COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

July 11, 2008

Appearances:

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

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

Peter Browne . . . . . Doctors Kara Laing et al

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

Darlene Russell. . . . . Members of the Breast Cancer
. . . . . Testing Class Action

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

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DR. PAUL NEIL - RESUMES THE STAND

DR. ESSANDOH KWEKU DANKWA - AFFIRMED

THE COMMISSIONER:
Q. Mr. Coffey.
DR. PAUL NEIL, EXAMINATION BY BERNARD COFFEY, Q.C. (CONT'D)
COFFEY, Q.C.:
Q. Thank you, Commissioner. Commissioner, there are several more exhibits. Going to ask that they be entered please. They are Exhibit numbers 2195, 2272, 2299 and 1849
THE COMMISSIONER:
Q. Entered.
EXHIBIT ENTERED AND MARKED P- 2195
EXHIBIT ENTERED AND MARKED P- 2272
EXHIBIT ENTERED AND MARKED P- 2299
EXHIBIT ENTERED AND MARKED P- 1849
COFFEY, Q.C.:
Q. Thank you, Commissioner. If we could, Registrar, please, bring up Exhibit 2299, please?
THE COMMISSIONER:
Q. Mr. Browne, you're, I think, the furthest away from the witness and while we have some advantages today, there is the disadvantage of additional noise. So if you have difficulty hearing the witness, would you please let me

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know?
MR. BROWNE:
Q. I will, Commissioner.
COFFEY, Q.C.:
Q. That's, I take it, Doctor, a subtle way of asking you to speak up.
DR. NEIL:
A. Okay, no problem.
COFFEY, Q.C.:
Q. Thanks, Doctor. Doctor, here on the screen, this exhibit is entitled Association of Directors of Anatomical and Surgical Pathology.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. And you provided us, thank you, yesterday with this document. What is this, Doctor?
DR. NEIL:
A. This is a document that I retrieved from a U.S. source recommending quality assurance and improvements in surgical and autopsy pathology, which I've perused on various occasions, and I think it's a very good document.

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COFFEY, Q.C.:
Q. This is the document, I take it, that you referred to yesterday as you were looking at as a possible template?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. For quality assurance and quality improvement?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Okay. I'm not going to take you actually through it, Doctor, you know, in detail, but this is it and the Commissioner can read it, and this is certainly what you had in mind?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Registrar, could we bring up, please, Exhibit P-1849? Now Doctor, these are your handwritten notes?
DR. NEIL:
A. That's correct.
COFFEY, Q.C.:
Q. Okay, and there are four pages of them.

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Looking at the first page now which begins "letter September 6th, 2005" and there are a number of bullets below it, and then the second page begins "results ER/PR" and then there are notes that follow that, ending with a page entitled "results 939 patients."
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Okay. Doctor, these four pages of notes, do they actually relate to the same day?
DR. NEIL:
A. No.
COFFEY, Q.C.:
Q. Okay, could you--then looking back at it, I understand from a comment Mr. Browne made to me yesterday that the first page stands on its own?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Okay, and if you could, perhaps you could indicate to the Commissioner what this is and just take us through it?
DR. NEIL:

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

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back individually, you know, for each patient from Dr. Cook -

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. - that you attended to having them entered in Meditec?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. Were the reports, if a pathologist was still on staff related to that patient, were those individual reports then referred to a particular pathologist?

DR. NEIL:

A. If the pathologist on staff was still there, he got those reports. All other reports came to me.

COFFEY, Q.C.:

Q. Okay, so I had understood that yesterday, in bulk they came to you?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. They were funnelled through you?

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DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. You ensured that they were entered in Meditec?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. And for those doctors--for those patients for whom the pathologist who had dealt with the original ER/PR was still on staff, he or she got the copies?

DR. NEIL:

A. Yes, he got those.

COFFEY, Q.C.:

Q. And the purpose of giving him, I take it in the main it was his, was what? What was the purpose?

DR. NEIL:

A. The purpose was to sign the report, verify that what was typed was actually what was on the report from Dr. Cook and sign it.

COFFEY, Q.C.:

Q. Okay, so the actual entry then of--for example, if it wasn't your patient, if it was Dr. Luer, for example, the report--Dr. Cook's

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report would at some point, after you received it, end up in Dr. Luer's hands?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. And after the data was entered into Meditec, Dr. Luer was responsible, because it was originally his patient, to go in and satisfy himself that it's appropriate to sign it?

DR. NEIL:

A. Yes, correct.

COFFEY, Q.C.:

Q. Okay, and for those doctors that were no longer on staff, who did that signing?

DR. NEIL:

A. I did.

COFFEY, Q.C.:

Q. Doctor, if we could, please, apologize, page two, three and four of this exhibit, what do they relate to?

DR. NEIL:

A. Page two, three and four go together. These are my handwritten notes of a teleconference that occurred later when the results of the ER/PR testing came back and it was an

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explanation from Dr. Denic as to really what the time lines were and what the results were and what the recommendations were of all the investigations that occurred up to that point. So these were notes that I took and for my own interest and I put them in my file.

COFFEY, Q.C.:

Q. Now Doctor, here, are you able to recall which particular teleconference or video conference this was?

DR. NEIL:

A. As we discussed yesterday, I think this was the case, the only teleconference that I really remember attending, it was the video conference that Dr. Elms, Ford Elms was there as well. I didn't make notes of Dr. Elms' presentation. I just made notes of the presentation from Dr. Denic.

COFFEY, Q.C.:

Q. And Doctor, here, on the third page, and because you've written "problem was, question" and then you've got written "reporting varied. Different technology, DAKO etcetera, Ventana, antibody and antigen."

DR. NEIL:

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A. Yes.
COFFEY, Q.C.:
Q. "No national lab accreditation process"--I'm sorry, can you read that?
DR. NEIL:
A. "No national lab accreditation process, but now started."
COFFEY, Q.C.:
Q. "But now started. Staining complex."
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. "From tissue procurement to reporting"
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. The staining is complex, I take it, the process?
DR. NEIL:
A. Yes, that's correct.
COFFEY, Q.C.:
Q. Then you've got written out here, "needs direction" in capital letters and an asterisk.
DR. NEIL:
A. Yes.

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COFFEY, Q.C.:
Q. "Variation in other labs. Limited resources, lack of QA."
DR. NEIL:
A. Correct.
COFFEY, Q.C.:
Q. "Turnover of pathologists/oncologists."
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. And then "external reviewers recommended reinstatement."
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, during this presentation or talk by Dr. Denic, do you recall if Dr. Denic referred at any time to the observations of the external reviewers in relation to--external reviewer, Dr. Banerjee, in relation to the usage or non usage of internal controls by the pathologists? Did the subject of internal controls and their utilization come up?
DR. NEIL:
A. I would have written that down, I think.

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COFFEY, Q.C.:
Q. Yes, and it's not there, so -
DR. NEIL:
A. It's not there.
COFFEY, Q.C.:
Q. - it's not. And because I take it, that kind of a remark in that context would have been directed at the pathologists?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. And you'd be certain to write that down.
DR. NEIL:
A. I would have. I wrote what I think are good notes. It wasn't there.
COFFEY, Q.C.:
Q. Now Doctor, if I could, Registrar, please, Exhibit 2195, please? Now Doctor, these are two exhibits, you provided these actual copies to us yesterday. Thank you for that. This is a fax transmission to yourself from Judy at Eastern Health and it just says "as requested" the first page. Then the pages that follow, page two is entitled "procedure, ductal carcinoma in situ reporting." Goes on to the

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third page and then there's a "pathology procedures manual, anatomic pathology/grossing protocols." The title is "breast needle core biopsy, standardized grossing" and then there's a pathology procedures manual titled "breast sentinel node lymph node" then there's following page, "Pathology Procedures Manual" title "cancer lumpectomy specimen, breast conserving surgery." Continues on to page seven. Page eight has a canned text needle core biopsy reporting, BCBR, and page nine is the same thing.

Now Doctor, I'm going to show you those and I want to bring up, please, if I could, Exhibit, Registrar, 2272? Doctor, this is a-- it begins on page one, again it's a fax transmission from Eastern Health, a cover sheet to yourself, May 31st 2007, from Judy. It's written "as requested, including one path procedure sheet I had left out." And then page two of this exhibit is an e-mail, Nash Denic, May 31st, 2007 to Judy Thomas, forwarding a memorandum with a number of attachments and they are synoptic DCIS.bb.doc, breast needle core biopsies, standardized

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grossing and if one wants to look, they match the documents that we just looked at.

DR. NEIL:

A. Yes, they do.

COFFEY, Q.C.:

Q. And there's a memorandum below it to pathologists in Newfoundland, I'm going to take you to in a moment, and then the fourth page of this exhibit is the Pathology Procedures Manual, title breast needle core biopsy, standardized reporting. So I take it, Doctor, would I be correct in surmising that in Exhibit 2195, Judy had faxed you a number of documents, those attachments?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. And then one was missing?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. And she sent the final one with that note?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

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Q. Now Doctor, looking at this e-mail, Doctor, do you recall--do you recall, Doctor, how this came about? I mean, this transmission of these documents to yourself, what led to this, in May of 2007?

DR. NEIL:

A. We wanted to have standardized protocols for examination of breast tissues, standard protocols for fixation. This e-mail came from Dr. Denic to all pathologists in Newfoundland. Unfortunately, the e-mail didn't come through to me. That's the reason for the faxes.

COFFEY, Q.C.:

Q. Okay.

DR. NEIL:

A. So I called Judy and said "I didn't get the attachments. Please send it over to me right away," which she did.

COFFEY, Q.C.:

Q. So you got the e-mail without the attachments?

DR. NEIL:

A. I got--I didn't get the attachments.

COFFEY, Q.C.:

Q. Okay.

DR. NEIL:

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A. That's why the faxes are there. I went looking for the fax, looking for that attachment and got it through a fax instead. In any event, I did get it.

COFFEY, Q.C.:

Q. Now, Doctor, if we could, please -- could the Registrar please bring up P-0854. Doctor, this is an e-mail from John Abbott who was then the Deputy Minister to Oscar Howell, the VP Medical of Eastern Health, May 23rd, 2007, and it says -- after asking Dr. Howell to call, Mr. Abbott says, "I also need for you to arrange a conference call tomorrow a.m. with other VPs of Medical Service in province on the ER/PR issue, and current testing processes. Please include Cathi Bradbury and Moira Hennessey in call".

DR. NEIL:

A. Uh-hm.

COFFEY, Q.C.:

Q. And then the Commissioner has heard that there was, in fact, a teleconference the next day across the province involving a number of VP medicals from the health authorities.

DR. NEIL:

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A. Yes.

COFFEY, Q.C.:

Q. Did you participate in that teleconference, do you recall?

DR. NEIL:

A. Not that I recall, no.

COFFEY, Q.C.:

Q. Doctor, this memo -- if we could look back please at Exhibit P-2272, and before I leave the topic of that May 24th teleconference, do you ever recall being told by Dr. Jenkins about what went on during it or what it was about?

DR. NEIL:

A. No.

COFFEY, Q.C.:

Q. Okay, and again --

DR. NEIL:

A. I've had a lot of conversations with Dr. Jenkins, so --

COFFEY, Q.C.:

Q. I appreciate that. This particular thing would have involved the issue of the other three health authorities as at that point not utilizing Eastern Health for ER/PR testing.

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DR. NEIL:
A. Okay, okay.
COFFEY, Q.C.:
Q. Do you recall that being --
DR. NEIL:
A. Yes, yes.
COFFEY, Q.C.:
Q. What do you recall about being told about that?
DR. NEIL:
A. Well, I was asking were we, in fact, sending back to Eastern Health, and if we weren't, why, and we have discussed that already.
COFFEY, Q.C.:
Q. So you told Dr. Jenkins what you told the Commissioner?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Now looking at this, Doctor, this particular memorandum by e-mail, did you have any heads up that this was coming to you?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:

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Q. And you understood, I take it at the time -- you pointed out that there was some thought in the pathology community that this should be somehow standardized?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. The approach in the province. What then happened? You received this -- you received the e-mail and then the fax. What then happened, Doctor?
DR. NEIL:
A. This got circulated to all our pathologists and, in effect, this is what we adopted, mostly notably the fixation protocols.
COFFEY, Q.C.:
Q. And in relation to that, if you could bring up, please, Exhibit P-2195, page 10, please, Registrar. This is the fixation protocol you're speaking of?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Now, Doctor, have you received any -- since that time, since May 31st, 2007, have you

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received anything further in relation to pathology procedures manuals, policy manuals generally, anything else since?
DR. NEIL:
A. No.
COFFEY, Q.C.:
Q. And so when you said yesterday to the Commissioner that you had received a procedure -- written procedure from Eastern Health relating to fixation and Western Memorial is now following that --
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. This is the document you're talking about?
DR. NEIL:
A. This is it.
COFFEY, Q.C.:
Q. If we could, please, as well -- I'm just going to go to page 11. Now this is a document -- it came separately when we look back at the attachments.
DR. NEIL:
A. Okay.
COFFEY, Q.C.:

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

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is a document headed "Pathology Division", and pathology/specimen collection and handling, the number is PRC-PAT-102. It's two pages long. The title is "Fixation procedure for pathology specimens". The issuing authority is Dr. Nash Denic and Terry Gulliver. The signatures are indicated to be March 17, 2008, the issue date is March 19, 2008; the date effective, March 19th, 2008. It has headings; overview, safety precautions, and procedure. There are four procedures and there are references below. Now if we could go back -- have you seen this before or received a copy of it?

DR. NEIL:

A. No, I haven't.

COFFEY, Q.C.:

Q. If we could look, please, back at page nine, the same exhibit. Now, Doctor, this is a document on Eastern Health letterhead. It's called "Fixation policy". The policy name is fixation policy, the laboratory 410J-PCO-010. The issuing authority signed and dated, Nash Denic, February 4th, 2008, Terry Gulliver, February 5th, 2008, and it's a level four

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document apparently. The original approval date is February 4th, as I've said, and review date is said to be February 4th, 2009, and the document itself has headings; overview, policy, scope, purpose, and a procedure with five steps noted. Doctor -- and I should go on with this particular one. As well there are supporting documents noted and linkages to, I take it, what I understand are other policies and procedures. Doctor, have you received a copy of the document at page nine?

DR. NEIL:

A. No.

COFFEY, Q.C.:

Q. Doctor, at the time back in May 31st, 2007, when you received Dr. Denic's memo to all pathologists in Newfoundland, and then you got the --

DR. NEIL:

A. Uh-hm.

COFFEY, Q.C.:

Q. Policies such as you did or procedures such as you did at the time.

DR. NEIL:

A. Uh-hm.

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COFFEY, Q.C.:

Q. Did you have any understanding about what you might or might not receive from Eastern Health if they changed or added to their policies and procedures? What is the expectation?

DR. NEIL:

A. Dr. Denic did say that they were going to do policies and procedure manuals.

COFFEY, Q.C.:

Q. Yes.

DR. NEIL:

A. It was my understanding that some of these would be shared, and it's still my understanding that some of these would be shared. It looks like they've got a lot of work done.

COFFEY, Q.C.:

Q. Yes. Well, in fact, that document that took all that time to load --

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. Exhibit P-2157.

DR. NEIL:

A. Yes.

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COFFEY, Q.C.:

Q. I'll just let you know, Doctor, that after you leave here today, if you want to see --

DR. NEIL:

A. I would like to have a copy of that.

COFFEY, Q.C.:

Q. What the Commission has received -- it's on the website. Actually now it's on the website.

DR. NEIL:

A. Okay.

COFFEY, Q.C.:

Q. As of the past week or so.

DR. NEIL:

A. Uh-hm.

COFFEY, Q.C.:

Q. It's on the Commission's website, that is.

DR. NEIL:

A. Uh-hm, okay.

COFFEY, Q.C.:

Q. So, Doctor, in particular because you did -- as you pointed out to the Commissioner, if we look back at Exhibit P-2195, at page 10, they fixation policy that you received a copy of as it was.

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DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. In May of 2007, the comparable fixation procedures or policies that I just showed you.
DR. NEIL:
A. Should be the same.
COFFEY, Q.C.:
Q. Should be the same, and if they are different, I take it you'd like to see the differences and nuances or possible differences?
DR. NEIL:
A. Certainly.
COFFEY, Q.C.:
Q. Okay. I'm not going to take you to -- there are some particular -- if we could, please, Exhibit P-2157, page 10. In particular, Doctor, I'm going to take you to -- this is the fixation policy generally, okay.
DR. NEIL:
A. Uh-hm.
COFFEY, Q.C.:
Q. Go back to see -- fixation policy, and this refers to really all tissues, okay.
DR. NEIL:

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A. Yes.
COFFEY, Q.C.:
Q. Requiring formalin fixation. There's, for example, number five here in procedure, the date and time of fixation must be documented on the requisition.
DR. NEIL:
A. Uh-hm.
COFFEY, Q.C.:
Q. When you look back at the one that you were given back in May of 2007, that's not referred to, is it?
DR. NEIL:
A. No.
COFFEY, Q.C.:
Q. And again I'm not going to take you through -- they can be compared and there are differences between them?
DR. NEIL:
A. Yes, there are.
COFFEY, Q.C.:
Q. Looking at Exhibit P-2195, please, Doctor, this is the one that you received in May and you've indicated to the Commissioner that Western has been following since. Doctor, the

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procedures here, was there a written -- a comparable written procedure in existence in Western Memorial or Western Health prior to May, 2007? Did you have a fixation policy for Western Memorial or Western Health?
DR. NEIL:
A. Not that I'm aware of. I'm not saying it's not there, but I'm not aware of it.
COFFEY, Q.C.:
Q. And now this procedure that's outlined here, I understand this is a general procedure, it's not applicable to any one particular type of --
DR. NEIL:
A. No, but I do have to make a point about procedures. Standard pathology textbooks, Ackerman being one of them, has standard grossing procedures back in the back part of the textbook which we refer to quite frequently. This fixation issue is probably there.
COFFEY, Q.C.:
Q. Included in that?
DR. NEIL:
A. Included in the --

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COFFEY, Q.C.:
Q. In a standard text?
DR. NEIL:
A. Yes, in a standard text.
COFFEY, Q.C.:
Q. And now in terms of Western Memorial or Western Health's practises, including that in Stephenville, okay --
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Because this would begin, in effect, at the surgery.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. In the OR. Do you know if Western Memorial or Western Health was following this procedure set out here in this exhibit, the one of May, 2007, or that you received May, 2007, before that? Was this being done?
DR. NEIL:
A. For the most part. Number four being one that comes to mind in that these are thin slices.
COFFEY, Q.C.:

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

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of business at Western Memorial, when would that specimen did come out of the formalin and be put into the processor?
DR. NEIL:
A. Sometime the next day.
COFFEY, Q.C.:
Q. Which would be when the next day, generally?
DR. NEIL:
A. It could be --
COFFEY, Q.C.:
Q. Early the next morning, generally?
DR. NEIL:
A. It could be early the next morning. It could be later on in the day, but remember when it comes out of the formalin after it's been bread loafed --
COFFEY, Q.C.:
Q. Yes.
DR. NEIL:
A. The tissue, the tumour tissue being blocked and put in a cassette, still remains in formalin.
COFFEY, Q.C.:
Q. When it goes into the --
DR. NEIL:

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

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Q. If you set out to create what you're going to see now in Exhibit P-2157, okay?
DR. NEIL:
A. Okay.
COFFEY, Q.C.:
Q. If you set out to create that, that sort of a kind of, for the whole Laboratory Medicine Program, I'm not saying that all relates to it, but if it does, okay.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. For the whole of the Laboratory Medicine Program, the pathology end of it that you're involved in.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Do you have the resources available to you right now to -
DR. NEIL:
A. No.
COFFEY, Q.C.:
Q. What would you have to do in order to actually accomplish that, if you set out to do it?

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Would you have to, in effect, use someone else's and modify it to your own situation?

DR. NEIL:

A. I would like to have that, that would certainly make my job very much easier. I need resources--I need, personally, I need the time to go through that, to adopt the procedures from that document and other documents and customize those to Western Health. I look at some of the stuff as my responsibility as laboratory director, in consultation with our laboratory manager. Now our laboratory manager does have procedure manuals, procedure and policy manuals for technologists and general lab procedures which are constantly updated, so there are policies and procedure manuals for technologists.

COFFEY, Q.C.:

Q. On that end of the -

DR. NEIL:

A. On that end of it. Some of the things that I'm talking about are policies and procedures that apply to pathologists, per se.

COFFEY, Q.C.:

Q. Yes.

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DR. NEIL:

A. And we have a fair number of them, as I mentioned, in the standard pathology textbooks; Ackerman being one of them. But things need to be fine tuned and we need to have a lot more policies and procedure manuals that apply directly to the work that we do. For me to do that, in the situation that we're in today and the situation has been like that for awhile, the amount of work that I have on an administrative side, verses the service work that I'm doing today, doesn't balance out. The service work comes first and when I have a pile of slides on the side of my desk and a surgeon phones me and says, what's the result on Mrs. so and so or Mr. so and so, and they've done it, and I haven't gotten to it because I'm doing administrative work, well that can't happen. And to pass it along to my colleagues, they're just as overworked as I am. So the resources that I would like to have six months or so dedicated solely to policies and procedures and six months is just off the top of my head.

COFFEY, Q.C.:

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Q. To actually get the breathing space, as it were, to actually -

DR. NEIL:

A. I need some breathing time, exactly, and I've actually said that to our administration and they've been considering that. Hopefully by the end of this month, I'll have another pathologist; maybe by the fall, I'll have a pathology assistant, but I'm not hopeful because those people are rare. We have been told that we have additional technology staff available to us or will be having additional technology staff available to us.

COFFEY, Q.C.:

Q. When were you told that?

DR. NEIL:

A. In the last week.

COFFEY, Q.C.:

Q. And who told you that? Who did you get the news from?

DR. NEIL:

A. It came from Dr. Jenkins. Actually there's seven staff in total, but that doesn't really alleviate my concern about policies and procedures for pathologists. And in that

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policies and procedures for pathologists, is a document you brought up earlier, the QA document, which is what I need to refine and produce for, not only us, but I think that should be for the whole province. You need time to do those things. I don't have it.

COFFEY, Q.C.:

Q. Doctor, if we could, please, ask you to, Registrar, bring up Exhibit P-2287? Doctor, this is a series of e-mails but they go back to November 30th, 2007 and there's an e-mail from Patricia Pilgrim to Dr. Jenkins involving communication of test results, ER/PR and there's various headings in that, for the living patients whose results have not changed; for the living patients whose results have changed; for deceased patients within Eastern Health region; and finally for deceased patients from other regions. Now, then that e-mail was forwarded by Dr. Jenkins on December 17th to yourself, saying, "Please provide your feedback on the proposed process" and it was sent to you and Hedy Dalton Kenny?

DR. NEIL:

A. Yes.

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COFFEY, Q.C.:
Q. And who is that?
DR. NEIL:
A. Hedy is the regional director of laboratory services.
COFFEY, Q.C.:
Q. And it notes, she's written back saying, "Paul is not in the office today, I will consult with him when he returns." And she goes on to suggest that "notification of next of kin of those deceased patients whose results were changed be done by Eastern Health personnel, not by the co-ordinator at Western. Western Health will provide the required contact information of the next of kin." Doctor, from the perspective of the deceased patients, I take it that in 2007 you were asked to provide, you referred to that yesterday I believe, the blocks, the appropriate blocks and slides if necessary for retesting.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. The results came back.
DR. NEIL:

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A. Yes.
COFFEY, Q.C.:
Q. And they've been entered into the Meditec system appropriately, in Western.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. In terms of that process, when did that conclude, your end of it, your involvement in terms of entering the data? Do you remember when?
DR. NEIL:
A. The process of deceased patients, finding out who they were and getting the work done occurred over a period of several weeks, maybe even a month or more. We did get several letters from Robert Thompson and they came through Susan Gillam, our CEO, and as she got those letters, we did what we needed to do in finding the patients and sending them off appropriately. So a timeframe is probably weeks to maybe a month or more.
COFFEY, Q.C.:
Q. And that concluded approximately when, do you remember?

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DR. NEIL:
A. It's been several months now or more. I can't give you an exact date because I don't know it.
THE COMMISSIONER:
Q. I'm sorry?
DR. NEIL:
A. I said I can't give him an exact date because I don't know the exact date. If I had my material, I could.
COFFEY, Q.C.:
Q. Yes, and again, the point is, Doctor, you've been through it -
DR. NEIL:
A. Yes, it's done.
COFFEY, Q.C.:
Q. - and it's done. I just wanted to have that. And I take it that you entered into that process of retesting the deceased tissue samples when you were asked to do so by Eastern Health?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Provide the material and -

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DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. Okay. If we could, please, Exhibit P-2290? And, Doctor, this is a letter, it's from yourself April 1st, 2008. It's to a particular doctor, which the name is redacted and I'll just have you have a look at that for a moment, okay, and read it to yourself. And then if I could, please, bring up Exhibit P-2291? And this, again, would you have a look at that, Doctor? Again, it's to a doctor, it's a letter from yourself, I understand, and both of the letters refer to, "Please find enclosed reports on the above-mentioned patient", whose name is redacted. And in particular, Doctor, the surgical number here on this page, 291, you'll see is a 1997 number?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. And the SU signifies what?
DR. NEIL:
A. It's surgical.

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COFFEY, Q.C.:
Q. That's the utilization by Western Memorial?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. If we could bring up again, please, Exhibit P-0290? And, Doctor, you'll see here the surgical number here is a 1997 case too?
DR. NEIL:
A. Uh-hm.
COFFEY, Q.C.:
Q. It's a different number, but--do you recall what this was about generally, Doctor, these particular cases? Like why in April of 2008 they were being dealt with?
DR. NEIL:
A. There may have been some discrepancies in the diagnosis and if I knew the names of those patients, it would certainly job my memory a bit more, but I don't know the names of those patients because they're obviously not on the screen.
COFFEY, Q.C.:
Q. Yes. And if I could here, this particular one, this is 2290, I believe, yes, in the text

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you refer to being unclear as to the patient's clinical situation at that point and yourself and Dr. Jenkins discuss the appropriate course of action with Dr. Laing and you're saying to this physician, you're addressing this letter to, "as you are the physician in this case, it was recommended that you discuss her clinical situation with Dr. Ganguly, who is following the patient and subsequently discuss her clinical situation and enclose reports." So, Doctor, do you know if there were any people from 1997 missed, as it were? Do you know if that -
DR. NEIL:
A. Not that I'm aware of.
COFFEY, Q.C.:
Q. Not that you're aware of, okay, so this wouldn't relate to that -
DR. NEIL:
A. And this was my concern all along, not to miss patients.
COFFEY, Q.C.:
Q. So this doesn't relate to that.
DR. NEIL:
A. No, there are no missed patients to my

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knowledge.
COFFEY, Q.C.:
Q. And as well, if we could, Exhibit P-2292 please? Again, this is a letter of April 1, 2008, there are three of them on the same date and this relates to, I take it this is addressed to a doctor whose name is redacted, and again -
DR. NEIL:
A. I can tell you in general what these cases mean.
COFFEY, Q.C.:
Q. Yes, in the early '08, that's what -
DR. NEIL:
A. In general what these cases mean, and discrepancy is not really the right word because they're not really a discrepancy per se. As we discussed earlier, we have DCIS patients and DCIS patients with microinvasion. To reconcile the diagnosis, the Mount Sinai diagnosis and the Western diagnosis on our spreadsheets, sometimes we would have a difference.
COFFEY, Q.C.:
Q. Yes.

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DR. NEIL:
A. Simply because of a sampling those particular blocks and at some time you may see DCIS, you cut another sample from that particular block, you may see three or four more cells outside that duct which now become microinvasive which requires ER/PR testing. But by sampling these particular tissues further -
COFFEY, Q.C.:
Q. You'd have to go through more blocks.
DR. NEIL:
A. You would have to go through more blocks. That's why a so-called discrepancy may come up. It's a sampling thing, so to reconcile those sampling issues, I wrote physicians, I further got further consultations to make sure that these particular patients had ER/PR results, if needed.
COFFEY, Q.C.:
Q. If there was an invasive component, they needed it.
DR. NEIL:
A. It there was an invasive component, they needed it.
COFFEY, Q.C.:

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Q. Doctor, I had understood yesterday you told the Commissioner that, in fact, that process had begun really in the middle of 2007, in the summer.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. In fact there's correspondence there about it.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. That's why in 2008 then, for some patients anyway, that was still being pursued?
DR. NEIL:
A. It was still being pursued.
COFFEY, Q.C.:
Q. Okay, that was what--Doctor, before I leave it, you did, in answering an earlier question, refer to the fact that on the technologist end or side of the lab there are written policies and procedures that are constantly being updated?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:

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Q. How long have they been in existence?
DR. NEIL:
A. Years and years.
COFFEY, Q.C.:
Q. And who is responsible for them, actually maintaining them?
DR. NEIL:
A. Ultimately responsible would be the regional director of Laboratory Services.
COFFEY, Q.C.:
Q. Who is currently?
DR. NEIL:
A. Who is Hedy Dalton Kenny and her predecessors, of course.
COFFEY, Q.C.:
Q. Would you anticipate that some of those written policies and procedures would relate to breast tissue?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. In particular, and in some perhaps in a more general way, a fixation wouldn't cover -
DR. NEIL:
A. The fixation may not be there, I don't know.

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

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to discuss." And then Dr. Jenkins goes back to Moira Hennessey later that day saying "Further to our phone call a short while ago, I have confirmed with Dr. Neil that our ER/PR specimens are still going to Mount Sinai. As well, regarding the tissue fixation standards circulated by Dr. Denic, Dr. Neil confirms that we are following that standard." And you've told the Commissioner about that earlier.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. If I could, please, on this, if we could bring up finally Exhibit P-2294 please? Now, Doctor, these would be Dr. Jenkins' notes, I take it.
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. You recognize his handwriting?
DR. NEIL:
A. Yes.
COFFEY, Q.C.:
Q. And it's about the telephone call with Moira

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Hennessey, but number two, he says, "we are following the fixation standard as best we can" and he is quoting, in effect, from you.

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. "Occasionally specimen comes in on Thursday, we are meeting the standard, some controversy around this in the literature. We have met the standard in all cases to the best of Paul's knowledge." So that in April 2008, apparently Ms. Hennessey, on behalf of the Department was requiring of Western Memorial as to the fixation policy in place and whether it was being followed.

DR. NEIL:

A. Uh-hm.

COFFEY, Q.C.:

Q. Now if we could, P-2296 please? Doctor, this is two e-mails of May 6th involving, well the first of them is from yourself, to J. Grabka. And you say, "Jeanette, please have Sharon distribute this memo to the appropriate people, I do not know to send it to in the OR. I spoke to Shirley Butt's replacement. Maybe

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

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DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. - their personnel. In Western Memorial and now Western Health, is there any particular formal linkage between them? Like, who has to, in effect, convey your request/demand as it were to the OR and an OR personnel and have it imposed, as it were, if necessary, imposed on them or have them accommodate your concerns? I'm trying to get some sense for the Commissioner, in Western as to the interface between the operating room personnel and the laboratory medicine personnel in relation to policies or procedures that they might carry out that impact you or vice versa. So, could you tell the Commissioner how that's -

DR. NEIL:

A. When I said I do not know who to send it to in the OR, I just didn't know the name of the person.

COFFEY, Q.C.:

Q. Even that, that's, even that I'm getting at, okay.

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DR. NEIL:

A. I didn't know the name of the person. Heads of department change frequently and unfortunately, I don't always keep up on the changes. So, when I said, send it to the OR, I meant, send it to the person who is in charge, the nurse, co-ordinator, whatever you want to call him or her. Hedy or Jeanette would know this; if they didn't know it, they would find out. It's the person in charge that I wanted it sent to.

COFFEY, Q.C.:

Q. But in relation to that then, here's what I'm getting at, is having sent it to the person in charge -

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. - do you have the ability in your position to impose it upon them or what happens, if -

DR. NEIL:

A. I hope I do.

COFFEY, Q.C.:

Q. Okay. That's what I'm asking in terms of that because the Commissioner has heard about

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Eastern Health, at least, seen some documentation involving Eastern Health, request of a similar nature.

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. Okay. In terms of scheduling of surgery throughout the day, in their case. So, from your perspective, in your position, when you sent that memo -

DR. NEIL:

A. I expected it to be acted on.

COFFEY, Q.C.:

Q. Acted upon. And if not, to enter into a dialogue as to why it couldn't have and discuss it further.

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. So, from your perspective in terms of your own view of your own sphere of authority, having sent it, unless you heard to the contrary, you expected -

DR. NEIL:

A. I expected it to be done. To me it's a

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serious issue. It is a serious issue, period. So, it should be acted upon. As I've said in an e-mail, I did discuss it with Dr. Jenkins, he was aware of it, should be done.

COFFEY, Q.C.:

Q. Commissioner, thank you. Thank you, Dr. Neil. I've gone a little bit longer than what I thought, but -

DR. NEIL:

A. Thank you

THE COMMISSIONER:

Q. Do you have any questions, Ms. Brazil?

MS. BRAZIL:

Q. I have no questions for this witness, Commissioner, thank you.

THE COMMISSIONER:

Q. Thank you. Mr. Simmons?

DR. PAUL NEIL, EXAMINATION BY MR. DANIEL SIMMONS

MR. SIMMONS:

Q. Thank you, Commissioner. Commissioner, I can see there's an advantage now to being on this side of the room because the air is cooler, closer to the air conditioners. Dr. Neil -

THE COMMISSIONER:

Q. Well, you blew it on the first day apparently

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when you went on the other side.

MR. SIMMONS:

Q. I did.

THE COMMISSIONER:

Q. I'm sure there are advantages to being on that side or the room, as well.

MR. SIMMONS:

Q. There are. Dr. Neil, I'm Dan Simmons, I'm the lawyer for Eastern Health. I've got a few questions for you. I won't be too long. First, can I bring up Exhibit P-2297 please? Mr. Coffey showed you earlier these pathology reports here. This particular one from Western Memorial and this is from 2003 and it's one that was--there's an addendum on this one completed by Dr. Luer. It's the one that referred to poor quality of sections in staining precluding assessment for estrogen receptor on this particular sample.

DR. NEIL:

A. Yes.

MR. SIMMONS:

Q. Can you tell from these pathology reports where the sample originated, whether it was at Western Memorial Hospital itself or whether at

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Sir Thomas Roddick Hospital in Stephenville.

DR. NEIL:

A. This originated at Western Memorial,

MR. SIMMONS:

Q. This one originated at Western, and you can tell from the pathology report?

DR. NEIL:

A. I can tell -- yes, I can tell by looking at that.

MR. SIMMONS:

Q. Okay, by the surgical number or --

DR. NEIL:

A. No, by the physician name.

MR. SIMMONS:

Q. I see, okay, and that's the way you can do that, and you told us, I think, that you recall there being one occasion when Dr. Luer had raised an issue like this with you verbally?

DR. NEIL:

A. Yes.

MR. SIMMONS:

Q. And one occasion when -- was it, Dr. Curren (phonetic).

DR. NEIL:

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A. Correct.
MR. SIMMONS:
Q. Had raised a similar issue?
DR. NEIL:
A. Correct.
MR. SIMMONS:
Q. You gave us also a very helpful chart which shows the different pathologists that had been at Western Memorial at different times.
DR. NEIL:
A. Uh-hm.
MR. SIMMONS:
Q. How they changed relatively frequently over the years, I guess.
DR. NEIL:
A. Yes.
MR. SIMMONS:
Q. Prior to 2005, had you had any other comments or complaints from any of those other pathologists about the quality of the ER or PR slides that had been returned?
DR. NEIL:
A. No, not that I recall.
MR. SIMMONS:
Q. And those pathologists generally, had they

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come to Corner Brook from other institutions and other parts of Canada or the United States?
DR. NEIL:
A. They generally came from other institutions in the US.
MR. SIMMONS:
Q. Yes.
DR. NEIL:
A. Where their training occurred, not exclusively --
MR. SIMMONS:
Q. So this --
DR. NEIL:
A. There were some people who were trained -- prior to 2005, there were people trained in St. John's as well that worked for us.
MR. SIMMONS:
Q. So there were some that were trained in St. John's, but there were pathologists who had trained in various other locations and institutions.
DR. NEIL:
A. Yes.
MR. SIMMONS:

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Q. In the United States?
DR. NEIL:
A. Yes.
MR. SIMMONS:
Q. And elsewhere in Canada as well?
DR. NEIL:
A. And else where in Canada.
MR. SIMMONS:
Q. So would you have expected them to have come with some diversity of knowledge?
DR. NEIL:
A. Certainly.
MR. SIMMONS:
Q. You'd certainly like to expect when they were looking at those slides?
DR. NEIL:
A. Certainly.
MR. SIMMONS:
Q. And none of those had raised any concerns?
DR. NEIL:
A. None of those had raised concerns.
MR. SIMMONS:
Q. Okay, and when a pathologist gets the end result slide which has the estrogen receptor stain or the progesterone receptor stain on

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it, do I understand correctly from what we've heard that the quality of the end product might be affected by any of the steps along the way, beginning with the operating room and the adequacy of fixation at the outset of the process?
DR. NEIL:
A. Certainly.
MR. SIMMONS:
Q. And for this particular slide that Dr. Luer commented on, the fixation and processing portion would have happened at Western Memorial?
DR. NEIL:
A. Yes.
MR. SIMMONS:
Q. And it's the block that would have gone to St. John's to be processed into the stain slide there?
DR. NEIL:
A. Correct.
MR. SIMMONS:
Q. A couple of questions for you about identification of the patients whose samples were to be retested once you were asked to do

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that in 2005, and you described for us how you had Meditec records available from 1999 forward?

DR. NEIL:

A. Correct.

MR. SIMMONS:

Q. And prior to that you had an earlier system which wasn't as user friendly, I guess, as the lingo goes.

DR. NEIL:

A. Correct.

MR. SIMMONS:

Q. But in your Meditec system, were you able to do a search of that system and identify the results of the ER/PR testing or would it only identify the fact that an ER or PR test had been done?

DR. NEIL:

A. It would identify the fact that an ER/PR test was done.

MR. SIMMONS:

Q. Yes.

DR. NEIL:

A. If you actually looked at the patient record you could see the result.

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MR. SIMMONS:

Q. Okay. So, in order to determine which patient results spell within or outside of the retest criteria, there wasn't an automated way to do that.

DR. NEIL:

A. No.

MR. SIMMONS:

Q. You had to read the text of the pathology reports, did you?

MR. SIMMONS:

Q. Yes, you did.

DR. NEIL:

A. Yes.

MR. SIMMONS:

Q. Now, you also said that at a later point in the process you wanted to identify those patients who were deceased at that time and that you used Meditec as a tool to assist you in doing that?

DR. NEIL:

A. Yes.

MR. SIMMONS:

Q. Would you know how information about whether a patient had died would find its way into your

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hospital Meditec system?

DR. NEIL:

A. Yes.

MR. SIMMONS:

Q. How would that happen?

DR. NEIL:

A. There was usually a death record.

MR. SIMMONS:

Q. Okay. If the patient had not died at the institution or somehow affiliated with Western Health, would those records find their way into your Meditec system?

DR. NEIL:

A. If the patient had died outside -

MR. SIMMONS:

Q. If the patient had died in St. John's, for example.

DR. NEIL:

A. I generally wouldn't know it.

MR. SIMMONS:

Q. You wouldn't know.

DR. NEIL:

A. Not from our record.

MR. SIMMONS:

Q. Right. So, your record would identify those

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patients who had died and a record of that was generated at Western Memorial or some affiliated institution.

DR. NEIL:

A. Yes.

MR. SIMMONS:

Q. So, by necessity, that wouldn't necessarily be a complete list of the patients who were deceased?

DR. NEIL:

A. No.

MR. SIMMONS:

Q. That was the best source that you were aware of.

DR. NEIL:

A. The only source that I had.

MR. SIMMONS:

Q. You were asked some questions again a few moments ago about your memo concerning the scheduling of breast surgeries at Western Memorial. And I believe you told us yesterday that most of those surgeries are done by a single surgeon, are they?

DR. NEIL:

A. On Thursday, yes.

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MR. SIMMONS:
Q. On Thursdays. And how many surgeons do you have at Western Memorial, surgeons who would perform breast surgery.
DR. NEIL:
A. Well, one surgeon is a breast surgeon and she operates on Wednesday.
MR. SIMMONS:
Q. Yes. So, I suspect she would do most of the cases.
DR. NEIL:
A. She does most of the cases, yes.
MR. SIMMONS:
Q. Okay. So, was it particularly difficult at Western Memorial to be able to schedule things so that surgeries didn't happen on Thursday or Fridays? Were there any challenges to that at your institution?
DR. NEIL:
A. Not really because it's a small institution and I know people and, as I mentioned in my testimony yesterday, I spoke to that particular surgeon and her husband and got them to switch their days.
MR. SIMMONS:

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

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Health? Is there a framework?
DR. NEIL:
A. There is a framework?
MR. SIMMONS:
Q. Has that framework been applied in laboratory medicine?
DR. NEIL:
A. We are in the process of doing that.
MR. SIMMONS:
Q. In the process -
DR. NEIL:
A. As I mentioned earlier, it's a time consuming process and I have some work done, but I would like more time to complete that work.
MR. SIMMONS:
Q. Yes, okay. And in order to implement a policy or adopt a procedure, are there any occasions when anyone that you're aware of in Western Health has to go outside the organization for approval or is the sign off on policy and procedure always completely within your organization?
DR. NEIL:
A. To my knowledge, we can sign off within the organization.

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MR. SIMMONS:
Q. Right. And is there anything in place, formally or informally in this province that you're aware of that requires that any type of policies be standardized across the different regional health authorities? And you wouldn't be aware of all areas, I know, but within the areas that you're familiar with.
DR. NEIL:
A. Are there--I want to understand your question.
MR. SIMMONS:
Q. Is there any regime in this province to ensure that, in specific, that the Western Health's fixation policy is the same as the one at Eastern Health, as that example?
DR. NEIL:
A. No.
MR. SIMMONS:
Q. No.
DR. NEIL:
A. I would like to ensure that it is because we are treating the same tissues. It should be a standard protocol across Canada.
MR. SIMMONS:
Q. Right, but one authority has no power to

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impose a policy or procedure on another?
DR. NEIL:
A. No.
MR. SIMMONS:
Q. No, but obviously co-operation and working together is the way to go to see that happen.
DR. NEIL:
A. Co-operation is of upmost importance.
MR. SIMMONS:
Q. Yes, okay. Thank you very much, Dr. Neil, that's all I have.
DR. NEIL:
A. You're welcome.
THE COMMISSIONER:
Q. Mr. Pritchett?
MR. PRITCHETT:
Q. We have no questions, Commissioner.
THE COMMISSIONER:
Q. Thank you. Ms. Newbury?
DR. PAUL NEIL, EXAMINATION BY MS. JENNIFER NEWBURY
MS. NEWBURY:
Q. Good morning, Dr. Neil.
DR. NEIL:
A. Good morning.
MS. NEWBURY:

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Q. Jennifer Newbury for the Canadian Cancer Society, Newfoundland and Labrador Division. I just have a few questions for you this morning and I want to start with the topic of disclosure. And I understood that it was your evidence that you felt that you didn't personally have any role to play in terms of communicating with patients -
DR. NEIL:
A. That's correct.
MS. NEWBURY:
Q. - regarding that issue.
DR. NEIL:
A. I wasn't asked to participate.
MS. NEWBURY:
Q. You were -
DR. NEIL:
A. No.
MS. NEWBURY:
Q. Oh, you weren't asked to -
DR. NEIL:
A. I was not asked to participate in disclosure.
MS. NEWBURY:
Q. And I believe it was also your evidence that you couldn't recall if you had advised Dr.

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

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

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

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DR. NEIL:
A. No, I wasn't.
MS. NEWBURY:
Q. - whether or not that should be an issue to be addressed.
DR. NEIL:
A. No I wasn't.
MS. NEWBURY:
Q. Regardless of what the outcome might be.
DR. NEIL:
A. No, I wasn't.
MS. NEWBURY:
Q. Okay.
DR. NEIL:
A. I knew it would arise.
MS. NEWBURY:
Q. Ultimately -
DR. NEIL:
A. Ultimately, it would arise.
MS. NEWBURY:
Q. Right, but you were thinking--was it your opinion that more than likely the disclosure would take place after the results had come back?
DR. NEIL:

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A. Yes, that was my opinion.
MS. NEWBURY:
Q. And was that perhaps why you didn't alert someone to it, that you were thinking this is an issue for later when we have the results back.
DR. NEIL:
A. I would like to see that we have proven that we have a problem.
MS. NEWBURY:
Q. Okay. And at that time, as of June 14th, 2005, did you have any idea whatsoever what the scope of the problem -
DR. NEIL:
A. No, no.
MS. NEWBURY:
Q. - that was being investigated.
DR. NEIL:
A. No, no, yes.
MS. NEWBURY:
Q. And if you had thought that there was a greater chance that, you know, a fairly significant number of the tests might change, would you have been more inclined to delve into that a bit earlier on?

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

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organization and there was some reason to be concerned about the results, such that you required a retest, as a pathologist, do you feel that you have any responsibility in that situation regarding disclosure.

DR. NEIL:

A. Most definitely.

MS. NEWBURY:

Q. And what would you be responsible for -

DR. NEIL:

A. If there is a situation in my hospital, my lab, that patients need to have information, if disclosure has to occur, my first move would be to talk to senior management and the appropriate people in the appropriate department and I've done this, and say, we got a problem and we need to deal with it.

MS. NEWBURY:

Q. And you would go directly to senior management?

DR. NEIL:

A. Yes.

MS. NEWBURY:

Q. Would you include any treating physicians?

DR. NEIL:

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A. Senior management would be the first people I would go to.

MS. NEWBURY:

Q. Okay. And whether they bring in treating physicians, that would be -

DR. NEIL:

A. They are, I won't say trained, but they are more experienced in disclosure than I am and I totally rely on their abilities in disclosure, but it was my responsibility to say, I have a problem, which I've done.

MS. NEWBURY:

Q. Are there any written policies at Western Memorial about -

DR. NEIL:

A. There is a disclosure policy at Western, yes.

MS. NEWBURY:

Q. Okay. And how long has that policy been in place?

DR. NEIL:

A. I don't know the answer to that, but it's been several years, I think.

MS. NEWBURY:

Q. And that's a general disclosure policy -

DR. NEIL:

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A. It's a general disclosure policy.

MS. NEWBURY:

Q. - applicable to everyone in the institution?

DR. NEIL:

A. Yes, yes. I know there has been a recent change, a recent update in a disclosure policy in the last several months. It may have been several years before that one had changed. It may have existed in our institution for quite a long time. I just don't know the answer to that, but I know it does exist.

MS. NEWBURY:

Q. Okay. I'm not sure if that's been provided.

UNKNOWN SPEAKER:

Q. (Inaudible).

MS. NEWBURY:

Q. It hasn't been provided. Perhaps Mr. Pritchett can provide a copy of that.

DR. NEIL:

A. I know you're going to be interviewing Dr. Jenkins, he can provide that.

MS. NEWBURY:

Q. Okay. And just on the issue then of thinking about, perhaps back in June or at whatever stage you're involved in this, at what point

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do you go into the office of Dr. Jenkins, senior management or someone else, -

DR. NEIL:

A. Yes.

DR. NEIL:

A. - was it clear in your mind, given your interaction with Eastern Health here, which organization would have the primary responsibility to take the steps or to consider when and how disclosure should take place with regard to the patient. I'm just wondering if that was a factor here, that Eastern Health is involved in conducting the retesting, you're involved in providing information.

DR. NEIL:

A. Yes.

MS. NEWBURY:

Q. Did that, in any way, influence you in terms of not taking the decision earlier to go to senior management.

DR. NEIL:

A. This was an Eastern Health issue. Eastern Health asked me to do several things which I did. Obviously, Eastern Health has a role and

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still does have a role to play in this whole issue. To answer your question, yes, I would think because it was an Eastern Health issue, I did what Eastern Health asked me to do, disclosure to patients would be an Eastern Health issue, primarily. Now, I'm sure that Western would be involved with it, but primarily it would be Eastern Health.

MS. NEWBURY:

Q. So, it's your sense that Eastern Health would be primarily responsible for making those decisions, but consultation would take place with Western Health.

DR. NEIL:

A. Yes, yes. To put things in perspective, I didn't really consider disclosure; it was not in my focus.

MS. NEWBURY:

Q. It wasn't on your radar at all.

DR. NEIL:

A. It was not on my radar. I wanted to do what I had to do.

MS. NEWBURY:

Q. And are there any written policies in place, generally speaking, not just dealing with

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disclosure issues, but dealing generally with interaction when using Eastern Health as a tertiary care centre, just to deal with communication issues and -

DR. NEIL:

A. Not that I'm aware of.

MS. NEWBURY:

Q. - allocating responsibilities.

DR. NEIL:

A. Not that I'm aware of.

MS. NEWBURY:

Q. Is there any, I guess, less formal means of resolving conflicts or communication issues that might arise between Western Memorial or Western Regional Health Authority and Eastern Health when you're using the services of Eastern Health as a tertiary care centre?

DR. NEIL:

A. I have and still have a good working relationship with many of the pathologists and lab directors, managers, whatever their positions may be called. I can pick up the phone at any time.

MS. NEWBURY:

Q. Okay, and that's on a peer to peer basis?

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DR. NEIL:

A. On a peer to peer basis.

MS. NEWBURY:

Q. And you -- I think you indicated earlier that you're -- the lab technologists might likewise call lab technologists at Eastern Health?

DR. NEIL:

A. Yes, and I've instructed them to do that on various occasion.

MS. NEWBURY:

Q. But when you get into sort of more complicated organizational type issues, is there any mechanism in place, not so much, you know, dealing with the technicalities of a particular patient's test?

DR. NEIL:

A. Not that I'm aware of.

MS. NEWBURY:

Q. Okay.

DR. NEIL:

A. Not that I'm aware of.

MS. NEWBURY:

Q. I think one example you gave yesterday of some, I guess, question about whose responsible for paying the costs of ER/PR

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testing --

DR. NEIL:

A. Yes.

MS. NEWBURY:

Q. Which, I think, was being sent along to Western Memorial by Eastern Health, and you had some doubts as to whether or not you ought to be paying for those ER/PR tests.

DR. NEIL:

A. Yes.

MS. NEWBURY:

Q. If you had wanted to push that particular issue, is there someone in Western Memorial who is the point person responsible for resolving those types of issues?

DR. NEIL:

A. That's an issue between lab managers, I believe.

MS. NEWBURY:

Q. Is it?

DR. NEIL:

A. Yeah.

MS. NEWBURY:

Q. Okay. So there's no sort of catchall person or department within Western Memorial

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responsible for that?
DR. NEIL:
A. Well, you know, not one person per se. If I were to say today how would I approach that problem, I would include three people in those discussions from Western; lab manager, our financial person, and myself.
MS. NEWBURY:
Q. Okay, and if it were something not relating to cost issue, if it had to do with a communication issue or allocating responsibility when things get complicated, because I take it here you have oncologists coming from --
DR. NEIL:
A. Yes.
MS. NEWBURY:
Q. From Eastern Health to Western Memorial to the Cancer Clinic here, so not only do you have the lab results or the specimens going to Eastern Health for some testing, you also have oncologists coming out from Eastern Health --
DR. NEIL:
A. Yes.
MS. NEWBURY:

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Q. When things get complicated, is there anyone you would look to in that situation, or does it depend on the situation?
DR. NEIL:
A. It depends -- well, I would think that anything to do with any of the health authorities across the province that are outside by area would be dealt with by VP of Medical Services.
MS. NEWBURY:
Q. And is there anything in place that would trigger involvement by that particular person when things get complicated? Do you have any criteria, you know, when you have this sort of a problem, alert VP of Medical Services?
DR. NEIL:
A. If it's outside my area --
MS. NEWBURY:
Q. Uh-hm.
DR. NEIL:
A. And sometimes even within my area, if I have a difficult problem, my next person up the line is VP Medical Services.
MS. NEWBURY:
Q. Okay. So as soon as you can't resolve

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something, either because it's complicated or because it's outside your area --
DR. NEIL:
A. If -- yes, he's my contact, and in his absence, the CEO.
MS. NEWBURY:
Q. I think you had indicated in your evidence yesterday that you don't keep track of trends within your department regarding positivity rates --
DR. NEIL:
A. Correct.
MS. NEWBURY:
Q. For ER/PR testing. Are there any other trends that you monitor -- are there any trends that you monitor within your department regarding breast cancer generally?
DR. NEIL:
A. No.
MS. NEWBURY:
Q. Okay, and I understand from your evidence yesterday that Western Memorial has regularly supplied information to the Cancer Registry?
DR. NEIL:
A. Yes.

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MS. NEWBURY:
Q. Back from the entire time that you've been working there?
DR. NEIL:
A. Yes.
MS. NEWBURY:
Q. And do you know how long before you commenced work at Western Memorial that that practice was in place?
DR. NEIL:
A. I would say that practice has occurred for many years.
MS. NEWBURY:
Q. And that's a consistent practice with each and every diagnosis?
DR. NEIL:
A. Any cancer diagnosis.
MS. NEWBURY:
Q. Any cancer diagnosis, okay, and what type of information would be supplied to the Cancer Registry?
DR. NEIL:
A. It's the tumour type, and all that goes along with that.
MS. NEWBURY:

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Q. Okay, so the grade, stage?
DR. NEIL:
A. Yes.
MS. NEWBURY:
Q. Okay. Is there any follow up information ever provided to the Cancer Registry regarding that particular patient? Do you -- you know, if there any additions or any changes in the diagnosis, would that be provided to the Cancer Registry?
DR. NEIL:
A. If there's a change in the patient's diagnosis -- every time there's a cancer, we send those results to the Cancer Clinic.
MS. NEWBURY:
Q. And on what format do the reports go? Do you know that offhand?
DR. NEIL:
A. Offhand, I don't know. We've been having some difficulty with transmission. We've done it historically way back when through just mail.
MS. NEWBURY:
Q. Okay.
DR. NEIL:
A. But we've been trying to get systems in where

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we can do all that electronically.
MS. NEWBURY:
Q. Okay.
DR. NEIL:
A. It would be unfair for me to say one or the other because I don't do that.
MS. NEWBURY:
Q. And who in Western Memorial would know that information?
DR. NEIL:
A. Our lab manager.
MS. NEWBURY:
Q. Lab manager. Do you happen to know whether the ER/PR test results would be provided to the Cancer Registry?
DR. NEIL:
A. Yes, because they are part of the patient record.
MS. NEWBURY:
Q. Okay. So it actually would give the rate of positivity results?
DR. NEIL:
A. It would be one of the data fields in the patient reports.
MS. NEWBURY:

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Q. And how long has the inclusion of ER/PR test results been provided to the Cancer Registry?
DR. NEIL:
A. As long as I can remember.
MS. NEWBURY:
Q. And do you have --
DR. NEIL:
A. Because it's part of the patient report.
MS. NEWBURY:
Q. Okay.
DR. NEIL:
A. It's part of the patient report.
MS. NEWBURY:
Q. And do you have any understanding as to what this information is used for by the Cancer Registry, what is the whole purpose of doing that exercise?
DR. NEIL:
A. It's a registry, it's a database.
MS. NEWBURY:
Q. Okay. Do you ever avail of the information, aside from in this case you used it to help you retrieve patient information?
DR. NEIL:
A. On a routine basis, no.

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MS. NEWBURY:
Q. Are you ever provided with any overall stats or trends?
DR. NEIL:
A. If I want it, I can get it.
MS. NEWBURY:
Q. You could?
DR. NEIL:
A. Yes.
MS. NEWBURY:
Q. And do you know if anyone else in your hospital ever uses that information for any research?
DR. NEIL:
A. Not that I'm aware of.
MS. NEWBURY:
Q. Thank you, Dr. Neil. Those are all the questions I have.
DR. NEIL:
A. Thank you.
COMMISSIONER:
Q. Ms. Russell.
DR. PAUL NEIL, EXAMINATION BY MS DARLENE RUSSELL
MS. RUSSELL:
Q. Hello, Dr. Neil. I'm Darlene Russell, co-

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counsel for the breast cancer testing class action. I believe that you said yesterday that you have 30 to 40 breast cancer cases at Western Health per year?

DR. NEIL:

A. Yes.

MS. RUSSELL:

Q. Okay. So that would involve approximately 30 to 40, I guess, ER/PR tests as well?

DR. NEIL:

A. Yes.

MS. RUSSELL:

Q. Okay. Out of those, do you know how many are negative per year?

DR. NEIL:

A. I don't have those statistics.

MS. RUSSELL:

Q. Okay. Do you know how many were negative between '97 and 2005, the total number?

DR. NEIL:

A. I don't have those statistics.

MS. RUSSELL:

Q. Do you know how many you sent away for retesting, how many ER/PR tests -- because you would have sent all the negatives.

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DR. NEIL:

A. Yes.

MS. RUSSELL:

Q. Between '97 and 2005?

DR. NEIL:

A. We sent approximately 250.

MS. RUSSELL:

Q. About 250 total?

DR. NEIL:

A. Yes.

MS. RUSSELL:

Q. For '97 to 2005?

DR. NEIL:

A. Yes.

MS. RUSSELL:

Q. Okay, how many of these turned out to be false negative?

DR. NEIL:

A. I don't have those statistics.

MS. RUSSELL:

Q. Okay. You have spreadsheets on all this information, do you?

DR. NEIL:

A. Yes, but I didn't do a statistical analysis on those.

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MS. RUSSELL:

Q. Okay, but that wouldn't be a difficult thing to do?

DR. NEIL:

A. No, but it wasn't -- it wasn't my focus. This data was being collected and collated by Eastern Health, CIHI, I believe, and others.

MS. RUSSELL:

Q. You still have those spreadsheets?

DR. NEIL:

A. I have those -- I have spreadsheets, yes.

MS. RUSSELL:

Q. Could we get a copy of those with the appropriate information redacted, obviously, or the confidential information?

DR. NEIL:

A. I have no problem with that. I'm not --

COMMISSIONER:

Q. Is that information not in another form in another exhibit?

MR. BROWNE:

Q. Commissioner, this information is not something that we would have necessarily gone back to, all of this (inaudible) gone back with respect to -

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COMMISSIONER:

Q. I'm thinking about the NLCHI stuff.

COFFEY, Q.C.:

Q. I believe, Commissioner, what she's asking for here is the spreadsheets that went -- the listing that went with the -- the doctor had spreadsheets with each year --

MS. RUSSELL:

Q. He had his own spreadsheets.

COFFEY, Q.C.:

Q. -- and on the way out, not the information coming back. We've got that in another form. I think you're asking here to --

DR. NEIL:

A. What went out?

MS. RUSSELL:

Q. Yes.

COMMISSIONER:

Q. Oh, as opposed to the information that came back. Sorry.

COFFEY, Q.C.:

Q. Yes, oh, yes.

MR. BROWNE:

Q. I'm clear on that as well.

COMMISSIONER:

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Q. Okay, so we're --
DR. NEIL:
A. I have -- with the names gone, of course?
MS. RUSSELL:
Q. With the names gone, yes.
DR. NEIL:
A. I have no problem with that.
MS. RUSSELL:
Q. Okay, and we have specific identification that tells how many negatives came back for Corner Brook in other documents, and could we get those numbers -- would you mind compiling those numbers that I just requested?
COMMISSIONER:
Q. What you're asking the witness for is a copy of a document that already exists with the identifying names redacted?
MS. RUSSELL:
Q. Yes.
COMMISSIONER:
Q. And I think the witness has said he's prepared to do that.
DR. NEIL:
A. I can certainly --
COMMISSIONER:

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Q. If he has a copy of it still.
DR. NEIL:
A. I can certainly provide that -- those are my working documents that I spoke to Mr. Coffey about yesterday.
MS. RUSSELL:
Q. Okay.
DR. NEIL:
A. And there are copies of that. I'm more than prepared to give them to you.
MS. RUSSELL:
Q. Okay.
DR. NEIL:
A. With the names removed.
MS. RUSSELL:
Q. Thank you. No further questions.
COMMISSIONER:
Q. Thank you, Ms. Russell. Mr. Pike.
MR. PIKE:
Q. No questions, Commissioner. Thank you.
COMMISSIONER:
Q. Mr. Browne.
DR. PAUL NEIL, EXAMINATION BY MR. PETER BROWNE
MR. BROWNE:
Q. Good morning, Dr. Neil

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DR. NEIL:
A. Good morning.
MR. BROWNE:
Q. You'll be glad to know when I come up to the podium, it means things are drawing hopefully to an end.
DR. NEIL:
A. Good.
MR. BROWNE:
Q. Just a couple of areas to cover off. Firstly, you were shown a couple of exhibits by Mr. Coffey regarding the fixation policies for both the copies you received in 2007 and subsequently the new document that was dated in 2008?
DR. NEIL:
A. Yes.
MR. BROWNE:
Q. Several of the references in that material refer to Ackerman's. Is that the textbook that you have at your institution?
DR. NEIL:
A. Yes, it is.
MR. BROWNE:
Q. Okay. As well, I had -- I had made a note to

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speak t you about your administrative and clinical responsibility. I think Mr. Coffey covered that off to some extent this morning. Is there anything in addition to what he asked that you want to add to that in terms of you are a unique -- you carry a unique position in that you have both clinical duties and administrative duties.
DR. NEIL:
A. Yes.
MR. BROWNE:
Q. Are there any observations or comments that you want to provide the Commissioner with regard to that unique position that may be relevant to this?
DR. NEIL:
A. Well, I think I covered most of it with Mr. Coffey. You know, it's a role -- it's a role that -- yes, it's a dual role, and I'm finding that the service part of that role is more time consuming than I want it to be. I think I've made my point on that.
MR. BROWNE:
Q. We've heard from Dr. Cook, in particular, about the -- he's clinical chief or was

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clinical chief for Eastern Health, about the division of time and so on. Is there -- in your institution is there expectation of how much service time and administrative time you're supposed to divide?

DR. NEIL:

A. The expectation is, from my position at least, half time administrative. I'm finding it's more.

MR. BROWNE:

Q. As well Mr. Coffey asked you yesterday, I believe, about continuing medical education and he asked you about the financial side and the time side, and I think you indicated that it was approximately one week in duration that you have?

DR. NEIL:

A. One week is what has been historically in Western for all physicians.

MR. BROWNE:

Q. And I just want to tie that back to your responsibility as sort of an administrative -- your administrative responsibilities for the department.

DR. NEIL:

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A. Uh-hm.

MR. BROWNE:

Q. And presumably for your colleagues. As your capacity, should there be more time for somebody who is in an administrative position to, say, go to -- to have more continuing medical education to bring back information for the department and disseminate that to your colleagues?

DR. NEIL:

A. I would like to have a lot more time.

MR. BROWNE:

Q. And we saw that this morning. I think you indicated you wanted six months to work on --

DR. NEIL:

A. Six months would be wonderful. Probably a little bit unrealistic, but --

MR. BROWNE:

Q. Sure, and I appreciate that that was sort of a bit of a facetious comment, but nevertheless, the point being that if individuals who are charged with respective institutions, should they have necessarily -- if they're bringing back information or expectation, disseminating information, additional time to do that?

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DR. NEIL:

A. Most definitely.

MR. BROWNE:

Q. And finally, Doctor, and you alluded to this yesterday in some questioning from the Commissioner, do you have any statements or recommendations you would like to make to the Commissioner?

DR. NEIL:

A. I'd like to add a couple of words, if you didn't mind.

MR. BROWNE:

Q. Please do.

DR. NEIL:

A. First of all, I'd just like to thank the Commissioner and Commission counsel for giving me the opportunity to come here and express my thoughts and my views. I'd like to first of all speak to the people of Western Newfoundland, and I'd like to ensure those ladies particularly that we have done everything possible to comply with the recall, and ensure that what we have done, we have done to the best of our ability because this is a serious issue. I'd like to thank

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everybody in Western Health for assisting me. It's not only me that has done a fair amount of work, and I have, all of our staff have done a tremendous amount of work; lab staff, lab managers, senior administration, these people have done a tremendous amount of work. So I'd like to ensure the people of Western Newfoundland that we've done all we can. On a go forward basis, I'd also like to ensure them that all procedures regarding tissue preparation and processing are currently in place to the best of our ability, and we are sending our specimens to Mount Sinai, so rest assured that the results in my opinion are the proper results and they have no concerns. Finally, I'd like to recommend to the Commission that as laboratory directors, and all labs across the province, continue our dialogue and consultation in order to improve and provide best quality laboratory service that this province can offer. I've alluded to some examples of how we can do that, and one was the quality assurance document that came up early this morning.

MR. BROWNE:

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Q. Yes.
DR. NEIL:
A. That and other things like that are things that we should be, as a group of people, lab directors, and others that need to be involved, get together and make sure we have the proper procedures in place, and we've done a lot of work -- Eastern Health has done a lot of work, but there's a lot more that needs to be done. I've alluded to the time that I need to do some of this work, and I just hope that we can get it done because we need a quality laboratory service in this province, and I speak of this province because we're a small province, 500,000 people. We need quality work and we can do it together, not as separate boards or separate health authorities, we need to do it together. That applies, I guess, in every aspect of medicine, but I can only speak to my own, laboratory medicine.
MR. BROWNE:
Q. You mentioned to me about some type of think tank?
DR. NEIL:

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

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

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

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here in St. John's. It has worked and it should continue and I think the plan is for that to continue. Bring speakers in, bring people who can help us in our work. But that doesn't mean that you can't go out. You need national exposure, and for smaller communities -

THE COMMISSIONER:

Q. And in your view, perhaps international?

DR. NEIL:

A. And international, yes.

THE COMMISSIONER:

Q. What about the use of--well, obviously you already do it, because you're involved in that CAP program.

DR. NEIL:

A. Yes.

THE COMMISSIONER:

Q. So that I'm just wondering are there, using technology, ways of assisting you, and secondly, whether or not because of the numbers or lack of numbers that you see of certain kinds of things -

DR. NEIL:

A. Yes.

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THE COMMISSIONER:

Q. - have you considered whether or not you can or should be doing certain tests?

DR. NEIL:

A. I know what you're talking about. The internet is good, but it's not--it can't replace people and talking to your colleagues one on one. For things we don't see often, are you talking about centralizing some services or centralizing breast services?

THE COMMISSIONER:

Q. Well, that's the question I'm raising, as to whether or not--I think there's--it comes from two perspectives. One is whether or not for optimum service, you really have to have sufficient numbers -

DR. NEIL:

A. Yes.

THE COMMISSIONER:

Q. - to enable you to keep your skills up as a pathologist?

DR. NEIL:

A. Yes.

THE COMMISSIONER:

Q. And there may be an economic side of it as

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well, whether or not the, either equipment required or the training required is out of proportion with the number of cases that you have to deal with for particular kinds of pathology.

DR. NEIL:

A. Yes. I'll give you a good example. I had mentioned a dermatologist has come to Corner Brook. He's very good, very active. He's giving us material that we very rarely see sometimes. We have to recognize our limitations. We're not trained dermatopathologists, which is why I initiated a consultation service with Gamma DynaCare. You have to have the subspecialists that you can rely on. I think Dr. Cook also mentioned it in his remarks. Subspecialty training is vitally important, but we're in a small province. To think that we're going to get subspecialty training in all areas is probably unrealistic. But we can certainly strive for that, and hopefully with what's happened recently, we'll be able to better do that. But when you look at a smaller population outside--a smaller population of pathologists

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outside this province, outside St. John's, we have to recognize that we have to have some place to send our breast cases that are difficult, send our prostate cases that are difficult, discuss that, learn from that, because these are very--they're very important cases and they take up a lot of time if you haven't got a subspecialist to help you out with these. The pathologists on the periphery are general pathologists. They deal with routine stuff and very well, but we have to recognize our limitations and subspecialists are of vital importance.

So I guess, to answer your question, yes, all the difficult breast cases, and this is what, I think, Maurice has been doing in Grand Falls, his difficult breast cases, he's been sending to Bev Carter, and unfortunately, Bev's not here any more. So what does he do? I don't know the answer to that. Hopefully we'll get someone to replace her. This is the think tank I'm talking about, because all these issues, we can't resolve these issues here today, but I think a think tank can come up with some sort of idea as to how we're

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going to provide the best solution in this province for the limited number of patients that we have and certainly the limited number of pathologists that we have.

THE COMMISSIONER:

Q. Thank you.

DR. NEIL:

A. Thank you.

MR. BROWNE:

Q. Thank you, Commissioner.

THE COMMISSIONER:

Q. Thank you, Mr. Browne. Mr. Coffey, is there anything arising?

DR. PAUL NEIL, RE-EXAMINATION BY BERNARD COFFEY, Q.C.

COFFEY, Q.C.:

Q. Yes, just one question, Commissioner. Doctor, in answering a question for Ms. Newbury, you said, you know, you made a comment "when we have a problem, we deal with it" in relation to -

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. And you, certainly, the documentation that we've seen, I think I alluded to it yesterday

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and what I hope is a jocular fashion, that you're, if nothing else, persistent.

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. Okay. Doctor, just on that point, because certainly after your conversation with Dr. Cook in August, late August and then his memo of September 6th, we've seen that Western provided the material, you know, kind of almost day to day at one point.

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. In early October. And you'd received the June 14th memo and it wasn't until late August, early September that, as you say "if there's a problem, we addressed it."

DR. NEIL:

A. Yeah.

COFFEY, Q.C.:

Q. Can you offer a comment or explain to the Commissioner, because it'll occur to somebody, bearing in mind how diligently it was pursued late summer, early fall -

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DR. NEIL:

A. In September and not June?

COFFEY, Q.C.:

Q. Yes, and in terms of--well, the initial one was just one year in June?

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. And I appreciate you didn't have the benefit of all the detailed memo and the conversation with Dr. Cook.

DR. NEIL:

A. Yes.

COFFEY, Q.C.:

Q. So can you explain, but there's apparently a difference in speed of approach anyway.

DR. NEIL:

A. Yes. There are several reasons for that. Number one, in June, the middle of June, and that's really the first memo that I had that I had to do this. We took it as a serious issue, but the workload in Western, and I'm sure in every other institution, for, you know, technologists and clerical staff and ourselves, we tried to do the task that was

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presented to us in a regular working time. In other words, do your own work and try to do this as well, and it became a little bit taxing, and I instructed our staff to do exactly what was there. I was away for the month of July or the better part of July, and whether that had anything to do with it or not, I don't know, but I was away, and when I came back, it was a slow process, and in order to do it at the level that we did it in September, we had to dedicate our staff totally to doing this, outside their regular working hours.

COFFEY, Q.C.:

Q. So there was a lot of overtime?

DR. NEIL:

A. There was a lot of overtime and weekends, and that's the real difference.

COFFEY, Q.C.:

Q. Okay, so in late August, early in September, in particular, there were a lot of staff called back -

DR. NEIL:

A. A lot of staff called back and not one person or two people, but a lot of dedicated staff.

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When I made my remarks, I really mean that these people worked hard.

COFFEY, Q.C.:

Q. So just again for the Commissioner, so she understands, you know, kind of the difference in -

DR. NEIL:

A. That's the difference. We pulled out all stops in September.

COFFEY, Q.C.:

Q. Thank you, Commissioner, I just wanted -

THE COMMISSIONER:

Q. Thank you. Thank you very much, Dr. Neil, for your contribution. It's been most interesting hearing about the perspective of the West coast.

DR. NEIL:

A. Thank you very much.

THE COMMISSIONER:

Q. I suggest we take the morning break and then we can continue with the next witness.

(RECESS)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey.

COFFEY, Q.C.:

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Q. Thank you. The next witness is Dr. Dankwa.

DR. ESSANDOH KWEKU DANKWA, AFFIRMED, EXAMINATION BY BERNARD COFFEY, Q.C.

REGISTRAR:

Q. Would you please state and spell your complete name for the Commission?

DR. DANKWA:

A. My name is Essandoh Kweku Dankwa. Essandoh is spelled E-S-S-A-N-D-O-H. Kweku is K-W-E-K-U, and my surname, Dankwa, D-A-N-K-W-A.

REGISTRAR:

Q. Thank you.

COFFEY, Q.C.:

Q. Thank you, Doctor. Commissioner, there are further exhibits I'm going to ask that be entered, please. They are exhibit numbers P-2196 -

THE COMMISSIONER:

Q. Sorry, would you give me that number again, please?

COFFEY, Q.C.:

Q. P-2196 through P-2223 inclusive.

THE COMMISSIONER:

Q. Okay, entered.

EXHIBITS ENTERED AND MARKED P-2196 THROUGH P-2223

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COFFEY, Q.C.:

Q. Thank you, Registrar. If I could, please, Exhibit P-2196? Now, Doctor, this is a curriculum vitae, and I take it it's yours?

DR. DANKWA:

A. Yes, it is.

COFFEY, Q.C.:

Q. Doctor, if I could, please, I'm going to ask you to outline for the Commissioner your professional educational background and your professional background, please?

DR. DANKWA:

A. I grew up in Ghana, West Africa, where I did my basic medical training at the University of Ghana Medical School located in Accra. I completed my medical training in 1980. Following that, I did my--started my post-graduate training in pathology in Ghana, West Africa. In 1984, I moved over to the United Kingdom, to Bristol on a British Council Scholarship by competition.

In Bristol, that was where I had my first introduction to immunohistochemistry and I stayed in Bristol until 1988, to complete my training in pathology, culminating in me

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obtaining the membership of the Royal College of Pathologists, by examination.

COFFEY, Q.C.:

Q. That's in the UK?

DR. DANKWA:

A. In the UK, yes, and following that, I worked in the United Kingdom until 1993 when I moved over to the United States, worked as a fellow and staff pathologist at the Armed Forces Institute of Pathology in Washington, and I was there until 1995--1994. While I was there, I saw the job opportunity in St. Anthony. I applied for it, and I was successful. I moved back to United Kingdom for a couple of months, working in London, before I resumed the job in St. Anthony, where I have been until now.

COFFEY, Q.C.:

Q. And Doctor, in St. Anthony, what is your position?

DR. DANKWA:

A. I'm the only pathologist there and also the Director of Pathology over there. I have other responsibilities too, outside of pathology.

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COFFEY, Q.C.:
Q. Could you explain those to the Commissioner, please?
DR. DANKWA:
A. Yes. I'm also the Associate VP of Medical Service. So I have the responsibility of looking at the medical service as a whole, in addition to my directorship as pathologist and the only pathologist there.
COFFEY, Q.C.:
Q. So you're the VP Medical Services.
DR. DANKWA:
A. Associate VP
COFFEY, Q.C.:
Q. Associate VP Medical Services. So there's yourself and one other?
DR. DANKWA:
A. Right, the overall VP is Michael Jong, who is in Goose Bay.
COFFEY, Q.C.:
Q. And we'll see Dr. Jong's name, I think, in some of the materials.
DR. DANKWA:
A. Right.
COFFEY, Q.C.:

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Q. So Michael Jong is the VP Medical?
DR. DANKWA:
A. Medical Services, yes.
COFFEY, Q.C.:
Q. For the -
DR. DANKWA:
A. The entire region.
COFFEY, Q.C.:
Q. - in the region, and that's Labrador Grenfell?
DR. DANKWA:
A. Grenfell, correct.
COFFEY, Q.C.:
Q. You're the associate?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. You're also the Director of Pathology?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And you are the pathologist?
DR. DANKWA:
A. The only pathologist, yes.
COFFEY, Q.C.:
Q. Doctor, and I'll refer to Labrador Grenfell

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generally in this context, perhaps I'll just use the short--refer to it as St. Anthony.
DR. DANKWA:
A. Right, okay.
COFFEY, Q.C.:
Q. And when it involves Labrador, I'll distinguish, okay?
DR. DANKWA:
A. Sure.
COFFEY, Q.C.:
Q. But Doctor, in St. Anthony, the technologists, how are they organized and whom do they report to?
DR. DANKWA:
A. The technologists, we have about 12--we have 12 of them, and then a secretary, and they report directly to the Director of--Regional Director of Diagnostic Services, but indirectly to me. They report directly to the Regional Director and then indirectly -
COFFEY, Q.C.:
Q. And then he reports to whom?
DR. DANKWA:
A. To the VP Medical Service, that is Dr. Michael Jong.

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COFFEY, Q.C.:
Q. And then you say indirectly they report to you? How does that work?
DR. DANKWA:
A. We have--even though their reporting lines is to the Regional Director, there is always a regular communication between me, the regional director and then directly to the staff as well.
COFFEY, Q.C.:
Q. So you, I take it, routinely deal with the technologists directly yourself?
DR. DANKWA:
A. All the time.
COFFEY, Q.C.:
Q. All the time, and I'll be talking to you further about that.
DR. DANKWA:
A. Sure, okay.
COFFEY, Q.C.:
Q. That's the structure?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. How long has that structure been in place?

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DR. DANKWA:
A. Those are altered to this particular arrangement in 2005, when the new regional board was instituted.
COFFEY, Q.C.:
Q. So before 2005, what was the structure?
DR. DANKWA:
A. Before 2005, we had a manager of the lab who was restricted mainly to the laboratory service, rather than radiology. When we say the diagnostic services, we include the radiology as well. But prior to 2005, we had a manager who was restricted to the laboratory services.
COFFEY, Q.C.:
Q. Laboratory services, and how about your own role, before 2005?
DR. DANKWA:
A. Before 2005, it was virtually the same. I was responsible for the laboratory and then I was also the medical director at that time, so I was responsible.
COFFEY, Q.C.:
Q. And your interaction with technologists in St. Anthony -

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DR. DANKWA:
A. Was the same.
COFFEY, Q.C.:
Q. Was similar?
DR. DANKWA:
A. Yeah, similar.
COFFEY, Q.C.:
Q. Okay, Doctor, I'm going to go back then to-- because you made a reference--a comment to the Commissioner about the fact that when you arrived in Bristol, in the UK, and what year was that?
DR. DANKWA:
A. This was in 1984.
COFFEY, Q.C.:
Q. '84, and in effect, I take it, you did a residency there?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. You were--that was your first introduction to or exposure to immunohistochemistry?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:

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Q. And IHC processes?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Could you tell the Commissioner about that, what you found in Bristol at the time and what your initial exposure was?
DR. DANKWA:
A. Right. Prior to coming to Bristol, we had read a lot in the literature about the values of immunohistochemistry and what it could do. So to me, before I got to Bristol, it was something in the literature, not actually in practice. But when I got to Bristol, it was actually in practice. Not only were they producing the antibodies themselves, they were also using it in diagnostic services and they were evaluating the antibodies and applying it to their diagnostic process in the area.
COFFEY, Q.C.:
Q. And the institution in Bristol at the time, do you recall the actual name of the institution that you were working for?
DR. DANKWA:
A. I was in the, what they call the Bristol Royal

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Infirmary, that was the main one I was in for most of the time, but I rotated through the other, the other centres as well.
COFFEY, Q.C.:
Q. Now this particular centre, the Bristol Royal Infirmary, was that involved in particular-- did it have any particular involvement or expertise in IHC?
DR. DANKWA:
A. The pathologists and the trainees there were provided support for their site laboratories that were there within the university and so with almost every investigation, they would involve some of us in their process.
COFFEY, Q.C.:
Q. And how much--I suppose what I'm trying to ask you, Doctor, was there anything particular about Bristol in terms of IHC generally in the UK at that time, anything--were they more involved in it than other spots?
DR. DANKWA:
A. They were certainly more involved than others, I would say.
COFFEY, Q.C.:
Q. What do you recall about that? Can you tell

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the Commissioner about -
DR. DANKWA:
A. There were a lot of research projects that were taking place and almost every division in the hospital, not only pathology, but surgical, internal medicine, were all pursuing some aspects of immunohistochemistry and we, as pathologists, were involved with the microscopic aspect of review and things.
COFFEY, Q.C.:
Q. Now at that time, you know, in the period, you said 1985 through '88?
DR. DANKWA:
A. 1984.
COFFEY, Q.C.:
Q. '84, I'm sorry, through '88. Were you exposed to using the IHC process for detection of estrogen receptors and progesterone receptors?
DR. DANKWA:
A. At that time the estrogen receptors or the assays were being done as a biochemical assay. But I was therefore to bring it into the laboratory using immunohistochemical stains, yes. When I started there.
COFFEY, Q.C.:

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Q. When you started, that was kind of the beginning -
DR. DANKWA:
A. That was the beginning, yes.
COFFEY, Q.C.:
Q. And, Doctor, how far--well I'll just ask you, did you ever do any, do you recall any ER or PR IHC analysis before you left in 1998? Had it advanced to the point where you were involved in it?
DR. DANKWA:
A. I cannot recall exactly because there were so many immunohistochemical antibodies that were coming into the technical--coming into use that I could not exactly recall when it came into being.
COFFEY, Q.C.:
Q. And Doctor, after 1988 you moved to?
DR. DANKWA:
A. I worked around the United Kingdom as consultant pathologist and then moved in 1993 to the USA, Armed Forces Institute of Pathology.
COFFEY, Q.C.:
Q. Between '88 and '93, were you ever involved in

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ER/PR IHC testing?
DR. DANKWA:
A. It must have occurred between that period and when I was in Washington, yes.
COFFEY, Q.C.:
Q. But it doesn't stand out particularly in your mind?
DR. DANKWA:
A. It doesn't stand out particularly, no.
COFFEY, Q.C.:
Q. Okay, in the Armed Forces Institute in Washington and the United States, you were there for what purpose at that time?
DR. DANKWA:
A. In the other breast and gynecology pathology.
COFFEY, Q.C.:
Q. I'm sorry, at the?
DR. DANKWA:
A. Other breast and gynecologic pathology, I was an x-raying pathologist, as a staff pathologist, doing the fellowship.
COFFEY, Q.C.:
Q. Okay, I was just going to ask you about that, so you decided to come and I presume you had to apply for it.

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DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. In 1993 you arrived in the United States and you were there for a year?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And what exactly was it you were doing there at the time?
DR. DANKWA:
A. Involved in reviewing referrals of cases, diagnostically difficult cases in breast and gynecologic pathology.
COFFEY, Q.C.:
Q. Breast, the two areas.
DR. DANKWA:
A. And gynecologic areas, yes.
COFFEY, Q.C.:
Q. Now in that particular institution, I'll ask you first, that program or course, is that a year-long course?
DR. DANKWA:
A. A year long program.
COFFEY, Q.C.:

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Q. Would that, in effect, have been some sort of subspecialization?
DR. DANKWA:
A. Yes, it would have been, yes.
COFFEY, Q.C.:
Q. How much were you exposed to ER/PR IHC testing there, at that time?
DR. DANKWA:
A. I cannot say exactly how much, but there were a variety of immunohistochemical tests that were coming through at the same time, so whenever the problem posed itself as having to use the immunohistochemical process, we did use them.
COFFEY, Q.C.:
Q. In the course of this consult work -
DR. DANKWA:
A. Exactly.
COFFEY, Q.C.:
Q. - you needed it done.
DR. DANKWA:
A. We would have done it, yes.
COFFEY, Q.C.:
Q. Doctor, at that time how would you have learned how to read an ER or PR slide, how did

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

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staining was and attempt also to quantify it, so there were different approaches in the interpretation of immunohistochemistry and for that matter, ER/PR.
COFFEY, Q.C.:
Q. And in particular ER/PR, you say like positive or negative?
DR. DANKWA:
A. Negative, yes.
COFFEY, Q.C.:
Q. What was your understanding of what was positive or negative, at least in the view of these people you were dealing with in the 90s?
DR. DANKWA:
A. If the staining was present, it was positive.
COFFEY, Q.C.:
Q. Okay, if there was any amount of nuclear staining--I think it's nuclei staining.
DR. DANKWA:
A. It was nuclei staining, yes.
COFFEY, Q.C.:
Q. It was positive.
DR. DANKWA:
A. It was positive, yes.
COFFEY, Q.C.:

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Q. And it was on either/or?
DR. DANKWA:
A. Yes, exactly.
COFFEY, Q.C.:
Q. And you said other pathologists, though, you found were attempting to quantify -
DR. DANKWA:
A. Quantify what they were seeing, yes.
COFFEY, Q.C.:
Q. As a percentage, I take it?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. So I take it then, Doctor, in terms of the pathologists you were dealing with at that time, the Armed Forces Institute, there was no standard way of doing it?
DR. DANKWA:
A. No. And this would have occurred anywhere from Bristol into the US.
COFFEY, Q.C.:
Q. All the way into the US.
DR. DANKWA:
A. Yes, exactly, yeah.
COFFEY, Q.C.:

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Q. Doctor, I'll ask you know, do you know a Dr. Khalifa?
DR. DANKWA:
A. Yes, indeed I do, yes.
COFFEY, Q.C.:
Q. And where did you first meet Dr. Khalifa?
DR. DANKWA:
A. I met him when I was down in the United States.
COFFEY, Q.C.:
Q. At the Armed Forces -
DR. DANKWA:
A. It wasn't in the Armed Forces Institute. When I joined the Armed Forces Institute, they automatically assumed that I knew him because he had also come from Africa, but I didn't.
COFFEY, Q.C.:
Q. I appreciate the comment, Doctor.
DR. DANKWA:
A. So his contact information was given to me and we met, I think around, in another setting, at another hospital in Washington, D.C., yes.
COFFEY, Q.C.:
Q. But it was during your year at the Armed Forces Institute while you were posted, or

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working in that institute.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. You did come to meet Dr. Khalifa?
DR. DANKWA:
A. Exactly, yes.
COFFEY, Q.C.:
Q. Did you ever work with him in the United States professionally, like in the same institution?
DR. DANKWA:
A. No, I didn't.
COFFEY, Q.C.:
Q. Just while I'm on that topic, after you left the United States and went to St. Anthony, did you ever meet Dr. Khalifa again?
DR. DANKWA:
A. Yes, when I was in St. Anthony, I came down to the Health Science Centre when I was preparing to do my, take my membership, the Canadian membership and during that time, I run into Dr. Khalifa by accident in a corridor.
COFFEY, Q.C.:
Q. In the corridor of the General Hospital, I

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take it?
DR. DANKWA:
A. In the hospital, yeah.
COFFEY, Q.C.:
Q. Doctor, you mention it, the Canadian College, did you take the test?
DR. DANKWA:
A. Yes, I did.
COFFEY, Q.C.:
Q. And were you successful?
DR. DANKWA:
A. Yes, I was.
COFFEY, Q.C.:
Q. And when was that, Doctor, when did you -
DR. DANKWA:
A. It's what I think, '97.
COFFEY, Q.C.:
Q. Okay, around that, it would be in your -
DR. DANKWA:
A. Yes, it will be in my C.V. yes.
COFFEY, Q.C.:
Q. So, Doctor, to go, to come back to your accepting of a position in St. Anthony, Newfoundland.
DR. DANKWA:

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A. Yes.
COFFEY, Q.C.:
Q. Doctor, had you ever worked--perhaps the Commissioner to get some sense of it, how big of an institution is the hospital in St. Anthony? How many patients does it handle, you know, what kind of approximate staff sizes and so on, could you tell us?
DR. DANKWA:
A. It's a 52 bed hospital currently. It has about 500 staff working there. For physicians in total, it's roundabout 30 physicians. We have surgeons, obstetricians, pediatricians and I'm a pathologist and family physicians around as well.
COFFEY, Q.C.:
Q. And the geographic area covered?
DR. DANKWA:
A. It covers south for the, when it comes to pathology, it covers the northern Newfoundland and the whole of Labrador.
COFFEY, Q.C.:
Q. Now, Doctor, how long have you been responsible for the pathology in Labrador?
DR. DANKWA:

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A. The pathology in Labrador originating from Goose Bay, I was responsible up until 2006 and then Captain William Jackman, that is in Labrador City, was prior to that sending their cases on to, I think the St. Clare's Hospital.

COFFEY, Q.C.:

Q. Their pathology was -

DR. DANKWA:

A. Their pathology work was going there and since 2007, all the pathology from Labrador had also been coming to St. Anthony.

COFFEY, Q.C.:

Q. So just so I understand it and so the Commissioner does, when you arrived in 1995 in St. Anthony, the hospital itself, you would be responsible for the pathology there?

DR. DANKWA:

A. Pathology, yes.

COFFEY, Q.C.:

Q. And at that point in time Labrador City, Wabush, that area, was sending its pathology specimens to St. Clare's in St. John's.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

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Q. And that changed in?

DR. DANKWA:

A. 2007.

COFFEY, Q.C.:

Q. Okay. And the other hospitals there, that would generate the pathology specimens -

DR. DANKWA:

A. Continuity count, St. Anthony.

COFFEY, Q.C.:

Q. So when you arrived as well, so we have to go back to the time you arrived in '95. When you arrived at the hospital in Goose Bay, which is the Happy Valley/Goose Bay medical facility, any pathology specimens they generated from the time you arrived in '95 would come to St. Anthony, to you?

DR. DANKWA:

A. Correct, yes.

COFFEY, Q.C.:

Q. And that has continued up to what point?

DR. DANKWA:

A. Up to this day.

COFFEY, Q.C.:

Q. Okay, up to this point?

DR. DANKWA:

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A. Yes, up to this point, yes.

COFFEY, Q.C.:

Q. So you made a reference to 2006 -

DR. DANKWA:

A. Yes, because we were separate boards to begin with and Goose Bay and Captain William Jackman in Labrador City, was one board, a new one -

COFFEY, Q.C.:

Q. Yes.

DR. DANKWA:

A. But the Goose Bay work was coming on to St. Anthony, but not the Captain William Jackman.

COFFEY, Q.C.:

Q. Okay, so in the days before the most recent amalgamation of the boards -

DR. DANKWA:

A. Exactly.

COFFEY, Q.C.:

Q. Jackman sent its to St. Clare's.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And the Happy Valley/Goose Bay -

DR. DANKWA:

A. Send this to St. Anthony.

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COFFEY, Q.C.:

Q. - which be sending it to yourself?

DR. DANKWA:

A. Yes, correct.

COFFEY, Q.C.:

Q. And that still continues?

DR. DANKWA:

A. That still continues, yes.

COFFEY, Q.C.:

Q. Okay. Doctor, in St. Anthony when you arrived there in 1995, the whole time you had been in St. Anthony, have you ever had another, at any point, another pathologist there with you?

DR. DANKWA:

A. Yes, when I arrived in '95, there was another pathologist, but his prime aim was being in the public health, was working, so we co-shared some responsibilities in pathology, but I was the main pathologist.

COFFEY, Q.C.:

Q. And how long did -

DR. DANKWA:

A. He was there until '99, 2000.

COFFEY, Q.C.:

Q. Until 2000?

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

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

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Q. Who may be passing through from Memorial's Medical School?
DR. DANKWA:
A. Yes, exactly. And so quite often there will be a number of interruptions going through the day and with the reporting of histology slides, you want to be a bit more focused when you are doing that, so I end up actually reporting most of my cases in the evening when everybody is gone and it's quiet and on the weekends as well.
COFFEY, Q.C.:
Q. Now, Doctor, in terms of--and reporting of histology is, I take it, you're looking at the slides, the H&E slides generally and making diagnoses and dictating them and so on.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. The aspect of your job that involves grossing -
DR. DANKWA:
A. Yes, indeed it does.
COFFEY, Q.C.:
Q. Could you explain to the Commissioner, please,

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

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

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leave them overnight to let the penetration occur. The formalin, if it's very bloody--sorry for my words.

COFFEY, Q.C.:

Q. No, it is what it is.

DR. DANKWA:

A. All right, okay. We would have the formalin changed by the end of the day so that it would get fresh formalin on the breast specimen for the following day.

COFFEY, Q.C.:

Q. So, Doctor, in terms of, for example, if there's a breast operation in the morning or it's concluded by, for example, 2:00 and the specimen is down to yourself, it would come in a container to you?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Would it be immersed in formalin?

DR. DANKWA:

A. It would be immersed in formalin and the ratio I've advised them is ten to one volume of formalin to the specimen.

COFFEY, Q.C.:

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Q. Doctor, and you've indicated that you encourage surgeons to, if they can, to excise, at least put one cut into the tissue so that in effect the tumour is exposed to formalin.

DR. DANKWA:

A. Yes, formalin.

COFFEY, Q.C.:

Q. Correctly.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. So you would get the breast tissue in formalin, you would then--have we heard the term "bread loafing" after your inking -

DR. DANKWA:

A. Yes, exactly, bread loafing.

COFFEY, Q.C.:

Q. Is the phrase that's used. Now, Doctor, is there any particular procedure for bread loafing breast tissue? Is there any particular widths of the cutting slices that you use or -

DR. DANKWA:

A. If it's a lump, I call it biopsy, but they may use the term lumpectomy, there's a lump, small

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lump, I try to bisect the thickness about the same thickness as a cassette that I am going to place it in, that we are looking at roughly around 3 millimetres wide. If it's a mastectomy specimen, a bigger specimen, then we're limited to about 5 to 10 millimetres thickness.

COFFEY, Q.C.:

Q. It has to be a bit thicker because -

DR. DANKWA:

A. A bit thicker because of the size of the specimen, yes.

COFFEY, Q.C.:

Q. And so that would be done, I take it, in St. Anthony--if it's a St. Anthony operation, that would be done the day of the operation?

DR. DANKWA:

A. The day of the operation, yes.

COFFEY, Q.C.:

Q. Are there any circumstances that you can--well, first of all this procedure in terms of the slicing of the tissue to those widths you've described, how long have you been using that process?

DR. DANKWA:

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A. Ever since I started my training in Ghana and then continued it in Bristol, there was a breast unit attached to Bristol.

COFFEY, Q.C.:

Q. Okay, so that's the approach you've used all your medical life.

DR. DANKWA:

A. All the time, yes.

COFFEY, Q.C.:

Q. So that's done, Doctor, are there any circumstances where that wouldn't get done on the same day as the operation in St. Anthony?

A St. Anthony operation?

DR. DANKWA:

A. I've trained my lab techs to do that if I am not there, so that unless a trained lab tech wasn't there, then that may happen, but otherwise, they look out for it and then do it.

COFFEY, Q.C.:

Q. And how long have the lab techs in St. Anthony been doing this, you know, if you're not there, how long ago did you train them?

DR. DANKWA:

A. I have been doing this for a long while.

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Certainly, not the very time that I was around because there were two of us and as soon as we became, as soon as I happened to be the only person.

COFFEY, Q.C.:

Q. So since around 2000?

DR. DANKWA:

A. Around 2000, I tried encouraging them to do that and then change the formalin as well.

COFFEY, Q.C.:

Q. Toward the end of the day.

DR. DANKWA:

A. Yes, yes.

COFFEY, Q.C.:

Q. So the understanding I take it then you had with your technologists is, if I'm there, I will do it.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. You know, that day.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And if I'm not there for some reason, then the

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technologists are supposed to do this bread loafing?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And how about, are they trained also to put in the paper -

DR. DANKWA:

A. They could yes, without that, the fixation wouldn't happen because the tissues would collapse back into position again, yes.

COFFEY, Q.C.:

Q. So they're trained, in effect, to do the bread loafing that you do?

DR. DANKWA:

A. Yes, exactly.

COFFEY, Q.C.:

Q. Is there any understanding that you have with them that they are to do it that day?

DR. DANKWA:

A. Oh yes, they get that and then also make sure they open any container just to make sure that there's enough formalin, so as soon as they open it and there isn't enough formalin, I encourage them to cut through, yes.

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COFFEY, Q.C.:

Q. And, Doctor, I take it then it would be fixed overnight?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And when you come in the next day, what happens then with the breast tissue?

DR. DANKWA:

A. I describe it and then take representative blocks of the areas of interest, including the tumour, the surrounding tissue, representative areas of normal tissue and the nipple and part of the skin above the tumour and then the excision margins as well.

COFFEY, Q.C.:

Q. And they're, I take it, made of a proper size to go in the cassettes?

DR. DANKWA:

A. Correct, yes.

COFFEY, Q.C.:

Q. And, Doctor, you've indicated, I believe, that generally it's in the afternoons that you do the grossing.

DR. DANKWA:

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A. Yes.
COFFEY, Q.C.:
Q. So I take it, on day one, surgery, Monday, surgery on Monday. Monday afternoon the bread loafing would occur?
DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. Tuesday afternoon, I take it, would be the grossing -
DR. DANKWA:
A. Yes, exactly.
COFFEY, Q.C.:
Q. And preparation for cassettes.
DR. DANKWA:
A. Correct.
COFFEY, Q.C.:
Q. And then when does the tissue processing?
DR. DANKWA:
A. The same night after I have taken the representative blocks, they go onto the processing slide.
COFFEY, Q.C.:
Q. Now you did indicate when you first alluded to this earlier, that you would oversee or make

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sure the technologists were doing that end of it properly?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Like where does that occur within the lab, like the tissue processor in comparison to where you're doing a grossing?
DR. DANKWA:
A. Well the, with the grossing, the technicians would be there when I'm doing the grossing.
COFFEY, Q.C.:
Q. Okay.
DR. DANKWA:
A. But when it comes to embedding, once the tissue had gone through the processor, it is then the technician's responsibility to take on the next step, yes.
COFFEY, Q.C.:
Q. Okay, so before it goes into the tissue processor, I take it, is that near the grossing bench?
DR. DANKWA:
A. Yes, it is, yes.
COFFEY, Q.C.:

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Q. Who is responsible for operating in your hospital the tissue processor unit?
DR. DANKWA:
A. There are two areas of responsibility, there is the biomedics have a role in some regular maintenance of the thing, and then we have the companies themselves that we purchase the processor from, also have some role in maintaining it, but some of the daily maintenance requirements are done by the technicians.
COFFEY, Q.C.:
Q. The technologists.
DR. DANKWA:
A. Yes, the technologists, things like changing the formalin, making sure that the various reagents are in good condition.
COFFEY, Q.C.:
Q. Now, is there any--and in terms of that, Doctor, are the people, the technologists who are responsible for maintaining on a daily basis the tissue processor unit, do they report to you or do they report to the technology side? In relation to the tissue processor?

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

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breast tumour, what are you looking for, in terms of choosing tissue to go into the cassettes? What are you looking--what sorts of things do you look for as criteria, as to whether or not the tissue ends up in a cassette?

DR. DANKWA:

A. Well, if it's a case that you're suspecting a tumour, then my main focus is making sure that I can make the diagnosis or confirm it or refute it. So I look for the suspicious areas when I look at a specimen grossly, and then select samples from there. But in addition to that, I also look at--I want to see how the tumour is behaving at the edge between the tumour itself and then the normal tissue, and then I would also like to be able to give certain additional information to the surgeon, like whether the tumour is completely removed or not, and whether the nipple is involved or not, because these have got prognostic significance to the surgeon and I just want to also assess the changes in the normal breast tissue. By that, we also give a reflection as to what may be happening in the other breast

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as well.

COFFEY, Q.C.:

Q. So the choice of the tissue to go into the cassettes is yours?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. The tissue, then you, in effect, oversee the tissue ending up in the tissue processor?

DR. DANKWA:

A. Right.

COFFEY, Q.C.:

Q. You described that, and that would--I take it the tissue processor works overnight?

DR. DANKWA:

A. It does, yes, automated, yeah.

COFFEY, Q.C.:

Q. And then the next day then, what happens with the tissue?

DR. DANKWA:

A. Hopefully by the next day, everything would have come out to a stage where the specimen in the cassette could now be blocked. What we say blocked, it would then be placed in paraffin wax.

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COFFEY, Q.C.:

Q. And who's responsible for doing that?

DR. DANKWA:

A. By the technician, yes.

COFFEY, Q.C.:

Q. And then what happens, for example, in breast tissue?

DR. DANKWA:

A. Yes. Once it's placed in the paraffin wax, it's allowed to set and then it's often--they often use a frozen deck to help it to set and following that, they take it off and then use a microtome, a sharp blade, in making thin sections of it and then use a glass slide to pick them up from a warm water bath, have it stick to the glass slide and then apply various stains to it and normally the H & E to begin with.

COFFEY, Q.C.:

Q. H & E to begin?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Okay, and so that would be routine? The H & E -

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DR. DANKWA:

A. Routine, yes.

COFFEY, Q.C.:

Q. - they'd know to do certain -

DR. DANKWA:

A. Exactly, routine.

COFFEY, Q.C.:

Q. Do they prepare a H & E slide for each block?

DR. DANKWA:

A. Yes, they do, yes.

COFFEY, Q.C.:

Q. So then what happens to the H & E slides, the blocks, where do they go?

DR. DANKWA:

A. They come to me, and then I read them and report. If I'm happy with what I have seen, I report them. If I need some more additional blocks or whatever, I'd go back to the breast and take some additional blocks.

COFFEY, Q.C.:

Q. In the meantime, where would the breast tissue be?

DR. DANKWA:

A. It would be in formalin, put back in formalin.

COFFEY, Q.C.:

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Q. Okay, the breast tissue that did not--was not chosen to go into the tissue processor initially -
DR. DANKWA:
A. Yeah, it would stay in the formalin.
COFFEY, Q.C.:
Q. It would stay in the formalin?
DR. DANKWA:
A. In formalin, yes.
COFFEY, Q.C.:
Q. Doctor, I take it then, you would use the H & E slides to make your diagnosis and your microscopic interpretation. When does the ER/PR testing come into this?
DR. DANKWA:
A. When in my interpretation I establish that there is a case of malignancy, then that is the time that I make a selection of a block, a corresponding block to a glass slide that has got a tumour in it that I'm satisfied with to go--corresponding block to go for ER/PR
COFFEY, Q.C.:
Q. Is there any particular criteria that you utilize as to which slide and therefore which block?

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DR. DANKWA:
A. Right, I tend to look for a slide that shows a representative size of the tumour and just some normal tissue, so that there is a transition from normal to the tumour, yes.
COFFEY, Q.C.:
Q. And why do you look for normal tissue?
DR. DANKWA:
A. That is where we get our internal control from.
COFFEY, Q.C.:
Q. Now the idea of doing that, like if possible, at all possible that's got representative tumour and normal tissue, how long have you known that that's the correct approach?
DR. DANKWA:
A. For as long as I've been doing immunohistochemistry. It doesn't have to be breast. Even with any other tumour of the skin or whatever, if I'm going to do immunohistochemistry, I choose an adjacent area showing the reflective or normal tissue changing onto the tumour, so that I can make comparative change as to what is really happening.

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COFFEY, Q.C.:
Q. So you choose a particular slide, and therefore a particular block?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Use the slide to specify a block?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Order ER and PR?
DR. DANKWA:
A. Correct, yes.
COFFEY, Q.C.:
Q. And I take it this goes back to the time--well, we'll come to when all this started in St. Anthony, but from the time it started or became available in St. Anthony, you would do that. What then happens, Doctor, with ER/PR?
DR. DANKWA:
A. I send the block off. I mean, if we are looking at when they were doing it here in St. John's, we send the block off and fill in, complete a form indicating what test I wanted and usually I select the ER/PR and don't

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accompany it with a letter, but just the request. To start off with, I started accompanying it with a letter and then eventually became just -
COFFEY, Q.C.:
Q. In the early days.
DR. DANKWA:
A. In the early days, yeah, and then it came to just a form, to complete a form with a representative block, and then the block would go. Another slide, another H & E slide would be made and then ER/PR stains would be done on two other slides and separate controls would also be made, and then sent-
COFFEY, Q.C.:
Q. In St. John's?
DR. DANKWA:
A. In St. John's, yes, and then sent back to me.
COFFEY, Q.C.:
Q. So what would you get back from St. John's?
DR. DANKWA:
A. I would get the H & E, the ER/PR glass slide, two separate slides, and then the controls for ER and then for PR, yes.
COFFEY, Q.C.:

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Q. Now Doctor, would you always get a control slide back?
DR. DANKWA:
A. As far as I can remember, yes, I would.
COFFEY, Q.C.:
Q. And would the requisition form come back to you?
DR. DANKWA:
A. Yes, it would also come back.
COFFEY, Q.C.:
Q. And then what would you do, Doctor? Okay, you -
DR. DANKWA:
A. Then I would interpret it, I would look through--look at the slide, interpret it, and then -
COFFEY, Q.C.:
Q. And what would you be looking for?
DR. DANKWA:
A. I would be looking for the staining of the tumour, but prior to that, I look--first I look at the H & E slide to make sure that it is the same block that I sent, the slide that come back, and then I look at the controls to make sure the controls have worked, because

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if they are -
COFFEY, Q.C.:
Q. External controls?
DR. DANKWA:
A. The St. John's controls, to make sure that they have worked. I mean, I never came across any situation where they didn't work, because I wouldn't report it otherwise. Following that, then I would look at the tumour itself or the (unintelligible) and normal tissue.
COFFEY, Q.C.:
Q. And what would you be looking for there, Doctor?
DR. DANKWA:
A. When I look down the microscope, my reflex action is to look at the internal control to see if that had worked.
COFFEY, Q.C.:
Q. And what does worked mean in this context?
DR. DANKWA:
A. That is if it's staining positively in the normal tissue, and then I compare it with the tumour component of the -
COFFEY, Q.C.:
Q. Now if the internal control, i.e. the normal

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tissue, you're looking for nuclear staining, I take it?
DR. DANKWA:
A. Nuclear staining, correct.
COFFEY, Q.C.:
Q. In this context. Doctor, if it stains, I take it, it stained, then you're prepared--you look at the tumour.
DR. DANKWA:
A. Yes, I'm prepared to go ahead and look at the tumour, yes.
COFFEY, Q.C.:
Q. If it doesn't stain, what do you -
DR. DANKWA:
A. If it doesn't stain, then I may have to request it again, but it depends on where the tumour is not staining. If it's the normal tissue is in close, so close proximity to the tumour itself, there are some of them that would not stain and it's a natural process.
COFFEY, Q.C.:
Q. That the--where at times, it's your understanding, that where there's normal tissue involved on the slide -
DR. DANKWA:

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A. Yes.
COFFEY, Q.C.:
Q. - and it's in very close proximity to the tumour?
DR. DANKWA:
A. Yeah.
COFFEY, Q.C.:
Q. What is it--you might see what happen?
DR. DANKWA:
A. Sometimes they will not stain because the whole area is changing. It's becoming tumourous, but it looks normal. So that it would have characteristics of a tumour itself.
COFFEY, Q.C.:
Q. So what appears, at least, at first blush to you to be, as best you can tell, normal tissue -
DR. DANKWA:
A. Normal tissue, yes.
COFFEY, Q.C.:
Q. - is not staining, but you would normally expect it to stain?
DR. DANKWA:
A. Yes, yeah.
COFFEY, Q.C.:

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Q. What do you do then, Doctor?
DR. DANKWA:
A. If I were to have a case like that, then I may probably request a restain, just to make sure.
COFFEY, Q.C.:
Q. Do you recall doing that?
DR. DANKWA:
A. No.
COFFEY, Q.C.:
Q. Do you recall ever doing it, in fact?
DR. DANKWA:
A. No, never doing that.
COFFEY, Q.C.:
Q. Do you recall, Doctor, in terms of ER/PR IHC testing while you're in St. Anthony, have you ever had occasion to request repeats of ER or PR tests?
DR. DANKWA:
A. Yes, I have.
COFFEY, Q.C.:
Q. And why was that, do you recall?
DR. DANKWA:
A. In one case that I can remember clearly--I can't remember that particular case, but I can remember the circumstance. I didn't see the

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

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

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

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then there's phase two and phase three, and he says "attached, please find a proposal for uniform reporting of ER IHC staining" and he refers to the proposal having been discussed with many of his colleagues "who mostly agree with its content and accept it as a policy," and then that's the proposal for uniform reporting of ER/PR immunohistochemical assessment, February 1998, 1-2-3, and then some examples.

Now Doctor, going to try and put this now in some context, from your perspective, okay, in St. Anthony. When you arrived in St. Anthony in 1995, ER/PR was being tested how?

DR. DANKWA:

A. We were sending the cases, the blocks on to Halifax to be performed.

COFFEY, Q.C.:

Q. And what--so at that time, there was an IHC process?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Being done in Halifax?

DR. DANKWA:

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A. In Halifax, correct.

COFFEY, Q.C.:

Q. In the hospital in Halifax?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. For St. Anthony?

DR. DANKWA:

A. Yes, right.

COFFEY, Q.C.:

Q. And they were reporting it as a percentage or positive or negative or both?

DR. DANKWA:

A. They were reporting positive and negative.

COFFEY, Q.C.:

Q. That was just either or?

DR. DANKWA:

A. Yes, exactly.

COFFEY, Q.C.:

Q. Did you have any understanding at the time, from them, as to what was meant by negative and positive?

DR. DANKWA:

A. They didn't really qualify it with any statement, but my understanding then would have been that when they see any positivity, they would have called it as positive?

COFFEY, Q.C.:

Q. Any being any cells at all?

DR. DANKWA:

A. Yes, any cells at all.

COFFEY, Q.C.:

Q. Doctor, did you have any sense, when you arrived, as to how long that process of sending the blocks from St. Anthony to Halifax for ER/PR IHC had been going on?

DR. DANKWA:

A. Not at that time, no.

COFFEY, Q.C.:

Q. Have you made any inquiries since?

DR. DANKWA:

A. No, I didn't make any inquiries.

COFFEY, Q.C.:

Q. So because the Commissioner has heard, for example, in St. John's, here the testing was being done by biochemical assay here in St. John's.

DR. DANKWA:

A. All right.

COFFEY, Q.C.:

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Q. Back in '95, it was, okay?

DR. DANKWA:

A. Yes, yes.

COFFEY, Q.C.:

Q. So in St. Anthony, during your time there, biochemical assays for ER/PR were not being used?

DR. DANKWA:

A. No, they weren't being used, no.

COFFEY, Q.C.:

Q. Then what happened, Doctor, in terms of his--okay, '95, it becomes '96, becomes '97.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And we have this memo, February 1998.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Now did you ever receive this memo?

DR. DANKWA:

A. Not as far as I can remember, no.

COFFEY, Q.C.:

Q. And though you have indicated that at some point, you began--St. Anthony began to have

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ER/PR IHC testing done in St. John's?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. How did that come about, do you recall?
DR. DANKWA:
A. I was sending my cases on to Khalifa, Dr. Khalifa to report. When we met on one occasion, he indicated that they were trying to establish and have the tests done in St. John's.
COFFEY, Q.C.:
Q. Okay, sorry, just back up a bit there. So you're up there, doing your work in St. Anthony in '95 and '96.
DR. DANKWA:
A. Right, yeah.
COFFEY, Q.C.:
Q. And any ER/PR that you order, the blocks being packaged, with the appropriate request and sent to Halifax?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And the report comes back to you?

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DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. At that time, you would dictate the report into--or make a--create a report?
DR. DANKWA:
A. From the Halifax report, yes, we would transcribe them into our own reporting structure there, yes.
COFFEY, Q.C.:
Q. And I'll be talking to you more about the systems that existed for that, but--and with the understanding, I take it, that the surgeon or the oncologist would deal appropriately with the result from Halifax?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. So you ran into Dr. Khalifa?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And the subject came up about ER/PR?
DR. DANKWA:
A. Yes.

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

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

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this pursue where this test could be done with a relatively high efficiency and reliability, I came to believe that we were probably ready to move into the next two and final phases", and phase two is described as each pathologist will be asked to report results of his or her own cases, as indicated by the brown staining of nuclei of the invasive neoplastic cells. This phase will start March 1, 1998, and it goes on from there. Now, Doctor, when you'd been utilizing Halifax, who had actually been reporting the results?

DR. DANKWA:

A. It was in Halifax.

COFFEY, Q.C.:

Q. The actual reading of the slides?

DR. DANKWA:

A. Yes, they were reading it in Halifax, yes.

COFFEY, Q.C.:

Q. Did the slides that Halifax created, the ER/PR slides, did they come to you?

DR. DANKWA:

A. No, they never did. They had a block and then they would do their slides, and keep them.

COFFEY, Q.C.:

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Q. And so they would keep the block too?

DR. DANKWA:

A. They would keep the slides, but they would send back the block.

COFFEY, Q.C.:

Q. Okay. Send the block out with a request?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Get the paper report back.

DR. DANKWA:

A. Right.

COFFEY, Q.C.:

Q. With the block, and they keep their slides?

DR. DANKWA:

A. That's right, yes.

COFFEY, Q.C.:

Q. So what then happened with respect to Dr. Khalifa in St. John's and ER/PR?

DR. DANKWA:

A. When he indicated to me that they were prepared to now start interpreting ER/PRs for us, I started sending him my cases.

COFFEY, Q.C.:

Q. And that, in effect, meant what? You would

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send that kind of covering letter with --

DR. DANKWA:

A. I would send -- yes, send a block to him, and then he would interpret it. He would do the stains and then interpret it and send a report back to us.

COFFEY, Q.C.:

Q. And with his report on whether it was positive or negative and percentage?

DR. DANKWA:

A. Yes, yes, exactly.

COFFEY, Q.C.:

Q. And that report, you would do what with that?

DR. DANKWA:

A. I would also do -- transcribe that into our own system and then release that as a supplementary report to the clinician.

COFFEY, Q.C.:

Q. Then what happened, Doctor, because he was reporting initially?

DR. DANKWA:

A. Yes, he was reporting and then eventually he indicated to me that they've established their confidence in doing this reporting, and they would like us to interpret it ourselves. I

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said that was fine. So they would do the staining and send them back to us to interpret.

COFFEY, Q.C.:

Q. Which, in effect, you'd send the blocks in with the request.

DR. DANKWA:

A. Blocks in.

COFFEY, Q.C.:

Q. Either in a letter form or a requisition form?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And the staining would be done?

DR. DANKWA:

A. Done, yeah.

COFFEY, Q.C.:

Q. The slides would come to you?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. You would read those slides.

DR. DANKWA:

A. Right.

COFFEY, Q.C.:

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Q. In the way you've described to the Commissioner.
DR. DANKWA:
A. Exactly.
COFFEY, Q.C.:
Q. And report them yourself?
DR. DANKWA:
A. That's right.
COFFEY, Q.C.:
Q. Now, Doctor, when was it that started, do you recall, when you ended up reporting your own ER/PR?
DR. DANKWA:
A. It must have been somewhere in '98. I don't have the exact date.
COFFEY, Q.C.:
Q. And, Doctor at that point when was the last time that you had reported ER/PR IHC?
DR. DANKWA:
A. It must have been three years earlier.
COFFEY, Q.C.:
Q. In the United States?
DR. DANKWA:
A. In the United States. It must have been somewhere around there, yeah.

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COFFEY, Q.C.:
Q. Again so the Commissioner can get some sense of this --
DR. DANKWA:
A. Yes, okay.
COFFEY, Q.C.:
Q. You know, for example, from 1998 --
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And really up to the present, how many breast -- how many ER and PR cases would come out of St. Anthony?
DR. DANKWA:
A. We were getting roughly about -- close to about 15 to 20 cases, about 15 to 20 cases.
COFFEY, Q.C.:
Q. A year?
DR. DANKWA:
A. A year.
COFFEY, Q.C.:
Q. So, in effect, really somewhere between one to two cases per month?
DR. DANKWA:
A. One to two per month, yes, that's correct.

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COFFEY, Q.C.:
Q. Doctor, over the years have you kept any statistics in relation to the results?
DR. DANKWA:
A. No, I haven't.
COFFEY, Q.C.:
Q. I take it if you're only seeing one or two ER and PR slides per month, would you really, in effect, ever have been in a position to have noticed any trend?
DR. DANKWA:
A. Probably not.
COFFEY, Q.C.:
Q. I take it, just because there were just so few of them?
DR. DANKWA:
A. Yes, that's correct, yes.
COFFEY, Q.C.:
Q. What percentage of your overall work would the ER and PR be?
DR. DANKWA:
A. For ER/PR per se, less than .5 percent.
COFFEY, Q.C.:
Q. Less than --
DR. DANKWA:

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A. .5 percent, yes.
COFFEY, Q.C.:
Q. And that's your clinical work, of course, I'm talking about.
DR. DANKWA:
A. Yes, yeah, as pathology work, yeah.
COFFEY, Q.C.:
Q. Doctor, I'm going to be asking you about then what happened in relation to the matter that brings us here today, the retesting, but before we get to that, you had started, and you told the Commissioner about what would happen or happens with surgical specimens that are generated within the St. Anthony Hospital.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And you did say, and you had a caveat, that's that, the other hospitals are in a different position.
DR. DANKWA:
A. Right, okay.
COFFEY, Q.C.:
Q. Can you tell the Commissioner, please, about those?

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DR. DANKWA:
A. Right. How these -- how specimens are handled in Goose Bay and Lab City are fairly similar. The surgeon when they remove the specimen would place them in formalin immediately. Again I've also encouraged them to make an incision through the tumour if they could. If that is done, I mean, once it's in formalin, it goes down to the lab. Now the specimens are then packaged, cellotaped to make sure there are no leakages, whatever. I've also encouraged the technicians to actually make sure they open the containers and ensure there's adequate formalin on it, the same ratio, ten to one.
COFFEY, Q.C.:
Q. Which technologists were they?
DR. DANKWA:
A. These are the technologists in Goose Bay and Lab City. These are packaged and normally shipped every other day, and if possible, they ship them on a daily basis. Quite often it depends on the availability of flights and when specimens come in. Once they are shipped and they get in, we have technologists waiting

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to receive them, and they often fax us a list of the cases that are coming down we have an idea of what is coming through, and if it's a breast or any live specimen, the technicians in St. Anthony are ready to start bread loafing -- painting it and then bread loafing them if I'm not there physically.
COFFEY, Q.C.:
Q. And if you're there?
DR. DANKWA:
A. And if I'm there I'll do it myself.
COFFEY, Q.C.:
Q. I take it that that would be -- what kind of then time delay can there be? I mean, if it gets down kind of the quickest it could from surgery in Labrador --
DR. DANKWA:
A. Yeah.
COFFEY, Q.C.:
Q. And we'll work our way from there, I mean, what's the quickest it could get to you?
DR. DANKWA:
A. On the average -- on the average we are looking at 48 hours.
COFFEY, Q.C.:

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Q. Before it would get to you?
DR. DANKWA:
A. Before it gets to me, yes.
COFFEY, Q.C.:
Q. And when it would get to you or your technologist in St. Anthony, that's when the bread loafing --
DR. DANKWA:
A. Bread loafing would occur.
COFFEY, Q.C.:
Q. And the process would pick up from there?
DR. DANKWA:
A. Yes, exactly.
COFFEY, Q.C.:
Q. What are the potential negative consequences of that delay, Doctor?
DR. DANKWA:
A. That would be mainly delayed fixation. If a specimen is large enough and there is not adequate penetration of formalin, that delay -- there will be a delayed fixation.
COFFEY, Q.C.:
Q. And with -- I take it that that can have consequences for the cellular structure?
DR. DANKWA:

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A. Oh, yes, yes, it can.
COFFEY, Q.C.:
Q. Can it make -- first of all, can it make diagnosis more difficult?
DR. DANKWA:
A. It can hinder diagnosis, but quite often the formalin penetration is good enough for you to interpret what you see.
COFFEY, Q.C.:
Q. What about its effects on IHC staining, in particular, for example, ER/PR staining?
DR. DANKWA:
A. It potentially could have an effect, but generally once the fixation had occurred, the preservation -- once we can actually interpret the tissue, then the next -- almost invariably the antigen may have been preserved as well.
COFFEY, Q.C.:
Q. May have been preserved as well?
DR. DANKWA:
A. May have been preserved as well, yes, for it to be interpreted, yes.
COFFEY, Q.C.:
Q. I take it then, Doctor, there's no tissue processor in St. Anthony?

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DR. DANKWA:
A. In Goose Bay?
COFFEY, Q.C.:
Q. In Goose Bay.
DR. DANKWA:
A. No, there is not.
COFFEY, Q.C.:
Q. There's none in Labrador City?
DR. DANKWA:
A. No, no.
COFFEY, Q.C.:
Q. And during your tenure in St. Anthony, there has never been a tissue processor in Lab City --
DR. DANKWA:
A. Lab City.
COFFEY, Q.C.:
Q. Or St. Anthony -- sorry, or Goose Bay?
DR. DANKWA:
A. As far as I know, none. They would -- in fact, to make use of it, you would have to have a pathologist there. You'd have to have a pathologist to make use of it.
COFFEY, Q.C.:
Q. Because you have to have the tissue grossed?

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DR. DANKWA:
A. Yes, exactly, to use it, yeah.
COFFEY, Q.C.:
Q. As that process that you described from Goose Bay or -- well, now since, I take it, 2005 or '06 involving Lab City, of transporting specimens to St. Anthony, has that really changed or is it, in effect, the same throughout the years?
DR. DANKWA:
A. It's relatively stayed the same, but we have been encouraging more frequent transportation to gather cases across, but the limitation of transportation has always been a major challenge, and the staffing situation has been another issue.
COFFEY, Q.C.:
Q. Now, Doctor, if the transportation issue was to be addressed, at what level within your organization would that have to be addressed?
DR. DANKWA:
A. It would be by the senior executive that would have to -- the CEO and then --
COFFEY, Q.C.:
Q. And Dr. Jong?

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

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COFFEY, Q.C.:
Q. I take it that you, looking at the -- through the microscope at the slides, have to deal with the end product if there's a problem?
DR. DANKWA:
A. Oh, yes.
COFFEY, Q.C.:
Q. And, therefore, if there is -- if there's fixation problems apparent, you would have to take it up with --
DR. DANKWA:
A. I would take it up, yes.
COFFEY, Q.C.:
Q. Doctor, over the years have you noticed such problems?
DR. DANKWA:
A. We do get them, yes.
COFFEY, Q.C.:
Q. And how frequently would you see such problems and how were they addressed?
DR. DANKWA:
A. It's infrequent, but once I see it, I start working from the lab backwards looking at things like the processor as the first thing I look at to see if the change is actually

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uniform, if what looks like a fixation issue is uniform because that would tell me that it's probably something that is affecting all the tissues at the same time. So that will help me eliminate the processor, and then I'll go back to the fixation, and then see where the sample has been coming from and how it was submitted, and then address it from there.

COFFEY, Q.C.:

Q. So you'd actually troubleshoot that particular thing --

DR. DANKWA:

A. Oh, yes.

COFFEY, Q.C.:

Q. All the way back through the chain?

DR. DANKWA:

A. All the way back, yes, and having said that, as specimens come in and they are opened -- if I open them first and I see there is no adequate formalin, I call back and I tell the technician, the lead technician, to follow it up or I call the tech, the appropriate tech to deal with it.

COFFEY, Q.C.:

Q. And take it up with somebody --

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DR. DANKWA:

A. Somebody else, yes, exactly.

COFFEY, Q.C.:

Q. And to --

DR. DANKWA:

A. Address it.

COFFEY, Q.C.:

Q. And admonish them to get it right, in effect?

DR. DANKWA:

A. In a nice way.

COFFEY, Q.C.:

Q. Yes. Doctor, how many breast cancer cases would come to St. Anthony out of Labrador? You said 15 to 20 for St. Anthony in total. How many would you get out of Labrador?

DR. DANKWA:

A. I would say probably about four or five.

COFFEY, Q.C.:

Q. So out of the 15 to 20 coming out of your institution entirely, four or five of those would originate in Labrador?

DR. DANKWA:

A. Four or five might come from there, yes.

COFFEY, Q.C.:

Q. Per year?

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DR. DANKWA:

A. Per year, yes. These are rough estimates, yes.

COFFEY, Q.C.:

Q. Doctor, if I could, please, I'm going to ask the Registrar to bring up Exhibit P-1650. Doctor, this is a letter from yourself as the Assistant Executive Director, Medical Services, Labrador Grenfell Regional Integrated Health Authority. It's dated April 20th, 2005, to Susan King, as the immediate past President of the NLMA, co-chair, physician liaise, Services Liaison Committee, and says, "Dear Ms. King, thank you for your letter of March 24th, 2005, requesting feedback on issues with respect to pathology in this province. Indeed the presentation is a good reflection of the realities on the ground. The corrective measures suggested to help prevent burnout and losses of pathologists are valid and supported. In addition to the compensation for permanent pathology staff and other issues that need to be closely examined, is the compensation for locums. Currently it is extremely difficult to attract locums to help relieve pathologists

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as locum pathologists are better paid elsewhere. I'm pleased that these issues have been brought to attention to address in the coming MOU", which would be Memorandum of Understanding. Doctor, what was this about?

DR. DANKWA:

A. I'm trying to remember now exactly what prompted me to write this.

COFFEY, Q.C.:

Q. I take it this has something -- she is the --

DR. DANKWA:

A. She was the President of -- and past President of the NLMA. I'm wondering if they came to have a meeting with our staff and told us what they had in context of what they are planning to present to the Department of Health in negotiating for the Memorandum of Understanding. It must -- I'm not sure if it was a response to a letter, but I think there must have been some issues that were discussed that led me to --

COFFEY, Q.C.:

Q. In particular, Doctor, I wanted to ask you about in context of where you work and have worked for many years now.

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

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

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DR. DANKWA:
A. We are getting a lot more work than we did get before.
COFFEY, Q.C.:
Q. Workloads.
DR. DANKWA:
A. Workloads, yeah. So it has become extremely difficult for them to provide the cover. So what I have ended up doing now is gone out of province, liaising with Gamma Dynacare. Coming here, that was what I did. I contacted them to see if they would be prepared to cover me for the time that I will be away.
COFFEY, Q.C.:
Q. Like that you could be here now?
DR. DANKWA:
A. Yes, and they have, in effect, agreed to cover for this. They made sure that -- they've stated that it was for the five days.
COFEY, Q.C.:
Q. Yes.
DR. DANKWA:
A. The hours are getting overwhelmed, and what they want to get is early slides, not a white tissue. So the white tissue will be piling up

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there. Those white tissue that the technicians cannot handle are being left there for me to go and do. So by Monday when I get back, I'll have a stack of work to deal with. So it's not making it easy to make any alternatives either to take holidays or to go and get continuing education or to do something else.
COFFEY, Q.C.:
Q. Okay, and, Doctor, as you sit here now today, in relation to the ability of yourself -- I take it, finding a replacement for yourself, a locum, so that you can get a month's holiday, for example --
DR. DANKWA:
A. Right, yes.
COFFEY, Q.C.:
Q. Whose responsibility is it to find the person to replace you?
DR. DANKWA:
A. Myself.
COFFEY, Q.C.:
Q. It's yourself, it's you.
DR. DANKWA:
A. Because I happen to also be the Associate VP

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of Medical Services.
COFFEY, Q.C.:
Q. Yes, that's what I was getting at.
DR. DANKWA:
A. That's right, yeah.
COFFEY, Q.C.:
Q. You can't just look to somebody else?
DR. DANKWA:
A. No.
COFFEY, Q.C.:
Q. And complain to them about the fact that he or she hasn't gotten you a replacement.
DR. DANKWA:
A. That's right.
COFFEY, Q.C.:
Q. You have to do it yourself.
DR. DANKWA:
A. Yes, yeah.
COFFEY, Q.C.:
Q. Doctor --
DR. DANKWA:
A. But I must say, though, I do get help too from Dr. Michael Jong, and I often contact -- if he gets any word of any availability of somebody, yes.

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COFFEY, Q.C.:
Q. Doctor, has anything changed even up to today in terms of making a locum in St. Anthony any more attractive for anyone? Has the compensation changed in any way for locums? Has the compensation for locums changed?
DR. DANKWA:
A. Compensation --
COFFEY, Q.C.:
Q. Compensation for locums?
DR. DANKWA:
A. Oh, for compensation, yes, it's improved with a recent announcement by government about locum rates has gone up, yes.
COFFEY, Q.C.:
Q. We understand, and the Commission has heard, that there has been an increase in the remuneration or income for pathologists.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Generally within the province.
DR. DANKWA:
A. Exactly.
COFFEY, Q.C.:

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Q. I wanted to ask you, in particular, about locums.
DR. DANKWA:
A. Yeah.
COFFEY, Q.C.:
Q. At the same time, did that change for locums?
DR. DANKWA:
A. Not very much, not very much. It's probably gotten worse because the issue that is happening now, it's making a lot of people hesitant, what is going on now is making people hesitant actually coming in at the moment.
COFFEY, Q.C.:
Q. So in terms of the -- I think you just said that the locum package has --
DR. DANKWA:
A. Has improved.
COFFEY, Q.C.:
Q. Improved?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. But how much -- has it improved enough for you to be able to get someone to come in and do a

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locum for you?
DR. DANKWA:
A. It's still not as competitive as elsewhere.
COFFEY, Q.C.:
Q. That's what I'm getting at.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Okay, that's what I'm getting at. So it is still not as -- even the current one today --
DR. DANKWA:
A. It's not good enough.
COFFEY, Q.C.:
Q. Is not as comparative as, for example, Ontario or --
DR. DANKWA:
A. Correct, yes.
COFFEY, Q.C.:
Q. Or other spots.
DR. DANKWA:
A. That's right.
COFFEY, Q.C.:
Q. For locums?
DR. DANKWA:
A. For locums, yes, that's right.

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COMMISSIONER:
Q. Mr. Coffey, wherever you can find a appropriate spot to take the luncheon beak.
COFFEY, Q.C.:
Q. Actually, Commissioner this is a good point because I'm going to go on really then to the 2003 and '05 situations, okay.
COMMISSIONER:
Q. Then we'll break until five after two.
COFFEY, Q.C.:
Q. Thank you, Commissioner.
(LUNCH BREAK)
COMMISSIONER:
Q. Mr. Coffey.
COFFEY, Q.C.:
Q. Thank you, Commissioner. Just one moment, please, Commissioner, just to make sure here -- Exhibit P-0113, please. Now, Doctor, after Dr Khalifa approached you in 1998 about having the cases sent to St. John's, the ER/PR, the slides prepared there and sent back to you for reporting, between then and April of 2003, okay --
DR. DANKWA:
A. Yes.

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COFFEY, Q.C.:
Q. Did you ever have any reason to believe that there was any problem with the ER/PR cases?
DR. DANKWA:
A. No.
COFFEY, Q.C.:
Q. Now this memo, it's page one of Exhibit P-0113. It's to pathologists, HSC, St. Clare's and out of town hospitals from Dr. G. Ejeckam, and the subject is immunohistochemical stains and the date is April 4, 2003. Doctor, did you receive this?
DR. DANKWA:
A. No, I did not.
COFFEY, Q.C.:
Q. You didn't?
DR. DANKWA:
A. No, I didn't, no.
COFFEY, Q.C.:
Q. You've -- I take it -- well, I'll ask you, when did you first become aware of this particular memo's existence?
DR. DANKWA:
A. It was in the -- when I was invited to come --
COFFEY, Q.C.:

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Q. And be interviewed?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. By the Commission counsel?
DR. DANKWA:
A. By the Commission counsel, yes.
COFFEY, Q.C.:
Q. Okay, Doctor, now you've had a chance, I take it, since then, of course, to read it.
DR. DANKWA:
A. Yes, I have.
COFFEY, Q.C.:
Q. Which refers to these eight stains. Were you aware back in 2003 that this had happened even, back at that time?
DR. DANKWA:
A. No, I wasn't.
COFFEY, Q.C.:
Q. Doctor, at page two of that Exhibit P-0113, there's a memo of May 2nd, 2003, from Dr Ejeckam to pathologists, HSC, St. Clare's, and out of town hospitals, and the subject is ER/PR immunohistochemical stains, and it just begins with, "I am glad to inform you we have

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rectified the difficulties related to the immuno stain of ER/PR. Therefore, we can now resume regular requests for these antibody stains. I will, however, like to make the following -- bring the following information to your attention", and it goes on for three pages. Now, Doctor, did you receive a copy of this in 2003?
DR. DANKWA:
A. No, I didn't.
COFFEY, Q.C.:
Q. When did you first become aware of this?
DR. DANKWA:
A. It was before this -- before the initial interview I had with you.
COFFEY, Q.C.:
Q. Was it just before that?
DR. DANKWA:
A. Yes, before that.
COFFEY, Q.C.:
Q. Before the time that myself and Ms. Chaytor --
DR. DANKWA:
A. In March, yes.
COFFEY, Q.C.:
Q. In March of this year?

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DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. You've had a chance to look at this since, Doctor?
DR. DANKWA:
A. Yes, I have.
COFFEY, Q.C.:
Q. The contents of this, the first paragraph on page one of the memo, "Results of the immuno stains may be affected by", and he talks about delayed fixation, over fixation, under fixation, and so on, okay.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And the contents of this, was any of this -- when you saw this in --
DR. DANKWA:
A. March.
COFFEY, Q.C.:
Q. March of 2008, was any of this information new to you as information?
DR. DANKWA:
A. No, it wasn't.

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COFFEY, Q.C.:
Q. You were already aware of this?
DR. DANKWA:
A. Aware of the information in it, yes.
COFFEY, Q.C.:
Q. And how long would you have been aware of this sort of information?
DR. DANKWA:
A. From my training back in Bristol, and my exposure down in Washington, DC, yes.
COFFEY, Q.C.:
Q. Now, Doctor, in St. Anthony --
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. For example, between 1998 then and 2003, or actually all the way up to 2005 for that matter, in reporting ER/PR, you reported it how? What format would you use?
DR. DANKWA:
A. Yes. I would state the intensity of staining if there was any, and then I will qualify it also by stating how much of the tumour is actually -- by stating the percentage, how much of the tumour is involved. So I will

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give the percentage, yes, it's staining, how strongly it is staining, and what percentage it is.
COFFEY, Q.C.:
Q. And, Doctor, what sort of terminology would you use in a pathology report, the addendum is what this would be --
DR. DANKWA:
A. Right, addendum.
COFFEY, Q.C.:
Q. To describe intensity, what sorts of categorizations would you use?
DR. DANKWA:
A. I would use -- I would yes, weak, moderate, and then marked.
COFFEY, Q.C.:
Q. Marked?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Meaning strong, I take it, or intense?
DR. DANKWA:
A. Strong, yes -- or sometimes strong, actually, yes.
COFFEY, Q.C.:

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Q. And that sort of characterization you learned to do back from your days in the UK and --
DR. DANKWA:
A. UK and --
COFFEY, Q.C.:
Q. And in the US?
DR. DANKWA:
A. Yes, yes.
COFFEY, Q.C.:
Q. And the fact that this memo had been sent out, or a memo like this in May of 2003 by Dr. Ejeckam, that fact that this had even occurred, you first learned about when?
DR. DANKWA:
A. In March.
COFFEY, Q.C.:
Q. Of this year?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, in paragraph seven of this, for example, there's a reference -- not for example, it says here "ER positive tumours", and it lists particular types of tumours.
DR. DANKWA:

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A. Sure.
COFFEY, Q.C.:
Q. I take it -- and we understand this is written here to suggest that these particular types of tumours, and as well Dr. Ejeckam has told the Commissioner he should have included --
DR. DANKWA:
A. Lobular.
COFFEY, Q.C.:
Q. Lobular as well, "statistically they are more likely to be positive".
DR. DANKWA:
A. Correct, yes.
COFFEY, Q.C.:
Q. Doctor, you would have been aware of that?
DR. DANKWA:
A. Yes, I would have been, yes.
COFFEY, Q.C.:
Q. From years ago?
DR. DANKWA:
A. From years back, yes.
COFFEY, Q.C.:
Q. Doctor, in examining patient slides in St. Anthony, when you were checking the slides, would you bring to bear your diagnosis as to

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the type of tumour in the sense that -- it's a breast tumour, but a tubular versus a lobular versus -- in terms of what you were looking at on the slide, what you expected to see and --
DR. DANKWA:
A. Yes, if I get a tumour, and I make a diagnosis of malignancy, I would have to quality what type of malignancy it is and grade it as well, yes.
COFFEY, Q.C.:
Q. And if, for example, you had called a tumour a low nuclear grade ductal tumour --
DR. DANKWA:
A. Right, yes.
COFFEY, Q.C.:
Q. And then you sent off for ER/PR --
DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. Testing, and the slides came back, when you looked down through the scope at the H & E -- I'm sorry, the ER/PR slides, what would you be expecting then to see?
DR. DANKWA:
A. I would naturally be expecting that to be

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positive. The way I look at it is whenever any tumour is of low grade or well differentiated, as you may say, it tends to stain as a normal tissue that is in the substance. So that will be my normal expectation.
COFFEY, Q.C.:
Q. And if you come across a tumour that didn't accord with your expectation in that regard?
DR. DANKWA:
A. If it didn't, okay, I'll critically look at the controls again to make sure that there isn't something that I've missed, and if the controls are working, that's the external and internal controls are working, I'll go ahead and report it.
COFFEY, Q.C.:
Q. You'll report it as to what you'd seen?
DR. DANKWA:
A. As to what I've seen, yes.
COFFEY, Q.C.:
Q. Okay. Doctor, what has been referred to here by various witnesses at times who have testified here, ER/PR matter, issue, or concern, when did you first become aware of

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it?
DR. DANKWA:
A. 2005, when I got a letter from Dr. Don Cook.
COFFEY, Q.C.:
Q. And if we could, please, Exhibit P-2199. Doctor, this is a memo of June 14th, 2005. It's to all laboratory directors, which you're listed as the last in the order here, St. Anthony.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Dr. Dankwa, and it's from Dr. Cook, and it's -- is this the memo you're referring to?
DR. DANKWA:
A. Yes, indeed.
COFFEY, Q.C.:
Q. So, Doctor -- the Commissioner has already seen this a number of times and had it read out to her. Doctor, when you first received this, what, if anything, was your response in the sense of -- what was your reaction?
DR. DANKWA:
A. I was a bit curious at that letter. I wondered what was really behind it all. So I

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pondered a little around it because sometimes you occasionally wonder whether the research process that is coming through, but without going through the research review process. So after giving it some concentration, I called Dr. Don Cook to find out exactly what it is about, and then he explained the circumstances surrounding it, and I took his word for it.

COFFEY, Q.C.:

Q. And what did he tell you about the circumstances?

DR. DANKWA:

A. If I remember correctly, he mentioned about a lady who was negative by their test, and the oncologist, I think -- it looks like they must have repeated and it was still negative. The oncologist, the local oncologist here, was concerned about the case and had a discussion with a colleague of his in the United States, who raised the comment that usually those tumours tend to be positive, and based on that, I think they had it retested and it was retested as positive. That is what seemed to have started this.

COFFEY, Q.C.:

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Q. So Dr. Cook explained that to you?

DR. DANKWA:

A. Yes, he did.

COFFEY, Q.C.:

Q. And did you discuss -- this memo does go on to say that -- talks about the Ventana System being fully automated.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. To be more sensitive than the previous DAKO method. "Most of these false negatives have occurred during the year 2002".

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And they've already told you we're aware of a number of negative ER and PR that have converted.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. On retesting. So, Doctor, Dr. Cook had told you about this one patient that had converted.

DR. DANKWA:

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A. Yes.

COFFEY, Q.C.:

Q. And, of course, you're being told here there's a number of others?

DR. DANKWA:

A. A number of others, yes.

COFFEY, Q.C.:

Q. Did he discuss with you at the time, like, what proportion of people that they had -- were finding were converting?

DR. DANKWA:

A. No, he didn't.

COFFEY, Q.C.:

Q. Okay. So you were satisfied after your conversation with Dr. Cook that this was something that you had to attend to?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And what then happened? Would you explain to the Commissioner then how you had to go about searching for cases --

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

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Q. And in doing so, perhaps if I could, have you begin with the information collection system that existed for pathology reports when you arrived in St. Anthony, take us up to the present, and then you can fit then what you did into that?

DR. DANKWA:

A. Into that, okay. The information system that existed when I arrived was that they had a computer, but they just basically typed the results and then printed it out in hard copy sheets. It wasn't filed in any electronic file system. So there wasn't any electronic information, it was all paper documentation that was there. That continued until 2003, July/August, when we moved onto the Meditec System which is an electronic filing system, and up to this day that is what we have.

COFFEY, Q.C.:

Q. Now the Meditec System, after it was implemented in the middle of 2003, okay --

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. The version of it that is in use in St.

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Anthony, is that able to be searched -- using Meditec, are you able to search for and identify every patient who has had an ER/PR test done?

DR. DANKWA:

A. I can't say specifically for ER/PR, but I could search for something like "breast".

COFFEY, Q.C.:

Q. Okay, breast.

DR. DANKWA:

A. Yes, yeah.

COFFEY, Q.C.:

Q. And from that, you'd get breast carcinoma?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And then ER/PR?

DR. DANKWA:

A. And then ER/PR, yes.

COFFEY, Q.C.:

Q. With that in mind then, Doctor, so this request involving 2002 is before the Meditec?

DR. DANKWA:

A. Meditec, correct, yes.

COFFEY, Q.C.:

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Q. When you first got this then and after your conversation with Dr. Cook--do you recall approximately when your conversation with Dr. Cook would have been?

DR. DANKWA:

A. I can't recall exactly what date that was.

COFFEY, Q.C.:

Q. And so if we could, before I get actually into it further, Exhibit P-0590, please? Now Dr. Dankwa, this is a letter from Dr. Donald Cook as clinical chief to again, lab directors, including yourself, there second from the last addressee. It's September 6th, 2005, ER and PRs, here in the title. "I wish to advise you that we are doing a review of our estrogen and progesterone receptors. I expect to have more information within the next few weeks and will keep you updated. Please note the following points" and there's a number of them.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Did you receive this memo?

DR. DANKWA:

A. Yes, I did.

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COFFEY, Q.C.:

Q. Okay, if we could, please, bring up Exhibit P-1736? Doctor, these are handwritten notes created by Dr. Cook, and the second entry here, September 7th, 2005 at ten a.m., he says "spoke to Dr. Dankwa from St. Anthony. Updated him on situation and gave background information before my memo went out," and that memo is the September 6th one he's told us.

DR. DANKWA:

A. Right.

COFFEY, Q.C.:

Q. Do you recall Dr. Cook phoning you and giving you a heads up about the September 6th memo?

DR. DANKWA:

A. I knew we had a talk about it sometime, yes, but I can't recall the exact date.

COFFEY, Q.C.:

Q. Now Doctor, if we could, please, Registrar, Exhibit P-0590 again? This September 6th, 2005 memo, Doctor, do you recall approximately when it was you would have received that?

DR. DANKWA:

A. Not exactly, no.

COFFEY, Q.C.:

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Q. I take it, in the normal course, when it -

DR. DANKWA:

A. Yeah.

COFFEY, Q.C.:

Q. How far, if at all, had you gotten with responding to the June 14th 2005 memo, gathering the material he wanted in June, by the time you got the September 6th memo?

DR. DANKWA:

A. By the time I got the September 6th memo, we had already sent the requested information to Don Cook's secretary.

COFFEY, Q.C.:

Q. If we could bring up again, please, Exhibit P-2199? Doctor, this handwriting here, do you recognize -

DR. DANKWA:

A. That's my secretary's handwriting, yes.

COFFEY, Q.C.:

Q. And this says "sent September 8th '05, names at back. Please return ASAP when study complete."

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

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Q. And if we could show the Commissioner, at back, I take it, these are the -
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. - well, the names and the MCP numbers are redacted, but surgical numbers, 1-2-3-4-5, perhaps 6.
DR. DANKWA:
A. Six, it was six, yeah.
COFFEY, Q.C.:
Q. Six patients?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. For 2002.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. That had negative?
DR. DANKWA:
A. Negatives, yes.
COFFEY, Q.C.:
Q. ER/PR?
DR. DANKWA:

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

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

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did you go about identifying those patients?
DR. DANKWA:
A. At the end of each year, we go back to our file and initially the files--we have a file for current year in which we file the patients records in alphabetical order. So at the end of every year, these are all bound up in a binder in alphabetical order and kept in our archive system. So when these requests came, we just went back to the archive for the particular years that were concerned and then just thumbed through, because we had no way of doing it.
COFFEY, Q.C.:
Q. In terms, just so the Commissioner understands this, okay. So you've got, for example, a 1998, a 1999 and 2000?
DR. DANKWA:
A. Yes, that's right.
COFFEY, Q.C.:
Q. Each year.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. At the beginning of 1999, you would start--

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we'd file away in binders all the '98 ones?
DR. DANKWA:
A. Exactly, yes.
COFFEY, Q.C.:
Q. And in '99 then, as a particular patient, you say a file?
DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. Is that a file just containing their pathology report?
DR. DANKWA:
A. Yes, a file containing the pathology report, yes.
COFFEY, Q.C.:
Q. And for a patient with a name beginning with A, that would be first.
DR. DANKWA:
A. Yes, first, yeah.
COFFEY, Q.C.:
Q. And then B, C, Ds would follow and as the year would go on, they'd be inserted in alphabetical order?
DR. DANKWA:
A. Yes.

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COFFEY, Q.C.:
Q. As they're filed away.
DR. DANKWA:
A. Yes, so we would have one layer of one year. So '98 will be on one level of the shelf. Another shelf will be, say, '99. The next would be 2000, just like that.
COFFEY, Q.C.:
Q. And every patient that you had done any pathology work for -
DR. DANKWA:
A. Would be in that binder, yes.
COFFEY, Q.C.:
Q. And from A to Z literally.
DR. DANKWA:
A. A to Z, yes.
COFFEY, Q.C.:
Q. So that when you had--then, when you requested, for example, initially for 2002, what actually physically had to happen? For example, how many reports would there be for 2002? How many -
DR. DANKWA:
A. You're looking at close to about over 2000, getting close to 3,000.

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COFFEY, Q.C.:
Q. For that particular year?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Reports?
DR. DANKWA:
A. Reports, yes.
COFFEY, Q.C.:
Q. For any one year?
DR. DANKWA:
A. Any one year. Initially, in '97, '96/97, it was probably around about 2,000, but the numbers kept increasing.
COFFEY, Q.C.:
Q. And by the time--well, for example, the last full year would be 2002?
DR. DANKWA:
A. Yes, yeah.
COFFEY, Q.C.:
Q. How many would you be -
DR. DANKWA:
A. We would be getting close to 3,000, yeah, and for--depending on what type of case it is, we may have about three or two pages, so you are

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looking for every year, at least looking at two to three thousand pages to sort through.
COFFEY, Q.C.:
Q. And the only order in which they are is alphabetical by name?
DR. DANKWA:
A. Just alphabetical order, by names, yes.
COFFEY, Q.C.:
Q. In that, you would have biopsies for kidney -
DR. DANKWA:
A. Kidney, spleen -
COFFEY, Q.C.:
Q. - liver, lung, whatever?
DR. DANKWA:
A. - anything, yes, exactly.
COFFEY, Q.C.:
Q. Just all in -
DR. DANKWA:
A. All in the file, yes.
THE COMMISSIONER:
Q. So I understand--what was it five, six patients that you actually came up with for 2002?
COFFEY, Q.C.:
Q. Six, Commissioner.

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

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

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and any case that had any supplemental report, that had ER/PR on it. So all that was pulled together and I would be looking through myself as well.
COFFEY, Q.C.:
Q. Okay. So they would identify breast cases and anything with ER or PR on it?
DR. DANKWA:
A. Breast cases and then ER/PR on it, yes, exactly.
COFFEY, Q.C.:
Q. And they would bring those cases to your attention?
DR. DANKWA:
A. Yes, and I'll look through it. I also thumbed through some of them myself.
COFFEY, Q.C.:
Q. And then, Doctor, so those cases, I take it, would involve some results that are ER/PR positives?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. As well as negatives?
DR. DANKWA:

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A. As negatives, yes.
COFFEY, Q.C.:
Q. So would you--you'd get all the ER/PR cases?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Positive or negative?
DR. DANKWA:
A. Exactly, yes.
COFFEY, Q.C.:
Q. And then you would look through them for what?
DR. DANKWA:
A. Looking for those that were reading negative, yes.
COFFEY, Q.C.:
Q. And then when the September 6th--if we could, please, Exhibit P-0590? September 6th memo came in, here what is positive and negative is actually spelled out here?
DR. DANKWA:
A. Spelled out, yes.
COFFEY, Q.C.:
Q. And it's not necessarily exactly in accordance with -
DR. DANKWA:

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A. Way I report, no.
COFFEY, Q.C.:
Q. - with yours, so what--for example, as an example, would be, the second bullet here, for the period covering the year 2002, ER negative would be defined as ten percent or less?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And you had originally gone through identifying them anything that was five, for example, was positive and you hadn't identified it?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. So did you--was that--your search the second time through -
DR. DANKWA:
A. Yes, we had to go through it again, yes, yeah. So basically, and bear in mind too that I had one secretary, I was the only one, and then we had a lead tech. We still had to do our regular work as well as take on this. So when I saw the second memo, I knew we had a

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

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A. We got--the print out was somewhere towards the end of October 2005 when a print out was made, but I think we got it around November sometime.
COFFEY, Q.C.:
Q. And this was a print out from whom?
DR. DANKWA:
A. From--Judy Thomas printed it out, I think, from the either St. Clare's electronic system or St. John's Meditec system. Printing out cases of all breast cancers that have gone through the system here.
COFFEY, Q.C.:
Q. That had gone through their system but had originated -
DR. DANKWA:
A. From us.
COFFEY, Q.C.:
Q. From St. Anthony?
DR. DANKWA:
A. From St. Anthony, yes.
COFFEY, Q.C.:
Q. And in the meantime, this thumbing through -
DR. DANKWA:
A. Was going on, yes.

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COFFEY, Q.C.:
Q. - manually, was still going on?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Was the Meditec system ever, before '03, '04 and '05 at St. Anthony ever searched?
DR. DANKWA:
A. We use the Meditec to site the latter part of '03 to '05, but we still had to thumb through the 2003 because we weren't sure what the Meditec was going to cover for us, yes.
COFFEY, Q.C.:
Q. Doctor, as you indicated, there's well over 10,000 pages of reports.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Probably, as you say, I think 13 to 15,000 or so.
DR. DANKWA:
A. Sure, yeah.
COFFEY, Q.C.:
Q. Doctor, to your knowledge, has anyone ever actually thumbed through all of them?

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DR. DANKWA:
A. Now, yes.
COFFEY, Q.C.:
Q. Okay.
DR. DANKWA:
A. But at that time, no.
COFFEY, Q.C.:
Q. And when did the -
DR. DANKWA:
A. Thumbing through.
COFFEY, Q.C.:
Q. - when did the final thumbing through, when did that occur?
DR. DANKWA:
A. That occurred last year when the Commission of Inquiry was struck and then there was a request for all our ER/PR cases.
COFFEY, Q.C.:
Q. And that has to do with the statistical -
DR. DANKWA:
A. The statistical, yes, gathering of information, yes.
COFFEY, Q.C.:
Q. Okay, so that was in ’07.
DR. DANKWA:

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A. In ’07, I think. It was around June or July, thereabouts, yes.
COFFEY, Q.C.:
Q. And I’ll come to that then. So in the initial identification of patients in 2005 for retesting, do you know how many of the--like were any particular years gone through? I take it 2002 was probably gone through.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. At least using your criteria for negative.
DR. DANKWA:
A. Yes, exactly.
COFFEY, Q.C.:
Q. How about the other years, did anybody ever actually go through all the paper at the time?
DR. DANKWA:
A. The paper, I think we might have done the 2003, 2002, and probably 2001, because we were working backwards, yes.
COFFEY, Q.C.:
Q. And your Meditec system was checked for ’03, ’04 and ’05?
DR. DANKWA:

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A. Yes, exactly.
COFFEY, Q.C.:
Q. Then for the years prior to those years you’ve just referred to, you would have been relying upon the spreadsheet you received from St. John’s in -
DR. DANKWA:
A. Yes, exactly.
COFFEY, Q.C.:
Q. - in October of ’05?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. To identify your patients for ’97, ’98 and ’99 -
DR. DANKWA:
A. Correct.
COFFEY, Q.C.:
Q. - and 2000?
DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. Doctor, the September 6th memo, as you indicated, when you got it, you realized that this is a much more arduous or monumental

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task?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. You know, sitting in St. Anthony yourself. Did you contact anyone about what was going on here, in the sense of kind of what--why was this all now necessary?
DR. DANKWA:
A. No, at that time, I didn’t. We hadn’t had any results back. We didn’t know exactly whether there was any significant change in our results or not. So I had nothing really to work with.
COFFEY, Q.C.:
Q. To judge how many people this might involve, in the sense of would have changed results, you had no idea?
DR. DANKWA:
A. I had no idea. Had no idea then.
COFFEY, Q.C.:
Q. Did you have any sense, by September 2005, as to how many conversions there had been in the St. John’s group that had been retested? Anybody tell you?

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

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A. I took that option, yes.
COFFEY, Q.C.:
Q. If we could go back then, please, to P-1779? this is a letter of September 26th, 2005 to yourself from Dr. Mullen?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Brendan Mullen of Mount Sinai and I take it then you were prepared to and did take up Dr. Mullen's offer.
DR. DANKWA:
A. Offer, yes, I did.
COFFEY, Q.C.:
Q. So, Doctor, just while we're on this topic, I take it from this point on, any ER/PR and HER2/neu you wanted done -
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Has been done at Mount Sinai?
DR. DANKWA:
A. Yes, adapt (phonetic).
COFFEY, Q.C.:
Q. And how does that arrangement work?

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

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terms of its timeliness?
DR. DANKWA:
A. Very good, yes.
COFFEY, Q.C.:
Q. Doctor, if we could, please, before I leave the topic of the pre-2005 days, I've referred you to Dr. Ejeckam's memos. Do you know who Dr. Ejeckam was?
DR. DANKWA:
A. Yes, I do. I met him when he was here working in the Health Sciences Centre, yes, but I didn't know him before then.
COFFEY, Q.C.:
Q. Did you acquire any understanding as to how involved or uninvolved he was in IHC? Did you have any understanding of that?
DR. DANKWA:
A. I had no idea.
COFFEY, Q.C.:
Q. You just knew him as a fellow pathologist?
DR. DANKWA:
A. Yes, exactly.
COFFEY, Q.C.:
Q. Now, Doctor, if I could please, Exhibit P-2202? And, Doctor, again, I apologize,

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Commissioner for doing this out of turn, but while I'm, so I don't forget it, we spoke this morning, Doctor, about the problems with you getting the replacement. This is entitled "Leave dates for 2002 through 2005"?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And you prepared this at whose request?

DR. DANKWA:

A. You requested it at the last meeting.

COFFEY, Q.C.:

Q. During our interview?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And, Doctor, this then I take it is a summary of the leave dates you've had during those years?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. To give the Commissioner some sense of how often you can get away and for the periods in question.

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DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Doctor, while I'm thinking about this now, as the sole pathologist in St. Anthony, I take it then, Doctor, that your normal work week is Monday to Friday in the sense of you're scheduled to be in at work.

DR. DANKWA:

A. Yes, correct.

COFFEY, Q.C.:

Q. They expect to find out at the office Monday to Friday.

DR. DANKWA:

A. Official, yes.

COFFEY, Q.C.:

Q. As a practical matter, being the sole pathologist in the community, how much actual time does it take?

DR. DANKWA:

A. Once I'm in St. Anthony, I'm at work, I could be called in any time and I work on weekends, public holidays, you name it, I'm there.

THE COMMISSIONER:

Q. Doctor Dankwa, this morning you spoke about the advantage of being the sole pathologist.

DR. DANKWA:

A. Yes.

THE COMMISSIONER:

Q. I think you're now telling me one of the disadvantages of being a sole pathologist. What about the flip side of having to deal with colleagues, in the sense of being able to consult with somebody who has your kind of training about a difficult case or something of that nature? How do you manage that?

DR. DANKWA:

A. Whenever I am faced with any case that I have some concerns about, having colleagues in place that I've trained, I quickly send them on for referrals and they very willingly provide a support and knowing my colleagues here too, in St. John's, I consult them too with some cases and they are always very helpful.

THE COMMISSIONER:

Q. But by its very nature, because you are by yourself, the consultation process therefore takes much more time than it would if you were here in St. John's or even in Corner Brook?

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DR. DANKWA:

A. Will colleagues, I agree, yes.

COFFEY, Q.C.:

Q. If we could, please, Exhibit--trying to get some sense, Doctor, of what distribution, as the Commissioner knows, like how many memos kind of got to you and how many didn't, okay?

DR. DANKWA:

A. Okay.

COFFEY, Q.C.:

Q. Exhibit P-1388 please? And this is a fax cover sheet, the first page to Boyd Rowe. Who is Boyd Rowe?

DR. DANKWA:

A. He is a chief executive officer for Labrador Grenfell Health.

COFFEY, Q.C.:

Q. And this is dated July 12th, 2005 and you write "Boyd, attached are copies of all the correspondence that we have received so far with regard to ER/PR."

DR. DANKWA:

A. Correct.

COFFEY, Q.C.:

Q. And it's signed by yourself, so if we find it

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in this exhibit, and I'll take you through it, as of July, 2007, this is what you had searched your files for and provided to your CEO?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. What you had.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. If we could, that's the June 14th memo, page 2. Page 3 is a letter to yourself involving Herceptin from Dr. Laing advising you about the fact that Herceptin--advising you about the current data for Herceptin at the time. And I take it that this is in this file because Herceptin relates to ER/PR?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And HER2/neu, well actually HER2/neu, I suppose. There's a July 28th, 2005 memo from Dr. Cook on HER2/neu and at the bottom of the last paragraph, he says, "When choosing blocks

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to send for both hormone receptor testing and HER2/neu, please select a section that contains both tumour and normal or benign epithelium."

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. I take it, that wasn't news to you.

DR. DANKWA:

A. No, no.

COFFEY, Q.C.:

Q. September 6th memo you had received?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. September 26th letter from Dr. Mullen. Doctor, here at page 8 of the exhibit, there's a "Dear Physician" letter on Eastern Health stationery and it's over the name of Dr. Robert Williams, Vice-President of Medical Services, October 4th, 2005. And I take it, Doctor, this is something that, a letter advising physicians throughout the province about the ER/PR matter?

DR. DANKWA:

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A. Right.

COFFEY, Q.C.:

Q. Do you recall how you came to receive this?

DR. DANKWA:

A. I don't. At that time we were getting quite some communications like this, but I don't remember how I got it, received this one, no.

COFFEY, Q.C.:

Q. Now, Doctor, when the ER/PR matter came up, particularly after that September--well, I'll say before the September 6th memo.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Who, within your organization, if anyone, other than your secretary had you informed about this request for the 2002 cases?

DR. DANKWA:

A. For the 2002? Nobody, nobody.

COFFEY, Q.C.:

Q. Is there any reason you wouldn't have informed Dr. Jong about that time about that?

DR. DANKWA:

A. At that time, my understanding was they were trying to find out whether things had really

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affected cases or not. So it was still under--they were investigating it internally to see if there was any problem or not, yeah.

COFFEY, Q.C.:

Q. Doctor, when you got the June 14th memo, did you understand that they would be creating new slides and analyzing the slides and giving you a result, or that they would be sending you new slides to look at or did you know?

DR. DANKWA:

A. Oh, I got the impression that they would be analyzing the result, they were be creating new slides and analyzing the results, yes.

COFFEY, Q.C.:

Q. And did you anticipate that you would actually be getting the results too, at some point?

DR. DANKWA:

A. Yes, at some point, yes.

COFFEY, Q.C.:

Q. So the September 6th memo, 2005, when you got that, did you inform anybody in your organization, your superiors about that?

DR. DANKWA:

A. No, I didn't because at that stage, we still hadn't had any results and we didn't know

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exactly whether it was going to turn out to be anything significant or relevant, yeah.

COFFEY, Q.C.:

Q. And that was so, despite the fact that you were facing having to go through thousands and thousands of documents.

DR. DANKWA:

A. Exactly, yes.

COFFEY, Q.C.:

Q. But you still didn't -

DR. DANKWA:

A. I still didn't, because we hadn't had any results for us to really note whether there was any change of anything, yes.

COFFEY, Q.C.:

Q. When did you first tell Dr. Jong?

DR. DANKWA:

A. I can't remember exactly, but I think towards the end of 2006, there may have been some communication or it was already in the news at some stage, even before -

COFFEY, Q.C.:

Q. This would be 2005, probably.

DR. DANKWA:

A. Oh, sorry, 2005, yes, sorry.

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COFFEY, Q.C.:

Q. Okay, so what I'll do is I'll ask--well actually I'll take you then, Doctor, through--because that's page 8 there, page 9 of Exhibit P-1388 is an e-mail from Alison Dower to Addictions, is the address, Friday, October 7th, 2005. Subject is "Estrogen Receptors/Progesterone Receptors", it's on Labrador Grenfell Regional Integrated Health Authority letterhead. Internal memorandum to all staff from Dr. Michael Jong, VP Medical Affairs.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. It's dated October 7th, 2005 and he writes, "Dear Staff, many of you may have heard in the media about the issue of breast cancer patients and the testing for estrogen receptors, progesterone receptors at Eastern Health. Labrador Grenfell Health is currently working with Eastern Health to resubmit previously collected tissue samples from breast cancer patients for retesting from the period of '97 to 2004. The retesting will not

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change an individual's diagnosis, but it may be one of the factors considered in determining the type of treatment a patient will receive. Please find attached a hand-out that has been prepared for physicians, public health nurses, the provincial breast screening program, nursing administrators and other groups, to provide to their clients who may have concerns about this issue. Sincerely, Dr. Michael Jong." And there's obviously an attachment, ER/PR client -

DR. DANKWA:

A. Information.

COFFEY, Q.C.:

Q. If we look to the next page of this exhibit, page 10, there's a document there entitled "Client Hand-out" with the headings "What is ER/PR? What is happening now? Why are some test results different?" And then, finally, "As a breast cancer patient, I haven't been contacted, what should I do?" Now, Doctor, I take it then you would have spoken to Dr. Jong before October 7th?

DR. DANKWA:

A. I would expect so, yes.

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COFFEY, Q.C.:

Q. It had gone public. Do you know if you were the one who brought the fact, the ER/PR matter to Dr. Jong's attention?

DR. DANKWA:

A. I'm not sure how it really started, but we definitely had some discussions, yes.

COFFEY, Q.C.:

Q. And how did this "Client Hand-out" come to be prepared, do you know?

DR. DANKWA:

A. I can't remember exactly how it did, but I know that I had discussions with Alison Dower, who is our communications, media communications manager and so I would have discussed having some information as to how we are handling cases.

COFFEY, Q.C.:

Q. So, the information contained here on page 10 of the exhibit entitled "Client Hand-out", would some of this information for her come from you?

DR. DANKWA:

A. Some of it might have, yes.

COFFEY, Q.C.:

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Q. Doctor, here the "what is happening now, why are some test results different", the second last paragraph says, "Labrador Grenfell Health will be submitting previously collected tissue samples to Eastern Health for this retesting. Patients will not be required to come to hospital or have any additional testing. Please note, only a small percentage of breast cancer patients may be affected by this retesting".

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. At that point in time, did you have any understanding or had anybody given you any understanding as to how many might be affected by this?

DR. DANKWA:

A. No.

COFFEY, Q.C.:

Q. So, the assertion that only a small percentage of them might be affected, was that your thought at the time?

DR. DANKWA:

A. No, it think they were probably gathering,

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through my discussions with them, they wanted to know maybe the numbers of cases that we were looking at. And I might have given them the 2002 information.

COFFEY, Q.C.:

Q. That would be, for example, it would be six negatives out of approximately 20 a year.

DR. DANKWA:

A. Yes, exactly, yes.

COFFEY, Q.C.:

Q. That had to be retested.

DR. DANKWA:

A. Exactly.

COFFEY, Q.C.:

Q. Doctor, the notion at that point then of when you're speaking to Dr. Jong, September/October 2005, did the subject of patient notification come up, notifying patients about the fact that they were being retested at all?

DR. DANKWA:

A. No, when the initial request came through, I looked--with my discussions with Dr. Jong, no, I don't remember us discussing that, no.

COFFEY, Q.C.:

Q. And if patients were to be notified, you know,

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by Labrador Grenfell of the fact that their tissue was being retested, whose decision would that be? At what level in your organization would that occur? Would that be your decision or Dr. Jong's, to actually contact the patients and tell them, your tissue is being retested.

DR. DANKWA:

A. If it was something that was out--the best example I can give is if someone is doing a research on a patient, then it is the person who is performing the research would have to identify what they are doing and communicate with a patient, yes.

COFFEY, Q.C.:

Q. That's research.

DR. DANKWA:

A. Research, yes.

COFFEY, Q.C.:

Q. Now, did you -

DR. DANKWA:

A. I didn't view this as a research. I viewed this as a clinical service.

COFFEY, Q.C.:

Q. And does Labrador Grenfell have a disclosure

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policy do you know? Disclosure in the sense of if there's an adverse event or a potential adverse event.

DR. DANKWA:

A. If--yes. We have a form that we complete and it goes through the chain informing different levels what had happened, what measures had been taken.

COFFEY, Q.C.:

Q. Was any such form ever filled out here for this?

DR. DANKWA:

A. No, no.

COFFEY, Q.C.:

Q. Why not?

DR. DANKWA:

A. I didn't see this as an adverse reaction, at least, I saw it as a clinical issue that we're trying to work through and we hadn't really had any results really to work with. So, that is how I saw it.

COFFEY, Q.C.:

Q. And were there--I'll just skip ahead--were there any patients with conversions in St. Anthony?

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DR. DANKWA:
A. There were some patients that had conversion, yes.
COFFEY, Q.C.:
Q. And in relation to those patients, has any such form been filled out?
DR. DANKWA:
A. No.
COFFEY, Q.C.:
Q. Looking back on it, should there have been one filled out for the patients when you knew there was a change result, conversion with a treatment change?
DR. DANKWA:
A. It's difficult -
MR. BROWNE:
Q. Excuse me, it's maybe a difficult question -
COFFEY, Q.C.:
Q. I appreciate that, it may be too. Doctor, I'll just ask you, did it even occur to you in this particular context to fill out such a form?
DR. DANKWA:
A. No.
COFFEY, Q.C.:

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Q. Okay. And I take it that this form is the sort of form that you'd fill out, an individual patient, an individual event.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. That's the sort of mindset.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Here in terms of the conversions that did occur and treatment changes that did occur for Authority's patients, bearing in mind what the policy is within your institution, would these cases fit that policy?
DR. DANKWA:
A. I haven't seen that policy being used in that sense. So, it wasn't something that really struck me, otherwise we would have completed it, yes.
COFFEY, Q.C.:
Q. Certainly if it had struck you and you thought it was applicable, you would have -
DR. DANKWA:
A. I would have completed it, yes.

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COFFEY, Q.C.:
Q. Doctor, now you've described there's a policy that if there is an adverse event, you have to report it up the chain.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. How about, is there an adverse events policy that your authority has to deal with informing the patient about the adverse event? For example, Eastern Health has a written policy, all spelled out about if an adverse event happens, certain things have to happen including telling the patient about it.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Is there such a policy in Labrador Grenfell do you know?
DR. DANKWA:
A. We do, the policy that we have, it's a form and there is a step-by-step process of what-- we do have something along that line, yes.
COFFEY, Q.C.:
Q. Okay. And if I could then, after you finish

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here today, when you return to St. Anthony, if you'd make inquiries and perhaps through your counsel -
DR. DANKWA:
A. And get a copy.
COFFEY, Q.C.:
Q. - and provide a copy to us?
DR. DANKWA:
A. Sure.
COFFEY, Q.C.:
Q. This policy or these policies--policy, sorry.
DR. DANKWA:
A. It's a form, yes.
COFFEY, Q.C.:
Q. A form, how long has that been in effect?
DR. DANKWA:
A. As far as I've known, it is.
COFFEY, Q.C.:
Q. It's been there for years?
DR. DANKWA:
A. Yes.
MR. BROWNE:
Q. Excuse me, Mr. Coffey, maybe (inaudible) I think you may be referring to an incident report, this -

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COFFEY, Q.C.:
Q. Yes, adverse event and that's quite -
MR. BROWNE:
Q. (Inaudible).
COFFEY, Q.C.:
Q. So, this form, do you know, does it say--Mr. Browne makes the point that maybe it's an incident -
DR. DANKWA:
A. Incident, yes, incident, yes, that's the way we refer to it most of the time, yes.
COFFEY, Q.C.:
Q. That's the way you would phrase -
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. An adverse event, is that recognized within Labrador Grenfell's approach to -
DR. DANKWA:
A. It is, but my belief, I may be mistaken on it, my belief is that we've used the same form for it, yes.
THE COMMISSIONER:
Q. Just so that I'm clear, you're asking the witness to identify whatever forms relate to

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either an incident or an adverse event, if they so exist within his organization and to communicate those to us through his counsel?
COFFEY, Q.C.:
Q. Yes.
DR. DANKWA:
A. Yes.
THE COMMISSIONER:
Q. Thank you.
COFFEY, Q.C.:
Q. Doctor, if you could, just looking at Dr. Jong's memo to all the staff, here, of course, I've read it out, it's being prepared for physicians, public health nurses and other groups to provide to their clients who may have concerns about this ER/PR matter. Doctor, did you ever take any steps to communicate with clinicians in your health authority area concerning the ER/PR matter itself?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Could you tell the Commissioner about that?
DR. DANKWA:

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A. We do have regular medical staff meetings and during those medical staff meetings, I update them on the ER/PR -
COFFEY, Q.C.:
Q. I take it, that's really from September 2005 onward.
DR. DANKWA:
A. Right on, yes, because I knew that questions would be coming for it and they would be involved.
COFFEY, Q.C.:
Q. And so what would you inform them about? What sorts of things?
DR. DANKWA:
A. I would be telling them about what we're doing with respect to collection of samples, having them retested and when the results came, how it would be redistributed.
COFFEY, Q.C.:
Q. Okay. Now Doctor, what then happened then as the fall of 2005 went on in relation to identifying the patients? You've indicated that in October 2005 you got this spreadsheet from St. John's.
DR. DANKWA:

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A. It was printed out towards the end of October, but might have gotten it some time in November.
COFFEY, Q.C.:
Q. And then having received that spreadsheet, what did you do?
DR. DANKWA:
A. We started going through the list identifying all those cases and looking at the reports and looking at ER/PR status on that, identifying those that fell within the criteria and then went back to identify the slides and the blocks from the archives?
COFFEY, Q.C.:
Q. And then what happened, Doctor?
DR. DANKWA:
A. And we identified all of them by--it was towards, I think, Christmas break of that period and we held onto them because we were concerned that we might lose them if we send them by mail to the Health Sciences Centre around that period.
COFFEY, Q.C.:
Q. Over the Christmas holidays.
DR. DANKWA:

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A. Over the Christmas holiday breaks, the mailing system, so -
COFFEY, Q.C.:
Q. And from your perspective, although they were ready before Christmas, you were concerned that because of the mail volume, you didn't want to put them in the mail.
DR. DANKWA:
A. Yes, I don't want to risk it, yes. We've had experience before, so.
COFFEY, Q.C.:
Q. And so the ER/PR negative cases, okay, other than the six that went in September -
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. - 2005, September 8th, 2005, all the others from St. Anthony in the kind of first grouping were sent in January, in fact, send in January of 2006.
DR. DANKWA:
A. Yes, yes.
COFFEY, Q.C.:
Q. So, they were all gathered up -
DR. DANKWA:

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A. Yes, and sent on.
COFFEY, Q.C.:
Q. All the years and sent off.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Okay. And Doctor, what then happened?
DR. DANKWA:
A. Waited for the results to come back.
COFFEY, Q.C.:
Q. And then what happened, Doctor?
DR. DANKWA:
A. We had a spreadsheet faxed to us, I think it was in March with the results.
COFFEY, Q.C.:
Q. Okay.
DR. DANKWA:
A. And there was a meeting, a conference call to tell us about how it was going to be--the results were going to be sent out and the results were then transcribed and sent to us.
COFFEY, Q.C.:
Q. So, this conference call was with whom?
DR. DANKWA:
A. Well, this was with all pathologists and

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including the Health Sciences Centre.
COFFEY, Q.C.:
Q. And who is the spokesperson for the Health Sciences Centre?
DR. DANKWA:
A. I think it was Don Cook, yes.
COFFEY, Q.C.:
Q. And what were you told about how the results then--you had already got a spreadsheet giving you the results.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. What were you told about what would happen?
DR. DANKWA:
A. They were going to transcribe the results in a report format and send them to us. And when we get them, we have to send them, a copy, to the family physician and to the surgeon, when we get them. And that was a part--I think a copy to us to go to the oncologist as well.
COFFEY, Q.C.:
Q. So, Doctor, and these individual reports eventually came?
DR. DANKWA:

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

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submitting these to you at your respective sites. When you receive these reports, please ensure that are incorporated into your hospital information or laboratory information systems. I expect that you will be receiving the first of these reports within the next two weeks. Signed, Donald Cook".

Now, Doctor, did you have any understanding about what would happen with respect to reviewing the results in the sense that, changed results and how they would be handled?

DR. DANKWA:

A. My understanding was there was going to be a panel set up and that panel -

COFFEY, Q.C.:

Q. Where did you get that understanding?

DR. DANKWA:

A. Oh, I think, again, it was one of our conference calls that was made. It was going to be the process, when they got the result, they would review it as a group with the pathologist and oncologist to determine whether there is a need to alter the treatment or not.

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COFFEY, Q.C.:

Q. From your perspective, did you have any concerns or problems about such a group being involved? Was there anything that struck you that, any reluctance you had to have the cases from St. Anthony go through that panel?

DR. DANKWA:

A. No, I didn't have any problems, no.

COFFEY, Q.C.:

Q. Doctor, the patients from St. Anthony who went through the panel process and treatment changes were advised or not, as the case might be, do you know how those patients were informed?

DR. DANKWA:

A. My understanding was that those who needed, who had an altered treatment or mode of treatment would be sent a panel letter through the other GPs or surgeons as well. And they would be responsible to contact the patients.

COFFEY, Q.C.:

Q. The individual attending physicians.

DR. DANKWA:

A. Attending physicians, yes.

COFFEY, Q.C.:

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Q. So, those panelling letters, I'll call them, you did not expect in your capacity at VP, Associate VP in Labrador Grenfell to actually get a copy.

DR. DANKWA:

A. No, no.

COFFEY, Q.C.:

Q. Did you receive a copy?

DR. DANKWA:

A. I never did, no.

COFFEY, Q.C.:

Q. Exhibit P-2204, please. Now Doctor, this is an e-mail from yourself, March 17th, 2006 to Dr. Jong and you say, "Hello Michael, this is the follow up of our discussion on this issue. On March 6th, 2006 we received the spreadsheet printout of the results of the repeat tests done in Toronto on the cases from our region. On the form there's an indication of the receipt of our cases in Toronto on January 24th, 2006. As I explained, the cases were sent from St. Anthony to St. John's and were then forwarded to Toronto. For each case there were the original slides, copies of the original report and the block on which the

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tests were performed. I presume St. John's must have received our cases at the latest by mid January. As you may recall there was an initial discussion as to what the direction might be on the ER/PR situation during the fall of last year. During that period, requests came in piecemeal up until November when a general call in for all cases. We received a list from the cancer foundation just before Christmas on the remainder of our cases. Those cases were sent in January and the results included in the spreadsheet mentioned". That is the results in this context, I take it, is your search.

DR. DANKWA:

A. Yes, my cases.

COFFEY, Q.C.:

Q. Cases. "I'm still puzzled as to what St. John's may have received recently from us. I hope this clarifies the situation. Thanks". Doctor, I take it, the first part of this generally is just a summary of what was going on in March.

DR. DANKWA:

A. Yes.

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COFFEY, Q.C.:
Q. And then there's an account here in the middle of the e-mail about what had happened in late 2005. Had there been any issue come to your attention, any concern expressed by anybody about St. Anthony not getting their cases in until January of '06? Did anybody raise a complaint about that?
DR. DANKWA:
A. No, the first time I got any hints were when Michael Jong called me and other discussions.
COFFEY, Q.C.:
Q. And what did Dr. Jong say to you about that?
DR. DANKWA:
A. They had had a VP medical meeting and it was there that he got the inference that we may not have sent our cases, we may not have sent our cases.
COFFEY, Q.C.:
Q. May not have sent them or may have sent them late.
DR. DANKWA:
A. The impression I was getting from him, I may have misunderstood him, but it sounded almost as if we hadn't even sent our cases yet.

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COFFEY, Q.C.:
Q. Okay.
DR. DANKWA:
A. So, it really took me by surprise because we had the results of those cases.
COFFEY, Q.C.:
Q. And then final reference you say, "I'm still puzzled as to what St. John's may have received recently from us". What were you talking about there?
DR. DANKWA:
A. Yes, because it also sounded that if there was anything sent, they had just recently received it, but I had results. So, I wasn't sure what it was that I had sent to them that they had just recently received.
COFFEY, Q.C.:
Q. So, did you make any further inquiries in that regard to have that final sentence clarified as to what -
DR. DANKWA:
A. It was Michael Jong, I mean, he didn't really get back to me with anything further on that.
COFFEY, Q.C.:
Q. Now, if we could, Exhibit P-2203, please. Now

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Doctor, I apologize, for the quality of this, but there you have it. Thank you. Do you recognize this, Doctor?
DR. DANKWA:
A. Yes, I do.
COFFEY, Q.C.:
Q. And is this the spreadsheet you referred to in your e-mail?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And so it's ER/PR received from St. Anthony site January 24th, '06.
DR. DANKWA:
A. Yes, that's right.
COFFEY, Q.C.:
Q. And there's a listing then, well the RS numbers are redacted, the surgical numbers are there. I take it these are St. Anthony surgical numbers?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And then there's a block number or block identification, the patients' names are

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redacted and then there's the tumour or tumour classification column and then there's a column for ER, PR and a reference to IC, probably internal control and fixation would be the final column?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Now, Doctor, these then I take it were the reported results from Mount Sinai?
DR. DANKWA:
A. Right, yes.
COFFEY, Q.C.:
Q. And you understood that they would be reporting on the slides that they had created?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, did you ever have occasion or have you ever had occasion to compare the results here to the original results reported from your institution?
DR. DANKWA:
A. Yes, I did look and made a comparison with it, yes.

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COFFEY, Q.C.:
Q. Okay. And what did you find in comparison?
DR. DANKWA:
A. It looked like about 45 percent, around 45 to 50 percent had a change in the results.
COFFEY, Q.C.:
Q. Had a change in the results in the sense of converted.
DR. DANKWA:
A. Yes, yes -
COFFEY, Q.C.:
Q. I shouldn't use that word.
DR. DANKWA:
A. Right, okay.
COFFEY, Q.C.:
Q. I apologize. Had a change in results -
DR. DANKWA:
A. Had a change in the results, yes.
COFFEY, Q.C.:
Q. Were there any, Doctor, that you had reported as ER positive, low positive for example, because otherwise it wouldn't have been retested, that went to zero? Did you have any what are called retro converters?
DR. DANKWA:

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A. No, I don't remember any such cases, yes.
COFFEY, Q.C.:
Q. And those cases then that were changed results in, when you looked at them and compared them, the original results and Mount Sinai's, do you recall approximately how many or what percentage or proportion had a significant change in result as opposed to, like, moving from, for example, ten to fifteen which Dr. Mullen has told that wouldn't be remarkable.
DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. Or even--I'm thinking about the change from, for example, from five to 95.
DR. DANKWA:
A. Right, looking roughly about 40 percent or thereabouts, yes.
COFFEY, Q.C.:
Q. Okay. Do you have any thoughts then about why that might be so. Like, how could it go from, the results that you had, based upon the slides that you had received over the years from '98 through 2005 and they're retested in Mount Sinai in 2005 or '06, what could account

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for the change in results in about 40 percent of cases?
DR. DANKWA:
A. In this situation, we are looking at different slides. We are looking at the same slides that would be probably, would have a different discussion.
COFFEY, Q.C.:
Q. Yes.
DR. DANKWA:
A. Looking at a different slide, so there are many factors that would come into play here. The technology is the first thing that comes to mind and that is assuming that we are talking about the same blocks and the same tissues because there are changes from--you can get changes from one block to the next and one and from one slide to the next section. So, I would, barring everything, barring the fact that we may have different ways of viewing the same thing, I would feel that it would be the technology application to the tissues.
COFFEY, Q.C.:
Q. The processing the tissue into the block to do

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a slide.
DR. DANKWA:
A. And the staining--from the slide, from the blank slide to a stained slide, that process, would make a big difference.
COFFEY, Q.C.:
Q. I'll have you then--so, form your perspective, looking at it and reflecting upon it, because a block,I take it--if it's the same block used at Mount Sinai as was used in St. John's when you ordered -
DR. DANKWA:
A. Yes, would be the same, I'm looking at it the same, yes, but we know too that from one level to another, there could be a change, yes.
COFFEY, Q.C.:
Q. But--and I appreciate it--so, generally though Doctor, assuming that it's generally within the same tissue -
DR. DANKWA:
A. Yes, sure, yes.
COFFEY, Q.C.:
Q. You would have understood that in St. John's, say in 2002, they created a slide, they created the tissue to go onto the slide,

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processed it, stained it, you get to read it.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Mount Sinai, in effect, did the same thing?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Except you didn't read it, Dr. Mullen did.
DR. DANKWA:
A. No.
COFFEY, Q.C.:
Q. You attribute the difference in what appear on the slide to what occurred between the block sitting there --
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. That process, going onto the slide itself --
DR. DANKWA:
A. And then staining --
COFFEY, Q.C.:
Q. And the staining, the final version of the stain --
DR. DANKWA:

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A. Yes.
COFFEY, Q.C.:
Q. Whatever happened in between --
DR. DANKWA:
A. Whatever happened, yes, throughout that period, yes.
COFFEY, Q.C.:
Q. And have you had an opportunity, Doctor, to look at the original slides for these patients?
DR. DANKWA:
A. No, I haven't.
COFFEY, Q.C.:
Q. In the sense of now?
DR. DANKWA:
A. No, to compare it, no, I haven't.
COFFEY, Q.C.:
Q. Would you be interested in doing so?
DR. DANKWA:
A. Oh, very much so, yes.
COFFEY, Q.C.:
Q. What would you be looking for?
DR. DANKWA:
A. Well, just looking because of what we've heard about what we have or have not looked, and

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

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DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. What were they about, Doctor?
DR. DANKWA:
A. These were cover letters I had to go with the retested results to the doctors to inform them about it so that they are made aware of it.
COFFEY, Q.C.:
Q. So what would be attached to this?
DR. DANKWA:
A. This would be the report. The report --
COFFEY, Q.C.:
Q. That's that page or two page report?
DR. DANKWA:
A. Yes, from the -- transcribed report from Mount Sinai, yes.
COFFEY, Q.C.:
Q. So would you send them a copy of Don Cook's report, or your version of Don Cook's --
DR. DANKWA:
A. My version of Don Cook's report, but Don Cook's report and my version will go to the oncologist.
COFFEY, Q.C.:

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Q. Doctor, were you involved -- the Commissioner has heard about some patients who fell into the category of DCIS.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And Mount Sinai reported certain patients as DCIS and then some attention or inquiry occurred into whether or not they were really DCIS or not.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Were you involved -- were any of your patients involved in that?
DR. DANKWA:
A. I had one case of DCIS, but that was also confirmed as a DCIS, and her test as far as I remember was not repeated.
COFFEY, Q.C.:
Q. Okay, and you had originally --
DR. DANKWA:
A. Done it.
COFFEY, Q.C.:
Q. Done it as DCIS?

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DR. DANKWA:
A. Yes, yes.
COFFEY, Q.C.:
Q. You had classified the patient as DCIS?
DR. DANKWA:
A. Yes, I had.
COFFEY, Q.C.:
Q. And Mount Sinai --
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Did the same thing?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, were you involved at all in notifying patients about their results in the sense of directly?
DR. DANKWA:
A. No, no, it always went to the clinician, and the clinician notified the patients.
COFFEY, Q.C.:
Q. How about patients whose results were confirmed by Mount Sinai to be negative?
DR. DANKWA:

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A. They were also notified.
COFFEY, Q.C.:
Q. And who notified them?
DR. DANKWA:
A. It's all the clinicians.
COFFEY, Q.C.:
Q. In St. Anthony?
DR. DANKWA:
A. In St. Anthony, yes, and in Goose Bay as well.
COFFEY, Q.C.:
Q. It was the doctors doing it?
DR. DANKWA:
A. The doctors doing it, yes.
COFFEY, Q.C.:
Q. And it was done through the mechanism of you sending out these reports with a covering letter?
DR. DANKWA:
A. Correct.
COFFEY, Q.C.:
Q. And you understood that in them getting -- those doctors getting those letters and reports, it would be up to them to tell the patients?
DR. DANKWA:

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

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sites have been set up to view Dr Denic's presentation from the main auditorium, Health Sciences Centre, as follows", and there's a particular time. So, Doctor, do you recall whether in November, 2006, you were invited to participate in a videoconference?

DR. DANKWA:

A. Yes, I do.

COFFEY, Q.C.:

Q. And can you tell the Commissioner about how that came about and what you recall about it?

DR. DANKWA:

A. We have this e-mail coming. It was also followed by phone calls to make sure that those of us who have facility to set up videoconference in were prepared to participate in this. This was basically a conference that was notifying us about where they are over the issues of the ER/PR, and what that are looking at in a go forward basis, and at that conference Dr. Ford Elms did a presentation as to what he had learned, having gone out to the United States to get some experience in immunohistochemistry. That was the main thrust of it, and to -- and the

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information too that Eastern Health was looking at -- raised that and the ER/PR testing.

COFFEY, Q.C.:

Q. Now in relation to the restarting -- I'll ask you. The presentation that you saw that day --

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Slide shows -- slide presentations, were you ever given a copy of those or offered a copy of those?

DR. DANKWA:

A. No, I wasn't.

COFFEY, Q.C.:

Q. You were advised that Eastern Health was restarting the ER and PR in St. John's?

DR. DANKWA:

A. Would be.

COFFEY, Q.C.:

Q. Or would be?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Were you invited -- was St. Anthony invited to

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send their cases to St. John's?

DR. DANKWA:

A. I am not sure whether the initial phase, they indicated that they were going to open it up to everybody, but they were definitely going to look at starting, but with the intention that everybody would be sending their cases there.

COFFEY, Q.C.:

Q. Okay. So subsequent to that videoconference, and when you became aware, we understanding in February of 2007, that the retesting started -- - I'm sorry, the testing restarted in St. John's, can you tell us, please, whether you've ever been approached since about sending St. Anthony's cases to St. John's for ER/PR?

DR. DANKWA:

A. Yes, it has happened, yes.

COFFEY, Q.C.:

Q. And when were you approached about that, do you recall?

DR. DANKWA:

A. I can't remember the exact date, but in between -- as soon as they started, they made

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it clear that they are open to accepting our cases for retesting.

COFFEY, Q.C.:

Q. And I take it --

DR. DANKWA:

A. For testing, yes.

COFFEY, Q.C.:

Q. I take it that you have not taken them up on the offer yet?

DR. DANKWA:

A. I haven't gone that way just yet.

COFFEY, Q.C.:

Q. And have you spoken to anybody about that?

DR. DANKWA:

A. No.

COFFEY, Q.C.:

Q. Okay, can you tell the Commissioner why you haven't taken them up on that?

DR. DANKWA:

A. Well, I have been sending my cases on to Mount Sinai since then, and my -- my view is since they introduced a protocol about fixation policies, I just felt that to -- they also indicated that they would feel a bit more comfortable if in reporting these cases we

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have met the times of their fixation policies, and I felt that until such a time that we could really clearly state, document evidence that we have met those policies, I would feel more comfortable sending it to another place where they are willing to do that.

COFFEY, Q.C.:

Q. And, Doctor, I want to come back to that before I conclude my questions for you, Doctor, but if we could bring up, please, Exhibit P-2208. Doctor, I understand that there was a -- before I get into this particular e-mail, there was a teleconference in late May, 2007, involving the VP Medicals after this became very public in May of 2007.

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Did you participate in that teleconference?

DR. DANKWA:

A. No, I didn't.

COFFEY, Q.C.:

Q. Who from your organization did?

DR. DANKWA:

A. If you are talking about VP Medicals, it may

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have been Michael Jong, Dr. Michael Jong.

COFFEY, Q.C.:

Q. Were you told about the results of the teleconference in the sense of the subject matter of who was sending their material into St. John's?

DR. DANKWA:

A. Not as far as I can remember.

COFFEY, Q.C.:

Q. Okay. Doctor, here there's a series of e-mails, July 10th and 11th, involving Boyd Rowe, and to put this in context for you, this is the -- Reza and the creation of the ER/PR database request, and you referred to that earlier today.

DR. DANKWA:

A. Yeah.

COFFEY, Q.C.:

Q. And here the last of these e-mails, July 11th at 9:40 a.m. Don MacDonald is sending an e-mail to Reza saying, "Reza, please contact Dr. Dankwa to ensure we get the data we need". What was this about, Doctor? The e-mail below is, "Moira, we have started work on this. I've asked our pathologist, Dr. Dankwa, to be the

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contact person and I've forwarded your e-mail to him".

DR. DANKWA:

A. I believe this would be in reference to the Commission of Inquiry starting the investigation.

COFFEY, Q.C.:

Q. And, I take it then, that you have provided information to this organization that's collecting the data?

DR. DANKWA:

A. Yes, with some initial difficulties, yes.

COFFEY, Q.C.:

Q. Yes. So if we could then, we'll take you up on that difficulties issue when we come back.

DR. DANKWA:

A. Fine.

COMMISSIONER:

Q. Okay, we'll take the afternoon break.

(RECESS)

COMMISSIONER:

Q. Mr. Coffey.

COFFEY, Q.C.:

Q. Thank you, Commissioner. Doctor, a couple of other things before I get into 2000 and the

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end of 2007, and early '08, if we could, please, Registrar, Exhibit P-1811. Now, Doctor, I appreciate this e-mail was neither -- neither came from nor was it sent to you, but it's dated January 20th, 2006, and it's between Dr. Mullen and Dr. Cook. In effect, Dr. Mullen is saying, "Attached please find the ER/PR results for the Newfoundland Retrospective Review", at least up to that point, and he concludes by saying, "When you have had an opportunity", that's "you", Dr. Cook, "have had an opportunity to review the results, I would like to discuss some of the technical difficulties we encountered with processing and staining the specimens. Some of the same issues are present in the current Newfoundland and Labrador material". Doctor, has anyone ever spoken to you about concerns about fixation of tissue in the Labrador Grenfell area?

DR. DANKWA:

A. This is I presume since we started sending out cases as a go forward to Mount Sinai?

COFFEY, Q.C.:

Q. Yes.

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DR. DANKWA:
A. No.
COFFEY, Q.C.:
Q. And from your perspective, if -- your understanding with Dr. Mullen, I take it, is that if he has a problem with reporting your cases, being able to validly report your cases, he will let you know?
DR. DANKWA:
A. I would expect so, yes.
COFFEY, Q.C.:
Q. Now, Doctor, bearing in mind the geographic realities of the vast area that -- certainly it's vast from my perspective, Labrador City to St. Anthony is a long way, and Goose Bay to St. Anthony are long ways, geographically, but by transport, I mean, transportation.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, in terms of fixation of tissue, as the pathologist for Labrador Grenfell, from your perspective, what is achievable in terms of optimizing fixation, and does it depend upon where it's coming from, Goose Bay versus

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Labrador City, and St. Anthony?
DR. DANKWA:
A. I think when you talk about optimizing, you mean adequate fixation?
COFFEY, Q.C.:
Q. Yeah, and I appreciate you make the distinction, Doctor, because there's a difference between adequate, which is adequate for the purpose --
DR. DANKWA:
A. Right, yes.
COFFEY, Q.C.:
Q. You know, to be able to properly do your job.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Versus optimizing.
DR. DANKWA:
A. Optimizing, okay.
COFFEY, Q.C.:
Q. What do you --
DR. DANKWA:
A. If you use optimizing, like, really want to fix and process a tissue within 12 to 24 hours time, that will be a major challenge because

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

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

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authority is Terry Gulliver and Nash Denic and it spells out the purpose and procedure. Doctor, if we look back at the attachments to this e-mail, that is one of those, okay. If we could bring up, please -- so I'm going to ask you to think about it, have you ever received that page -- that memorandum or page four, and if we could bring up, please, Exhibit P-2195, and, Doctor, not the first page of this because that's just a fax transmission sheet, But the second page is entitled "procedure ductal carcinoma in situ reporting."

DR. DANKWA:

A. Yeah.

COFFEY, Q.C.:

Q. And then there's a--it's two pages long, then there's a Pathology Procedures Manual, title "breast needle core biopsy standardized grossing."

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. Then there's a title "breast sentinel node lymph node" and then "cancer lumpectomy

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specimen, breast conserving surgery" second page. Then a document, which is an attachment by itself, "canned text needle core biopsy reporting."

DR. DANKWA:

A. We are familiar, yes.

COFFEY, Q.C.:

Q. You've seen these?

DR. DANKWA:

A. I've seen these ones, yes.

COFFEY, Q.C.:

Q. And there's one here, page ten of the exhibit is titled fixation and there's a policy and a procedure for fixation?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And then it's a separate document in the attachments, but it's "for optimal tissue selection for immunohistochemical staining of breast cancer specimens, the following steps are suggested." So you would have, at some point, received these?

DR. DANKWA:

A. I did, yes, I have.

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COFFEY, Q.C.:

Q. Do you recall receiving, like when approximately? Dr. Neil has told us he received them late May 2007.

DR. DANKWA:

A. Well, that probably may be about right, that's sort of right time, yes.

COFFEY, Q.C.:

Q. And do you recall the context in which they were sent to you, and what was--you know, why they were sent to you and what, if anything, was expected of you?

DR. DANKWA:

A. I think this was a follow up of one of a conference calls in which they determined that they were going to send out a formalized way, an expectation of what needs to be done in order to optimize the staining techniques.

COFFEY, Q.C.:

Q. And I take it then, this was--before we took the break, you made a reference to the Commissioner in your response that you hadn't gone back to St. John's for ER/PR because they expect certain protocol to be followed and it was problematic to promise that you'd be able

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to do that?

DR. DANKWA:

A. Exactly, yes.

COFFEY, Q.C.:

Q. And would this be the fixation policy, in fact, you mean?

DR. DANKWA:

A. Yes, yes.

COFFEY, Q.C.:

Q. This is the one?

DR. DANKWA:

A. Yeah.

COFFEY, Q.C.:

Q. Doctor, in terms of this, if I just could, the procedure, ten percent buffer formalin, four percent formaldehyde, that wouldn't be a problem, I take it?

DR. DANKWA:

A. No, no.

COFFEY, Q.C.:

Q. "Tissue must be placed in formalin as quickly as possible after removal and at most, within 30 minutes."

DR. DANKWA:

A. That's not a problem.

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COFFEY, Q.C.:
Q. That wouldn't be a problem, and that's true even in Labrador City or Goose Bay?
DR. DANKWA:
A. Yes, exactly.
COFFEY, Q.C.:
Q. "Small biopsies should be fixed for no shorter than three hours and no longer than 24 hours."
DR. DANKWA:
A. Right, that's no problem for St. Anthony, but it may be a problem coming from elsewhere.
COFFEY, Q.C.:
Q. From Labrador City and Goose Bay?
DR. DANKWA:
A. From Labrador City and Goose Bay, yes.
COFFEY, Q.C.:
Q. And "larger specimens must be sliced into three to five millimetre slices and surrounded by a formalin ten times in volume as soon as possible after removal from the body." I take it that could be problematic for yourself?
DR. DANKWA:
A. That could be a problem, yeah. For St. Anthony, no, but for the external areas, for Goose Bay and Lab City, yes.

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COFFEY, Q.C.:
Q. And "larger specimens should be fixed for no shorter than 24, no longer than 48."
DR. DANKWA:
A. Yeah, that may work sometimes in all areas, but occasionally too, it may not, it may not work.
COFFEY, Q.C.:
Q. And in terms of this, Doctor, this reference to "a larger specimen should be fixed for no shorter than 24 hours," would you have understood that to mean 24 hours after the bread loafing?
DR. DANKWA:
A. No, 24 hours, I would say 24 hours once it's gone into formalin.
COFFEY, Q.C.:
Q. Formalin?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. In a place, for example, like Goose Bay or Labrador City where there--if you're, as a pathologist, lucky if a surgeon even makes the cut into the tumour at all or is able to.

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DR. DANKWA:
A. Sure.
COFFEY, Q.C.:
Q. What's the situation if the surgeon is not able to make the cut into the tumour and it has to take 24 hours to get down to St. Anthony, can that be problematic?
DR. DANKWA:
A. We'd have to work with what we get and achieve the best staining possible.
COFFEY, Q.C.:
Q. And I appreciate that. I'm using it as problematic here in terms of this?
DR. DANKWA:
A. Oh yes, it would be, yes. It would be, yes.
COFFEY, Q.C.:
Q. You wouldn't want to be able to promise St. John's that this particular tissue has complied with this if it came from Goose Bay?
DR. DANKWA:
A. Right, yes.
COFFEY, Q.C.:
Q. Okay. Do you think within St. Anthony itself, that you'd be able to give an assurance for the St. Anthony cases?

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DR. DANKWA:
A. Would be within that range, yes.
COFFEY, Q.C.:
Q. Doctor, the other policies that are attached, have you made any effort in St. Anthony to follow those?
DR. DANKWA:
A. We have had meetings with all the lab leaders in the Goose Bay and Lab City as well as St. Anthony, and I've actually, in principle, adopted the aim to achieve this. So all the lab techs have this and we've also notified even anybody who has any dealings with gathering of specimens to be abiding by all these policies.
COFFEY, Q.C.:
Q. Doctor, here, just if I could go back, because some of them are directed, I gather, particularly at -
DR. DANKWA:
A. Pathologists.
COFFEY, Q.C.:
Q. - at pathologists, and how about yourself, have you -
DR. DANKWA:

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A. I have actually been doing synoptic reporting since '97/98, yes.
COFFEY, Q.C.:
Q. And that, for example, if we could, the reference to page two, this procedure, patient's name and so on. Would you use that sort of format?
DR. DANKWA:
A. Yes, I do.
COFFEY, Q.C.:
Q. Okay.
DR. DANKWA:
A. It may not have--it may not be laid out the same way, but with the same contents, similar contents, yes.
COFFEY, Q.C.:
Q. And page--I'll just go to page four, the one entitled breast needle core biopsy standardized grossing, that would be something that you'd do, the grossing?
DR. DANKWA:
A. Yeah.
COFFEY, Q.C.:
Q. Have you made any attempt to comply with this?
DR. DANKWA:

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A. If it's a core biopsy, yes. It goes through the same similar processing.
COFFEY, Q.C.:
Q. Doctor, bearing in mind the institution and the size of it that you're working in and the resources available to you, at least up to now, has it been practical for you to have like the equivalent or create the equivalent sort of policies for yourself and your lab, in the sense of written policies, spelled out like they have, they started to do in this material?
DR. DANKWA:
A. We have some policies that way in existence before the Eastern one came in, and we have actually adapted the Eastern one almost in the same context for the whole of the region now, yes.
COFFEY, Q.C.:
Q. But are there a number of areas that you would not have written policies for?
DR. DANKWA:
A. We have covered all that.
COFFEY, Q.C.:
Q. I appreciate in this.

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DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. But would there be other areas that they have not covered in this material?
DR. DANKWA:
A. Not that I could think of immediately.
COFFEY, Q.C.:
Q. That you would--here's an example, Doctor.
DR. DANKWA:
A. Yes, okay.
COFFEY, Q.C.:
Q. Just to give you some context. If we could bring up, Exhibit P-2157, please? That's fine. It'll take a minute. Doctor, I'll explain what this is being--just it comes up on the screen here for you, this is a document that the Commission received from Eastern Health about a week ago.
DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. Okay, and it is--in fact, it's the binder, over an inch thick of pathology policies and then procedures, okay?

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DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And just to give you some sense of it, Doctor, that's the--the first page here, the pathology policies, there are seven listed there.
DR. DANKWA:
A. Right.
COFFEY, Q.C.:
Q. And we go on to the next page, pathology procedures, and you can just look at this as I scroll through it. General information, specimen collection and handling procedures, there's a whole list. Grossing procedures, routine pathology assistants, a whole list. Pathology technical and staining procedures, again, a list. Pathology quality management procedures and pathology reporting procedures, see draft--and these are both in draft.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And IHC policies and procedures.
DR. DANKWA:
A. Right, yes.

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COFFEY, Q.C.:
Q. Well, that wouldn't be applicable, I take it, where you are?
DR. DANKWA:
A. No, it wouldn't apply.
COFFEY, Q.C.:
Q. But the other ones above here, I take it many of them might have some actual day-to-day application in your lab.
DR. DANKWA:
A. Yes, indeed.
COFFEY, Q.C.:
Q. But would it be practical for you to actually go--or somebody in your lab to actually draft such policies?
DR. DANKWA:
A. With some of them, we may have policies there already in existence, yes, but we may not have it as comprehensive as this.
COFFEY, Q.C.:
Q. And that's what I was getting at, Doctor.
DR. DANKWA:
A. Okay, right.
COFFEY, Q.C.:
Q. So in order for you to--if your hospital or

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health authority was to have this sort of comprehensive or potentially comprehensive written policy and procedures, you would in effect have to adapt a larger institution's to your own situation?
DR. DANKWA:
A. Exactly, yes, correct. That is correct, yes.
COFFEY, Q.C.:
Q. I take it, Doctor, you've never seen a copy of this?
DR. DANKWA:
A. No, I haven't.
COFFEY, Q.C.:
Q. And while we're on this topic of these--if we could bring up, please, Registrar, Exhibits--first of all, Exhibit P-2219? This is a document entitled "Charles S. Curtis Memorial Hospital, Laboratory Policy and Procedure Manual." Section is histology, the topic is general organization, and then there's a number of dates.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. O, I take it that's the original?

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DR. DANKWA:
A. Original, yes.
COFFEY, Q.C.:
Q. Revised. So original is May 1985, revised March '91, revised April '99, and this particular one is numbered Roman numeral eight dash 05. Doctor, what is this?
DR. DANKWA:
A. These are policies guiding the techs as to what they do when they see--when they have to handle specimens.
COFFEY, Q.C.:
Q. So in effect, the original one of this predates your time.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And then it was revised in 1991, while you were--in fact, it's before your time as well.
DR. DANKWA:
A. Before, yes.
COFFEY, Q.C.:
Q. And revised in '99 while you were there?
DR. DANKWA:
A. Yes.

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COFFEY, Q.C.:
Q. This goes into the second page. Now this is a--I have a rule book for the technologists just to follow?
DR. DANKWA:
A. Correct, yes.
COFFEY, Q.C.:
Q. If we could, please, Registrar, Exhibit P-2220? Doctor, this is again, I take it, a similar sort of document?
DR. DANKWA:
A. Correct, yes.
COFFEY, Q.C.:
Q. And it's numbered Roman numeral eight dash 05. It begins, the original one, May of '85, revised March '91, April '99 and May of 2007.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And the subject is histology, the topic general organization, and miscellaneous information?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:

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Q. And just begin with number one, it says "the following procedures should be carried out to maintain a good quality work in the histology laboratory. No. 1, 'the American Optical' microtome is greased every week."
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And then it goes on, "2. check flush reagents on the processor every day" and it goes on and on.
DR. DANKWA:
A. Yes, yeah.
COFFEY, Q.C.:
Q. I shouldn't say on and on, it goes on for seven. Do you recall what was revised in May of '07?
DR. DANKWA:
A. May of '07, we had obtained the American Optical microtome.
COFFEY, Q.C.:
Q. Okay.
DR. DANKWA:
A. Which was a new system, yes.
COFFEY, Q.C.:

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Q. And that was added to the list?
DR. DANKWA:
A. Yes, and then the auto stainer in number four.
COFFEY, Q.C.:
Q. That was new?
DR. DANKWA:
A. Also acquired not long after that, yes, around that time, yes.
COFFEY, Q.C.:
Q. Exhibit P-2221? Again, this is a laboratory policy and procedure manual for Curtis Memorial Hospital. Again, the same number. The significance of this numbering, 8-05-06, what is that?
DR. DANKWA:
A. The binders have been made into--categorized into different groups and that is how the binding came to be, yes.
COFFEY, Q.C.:
Q. And on that point, binders?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. So what's in these binders?
DR. DANKWA:

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A. It's almost very similar to what you showed me from Eastern. So it's a binder with divisions in them and some of it will be showing what is happening in histology with equipment, and sometimes with how you behave in the lab and when you react to dangerous situations.
COFFEY, Q.C.:
Q. And I take it then, we only have--and I'm going to take the Commissioner to the ones we have, which you've provided through your counsel to us.
DR. DANKWA:
A. That's correct, okay.
COFFEY, Q.C.:
Q. But I take it that there's much more in these binders?
DR. DANKWA:
A. We may have some more, yes.
COFFEY, Q.C.:
Q. But as well, there's many different -
DR. DANKWA:
A. Different areas, yes.
COFFEY, Q.C.:
Q. If you're talking about binders, I mean, how much is involved?

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DR. DANKWA:
A. Well, I use the word binder, because even the staining, how they do the staining, like if you have to do H & E, what you need to do to do the H & E, these all come within a binder. I use the word binder, but I probably should say binder rather than binders. They are split into different sections.
COFFEY, Q.C.:
Q. But again, in terms of, for example, even how to do a H & E stain?
DR. DANKWA:
A. Exactly.
COFFEY, Q.C.:
Q. That's actually spelled out in writing?
DR. DANKWA:
A. It would be. Yes, it would be there, yes.
COFFEY, Q.C.:
Q. It's there.
DR. DANKWA:
A. It would be there, yes.
COFFEY, Q.C.:
Q. And it's been there for how long, as far as you know?
DR. DANKWA:

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A. As far as I know, yes.
COFFEY, Q.C.:
Q. When you came, there was such a -
DR. DANKWA:
A. Yes, there was some procedures there.
COFFEY, Q.C.:
Q. This particular one is policy for submission of pathology specimens. The topic is--yes, policy submission for specimens, and again, this was revised in May of '07. It goes back though to '85. Do you recall what the revision was, Doctor?
DR. DANKWA:
A. I think the MCP might have been the part two.
COFFEY, Q.C.:
Q. Okay.
DR. DANKWA:
A. We were running into a lot of problems with MCP and with our new Meditec system, it was rejecting cases as much as possible. So just ensuring that our staff make note of the correct MCPs.
COFFEY, Q.C.:
Q. That the specimens must be labelled with the MCP numbers?

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DR. DANKWA:
A. That's right, yes.
COFFEY, Q.C.:
Q. And Exhibit P-2222, please? And Doctor, this is from histology, operating guidelines. First, the original one apparently dates back to May of '85. It's revised most recently in May of 2007, and I take it this then is an operating guideline for the technologists as to how they're to go about their business in dealing with this particular subject matter?
DR. DANKWA:
A. That's true.
COFFEY, Q.C.:
Q. It includes normal operations, a heading, quality control, preventative maintenance and records and quality assurance.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. Whose responsibility is it, Doctor, to maintain the binder, as it were?
DR. DANKWA:
A. That is the lead lab technologist, but if there is an issue that I detect, then I would

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make sure we have that section updated accordingly.
COFFEY, Q.C.:
Q. Doctor, if we could, Registrar, Exhibit P-2223? Doctor, I just--do you recognize what this is?
DR. DANKWA:
A. Yes, I do.
COFFEY, Q.C.:
Q. What is it in the main? Is this your handwriting?
DR. DANKWA:
A. No, that is my secretary's handwriting. They document, whenever they send items out, they document them in a book.
COFFEY, Q.C.:
Q. Okay, and this is related to the ER/PR, this particular -
DR. DANKWA:
A. ER/PRs, yes.
COFFEY, Q.C.:
Q. Okay, I'm not going to take you through it, it's just for the Commissioner's benefit so that she knows what's contained in it? If we could go then, please, to Exhibit P-2209?

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

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there were some problems you ran into or some challenges?
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And can you tell the Commissioner about that?
DR. DANKWA:
A. Well at the initial phase, when the request came, I wondered about the confidentiality because the request was seeking the report of patients with the patient information, so I was initially very, very uneasy about releasing such information out and I had communications with the CEO and also had communications with, which was eventually communicated to Don MacDonald and it was Reza, Dr. Reza who started having conversations with me to try and resolve that.
COFFEY, Q.C.:
Q. And did it get resolved?
DR. DANKWA:
A. Well at the end he sent me a print out indicating that that was acceptable to release that sort of information.
COFFEY, Q.C.:

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

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

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DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. What was this about, Doctor, these six missed cases?
DR. DANKWA:
A. These were cases that we found when we were thumbing through now, this time, throughout the whole file.
COFFEY, Q.C.:
Q. In 2007?
DR. DANKWA:
A. Yes, and this is where we found the additional six cases.
COFFEY, Q.C.:
Q. And what's described here in Dr. Denic's e-mail, is that in fact what happened, that the blocks were sent by your to Mount Sinai directly?
DR. DANKWA:
A. Immediately, yes.
COFFEY, Q.C.:
Q. And the results, were they passed on then to the attending physicians?
DR. DANKWA:

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A. Oh yes, it was passed on to the attending physician, the surgeon, the GP and then to the oncologist with the original copy of the report.
COFFEY, Q.C.:
Q. Doctor, do you know if any of these patients, well I'll just show you so you can look at it. I take it some of them would have been considered to convert?
DR. DANKWA:
A. Change, yeah.
COFFEY, Q.C.:
Q. Do you know if any of these went through that panel process?
DR. DANKWA:
A. Not as far as I know, no.
COFFEY, Q.C.:
Q. Okay, and by that point in time, by September, October, 2007, it was get them retested at Mount Sinai and get the results back.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. And tell the attending physicians?
DR. DANKWA:

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

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check with our list to see whether they matched, so I'm wondering if it was the reverse.
COFFEY, Q.C.:
Q. And my question is an indirect way of asking you about the deceased patients for Labrador Grenfell, how were they handled, their cases handled by your -
DR. DANKWA:
A. We didn't handle them any differently from the living ones. We sent all of them out initially.
COFFEY, Q.C.:
Q. Initially.
DR. DANKWA:
A. Initially, right from the beginning, yes, and I think initially they weren't tested, even though they had the samples there, but subsequently they were tested and the results came back. And the results were faxed back, copied to the GPs and then to the surgeons and then back to the oncology, the same way as the living ones, yes.
COFFEY, Q.C.:
Q. And were they recorded in the Meditec chart or

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DR. DANKWA:
A. Yes, in the Meditec chart, those that were within the period, where they could be recorded in the Meditec -
COFFEY, Q.C.:
Q. There was a Meditec system in place.
DR. DANKWA:
A. Yes.
COFFEY, Q.C.:
Q. The patients for whom there was no Meditec -
DR. DANKWA:
A. It was transcribed, also typed in and kept as hardcopy sheets in our files.
COFFEY, Q.C.:
Q. In terms of your organization, Doctor, if deceased relatives want to know the results, who would they contact in the organization?
DR. DANKWA:
A. The surgeons would automatically contact the families, the surgeons or the GPs, they contacted, so contacts were made.
COFFEY, Q.C.:
Q. And Exhibit P-2218 please? Now, Doctor, this is a series of e-mails, the first two are

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August 16th, 2007 between yourself and Mr. MacDonald and then in April 1st, 2008, you forward it to Ms. Hennebury, who forwarded it to us. And your e-mail to Mr. MacDonald, you've written, "I have embedded my responses in your e-mail. I hope this answers your questions." And then before that, which is in effect his e-mail and your response?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. To his questions, you've written, or he has written to you or you have responded, "As you are aware, the Centre for Health Information is working on behalf of the Minister of Health to develop a database that will document events surrounding ER/PR testing for breast cancer patients from '97 to 2005. The Labrador Grenfell Health Authority recently provided the centre with demographic and pathology reports for all patients in your region that had ER/PR testing carried out at Eastern Health. This information was extremely valuable and I wish to thank your team for pulling it together in such a timely

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manner." I take it that's the reference to the week?

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. "We are now moving to the second phase of the project which involves events on how the retesting results were communicated to those patients who had their ER/PRs retested at Mount Sinai. Specifically we are asking for the following, one, date sample sent to Eastern Health" and I take it then this is your response, "These were sent in two batches, the first batch was sent September 2005 and the final batch sent after receiving a list of "affected cases" from the Cancer Centre in October of 2005."

DR. DANKWA:

A. That's right, yes.

COFFEY, Q.C.:

Q. Number two, he has written to you, "Date of and means by which patient informed sample was sent to Eastern Health for retesting." And you've responded, "Date is as stated above. The samples were sent to Eastern Health who

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

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patients unless the patients contacted us directly. Even so, we would initially advise the patients to contact their family physicians and/or surgeon. The usual practice of patients getting pathology results is through their clinicians and we maintained that level of communication."

DR. DANKWA:

A. Yes.

COFFEY, Q.C.:

Q. And then Mr. MacDonald has said to you, 5) "Date that outcome of re-test results and Tumour Board review sent to treating physicians." And you responded saying, "We obtained the results on January 2006 in a spreadsheet form and the final written results came in at different stages soon afterwards. As indicated as the results became available, they were communicated to the Family Physicians and Surgeons in writing from January-May, 2006." And then Mr. MacDonald requested "Date and means by which Labrador-Grenfell contacted patient or patient's families about re-test results." And your response is "Copies of the results were sent

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

DR. DANKWA:

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A. Accurately, but I notice that some of the times and dates, like on Section 5.

COFFEY, Q.C.:

Q. Okay, we'll go to that.

DR. DANKWA:

A. Section 5, "We obtained the results on January 2006", I think I was using the date on the form, rather than the -

COFFEY, Q.C.:

Q. That's that January 24th date.

DR. DANKWA:

A. Yes, rather than -

COFFEY, Q.C.:

Q. But the actual time you received it was?

DR. DANKWA:

A. It was probably March, it was probably March, yes.

COFFEY, Q.C.:

Q. And other than that, Doctor, I take it -

DR. DANKWA:

A. It was generally accurate, yes.

COFFEY, Q.C.:

Q. Doctor, is there anything further that we haven't covered that you think should be brought to the Commissioner's attention?

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DR. DANKWA:

A. Not that I can think of at the moment.

COFFEY, Q.C.:

Q. And certainly, if you do, Mr. Browne will be questioning you. Thank you, Commissioner?

THE COMMISSIONER:

Q. Ms. Brazil?

MS. BRAZIL:

Q. I have no questions, Commissioner.

THE COMMISSIONER:

Q. Mr. Simmons?

MR. SIMMONS:

Q. Thank you, Commissioner.

DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MR. DAN SIMMONS

MR SIMMONS:

Q. Hello, Dr. Dankwa, my name is Dan Simmons, I'm lawyer here for Eastern Health. I have just a couple of things for you. I'm going to bring you back to a document that Mr. Coffey showed you a moment ago, P-2211 please? This e-mail message referred to the six cases that you found when you were asked to go back and go through all of your pathology reports again.

DR. DANKWA:

A. Yes.

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MR SIMMONS:

Q. You turned them up, and you noted that--or you told us that those cases were sent directly to Mount Sinai for retesting and didn't go through Eastern Health, the way the earlier ones had.

DR. DANKWA:

A. That's correct, yes.

MR SIMMONS:

Q. When those results came back, was the fact that you had found six more and had them retested communicated to Eastern Health in any way from your board or was it just disclosed to the government people who contacted you looking for this information?

DR. DANKWA:

A. No, it was communicated to the oncologist. We sent it down to the oncologist, copies of the original report.

MR SIMMONS:

Q. So copies of the consultation reports that came back from Mount Sinai.

DR. DANKWA:

A. From Mount Sinai, yes.

MR SIMMONS:

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

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retesting.
DR. DANKWA:
A. Yes.
MR SIMMONS:
Q. And that a reason for that is that in order to have Eastern Health do that testing for you, Eastern Health had wanted to know that your board, your authority would be able to comply with the fixation policy that they circulated?
DR. DANKWA:
A. Yes.
MR SIMMONS:
Q. So I take it then, that Mount Sinai hasn't placed any similar requirement or condition on you?
DR. DANKWA:
A. No.
MR SIMMONS:
Q. Mr. Coffey had asked you if you had any thoughts about what could have happened for the test results to change for those samples that were tested at Mount Sinai, compared to the original tests done between '97 and 2005. And one of the things you said was that--I heard you to say was that we know that there

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can be a change from one level to another, and I wasn't quite sure what you meant when you referred to different levels. I wondered if you were referring to the fact that when you cut into a block of tissue -
DR. DANKWA:
A. Oh yes, sorry, that is what--thanks for reminding me.
MR SIMMONS:
Q. Okay, can you explain that a little more for me, what you meant by that?
DR. DANKWA:
A. Yes, we know that tumours show different variations inside a tumour mass itself, so depending upon what stage you are in the tumour, the tumour showed different views and we used that to describe as tumour heterogenicity, heterogeneous, yes.
MR SIMMONS:
Q. So, I think we've heard from others that there can be variation in the percentage of ER or PR cells that stain if you choose different blocks that come from the same tumour.
DR. DANKWA:
A. Yes.

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MR SIMMONS:
Q. Do you know if when the retests were done at Mount Sinai, if you were able to send all the same blocks that had been used for the original tests or if you had to substitute blocks in any cases?
DR. DANKWA:
A. At the initial stage we sent the original blocks, but if the tumour had been cut through the block, they were request an alternate block.
MR SIMMONS:
Q. Do you know if there were any requests that came back to you for alternate blocks?
DR. DANKWA:
A. I know there were about two or so that they had to do that.
MR SIMMONS:
Q. So in at least two of those cases, you had to send a different block than the original one?
DR. DANKWA:
A. Different block, yes, indeed, I did.
MR SIMMONS:
Q. And even in those cases where the retest was done on the original block, there is potential

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for there to be a different percentage just because the block has been cut through further and you're into a different part of the tumour?

DR. DANKWA:

A. Correct.

MR SIMMONS:

Q. The original tests that were done at St. John's and sent back to Labrador-Grenfell, for the first ones in 1998, Dr. Khalifa read them and just sent you a report.

DR. DANKWA:

A. Yes.

MR SIMMONS:

Q. But after that, I gather you or the other pathologist who used to work with you in St. Anthony, looked at all the slides and determined the percentage of positivity, if there was any.

DR. DANKWA:

A. Yes, right. I read most of them, I don't ever recall seeing any report by the other pathologist read.

MR SIMMONS:

Q. Right, okay, and you haven't had the

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opportunity to see the slides prepared at Mount Sinai for the retests?

DR. DANKWA:

A. No, no, I haven't.

MR SIMMONS:

Q. So you haven't had the opportunity to look at those and see if you would call the percentages the same as Dr. Mullen had called them?

DR. DANKWA:

A. That's correct.

MR SIMMONS:

Q. Is there known to be any variability between the way different pathologists will read the same slide?

DR. DANKWA:

A. Yes, it's well known, well established, yes.

MR SIMMONS:

Q. I believe you told us that for those slides that came back to St. Anthony from St. John's, the original tests, that you didn't recall ever not receiving a positive control slide?

DR. DANKWA:

A. That's correct.

MR SIMMONS:

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Q. And of those positive controls you saw, you didn't see any that failed?

DR. DANKWA:

A. That's correct.

MR SIMMONS:

Q. They all stained. And you were aware of the use of internal controls in ER/PR testing?

DR. DANKWA:

A. That's correct.

MR SIMMONS:

Q. And I presume you selected your tissue blocks so that when possible, you would have normal tissue in them?

DR. DANKWA:

A. That's correct.

MR SIMMONS:

Q. And do you recall having any occasions when the slides came back and you discovered that the internal control had failed?

DR. DANKWA:

A. Never.

MR SIMMONS:

Q. Never. And I take it that a positive internal--a positive external control and a positive internal control would both be

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indicators that the testing process had worked?

DR. DANKWA:

A. Correct.

MR SIMMONS:

Q. It would be, okay, fine. Thank you very much, Doctor.

THE COMMISSIONER:

Q. Mr. Pritchett?

MR. PRITCHETT:

Q. Just a few questions, Commissioner.

DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MR. BLAIR PRITCHETT

MR. PRITCHETT:

Q. Good afternoon, Dr. Dankwa, I'm Blair Pritchett and I'm here no behalf of Labrador-Grenfell Health Authority. I just have a few questions to clarify some of your earlier evidence. When Mr. Simmons was questioning you a minute ago, he reiterated that you had always noted a positive external control and a positive internal control when you were interpreting slides.

DR. DANKWA:

A. Yes, that's correct.

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

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

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different approaches in retrieving antigens and that would give you different outcomes. Concentrations of the antibodies that you use would also have an effect on this. Even the idea of the pH, the environment you are doing your stain, all this would have a contribution to the type of outcome that you may get from the staining.
MR. PRITCHETT:
Q. And if you had problems in those areas, you might get a negative score, but yet still have appropriate control?
DR. DANKWA:
A. Correct.
MR. PRITCHETT:
Q. Thank you, Dr. Dankwa. Those are my questions.
THE COMMISSIONER:
Q. Ms. Newbury?
DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MS. JENNIFER NEWBURY
MS. NEWBURY:
Q. Good afternoon, Dr. Dankwa. Jennifer Newbury for the Canadian Cancer Society, Newfoundland and Labrador Division.

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DR. DANKWA:
A. Good afternoon.
MS. NEWBURY:
Q. I just had a couple of questions for you this afternoon. First of all, I was wondering whether reports of cancer diagnosis from St. Anthony were provided to the Cancer Registry at the -
DR. DANKWA:
A. To the Cancer Registry?
MS. NEWBURY:
Q. Yes.
DR. DANKWA:
A. As opposed to the oncology -
MS. NEWBURY:
Q. As opposed to the Cancer Clinic, yes.
DR. DANKWA:
A. - Cancer Clinic, no.
MS. NEWBURY:
Q. And what I'm talking about now is throughout the time that you were at St. Anthony, was there ever a practice in place that once a diagnosis is made of cancer that a report of that is made -
DR. DANKWA:

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

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MS. NEWBURY:
Q. That was shortly after you arrived?
DR. DANKWA:
A. Not long after I arrived, yes.
MS. NEWBURY:
Q. Okay, and in your view, there was nothing to mandate that you provide this information?
DR. DANKWA:
A. No, nothing, no.
MS. NEWBURY:
Q. Were there any other means, less invasive, I guess, to a patient's privacy to provide information for perhaps statistical purposes?
DR. DANKWA:
A. I was prepared to provide numbers of tumour diagnosis, if they wanted those numbers, but I got the impression that they wanted the demographics as well and that wasn't -
MS. NEWBURY:
Q. And the demographics would include what specifically?
DR. DANKWA:
A. Well, name definitely was expected and then the address, anything that would identify that individual was also required.

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MS. NEWBURY:
Q. And who at the Cancer Registry did you speak to about that at the time?
DR. DANKWA:
A. At that time, at the onset of it, I wasn't talking directly to anybody in the Cancer Centre, but I was going through the oncology meds we had in our hospital who was collating those information and sending it on, but I had an opportunity to meet Bertha Paulse who was then the director of the oncology group, and she promised that she would have that addressed and I never saw it addressed, so I just continued my practice of not releasing the reports.
MS. NEWBURY:
Q. So did you speak to Ms. Paulse about that directly yourself?
DR. DANKWA:
A. Oh yes, I did, yes.
MS. NEWBURY:
Q. And when about, did you have that conversation with her?
DR. DANKWA:
A. This must have been probably around about

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

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DR. DANKWA:
A. The senior executive of the current Labrador Grenfell is aware of this.
MS. NEWBURY:
Q. Okay.
DR. DANKWA:
A. And they are in discussions with someone.
MS. NEWBURY:
Q. And have there been any active steps to take to try to resolve this?
DR. DANKWA:
A. Oh yes, a number, one of which was to try and get consent at the onset before the patient is even subjected to surgery.
MS. NEWBURY:
Q. Okay.
DR. DANKWA:
A. Rather than seek consent when the diagnosis had been made, but there are a lot of to and froes going on this.
MS. NEWBURY:
Q. Okay. So that's been discussed as an idea, but has a patient ever been approached to seek their consent to release the information?
DR. DANKWA:

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

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to report it believing that the test had worked successfully. But now with hindsight, we probably have to approach another technology to be applied to the tissue because if you go back to repeat, use the same technology, you'd probably get a repeated answer in the same way and you might report it and I wouldn't probably fault anyone who repeated the test by the same system and then send it on.
MS. NEWBURY:
Q. Just in terms of, you know, where we go from here and what might be done.
DR. DANKWA:
A. Yes.
MS. NEWBURY:
Q. You know, would there be a certain number of a certain quantity that you would see? Perhaps one wouldn't alarm you if you saw that -- maybe it would now.
DR. DANKWA:
A. Yeah, now.
MS. NEWBURY:
Q. Now it would?
DR. DANKWA:

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

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organization from a clinician's perspective or from a pathologist's perspective that you might be able to gain some insight from information at the Cancer Registry?

DR. DANKWA:

A. Yes, I don't know how might that would help me, but certainly it would be useful to have that ability to get access to that sort of information, and also it would contribute to that information.

MS. NEWBURY:

Q. Okay. Thank you, Dr. Dankwa. Those are all my questions.

DR. DANKWA:

A. Thank you.

COMMISSIONER:

Q. Ms. Russell.

MS. RUSSELL:

Q. No questions, Commissioner.

COMMISSIONER:

Q. Mr. Pike.

MR. PIKE:

Q. No questions.

COMMISSIONER:

Q. Mr. Browne.

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DR. ESSANDOH KWEKU DANKWA, EXAMINATION BY MR. PETER BROWNE

MR. BROWNE:

Q. Dr. Dankwa, you'll be pleased to see me come up to the lectern to know that things are almost over.

COMMISSIONER:

Q. Mr. Browne has had a good week that way.

MR. BROWNE:

Q. Yes, I have. Doctor, the topic of internal controls is a topic that's been of great interest here before the Commission. Before we get to that, though, just again, there are various types of specimens that are used for ER/PR, is that correct?

DR. DANKWA:

A. Yes.

MR. BROWNE:

Q. Can we just run through those various types again for the Commission?

DR. DANKWA:

A. We have -- I hope I list as much as I can remember. We have needle biopsy, and then trucut biopsy. Now these are two different operations. A needle biopsy is even finer

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compared with a trucut biopsy, which is a wider bore needle. So you get much more tissue than a needle biopsy. Then you have the other -- what I'll call a biopsy which is often a smaller piece of tissue, and then a lumpectomy, which is a bit larger than the standard biopsy, and then obviously you have the mastectomy.

MR. BROWNE:

Q. And then with regard to my earlier comment on internal controls, is it always possible to get internal control on all of these specimens?

DR. DANKWA:

A. Can I add another one to the list?

MR. BROWNE:

Q. Oh, I'm sorry, okay.

DR. DANKWA:

A. You can also do it on cytology specimens as well. Now it is not always --

COMMISSIONER:

Q. Sorry, I didn't hear what you said.

DR. DANKWA:

A. Cytology specimens. You can do an aspirate and then do a ER/PR on that. It is not always

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possible to get internal control because the main focus is actually on the tumour itself, and you aim to get internal control, but it may not necessarily be there.

MR. BROWNE:

Q. Thank you, Doctor. Now, Registrar, can we have Exhibit P-2203, please. Doctor, this is the spreadsheet you received, I assume, from Dr. Mullen. It's dated January, but is that when you received it?

DR. DANKWA:

A. Yes, I did, yes.

MR. BROWNE:

Q. 2006. Again I know it's hard to read, but as Mr. Coffey pointed out to you, the last column over is the commentary on fixation. Is that correct?

DR. DANKWA:

A. Yes, that is it.

MR. BROWNE:

Q. Now so that we're clear, these are the 23 -- these are the 23 cases that you compiled between 1997 and 2005.

DR. DANKWA:

A. Right.

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MR. BROWNE:
Q. Not the six additional cases that were found later?
DR. DANKWA:
A. That's correct, yes.
MR. BROWNE:
Q. So it covers that entire period?
DR. DANKWA:
A. Yes.
MR. BROWNE:
Q. And, Doctor, of that, the commentary on fixation, am I correct in looking at my numbers, 22 were adequately fixed and only one was --
DR. DANKWA:
A. That is correct.
MR. BROWNE:
Q. And when the internal controls were present, they stained?
DR. DANKWA:
A. They stained, yes.
MR. BROWNE:
Q. Now Mr. Coffey asked you about adverse events and incidents -- incident reports.
DR. DANKWA:

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A. Yes.
MR. BROWNE:
Q. And I think there may have been a bit of confusion there. Let me just go back over that for a minute. In your institution, is there somebody in charge of policies which may affect events such as adverse events or incidents?
DR. DANKWA:
A. Yes, we do have human resources personnel who organize all the policies, but we have an individual who is in charge, the risk management manager who is responsible for adverse events.
MR. BROWNE:
Q. And if there was an incident -- a patient incident and you filled out a form that you mentioned, a form for an adverse event, how would that operate? Would you contact the risk management person and they would advise you about the policy and how to go about things?
DR. DANKWA:
A. In some situations where you are not sure about which way to go, you will need to

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

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procedure manual. This one, in particular, Mr. Coffey asked you about, it was revised in 1999, is it possible that was subsequently revised in 2007?
DR. DANKWA:
A. Yes, in fact, when I saw the year there, I had a feeling that this has been revised, but the date have not been corrected.
MR. BROWNE:
Q. Okay. So this has possibly been revised?
DR. DANKWA:
A. It has possibly been revised, but the date --
MR. BROWNE:
Q. Again are you able to by just quickly looking at that -- probably I can scroll down for you, what if any revisions may have occurred in 2007?
DR. DANKWA:
A. Yes, if you'll stop there. On 11, the auto stainer, this came in in 2007.
MR. BROWNE:
Q. Okay, thank you. Doctor, lastly, is there any comment or recommendation you would like to make to the Commissioner?
DR. DANKWA:

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A. I don't have any comment, but I would just like to say thank you very much to the Commissioner, and thank you to Commission Co-Counsel. I hope I'm using the right words.

COMMISSIONER:

Q. They have been called things much worse.

DR. DANKWA:

A. Mr. Coffey and Sandra Chaytor. Then obviously, thank you very much, Mr. Browne, and Jane, for the spot you've given us, and to all of you for being patient and having me here. I'm relieved that I've had the opportunity to come here and share my views with the Commission, but I hope that the information that will be gathered here will be used positively to the improvement of our system within the organization and the province as a whole. I'd also like to say thank you to everybody in St. Anthony and Labrador Grenfell for their support and having me -- and retaining me there, and it's my intention to continue to be there because there's a lot of worry that pathologists are leaving and I may be one of them. Any time I jump into my car, they think that that is a

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one way trip. I will be back and I will continue to offer my services, not only just to maintain the services, but to improve upon it, and to assure all those who have one way or the other been affected by this, that I will continue to maintain the quality of service, and for those who are using our service, that I would say that our service is of a high quality and I will continue to maintain that, so still continue to be certain that our services will be offered in a much more quality way. Thank you.

MR. BROWNE:

Q. That's all the questions I have. Thank you.

COMMISSIONER:

Q. Thank you, Mr. Browne. Mr. Coffey, is there anything arising?

COFFEY, Q.C.:

Q. No, Commissioner, thank you.

COMMISSIONER:

Q. Thank you all. Thank you very much, Dr. Dankwa. I do appreciate your coming from St. Anthony to add another perspective, and like you, I do hope that the end product will be something that will be of benefit to the whole

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system.

DR. DANKWA:

A. Thank you.

COMMISSIONER:

Q. Thank you all. I don't suppose I have to remind you that we are not meeting on Monday, and ask you to be here on Tuesday at 9:30. Thank you.

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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 11th day of July, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 11th day of July, A.D., 2008

Judy Moss

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