15 A. Official, yes.  
 16 COFFEY, Q.C.:  
 17 Q. As a practical matter, being the sole  
 18 pathologist in the community, how much actual  
 19 time does it take?  
 20 DR. DANKWA:  
 21 A. Once I'm in St. Anthony, I'm at work, I could  
 22 be called in any time and I work on weekends,  
 23 public holidays, you name it, I'm there.  
 24 THE COMMISSIONER:  
 25 Q. Doctor Dankwa, this morning you spoke about

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1 the advantage of being the sole pathologist.  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 THE COMMISSIONER:  
 5 Q. I think you're now telling me one of the  
 6 disadvantages of being a sole pathologist.  
 7 What about the flip side of having to deal  
 8 with colleagues, in the sense of being able to  
 9 consult with somebody who has your kind of  
 10 training about a difficult case or something  
 11 of that nature? How do you manage that?  
 12 DR. DANKWA:  
 13 A. Whenever I am faced with any case that I have  
 14 some concerns about, having colleagues in  
 15 place that I've trained, I quickly send them  
 16 on for referrals and they very willingly  
 17 provide a support and knowing my colleagues  
 18 here too, in St. John's, I consult them too  
 19 with some cases and they are always very  
 20 helpful.  
 21 THE COMMISSIONER:  
 22 Q. But by its very nature, because you are by  
 23 yourself, the consultation process therefore  
 24 takes much more time than it would if you were  
 25 here in St. John's or even in Corner Brook?

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1 DR. DANKWA:  
 2 A. Will colleagues, I agree, yes.  
 3 COFFEY, Q.C.:  
 4 Q. If we could, please, Exhibit--trying to get  
 5 some sense, Doctor, of what distribution, as  
 6 the Commissioner knows, like how many memos  
 7 kind of got to you and how many didn't, okay?  
 8 DR. DANKWA:  
 9 A. Okay.  
 10 COFFEY, Q.C.:  
 11 Q. Exhibit P-1388 please? And this is a fax  
 12 cover sheet, the first page to Boyd Rowe. Who  
 13 is Boyd Rowe?  
 14 DR. DANKWA:  
 15 A. He is a chief executive officer for Labrador  
 16 Grenfell Health.  
 17 COFFEY, Q.C.:  
 18 Q. And this is dated July 12th, 2005 and you  
 19 write "Boyd, attached are copies of all the  
 20 correspondence that we have received so far  
 21 with regard to ER/PR."  
 22 DR. DANKWA:  
 23 A. Correct.  
 24 COFFEY, Q.C.:  
 25 Q. And it's signed by yourself, so if we find it

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1 in this exhibit, and I'll take you through it,  
 2 as of July, 2007, this is what you had  
 3 searched your files for and provided to your  
 4 CEO?  
 5 DR. DANKWA:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. What you had.  
 9 DR. DANKWA:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. If we could, that's the June 14th memo, page  
 13 2. Page 3 is a letter to yourself involving  
 14 Herceptin from Dr. Laing advising you about  
 15 the fact that Herceptin--advising you about  
 16 the current data for Herceptin at the time.  
 17 And I take it that this is in this file  
 18 because Herceptin relates to ER/PR?  
 19 DR. DANKWA:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. And HER2/neu, well actually HER2/neu, I  
 23 suppose. There's a July 28th, 2005 memo from  
 24 Dr. Cook on HER2/neu and at the bottom of the  
 25 last paragraph, he says, "When choosing blocks

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1 to send for both hormone receptor testing and  
 2 HER2/neu, please select a section that  
 3 contains both tumour and normal or benign  
 4 epithelium."  
 5 DR. DANKWA:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. I take it, that wasn't news to you.  
 9 DR. DANKWA:  
 10 A. No, no.  
 11 COFFEY, Q.C.:  
 12 Q. September 6th memo you had received?  
 13 DR. DANKWA:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. September 26th letter from Dr. Mullen.  
 17 Doctor, here at page 8 of the exhibit, there's  
 18 a "Dear Physician" letter on Eastern Health  
 19 stationery and it's over the name of Dr.  
 20 Robert Williams, Vice-President of Medical  
 21 Services, October 4th, 2005. And I take it,  
 22 Doctor, this is something that, a letter  
 23 advising physicians throughout the province  
 24 about the ER/PR matter?  
 25 DR. DANKWA:

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1 A. Right.  
 2 COFFEY, Q.C.:  
 3 Q. Do you recall how you came to receive this?  
 4 DR. DANKWA:  
 5 A. I don't. At that time we were getting quite  
 6 some communications like this, but I don't  
 7 remember how I got it, received this one, no.  
 8 COFFEY, Q.C.:  
 9 Q. Now, Doctor, when the ER/PR matter came up,  
 10 particularly after that September--well, I'll  
 11 say before the September 6th memo.  
 12 DR. DANKWA:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. Who, within your organization, if anyone,  
 16 other than your secretary had you informed  
 17 about this request for the 2002 cases?  
 18 DR. DANKWA:  
 19 A. For the 2002? Nobody, nobody.  
 20 COFFEY, Q.C.:  
 21 Q. Is there any reason you wouldn't have informed  
 22 Dr. Jong about that time about that?  
 23 DR. DANKWA:  
 24 A. At that time, my understanding was they were  
 25 trying to find out whether things had really

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1 affected cases or not. So it was still under-  
 2 -they were investigating it internally to see  
 3 if there was any problem or not, yeah.  
 4 COFFEY, Q.C.:  
 5 Q. Doctor, when you got the June 14th memo, did  
 6 you understand that they would be creating new  
 7 slides and analyzing the slides and giving you  
 8 a result, or that they would be sending you  
 9 new slides to look at or did you know?  
 10 DR. DANKWA:  
 11 A. Oh, I got the impression that they would be  
 12 analyzing the result, they were be creating  
 13 new slides and analyzing the results, yes.  
 14 COFFEY, Q.C.:  
 15 Q. And did you anticipate that you would actually  
 16 be getting the results too, at some point?  
 17 DR. DANKWA:  
 18 A. Yes, at some point, yes.  
 19 COFFEY, Q.C.:  
 20 Q. So the September 6th memo, 2005, when you got  
 21 that, did you inform anybody in your  
 22 organization, your superiors about that?  
 23 DR. DANKWA:  
 24 A. No, I didn't because at that stage, we still  
 25 hadn't had any results and we didn't know

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1 exactly whether it was going to turn out to be  
 2 anything significant or relevant, yeah.  
 3 COFFEY, Q.C.:  
 4 Q. And that was so, despite the fact that you  
 5 were facing having to go through thousands and  
 6 thousands of documents.  
 7 DR. DANKWA:  
 8 A. Exactly, yes.  
 9 COFFEY, Q.C.:  
 10 Q. But you still didn't -  
 11 DR. DANKWA:  
 12 A. I still didn't, because we hadn't had any  
 13 results for us to really note whether there  
 14 was any change of anything, yes.  
 15 COFFEY, Q.C.:  
 16 Q. When did you first tell Dr. Jong?  
 17 DR. DANKWA:  
 18 A. I can't remember exactly, but I think towards  
 19 the end of 2006, there may have been some  
 20 communication or it was already in the news at  
 21 some stage, even before -  
 22 COFFEY, Q.C.:  
 23 Q. This would be 2005, probably.  
 24 DR. DANKWA:  
 25 A. Oh, sorry, 2005, yes, sorry.

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1 COFFEY, Q.C.:  
 2 Q. Okay, so what I'll do is I'll ask--well  
 3 actually I'll take you then, Doctor, through--  
 4 because that's page 8 there, page 9 of Exhibit  
 5 P-1388 is an e-mail from Alison Dower to  
 6 Addictions, is the address, Friday, October  
 7 7th, 2005. Subject is "Estrogen  
 8 Receptors/Progesterone Receptors", it's on  
 9 Labrador Grenfell Regional Integrated Health  
 10 Authority letterhead. Internal memorandum to  
 11 all staff from Dr. Michael Jong, VP Medical  
 12 Affairs.  
 13 DR. DANKWA:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. It's dated October 7th, 2005 and he writes,  
 17 "Dear Staff, many of you may have heard in the  
 18 media about the issue of breast cancer  
 19 patients and the testing for estrogen  
 20 receptors, progesterone receptors at Eastern  
 21 Health. Labrador Grenfell Health is currently  
 22 working with Eastern Health to resubmit  
 23 previously collected tissue samples from  
 24 breast cancer patients for retesting from the  
 25 period of '97 to 2004. The retesting will not

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1 change an individual's diagnosis, but it may  
 2 be one of the factors considered in  
 3 determining the type of treatment a patient  
 4 will receive. Please find attached a hand-out  
 5 that has been prepared for physicians, public  
 6 health nurses, the provincial breast screening  
 7 program, nursing administrators and other  
 8 groups, to provide to their clients who may  
 9 have concerns about this issue. Sincerely,  
 10 Dr. Michael Jong." And there's obviously an  
 11 attachment, ER/PR client -  
 12 DR. DANKWA:  
 13 A. Information.  
 14 COFFEY, Q.C.:  
 15 Q. If we look to the next page of this exhibit,  
 16 page 10, there's a document there entitled  
 17 "Client Hand-out" with the headings "What is  
 18 ER/PR? What is happening now? Why are some  
 19 test results different?" And then, finally,  
 20 "As a breast cancer patient, I haven't been  
 21 contacted, what should I do?" Now, Doctor, I  
 22 take it then you would have spoken to Dr. Jong  
 23 before October 7th?  
 24 DR. DANKWA:  
 25 A. I would expect so, yes.

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1 COFFEY, Q.C.:  
 2 Q. It had gone public. Do you know if you were  
 3 the one who brought the fact, the ER/PR matter  
 4 to Dr. Jong's attention?  
 5 DR. DANKWA:  
 6 A. I'm not sure how it really started, but we  
 7 definitely had some discussions, yes.  
 8 COFFEY, Q.C.:  
 9 Q. And how did this "Client Hand-out" come to be  
 10 prepared, do you know?  
 11 DR. DANKWA:  
 12 A. I can't remember exactly how it did, but I  
 13 know that I had discussions with Alison Dower,  
 14 who is our communications, media  
 15 communications manager and so I would have  
 16 discussed having some information as to how we  
 17 are handling cases.  
 18 COFFEY, Q.C.:  
 19 Q. So, the information contained here on page 10  
 20 of the exhibit entitled "Client Hand-out",  
 21 would some of this information for her come  
 22 from you?  
 23 DR. DANKWA:  
 24 A. Some of it might have, yes.  
 25 COFFEY, Q.C.:

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1 Q. Doctor, here the "what is happening now, why  
 2 are some test results different", the second  
 3 last paragraph says, "Labrador Grenfell Health  
 4 will be submitting previously collected tissue  
 5 samples to Eastern Health for this retesting.  
 6 Patients will not be required to come to  
 7 hospital or have any additional testing.  
 8 Please note, only a small percentage of breast  
 9 cancer patients may be affected by this  
 10 retesting".  
 11 DR. DANKWA:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. At that point in time, did you have any  
 15 understanding or had anybody given you any  
 16 understanding as to how many might be affected  
 17 by this?  
 18 DR. DANKWA:  
 19 A. No.  
 20 COFFEY, Q.C.:  
 21 Q. So, the assertion that only a small percentage  
 22 of them might be affected, was that your  
 23 thought at the time?  
 24 DR. DANKWA:  
 25 A. No, it think they were probably gathering,

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1 through my discussions with them, they wanted  
 2 to know maybe the numbers of cases that we  
 3 were looking at. And I might have given them  
 4 the 2002 information.  
 5 COFFEY, Q.C.:  
 6 Q. That would be, for example, it would be six  
 7 negatives out of approximately 20 a year.  
 8 DR. DANKWA:  
 9 A. Yes, exactly, yes.  
 10 COFFEY, Q.C.:  
 11 Q. That had to be retested.  
 12 DR. DANKWA:  
 13 A. Exactly.  
 14 COFFEY, Q.C.:  
 15 Q. Doctor, the notion at that point then of when  
 16 you're speaking to Dr. Jong, September/October  
 17 2005, did the subject of patient notification  
 18 come up, notifying patients about the fact  
 19 that they were being retested at all?  
 20 DR. DANKWA:  
 21 A. No, when the initial request came through, I  
 22 looked--with my discussions with Dr. Jong, no,  
 23 I don't remember us discussing that, no.  
 24 COFFEY, Q.C.:  
 25 Q. And if patients were to be notified, you know,

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1 by Labrador Grenfell of the fact that their  
 2 tissue was being retested, whose decision  
 3 would that be? At what level in your  
 4 organization would that occur? Would that be  
 5 your decision or Dr. Jong's, to actually  
 6 contact the patients and tell them, your  
 7 tissue is being retested.  
 8 DR. DANKWA:  
 9 A. If it was something that was out--the best  
 10 example I can give is if someone is doing a  
 11 research on a patient, then it is the person  
 12 who is performing the research would have to  
 13 identify what they are doing and communicate  
 14 with a patient, yes.  
 15 COFFEY, Q.C.:  
 16 Q. That's research.  
 17 DR. DANKWA:  
 18 A. Research, yes.  
 19 COFFEY, Q.C.:  
 20 Q. Now, did you -  
 21 DR. DANKWA:  
 22 A. I didn't view this as a research. I viewed  
 23 this as a clinical service.  
 24 COFFEY, Q.C.:  
 25 Q. And does Labrador Grenfell have a disclosure

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1 policy do you know? Disclosure in the sense  
 2 of if there's an adverse event or a potential  
 3 adverse event.  
 4 DR. DANKWA:  
 5 A. If--yes. We have a form that we complete and  
 6 it goes through the chain informing different  
 7 levels what had happened, what measures had  
 8 been taken.  
 9 COFFEY, Q.C.:  
 10 Q. Was any such form ever filled out here for  
 11 this?  
 12 DR. DANKWA:  
 13 A. No, no.  
 14 COFFEY, Q.C.:  
 15 Q. Why not?  
 16 DR. DANKWA:  
 17 A. I didn't see this as an adverse reaction, at  
 18 least, I saw it as a clinical issue that we're  
 19 trying to work through and we hadn't really  
 20 had any results really to work with. So, that  
 21 is how I saw it.  
 22 COFFEY, Q.C.:  
 23 Q. And were there--I'll just skip ahead--were  
 24 there any patients with conversions in St.  
 25 Anthony?

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1 DR. DANKWA:  
 2 A. There were some patients that had conversion,  
 3 yes.  
 4 COFFEY, Q.C.:  
 5 Q. And in relation to those patients, has any  
 6 such form been filled out?  
 7 DR. DANKWA:  
 8 A. No.  
 9 COFFEY, Q.C.:  
 10 Q. Looking back on it, should there have been one  
 11 filled out for the patients when you knew  
 12 there was a change result, conversion with a  
 13 treatment change?  
 14 DR. DANKWA:  
 15 A. It's difficult -  
 16 MR. BROWNE:  
 17 Q. Excuse me, it's maybe a difficult question -  
 18 COFFEY, Q.C.:  
 19 Q. I appreciate that, it may be too. Doctor,  
 20 I'll just ask you, did it even occur to you in  
 21 this particular context to fill out such a  
 22 form?  
 23 DR. DANKWA:  
 24 A. No.  
 25 COFFEY, Q.C.:

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1 Q. Okay. And I take it that this form is the  
 2 sort of form that you'd fill out, an  
 3 individual patient, an individual event.  
 4 DR. DANKWA:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. That's the sort of mindset.  
 8 DR. DANKWA:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. Here in terms of the conversions that did  
 12 occur and treatment changes that did occur for  
 13 Authority's patients, bearing in mind what the  
 14 policy is within your institution, would these  
 15 cases fit that policy?  
 16 DR. DANKWA:  
 17 A. I haven't seen that policy being used in that  
 18 sense. So, it wasn't something that really  
 19 struck me, otherwise we would have completed  
 20 it, yes.  
 21 COFFEY, Q.C.:  
 22 Q. Certainly if it had struck you and you thought  
 23 it was applicable, you would have -  
 24 DR. DANKWA:  
 25 A. I would have completed it, yes.

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1 COFFEY, Q.C.:  
 2 Q. Doctor, now you've described there's a policy  
 3 that if there is an adverse event, you have to  
 4 report it up the chain.  
 5 DR. DANKWA:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. How about, is there an adverse events policy  
 9 that your authority has to deal with informing  
 10 the patient about the adverse event? For  
 11 example, Eastern Health has a written policy,  
 12 all spelled out about if an adverse event  
 13 happens, certain things have to happen  
 14 including telling the patient about it.  
 15 DR. DANKWA:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. Is there such a policy in Labrador Grenfell do  
 19 you know?  
 20 DR. DANKWA:  
 21 A. We do, the policy that we have, it's a form  
 22 and there is a step-by-step process of what--  
 23 we do have something along that line, yes.  
 24 COFFEY, Q.C.:  
 25 Q. Okay. And if I could then, after you finish

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1 here today, when you return to St. Anthony, if  
 2 you'd make inquiries and perhaps through your  
 3 counsel -  
 4 DR. DANKWA:  
 5 A. And get a copy.  
 6 COFFEY, Q.C.:  
 7 Q. - and provide a copy to us?  
 8 DR. DANKWA:  
 9 A. Sure.  
 10 COFFEY, Q.C.:  
 11 Q. This policy or these policies--policy, sorry.  
 12 DR. DANKWA:  
 13 A. It's a form, yes.  
 14 COFFEY, Q.C.:  
 15 Q. A form, how long has that been in effect?  
 16 DR. DANKWA:  
 17 A. As far as I've known, it is.  
 18 COFFEY, Q.C.:  
 19 Q. It's been there for years?  
 20 DR. DANKWA:  
 21 A. Yes.  
 22 MR. BROWNE:  
 23 Q. Excuse me, Mr. Coffey, maybe (inaudible) I  
 24 think you may be referring to an incident  
 25 report, this -

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1 COFFEY, Q.C.:

2 Q. Yes, adverse event and that's quite -

3 MR. BROWNE:

4 Q. (Inaudible).

5 COFFEY, Q.C.:

6 Q. So, this form, do you know, does it say--Mr.

7 Browne makes the point that maybe it's an

8 incident -

9 DR. DANKWA:

10 A. Incident, yes, incident, yes, that's the way

11 we refer to it most of the time, yes.

12 COFFEY, Q.C.:

13 Q. That's the way you would phrase -

14 DR. DANKWA:

15 A. Yes.

16 COFFEY, Q.C.:

17 Q. An adverse event, is that recognized within

18 Labrador Grenfell's approach to -

19 DR. DANKWA:

20 A. It is, but my belief, I may be mistaken on it,

21 my belief is that we've used the same form for

22 it, yes.

23 THE COMMISSIONER:

24 Q. Just so that I'm clear, you're asking the

25 witness to identify whatever forms relate to

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1 either an incident or an adverse event, if

2 they so exist within his organization and to

3 communicate those to us through his counsel?

4 COFFEY, Q.C.:

5 Q. Yes.

6 DR. DANKWA:

7 A. Yes.

8 THE COMMISSIONER:

9 Q. Thank you.

10 COFFEY, Q.C.:

11 Q. Doctor, if you could, just looking at Dr.

12 Jong's memo to all the staff, here, of course,

13 I've read it out, it's being prepared for

14 physicians, public health nurses and other

15 groups to provide to their clients who may

16 have concerns about this ER/PR matter.

17 Doctor, did you ever take any steps to

18 communicate with clinicians in your health

19 authority area concerning the ER/PR matter

20 itself?

21 DR. DANKWA:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. Could you tell the Commissioner about that?

25 DR. DANKWA:

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1 A. We do have regular medical staff meetings and

2 during those medical staff meetings, I update

3 them on the ER/PR -

4 COFFEY, Q.C.:

5 Q. I take it, that's really from September 2005

6 onward.

7 DR. DANKWA:

8 A. Right on, yes, because I knew that questions

9 would be coming for it and they would be

10 involved.

11 COFFEY, Q.C.:

12 Q. And so what would you inform them about? What

13 sorts of things?

14 DR. DANKWA:

15 A. I would be telling them about what we're doing

16 with respect to collection of samples, having

17 them retested and when the results came, how

18 it would be redistributed.

19 COFFEY, Q.C.:

20 Q. Okay. Now Doctor, what then happened then as

21 the fall of 2005 went on in relation to

22 identifying the patients? You've indicated

23 that in October 2005 you got this spreadsheet

24 from St. John's.

25 DR. DANKWA:

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1 A. It was printed out towards the end of October,

2 but might have gotten it some time in

3 November.

4 COFFEY, Q.C.:

5 Q. And then having received that spreadsheet,

6 what did you do?

7 DR. DANKWA:

8 A. We started going through the list identifying

9 all those cases and looking at the reports and

10 looking at ER/PR status on that, identifying

11 those that fell within the criteria and then

12 went back to identify the slides and the

13 blocks from the archives?

14 COFFEY, Q.C.:

15 Q. And then what happened, Doctor?

16 DR. DANKWA:

17 A. And we identified all of them by--it was

18 towards, I think, Christmas break of that

19 period and we held onto them because we were

20 concerned that we might lose them if we send

21 them by mail to the Health Sciences Centre

22 around that period.

23 COFFEY, Q.C.:

24 Q. Over the Christmas holidays.

25 DR. DANKWA:

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1 A. Over the Christmas holiday breaks, the mailing  
 2 system, so -  
 3 COFFEY, Q.C.:  
 4 Q. And from your perspective, although they were  
 5 ready before Christmas, you were concerned  
 6 that because of the mail volume, you didn't  
 7 want to put them in the mail.  
 8 DR. DANKWA:  
 9 A. Yes, I don't want to risk it, yes. We've had  
 10 experience before, so.  
 11 COFFEY, Q.C.:  
 12 Q. And so the ER/PR negative cases, okay, other  
 13 than the six that went in September -  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. - 2005, September 8th, 2005, all the others  
 18 from St. Anthony in the kind of first grouping  
 19 were sent in January, in fact, send in January  
 20 of 2006.  
 21 DR. DANKWA:  
 22 A. Yes, yes.  
 23 COFFEY, Q.C.:  
 24 Q. So, they were all gathered up -  
 25 DR. DANKWA:

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1 A. Yes, and sent on.  
 2 COFFEY, Q.C.:  
 3 Q. All the years and sent off.  
 4 DR. DANKWA:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. Okay. And Doctor, what then happened?  
 8 DR. DANKWA:  
 9 A. Waited for the results to come back.  
 10 COFFEY, Q.C.:  
 11 Q. And then what happened, Doctor?  
 12 DR. DANKWA:  
 13 A. We had a spreadsheet faxed to us, I think it  
 14 was in March with the results.  
 15 COFFEY, Q.C.:  
 16 Q. Okay.  
 17 DR. DANKWA:  
 18 A. And there was a meeting, a conference call to  
 19 tell us about how it was going to be--the  
 20 results were going to be sent out and the  
 21 results were then transcribed and sent to us.  
 22 COFFEY, Q.C.:  
 23 Q. So, this conference call was with whom?  
 24 DR. DANKWA:  
 25 A. Well, this was with all pathologists and

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1 including the Health Sciences Centre.  
 2 COFFEY, Q.C.:  
 3 Q. And who is the spokesperson for the Health  
 4 Sciences Centre?  
 5 DR. DANKWA:  
 6 A. I think it was Don Cook, yes.  
 7 COFFEY, Q.C.:  
 8 Q. And what were you told about how the results  
 9 then--you had already got a spreadsheet giving  
 10 you the results.  
 11 DR. DANKWA:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. What were you told about what would happen?  
 15 DR. DANKWA:  
 16 A. They were going to transcribe the results in a  
 17 report format and send them to us. And when  
 18 we get them, we have to send them, a copy, to  
 19 the family physician and to the surgeon, when  
 20 we get them. And that was a part--I think a  
 21 copy to us to go to the oncologist as well.  
 22 COFFEY, Q.C.:  
 23 Q. So, Doctor, and these individual reports  
 24 eventually came?  
 25 DR. DANKWA:

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1 A. Yes, they did.  
 2 COFFEY, Q.C.:  
 3 Q. And you did what with the reports?  
 4 DR. DANKWA:  
 5 A. We first transcribed them into our MediTec  
 6 system.  
 7 COFFEY, Q.C.:  
 8 Q. Who signed them in.  
 9 DR. DANKWA:  
 10 A. I signed them in. And then we release a copy  
 11 to the surgeon, copy to the family physician  
 12 and a copy to the oncologist with the original  
 13 letter than came--the original report.  
 14 COFFEY, Q.C.:  
 15 Q. If we could, please, Exhibit P-1091. Doctor,  
 16 here there's a memo, this is February 1st,  
 17 2006, it's again to pathologists throughout  
 18 Newfoundland or at least certain people, heads  
 19 of various laboratories. You're listed there  
 20 as the third last in this row, I'm sorry, this  
 21 column. It says, "we've received most of the  
 22 results from Mount Sinai regarding ER/PR  
 23 process. The results from Mount Sinai were  
 24 issued on Excel spreadsheets. I will be  
 25 issuing individual reports on patients and



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1 submitting these to you at your respective  
 2 sites. When you receive these reports, please  
 3 ensure that are incorporated into your  
 4 hospital information or laboratory information  
 5 systems. I expect that you will be receiving  
 6 the first of these reports within the next two  
 7 weeks. Signed, Donald Cook".  
 8 Now, Doctor, did you have any  
 9 understanding about what would happen with  
 10 respect to reviewing the results in the sense  
 11 that, changed results and how they would be  
 12 handled?  
 13 DR. DANKWA:  
 14 A. My understanding was there was going to be a  
 15 panel set up and that panel -  
 16 COFFEY, Q.C.:  
 17 Q. Where did you get that understanding?  
 18 DR. DANKWA:  
 19 A. Oh, I think, again, it was one of our  
 20 conference calls that was made. It was going  
 21 to be the process, when they got the result,  
 22 they would review it as a group with the  
 23 pathologist and oncologist to determine  
 24 whether there is a need to alter the treatment  
 25 or not.

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1 COFFEY, Q.C.:  
 2 Q. From your perspective, did you have any  
 3 concerns or problems about such a group being  
 4 involved? Was there anything that struck you  
 5 that, any reluctance you had to have the cases  
 6 from St. Anthony go through that panel?  
 7 DR. DANKWA:  
 8 A. No, I didn't have any problems, no.  
 9 COFFEY, Q.C.:  
 10 Q. Doctor, the patients from St. Anthony who went  
 11 through the panel process and treatment  
 12 changes were advised or not, as the case might  
 13 be, do you know how those patients were  
 14 informed?  
 15 DR. DANKWA:  
 16 A. My understanding was that those who needed,  
 17 who had an altered treatment or mode of  
 18 treatment would be sent a panel letter through  
 19 the other GPs or surgeons as well. And they  
 20 would be responsible to contact the patients.  
 21 COFFEY, Q.C.:  
 22 Q. The individual attending physicians.  
 23 DR. DANKWA:  
 24 A. Attending physicians, yes.  
 25 COFFEY, Q.C.:

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1 Q. So, those panelling letters, I'll call them,  
 2 you did not expect in your capacity at VP,  
 3 Associate VP in Labrador Grenfell to actually  
 4 get a copy.  
 5 DR. DANKWA:  
 6 A. No, no.  
 7 COFFEY, Q.C.:  
 8 Q. Did you receive a copy?  
 9 DR. DANKWA:  
 10 A. I never did, no.  
 11 COFFEY, Q.C.:  
 12 Q. Exhibit P-2204, please. Now Doctor, this is  
 13 an e-mail from yourself, March 17th, 2006 to  
 14 Dr. Jong and you say, "Hello Michael, this is  
 15 the follow up of our discussion on this issue.  
 16 On March 6th, 2006 we received the spreadsheet  
 17 printout of the results of the repeat tests  
 18 done in Toronto on the cases from our region.  
 19 On the form there's an indication of the  
 20 receipt of our cases in Toronto on January  
 21 24th, 2006. As I explained, the cases were  
 22 sent from St. Anthony to St. John's and were  
 23 then forwarded to Toronto. For each case  
 24 there were the original slides, copies of the  
 25 original report and the block on which the

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1 tests were performed. I presume St. John's  
 2 must have received our cases at the latest by  
 3 mid January. As you may recall there was an  
 4 initial discussion as to what the direction  
 5 might be on the ER/PR situation during the  
 6 fall of last year. During that period,  
 7 requests came in piecemeal up until November  
 8 when a general call in for all cases. We  
 9 received a list from the cancer foundation  
 10 just before Christmas on the remainder of our  
 11 cases. Those cases were sent in January and  
 12 the results included in the spreadsheet  
 13 mentioned". That is the results in this  
 14 context, I take it, is your search.  
 15 DR. DANKWA:  
 16 A. Yes, my cases.  
 17 COFFEY, Q.C.:  
 18 Q. Cases. "I'm still puzzled as to what St.  
 19 John's may have received recently from us. I  
 20 hope this clarifies the situation. Thanks".  
 21 Doctor, I take it, the first part of this  
 22 generally is just a summary of what was going  
 23 on in March.  
 24 DR. DANKWA:  
 25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. And then there's an account here in the middle

3 of the e-mail about what had happened in late

4 2005. Had there been any issue come to your

5 attention, any concern expressed by anybody

6 about St. Anthony not getting their cases in

7 until January of '06? Did anybody raise a

8 complaint about that?

9 DR. DANKWA:

10 A. No, the first time I got any hints were when

11 Michael Jong called me and other discussions.

12 COFFEY, Q.C.:

13 Q. And what did Dr. Jong say to you about that?

14 DR. DANKWA:

15 A. They had had a VP medical meeting and it was

16 there that he got the inference that we may

17 not have sent our cases, we may not have sent

18 our cases.

19 COFFEY, Q.C.:

20 Q. May not have sent them or may have sent them

21 late.

22 DR. DANKWA:

23 A. The impression I was getting from him, I may

24 have misunderstood him, but it sounded almost

25 as if we hadn't even sent our cases yet.

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1 COFFEY, Q.C.:

2 Q. Okay.

3 DR. DANKWA:

4 A. So, it really took me by surprise because we

5 had the results of those cases.

6 COFFEY, Q.C.:

7 Q. And then final reference you say, "I'm still

8 puzzled as to what St. John's may have

9 received recently from us". What were you

10 talking about there?

11 DR. DANKWA:

12 A. Yes, because it also sounded that if there was

13 anything sent, they had just recently received

14 it, but I had results. So, I wasn't sure what

15 it was that I had sent to them that they had

16 just recently received.

17 COFFEY, Q.C.:

18 Q. So, did you make any further inquiries in that

19 regard to have that final sentence clarified

20 as to what -

21 DR. DANKWA:

22 A. It was Michael Jong, I mean, he didn't really

23 get back to me with anything further on that.

24 COFFEY, Q.C.:

25 Q. Now, if we could, Exhibit P-2203, please. Now

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1 Doctor, I apologize, for the quality of this,

2 but there you have it. Thank you. Do you

3 recognize this, Doctor?

4 DR. DANKWA:

5 A. Yes, I do.

6 COFFEY, Q.C.:

7 Q. And is this the spreadsheet you referred to in

8 your e-mail?

9 DR. DANKWA:

10 A. Yes.

11 COFFEY, Q.C.:

12 Q. And so it's ER/PR received from St. Anthony

13 site January 24th, '06.

14 DR. DANKWA:

15 A. Yes, that's right.

16 COFFEY, Q.C.:

17 Q. And there's a listing then, well the RS

18 numbers are redacted, the surgical numbers are

19 there. I take it these are St. Anthony

20 surgical numbers?

21 DR. DANKWA:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. And then there's a block number or block

25 identification, the patients' names are

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1 redacted and then there's the tumour or tumour

2 classification column and then there's a

3 column for ER, PR and a reference to IC,

4 probably internal control and fixation would

5 be the final column?

6 DR. DANKWA:

7 A. Yes.

8 COFFEY, Q.C.:

9 Q. Now, Doctor, these then I take it were the

10 reported results from Mount Sinai?

11 DR. DANKWA:

12 A. Right, yes.

13 COFFEY, Q.C.:

14 Q. And you understood that they would be

15 reporting on the slides that they had created?

16 DR. DANKWA:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. Doctor, did you ever have occasion or have you

20 ever had occasion to compare the results here

21 to the original results reported from your

22 institution?

23 DR. DANKWA:

24 A. Yes, I did look and made a comparison with it,

25 yes.

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1 COFFEY, Q.C.:

2 Q. Okay. And what did you find in comparison?

3 DR. DANKWA:

4 A. It looked like about 45 percent, around 45 to

5 50 percent had a change in the results.

6 COFFEY, Q.C.:

7 Q. Had a change in the results in the sense of

8 converted.

9 DR. DANKWA:

10 A. Yes, yes -

11 COFFEY, Q.C.:

12 Q. I shouldn't use that word.

13 DR. DANKWA:

14 A. Right, okay.

15 COFFEY, Q.C.:

16 Q. I apologize. Had a change in results -

17 DR. DANKWA:

18 A. Had a change in the results, yes.

19 COFFEY, Q.C.:

20 Q. Were there any, Doctor, that you had reported

21 as ER positive, low positive for example,

22 because otherwise it wouldn't have been

23 retested, that went to zero? Did you have any

24 what are called retro converters?

25 DR. DANKWA:

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1 A. No, I don't remember any such cases, yes.

2 COFFEY, Q.C.:

3 Q. And those cases then that were changed results

4 in, when you looked at them and compared them,

5 the original results and Mount Sinai's, do you

6 recall approximately how many or what

7 percentage or proportion had a significant

8 change in result as opposed to, like, moving

9 from, for example, ten to fifteen which Dr.

10 Mullen has told that wouldn't be remarkable.

11 DR. DANKWA:

12 A. Right.

13 COFFEY, Q.C.:

14 Q. Or even--I'm thinking about the change from,

15 for example, from five to 95.

16 DR. DANKWA:

17 A. Right, looking roughly about 40 percent or

18 thereabouts, yes.

19 COFFEY, Q.C.:

20 Q. Okay. Do you have any thoughts then about why

21 that might be so. Like, how could it go from,

22 the results that you had, based upon the

23 slides that you had received over the years

24 from '98 through 2005 and they're retested in

25 Mount Sinai in 2005 or '06, what could account

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1 for the change in results in about 40 percent

2 of cases?

3 DR. DANKWA:

4 A. In this situation, we are looking at different

5 slides. We are looking at the same slides

6 that would be probably, would have a different

7 discussion.

8 COFFEY, Q.C.:

9 Q. Yes.

10 DR. DANKWA:

11 A. Looking at a different slide, so there are

12 many factors that would come into play here.

13 The technology is the first thing that comes

14 to mind and that is assuming that we are

15 talking about the same blocks and the same

16 tissues because there are changes from--you

17 can get changes from one block to the next and

18 one and from one slide to the next section.

19 So, I would, barring everything, barring the

20 fact that we may have different ways of

21 viewing the same thing, I would feel that it

22 would be the technology application to the

23 tissues.

24 COFFEY, Q.C.:

25 Q. The processing the tissue into the block to do

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1 a slide.

2 DR. DANKWA:

3 A. And the staining--from the slide, from the

4 blank slide to a stained slide, that process,

5 would make a big difference.

6 COFFEY, Q.C.:

7 Q. I'll have you then--so, form your perspective,

8 looking at it and reflecting upon it, because

9 a block, I take it--if it's the same block used

10 at Mount Sinai as was used in St. John's when

11 you ordered -

12 DR. DANKWA:

13 A. Yes, would be the same, I'm looking at it the

14 same, yes, but we know too that from one level

15 to another, there could be a change, yes.

16 COFFEY, Q.C.:

17 Q. But--and I appreciate it--so, generally though

18 Doctor, assuming that it's generally within

19 the same tissue -

20 DR. DANKWA:

21 A. Yes, sure, yes.

22 COFFEY, Q.C.:

23 Q. You would have understood that in St. John's,

24 say in 2002, they created a slide, they

25 created the tissue to go onto the slide,

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1 processed it, stained it, you get to read it.  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. Mount Sinai, in effect, did the same thing?  
 6 DR. DANKWA:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. Except you didn't read it, Dr. Mullen did.  
 10 DR. DANKWA:  
 11 A. No.  
 12 COFFEY, Q.C.:  
 13 Q. You attribute the difference in what appear on  
 14 the slide to what occurred between the block  
 15 sitting there --  
 16 DR. DANKWA:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. That process, going onto the slide itself --  
 20 DR. DANKWA:  
 21 A. And then staining --  
 22 COFFEY, Q.C.:  
 23 Q. And the staining, the final version of the  
 24 stain --  
 25 DR. DANKWA:

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. Whatever happened in between --  
 4 DR. DANKWA:  
 5 A. Whatever happened, yes, throughout that  
 6 period, yes.  
 7 COFFEY, Q.C.:  
 8 Q. And have you had an opportunity, Doctor, to  
 9 look at the original slides for these  
 10 patients?  
 11 DR. DANKWA:  
 12 A. No, I haven't.  
 13 COFFEY, Q.C.:  
 14 Q. In the sense of now?  
 15 DR. DANKWA:  
 16 A. No, to compare it, no, I haven't.  
 17 COFFEY, Q.C.:  
 18 Q. Would you be interested in doing so?  
 19 DR. DANKWA:  
 20 A. Oh, very much so, yes.  
 21 COFFEY, Q.C.:  
 22 Q. What would you be looking for?  
 23 DR. DANKWA:  
 24 A. Well, just looking because of what we've heard  
 25 about what we have or have not looked, and

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1 what we've missed or overlooked. It would be  
 2 nice to look at it and reflect back on what I  
 3 thought I had seen.  
 4 COFFEY, Q.C.:  
 5 Q. If we could, please, Exhibit P-2206. Doctor,  
 6 what are these? These are letters dated March  
 7 19th, 2006, they're addressed to different  
 8 doctors.  
 9 DR. DANKWA:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. And the text -- I'll read the first text,  
 13 "Enclosed are results from the recent  
 14 retesting of all negative ER and PRs for  
 15 clients in our region. Since the surgeon that  
 16 has completed the procedure is no longer with  
 17 us, I'm forwarding a copy of the results to  
 18 you for your information", and then there's a  
 19 second doctor, Dr. Forsey, in the top right  
 20 hand side, "As a result of the recent  
 21 retesting of all negative ER and PR clients in  
 22 our region, I am enclosing a copy of these  
 23 reports for your information". There's two  
 24 other doctors listed there and, in fact, when  
 25 we turn to the next page, we'll see more.

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1 DR. DANKWA:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. What were they about, Doctor?  
 5 DR. DANKWA:  
 6 A. These were cover letters I had to go with the  
 7 retested results to the doctors to inform them  
 8 about it so that they are made aware of it.  
 9 COFFEY, Q.C.:  
 10 Q. So what would be attached to this?  
 11 DR. DANKWA:  
 12 A. This would be the report. The report --  
 13 COFFEY, Q.C.:  
 14 Q. That's that page or two page report?  
 15 DR. DANKWA:  
 16 A. Yes, from the -- transcribed report from Mount  
 17 Sinai, yes.  
 18 COFFEY, Q.C.:  
 19 Q. So would you send them a copy of Don Cook's  
 20 report, or your version of Don Cook's --  
 21 DR. DANKWA:  
 22 A. My version of Don Cook's report, but Don  
 23 Cook's report and my version will go to the  
 24 oncologist.  
 25 COFFEY, Q.C.:

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1 Q. Doctor, were you involved -- the Commissioner  
 2 has heard about some patients who fell into  
 3 the category of DCIS.  
 4 DR. DANKWA:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. And Mount Sinai reported certain patients as  
 8 DCIS and then some attention or inquiry  
 9 occurred into whether or not they were really  
 10 DCIS or not.  
 11 DR. DANKWA:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. Were you involved -- were any of your patients  
 15 involved in that?  
 16 DR. DANKWA:  
 17 A. I had one case of DCIS, but that was also  
 18 confirmed as a DCIS, and her test as far as I  
 19 remember was not repeated.  
 20 COFFEY, Q.C.:  
 21 Q. Okay, and you had originally --  
 22 DR. DANKWA:  
 23 A. Done it.  
 24 COFFEY, Q.C.:  
 25 Q. Done it as DCIS?

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1 DR. DANKWA:  
 2 A. Yes, yes.  
 3 COFFEY, Q.C.:  
 4 Q. You had classified the patient as DCIS?  
 5 DR. DANKWA:  
 6 A. Yes, I had.  
 7 COFFEY, Q.C.:  
 8 Q. And Mount Sinai --  
 9 DR. DANKWA:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. Did the same thing?  
 13 DR. DANKWA:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. Doctor, were you involved at all in notifying  
 17 patients about their results in the sense of  
 18 directly?  
 19 DR. DANKWA:  
 20 A. No, no, it always went to the clinician, and  
 21 the clinician notified the patients.  
 22 COFFEY, Q.C.:  
 23 Q. How about patients whose results were  
 24 confirmed by Mount Sinai to be negative?  
 25 DR. DANKWA:

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1 A. They were also notified.  
 2 COFFEY, Q.C.:  
 3 Q. And who notified them?  
 4 DR. DANKWA:  
 5 A. It's all the clinicians.  
 6 COFFEY, Q.C.:  
 7 Q. In St. Anthony?  
 8 DR. DANKWA:  
 9 A. In St. Anthony, yes, and in Goose Bay as well.  
 10 COFFEY, Q.C.:  
 11 Q. It was the doctors doing it?  
 12 DR. DANKWA:  
 13 A. The doctors doing it, yes.  
 14 COFFEY, Q.C.:  
 15 Q. And it was done through the mechanism of you  
 16 sending out these reports with a covering  
 17 letter?  
 18 DR. DANKWA:  
 19 A. Correct.  
 20 COFFEY, Q.C.:  
 21 Q. And you understood that in them getting --  
 22 those doctors getting those letters and  
 23 reports, it would be up to them to tell the  
 24 patients?  
 25 DR. DANKWA:

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1 A. That's correct, yeah.  
 2 COFFEY, Q.C.:  
 3 Q. Doctor, what's your then next memory? Okay,  
 4 this is, I take it, in the spring -- winter  
 5 and spring, certainly where you are, in March  
 6 and April of '06, notifying the patients.  
 7 What's your next memory then of the ER/PR  
 8 matter, your involvement? Do you have any --  
 9 DR. DANKWA:  
 10 A. I don't have a --  
 11 COFFEY, Q.C.:  
 12 Q. If I could, please, then Exhibit P-2207.  
 13 Doctor, this is an e-mail from Denise Dunn,  
 14 who is the Executive Assistant to Dr. Oscar  
 15 Howell, VP Medical Services, Eastern Health,  
 16 Friday, November 17th, 2006. It's to a number  
 17 of doctors, and you'll see that your name is  
 18 right there.  
 19 DR. DANKWA:  
 20 A. That's right.  
 21 COFFEY, Q.C.:  
 22 Q. The subject is "An ER/PR November 20th 5:15  
 23 videoconference sites", and below that the e-  
 24 mail, again the same date to a number of  
 25 doctors, including yourself, "Videoconference

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1 sites have been set up to view Dr Denic's  
 2 presentation from the main auditorium, Health  
 3 Sciences Centre, as follows", and there's a  
 4 particular time. So, Doctor, do you recall  
 5 whether in November, 2006, you were invited to  
 6 participate in a videoconference?  
 7 DR. DANKWA:  
 8 A. Yes, I do.  
 9 COFFEY, Q.C.:  
 10 Q. And can you tell the Commissioner about how  
 11 that came about and what you recall about it?  
 12 DR. DANKWA:  
 13 A. We have this e-mail coming. It was also  
 14 followed by phone calls to make sure that  
 15 those of us who have facility to set up  
 16 videoconference in were prepared to  
 17 participate in this. This was basically a  
 18 conference that was notifying us about where  
 19 they are over the issues of the ER/PR, and  
 20 what that are looking at in a go forward  
 21 basis, and at that conference Dr. Ford Elms  
 22 did a presentation as to what he had learned,  
 23 having gone out to the United States to get  
 24 some experience in immunohistochemistry. That  
 25 was the main thrust of it, and to -- and the

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1 information too that Eastern Health was  
 2 looking at -- raised that and the ER/PR  
 3 testing.  
 4 COFFEY, Q.C.:  
 5 Q. Now in relation to the restarting -- I'll ask  
 6 you. The presentation that you saw that day --  
 7 DR. DANKWA:  
 8 A. Yes.  
 9 COFFEY, Q.C.:  
 10 Q. Slide shows -- slide presentations, were you  
 11 ever given a copy of those or offered a copy  
 12 of those?  
 13 DR. DANKWA:  
 14 A. No, I wasn't.  
 15 COFFEY, Q.C.:  
 16 Q. You were advised that Eastern Health was  
 17 restarting the ER and PR in St. John's?  
 18 DR. DANKWA:  
 19 A. Would be.  
 20 COFFEY, Q.C.:  
 21 Q. Or would be?  
 22 DR. DANKWA:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. Were you invited -- was St. Anthony invited to

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1 send their cases to St. John's?  
 2 DR. DANKWA:  
 3 A. I am not sure whether the initial phase, they  
 4 indicated that they were going to open it up  
 5 to everybody, but they were definitely going  
 6 to look at starting, but with the intention  
 7 that everybody would be sending their cases  
 8 there.  
 9 COFFEY, Q.C.:  
 10 Q. Okay. So subsequent to that videoconference,  
 11 and when you became aware, we understanding in  
 12 February of 2007, that the retesting started -  
 13 - I'm sorry, the testing restarted in St.  
 14 John's, can you tell us, please, whether  
 15 you've ever been approached since about  
 16 sending St. Anthony's cases to St. John's for  
 17 ER/PR?  
 18 DR. DANKWA:  
 19 A. Yes, it has happened, yes.  
 20 COFFEY, Q.C.:  
 21 Q. And when were you approached about that, do  
 22 you recall?  
 23 DR. DANKWA:  
 24 A. I can't remember the exact date, but in  
 25 between -- as soon as they started, they made

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1 it clear that they are open to accepting our  
 2 cases for retesting.  
 3 COFFEY, Q.C.:  
 4 Q. And I take it --  
 5 DR. DANKWA:  
 6 A. For testing, yes.  
 7 COFFEY, Q.C.:  
 8 Q. I take it that you have not taken them up on  
 9 the offer yet?  
 10 DR. DANKWA:  
 11 A. I haven't gone that way just yet.  
 12 COFFEY, Q.C.:  
 13 Q. And have you spoken to anybody about that?  
 14 DR. DANKWA:  
 15 A. No.  
 16 COFFEY, Q.C.:  
 17 Q. Okay, can you tell the Commissioner why you  
 18 haven't taken them up on that?  
 19 DR. DANKWA:  
 20 A. Well, I have been sending my cases on to Mount  
 21 Sinai since then, and my -- my view is since  
 22 they introduced a protocol about fixation  
 23 policies, I just felt that to -- they also  
 24 indicated that they would feel a bit more  
 25 comfortable if in reporting these cases we

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1 have met the times of their fixation policies,  
 2 and I felt that until such a time that we  
 3 could really clearly state, document evidence  
 4 that we have met those policies, I would feel  
 5 more comfortable sending it to another place  
 6 where they are willing to do that.  
 7 COFFEY, Q.C.:  
 8 Q. And, Doctor, I want to come back to that  
 9 before I conclude my questions for you,  
 10 Doctor, but if we could bring up, please,  
 11 Exhibit P-2208. Doctor, I understand that  
 12 there was a -- before I get into this  
 13 particular e-mail, there was a teleconference  
 14 in late May, 2007, involving the VP Medicals  
 15 after this became very public in May of 2007.  
 16 DR. DANKWA:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. Did you participate in that teleconference?  
 20 DR. DANKWA:  
 21 A. No, I didn't.  
 22 COFFEY, Q.C.:  
 23 Q. Who from your organization did?  
 24 DR. DANKWA:  
 25 A. If you are talking about VP Medicals, it may

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1 have been Michael Jong, Dr. Michael Jong.  
 2 COFFEY, Q.C.:  
 3 Q. Were you told about the results of the  
 4 teleconference in the sense of the subject  
 5 matter of who was sending their material into  
 6 St. John's?  
 7 DR. DANKWA:  
 8 A. Not as far as I can remember.  
 9 COFFEY, Q.C.:  
 10 Q. Okay. Doctor, here there's a series of e-  
 11 mails, July 10th and 11th, involving Boyd  
 12 Rowe, and to put this in context for you, this  
 13 is the -- Reza and the creation of the ER/PR  
 14 database request, and you referred to that  
 15 earlier today.  
 16 DR. DANKWA:  
 17 A. Yeah.  
 18 COFFEY, Q.C.:  
 19 Q. And here the last of these e-mails, July 11th  
 20 at 9:40 a.m. Don MacDonald is sending an e-  
 21 mail to Reza saying, "Reza, please contact Dr.  
 22 Dankwa to ensure we get the data we need".  
 23 What was this about, Doctor? The e-mail below  
 24 is, "Moirra, we have started work on this. I've  
 25 asked our pathologist, Dr. Dankwa, to be the

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1 contact person and I've forwarded your e-mail  
 2 to him".  
 3 DR. DANKWA:  
 4 A. I believe this would be in reference to the  
 5 Commission of Inquiry starting the  
 6 investigation.  
 7 COFFEY, Q.C.:  
 8 Q. And, I take it then, that you have provided  
 9 information to this organization that's  
 10 collecting the data?  
 11 DR. DANKWA:  
 12 A. Yes, with some initial difficulties, yes.  
 13 COFFEY, Q.C.:  
 14 Q. Yes. So if we could then, we'll take you up  
 15 on that difficulties issue when we come back.  
 16 DR. DANKWA:  
 17 A. Fine.  
 18 COMMISSIONER:  
 19 Q. Okay, we'll take the afternoon break.  
 20 (RECESS)  
 21 COMMISSIONER:  
 22 Q. Mr. Coffey.  
 23 COFFEY, Q.C.:  
 24 Q. Thank you, Commissioner. Doctor, a couple of  
 25 other things before I get into 2000 and the

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1 end of 2007, and early '08, if we could,  
 2 please, Registrar, Exhibit P-1811. Now,  
 3 Doctor, I appreciate this e-mail was neither -  
 4 - neither came from nor was it sent to you,  
 5 but it's dated January 20th, 2006, and it's  
 6 between Dr. Mullen and Dr. Cook. In effect,  
 7 Dr. Mullen is saying, "Attached please find  
 8 the ER/PR results for the Newfoundland  
 9 Retrospective Review", at least up to that  
 10 point, and he concludes by saying, "When you  
 11 have had an opportunity", that's "you", Dr.  
 12 Cook, "have had an opportunity to review the  
 13 results, I would like to discuss some of the  
 14 technical difficulties we encountered with  
 15 processing and staining the specimens. Some  
 16 of the same issues are present in the current  
 17 Newfoundland and Labrador material". Doctor,  
 18 has anyone ever spoken to you about concerns  
 19 about fixation of tissue in the Labrador  
 20 Grenfell area?  
 21 DR. DANKWA:  
 22 A. This is I presume since we started sending out  
 23 cases as a go forward to Mount Sinai?  
 24 COFFEY, Q.C.:  
 25 Q. Yes.

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1 DR. DANKWA:  
 2 A. No.  
 3 COFFEY, Q.C.:  
 4 Q. And from your perspective, if -- your  
 5 understanding with Dr. Mullen, I take it, is  
 6 that if he has a problem with reporting your  
 7 cases, being able to validly report your  
 8 cases, he will let you know?  
 9 DR. DANKWA:  
 10 A. I would expect so, yes.  
 11 COFFEY, Q.C.:  
 12 Q. Now, Doctor, bearing in mind the geographic  
 13 realities of the vast area that -- certainly  
 14 it's vast from my perspective, Labrador City  
 15 to St. Anthony is a long way, and Goose Bay to  
 16 St. Anthony are long ways, geographically, but  
 17 by transport, I mean, transportation.  
 18 DR. DANKWA:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Doctor, in terms of fixation of tissue, as the  
 22 pathologist for Labrador Grenfell, from your  
 23 perspective, what is achievable in terms of  
 24 optimizing fixation, and does it depend upon  
 25 where it's coming from, Goose Bay versus

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1 Labrador City, and St. Anthony?  
 2 DR. DANKWA:  
 3 A. I think when you talk about optimizing, you  
 4 mean adequate fixation?  
 5 COFFEY, Q.C.:  
 6 Q. Yeah, and I appreciate you make the  
 7 distinction, Doctor, because there's a  
 8 difference between adequate, which is adequate  
 9 for the purpose --  
 10 DR. DANKWA:  
 11 A. Right, yes.  
 12 COFFEY, Q.C.:  
 13 Q. You know, to be able to properly do your job.  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. Versus optimizing.  
 18 DR. DANKWA:  
 19 A. Optimizing, okay.  
 20 COFFEY, Q.C.:  
 21 Q. What do you --  
 22 DR. DANKWA:  
 23 A. If you use optimizing, like, really want to  
 24 fix and process a tissue within 12 to 24 hours  
 25 time, that will be a major challenge because

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1 you literally have to have flights available  
 2 sending in the specimen literally as they come  
 3 out of the patient, to me, that time and  
 4 sequence, but to have fixation that is  
 5 sufficiently good enough to get these tests  
 6 done, that is possible, yes.  
 7 COFFEY, Q.C.:  
 8 Q. Doctor, if we could, please, Exhibit P-2209.  
 9 Actually, I apologize, before I go to that,  
 10 Registrar, Exhibit P-2272. Doctor, the first  
 11 page of this involves Dr. Neil, but the second  
 12 page of the exhibit is an e-mail from Nash  
 13 Denic to Judy Thomas, May 31st, 2007, and  
 14 there are a number of -- the subject is  
 15 memorandum, and there are a number of  
 16 attachments. You'll see them listed there;  
 17 synoptic DCIS, and they're all listed out  
 18 here, and below it there's a text of a  
 19 memorandum to pathologists in Newfoundland.  
 20 It's from Dr. Nash Denic, Clinical Chief,  
 21 Laboratory Medicine Program, Dr. Beverley  
 22 Carter, breast pathology subspecialty group  
 23 leader, and Dr. Joy McCarthy, Chair, breast  
 24 disease site group, Cancer Care Program,  
 25 Eastern Health. It's dated May 31st, 2007,

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1 and the subject is re; breast pathology.  
 2 Doctor, just look at this, it begins by  
 3 saying, "Please find enclosed a number of  
 4 evidence based policies in current use at the  
 5 St. John's Hospitals of Eastern Health. These  
 6 policies refer to the grossing and reporting  
 7 of breast specimens. These policies directly  
 8 address items that were identified in recent  
 9 ER review as possible contributing factors",  
 10 and it goes on from there. Now have you ever  
 11 received a copy of -- not the e-mail, but the  
 12 memorandum, this part of it?  
 13 DR. DANKWA:  
 14 A. It doesn't look familiar, no. It doesn't look  
 15 familiar.  
 16 COFFEY, Q.C.:  
 17 Q. And if I could, and this may assist you --  
 18 because I'm not suggesting that you ever did  
 19 receive it at all, I'm just asking the  
 20 question. I look to page four because  
 21 attached to this is a document entitled  
 22 "Pathology Procedures Manual". The section is  
 23 anatomic pathology/reporting protocols and the  
 24 title is "Breast Needle Core Biopsies  
 25 Standardized Reporting", and its issuing



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1 authority is Terry Gulliver and Nash Denic and  
 2 it spells out the purpose and procedure.  
 3 Doctor, if we look back at the attachments to  
 4 this e-mail, that is one of those, okay. If  
 5 we could bring up, please -- so I'm going to  
 6 ask you to think about it, have you ever  
 7 received that page -- that memorandum or page  
 8 four, and if we could bring up, please,  
 9 Exhibit P-2195, and, Doctor, not the first  
 10 page of this because that's just a fax  
 11 transmission sheet, But the second page is  
 12 entitled "procedure ductal carcinoma in situ  
 13 reporting."  
 14 DR. DANKWA:  
 15 A. Yeah.  
 16 COFFEY, Q.C.:  
 17 Q. And then there's a--it's two pages long, then  
 18 there's a Pathology Procedures Manual, title  
 19 "breast needle core biopsy standardized  
 20 grossing."  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. Then there's a title "breast sentinel node  
 25 lymph node" and then "cancer lumpectomy

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1 specimen, breast conserving surgery" second  
 2 page. Then a document, which is an attachment  
 3 by itself, "canned text needle core biopsy  
 4 reporting."  
 5 DR. DANKWA:  
 6 A. We are familiar, yes.  
 7 COFFEY, Q.C.:  
 8 Q. You've seen these?  
 9 DR. DANKWA:  
 10 A. I've seen these ones, yes.  
 11 COFFEY, Q.C.:  
 12 Q. And there's one here, page ten of the exhibit  
 13 is titled fixation and there's a policy and a  
 14 procedure for fixation?  
 15 DR. DANKWA:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. And then it's a separate document in the  
 19 attachments, but it's "for optimal tissue  
 20 selection for immunohistochemical staining of  
 21 breast cancer specimens, the following steps  
 22 are suggested." So you would have, at some  
 23 point, received these?  
 24 DR. DANKWA:  
 25 A. I did, yes, I have.

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1 COFFEY, Q.C.:  
 2 Q. Do you recall receiving, like when  
 3 approximately? Dr. Neil has told us he  
 4 received them late May 2007.  
 5 DR. DANKWA:  
 6 A. Well, that probably may be about right, that's  
 7 sort of right time, yes.  
 8 COFFEY, Q.C.:  
 9 Q. And do you recall the context in which they  
 10 were sent to you, and what was--you know, why  
 11 they were sent to you and what, if anything,  
 12 was expected of you?  
 13 DR. DANKWA:  
 14 A. I think this was a follow up of one of a  
 15 conference calls in which they determined that  
 16 they were going to send out a formalized way,  
 17 an expectation of what needs to be done in  
 18 order to optimize the staining techniques.  
 19 COFFEY, Q.C.:  
 20 Q. And I take it then, this was--before we took  
 21 the break, you made a reference to the  
 22 Commissioner in your response that you hadn't  
 23 gone back to St. John's for ER/PR because they  
 24 expect certain protocol to be followed and it  
 25 was problematic to promise that you'd be able

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1 to do that?  
 2 DR. DANKWA:  
 3 A. Exactly, yes.  
 4 COFFEY, Q.C.:  
 5 Q. And would this be the fixation policy, in  
 6 fact, you mean?  
 7 DR. DANKWA:  
 8 A. Yes, yes.  
 9 COFFEY, Q.C.:  
 10 Q. This is the one?  
 11 DR. DANKWA:  
 12 A. Yeah.  
 13 COFFEY, Q.C.:  
 14 Q. Doctor, in terms of this, if I just could, the  
 15 procedure, ten percent buffer formalin, four  
 16 percent formaldehyde, that wouldn't be a  
 17 problem, I take it?  
 18 DR. DANKWA:  
 19 A. No, no.  
 20 COFFEY, Q.C.:  
 21 Q. "Tissue must be placed in formalin as quickly  
 22 as possible after removal and at most, within  
 23 30 minutes."  
 24 DR. DANKWA:  
 25 A. That's not a problem.

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1 COFFEY, Q.C.:

2 Q. That wouldn't be a problem, and that's true

3 even in Labrador City or Goose Bay?

4 DR. DANKWA:

5 A. Yes, exactly.

6 COFFEY, Q.C.:

7 Q. "Small biopsies should be fixed for no shorter

8 than three hours and no longer than 24 hours."

9 DR. DANKWA:

10 A. Right, that's no problem for St. Anthony, but

11 it may be a problem coming from elsewhere.

12 COFFEY, Q.C.:

13 Q. From Labrador City and Goose Bay?

14 DR. DANKWA:

15 A. From Labrador City and Goose Bay, yes.

16 COFFEY, Q.C.:

17 Q. And "larger specimens must be sliced into

18 three to five millimetre slices and surrounded

19 by a formalin ten times in volume as soon as

20 possible after removal from the body." I take

21 it that could be problematic for yourself?

22 DR. DANKWA:

23 A. That could be a problem, yeah. For St.

24 Anthony, no, but for the external areas, for

25 Goose Bay and Lab City, yes.

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1 COFFEY, Q.C.:

2 Q. And "larger specimens should be fixed for no

3 shorter than 24, no longer than 48."

4 DR. DANKWA:

5 A. Yeah, that may work sometimes in all areas,

6 but occasionally too, it may not, it may not

7 work.

8 COFFEY, Q.C.:

9 Q. And in terms of this, Doctor, this reference

10 to "a larger specimen should be fixed for no

11 shorter than 24 hours," would you have

12 understood that to mean 24 hours after the

13 bread loafing?

14 DR. DANKWA:

15 A. No, 24 hours, I would say 24 hours once it's

16 gone into formalin.

17 COFFEY, Q.C.:

18 Q. Formalin?

19 DR. DANKWA:

20 A. Yes.

21 COFFEY, Q.C.:

22 Q. In a place, for example, like Goose Bay or

23 Labrador City where there--if you're, as a

24 pathologist, lucky if a surgeon even makes the

25 cut into the tumour at all or is able to.

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1 DR. DANKWA:

2 A. Sure.

3 COFFEY, Q.C.:

4 Q. What's the situation if the surgeon is not

5 able to make the cut into the tumour and it

6 has to take 24 hours to get down to St.

7 Anthony, can that be problematic?

8 DR. DANKWA:

9 A. We'd have to work with what we get and achieve

10 the best staining possible.

11 COFFEY, Q.C.:

12 Q. And I appreciate that. I'm using it as

13 problematic here in terms of this?

14 DR. DANKWA:

15 A. Oh yes, it would be, yes. It would be, yes.

16 COFFEY, Q.C.:

17 Q. You wouldn't want to be able to promise St.

18 John's that this particular tissue has

19 complied with this if it came from Goose Bay?

20 DR. DANKWA:

21 A. Right, yes.

22 COFFEY, Q.C.:

23 Q. Okay. Do you think within St. Anthony itself,

24 that you'd be able to give an assurance for

25 the St. Anthony cases?

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1 DR. DANKWA:

2 A. Would be within that range, yes.

3 COFFEY, Q.C.:

4 Q. Doctor, the other policies that are attached,

5 have you made any effort in St. Anthony to

6 follow those?

7 DR. DANKWA:

8 A. We have had meetings with all the lab leaders

9 in the Goose Bay and Lab City as well as St.

10 Anthony, and I've actually, in principle,

11 adopted the aim to achieve this. So all the

12 lab techs have this and we've also notified

13 even anybody who has any dealings with

14 gathering of specimens to be abiding by all

15 these policies.

16 COFFEY, Q.C.:

17 Q. Doctor, here, just if I could go back, because

18 some of them are directed, I gather,

19 particularly at -

20 DR. DANKWA:

21 A. Pathologists.

22 COFFEY, Q.C.:

23 Q. - at pathologists, and how about yourself,

24 have you -

25 DR. DANKWA:

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1 A. I have actually been doing synoptic reporting  
 2 since '97/98, yes.  
 3 COFFEY, Q.C.:  
 4 Q. And that, for example, if we could, the  
 5 reference to page two, this procedure,  
 6 patient's name and so on. Would you use that  
 7 sort of format?  
 8 DR. DANKWA:  
 9 A. Yes, I do.  
 10 COFFEY, Q.C.:  
 11 Q. Okay.  
 12 DR. DANKWA:  
 13 A. It may not have--it may not be laid out the  
 14 same way, but with the same contents, similar  
 15 contents, yes.  
 16 COFFEY, Q.C.:  
 17 Q. And page--I'll just go to page four, the one  
 18 entitled breast needle core biopsy  
 19 standardized grossing, that would be something  
 20 that you'd do, the grossing?  
 21 DR. DANKWA:  
 22 A. Yeah.  
 23 COFFEY, Q.C.:  
 24 Q. Have you made any attempt to comply with this?  
 25 DR. DANKWA:

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1 A. If it's a core biopsy, yes. It goes through  
 2 the same similar processing.  
 3 COFFEY, Q.C.:  
 4 Q. Doctor, bearing in mind the institution and  
 5 the size of it that you're working in and the  
 6 resources available to you, at least up to  
 7 now, has it been practical for you to have  
 8 like the equivalent or create the equivalent  
 9 sort of policies for yourself and your lab, in  
 10 the sense of written policies, spelled out  
 11 like they have, they started to do in this  
 12 material?  
 13 DR. DANKWA:  
 14 A. We have some policies that way in existence  
 15 before the Eastern one came in, and we have  
 16 actually adapted the Eastern one almost in the  
 17 same context for the whole of the region now,  
 18 yes.  
 19 COFFEY, Q.C.:  
 20 Q. But are there a number of areas that you would  
 21 not have written policies for?  
 22 DR. DANKWA:  
 23 A. We have covered all that.  
 24 COFFEY, Q.C.:  
 25 Q. I appreciate in this.

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1 DR. DANKWA:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. But would there be other areas that they have  
 5 not covered in this material?  
 6 DR. DANKWA:  
 7 A. Not that I could think of immediately.  
 8 COFFEY, Q.C.:  
 9 Q. That you would--here's an example, Doctor.  
 10 DR. DANKWA:  
 11 A. Yes, okay.  
 12 COFFEY, Q.C.:  
 13 Q. Just to give you some context. If we could  
 14 bring up, Exhibit P-2157, please? That's  
 15 fine. It'll take a minute. Doctor, I'll  
 16 explain what this is being--just it comes up  
 17 on the screen here for you, this is a document  
 18 that the Commission received from Eastern  
 19 Health about a week ago.  
 20 DR. DANKWA:  
 21 A. Right.  
 22 COFFEY, Q.C.:  
 23 Q. Okay, and it is--in fact, it's the binder,  
 24 over an inch thick of pathology policies and  
 25 then procedures, okay?

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1 DR. DANKWA:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. And just to give you some sense of it, Doctor,  
 5 that's the--the first page here, the pathology  
 6 policies, there are seven listed there.  
 7 DR. DANKWA:  
 8 A. Right.  
 9 COFFEY, Q.C.:  
 10 Q. And we go on to the next page, pathology  
 11 procedures, and you can just look at this as I  
 12 scroll through it. General information,  
 13 specimen collection and handling procedures,  
 14 there's a whole list. Grossing procedures,  
 15 routine pathology assistants, a whole list.  
 16 Pathology technical and staining procedures,  
 17 again, a list. Pathology quality management  
 18 procedures and pathology reporting procedures,  
 19 see draft--and these are both in draft.  
 20 DR. DANKWA:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. And IHC policies and procedures.  
 24 DR. DANKWA:  
 25 A. Right, yes.

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1 COFFEY, Q.C.:

2 Q. Well, that wouldn't be applicable, I take it,

3 where you are?

4 DR. DANKWA:

5 A. No, it wouldn't apply.

6 COFFEY, Q.C.:

7 Q. But the other ones above here, I take it many

8 of them might have some actual day-to-day

9 application in your lab.

10 DR. DANKWA:

11 A. Yes, indeed.

12 COFFEY, Q.C.:

13 Q. But would it be practical for you to actually

14 go--or somebody in your lab to actually draft

15 such policies?

16 DR. DANKWA:

17 A. With some of them, we may have policies there

18 already in existence, yes, but we may not have

19 it as comprehensive as this.

20 COFFEY, Q.C.:

21 Q. And that's what I was getting at, Doctor.

22 DR. DANKWA:

23 A. Okay, right.

24 COFFEY, Q.C.:

25 Q. So in order for you to--if your hospital or

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1 health authority was to have this sort of

2 comprehensive or potentially comprehensive

3 written policy and procedures, you would in

4 effect have to adapt a larger institution's to

5 your own situation?

6 DR. DANKWA:

7 A. Exactly, yes, correct. That is correct, yes.

8 COFFEY, Q.C.:

9 Q. I take it, Doctor, you've never seen a copy of

10 this?

11 DR. DANKWA:

12 A. No, I haven't.

13 COFFEY, Q.C.:

14 Q. And while we're on this topic of these--if we

15 could bring up, please, Registrar, Exhibits--

16 first of all, Exhibit P-2219? This is a

17 document entitled "Charles S. Curtis Memorial

18 Hospital, Laboratory Policy and Procedure

19 Manual." Section is histology, the topic is

20 general organization, and then there's a

21 number of dates.

22 DR. DANKWA:

23 A. Yes.

24 COFFEY, Q.C.:

25 Q. O, I take it that's the original?

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1 DR. DANKWA:

2 A. Original, yes.

3 COFFEY, Q.C.:

4 Q. Revised. So original is May 1985, revised

5 March '91, revised April '99, and this

6 particular one is numbered Roman numeral eight

7 dash 05. Doctor, what is this?

8 DR. DANKWA:

9 A. These are policies guiding the techs as to

10 what they do when they see--when they have to

11 handle specimens.

12 COFFEY, Q.C.:

13 Q. So in effect, the original one of this

14 predates your time.

15 DR. DANKWA:

16 A. Yes.

17 COFFEY, Q.C.:

18 Q. And then it was revised in 1991, while you

19 were--in fact, it's before your time as well.

20 DR. DANKWA:

21 A. Before, yes.

22 COFFEY, Q.C.:

23 Q. And revised in '99 while you were there?

24 DR. DANKWA:

25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. This goes into the second page. Now this is

3 a--I have a rule book for the technologists

4 just to follow?

5 DR. DANKWA:

6 A. Correct, yes.

7 COFFEY, Q.C.:

8 Q. If we could, please, Registrar, Exhibit P-

9 2220? Doctor, this is again, I take it, a

10 similar sort of document?

11 DR. DANKWA:

12 A. Correct, yes.

13 COFFEY, Q.C.:

14 Q. And it's numbered Roman numeral eight dash 05.

15 It begins, the original one, May of '85,

16 revised March '91, April '99 and May of 2007.

17 DR. DANKWA:

18 A. Yes.

19 COFFEY, Q.C.:

20 Q. And the subject is histology, the topic

21 general organization, and miscellaneous

22 information?

23 DR. DANKWA:

24 A. Yes.

25 COFFEY, Q.C.:

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1 Q. And just begin with number one, it says "the  
 2 following procedures should be carried out to  
 3 maintain a good quality work in the histology  
 4 laboratory. No. 1, 'the American Optical'  
 5 microtome is greased every week."  
 6 DR. DANKWA:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. And then it goes on, "2. check flush reagents  
 10 on the processor every day" and it goes on and  
 11 on.  
 12 DR. DANKWA:  
 13 A. Yes, yeah.  
 14 COFFEY, Q.C.:  
 15 Q. I shouldn't say on and on, it goes on for  
 16 seven. Do you recall what was revised in May  
 17 of '07?  
 18 DR. DANKWA:  
 19 A. May of '07, we had obtained the American  
 20 Optical microtome.  
 21 COFFEY, Q.C.:  
 22 Q. Okay.  
 23 DR. DANKWA:  
 24 A. Which was a new system, yes.  
 25 COFFEY, Q.C.:

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1 Q. And that was added to the list?  
 2 DR. DANKWA:  
 3 A. Yes, and then the auto stainer in number four.  
 4 COFFEY, Q.C.:  
 5 Q. That was new?  
 6 DR. DANKWA:  
 7 A. Also acquired not long after that, yes, around  
 8 that time, yes.  
 9 COFFEY, Q.C.:  
 10 Q. Exhibit P-2221? Again, this is a laboratory  
 11 policy and procedure manual for Curtis  
 12 Memorial Hospital. Again, the same number.  
 13 The significance of this numbering, 8-05-06,  
 14 what is that?  
 15 DR. DANKWA:  
 16 A. The binders have been made into--categorized  
 17 into different groups and that is how the  
 18 binding came to be, yes.  
 19 COFFEY, Q.C.:  
 20 Q. And on that point, binders?  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. So what's in these binders?  
 25 DR. DANKWA:

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1 A. It's almost very similar to what you showed me  
 2 from Eastern. So it's a binder with divisions  
 3 in them and some of it will be showing what is  
 4 happening in histology with equipment, and  
 5 sometimes with how you behave in the lab and  
 6 when you react to dangerous situations.  
 7 COFFEY, Q.C.:  
 8 Q. And I take it then, we only have--and I'm  
 9 going to take the Commissioner to the ones we  
 10 have, which you've provided through your  
 11 counsel to us.  
 12 DR. DANKWA:  
 13 A. That's correct, okay.  
 14 COFFEY, Q.C.:  
 15 Q. But I take it that there's much more in these  
 16 binders?  
 17 DR. DANKWA:  
 18 A. We may have some more, yes.  
 19 COFFEY, Q.C.:  
 20 Q. But as well, there's many different -  
 21 DR. DANKWA:  
 22 A. Different areas, yes.  
 23 COFFEY, Q.C.:  
 24 Q. If you're talking about binders, I mean, how  
 25 much is involved?

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1 DR. DANKWA:  
 2 A. Well, I use the word binder, because even the  
 3 staining, how they do the staining, like if  
 4 you have to do H & E, what you need to do to  
 5 do the H & E, these all come within a binder.  
 6 I use the word binder, but I probably should  
 7 say binder rather than binders. They are  
 8 split into different sections.  
 9 COFFEY, Q.C.:  
 10 Q. But again, in terms of, for example, even how  
 11 to do a H & E stain?  
 12 DR. DANKWA:  
 13 A. Exactly.  
 14 COFFEY, Q.C.:  
 15 Q. That's actually spelled out in writing?  
 16 DR. DANKWA:  
 17 A. It would be. Yes, it would be there, yes.  
 18 COFFEY, Q.C.:  
 19 Q. It's there.  
 20 DR. DANKWA:  
 21 A. It would be there, yes.  
 22 COFFEY, Q.C.:  
 23 Q. And it's been there for how long, as far as  
 24 you know?  
 25 DR. DANKWA:

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1 A. As far as I know, yes.  
 2 COFFEY, Q.C.:  
 3 Q. When you came, there was such a -  
 4 DR. DANKWA:  
 5 A. Yes, there was some procedures there.  
 6 COFFEY, Q.C.:  
 7 Q. This particular one is policy for submission  
 8 of pathology specimens. The topic is--yes,  
 9 policy submission for specimens, and again,  
 10 this was revised in May of '07. It goes back  
 11 though to '85. Do you recall what the  
 12 revision was, Doctor?  
 13 DR. DANKWA:  
 14 A. I think the MCP might have been the part two.  
 15 COFFEY, Q.C.:  
 16 Q. Okay.  
 17 DR. DANKWA:  
 18 A. We were running into a lot of problems with  
 19 MCP and with our new Meditec system, it was  
 20 rejecting cases as much as possible. So just  
 21 ensuring that our staff make note of the  
 22 correct MCPs.  
 23 COFFEY, Q.C.:  
 24 Q. That the specimens must be labelled with the  
 25 MCP numbers?

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1 DR. DANKWA:  
 2 A. That's right, yes.  
 3 COFFEY, Q.C.:  
 4 Q. And Exhibit P-2222, please? And Doctor, this  
 5 is from histology, operating guidelines.  
 6 First, the original one apparently dates back  
 7 to May of '85. It's revised most recently in  
 8 May of 2007, and I take it this then is an  
 9 operating guideline for the technologists as  
 10 to how they're to go about their business in  
 11 dealing with this particular subject matter?  
 12 DR. DANKWA:  
 13 A. That's true.  
 14 COFFEY, Q.C.:  
 15 Q. It includes normal operations, a heading,  
 16 quality control, preventative maintenance and  
 17 records and quality assurance.  
 18 DR. DANKWA:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Whose responsibility is it, Doctor, to  
 22 maintain the binder, as it were?  
 23 DR. DANKWA:  
 24 A. That is the lead lab technologist, but if  
 25 there is an issue that I detect, then I would

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1 make sure we have that section updated  
 2 accordingly.  
 3 COFFEY, Q.C.:  
 4 Q. Doctor, if we could, Registrar, Exhibit P-  
 5 2223? Doctor, I just--do you recognize what  
 6 this is?  
 7 DR. DANKWA:  
 8 A. Yes, I do.  
 9 COFFEY, Q.C.:  
 10 Q. What is it in the main? Is this your  
 11 handwriting?  
 12 DR. DANKWA:  
 13 A. No, that is my secretary's handwriting. They  
 14 document, whenever they send items out, they  
 15 document them in a book.  
 16 COFFEY, Q.C.:  
 17 Q. Okay, and this is related to the ER/PR, this  
 18 particular -  
 19 DR. DANKWA:  
 20 A. ER/PRs, yes.  
 21 COFFEY, Q.C.:  
 22 Q. Okay, I'm not going to take you through it,  
 23 it's just for the Commissioner's benefit so  
 24 that she knows what's contained in it? If we  
 25 could go then, please, to Exhibit P-2209?

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1 Doctor, this is an e-mail from Don MacDonald,  
 2 August 27th, 2007, to a number of individuals,  
 3 including yourself, you're right there. "ER  
 4 testing-Communications", he writes, "This is  
 5 just a note to let you know that Dr. Reza may  
 6 be contacting you in the next few days to  
 7 discuss communication activities in your  
 8 region with respect to reporting results for  
 9 ER/PR testing. Assisting him in his  
 10 discussions will be Heather Predham from  
 11 Eastern Health. I thank you again for your  
 12 continuous support as we move towards  
 13 completing our work for the Ministry of  
 14 Health." Now, Doctor, were you then involved  
 15 in providing information to Reza and Dr.  
 16 MacDonald's people?  
 17 DR. DANKWA:  
 18 A. Yes, I did.  
 19 COFFEY, Q.C.:  
 20 Q. And what was the nature of your involvement?  
 21 DR. DANKWA:  
 22 A. I was involved in making sure that we identify  
 23 the ER/PRs in our cases to be sent on to him.  
 24 COFFEY, Q.C.:  
 25 Q. Now you indicated, I believe earlier that

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1 there were some problems you ran into or some  
 2 challenges?  
 3 DR. DANKWA:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. And can you tell the Commissioner about that?  
 7 DR. DANKWA:  
 8 A. Well at the initial phase, when the request  
 9 came, I wondered about the confidentiality  
 10 because the request was seeking the report of  
 11 patients with the patient information, so I  
 12 was initially very, very uneasy about  
 13 releasing such information out and I had  
 14 communications with the CEO and also had  
 15 communications with, which was eventually  
 16 communicated to Don MacDonald and it was Reza,  
 17 Dr. Reza who started having conversations with  
 18 me to try and resolve that.  
 19 COFFEY, Q.C.:  
 20 Q. And did it get resolved?  
 21 DR. DANKWA:  
 22 A. Well at the end he sent me a print out  
 23 indicating that that was acceptable to release  
 24 that sort of information.  
 25 COFFEY, Q.C.:

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1 Q. And so, was it done?  
 2 DR. DANKWA:  
 3 A. Yes, I felt I had no choice.  
 4 COFFEY, Q.C.:  
 5 Q. If we could, please, Exhibit P-2211? Now were  
 6 there any other challenges involved in  
 7 providing the information?  
 8 DR. DANKWA:  
 9 A. The major challenge was actually identifying  
 10 the cases, because once again, we had to go  
 11 through one by one, going through the files,  
 12 but it was not electronic, so manually go  
 13 through -  
 14 COFFEY, Q.C.:  
 15 Q. That approximately 13,000 -  
 16 DR. DANKWA:  
 17 A. 13,000 patients, yes.  
 18 COFFEY, Q.C.:  
 19 Q. Have they actually been gone through now?  
 20 DR. DANKWA:  
 21 A. Oh, they've all been gone through now, yes,  
 22 because we were given a deadline, one week to  
 23 provide that and I wasn't sure what the  
 24 implications would be if I didn't meet it, so  
 25 we had to employ more staff because being a

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1 Commission of Inquiry, who knows, there may be  
 2 legal consequences to this, so we got the  
 3 support from the organization and then pulled  
 4 the information together for all the staff.  
 5 COFFEY, Q.C.:  
 6 Q. Doctor, this e-mail, 2211, is from Nash Denic,  
 7 Dr. Denic, October 29th, 2007, to Pat Pilgrim,  
 8 who also works with Eastern Health. The  
 9 subject is "St. Anthony missed six cases of  
 10 ER/PR"?  
 11 DR. DANKWA:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. And then there's an attachment, "St. Anthony,  
 15 six missed cases". And Dr. Denic writes, "Hi  
 16 Pat/Heather, here's a list of patients that  
 17 St. Anthony had missed on a primary search.  
 18 Dr. Dankwa forwarded the blocks directly to  
 19 Mount Sinai Hospital and obtained the results.  
 20 He informed all the treating physicians and  
 21 oncologists. He faxed me the reports which I  
 22 put in a table enclosed. Please cross-check  
 23 them with your information and add them up, in  
 24 necessary." Page 2 is, in fact, I take it, a  
 25 spreadsheet of those cases?

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1 DR. DANKWA:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. What was this about, Doctor, these six missed  
 5 cases?  
 6 DR. DANKWA:  
 7 A. These were cases that we found when we were  
 8 thumbing through now, this time, throughout  
 9 the whole file.  
 10 COFFEY, Q.C.:  
 11 Q. In 2007?  
 12 DR. DANKWA:  
 13 A. Yes, and this is where we found the additional  
 14 six cases.  
 15 COFFEY, Q.C.:  
 16 Q. And what's described here in Dr. Denic's e-  
 17 mail, is that in fact what happened, that the  
 18 blocks were sent by your to Mount Sinai  
 19 directly?  
 20 DR. DANKWA:  
 21 A. Immediately, yes.  
 22 COFFEY, Q.C.:  
 23 Q. And the results, were they passed on then to  
 24 the attending physicians?  
 25 DR. DANKWA:

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1 A. Oh yes, it was passed on to the attending  
 2 physician, the surgeon, the GP and then to the  
 3 oncologist with the original copy of the  
 4 report.  
 5 COFFEY, Q.C.:  
 6 Q. Doctor, do you know if any of these patients,  
 7 well I'll just show you so you can look at it.  
 8 I take it some of them would have been  
 9 considered to convert?  
 10 DR. DANKWA:  
 11 A. Change, yeah.  
 12 COFFEY, Q.C.:  
 13 Q. Do you know if any of these went through that  
 14 panel process?  
 15 DR. DANKWA:  
 16 A. Not as far as I know, no.  
 17 COFFEY, Q.C.:  
 18 Q. Okay, and by that point in time, by September,  
 19 October, 2007, it was get them retested at  
 20 Mount Sinai and get the results back.  
 21 DR. DANKWA:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. And tell the attending physicians?  
 25 DR. DANKWA:

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1 A. The physicians, yes.  
 2 COFFEY, Q.C.:  
 3 Q. If we could, please, Exhibit P-2213? Doctor,  
 4 this is an e-mail, February 14th, 2008 from  
 5 Dianne Smith, to a number of individuals,  
 6 including yourself, that's your name right  
 7 there. Subject is listing of the deceased for  
 8 regions, request to NLCHI. She writes,  
 9 "Further to your conversation earlier this  
 10 week with Pat Pilgrim in which she indicated  
 11 she'd have a listing of involved deceased  
 12 patients' results for your respective region  
 13 area forwarded to you, this is to advise Don  
 14 MacDonald with the NLCHI, requires a direct  
 15 response from you for these listings. Please  
 16 forward Don an e-mail requesting a listing of  
 17 involved deceased patient results for your  
 18 respective region and area." Now, Doctor, did  
 19 you send a request to Don MacDonald looking  
 20 for the deceased patients, do you know?  
 21 DR. DANKWA:  
 22 A. I'm trying to remember whether we did it both  
 23 ways, at one stage we got a list in of  
 24 deceased patients from the, I don't know  
 25 whether from Dianne Smith, and we had to cross

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1 check with our list to see whether they  
 2 matched, so I'm wondering if it was the  
 3 reverse.  
 4 COFFEY, Q.C.:  
 5 Q. And my question is an indirect way of asking  
 6 you about the deceased patients for Labrador  
 7 Grenfell, how were they handled, their cases  
 8 handled by your -  
 9 DR. DANKWA:  
 10 A. We didn't handle them any differently from the  
 11 living ones. We sent all of them out  
 12 initially.  
 13 COFFEY, Q.C.:  
 14 Q. Initially.  
 15 DR. DANKWA:  
 16 A. Initially, right from the beginning, yes, and  
 17 I think initially they weren't tested, even  
 18 though they had the samples there, but  
 19 subsequently they were tested and the results  
 20 came back. And the results were faxed back,  
 21 copied to the GPs and then to the surgeons and  
 22 then back to the oncology, the same way as the  
 23 living ones, yes.  
 24 COFFEY, Q.C.:  
 25 Q. And were they recorded in the Meditec chart or

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1 -  
 2 DR. DANKWA:  
 3 A. Yes, in the Meditec chart, those that were  
 4 within the period, where they could be  
 5 recorded in the Meditec -  
 6 COFFEY, Q.C.:  
 7 Q. There was a Meditec system in place.  
 8 DR. DANKWA:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. The patients for whom there was no Meditec -  
 12 DR. DANKWA:  
 13 A. It was transcribed, also typed in and kept as  
 14 hardcopy sheets in our files.  
 15 COFFEY, Q.C.:  
 16 Q. In terms of your organization, Doctor, if  
 17 deceased relatives want to know the results,  
 18 who would they contact in the organization?  
 19 DR. DANKWA:  
 20 A. The surgeons would automatically contact the  
 21 families, the surgeons or the GPs, they  
 22 contacted, so contacts were made.  
 23 COFFEY, Q.C.:  
 24 Q. And Exhibit P-2218 please? Now, Doctor, this  
 25 is a series of e-mails, the first two are



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1 August 16th, 2007 between yourself and Mr.  
 2 MacDonald and then in April 1st, 2008, you  
 3 forward it to Ms. Hennebury, who forwarded it  
 4 to us. And your e-mail to Mr. MacDonald,  
 5 you've written, "I have embedded my responses  
 6 in your e-mail. I hope this answers your  
 7 questions." And then before that, which is in  
 8 effect his e-mail and your response?  
 9 DR. DANKWA:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. To his questions, you've written, or he has  
 13 written to you or you have responded, "As you  
 14 are aware, the Centre for Health Information  
 15 is working on behalf of the Minister of Health  
 16 to develop a database that will document  
 17 events surrounding ER/PR testing for breast  
 18 cancer patients from '97 to 2005. The  
 19 Labrador Grenfell Health Authority recently  
 20 provided the centre with demographic and  
 21 pathology reports for all patients in your  
 22 region that had ER/PR testing carried out at  
 23 Eastern Health. This information was  
 24 extremely valuable and I wish to thank your  
 25 team for pulling it together in such a timely

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1 manner." I take it that's the reference to  
 2 the week?  
 3 DR. DANKWA:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. "We are now moving to the second phase of the  
 7 project which involves events on how the  
 8 retesting results were communicated to those  
 9 patients who had their ER/PRS retested at  
 10 Mount Sinai. Specifically we are asking for  
 11 the following, one, date sample sent to  
 12 Eastern Health" and I take it then this is  
 13 your response, "These were sent in two  
 14 batches, the first batch was sent September  
 15 2005 and the final batch sent after receiving  
 16 a list of "affected cases" from the Cancer  
 17 Centre in October of 2005."  
 18 DR. DANKWA:  
 19 A. That's right, yes.  
 20 COFFEY, Q.C.:  
 21 Q. Number two, he has written to you, "Date of  
 22 and means by which patient informed sample was  
 23 sent to Eastern Health for retesting." And  
 24 you've responded, "Date is as stated above.  
 25 The samples were sent to Eastern Health who

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1 then forwarded them to Mount Sinai. I do not  
 2 know what dates the samples were sent from  
 3 Eastern Health to Mount Sinai." And then  
 4 three, Mr. MacDonald has written to you, "Name  
 5 of patient informing?" And you've responded,  
 6 "I'm not sure what this refers to, there was  
 7 communication with Dr. Cook concerning sending  
 8 specimens to Eastern Health for retesting.  
 9 Mrs. Cora Snow, pathology secretary at L.G.  
 10 Health, communicated with Judy Thomas,  
 11 secretary at Eastern Health, secretary at  
 12 Eastern Health on submission of the samples."  
 13 Four, he's written "Name of employer (Health  
 14 Authority) of person so informing patient."  
 15 And you've written--and I take it this is your  
 16 response, "This is Labrador-Grenfell Health.  
 17 With respect to informing patients with the  
 18 results, that was the responsibility of the  
 19 Family Physicians and the Surgeons in the care  
 20 of the patients. They were provided with the  
 21 results, one to the Family Physician and  
 22 another copy to the surgeon, as well as  
 23 sending copies to the Oncology Service at the  
 24 Eastern Health. We in the Pathology  
 25 Department did not directly communicate with

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1 patients unless the patients contacted us  
 2 directly. Even so, we would initially advise  
 3 the patients to contact their family  
 4 physicians and/or surgeon. The usual practice  
 5 of patients getting pathology results is  
 6 through their clinicians and we maintained  
 7 that level of communication."  
 8 DR. DANKWA:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And then Mr. MacDonald has said to you, 5)  
 12 "Date that outcome of re-test results and  
 13 Tumour Board review sent to treating  
 14 physicians." And you responded saying, "We  
 15 obtained the results on January 2006 in a  
 16 spreadsheet form and the final written results  
 17 came in at different stages soon afterwards.  
 18 As indicated as the results became available,  
 19 they were communicated to the Family  
 20 Physicians and Surgeons in writing from  
 21 January-May, 2006." And then Mr. MacDonald  
 22 requested "Date and means by which Labrador-  
 23 Grenfell contacted patient or patient's  
 24 families about re-test results." And your  
 25 response is "Copies of the results were sent

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1 to patients' family physicians and surgeons  
 2 between January-May, 2006. the physicians  
 3 were explicitly advised to contact their  
 4 patients with the results upon receipt soon  
 5 thereafter." And then 7, he's asked of you,  
 6 "Date of verification by Labrador-Grenfell  
 7 that treating physician reviewed re-test  
 8 results with patient." And then you've noted  
 9 or responded, "We trust our physicians to  
 10 communicate the results, as is the practise to  
 11 do so upon the receipt of the re-tested  
 12 results. Physicians' attention was brought to  
 13 this issue at medical staff meetings." And  
 14 then he concludes by saying, "We've been asked  
 15 to compile and report on this information to  
 16 the Ministry by September 7th; therefore, we  
 17 would appreciate it if you could provide this  
 18 data to us by Friday, August 25th. A  
 19 communication from you indicating the timeline  
 20 for retrieving this data would be  
 21 appreciated." So, Doctor, I take it then that  
 22 are you able to tell the Commissioner then, in  
 23 responding to these questions, you responded  
 24 accurately?  
 25 DR. DANKWA:

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1 A. Accurately, but I notice that some of the  
 2 times and dates, like on Section 5.  
 3 COFFEY, Q.C.:  
 4 Q. Okay, we'll go to that.  
 5 DR. DANKWA:  
 6 A. Section 5, "We obtained the results on January  
 7 2006", I think I was using the date on the  
 8 form, rather than the -  
 9 COFFEY, Q.C.:  
 10 Q. That's that January 24th date.  
 11 DR. DANKWA:  
 12 A. Yes, rather than -  
 13 COFFEY, Q.C.:  
 14 Q. But the actual time you received it was?  
 15 DR. DANKWA:  
 16 A. It was probably March, it was probably March,  
 17 yes.  
 18 COFFEY, Q.C.:  
 19 Q. And other than that, Doctor, I take it -  
 20 DR. DANKWA:  
 21 A. It was generally accurate, yes.  
 22 COFFEY, Q.C.:  
 23 Q. Doctor, is there anything further that we  
 24 haven't covered that you think should be  
 25 brought to the Commissioner's attention?

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1 DR. DANKWA:  
 2 A. Not that I can think of at the moment.  
 3 COFFEY, Q.C.:  
 4 Q. And certainly, if you do, Mr. Browne will be  
 5 questioning you. Thank you, Commissioner?  
 6 THE COMMISSIONER:  
 7 Q. Ms. Brazil?  
 8 MS. BRAZIL:  
 9 Q. I have no questions, Commissioner.  
 10 THE COMMISSIONER:  
 11 Q. Mr. Simmons?  
 12 MR. SIMMONS:  
 13 Q. Thank you, Commissioner.  
 14 DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MR. DAN SIMMONS  
 15 MR SIMMONS:  
 16 Q. Hello, Dr. Dankwa, my name is Dan Simmons, I'm  
 17 lawyer here for Eastern Health. I have just a  
 18 couple of things for you. I'm going to bring  
 19 you back to a document that Mr. Coffey showed  
 20 you a moment ago, P-2211 please? This e-mail  
 21 message referred to the six cases that you  
 22 found when you were asked to go back and go  
 23 through all of your pathology reports again.  
 24 DR. DANKWA:  
 25 A. Yes.

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1 MR SIMMONS:  
 2 Q. You turned them up, and you noted that--or you  
 3 told us that those cases were sent directly to  
 4 Mount Sinai for retesting and didn't go  
 5 through Eastern Health, the way the earlier  
 6 ones had.  
 7 DR. DANKWA:  
 8 A. That's correct, yes.  
 9 MR SIMMONS:  
 10 Q. When those results came back, was the fact  
 11 that you had found six more and had them  
 12 retested communicated to Eastern Health in any  
 13 way from your board or was it just disclosed  
 14 to the government people who contacted you  
 15 looking for this information?  
 16 DR. DANKWA:  
 17 A. No, it was communicated to the oncologist. We  
 18 sent it down to the oncologist, copies of the  
 19 original report.  
 20 MR SIMMONS:  
 21 Q. So copies of the consultation reports that  
 22 came back from Mount Sinai.  
 23 DR. DANKWA:  
 24 A. From Mount Sinai, yes.  
 25 MR SIMMONS:

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1 Q. Went to the oncologists treating the patients?  
 2 DR. DANKWA:  
 3 A. There was an address that we had to direct  
 4 these reports to and we send them to that  
 5 address.  
 6 MR SIMMONS:  
 7 Q. Yes, so they went to the oncologists at the  
 8 Cancer Clinic, I guess.  
 9 DR. DANKWA:  
 10 A. Cancer Clinic, yes.  
 11 MR SIMMONS:  
 12 Q. But they weren't, otherwise, sent either to  
 13 the laboratory at the Health Science Centre at  
 14 Eastern Health or to the clinical chief of  
 15 pathology at Eastern Health?  
 16 DR. DANKWA:  
 17 A. No, I think, if I remember correctly, I called  
 18 them to let them know because when I  
 19 discovered them, I was a little bit uneasy  
 20 that we have missed those cases, so I called,  
 21 I think I called Don Cook about it, yeah.  
 22 MR SIMMONS:  
 23 Q. Okay. You've told us that Labrador-Grenfell  
 24 has continued to use Mount Sinai for retesting  
 25 current--for testing current ER/PR cases, not

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1 retesting.  
 2 DR. DANKWA:  
 3 A. Yes.  
 4 MR SIMMONS:  
 5 Q. And that a reason for that is that in order to  
 6 have Eastern Health do that testing for you,  
 7 Eastern Health had wanted to know that your  
 8 board, your authority would be able to comply  
 9 with the fixation policy that they circulated?  
 10 DR. DANKWA:  
 11 A. Yes.  
 12 MR SIMMONS:  
 13 Q. So I take it then, that Mount Sinai hasn't  
 14 placed any similar requirement or condition on  
 15 you?  
 16 DR. DANKWA:  
 17 A. No.  
 18 MR SIMMONS:  
 19 Q. Mr. Coffey had asked you if you had any  
 20 thoughts about what could have happened for  
 21 the test results to change for those samples  
 22 that were tested at Mount Sinai, compared to  
 23 the original tests done between '97 and 2005.  
 24 And one of the things you said was that--I  
 25 heard you to say was that we know that there

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1 can be a change from one level to another, and  
 2 I wasn't quite sure what you meant when you  
 3 referred to different levels. I wondered if  
 4 you were referring to the fact that when you  
 5 cut into a block of tissue -  
 6 DR. DANKWA:  
 7 A. Oh yes, sorry, that is what--thanks for  
 8 reminding me.  
 9 MR SIMMONS:  
 10 Q. Okay, can you explain that a little more for  
 11 me, what you meant by that?  
 12 DR. DANKWA:  
 13 A. Yes, we know that tumours show different  
 14 variations inside a tumour mass itself, so  
 15 depending upon what stage you are in the  
 16 tumour, the tumour showed different views and  
 17 we used that to describe as tumour  
 18 heterogeneity, heterogeneous, yes.  
 19 MR SIMMONS:  
 20 Q. So, I think we've heard from others that there  
 21 can be variation in the percentage of ER or PR  
 22 cells that stain if you choose different  
 23 blocks that come from the same tumour.  
 24 DR. DANKWA:  
 25 A. Yes.

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1 MR SIMMONS:  
 2 Q. Do you know if when the retests were done at  
 3 Mount Sinai, if you were able to send all the  
 4 same blocks that had been used for the  
 5 original tests or if you had to substitute  
 6 blocks in any cases?  
 7 DR. DANKWA:  
 8 A. At the initial stage we sent the original  
 9 blocks, but if the tumour had been cut through  
 10 the block, they were request an alternate  
 11 block.  
 12 MR SIMMONS:  
 13 Q. Do you know if there were any requests that  
 14 came back to you for alternate blocks?  
 15 DR. DANKWA:  
 16 A. I know there were about two or so that they  
 17 had to do that.  
 18 MR SIMMONS:  
 19 Q. So in at least two of those cases, you had to  
 20 send a different block than the original one?  
 21 DR. DANKWA:  
 22 A. Different block, yes, indeed, I did.  
 23 MR SIMMONS:  
 24 Q. And even in those cases where the retest was  
 25 done on the original block, there is potential

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1 for there to be a different percentage just  
 2 because the block has been cut through further  
 3 and you're into a different part of the  
 4 tumour?  
 5 DR. DANKWA:  
 6 A. Correct.  
 7 MR SIMMONS:  
 8 Q. The original tests that were done at St.  
 9 John's and sent back to Labrador-Grenfell, for  
 10 the first ones in 1998, Dr. Khalifa read them  
 11 and just sent you a report.  
 12 DR. DANKWA:  
 13 A. Yes.  
 14 MR SIMMONS:  
 15 Q. But after that, I gather you or the other  
 16 pathologist who used to work with you in St.  
 17 Anthony, looked at all the slides and  
 18 determined the percentage of positivity, if  
 19 there was any.  
 20 DR. DANKWA:  
 21 A. Yes, right. I read most of them, I don't ever  
 22 recall seeing any report by the other  
 23 pathologist read.  
 24 MR SIMMONS:  
 25 Q. Right, okay, and you haven't had the

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1 opportunity to see the slides prepared at  
 2 Mount Sinai for the retests?  
 3 DR. DANKWA:  
 4 A. No, no, I haven't.  
 5 MR SIMMONS:  
 6 Q. So you haven't had the opportunity to look at  
 7 those and see if you would call the  
 8 percentages the same as Dr. Mullen had called  
 9 them?  
 10 DR. DANKWA:  
 11 A. That's correct.  
 12 MR SIMMONS:  
 13 Q. Is there known to be any variability between  
 14 the way different pathologists will read the  
 15 same slide?  
 16 DR. DANKWA:  
 17 A. Yes, it's well known, well established, yes.  
 18 MR SIMMONS:  
 19 Q. I believe you told us that for those slides  
 20 that came back to St. Anthony from St. John's,  
 21 the original tests, that you didn't recall  
 22 ever not receiving a positive control slide?  
 23 DR. DANKWA:  
 24 A. That's correct.  
 25 MR SIMMONS:

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1 Q. And of those positive controls you saw, you  
 2 didn't see any that failed?  
 3 DR. DANKWA:  
 4 A. That's correct.  
 5 MR SIMMONS:  
 6 Q. They all stained. And you were aware of the  
 7 use of internal controls in ER/PR testing?  
 8 DR. DANKWA:  
 9 A. That's correct.  
 10 MR SIMMONS:  
 11 Q. And I presume you selected your tissue blocks  
 12 so that when possible, you would have normal  
 13 tissue in them?  
 14 DR. DANKWA:  
 15 A. That's correct.  
 16 MR SIMMONS:  
 17 Q. And do you recall having any occasions when  
 18 the slides came back and you discovered that  
 19 the internal control had failed?  
 20 DR. DANKWA:  
 21 A. Never.  
 22 MR SIMMONS:  
 23 Q. Never. And I take it that a positive  
 24 internal--a positive external control and a  
 25 positive internal control would both be

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1 indicators that the testing process had  
 2 worked?  
 3 DR. DANKWA:  
 4 A. Correct.  
 5 MR SIMMONS:  
 6 Q. It would be, okay, fine. Thank you very much,  
 7 Doctor.  
 8 THE COMMISSIONER:  
 9 Q. Mr. Pritchett?  
 10 MR. PRITCHETT:  
 11 Q. Just a few questions, Commissioner.  
 12 DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MR. BLAIR  
 13 PRITCHETT  
 14 MR. PRITCHETT:  
 15 Q. Good afternoon, Dr. Dankwa, I'm Blair  
 16 Pritchett and I'm here no behalf of Labrador-  
 17 Grenfell Health Authority. I just have a few  
 18 questions to clarify some of your earlier  
 19 evidence. When Mr. Simmons was questioning  
 20 you a minute ago, he reiterated that you had  
 21 always noted a positive external control and a  
 22 positive internal control when you were  
 23 interpreting slides.  
 24 DR. DANKWA:  
 25 A. Yes, that's correct.

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1 MR. PRITCHETT:  
 2 Q. And so just moving forward, when you were  
 3 speaking with Mr. Coffey about the cases that  
 4 converted, you had indicated that you felt the  
 5 problem with those slides was probably in the  
 6 processing or staining of those slides. Does  
 7 that answer in any way reflect on your  
 8 interpretation of the controls of the samples?  
 9 DR. DANKWA:  
 10 A. I don't think so.  
 11 MR. PRITCHETT:  
 12 Q. Could you maybe explain for us a little then  
 13 why you think the problem lay in the  
 14 processing and staining of the slides, rather  
 15 than some other part of the ER/PR process?  
 16 DR. DANKWA:  
 17 A. For me, as a pathologist at the receiving end  
 18 of the slide, my expectation when I get a  
 19 slide is that the appropriate processing had  
 20 gone through in making the particular stain.  
 21 So the guide that I have in determining  
 22 whether the process had worked is that of  
 23 external and then the internal control, if it  
 24 is present. So if it's there, and if that  
 25 same test is repeated, where there are

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1 positive and external, positive and internal  
 2 control and is reflecting a different type of  
 3 picture from what I've seen originally, then  
 4 the only area that I can attribute it to is  
 5 the methodology in trying to get that stain to  
 6 work, and I know, from experience, that  
 7 depending on what technique you use, you may  
 8 get different results with both internal and  
 9 external controls working. They will still  
 10 show different results.  
 11 MR. PRITCHETT:  
 12 Q. And what elements of the processing, in  
 13 particular, could be problematic so that you  
 14 would get a positive internal and external  
 15 control, but still have a bad result?  
 16 DR. DANKWA:  
 17 A. Some of the stages, now, I'm not a technician  
 18 at the moment, so my -  
 19 MR. PRITCHETT:  
 20 Q. No, we understand that.  
 21 DR. DANKWA:  
 22 A. - my information is a bit limited in that  
 23 sense, but with the exposures that I've had,  
 24 we know that antigen retrieval is a major  
 25 component. There are different processes,

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1 different approaches in retrieving antigens  
 2 and that would give you different outcomes.  
 3 Concentrations of the antibodies that you use  
 4 would also have an effect on this. Even the  
 5 idea of the pH, the environment you are doing  
 6 your stain, all this would have a contribution  
 7 to the type of outcome that you may get from  
 8 the staining.  
 9 MR. PRITCHETT:  
 10 Q. And if you had problems in those areas, you  
 11 might get a negative score, but yet still have  
 12 appropriate control?  
 13 DR. DANKWA:  
 14 A. Correct.  
 15 MR. PRITCHETT:  
 16 Q. Thank you, Dr. Dankwa. Those are my  
 17 questions.  
 18 THE COMMISSIONER:  
 19 Q. Ms. Newbury?  
 20 DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MS. JENNIFER  
 21 NEWBURY  
 22 MS. NEWBURY:  
 23 Q. Good afternoon, Dr. Dankwa. Jennifer Newbury  
 24 for the Canadian Cancer Society, Newfoundland  
 25 and Labrador Division.

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1 DR. DANKWA:  
 2 A. Good afternoon.  
 3 MS. NEWBURY:  
 4 Q. I just had a couple of questions for you this  
 5 afternoon. First of all, I was wondering  
 6 whether reports of cancer diagnosis from St.  
 7 Anthony were provided to the Cancer Registry  
 8 at the -  
 9 DR. DANKWA:  
 10 A. To the Cancer Registry?  
 11 MS. NEWBURY:  
 12 Q. Yes.  
 13 DR. DANKWA:  
 14 A. As opposed to the oncology -  
 15 MS. NEWBURY:  
 16 Q. As opposed to the Cancer Clinic, yes.  
 17 DR. DANKWA:  
 18 A. - Cancer Clinic, no.  
 19 MS. NEWBURY:  
 20 Q. And what I'm talking about now is throughout  
 21 the time that you were at St. Anthony, was  
 22 there ever a practice in place that once a  
 23 diagnosis is made of cancer that a report of  
 24 that is made -  
 25 DR. DANKWA:

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1 A. To the Cancer -  
 2 MS. NEWBURY:  
 3 Q. - at the time it was NCTRF, the Newfoundland  
 4 Cancer Treatment Research Foundation.  
 5 DR. DANKWA:  
 6 A. Right, okay. Thanks for that question. When  
 7 I came to St. Anthony initially, all the  
 8 cancer diagnosis that were made were literally  
 9 sent automatically to the Cancer Registry. I  
 10 naturally went along with it until it became  
 11 apparent, I think probably in '96 or '97 or  
 12 thereabouts, that this was not something that  
 13 was mandated, and so patient's reports were  
 14 being released. These were patient's reports  
 15 where demographics and everything were being  
 16 released without consent from the patient and  
 17 it wasn't sort of a mandated act. And that  
 18 came to my attention because I had a  
 19 confrontation from a patient who had been  
 20 contacted from the--I think by one of the  
 21 oncologists when that patient didn't want to  
 22 be seen by the Cancer--by the group in St.  
 23 John's. So that really drew that to my  
 24 attention and I ceased releasing any report  
 25 out until there was consent, yes.

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1 MS. NEWBURY:  
 2 Q. That was shortly after you arrived?  
 3 DR. DANKWA:  
 4 A. Not long after I arrived, yes.  
 5 MS. NEWBURY:  
 6 Q. Okay, and in your view, there was nothing to  
 7 mandate that you provide this information?  
 8 DR. DANKWA:  
 9 A. No, nothing, no.  
 10 MS. NEWBURY:  
 11 Q. Were there any other means, less invasive, I  
 12 guess, to a patient's privacy to provide  
 13 information for perhaps statistical purposes?  
 14 DR. DANKWA:  
 15 A. I was prepared to provide numbers of tumour  
 16 diagnosis, if they wanted those numbers, but I  
 17 got the impression that they wanted the  
 18 demographics as well and that wasn't -  
 19 MS. NEWBURY:  
 20 Q. And the demographics would include what  
 21 specifically?  
 22 DR. DANKWA:  
 23 A. Well, name definitely was expected and then  
 24 the address, anything that would identify that  
 25 individual was also required.

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1 MS. NEWBURY:  
 2 Q. And who at the Cancer Registry did you speak  
 3 to about that at the time?  
 4 DR. DANKWA:  
 5 A. At that time, at the onset of it, I wasn't  
 6 talking directly to anybody in the Cancer  
 7 Centre, but I was going through the oncology  
 8 meds we had in our hospital who was collating  
 9 those information and sending it on, but I had  
 10 an opportunity to meet Bertha Paulse who was  
 11 then the director of the oncology group, and  
 12 she promised that she would have that  
 13 addressed and I never saw it addressed, so I  
 14 just continued my practice of not releasing  
 15 the reports.  
 16 MS. NEWBURY:  
 17 Q. So did you speak to Ms. Paulse about that  
 18 directly yourself?  
 19 DR. DANKWA:  
 20 A. Oh yes, I did, yes.  
 21 MS. NEWBURY:  
 22 Q. And when about, did you have that conversation  
 23 with her?  
 24 DR. DANKWA:  
 25 A. This must have been probably around about

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1 2000, the year 2000 or so, around that time,  
 2 yes.  
 3 MS. NEWBURY:  
 4 Q. Okay, and did you have any conversations with  
 5 anyone else to get any guidance about that,  
 6 someone else from within Labrador, in the  
 7 Labrador area. I guess you weren't part of  
 8 Labrador Grenfell at the time, but -  
 9 DR. DANKWA:  
 10 A. We have had discussions internally about  
 11 trying to see if there are ways we can go  
 12 around so that our statistics are also made  
 13 available, so the province is aware, but that  
 14 is something that we still, even today, are  
 15 still working on.  
 16 MS. NEWBURY:  
 17 Q. And there weren't any discussions with anyone  
 18 from the Department of Health, for example?  
 19 DR. DANKWA:  
 20 A. I'm not sure how far the discussions have gone  
 21 with other members of the staff, because now  
 22 the senior executive is quite well aware and  
 23 are involved in the discussions.  
 24 MS. NEWBURY:  
 25 Q. Sorry, who is quite aware?

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1 DR. DANKWA:  
 2 A. The senior executive of the current Labrador  
 3 Grenfell is aware of this.  
 4 MS. NEWBURY:  
 5 Q. Okay.  
 6 DR. DANKWA:  
 7 A. And they are in discussions with someone.  
 8 MS. NEWBURY:  
 9 Q. And have there been any active steps to take  
 10 to try to resolve this?  
 11 DR. DANKWA:  
 12 A. Oh yes, a number, one of which was to try and  
 13 get consent at the onset before the patient is  
 14 even subjected to surgery.  
 15 MS. NEWBURY:  
 16 Q. Okay.  
 17 DR. DANKWA:  
 18 A. Rather than seek consent when the diagnosis  
 19 had been made, but there are a lot of to and  
 20 froes going on this.  
 21 MS. NEWBURY:  
 22 Q. Okay. So that's been discussed as an idea,  
 23 but has a patient ever been approached to seek  
 24 their consent to release the information?  
 25 DR. DANKWA:

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1 A. This has not happened in a formalized manner,  
 2 no.  
 3 MS. NEWBURY:  
 4 Q. And you'd indicated that, earlier in your  
 5 evidence, that you were familiar with certain  
 6 types of tumours that were expected to be,  
 7 more likely than not, to be ER positive, and  
 8 you'd mentioned some low grade or well  
 9 differentiated tumours and lobular carcinoma,  
 10 invasive lobular carcinoma as an example. If  
 11 you saw such tumours repeatedly showing up as  
 12 ER negative, as opposed to ER positive, and  
 13 perhaps you didn't have the numbers in St.  
 14 Anthony to do that, but if you had sufficient  
 15 numbers and if you did see a repeated pattern  
 16 of ER negative patients for some of those  
 17 types of tumours, what, if anything, would  
 18 that cause you to do?  
 19 DR. DANKWA:  
 20 A. It's easier for me to answer it by hindsight.  
 21 MS. NEWBURY:  
 22 Q. Yes, I appreciate that.  
 23 DR. DANKWA:  
 24 A. But if the internal and external controls are  
 25 working, the chances are that you are likely

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1 to report it believing that the test had  
 2 worked successfully. But now with hindsight,  
 3 we probably have to approach another  
 4 technology to be applied to the tissue because  
 5 if you go back to repeat, use the same  
 6 technology, you'd probably get a repeated  
 7 answer in the same way and you might report it  
 8 and I wouldn't probably fault anyone who  
 9 repeated the test by the same system and then  
 10 send it on.  
 11 MS. NEWBURY:  
 12 Q. Just in terms of, you know, where we go from  
 13 here and what might be done.  
 14 DR. DANKWA:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. You know, would there be a certain number of a  
 18 certain quantity that you would see? Perhaps  
 19 one wouldn't alarm you if you saw that --  
 20 maybe it would now.  
 21 DR. DANKWA:  
 22 A. Yeah, now.  
 23 MS. NEWBURY:  
 24 Q. Now it would?  
 25 DR. DANKWA:

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1 A. Oh, yeah, it definitely would, yes.  
 2 MS. NEWBURY:  
 3 Q. So it doesn't even get to the point that you  
 4 would need to have sufficient numbers.  
 5 DR. DANKWA:  
 6 A. I wouldn't wait for the second one, yes.  
 7 MS. NEWBURY:  
 8 Q. And even though you aren't mandated to provide  
 9 information to the Cancer Registry, and given  
 10 that you're from a fairly small hospital  
 11 organization relative to some others here in  
 12 the province, would it be beneficial for you  
 13 to be able to resolve that issue? Would you  
 14 see any uses for you as a pathologist in terms  
 15 of having information recorded in the registry  
 16 so that perhaps your information is part of a  
 17 larger group of cancer diagnosis?  
 18 DR. DANKWA:  
 19 A. I'll be very willing to go along with that  
 20 one. That is why we've been working on it to  
 21 try to resolve this situation.  
 22 MS. NEWBURY:  
 23 Q. So do you see that that would have a role, not  
 24 just perhaps for research purposes, but for if  
 25 you have issues or concerns within your own

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1 organization from a clinician's perspective or  
 2 from a pathologist's perspective that you  
 3 might be able to gain some insight from  
 4 information at the Cancer Registry?  
 5 DR. DANKWA:  
 6 A. Yes, I don't know how might that would help  
 7 me, but certainly it would be useful to have  
 8 that ability to get access to that sort of  
 9 information, and also it would contribute to  
 10 that information.  
 11 MS. NEWBURY:  
 12 Q. Okay. Thank you, Dr. Dankwa. Those are all  
 13 my questions.  
 14 DR. DANKWA:  
 15 A. Thank you.  
 16 COMMISSIONER:  
 17 Q. Ms. Russell.  
 18 MS. RUSSELL:  
 19 Q. No questions, Commissioner.  
 20 COMMISSIONER:  
 21 Q. Mr. Pike.  
 22 MR. PIKE:  
 23 Q. No questions.  
 24 COMMISSIONER:  
 25 Q. Mr. Browne.

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1 DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MR. PETER  
 2 BROWNE  
 3 MR. BROWNE:  
 4 Q. Dr. Dankwa, you'll be pleased to see me come  
 5 up to the lectern to know that things are  
 6 almost over.  
 7 COMMISSIONER:  
 8 Q. Mr. Browne has had a good week that way.  
 9 MR. BROWNE:  
 10 Q. Yes, I have. Doctor, the topic of internal  
 11 controls is a topic that's been of great  
 12 interest here before the Commission. Before  
 13 we get to that, though, just again, there are  
 14 various types of specimens that are used for  
 15 ER/PR, is that correct?  
 16 DR. DANKWA:  
 17 A. Yes.  
 18 MR. BROWNE:  
 19 Q. Can we just run through those various types  
 20 again for the Commission?  
 21 DR. DANKWA:  
 22 A. We have -- I hope I list as much as I can  
 23 remember. We have needle biopsy, and then  
 24 trucut biopsy. Now these are two different  
 25 operations. A needle biopsy is even finer

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1 compared with a trucut biopsy, which is a  
 2 wider bore needle. So you get much more  
 3 tissue than a needle biopsy. Then you have  
 4 the other -- what I'll call a biopsy which is  
 5 often a smaller piece of tissue, and then a  
 6 lumpectomy, which is a bit larger than the  
 7 standard biopsy, and then obviously you have  
 8 the mastectomy.  
 9 MR. BROWNE:  
 10 Q. And then with regard to my earlier comment on  
 11 internal controls, is it always possible to  
 12 get internal control on all of these  
 13 specimens?  
 14 DR. DANKWA:  
 15 A. Can I add another one to the list?  
 16 MR. BROWNE:  
 17 Q. Oh, I'm sorry, okay.  
 18 DR. DANKWA:  
 19 A. You can also do it on cytology specimens as  
 20 well. Now it is not always --  
 21 COMMISSIONER:  
 22 Q. Sorry, I didn't hear what you said.  
 23 DR. DANKWA:  
 24 A. Cytology specimens. You can do an aspirate  
 25 and then do a ER/PR on that. It is not always

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1 possible to get internal control because the  
 2 main focus is actually on the tumour itself,  
 3 and you aim to get internal control, but it  
 4 may not necessarily be there.  
 5 MR. BROWNE:  
 6 Q. Thank you, Doctor. Now, Registrar, can we  
 7 have Exhibit P-2203, please. Doctor, this is  
 8 the spreadsheet you received, I assume, from  
 9 Dr. Mullen. It's dated January, but is that  
 10 when you received it?  
 11 DR. DANKWA:  
 12 A. Yes, I did, yes.  
 13 MR. BROWNE:  
 14 Q. 2006. Again I know it's hard to read, but as  
 15 Mr. Coffey pointed out to you, the last column  
 16 over is the commentary on fixation. Is that  
 17 correct?  
 18 DR. DANKWA:  
 19 A. Yes, that is it.  
 20 MR. BROWNE:  
 21 Q. Now so that we're clear, these are the 23 --  
 22 these are the 23 cases that you compiled  
 23 between 1997 and 2005.  
 24 DR. DANKWA:  
 25 A. Right.



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1 MR. BROWNE:  
 2 Q. Not the six additional cases that were found  
 3 later?  
 4 DR. DANKWA:  
 5 A. That's correct, yes.  
 6 MR. BROWNE:  
 7 Q. So it covers that entire period?  
 8 DR. DANKWA:  
 9 A. Yes.  
 10 MR. BROWNE:  
 11 Q. And, Doctor, of that, the commentary on  
 12 fixation, am I correct in looking at my  
 13 numbers, 22 were adequately fixed and only one  
 14 was --  
 15 DR. DANKWA:  
 16 A. That is correct.  
 17 MR. BROWNE:  
 18 Q. And when the internal controls were present,  
 19 they stained?  
 20 DR. DANKWA:  
 21 A. They stained, yes.  
 22 MR. BROWNE:  
 23 Q. Now Mr. Coffey asked you about adverse events  
 24 and incidents -- incident reports.  
 25 DR. DANKWA:

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1 A. Yes.  
 2 MR. BROWNE:  
 3 Q. And I think there may have been a bit of  
 4 confusion there. Let me just go back over  
 5 that for a minute. In your institution, is  
 6 there somebody in charge of policies which may  
 7 affect events such as adverse events or  
 8 incidents?  
 9 DR. DANKWA:  
 10 A. Yes, we do have human resources personnel who  
 11 organize all the policies, but we have an  
 12 individual who is in charge, the risk  
 13 management manager who is responsible for  
 14 adverse events.  
 15 MR. BROWNE:  
 16 Q. And if there was an incident -- a patient  
 17 incident and you filled out a form that you  
 18 mentioned, a form for an adverse event, how  
 19 would that operate? Would you contact the  
 20 risk management person and they would advise  
 21 you about the policy and how to go about  
 22 things?  
 23 DR. DANKWA:  
 24 A. In some situations where you are not sure  
 25 about which way to go, you will need to

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1 contact her. It's now a "her" who's  
 2 responsible, so you need to contact her and  
 3 she will give you the appropriate direction.  
 4 MR. BROWNE:  
 5 Q. And as far as you know, policies exist with  
 6 regard to these --  
 7 DR. DANKWA:  
 8 A. As far as I know, yes.  
 9 MR. BROWNE:  
 10 Q. Mr. Coffey also asked you about conversion and  
 11 treatment changes. Not getting into the  
 12 distinctions there, Doctor, just my question  
 13 relates specifically to whether or not you  
 14 have any direct knowledge of the patients that  
 15 were -- where their results changed, do you  
 16 know if, in fact, directly there were any  
 17 treatment changes?  
 18 DR. DANKWA:  
 19 A. I don't have any direct knowledge.  
 20 MR. BROWNE:  
 21 Q. Registrar, if we could see Exhibit 2219,  
 22 please, and, Doctor, I'm not proposing to go  
 23 through -- these were exhibits that Mr. Coffey  
 24 went through with you extensively this  
 25 afternoon from your hospital's lab policy and

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1 procedure manual. This one, in particular,  
 2 Mr. Coffey asked you about, it was revised in  
 3 1999, is it possible that was subsequently  
 4 revised in 2007?  
 5 DR. DANKWA:  
 6 A. Yes, in fact, when I saw the year there, I had  
 7 a feeling that this has been revised, but the  
 8 date have not been corrected.  
 9 MR. BROWNE:  
 10 Q. Okay. So this has possibly been revised?  
 11 DR. DANKWA:  
 12 A. It has possibly been revised, but the date --  
 13 MR. BROWNE:  
 14 Q. Again are you able to by just quickly looking  
 15 at that -- probably I can scroll down for you,  
 16 what if any revisions may have occurred in  
 17 2007?  
 18 DR. DANKWA:  
 19 A. Yes, if you'll stop there. On 11, the auto  
 20 stainer, this came in in 2007.  
 21 MR. BROWNE:  
 22 Q. Okay, thank you. Doctor, lastly, is there any  
 23 comment or recommendation you would like to  
 24 make to the Commissioner?  
 25 DR. DANKWA:

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1 A. I don't have any comment, but I would just  
 2 like to say thank you very much to the  
 3 Commissioner, and thank you to Commission Co-  
 4 Counsel. I hope I'm using the right words.  
 5 COMMISSIONER:  
 6 Q. They have been called things much worse.  
 7 DR. DANKWA:  
 8 A. Mr. Coffey and Sandra Chaytor. Then  
 9 obviously, thank you very much, Mr. Browne,  
 10 and Jane, for the spot you've given us, and to  
 11 all of you for being patient and having me  
 12 here. I'm relieved that I've had the  
 13 opportunity to come here and share my views  
 14 with the Commission, but I hope that the  
 15 information that will be gathered here will be  
 16 used positively to the improvement of our  
 17 system within the organization and the  
 18 province as a whole. I'd also like to say  
 19 thank you to everybody in St. Anthony and  
 20 Labrador Grenfell for their support and having  
 21 me -- and retaining me there, and it's my  
 22 intention to continue to be there because  
 23 there's a lot of worry that pathologists are  
 24 leaving and I may be one of them. Any time I  
 25 jump into my car, they think that that is a

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1 one way trip. I will be back and I will  
 2 continue to offer my services, not only just  
 3 to maintain the services, but to improve upon  
 4 it, and to assure all those who have one way  
 5 or the other been affected by this, that I  
 6 will continue to maintain the quality of  
 7 service, and for those who are using our  
 8 service, that I would say that our service is  
 9 of a high quality and I will continue to  
 10 maintain that, so still continue to be certain  
 11 that our services will be offered in a much  
 12 more quality way. Thank you.  
 13 MR. BROWNE:  
 14 Q. That's all the questions I have. Thank you.  
 15 COMMISSIONER:  
 16 Q. Thank you, Mr. Browne. Mr. Coffey, is there  
 17 anything arising?  
 18 COFFEY, Q.C.:  
 19 Q. No, Commissioner, thank you.  
 20 COMMISSIONER:  
 21 Q. Thank you all. Thank you very much, Dr.  
 22 Dankwa. I do appreciate your coming from St.  
 23 Anthony to add another perspective, and like  
 24 you, I do hope that the end product will be  
 25 something that will be of benefit to the whole

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1 system.  
 2 DR. DANKWA:  
 3 A. Thank you.  
 4 COMMISSIONER:  
 5 Q. Thank you all. I don't suppose I have to  
 6 remind you that we are not meeting on Monday,  
 7 and ask you to be here on Tuesday at 9:30.  
 8 Thank you.

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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 11th day of July, A.D., 2008 before  
 6 the Honourable Justice Margaret A. Cameron,  
 7 Commissioner, at the Commission of Inquiry, St.  
 8 John's, Newfoundland and Labrador and was  
 9 transcribed by me to the best of my ability by  
 10 means of a sound apparatus.  
 11 Dated at St. John's, Newfoundland and Labrador  
 12 this 11th day of July, A.D., 2008  
 13 Judy Moss

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Inquiry on Hormone Receptor Testing

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