COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

July 17, 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/Jane Hennebury . . . . . 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

LIST OF EXHIBITS

TABLE OF CONTENTS

THE COMMISSIONER:

Q. Please be seated. Ms. Chaytor.

MS. MARY BUTLER, RESUMES STAND, EXAMINATION BY MS. SANDRA CHAYTOR (CONT'D)

CHAYTOR, Q.C.:

Q. Good morning, Commissioner. Good morning, Ms. Butler.

MS. BUTLER:

A. Good morning.

CHAYTOR, Q.C.:

Q. Commissioner, there were a number of exhibits entered yesterday as P exhibits and I'm going to ask that those exhibits be cancelled and we enter them as C exhibits. They are pathology records with names redacted, but just to be on the side of caution, we'll have them entered as C exhibits instead. And those are P- 1842 through to P-1847 inclusive, and the new numbers will be C-0174, C-0175, C-0176, C-0177, C-0178 and C-0179.

THE COMMISSIONER:

Q. All right then, P-1842 through to 1847 cancelled and they become C-0174, 75, 76, 77, 78 and 79.

EXHIBITS P-1842 THROUGH P-1847 CANCELLED

Page 5

EXHIBITS RE-ENTERED AND MARKED AS C-0174 THROUGH C-0179
CHAYTOR, Q.C.:
Q. Yes, not necessarily in that order though, Commissioner. I can give you which become which, if that's helpful. It may be helpful to counsel actually because they can make the changes on their documents.
THE COMMISSIONER:
Q. Yes, but won't we produce them as C forms to people?
CHAYTOR, Q.C.:
Q. We will produce them as C forms, yes, but I will be referring to them this morning.
THE COMMISSIONER:
Q. Oh, okay.
CHAYTOR, Q.C.:
Q. And they may not have them. What I'll do is when I bring the exhibit up, I will indicate which it was, the original number.
THE COMMISSIONER:
Q. All right, thank you.
CHAYTOR, Q.C.:
Q. If we could have, please, Registrar, 2173, page 60? Ms. Butler, when we finished up yesterday, I was taking you through a number

Page 6

of pages in this exhibit. You'll recall this exhibit is a list of request forms for ER/PR testing in 2003.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And on this particular form, which is the requisition, looks like it came in from Dr. Dankwa on April 10th, 2003, and the test was carried out by you on May 2nd, 2003 and I take it this would be a repeat on May 30th, 2003?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And it's written here "tissue washing off." Is that your handwriting?
MS. BUTLER:
A. That's mine.
CHAYTOR, Q.C.:
Q. Okay. Now it's not signed again on May 30th, but is that your writing?
MS. BUTLER:
A. That's my writing again, yes.
CHAYTOR, Q.C.:
Q. So you repeated the test later on in the

Page 7

month?
MS. BUTLER:
A. Later on, yes.
CHAYTOR, Q.C.:
Q. Okay, and then at page 62 of the exhibit, we have a request from--can you--the doctor's name here, is it Dr. Luer?
MS. BUTLER:
A. I think so.
CHAYTOR, Q.C.:
Q. May 15th, 2003, and this is for estrogen as well as HER2/neu?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And this one is--the ER/PR is done May 26th '03 and then the HER2/neu is May 30th. So in this case where we see your name signed twice, it's two different tests?
MS. BUTLER:
A. Two different tests.
CHAYTOR, Q.C.:
Q. Okay, and if that were to be the case, you would write in the second test or the second test would also be indicated up in the--would

Page 8

be circled in the index, I take it?
MS. BUTLER:
A. I think so, yes.
CHAYTOR, Q.C.:
Q. Okay. Then on the back of that form, we have June 5th, 2003 in the corner. So I take it that's when you sent it back?
MS. BUTLER:
A. That's when I sent it, yes.
CHAYTOR, Q.C.:
Q. And what does it mean to have a check mark and the number 50?
MS. BUTLER:
A. Whenever you sent out a case, you had to sign it off the system.
CHAYTOR, Q.C.:
Q. What's the significance of the 50? What does 50 mean? What's the significance?
MS. BUTLER:
A. That's S-O, signed out.
CHAYTOR, Q.C.:
Q. Oh, that's signed out, thank you. There you go, learned something new today.
MS. BUTLER:
A. Always had to have reminders.

Page 9

CHAYTOR, Q.C.:
Q. So that's what you would normally do on the back of your form when it's signed out?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and then if we look at 68, this is another test for Dr. Luer, and I believe it's March 20th, 2003?
MS. BUTLER:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And HER2/neu is crossed off and estrogen and progesterone is still circled, and the original test is done by Mr. Simms, March 26th '03, and then we have your signature for May 2nd, 2003?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. So would that have been a repeat of the ER/PR?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And then you did the HER2/neu on May 30th, 2003?

Page 10

MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And on this form again, you've indicated checked by Dr. Ejeckam?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. So in May of--on May 2nd, 2003, this is your writing?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. It was checked by Dr. Ejeckam?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And again, that meant that he checked all the slides?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Not just the control slides?
MS. BUTLER:
A. Yes.

Page 11

CHAYTOR, Q.C.:
Q. On May 2nd, and we see up here in the corner, it's indicated that it was a repeat.
MS. BUTLER:
A. Repeat, yes.
CHAYTOR, Q.C.:
Q. So that's a repeat from the March test?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. If we could have, please, Registrar, page 78? Page 78 has written at the top "repeat with control on slide" and this is, I think--the dates are difficult to see on this. Would it be June or March of '03? Not sure?
MS. BUTLER:
A. I'm not sure.
CHAYTOR, Q.C.:
Q. Okay, and I don't know if you can read this or not. Is this your handwriting?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. It says "the staining on the test" and then there's something, not sure what's written

Page 12

there.
MS. BUTLER:
A. No. It's something about, I think, Pat wanted--I'm not sure if that's only started--I'm not sure of the date line when we started putting controls on the slides.
CHAYTOR, Q.C.:
Q. That seems to be -
MS. BUTLER:
A. But I think she may have requested that I put a control on the slide, so she could compare it all on the one slide.
CHAYTOR, Q.C.:
Q. And which pathologist is that?
MS. BUTLER:
A. Dr. Pat Wadden.
CHAYTOR, Q.C.:
Q. Dr. Pat Wadden, okay. So this may have predated, in 2003, this may have predated the actual practice which eventually evolved of putting your control, positive control, on the patient slide?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:

Page 13

Q. But she had asked "repeat with control on slide." She had asked that that happen at this point in time?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and that is--is that your writing "repeat with control on slide"?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and you recall Dr. Wadden requesting that?
MS. BUTLER:
A. I remember her requesting that.
CHAYTOR, Q.C.:
Q. Did any other doctors request that?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. And did she ever request it again? Is that then what she wanted for her cases?
MS. BUTLER:
A. I think she was having some issue with this case and she wanted to see it all, everything

Page 14

together.
CHAYTOR, Q.C.:
Q. Okay. Now, Ms. Butler, we spent a fair bit of time yesterday going through your worksheets and the work that you were doing with Dr. Ejeckam back in 2003, and took you through quite a number of repeats that were done in that time period of tests.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. ER/PR tests. As a result of your efforts and Dr. Ejeckam's efforts, did it ever come to your attention as to whether or not any repeats of the test resulted in changed results for the patients?
MS. BUTLER:
A. He never discussed that part with me.
CHAYTOR, Q.C.:
Q. You didn't know the outcome of any of your work?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. Okay, and whether or not there was any then

Page 15

changes in the results, that wasn't discussed with you and didn't come to your attention at any point in time?
MS. BUTLER:
A. Not with results, no.
CHAYTOR, Q.C.:
Q. And of course, Dr. Ejeckam has been here and in looking at--in being asked questions about whether--why a review didn't take place back in 2003, given the issues he identified, he indicated that there was no index case. Have you become aware of that term "index case" in the context of ER/PR?
MS. BUTLER:
A. I have heard about it, yes.
CHAYTOR, Q.C.:
Q. You have heard about it, and when did you first hear of an index case?
MS. BUTLER:
A. I just heard it, it was discussed with me. I was present when Barry Dyer said about this index case.
CHAYTOR, Q.C.:
Q. And was that in 2005, after Dr. Cook's memo came out? Is that around the time period?

Page 16

MS. BUTLER:
A. (Unintelligible) be--date line I can't -
CHAYTOR, Q.C.:
Q. Well, it's not something I take it you've heard in the past -
MS. BUTLER:
A. No, I haven't.
CHAYTOR, Q.C.:
Q. You didn't hear it this year?
MS. BUTLER:
A. No, no.
CHAYTOR, Q.C.:
Q. Was it around the time that you became aware of the issues about ER/PR in 2005?
MS. BUTLER:
A. I think with me it was just much later, because I didn't really get into things.
CHAYTOR, Q.C.:
Q. So later than that?
MS. BUTLER:
A. I didn't get into discussions on, and like e-mails and that, I didn't bother too much. I just knew that there was things happening, but I never got into them. Just did my work when they requested it.

Page 17

CHAYTOR, Q.C.:
Q. Yes, and in terms of what did you understand when Mr. Dyer talked to you about an index case? What did you understand that to mean?
MS. BUTLER:
A. Well, it took me a while to understand it, because I never got into not knowing--didn't know much about the reporting end of my work. So I just knew something--to me, something had happened that wasn't good.
CHAYTOR, Q.C.:
Q. So did you understand that it was--in referring to someone as an index patient, we understand that meant it was a patient whose test had changed on repeating.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Her ER/PR testing -
MS. BUTLER:
A. Had changed.
CHAYTOR, Q.C.:
Q. Yes, okay. If we could look, please, at the same exhibit, 2173, page 56? And this is May 23rd, 2003. So we understand from the

Page 18

documentation we have that ER/PR would have resumed, but this is shortly after Dr. Ejeckam's adjustments, and you carried out this test. I guess that's the same date, May 23rd.
MS. BUTLER:
A. Looks like 29th.
CHAYTOR, Q.C.:
Q. 29th maybe, okay, and this is request by Dr. Ford Elms or pathologist is Dr. Ford Elms.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And the surgical number of this patient is an '02 case, and written over here it says "repeat ER/PR requested by Dr. Zaidi."
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Do you know who Dr. Zaidi is?
MS. BUTLER:
A. Not right now, no.
CHAYTOR, Q.C.:
Q. Do you know that if -
MS. BUTLER:

Page 19

A. He's an outside pathologist.
CHAYTOR, Q.C.:
Q. Is he a pathologist?
MS. BUTLER:
A. No, I don't know. Maybe he's a -
CHAYTOR, Q.C.:
Q. Or is he an oncologist?
MS. BUTLER:
A. - oncologist.
CHAYTOR, Q.C.:
Q. Oncologist, I believe, yes, okay. So how usual was that to have a repeat requested by an oncologist?
MS. BUTLER:
A. Unusual.
CHAYTOR, Q.C.:
Q. Unusual. And if we could look, please, at 2190, page 20? And if you remember the surgical number being 5231-02, page 20, this is the right page? Right here, sorry, line 15, 5231-03. You've indicated '03, but this is a May 29th run. So do you believe that should be '02?
MS. BUTLER:
A. '02.

Page 20

CHAYTOR, Q.C.:
Q. That should be an '02, so that's an error.
MS. BUTLER:
A. I guess I was writing all '03s and I just continued.
CHAYTOR, Q.C.:
Q. With '03, right, okay. So that would be the same test that was requested to be repeated by Dr. Zaidi?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and you ran that in your May 29th B batch?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And if we could look then, please, at Exhibit C-0074 (actual exhibit called up and referenced was C-0174)? And this was originally P-1843, and if--and you see the surgical number here again, SS5231, an '02 case, so same number?
MS. BUTLER:
A. Yes.

Page 21

CHAYTOR, Q.C.:
Q. And on page four of the--this is a pathology report. We'll see it's Dr. Elms who was the pathologist involved in the case.
MS. BUTLER:
A. Right.
CHAYTOR, Q.C.:
Q. And we'll see that there was an addendum two entered, August 29th 2002, signed off by Dr. Elms on that date indicating "immunohistochemical staining for progesterone receptors is positive in approximately 15 percent of lesional cells. Immunohistochemical staining for estrogen receptors is negative."
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And then signed off by Dr. Elms on June 11th, 2003, keeping in mind you did the test on May 29th, and it indicates "at the request of Dr. Zaidi, immunohistochemical staining for estrogen and progesterone receptors has been repeated. Estrogen receptors show faint positivity in approximately 10 to 15 of

Page 22

lesional cells. Progesterone receptors are unequivocally positive in approximately 75 percent of lesional cells." So this appears to be the pathology report following from your retest on May 29th.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Yes. So any change in the result for this particular patient in 2003, that was never discussed with you?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. And not brought to your attention?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. If we could look at, please, P-2190, page 11? And again, Ms. Butler, this is back to your worksheets of the work that you were doing in that time frame with Dr. Ejeckam.
MS. BUTLER:
A. Okay.
CHAYTOR, Q.C.:

Page 23

Q. And the case that I'd like you to look at this time is this one here at line 30, or 29, sorry, slide 29, and it's S4821-03, and then if we go ahead to page 16, and I believe I brought your attention to this yesterday, that that case was repeated, slide 13, 4821-03. So it was repeated then on May 7th '03 after ER/PR has resumed.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And if we could look, please, then at C-0175. We see the surgical number here. Just a reminder to others that this was originally P-1842, and the new exhibit number is C-0175. You'll see that here's the same specimen number, and if we look at the addendums, addendum #1 which was entered, I believe, May 6th, 2003, "When compared to controls the specimen is negative for HER-2-neu, ER, and PR". Addendum #2 entered May 9th, 2003, and again bearing in mind, I believe, our retest was May 7th and signed by Dr. Morris-Larkin, "The ER and PR were repeated due to quality assurance issues. The repeated stains show

Page 24

the following; ER positive in 80 percent of the cells, PR positive in 10 percent of the cells. This replaces the previous report. Phoned the Cancer Clinic voice mail on May 9th, 2003". Again, Ms. Butler, the fact of any patient having had a change in result in their ER/PR testing in 2003 resulting from retesting carried out by you and Dr. Ejeckam, that was never brought to your attention?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. When did you learn that there was an ER/PR issue as we've come to call it?
MS. BUTLER:
A. I guess when he approached me about just doing extra work. At that time there. So I guess I should have known something was going on there.
CHAYTOR, Q.C.:
Q. So when would that have been, when were you asked to do extra work?
MS. BUTLER:
A. Just your dates on the screen there in that '03 period, that's when I look at that date

Page 25

when I did all the controls.
CHAYTOR, Q.C.:
Q. So in 2003, you became aware that there was something with ER?
MS. BUTLER:
A. Something going on that I had to do a lot of extra work.
CHAYTOR, Q.C.:
Q. And whether or not there were any changes to patient's results, that wasn't brought to your attention?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. But you knew there was something up?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And then when in 2005 did it again come -- was there anything else then brought to your attention about ER/PR after these adjustments in 2003 up until the summer or spring of 2005? Did you hear anything else about any concerns about ER/PR testing?
MS. BUTLER:

Page 26

A. No, it seemed like when I -- when we went through that period of "x" number of weeks just working on it, we had made some changes and then it just seemed to go away.
CHAYTOR, Q.C.:
Q. So things were quiet then on the ER/PR front?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. For some time?
MS. BUTLER:
A. Some time.
CHAYTOR, Q.C.:
Q. And then when did you next hear about it in terms of the issue then that unfolds in 2005? When were you made aware of that?
MS. BUTLER:
A. I can't -- I really can't say.
CHAYTOR, Q.C.:
Q. Did you learn about it in -- well, we know there was a memo sent out to the technologists in August of 2005 by Dr. Cook?
MS. BUTLER:
A. I would say my knowledge came about -- I'm sure we discussed it in the lab or something

Page 27

to that -- you know, someone may have known about it from somebody and I'm sure in the lab, a small lab, I'm sure we might have been upset about something, but I cannot remember someone coming in and telling us unless -- Barry had a habit of coming down when problems -- when he was approached with problems and alerting us to it, but that's the most communication that I would have received.
CHAYTOR, Q.C.:
Q. Okay. So whether or not you had heard about anything before Dr. Cook's memo of August 8th, you're uncertain?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. The fact if there were retests occurring in May, June, July, 2005, were you aware of that?
MS. BUTLER:
A. Only with doing it through Dr. Ejeckam on --
CHAYTOR, Q.C.:
Q. That's in 2003?
MS. BUTLER:
A. Yeah.
CHAYTOR, Q.C.:

Page 28

Q. Were you aware of retests taking place then in 2005 in the Ventana machine throughout June/July of 2005?
MS. BUTLER:
A. Again I'm not really sure. I know something was going on, but again I can't recall it totally.
CHAYTOR, Q.C.:
Q. I take it, it wasn't the same as what you had experienced in 2003 when you were aware that you were asked to do extra work in 2003?
MS. BUTLER:
A. No, because I was involved more with the DAKO machine and Ken and Barry were more involved with the Ventana machine.
CHAYTOR, Q.C.:
Q. Okay. So there was no extra work asked of you in 2005?
MS. BUTLER:
A. No, not me.
CHAYTOR, Q.C.:
Q. In that time period. If we could look, please, at P-0506. I believe we have a typed version. These are notes, Ms. Butler, of Dr. Williams and he's been kind enough to have

Page 29

them typed for us. July 15th, 2005, and this is a meeting of Mr. Gulliver, Drs. Cook and Williams, and it refers to a number of things here that were happening at that time period, and it refers to, "Reviewed meeting of July 14th, 2005, re; identifying all patients and getting tests done as soon as possible. Plan; pull one to two people to start process and assign", and I think that should be "assign Mary to cutting and testing only". We believe that refers to yourself, Mary Butler.

MS. BUTLER:

A. Yes.

CHAYTOR, Q.C.:

Q. Do you recall that happening in the middle of July, 2005, that you were assigned to cutting and testing?

MS. BUTLER:

A. I remember doing a lot of cutting.

CHAYTOR, Q.C.:

Q. In that time period, and was that a change in your regular duties?

MS. BUTLER:

A. No, well, we'd always have our -- you know what I mean, we'd always rotate cut, machine,

Page 30

kidney biopsies.

CHAYTOR, Q.C.:

Q. Now this would be for the breast tests. This would be for, specifically we understand, for the retesting of ER/PR?

MS. BUTLER:

A. I remember, like, maybe cutting them. I'm not sure about the testing them. I can't remember being -- when I was down on -- this would be Ventana time, right?

CHAYTOR, Q.C.:

Q. Yes, this is Ventana time. So were you --

MS. BUTLER:

A. I did do a lot of work on the Ventana in my turn, but I can't remember being singled out to run them all.

CHAYTOR, Q.C.:

Q. So you don't remember anyone coming to you, taking you out of your normal rotation and asking you to do cutting and testing only?

MS. BUTLER:

A. I can't remember doing that.

CHAYTOR, Q.C.:

Q. Okay. If we could look at P-0516, please, and again these are notes from Dr. Williams and

Page 31

page two is the typed version. This is now a meeting of July 21st, 2005, of the same individuals, and there's a number of items up to nine, "Agreed to get Dr. Carter information she needs. Dr. Carter to do only this service", and we understand this is the review of the ER/PR tests. "Mary Butler to report and take direction from Dr. Carter". Do you recall in July, 2005, someone coming to you and indicating that you are to take direction and report to Dr. Carter?

MS. BUTLER:

A. Mostly what I had to do there, I think, was just retrieve as many cases as I -- whatever cases they requested from the Health Science that were on our site to have them sent to her.

CHAYTOR, Q.C.:

Q. So you were asked to identify and retrieve blocks, is that right?

MS. BUTLER:

A. I was given numbers and then I had to retrieve those numbers and I had to send slides and blocks over to St. Clare's.

CHAYTOR, Q.C.:

Page 32

Q. Okay, and you did that, I take it?

MS. BUTLER:

A. Yes.

CHAYTOR, Q.C.:

Q. And how long did that go on? Did that go on for a period of weeks, months?

MS. BUTLER:

A. It went on for a while, but again I can't give you a time. I just know it seemed to be -- she'd send over a list of numbers and we'd try to track them down, and this other girl, Judy Quinlan, was the girl on the St. Clare's site.

CHAYTOR, Q.C.:

Q. Okay, and so you would -- Dr. Carter would provide you with a list of surgical numbers?

MS. BUTLER:

A. Just the surgical numbers, yes.

CHAYTOR, Q.C.:

Q. And then you would find those blocks and arrange to have them sent to her at St. Clare's?

MS. BUTLER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, and were you involved in getting any

Page 33

tests done on those blocks?
MS. BUTLER:
A. Not that I'm aware of. Mostly I can remember collecting blocks, but if she was getting numbers, someone had to perform the tests.
CHAYTOR, Q.C.:
Q. Okay.
MS. BUTLER:
A. Not necessarily being me.
CHAYTOR, Q.C.:
Q. And did anyone explain to you why you were doing that, why you were getting these blocks for Dr. Carter?
MS. BUTLER:
A. I was just thinking that it was -- I assumed that -- we knew that this ER/PR situation was going on and that she was doing some work. She was considered a breast specialist.
CHAYTOR, Q.C.:
Q. So you were aware at that point in time there was an issue with ER/PR?
MS. BUTLER:
A. Yes, I'm sure I was.
CHAYTOR, Q.C.:
Q. But you have no recollection of what you were

Page 34

told or who told you what the issue was?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. Did this involved -- this work that you did for Dr. Carter, did that involve overtime for you, were you having to work extra hours or was that fitted in in your regular day?
MS. BUTLER:
A. Fitting in, but I'm sure overtime was involved too.
CHAYTOR, Q.C.:
Q. Some overtime involved?
MS. BUTLER:
A. I would say, yes.
CHAYTOR, Q.C.:
Q. Okay.
MS. BUTLER:
A. Overtime seemed to be the name of the game with our work.
CHAYTOR, Q.C.:
Q. And that was the norm for you that you would at times have to work overtime?
MS. BUTLER:
A. Yes.

Page 35

CHAYTOR, Q.C.:
Q. So was there anything, in particular, in this time period that stands out as being you're really having to work a lot of extra hours?
MS. BUTLER:
A. Just that we, you know, with doing the extra breast work on top of all of our other work.
CHAYTOR, Q.C.:
Q. Okay. In early August, 2005, a representative from Ventana visited the lab, Carole Quevillon.
MS. BUTLER:
A. I never knew her last name. I called her Carole.
CHAYTOR, Q.C.:
Q. That's okay, I struggle with it too. So you were aware she was there?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and did you meet with her while she was there?
MS. BUTLER:
A. I was present in the lab while she was there, yes.

Page 36

CHAYTOR, Q.C.:
Q. So she didn't have individual meeting with you as such?
MS. BUTLER:
A. No, she just did her thing with the machine.
CHAYTOR, Q.C.:
Q. And what did you understand was the purpose of her visit on that occasion?
MS. BUTLER:
A. I'm not sure. Maybe I thought it was -- I'm not sure, but I knew it was attached to the issue, or if she was maintenance or -- I'm not really sure. She used to come to do our maintenance as well sometimes, and we could talk to her about where she knew the Ventana so well. She would give us pointers and things.
CHAYTOR, Q.C.:
Q. So she would come in from time to time and do that in any event?
MS. BUTLER:
A. Um.
CHAYTOR, Q.C.:
Q. And were you told the outcome of her visit or her review in August of 2005?

Page 37

MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. Were you made aware that she had some issues with maintenance on the Ventana machine?
MS. BUTLER:
A. Maintenance, I'm going to say yes because we always had a little bit of -- we always found it hard to fit in our maintenance because we wouldn't stop our work long enough to do our maintenance.
CHAYTOR, Q.C.:
Q. Tell me about that. So sometimes the maintenance didn't get done?
MS. BUTLER:
A. Occasionally when -- like, we did our daily maintenance on a regular basis. Every day actually you'd sign it off in the computer. Then the -- I think we had to do it daily, monthly, quarterly.
CHAYTOR, Q.C.:
Q. Okay.
MS. BUTLER:
A. So the monthly -- I think we managed to do the monthly a fair amount, quarterly, and then she

Page 38

had to do the last maintenance. So she'd be able to look in the computer and tell if the maintenance was done on the machine or not.
CHAYTOR, Q.C.:
Q. So after she attended in August, 2005, was the maintenance schedule then strictly adhered to?
MS. BUTLER:
A. I'm not going to say strictly, no.
CHAYTOR, Q.C.:
Q. There were still times it was missed?
MS. BUTLER:
A. We were trying. There were still times when we were -- we were programmed, I will call it, to get our work done, and we wouldn't -- we should have paid attention to stopping more to do maintenance.
CHAYTOR, Q.C.:
Q. Okay.
MS. BUTLER:
A. We were fortunate the machine was fine, nothing ever happened.
CHAYTOR, Q.C.:
Q. Okay, to your knowledge that would be?
MS. BUTLER:
A. To my knowledge, yes.

Page 39

CHAYTOR, Q.C.:
Q. And I take it, was that the same in the DAKO days at well in terms of not finding the time to stop you work to make sure maintenance was carried out?
MS. BUTLER:
A. Maintenance on DAKO was performed -- I think she only had so many tests and you had to do your cleaning there, and --
CHAYTOR, Q.C.:
Q. And was that done?
MS. BUTLER:
A. And then the maintenance on the machine was done by the outside department, biomedical department, I think it might have been.
CHAYTOR, Q.C.:
Q. Okay.
MS. BUTLER:
A. And they came down yearly because the tags used to be on the machine saying when they came.
CHAYTOR, Q.C.:
Q. They came annually, did they, to do a maintenance check?
MS. BUTLER:

Page 40

A. Maintenance, yeah.
CHAYTOR, Q.C.:
Q. So you as a technologist would do cleaning on a regular basis, though?
MS. BUTLER:
A. Yes, on a regular basis.
CHAYTOR, Q.C.:
Q. And was that always done when it was supposed to be done?
MS. BUTLER:
A. Yes, because we couldn't do -- she would stop and we couldn't go on with our work.
CHAYTOR, Q.C.:
Q. So the machine actually wouldn't continue?
MS. BUTLER:
A. She had a number of tests and once she reached that number, she wouldn't let you continue.
CHAYTOR, Q.C.:
Q. So that was the safety check built into that machine. If we could look, please, at P-0559. Ms Butler, this is a memo of Dr. Cook, August 8th, 2005, which went to Mr. Gulliver, Mr. Dyer, and the three IHC technologists, including yourself. Do you recall did you receive this memo?

Page 41

MS. BUTLER:
A. It was in the lab because we put it up on the wall.
CHAYTOR, Q.C.:
Q. So did you personally get a copy or was it posted in the lab?
MS. BUTLER:
A. It was posted in the lab.
CHAYTOR, Q.C.:
Q. And did --
MS. BUTLER:
A. Someone received it, one of the three, and then we put it on the wall.
CHAYTOR, Q.C.:
Q. So one of the three of you received it and posted it in the lab?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And did any -- so were you there when the memo was received, did it come with any other discussion around it?
MS. BUTLER:
A. I'm sure there was a discussion, but --
CHAYTOR, Q.C.:

Page 42

Q. Amongst the technologists?
MS. BUTLER:
A. Among the technologists. You know what I mean, if you work together, you know you're going to discuss things.
CHAYTOR, Q.C.:
Q. I'm just wondering if anyone ever who delivered the memo to you explained the background or the context of the memo to the technologists?
MS. BUTLER:
A. I'm not sure other than again Barry usually showed up in our lab when things were happening.
CHAYTOR, Q.C.:
Q. And what did you understand from this memo from a technical perspective was to happen with respect to ER/PR testing on a go-forward basis?
MS. BUTLER:
A. I think we were just supposed to -- no, that was the pathologist. I think we just had to -- we still had to keep doing them.
CHAYTOR, Q.C.:
Q. So you continued to do ER/PR testing?

Page 43

MS. BUTLER:
A. Continued to do them, yes.
CHAYTOR, Q.C.:
Q. And did anyone ever come and tell you otherwise to stop making the slides?
MS. BUTLER:
A. No, because I think they still have those slides in the fridge.
CHAYTOR, Q.C.:
Q. So you and Les and Ken continued on with your regular rotations in IHC until you -- continued on with your work in terms of doing the ER/PR testing?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. What do you next recall then? After you received this memo, you're continuing on as normal in terms of the technical side of the testing. What do you next recall, what was your involvement with the ER/PR issue? Do you have any other direct involvement?
MS. BUTLER:
A. Mostly in the lab--I don't know, we continued our three-way, you know, like how we did our

Page 44

work, cutting, staining, kidney biopsies and then with ER/PR, I'm just assuming we all--I know sometimes they were testing different things and I did a lot of the machine work and Ken would be involved with some of the doctors from St. Clare's, but I'm not sure if that was this time, you know, they would, you know, we split up our work so that it could free up, free those up to work with St. Clare's--Ken, especially, and Les went on to work on developing our control bank. So I don't know if all of this was happening at this time.
CHAYTOR, Q.C.:
Q. Okay, and we understand that Trish Wegrynowski and Dr. Banerjee attended at your lab and did reviews in the fall of 2005?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. You recall their visits?
MS. BUTLER:
A. Yes, I remember those visits.
CHAYTOR, Q.C.:
Q. And did you meet with them?
MS. BUTLER:

Page 45

A. They say we had a meeting in Barry's office. I can't recall it, but I can remember her in the lab with us all the time.
CHAYTOR, Q.C.:
Q. Okay, but you don't recall the presentation that she did on Barry's computer?
MS. BUTLER:
A. I can't remember it much. I'm sure I must have been there.
CHAYTOR, Q.C.:
Q. But you don't--that doesn't stick out in your mind.
MS. BUTLER:
A. It doesn't stick out in my mind for some reason.
CHAYTOR, Q.C.:
Q. So whether or not, I guess you're not able to tell me whether or not you found it to be of use or a good learning experience for you.
MS. BUTLER:
A. I found with Trish being in the lab, she was able to point out some things and started making me think about doing different things in our lab.
CHAYTOR, Q.C.:

Page 46

Q. Okay, so the couple of days she spent with you, you found that there were things that she made--that were of use to you?
MS. BUTLER:
A. Yes, I found her, you know, she was sort of--she was sort of helpful and she used to always say "I didn't come here to tear you apart or anything, but to help you." I remember her saying those things.
CHAYTOR, Q.C.:
Q. And you did find that it was helpful?
MS. BUTLER:
A. Yes, very.
CHAYTOR, Q.C.:
Q. Very helpful. And I understand that you also had an opportunity to go then to Mount Sinai in January of 2006.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. So a few months later you went to Mount Sinai and stayed there for a couple of weeks training?
MS. BUTLER:
A. Observing more than training.

Page 47

CHAYTOR, Q.C.:
Q. Okay, what was the purpose of that visit?
MS. BUTLER:
A. I went to see about formalin, just to check out mainly with the formalin and to -
CHAYTOR, Q.C.:
Q. The formalin?
MS. BUTLER:
A. Just look at how they did their--receiving their specimens and how long maybe they were keeping their specimens and -
CHAYTOR, Q.C.:
Q. And what was it about the formalin that you were observing?
MS. BUTLER:
A. Just to see if our lab was sort of comparable to their lab, you know, keeping it and how long we left our specimens.
CHAYTOR, Q.C.:
Q. Oh, okay, so how long the specimens would be in the fixative, in the formalin?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And were you making inquiries as to the type

Page 48

of formalin they were using and, was that one of the issues?
MS. BUTLER:
A. I didn't pay attention to the type, other than it was neutral buffered formalin, as it goes, when you say "type", company maybe, but it was neutral buffered formalin.
CHAYTOR, Q.C.:
Q. So at that point in time the Health Sciences was using commercial formalin.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Do you recall the days when you used to make your own formalin?
MS. BUTLER:
A. Yes, we had to make our own buffered formalin ourselves, yes.
CHAYTOR, Q.C.:
Q. And when did that stop?
MS. BUTLER:
A. Barry should be able to tell you that more than -
CHAYTOR, Q.C.:
Q. Barry would know, okay. And you don't know

Page 49

whether it had stopped prior to 2005?
MS. BUTLER:
A. No, I don't.
CHAYTOR, Q.C.:
Q. Okay, I'll ask then Mr. Dyer about that. So at Mount Sinai then, you made inquiries and observations as to practices regarding fixation, I take it?
MS. BUTLER:
A. Yes, fixation and then I was supposed to just oversee or just watch the different things they did in their lab, go to the IHC lab and just pay attention to, like, how they documented things.
CHAYTOR, Q.C.:
Q. So what did you understand was the purpose of your visit there?
MS. BUTLER:
A. Well we were very, we weren't good at documentation, so I understood it was more about how they did their documentation and to try and bring back some things to help us out with moving ahead with our documentation.
CHAYTOR, Q.C.:
Q. Okay, and I take it from documentation, you

Page 50

mean things like we've already discussed about documenting that you're maintaining your equipment, those kinds of things.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Did it also include documentation such as SOP, standard operating procedures?
MS. BUTLER:
A. SOPs, yes.
CHAYTOR, Q.C.:
Q. So this was an effort to learn how, what standard operating procedures they had in place and how you could adopt your own?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And did you, the whole two weeks that you were there, were you in the IHC lab or the entire pathology lab?
MS. BUTLER:
A. I was in the--combination, I was in both, IHC so many days and then I would go out into the main lab and I was in where the, where the PAs do their work, that's when you received the

Page 51

specimens and stuff like that.
CHAYTOR, Q.C.:
Q. And I take it you worked closely in that time period with Trish Wegrynowski?
MS. BUTLER:
A. Trish was there, yes.
CHAYTOR, Q.C.:
Q. And what did you, what impression did you have of Ms. Wegrynowski's level of expertise in IHC?
MS. BUTLER:
A. I thought she was very good, I thought she knew what she was talking about.
CHAYTOR, Q.C.:
Q. Did you have any--did you find when you came back, did you find our visit had been useful to Mount Sinai, and in particular, in terms of your own learning around IHC processes?
MS. BUTLER:
A. I found, the most thing I found it was good for my--a good pathway to lead into documentation, but as we had moved on to the Ventana and I was going into the lab, they were still using DAKO, so I didn't think that was of much use to me.

Page 52

CHAYTOR, Q.C.:
Q. So that part wasn't of much use because you were on a different system.
MS. BUTLER:
A. On a different system.
CHAYTOR, Q.C.:
Q. And I take it the issues around what happens to the specimen prior to it being put into the machine, up to that point in time certainly would be of use?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And if we could look then, please, at P-1848? And this is entitled "Mary Butler, Mount Sinai, January 8th to 21st, '06"?
MS. BUTLER:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And is this your document?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And there's 12 pages here. So you wrote this, did you?

Page 53

MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And when did you write this?
MS. BUTLER:
A. I'm not sure, sometime after I came back because I do have a weakness with having to write, put things on paper, so it took me a little while.
CHAYTOR, Q.C.:
Q. And did you have to submit this--so it took you a while after?
MS. BUTLER:
A. A while, yes.
CHAYTOR, Q.C.:
Q. Did you have to submit it to anyone?
MS. BUTLER:
A. We had a--Dr. Ejeckam wanted--well Ken was away and myself, and he wanted Les to--I think we had to present it to the pathologists.
CHAYTOR, Q.C.:
Q. Okay, and you indicate that the purpose of your visit was threefold: the fixation protocol, QA, and documentation activities for immunohistochemistry routine, where time

Page 54

permits." What does that mean, "where time permits"?
MS. BUTLER:
A. Mainly to be in the IHC lab and then what extra time was left over, to go out into the routine lab.
CHAYTOR, Q.C.:
Q. Okay, so this means routine lab.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. "Lines of communication with key pathologists." And what was it that you were--what were you trying to learn or observe in that respect?
MS. BUTLER:
A. To see how, you know, if their slides went out to different pathologists or how they interacted with their different pathologists.
CHAYTOR, Q.C.:
Q. Okay, and was there any concern about that then in your lab?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:

Page 55

Q. Why would you have to go to Mount Sinai and look at what they're doing?
MS. BUTLER:
A. Just to observe and make sure--well, I guess in the IHC lab, to see if there was, they had a main pathologist that they went to, which we didn't have.
CHAYTOR, Q.C.:
Q. And "the fixation at Mount Sinai are outlined in a manual and practice as follows" and then you say "all specimens were delivered to the receiving lab of pathology by porters. They were entered into the system and grossed the same day. The larger specimens were opened and left overnight to fix for grossing rounds the next day. The large cases were not opened immediately upon receipt, they were left until someone was available to handle. All specimens were to be placed in appropriate fixative, preferably 10 percent buffered formalin unless otherwise specified. All specimens receive fresh or in fixative other than that should be clearly labelled." And how did that compare then to what was happening at the Health Science at the time?

Page 56

MS. BUTLER:
A. They're similar.
CHAYTOR, Q.C.:
Q. So it was nothing that stood out as being different to you?
MS. BUTLER:
A. No, well the only thing that stood out as a little difference was I used to see that their doctors used to come in with their PAs and they'd have a discussion around their day's work on the beginning. I think that's happened--since we've developed our PAs, I think that's sort of happening now.
CHAYTOR, Q.C.:
Q. That's happening now, is it? Okay, and there's no indication here, though, about any times for a fixation, how long specimens should be left?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. But was that part of the fixation procedure and policy at Mount Sinai?
MS. BUTLER:
A. Yeah, they had it in a, I can't remember it

Page 57

now, but they had it in their SOPs.
CHAYTOR, Q.C.:
Q. Yes.
MS. BUTLER:
A. And every--they had SOPs, like at different stations they had their SOPs.
CHAYTOR, Q.C.:
Q. Okay, and I take it at the time that wasn't happening in the Health Sciences?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. The QA and documentation activities for immunohistochemistry and routine lab are outlined in a manual and practice as follows." Where was that manual kept? Was that also kept in the document stations in the lab, the manual about QA?
MS. BUTLER:
A. QA and immunohistochemistry, she had all her own in there and the routine lab had all their own.
CHAYTOR, Q.C.:
Q. Okay. "All sections of the department must have procedure manuals and all staff is

Page 58

expected to read and sign off to verify an understanding of the purpose, policies and procedures of the pathology lab."
MS. BUTLER:
A. Yes, they used to--you'd look in their books, in those manuals and you'd see that they all had signed. And any updates and everything occurred, that would be there, changes would be dated and signed as well.
CHAYTOR, Q.C.:
Q. Okay, and had that been happening at the Health Sciences?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. And now that you have a--we've seen a manual with policies and procedures, most of which were adopted this year.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Is that now a practice?
MS. BUTLER:
A. It's now moving ahead, yes.
CHAYTOR, Q.C.:

Page 59

Q. I'm sorry?
MS. BUTLER:
A. It's now moving ahead and things are starting to work out with the SOPs.
CHAYTOR, Q.C.:
Q. Have you had to sign off and indicate that you understand the purpose of the policies and the procedures?
MS. BUTLER:
A. I haven't been keeping up on it because where I was going to retire, I never--because I started coming out of the lab.
CHAYTOR, Q.C.:
Q. Do you know whether or not others have done that?
MS. BUTLER:
A. Yeah, I think the others are doing it. Now I--maybe I'm--after we came back, started to develop some of those books with the, like, corrective action books, antibodies and all that, now I filled out those, helped start filling out those books.
CHAYTOR, Q.C.:
Q. So if there was any, you mean if there was any corrective action undertaken, you would

Page 60

document it?
MS. BUTLER:
A. Document.
CHAYTOR, Q.C.:
Q. So you were following the procedure.
MS. BUTLER:
A. Yes, yes.
CHAYTOR, Q.C.:
Q. But you hadn't signed off saying -
MS. BUTLER:
A. I can't remember signing off.
CHAYTOR, Q.C.:
Q. - that you read it and understood it.
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. So is this your recommendation that three manuals should be developed?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And that was your recommendation coming out of Mount Sinai?
MS. BUTLER:
A. Yes.

Page 61

CHAYTOR, Q.C.:
Q. One for grossing, specimen entry; statement for grossing of all tissues processing and pathological procedures required; all antibodies and ancillary products must be documented and assessed for validation." And then, I'm not sure, but the next number I see here is three, so perhaps that's--it says "there are three manuals" -
MS. BUTLER:
A. Three, okay.
CHAYTOR, Q.C.:
Q. What's that?
MS. BUTLER:
A. Yeah, I'm not sure, it's been awhile.
CHAYTOR, Q.C.:
Q. All right, and these were antibody technical information for all antibodies and you go on from there, "all control tissues must be validated and documented".
MS. BUTLER:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. Had that been happening in any event?
MS. BUTLER:

Page 62

A. We had been trying to validate but we had no one, no pathologist to help us to finish off the process.
CHAYTOR, Q.C.:
Q. And I take it it wasn't being documented, if it wasn't being validated, there was no documentation.
MS. BUTLER:
A. No documentation.
CHAYTOR, Q.C.:
Q. And control documentation you indicate "will include verification of positivity, negativity of controls and signed off. Record of quality issues with immunohistochemical staining to include the date of occurrence, issue specimen, corrective action and date completed. Tissue control bank offers the pathologist the ability to document tissues that are positive for specific antibodies and immunofluorescence." These ideas, Ms. Butler, was this taken directly from what Mount Sinai was doing?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:

Page 63

Q. And the lines of communications with key pathologists are assessed through a pathologist designate in charge of the immunohistochemistry lab." So that's how they were doing it at Mount Sinai. I take it they had a pathologist in charge of the immunohistochemistry lab.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And any communication from other pathologists would go through that person?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. "The technologist has the freedom and ability to consult with a subspecialty pathologist about a specific antibody, but the designate pathologist in charge will make the final decision on all issues."
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And then you indicate a separate manual then for the body of the lab and the third one, I

Page 64

guess, the third manual you were recommending was for "immunohistochemistry lab which should contain the following"--and then you have a list.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And again this is taken from Mount Sinai's information, is it?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. "All mechanical equipment must be checked and documented daily. The following charts are being created." And what did you mean by that, the following charts are being created? Was that within the Health Science at that point in time?
MS. BUTLER:
A. I'm not--I'm thinking yes, because we did create a lot of--when I came back, she provided me with charts that she used and then we adapted them to our lab.
CHAYTOR, Q.C.:
Q. So prior to that, your visit in January of

Page 65

2006, did you have a daily temperature chart for your water baths, your ovens, your refrigerators? Did you have such daily temperature charts?
MS. BUTLER:
A. No, the only--we didn't have charts, no.
CHAYTOR, Q.C.:
Q. Did you have any record, whether you call it a chart or not, was there any record of -
MS. BUTLER:
A. Like we test our water baths and make sure they were at temperatures every day, our oven had a thermometer in it which we checked every day. The refrigerator -
CHAYTOR, Q.C.:
Q. There was no documentation -
MS. BUTLER:
A. No documentation, we just, I guess, visually.
CHAYTOR, Q.C.:
Q. And nothing anyone had to sign off verifying in fact they had done that?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. And again "The pH standardization chart will

Page 66

include the standards for QC, check the deionized water and buffer solutions", that's new, I take it, as well?
MS. BUTLER:
A. It's new, but we used to always pH any solutions we made up and needed to be pH'd, we'd pH them when they were made up.
CHAYTOR, Q.C.:
Q. But again, there was no documentation that that was taking place?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. And here it looks like we have a chart, ancillary products, prepared in house.
MS. BUTLER:
A. Yes, those came from Mount Sinai.
CHAYTOR, Q.C.:
Q. It's from Mount Sinai.
MS. BUTLER:
A. So, we either use--we just adopted some that looked very similar and started filling in--we used as many as we could after I came back. That's how we started off and then we started improving on it.

Page 67

CHAYTOR, Q.C.:
Q. And this is a temperature chart.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. So, did you adopt this or something similar to this? And this would be for your bath, water bath, your refrigerator, your oven and so on.
MS. BUTLER:
A. I think, yeah, at first we used to do it individually and then we combined it all together.
CHAYTOR, Q.C.:
Q. To something like this?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And on the form, would have the appropriate temperatures, was that done?
MS. BUTLER:
A. Yes, daily.
CHAYTOR, Q.C.:
Q. So, your form right now would have the appropriate temperatures should be?
MS. BUTLER:

Page 68

A. Every day someone is supposed to go in and check there, the temperatures of everything before they start their work.
CHAYTOR, Q.C.:
Q. And then you date it and you sign your initials.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And is that every technologists? So, the fact that Mary Butler did it, does that mean that Ken Green doesn't have to do it?
MS. BUTLER:
A. If you were cutting, you might--you'd be the one that would check. I'm not sure how they do it now, but when I was in the lab, if I was cutting, I'd check my oven, my water bath and whoever, maybe was on the stainer might make sure, the refrigerator.
CHAYTOR, Q.C.:
Q. So, the rule was that if you used it, you had to check the temperatures.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:

Page 69

Q. Okay. And in terms of then once you brought this chart in and filling the chart out, even if someone else had signed that they had done it for the same date, you would still redo it.
MS. BUTLER:
A. We had a habit of--even though we didn't document--I think basically in our minds we just had a habit of checking temperatures as we did things. Temperatures or whatever was to make sure our equipment was doing what it was supposed to do before we used it.
CHAYTOR, Q.C.:
Q. Did you ever work in the lab after this form was brought in or form of this nature?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And so if you signed and there was a date with your initials on it or if you saw Mr. Green had done, the same date with his initials, would you then, in any event, still check, for example, the water bath?
MS. BUTLER:
A. I'm thinking yes because I know if you look at some of our forms, you'd see--like sometimes,

Page 70

for a whole week we might, say, oh, we're checking one temperature, we might as well do it all and have it done.
CHAYTOR, Q.C.:
Q. And those are daily though, aren't they?
MS. BUTLER:
A. Daily, yes.
CHAYTOR, Q.C.:
Q. And this form here in terms of detection systems, lot numbers, expiry date, received, open, acceptable, the lab technicians -
MS. BUTLER:
A. This one here, I don't this we utilized that one.
CHAYTOR, Q.C.:
Q. Didn't use that?
MS. BUTLER:
A. I don't think so.
CHAYTOR, Q.C.:
Q. Did you have a similar form for keeping track of lots numbers of antibodies?
MS. BUTLER:
A. Well, the machine, our Ventana machine kept track of all of, and we could print it all off. And then when everything came in, it was

Page 71

kept, but I can't remember other that our machine keeping track of all of this for us. But now we have a binder called an ancillary binder, that's other things.
CHAYTOR, Q.C.:
Q. And here's an antibody -
MS. BUTLER:
A. It's taking a while now to--when you stop using something, you start losing your abilities, right. Your antibody, I remember that one.
CHAYTOR, Q.C.:
Q. Antibody, you remember this one. And did you adopt a similar form to that? That's at page nine of the exhibit.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. So, this would keep track of the lot number of the antibody?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. The expiry date, date received, date opened.
MS. BUTLER:

Page 72

A. Yes.
CHAYTOR, Q.C.:
Q. And what would acceptable mean?
MS. BUTLER:
A. Your pH, whether or not your pH was in the right range.
CHAYTOR, Q.C.:
Q. Okay.
MS. BUTLER:
A. This is all the information about the antibodies.
CHAYTOR, Q.C.:
Q. Antibody technical information.
MS. BUTLER:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And did you create a similar sheet or start using a similar sheet as this?
MS. BUTLER:
A. A similar sheet.
CHAYTOR, Q.C.:
Q. And this is a document control immunohistopathology laboratory record of quality issues.
MS. BUTLER:

Page 73

A. Issues, yes.
CHAYTOR, Q.C.:
Q. So, I take it this would be similar to any correction action.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And the correction action log which was adopted.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. And this is their worksheet which would be similar, I take it to the worksheets we looked at for you?
MS. BUTLER:
A. Yes, we have our own. We still kept--you didn't change your worksheets?
MS. BUTLER:
A. No, we just kept our own variation of our worksheets.
CHAYTOR, Q.C.:
Q. So, the format that we've looked at here in P-2190, that's still the format that's used.
MS. BUTLER:

Page 74

A. With the Ventana, you'd see a sheet of paper sort of divided up, up in four. Run one and then everything--run two -
CHAYTOR, Q.C.:
Q. Okay. So, those, of course, were for the DAKO, is 48.
MS. BUTLER:
A. The 1 to 48 were DAKO.
CHAYTOR, Q.C.:
Q. Okay. Other than your time then at Mount Sinai, did you also receive any further training in IHC?
MS. BUTLER:
A. Other than going to some conferences.
CHAYTOR, Q.C.:
Q. And I believe you went to a conference in Arizona in 2006.
MS. BUTLER:
A. I went to the NHS, yes.
CHAYTOR, Q.C.:
Q. Okay. And had you ever gone to such a conference or course before?
MS. BUTLER:
A. Not the NHS, no.
CHAYTOR, Q.C.:

Page 75

Q. Had you ever been to any conference or course on IHC?
MS. BUTLER:
A. When I'd go to the national conventions with our--our own national conventions. I'd attend whatever IHC lectures and that they offered.
CHAYTOR, Q.C.:
Q. And over the course of your career, how often was that?
MS. BUTLER:
A. I've been to a fair--I was trying to remember when I started going, but I can't, but I'd say I've been to at least ten.
CHAYTOR, Q.C.:
Q. At least ten?
MS. BUTLER:
A. At least ten of them.
CHAYTOR, Q.C.:
Q. And how many of those would have dealt with IHC?
MS. BUTLER:
A. That I can't remember because I'm not sure my date line of when I started.
CHAYTOR, Q.C.:
Q. And the one that you went to in 2006, did you

Page 76

find that to be beneficial?
MS. BUTLER:
A. Very.
CHAYTOR, Q.C.:
Q. Okay. And tell us about that, what did you think about that course?
MS. BUTLER:
A. I just thought I would have--my reaction was I would have loved to have a lot of this information years ago.
CHAYTOR, Q.C.:
Q. Ms. Butler, I asked you about the reviews by Dr. Banerjee and Ms. Wegrynowski and you said that you recall being in the lab with Ms. Wegrynowski while she was there. Did you actually get to meet Dr. Banerjee?
MS. BUTLER:
A. I actually met him, yes.
CHAYTOR, Q.C.:
Q. Okay. And did he ask any questions of you? Did you have any discussions with him?
MS. BUTLER:
A. No, he just walked into the lab and just did an overview of the lab.
CHAYTOR, Q.C.:

Page 77

Q. Okay. So, he didn't ask anything of you. You just met him to say hello kind of thing.
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. You weren't part of his review process?
MS. BUTLER:
A. No, just when a strange person comes in your lab, you sort of ask who they are.
CHAYTOR, Q.C.:
Q. And did he ask to see any particular equipment or what did he do while he was there?
MS. BUTLER:
A. I can't remember other than just meeting him and someone was showing him around and they did whatever.
CHAYTOR, Q.C.:
Q. And do you remember who was showing him around?
MS. BUTLER:
A. No, I can't remember now. It might have been one of the pathologists, but not really sure.
CHAYTOR, Q.C.:
Q. Okay. And after, in particular, Ms. Wegrynowski's review, did you ever see her

Page 78

report?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. Were you ever told the outcome of her review?
MS. BUTLER:
A. Only lately.
CHAYTOR, Q.C.:
Q. Only lately?
MS. BUTLER:
A. Only lately.
CHAYTOR, Q.C.:
Q. Okay. And when you say lately, do you mean since the Inquiry has started?
MS. BUTLER:
A. Since the Inquiry started, yes.
CHAYTOR, Q.C.:
Q. Okay. And have you then, in that time period since seen her reports, she actually did two reports.
MS. BUTLER:
A. Yes, I've seen them since.
CHAYTOR, Q.C.:
Q. Okay. And did you meet with her when she came back the second time in 2006?

Page 79

MS. BUTLER:
A. I can remember her coming back, but I can't remember actually doing--I don't know if she even came in the lab much the second time. So, I thought the second time coming back might have been just to--well, I guess she wanted to see if we were doing any of the information, but I can't remember a lot about her second visit.
CHAYTOR, Q.C.:
Q. Okay. And having recently reviewed her reports, what's your impression? What did you think of her findings and recommendations?
MS. BUTLER:
A. Well, she found that we had started a lot of the recommendations.
CHAYTOR, Q.C.:
Q. On her second review.
MS. BUTLER:
A. There were still a few and there's a few there, so I can't remember a lot of them, but some we had gone right ahead with it and did them. And some are still--I think they're working on it more since I've come out of the lab. But I think there's a few that might be

Page 80

outstanding.
CHAYTOR, Q.C.:
Q. Though in terms of what she recommended, did you take issue with it? Did you find that it was beneficial, helpful? What did you feel overall about her recommendations?
MS. BUTLER:
A. Overall, we used a lot of her recommendations. So, I would say we found it very helpful and we moved our IHC lab in that direction.
CHAYTOR, Q.C.:
Q. If we could just look at P-1576, please? This was a meeting September 24th, 2003 of the Division of Anatomical Pathology Pathologists meeting, page three I believe it is of the exhibit. Under "laboratory technical quality", it's written, "this was discussed with Barry Dyer, Terry Gulliver and Dr. Cook". The discussion included the technical quality of the slides, error of labelling, floater and others. Some of these issues have been documented. Dr. G. Ejeckam has given a lecture on quality assurance of the laboratory which was attended by one senior technologist. This program is available for all the lab

Page 81

technical staff at a suitable time, if interested. A log book is available in the reporting room to record all problems".

Back in September 2002, so this would have been the same year that you worked with Dr. Ejeckam on the ER/PR and other stains, are you the senior technologist who attended is lecture on quality assurance?

MS. BUTLER:

A. I think that I was. I remember being to one lecture when he had all the techs, he wanted all the techs to show him different things that could happen to different slides, you know, different scenarios on what could happen to slides, and just different things that would happen in your pathology lab.

CHAYTOR, Q.C.:

Q. So, in this process he actually showed you slides and what could happen to the slides.

MS. BUTLER:

A. Yes. And I think this is--I remember having that and I'm wondering if this is the same one.

CHAYTOR, Q.C.:

Q. Do you recall being the only person at the

Page 82

lecture?

MS. BUTLER:

A. Yes, because I don't think Barry was around at the time.

CHAYTOR, Q.C.:

Q. Okay.

MS. BUTLER:

A. And I was interest in what he, usually when they had something to say, I used to like to hear it, just to see if what I was thinking was the same way they were thinking on different issues like blocks and slides and stuff like that.

CHAYTOR, Q.C.:

Q. Okay. And do you recall some of the things that Dr. Ejeckam pointed out at that time?

MS. BUTLER:

A. Just different things in cutting, how slides would look if you cut them wrong, or if you didn't go deep enough or if you didn't cut a good section how it wouldn't be--not good for the pathologist for reading, things like that.

CHAYTOR, Q.C.:

Q. And was there any issue of cutting a block which had tumour and normal tissue? Was there

Page 83

any issue of that discussed?

MS. BUTLER:

A. No, this was just an overall lecture on any block or what could happen to anything in the lab.

CHAYTOR, Q.C.:

Q. And was there any attention paid, in this lecture, to external controls or -

MS. BUTLER:

A. Oh no.

CHAYTOR, Q.C.:

Q. Nothing like that, it was cutting.

MS. BUTLER:

A. This is just basically your basic lab, your start of your histology lab, nothing to do with IHC.

CHAYTOR, Q.C.:

Q. Okay. Nothing to do with IHC?

MS. BUTLER:

A. No.

CHAYTOR, Q.C.:

Q. Okay. Earlier, I believe yesterday and you've mentioned today that you're not, in the last few months, have not actually been in the lab working. And instead, you've been working for

Page 84

Mr. Dyer in helping organize and catalogue slides, that kind of thing. So, that's been for, I take it that was for getting the retests ready and sending off to Mount Sinai.

MS. BUTLER:

A. Yes, and different -

CHAYTOR, Q.C.:

Q. That would have been concluded though. So, I'm just wondering what it is that you would have been doing in the last few months.

MS. BUTLER:

A. Just mostly getting slides ready to go out when other people requested them, like the different lawyers, I guess, wanted materials.

CHAYTOR, Q.C.:

Q. And so other than organizing and cataloguing the slides, have you been doing any data management or any record keeping, anything like that?

MS. BUTLER:

A. Trying to keep all my ER/PR things so that I know how to--if I had to go look for other things, I'd know where to find them and just keeping all this in order. So, when they want some further testing sent off to Mount Sinai

Page 85

to get it ready and keep it, so that they know where it's to.

CHAYTOR, Q.C.:

Q. I guess, I'm just trying to get a sense about exactly what it is you're doing. Did you run into any difficulties in trying to, for example, organize or retrieve slides? Did you have any problems?

MS. BUTLER:

A. Well, you find a lot of things missing out of our files.

CHAYTOR, Q.C.:

Q. Okay. So, you found slides missing?

MS. BUTLER:

A. You do find, you know, you do and then you have to go different routes. Generally, I'm pretty good at tracing things down.

CHAYTOR, Q.C.:

Q. And where did you tend to have to look to trace things down?

MS. BUTLER:

A. Well, like over the years we have a lot of research going on in our hospital. So, then you'd have to, you know, you take your blocks and they may have been gone missing from a

Page 86

research project, but then they may have been in a lab, but may have not been returned to the files. So, you just have to sort of connect things to try to locate your blocks and slides.

CHAYTOR, Q.C.:

Q. Wouldn't there be a record of that? If somebody had taken blocks or slides, would there be a record that Dr. So And So has these blocks or slides?

MS. BUTLER:

A. Earlier years there wasn't and then we realized that with so much research ongoing, that we had to start informing them that they had to put notes in the files saying where things were. So, certain years there wasn't.

CHAYTOR, Q.C.:

Q. So, when did that start? When did the notes start appearing, around what year?

MS. BUTLER:

A. I'm not going to be able to tell you a date line. I remember one of the date lines might be Dr. Robb, when Dr. Robb was with us, his lab started doing it.

CHAYTOR, Q.C.:

Page 87

Q. Okay. And other than for research purposes, did you find that there were pathologists coming and taking slides or blocks or requesting that things be taken?

MS. BUTLER:

A. Over my lifetime with pathology, they'd come in and take things. Then later on in years we started getting more of a handle on it and realizing that we should know where everything is in our files and we're responsible for our files. So, we should know, but it's something that needs a, still needs work to it because we don't have good slide storage.

CHAYTOR, Q.C.:

Q. And while you were trying to catalogue and organize the slides and blocks, were you still encountering people coming and requesting to remove slides and blocks?

MS. BUTLER:

A. No, mostly us then. It would come down to mostly me and a couple of other, like Judy Quinlan, I saw her name mentioned and another worker at St. Clare's, he'd retrieve things.

CHAYTOR, Q.C.:

Q. Were you able to track down everything?

Page 88

MS. BUTLER:

A. I don't think we accomplished everything, no.

CHAYTOR, Q.C.:

Q. So, there were still slides missing?

MS. BUTLER:

A. Yes.

CHAYTOR, Q.C.:

Q. And blocks missing?

MS. BUTLER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. And if we could look please at P-0114? And just before I leave that, the idea though of slides or blocks being missing, we know, of course, blocks were able to produced for everyone who was retested obviously because retests were carried out on those individuals. Are you aware of any patient that hasn't been retested because no block could be found for that person?

MS. BUTLER:

A. No, I'm not aware of it.

CHAYTOR, Q.C.:

Q. So, it's no concern in that regard?

MS. BUTLER:

Page 89

A. No.
CHAYTOR, Q.C.:
Q. Okay. We have here P-0114 and this is a document entitled feedback from immunohistochemistry technologists, May 29th, 2007. And this would be a little bit over a year ago. Do you remember having any discussions with anyone as to any concern you may? If you just want to read down through the types of concerns, expressed concerns related to co-ordination of quality assurance activities for the entire immunohistochemical service and expressed concerns regarding communication and then there's sub-bullets under those. Does this look familiar to you, Ms. Butler?
MS. BUTLER:
A. It doesn't look familiar right now.
CHAYTOR, Q.C.:
Q. Sorry?
MS. BUTLER:
A. It doesn't look familiar right now.
CHAYTOR, Q.C.:
Q. Okay. And the issues that are discussed there, do you recall, for example, do you

Page 90

recall Heather Predham ever coming to you and asking for any feedback?
MS. BUTLER:
A. Heather Predham, I can remember her being in the lab. I can remember being present when she was there, but I can't remember her actual -
CHAYTOR, Q.C.:
Q. So, do you recall the purpose of her visit to find out whether or not there were any concerns of the technologists, with respect to, in particular, those two issues?
MS. BUTLER:
A. They're talking there about recommended training for technologists re: controls--never ever heard of that.
CHAYTOR, Q.C.:
Q. So, it says, "the vast majority of IHC SOPs were not signed off. The ER/PR one had been completed. No knowledge of feedback re: external proficiency testing, no knowledge of overall action plan or status of same". Were these any concerns that you had at the time or would have voiced?
MS. BUTLER:

Page 91

A. May 29th, October -
MS. BUTLER:
A. "Recommended training for technologists re: controls has not occurred. Overall feeling that QA activities for ER/PR are in place, but not the remaining IHC service".
MS. BUTLER:
A. No, there's nothing coming to mind right now.
CHAYTOR, Q.C.:
Q. Okay. So, if someone expressed those concerns, you don't believe it was you?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. And then "concerns regarding communications, requests for project type work are coming from numerous sources, clinical chief, IHC chief without explanation or knowledge of manager". Was that ever a concern of yours?
MS. BUTLER:
A. A lot of times in our lab we'd find out that Barry wasn't notified of anything and we'd always be concerned that well, he was our boss and that he should know about things before we'd move ahead with things.

Page 92

CHAYTOR, Q.C.:
Q. And "requests for documentation are coming in without the knowledge of manager". Were you aware that or was that happening, to your knowledge?
MS. BUTLER:
A. "Requests for documentations", I'd sort of have to know what documentations in order to -
CHAYTOR, Q.C.:
Q. To be able to answer that.
MS. BUTLER:
A. - be able to answer it.
CHAYTOR, Q.C.:
Q. "ER/PR retesting started without the knowledge of manager and manager was informed by the technologist after the fact". Were you aware that happened?
MS. BUTLER:
A. I'm thinking yes, because I always had the feeling that Barry was never kept--he was never informed by people involved. They'd always come to us and just demand things of us and then we'd wonder why he didn't know.
CHAYTOR, Q.C.:
Q. So, who would be coming and demanding things

Page 93

of you without Barry knowing?
MS. BUTLER:
A. I think it was Dr. Denic maybe, Dr.--the people that were involved with the retesting, I think.
CHAYTOR, Q.C.:
Q. With the retesting. And you didn't feel that Barry was kept in the loop on that?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. And so there were some concerns expressed. Did Mr. Dyer speak to the technologists about that or express concerns about that to you?
MS. BUTLER:
A. I'm sure he did. I'm sure he just said he should be informed, would like--it would be good for him to be informed. And as a rule, we wouldn't--if we found out something, we would ask him and if we wanted to order an antibody, that they'd come in say they'd want it ordered and we would say, have you asked Barry because he was the one that looked after the budgeting and just like to know. Nothing was ever refused, but still like to know.

Page 94

CHAYTOR, Q.C.:
Q. Okay. And if we could look please at P-0046? And this Dr. Banerjee's first report in October of 2005. It's just a section here under "other system flaws observed" which deals with communication and he refers to it at number five, "disconnect between laboratory program director, division manager, clinical site chief and laboratory director in decision making. The organizational charts indicate a complete separation of reporting structures into technical and clinical streams with no matrix, cross reporting between technical and medical leadership. This leads to frustration and resentment on both sides, lack of communication and lack of accountability and lack of buy in" and it goes on from there. So, in your experience, were you--is that the type of issue that you're referring to? Did you observe or have the impression that there was frustration or resentment between the technical and medical sides of the laboratory medicine program?
MS. BUTLER:
A. There was something going on there, but like,

Page 95

it was more, like where Barry wouldn't be informed of things. He'd find out at a later date, a lot of times through us. We'd say, did you know about this and he'd say no. But for a while you didn't know what side--you know, who you should be working for. Are you supposed to do exactly--you know, like several doctors may be coming in at one time and doing things and no one to go to. That would be our issue, mostly no one to go to, to iron out a situation. And then with Barry not being informed of different things that our lab would be asked to do and then we'd go and ask him if we would still go ahead with it, but he wouldn't know about it, that type of thing. If that's what you're asking.
CHAYTOR, Q.C.:
Q. So in terms of having one person that you could direct any questions or concerns to, one pathologist, you were lacking that for a lot of the time period?
MS. BUTLER:
A. For a lot of the time. Dr. Ejeckam was my biggest memory after Dr. Khalifa.
CHAYTOR, Q.C.:

Page 96

Q. Okay. So Dr. Khalifa, then Dr. Ejeckam, and then there was a bit of a void in terms of the one person that you could go to for assistance in terms of a pathologist?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. Ms. Butler, from a technical point of view, we know now that there were quite a number of patients who had changed results when they were retested at Mount Sinai, and there were some patients, as we saw as well in the work that you were doing back in 2003, who had changed results. From a technical point of view, can you offer any explanation as to how that could have occurred?
MS. BUTLER:
A. I don't -- how it would have occurred? Well, we just did -- we did our procedures, and when we weren't notified of -- you know what I mean, when someone was helping us to get through it, like when Dr. Ejeckam tried to help us, things were fine because you felt you had someone to help you, but after that and we ran a procedure or anything and no one

Page 97

commented on anything or -- our positive control which we could site and see was positive, and then send it to the pathologist. If they didn't come back with any problems, we couldn't fix anything not knowing that there was a problem.

CHAYTOR, Q.C.:

Q. So no one brought any issue -- if there was an issue with your process, nobody brought that to your attention?

MS. BUTLER:

A. No.

CHAYTOR, Q.C.:

Q. And other than you indicated yesterday Dr. Ejeckam on one occasion indicated his internal control wasn't working, did any other pathologist ever make such a concern known to you?

MS. BUTLER:

A. I'm thinking no because I just remember Dr. Ejeckam because he'd point out -- and he had a habit of he'd take you to his office and he would show you areas of slides with -- mainly with other IHCs, he'd point it out and say, and then he'd talk to you as if sometimes you

Page 98

had to -- well, he talked to you on a doctor level, and then he'd realize he wasn't -- you couldn't connect a lot, you could just only connect with what you understood about your stain and what you read in your data sheets, but not having been trained in the basis of it, you couldn't go on. So they had a habit of talking over our heads, I guess, and not realizing they were doing it.

CHAYTOR, Q.C.:

Q. Okay, and was that true of Dr. Ejeckam as well?

MS. BUTLER:

A. Dr. Ejeckam could be like it at times, and then he was a little bit difficult to understand as well. You had to get past his dialect type thing.

CHAYTOR, Q.C.:

Q. I'm just about done. There's one point, though, I'd like to clarify with you, and 2173 -- if we could have 2173, please. These are the requisition or request forms for the time period of 2003 that we looked at yesterday and again today, and -- okay, around page five, please, Registrar. Some of those forms we

Page 99

looked at have indicated on them "Checked by Dr. Ejeckam", and this one again on April 28th says, "Checked by Dr. Ejeckam". This one is checked by Dr. Ejeckam, and into -- these are all April 28th, they're all checked by Dr. Ejeckam. Again April 30th. Then May 2nd, "Checked by Dr. Ejeckam", and this May 2nd doesn't indicate that it's checked by Dr. Ejeckam, but this one here is checked by Dr. Ejeckam for the same date. Again for the same date, "Checked by Dr. Ejeckam". The same with that one at page 23, page 24, same date, "Checked by Dr. Ejeckam". I think I've covered that with you yesterday, but what did you understand Dr. Ejeckam was checking?

MS. BUTLER:

A. I would say -- well, I would say he was checking our controls plus his own internal controls, I would say.

CHAYTOR, Q.C.:

Q. And even though he's not the pathologist involved in these cases, he was looking at all the slides?

MS. BUTLER:

A. He was looking at all the slides -- I would

Page 100

say he was because when we were testing there, he did have cases from all over.

CHAYTOR, Q.C.:

Q. Yes. We'll see that that goes on, May 5th, goes on for some time.

MS. BUTLER:

A. So I'm thinking he didn't want anything to go out at that time until he checked them in that period of time until he was satisfied that everything was happening the way he wanted it to happen.

CHAYTOR, Q.C.:

Q. And then as of May 7th, I don't see that recorded any more. May 8th, we do have a "Checked by Dr. Ejeckam", but not May 7th. So why is it that sometimes he'd be checking and other times not?

MS. BUTLER:

A. I think he was checking all the time. It's just sometimes I was --

CHAYTOR, Q.C.:

Q. And you recorded some of them and you didn't others?

MS. BUTLER:

A. And some I didn't.

Page 101

CHAYTOR, Q.C.:
Q. And do you know how long that went on through 2003?
MS. BUTLER:
A. That he was checking those?
CHAYTOR, Q.C.:
Q. Yes.
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. Okay, and so if it's written on the bottom, he definitely checked it, but even if it's not written there, he may have still checked the case?
MS. BUTLER:
A. Yes.
CHAYTOR, Q.C.:
Q. So May 26th, for example, it's not written there, but he may still have been checking your --
MS. BUTLER:
A. He may still have checked it, yes, he may, and then it may have come to a point that he was satisfied with it and he might have let it go to the actual reading pathologist.

Page 102

CHAYTOR, Q.C.:
Q. I'm just going to check my notes here for a moment, Ms. Butler. Maybe we could go back, please, to -- there's one other thing on that exhibit, 2173 at page 13. On dates such as this, and this is one of the cases in which there was a retest, and it's written "ER/PR checked by Dr. Ejeckam". Was that, do you know, and I think it says something "Include controls, please" maybe or -- you've got two different dates there, the test run on April 30th and again on May 2nd. Did Dr. Ejeckam check both dates or was it just one?
MS. BUTLER:
A. I'm thinking maybe just -- maybe just one maybe, but I'm not really sure.
CHAYTOR, Q.C.:
Q. So you can't tell us what that would mean, whether he checked April 30th or May 2nd or both?
MS. BUTLER:
A. No.
CHAYTOR, Q.C.:
Q. Those are all my questions, Ms. Butler, unless there's anything else that you think would be

Page 103

helpful for the Commissioner to know, if there's anything I haven't asked you, but that it is relevant to looking into this matter and will be helpful for the Commissioner.
MS. BUTLER:
A. No, I think a lot of things were covered.
CHAYTOR, Q.C.:
Q. Is there anything else you can think of?
MS. BUTLER:
A. I can't think of anything right now.
CHAYTOR, Q.C.:
Q. And I'm sure some of the other lawyers may have some questions for you, so thank you.
MS. BUTLER:
A. Thank you.
COMMISSIONER:
Q. Ms. Brazil?
MS. BRAZIL:
Q. I have no questions for this witness, Commissioner.
COMMISSIONER:
Q. Thank you. Mr. Browne?
MR. BROWNE:
Q. No questions, thank you, Commissioner. Thank you, Ms. Butler.

Page 104

COMMISSIONER:
Q. Mr. Pritchett.
MR. PRITCHETT:
Q. No questions for this witness.
COMMISSIONER:
Q. All right then. Ms. Newbury.
MS. MARY BUTLER, EXAMINATION BY MS. JENNIFER NEWBURY
MS. NEWBURY:
Q. Good morning, Ms. Butler. My name is Jennifer Newbury. I represent the Canadian Cancer Society, Newfoundland and Labrador Division. I just have a couple of questions for you this morning. First of all, about your visit to Mount Sinai Hospital for training in January of 2006, I understand this morning that you indicated what your understanding of the purpose of that visit was, and I'm wondering, upon your arrival at Mount Sinai, did you have any different appreciation as to what you would be doing while you were there? Were the activities that you did at Mount Sinai consistent with what you understood you would be doing?
MS. BUTLER:
A. I just went for -- it wasn't for training. It

Page 105

was just observation.
MS. NEWBURY:
Q. Observation, okay, and were you involved in starting to develop standard operating procedures, actually sitting down to do that exercise while you were still at Mount Sinai?
MS. BUTLER:
A. It was -- I was thinking I may have been going to start, but I didn't, and Ken Green started doing the SOPs.
MS. NEWBURY:
Q. Okay. That was when you returned there, but was there any effort while you were at Mount Sinai to start to, I guess, begin that exercise?
MS. BUTLER:
A. I just read over a lot of theirs to get ideas.
MS. NEWBURY:
Q. And had you ever been involved in doing anything of that nature before going to Mount Sinai?
MS. BUTLER:
A. No, it was a new venture for me.
MS. NEWBURY:
Q. And before you left to go to Mount Sinai, did

Page 106

you think that you would at any point, either during that trip or when you returned, did you think that you would ever be involved in writing standard operating procedures?
MS. BUTLER:
A. I was thinking it was a possibility.
MS. NEWBURY:
Q. Okay. Is that something that came into your mind yourself or did anyone indicate that that would be?
MS. BUTLER:
A. No, but I guess where they considered I was senior technologist, maybe I would like to do it.
MS. NEWBURY:
Q. Okay, and I understood from Ms. Wegrynowski when she was working with you -- I understood from her evidence that she thought that you were starting to develop standard operating procedures there, but there was some indication --
MS. BUTLER:
A. At her hospital?
MS. NEWBURY:
Q. At Mount Sinai.

Page 107

MS. BUTLER:
A. She had wanted me to go in the first day I was there to try to write things, and, like, the SOPs and that. I wasn't comfortable doing that. I just wanted to observe and come back and try to develop it, but I think I realized it was out of my scope and I had to get a lot of help in computer things, I needed more --
MS. NEWBURY:
Q. Okay.
MS. BUTLER:
A. More update.
MS. NEWBURY:
Q. She'd indicated that she thought it was a computer issue and I think she indicated Microsoft Word was something you weren't familiar with?
MS. BUTLER:
A. Yes, I needed to get some computer --
MS. NEWBURY:
Q. Was that the primary impediment or was there any concern about the actual writing process itself?
MS. BUTLER:
A. No, I just needed to learn to deal with paper

Page 108

things, and I wasn't good at a paper trail, so I would have had a learning curve there to accomplish.
MS. NEWBURY:
Q. I think you had indicated when the Ventana equipment was brought in to Eastern Health, you also had a little uneasiness about using the computer?
MS. BUTLER:
A. I've always had an uneasiness with computers all my life. It's been a stumbling block for me until I get comfortable with learning the procedures.
MS. NEWBURY:
Q. Sure, and you did develop that comfort level after a couple of weeks or months?
MS. BUTLER:
A. Very much so, yes.
MS. NEWBURY:
Q. And I take it that given the timing that you were in high school, and that period of time that you attended trade school, that computers were not being taught as part of the curriculum at that time?
MS. BUTLER:

Page 109

A. No.
MS. NEWBURY:
Q. Have you ever had any computer training provided to you or have you taken your own courses since commencing work?
MS. BUTLER:
A. No. I've had some -- you could attend any you wanted to in the hospital.
MS. NEWBURY:
Q. Okay.
MS. BUTLER:
A. I've had basic when the computers came in at the hospital and things like that, but mostly applying to your own individual stations that you're working on.
MS. NEWBURY:
Q. Okay, just for the --
MS. BUTLER:
A. I even have a computer home now that I tossed aside, just not interested in it right now.
MS. NEWBURY:
Q. Okay, and so you think that you could have done more computer courses through the -- through Eastern Health?
MS. BUTLER:

Page 110

A. It wouldn't have been a problem.
MS. NEWBURY:
Q. Okay, it's just something that you didn't particularly have an interest in?
MS. BUTLER:
A. No.
MS. NEWBURY:
Q. And given the nature of your position, do you think more familiarity with the computers would have been beneficial to you, or do you think you had a comfort level learning what you needed to know?
MS. BUTLER:
A. No, I just liked to learn what I needed to know on a need to know basis.
MS. NEWBURY:
Q. And looking back now on your training session or your observation session, I guess, at Mount Sinai Hospital, would you have any recommendations as to how that experience might have been improved for you or was it, you know, a totally successful experience for you? Do you have any tips or recommendations for what future technologists might do?
MS. BUTLER:

Page 111

A. I would have liked to -- I would have been able to work more with her SOPs if she had to be a little -- I wasn't allowed to take any of her SOPs, I had to develop my own.
MS. NEWBURY:
Q. Okay.
MS. BUTLER:
A. I think if I had to have copies -- some hospitals will let you have their SOPs and then you can sort of make it as a project and work with it, and then adapt it to your own hospital, but I wasn't given that.
MS. NEWBURY:
Q. So if you could have taken that and worked on it in your own time and space --
MS. BUTLER:
A. Time -- I could have done it that way.
MS. NEWBURY:
Q. Okay, and is there anything else about the experience that you might have found useful?
MS. BUTLER:
A. I found very useful with the other parts of the lab. I went to PA, and looking at their PA programs, and looking at the other part of their labs. They were good.

Page 112

MS. NEWBURY:
Q. And when the testing resumed at Eastern Health in about February, 2007, re; the testing for ER/PR, did you have any involvement in that at all?
MS. BUTLER:
A. I'm having a problem because I -- at some point, I just decided to help run the lab. I knew how to run the lab, but Ken Green took over most of the things in the lab.
MS. NEWBURY:
Q. Okay, and was that -- I had understood from your evidence earlier that it might have been later on in the fall of 2000 (sic.) that that happened?
MS. BUTLER:
A. I came out of the lab when the new people came in.
MS. NEWBURY:
Q. Uh-hm.
MS. BUTLER:
A. So I was still there, but I still think I was involved more with the cutting of the cases, running the machines, so that Ken and Les could be freed up to do other issues.

Page 113

MS. NEWBURY:
Q. Were you aware -- I guess, just from being in the vicinity of Ken Green and his work regarding the testing that had resumed in February, 2007, you were aware of that, I take it?
MS. BUTLER:
A. I'm pretty well sure I should have been.
MS. NEWBURY:
Q. Were you aware of any quality assurance testing involving Mount Sinai during that period of time?
MS. BUTLER:
A. Mount Sinai? I'm going to say no. There's nothing coming to mind right now.
MS. NEWBURY:
Q. Okay. Thank you, those are all the questions I have.
COMMISSIONER:
Q. Thank you. Ms. Taylor?
MS. TAYLOR:
Q. No questions, Commissioner.
COMMISSIONER:
Q. Mr. Pike?
MR. PIKE:

Page 114

Q. No questions.
COMMISSIONER:
Q. Mr. Simmons?
MR. SIMMONS:
Q. Commissioner, it's about time for the break. I'm not sure if I'll have any questions at all, but --
COMMISSIONER:
Q. Do you want to take the break to think about it?
MR. SIMMONS:
Q. Okay.
COMMISSIONER:
Q. All right. We'll take the morning break.
(BREAK)
THE COMMISSIONER:
Q. Mr. Simmons?
MS. MARY BUTLER, EXAMINATION BY MR. DANIEL SIMMONS
MR. SIMMONS:
Q. Thank you, Commissioner. Ms. Butler, I have only one thing that I wanted to ask you about, and we'll just bring up, for reference, Exhibit P-2190, please? These were the worksheets that you went through in some detail with Ms. Chaytor, and they begin on

Page 115

April 9th, 2003, and I understand from your evidence that they represent testing that was done by you at Dr. Ejeckam's direction in April, May and into June of 2003, and I'm not going to go through these in any more detail, but I observed, looking through them, that there appear to be worksheets there for, at one or more days, from five consecutive weeks, starting in the week of the 9th of April and in each of the four weeks following that and you told us before, I believe, that normally there was a rotation of technologists from doing the immunohistochemical work to the grossing bench and into the general lab. Now in 2003, was that rotation normally something that was being done at that time?
MS. BUTLER:
A. That was our normal rotation, but I'm thinking that seeing there was an issue arising that they usually stayed with one technologist.
MR. SIMMONS:
Q. Okay.
MS. BUTLER:
A. So that would be less--the less people involved, the less reporting to do. So with

Page 116

one person, then you keep things more consistent.
MR. SIMMONS:
Q. Okay, and we've heard that, at this time, at the beginning of April '03, was when Peggy Welsh left?
MS. BUTLER:
A. She was starting--she never left until the end of that month.
MR. SIMMONS:
Q. And Les Simms was new?
MS. BUTLER:
A. Yes.
MR. SIMMONS:
Q. And Ken Green had been there since sometime in 2002?
MS. BUTLER:
A. Yes.
MR. SIMMONS:
Q. So do you know whether or not, during this five-week period when you were doing this IHC testing, do you know whether Mr. Green rotated into the immunohistochemical lab at any point in that time period?
MS. BUTLER:

Page 117

A. I'm thinking not, because I'm thinking that I was put there to do the work. Someone asked me to do the work.
MR. SIMMONS:
Q. So that it's--would it be fair to assume then that it's most likely that during this period in which Dr. Ejeckam was directing the testing, that you were probably the only technologist in the lab doing the IHC testing at that time?
MS. BUTLER:
A. Yes.
MR. SIMMONS:
Q. Okay, fine. Thank you very much.
MS. BUTLER:
A. Thank you.
THE COMMISSIONER:
Q. Thank you, Mr. Simmons. Is there anything arising?
CHAYTOR, Q.C.:
Q. No, nothing arising.
THE COMMISSIONER:
Q. All right. Thank you very much, Ms. Butler, for your assistance.
MS. BUTLER:

Page 118

A. Thank you.
THE COMMISSIONER:
Q. Yes, we have another witness ready?
COFFEY, Q.C.:
Q. Yes, Commissioner, Dr. Daniel Fontaine.
THE COMMISSIONER:
Q. All right. I think they've gone to get him.
COFFEY, Q.C.:
Q. Yes.
DR. DANIEL FONTAINE, SWORN, EXAMINATION BY BERNARD COFFEY, Q.C.
REGISTRAR:
Q. Would you please state and spell your complete name for the Commission?
DR. FONTAINE:
A. Daniel Fontaine, D-A-N-I-E-L F-O-N-T-A-I-N-E
REGISTRAR:
Q. Thank you.
COFFEY, Q.C.:
Q. Now, Doctor, I'm going to ask you to--I'm going to have to ask you to do something that's perhaps out of character for you, and that is to raise your voice.
DR. FONTAINE:
A. Speak up.

Page 119

COFFEY, Q.C.:
Q. Okay, because you're competing with the sound of the air conditioning here.
THE COMMISSIONER:
Q. And you won't like it if we don't have any of those machines.
DR. FONTAINE:
A. Okay. I can understand why. Thanks.
COFFEY, Q.C.:
Q. So your name is Daniel Fontaine. I take it, Doctor, you're a physician?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. If we could, please, Commissioner, I'm going to ask that certain exhibits be entered. Two of them, I'm going to ask, that had otherwise been put in to be held for now, I anticipate that they will go in afterward, after lunch, the two that I'm going to ask to hold, but in the meantime, if we could put in, please, Exhibits P-2330 and then 2332 through 2337 inclusive, and 233--well, no, that's it then, yes.
THE COMMISSIONER:

Page 120

Q. Okay. So it's Exhibits 2330?
COFFEY, Q.C.:
Q. Yes, and -
THE COMMISSIONER:
Q. 2332 through to 2337?
COFFEY, Q.C.:
Q. Inclusive, thank you.
THE COMMISSIONER:
Q. Entered, thank you.
EXHIBIT ENTERED AND MARKED P-2330
EXHIBITS ENTERED AND MARKED P-2332 THROUGH P-2337
COFFEY, Q.C.:
Q. Thank you, Commissioner. If we could bring up, when you're ready, Registrar, Exhibit P-2330, please? Doctor, I understand that this is your--this document, it's a redacted, but this is your curriculum vitae?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Okay, Doctor, I'm going to ask you, please, to outline for the Commissioner your educational and professional background?
DR. FONTAINE:
A. Okay. In 1985, I entered a diploma program of

Page 121

cytotechnology and became a lab technologist, practised in New Brunswick for several years. I then returned to school, went to University of New Brunswick where I was working on a Bachelor's Degree. Then I was accepted into medical school at Memorial, finishing in 1998. I then went on to Halifax to commence a five-year residency program in anatomical pathology.

COFFEY, Q.C.:

Q. And you finished that in?

DR. FONTAINE:

A. In 2003.

COFFEY, Q.C.:

Q. And Doctor, since 2003, what have you been doing?

DR. FONTAINE:

A. I've been practising at the Health Care Corporation or Eastern Health in Newfoundland with several interruptions of doing some locum work in New Brunswick.

COFFEY, Q.C.:

Q. And Doctor, I understand that you're a member of the--or a fellow of the Royal College of Physicians and Surgeons of Canada?

Page 122

DR. FONTAINE:

A. That's correct.

COFFEY, Q.C.:

Q. And you became so in 2003?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Doctor, in your career before becoming or going to university to become and eventually end up as a physician, what did you do before?

DR. FONTAINE:

A. I was a technologist, a cytotechnologist, which is in the realm of diagnostic cytology.

COFFEY, Q.C.:

Q. A cytotechnologist?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And could you briefly outline for the Commissioner what that involves?

DR. FONTAINE:

A. It's primarily involved with detection of cancer. The majority of our work is with PAP smears, probably comprises approximately 80 percent of what we do. The remainder is what

Page 123

we call non-gynecological specimens, again, different cancers and involving with their diagnosis.

COFFEY, Q.C.:

Q. And that's cytology?

DR. FONTAINE:

A. That's cytology, yes.

COFFEY, Q.C.:

Q. Now as a--then, in your training as a physician, particularly your training as a pathology--during your training as a pathology resident in Halifax, did you acquire any particular training in relation to cytology, compared to your fellow physicians?

DR. FONTAINE:

A. Not so much additional training, because I had training prior to going into that field, but there was a mandatory three-month rotation in cytology. I did complete a two-month elective here in Newfoundland in my residency training as well, in cytology.

COFFEY, Q.C.:

Q. Doctor, so I gather that you have a particular interest in the cytology aspects of pathology?

DR. FONTAINE:

Page 124

A. Correct.

COFFEY, Q.C.:

Q. And you've been involved in that since, in particular since finishing your residency program?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. What I'd like to ask you about is your exposure to immunohistochemistry. First of all, if you can recall what, if any, exposure you would have had as a medical student, first of all, as an undergraduate medical student?

DR. FONTAINE:

A. Undergraduate medical student, I would say I knew about immunohistochemistry as a cytotechnologist, but -

COFFEY, Q.C.:

Q. Yes, because you happened to be a technologist.

DR. FONTAINE:

A. - only for that, because of that training. As far as a medical student, it would only be if I was to ask a question related to that and I would not have been so inclined.

Page 125

COFFEY, Q.C.:
Q. And you trained at the medical school at Memorial University between 1994 and 1998?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, and you did, as you've indicated, a residency from 1998 through, I gather, 2003?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. Was that connected with Dalhousie University's medical program?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Based in Halifax?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And would that involve exposure to hospitals other than in Halifax?
DR. FONTAINE:
A. Yes. I spent a three-month rotation in St. John, New Brunswick, and I also did a six-

Page 126

month elective here in St. John's.
COFFEY, Q.C.:
Q. In relation to--I want to ask you then about in the period from '98 through 2003, your residency program in pathology. What, if any, exposure did you have to immunohistochemistry then?
DR. FONTAINE:
A. As part of the training in Halifax, we had a half day in pathology, if you will, where special topics relating to different aspects of pathology would be discussed. As part of that, we did have Dr. Geoffrey Rowden. He was a basic science researcher who was looking into immunohistochemical techniques and methods. So he would have given us several one-hour lectures on the basics of immunohistochemistry.
COFFEY, Q.C.:
Q. So several one-hour lectures on the science?
DR. FONTAINE:
A. On the science behind, yes.
COFFEY, Q.C.:
Q. And he would have been connected with Dalhousie University?

Page 127

DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Did you have any other exposure to immunohistochemistry?
DR. FONTAINE:
A. As part of our sign out in pathology, we would often be ordering immunohistochemistry as part of our learning and training experience.
COFFEY, Q.C.:
Q. And when in your residency program would that sort of ordering of the tests begin and how would the sign out occur?
DR. FONTAINE:
A. It's actually from day one, as soon as you came across a case. Whether you would actually be ordering it yourself or you would be discussing with attending pathologists and you'd have a discussion relating to if immuno could be helpful with a case. So more or less right from day one.
COFFEY, Q.C.:
Q. And that would be as, I take it, as you came across cases?
DR. FONTAINE:

Page 128

A. Correct.
COFFEY, Q.C.:
Q. If a particular IHC test was thought to be useful or potentially useful, it would be ordered?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Either by yourself as a resident or you would watch an attending physician?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. A senior resident or a pathologist, in fact, order it?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And presumably come to some understanding about why it's being done?
DR. FONTAINE:
A. Why are you ordering this, yes.
COFFEY, Q.C.:
Q. Doctor, was there any other--was there any formal training, other than what you've

Page 129

described, in relation to immunohistochemistry? Like what actually goes on in the immunohistochemistry lab or the laboratory concerning immunohistochemistry? I appreciate you had been a technologist yourself.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. I'm asking you, kind of leaving that aside and looking back on it, what, if any, exposure as a resident in pathology would you have to the IHC processes in the lab itself?

DR. FONTAINE:

A. Short of the discussions that you would have with the pathologist and the different issues--because again, Dr. Rowden would be speaking to the basics, again as part of those half-day presentations, immuno would be discussed in relation to particular subjects. So how immuno could help you with there. So those would be sort of the formal. There'd be a lot more informal present--or talks, if you will, corridor chats with technologists and having those discussions. But for as far as formal

Page 130

processes, it would be more or less limited to those academic half-day presentations.

COFFEY, Q.C.:

Q. Doctor, then throughout your residency then, as time went on over the period, would you be exposed to--or how would you, if at all, be exposed to, from what you would understand to be a technologist's perspective, the problems associated or potential problems associated with IHC testing? You're in kind of a unique situation as a former technologist.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. But as a resident, how, if at all, would you become aware of the problems that technologists might be having doing IHC staining or processing in providing appropriate slides for yourselves as physicians? Would you ever become aware of that, and if so, how?

DR. FONTAINE:

A. Again, through discussion with the technologists themselves. If you found a particular issue, you could go and have that

Page 131

discussion. There would often be quite open discussion with the attending pathologists and they may ask you, as part of your training, to go and discuss it with the technologist.

COFFEY, Q.C.:

Q. In particular, in relation to the Commission, we are interested, of course, in ER and PR IHC processes. When you started your residency in Halifax, what process was being utilized there to ascertain the ER and PR status of breast tumours?

DR. FONTAINE:

A. It was immunohistochemical techniques.

COFFEY, Q.C.:

Q. And in Halifax at the time, do you recall which, if any particular lab was doing the IHC testing in that area?

DR. FONTAINE:

A. It was the lab that, the VG lab essentially, because they had amalgamated their lab services to one lab for Halifax. So it was all being done on site.

COFFEY, Q.C.:

Q. In the one building?

DR. FONTAINE:

Page 132

A. Yes, one building.

COFFEY, Q.C.:

Q. So I'll ask you then, in terms of ER and PR, do you recall your initial exposure to that and how you learned about it as time went on? If you can just tell the Commissioner what you recall about it?

DR. FONTAINE:

A. Again, when I first started training in Halifax, Dr. Penny Barnes, who was the breast pathologist, had just returned from Nottingham, England, from fellowship training. So she had additional training in breast. So we would often have, again, these sessions and she would be presenting some of these sessions and discussing issues particular to ER/PR. Again, if you were selected to be signing out with Dr. Barnes, because she would get more of the breast cases. Again, the way that the practice was in Halifax, there was subspecialty preference streaming, if you will with cases. So there would be preference given to breast cases to Dr. Barnes. So you knew if you were signing out with Dr. Barnes, you would tend to see more of these ER/PR cases.

Page 133

COFFEY, Q.C.:
Q. Did you have occasion to do so?
DR. FONTAINE:
A. Yes, I did.
COFFEY, Q.C.:
Q. And how much, in terms of the time frame that that might involve? How often would you have been exposed to signing out cases with Dr. Barnes?
DR. FONTAINE:
A. It would probably depend on the rota, depending on how many residents are there and how many staff pathologists were there as well, and again the availability of Dr. Barnes. Now again, I should state that other pathologists were signing out ER/PR as well, but I felt that I concentrated on what Dr. Barnes was telling me, looking at that as being the most recent information.
COFFEY, Q.C.:
Q. And then are you able to give the Commissioner any kind of sense of how many ER and PR cases you would have been involved in as a resident?
DR. FONTAINE:
A. As a resident, because that would have been

Page 134

over the course of four years, it would range in the hundreds, like couple of hundred cases, I would say.
COFFEY, Q.C.:
Q. Of?
DR. FONTAINE:
A. Of ER/PR.
COFFEY, Q.C.:
Q. ER/PR
DR. FONTAINE:
A. Breast cancer cases, yes.
COFFEY, Q.C.:
Q. And what, if anything, do you recall about being told or taught or at the time, I take it, you would also, if you were so inclined, read about yourself -
DR. FONTAINE:
A. Oh yes.
COFFEY, Q.C.:
Q. - the strengths and weaknesses of that procedure, the potential pitfalls, things to look out for, how would--what do you recall about that?
DR. FONTAINE:
A. I would come across that--it depended--in

Page 135

talking with Dr. Barnes, it was a different thing when you talked to different pathologists. Different pathologists had different views on the reproducibility of immunohistochemistry, and even more so when it came to ER/PR because you could get some differing results if you were to repeat, even on the same block, as has been discussed in the course of the Inquiry, and that was well known amongst pathologists. So it was one of these things that it wouldn't be unexpected to see, and again, when we consider the interpretation as well, as being fairly loose, if you will.
COFFEY, Q.C.:
Q. Loose in what sense?
DR. FONTAINE:
A. Interpretative, more or less the standards. You were not counting cells. There were other areas in pathology where you would actually count cells and give percentages. Where in ER/PR, you would more or less eyeball the amount of tumour that is staining and then give a percentage from that end.
COFFEY, Q.C.:

Page 136

Q. Could you just explain to the Commissioner then, the differences between what you were doing in ER/PR and cell counting?
DR. FONTAINE:
A. Cell counting actually didn't apply. It would apply more to counting for mitotic figures. Again, not so much for immunohistochemistry. I've not seen another immuno that is so specific that you would count cells. So I use that as a comparative that is something else that we would use in histology, not so much in immuno. So again, it would be more looking for mitotic counts, we would actually count a number of cells, you'd count a hundred cells and then you would give a percentage from there, or protein high power fields.
COFFEY, Q.C.:
Q. And ER/PR, perhaps you could just explain then to the Commissioner, by the time you finished up in Halifax, finished your residency, what was your understanding of the appropriate way to approach ER and PR?
DR. FONTAINE:
A. That it was necessary to report ER/PR on every case of breast cancer and that it would

Page 137

determine whether a patient would be eligible for Tamoxifen or not. My training was you would report a percentage, that you would not determine whether it was positive or negative, beyond that, you would always tend to report the percentages.

COFFEY, Q.C.:

Q. So, for example, in your senior year as a resident, I take it in fact you were a chief resident -

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. At one point. As the chief resident, if you ordered an ER and PR for a breast cancer patient, how would you go about choosing it? Could you perhaps just describe for the Commissioner what you were taught in Halifax as to the appropriate approach to take, like literally step by step, what would you do?

DR. FONTAINE:

A. So essentially once we would receive--do you want me to start from the grossing?

COFFEY, Q.C.:

Q. Yes.

Page 138

DR. FONTAINE:

A. So essentially once we receive the gross, depending on the type of specimen, it may need orientation to that and depending on the specimen itself. Once that was determined, there would be a description given, it would be fixed if necessary, and again described again, and if any special procedures needed to be undertaken, they would be done. Then we would select areas for sampling. Important to include tumour and adjacent tissue.

COFFEY, Q.C.:

Q. Adjacent normal tissue?

DR. FONTAINE:

A. Normal tissue or what appeared to be normal tissue.

COFFEY, Q.C.:

Q. Yes.

DR. FONTAINE:

A. So then those slides would be handed off and processed, we would receive the slides the next day. Following, they would be cut, stained and then we would receive them for interpretation. Once we would look at the slides, we would select an appropriate block,

Page 139

which would have an internal control and select that block for -

COFFEY, Q.C.:

Q. And these slides are H&E slides?

DR. FONTAINE:

A. These are H&E slides, so selecting from that H&E slide, we would pick the one block that would have internal control and that would be selected for estrogen and progesterone staining.

COFFEY, Q.C.:

Q. And then what would happen?

DR. FONTAINE:

A. That would be sent for staining, then we would receive that, and then there would be an interpretation. Again, do you want me to speak to the resident -

COFFEY, Q.C.:

Q. Yeah, how would you go about the--yes, if you would please?

DR. FONTAINE:

A. Right, so in both times, as a more junior resident, what would happen is you would be sitting with the staff person and discussing the case. So you would be looking at the

Page 140

ER/PR and making a percentage determination from there and discussing some particular issues. Again you would look at the controls to see if the--external controls and the internal controls had worked to validate the run and the tissue itself. Then we'd have a discussion as to, well, what percentage do you think this is? What percentage do you think this is? So there'd be a bit of guess work, you would try to guess what the pathologist was going to say, so you'd hedge your bets.

COFFEY, Q.C.:

Q. This is as a junior -

DR. FONTAINE:

A. This is as a junior resident, so you're sort of trying to, you want to be in the ballpark, if you will. And then as you become more senior, you then do it on your own, so you're actually looking at the slides, you'll order the stains, examine the slides yourself, create a report and then hand it to the staff pathologist, who then would come back and tell you if they have made any corrections to that.

COFFEY, Q.C.:

Q. Now in doing this or arriving at a percentage

Page 141

in your senior residency, what physical and/or mental processes would you go through to determine that?

DR. FONTAINE:

A. I'd be looking at the tissue -

COFFEY, Q.C.:

Q. You'd get the stained slides back.

DR. FONTAINE:

A. Right, so I now have the slides, so I'd look at them under the microscope and my tendency was to look at them at low power, objective, and get a sense of, okay, did the stains work? So you want to make sure that your internal control and your external controls have actually worked.

COFFEY, Q.C.:

Q. And so, they work if what happens?

DR. FONTAINE:

A. If they're staining brown and there's nuclear staining, so again, when we think of immunoperoxidase, the pathologist who had this sort of imposed on them, if you will, like to refer to them as brown stains. You may have heard of this through the process of the inquiry. Essentially that is just saying

Page 142

they're labelled with a brown chromogen, so it does not tell you what the stain actually is, and then beyond that, you need to know where the antigen is localized. And it's very important with ER/PR. As to my mind, this was the first stain that I remember being an exclusive nuclear stain and this was one thing that I found with pathologists, again, this was relatively new. I don't know if it was common knowledge because we would have discussions and I would see some pathologists interpreting cytoplasmic staining as being positive.

COFFEY, Q.C.:

Q. For ER/PR?

DR. FONTAINE:

A. For ER/PR in Halifax. It wasn't common, but it would happen. They would say, because again, that would shift the percentages. They would see some cytoplasmic staining and say that was positive. Then we'd have a discussion as to, well, I've been told that it's only nuclear.

COFFEY, Q.C.:

Q. Dr. Barnes had told me -

Page 143

DR. FONTAINE:

A. Dr. Barnes says, exactly.

COFFEY, Q.C.:

Q. Go ahead, Doctor, so you'd be looking, as you told the Commissioner, you were trained to look for the staining of the controls nuclear staining, brown staining of the external controls and the internal control tissue.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. What would you then do, assuming, I take it that both stained.

DR. FONTAINE:

A. Now that I've recognized that both stained, so I'm comfortable that I can interpret this stain. I would then look at the entire tumour from that end and see how much of this tumour is staining. Again, keeping in mind that there are some pit falls because you can get antibody trapping, that's not actually true staining, if you will, so you're always, edge artifacts and all these things, so you're always sort of thinking is there a preference to certain area of the tumour itself where you

Page 144

will see more of the clones, or is it a diffused weak positivity, et cetera, et cetera.

COFFEY, Q.C.:

Q. Spread throughout the tumour tissue.

DR. FONTAINE:

A. Spread throughout the tumour and all those things, and then from that, then you would make a determination as to what percentage of these nuclei are actually staining.

COFFEY, Q.C.:

Q. Were you taught any particular method to go about doing that?

DR. FONTAINE:

A. No, it was more or less eyeballed, best to use the entire field, the entire tumour. Again, when we're talking fields, I would go to low power and try to make an assessment of overall how much of this tissue was actually staining with this antibody.

COFFEY, Q.C.:

Q. When you say go to low power, what actually physically is that?

DR. FONTAINE:

A. Right, because as you use the microscope, you

Page 145

have different objectives, so if you look at a microscope, there are these turning wheels, if you will, so you can look at tissues at different levels of magnification. So these objectives correlate back to levels of magnification. A two times or four times magnification is what we call low power; a ten or twenty is medium power and a 40 is a high power examination. So basically using those different fields. So what we would say was go to the lowest power objective and you can get a sense of how much of this bigger overall view, if you will. Sometimes you can pick up a tissue and just look at it and say this is going to be positive, but then you still need to firm that it is localized to the nucleus and that it's not cytoplasmic staining.

COFFEY, Q.C.:

Q. You can't just see that with your eyes?

DR. FONTAINE:

A. You can't just see it without a microscope.

COFFEY, Q.C.:

Q. And then low power, I take it you're seeing more of the tumour?

DR. FONTAINE:

Page 146

A. Correct.

COFFEY, Q.C.:

Q. And as the power increases, you're seeing a narrower or smaller and smaller area of the tumour?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. Doctor, what were you taught in Halifax about any situation where the external control, from your perspective, did not stain?

DR. FONTAINE:

A. If the external control did not stain, that run was invalid.

THE COMMISSIONER:

Q. I'm sorry, I -

DR. FONTAINE:

A. Sorry was invalid.

COFFEY, Q.C.:

Q. And what would then happen?

DR. FONTAINE:

A. That would be process to repeat.

COFFEY, Q.C.:

Q. And I take it the technologist would be requested to repeat.

Page 147

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. And would they be advised that -

DR. FONTAINE:

A. They would know because once they would receive that, they would say, well there's already one ordered on this, because they had a process of being able to know that there was already an ER/PR ordered on this case.

COFFEY, Q.C.:

Q. So if you saw an external control, for your ER/PR case, and it didn't work, you would send it -

DR. FONTAINE:

A. I would send it back for a repeat.

COFFEY, Q.C.:

Q. Repeat. And they understood that, for the whole process again, to create the ER and PR slides?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. Do you recall, Doctor, do you recall that happening at all?

Page 148

DR. FONTAINE:

A. In Halifax?

COFFEY, Q.C.:

Q. In Halifax, yes, external controls did not stain?

DR. FONTAINE:

A. It did happen, yes.

COFFEY, Q.C.:

Q. Would it be, do you recall, was it a common place or -

DR. FONTAINE:

A. Not a commonplace thing, so it's not exceptional, but I wouldn't say it was one of these exceptional rare events, but it would happen.

COFFEY, Q.C.:

Q. And did you ever become aware while you were there of any explanations for why, like yesterday's external control didn't stain for you? Would it be explained to you afterwards as to why that had come about?

DR. FONTAINE:

A. Not specifically, we would more or less, look, something must have gone wrong with the process, as I'm sure you have heard, there are

Page 149

a number of steps, so instead of triggering a mass investigation with a rare event, what we would do is, it's simpler to just repeat it and if it did work on the next time, then we were comfortable that obviously one of those steps did not work, but we didn't know which one it was. But it was, again, a rare event, but if we did see it as a commonplace issue, then it would require investigation.

COFFEY, Q.C.:

Q. And the internal controls, I've asked you about the external control, what about internal controls if they didn't stain for a particular case? What, if anything, would you do then?

DR. FONTAINE:

A. The same thing, it would be repeated.

COFFEY, Q.C.:

Q. And if it came back the second time?

DR. FONTAINE:

A. As negative?

COFFEY, Q.C.:

Q. Yes, as negative.

COFFEY, Q.C.:

Q. Then there would be a question of, okay, this

Page 150

would be more in line to ask more questions now. This is a repeated negative, sometimes what we could then do is actually pick another block, thinking that perhaps this fixation-- this is a fixation issue with this block in particular, so we would often just go to another block and see is it something unique to this block.

COFFEY, Q.C.:

Q. Doctor, thinking back on your residency training, did that occasionally happen, that it wouldn't stain the second time?

DR. FONTAINE:

A. The second time would be exceptional. I mean, I have come across it, but I can count on one hand the number of times that would have happened, and not only to myself, but again, there would be discussion as a group when that happened repeatedly.

COFFEY, Q.C.:

Q. If an internal control for a particular block, internal controls failed the second time, that would occasion discussion, as it were amongst -

DR. FONTAINE:

Page 151

A. That would trigger more investigation.

COFFEY, Q.C.:

Q. Do you recall what, if any, investigation in that regard revealed? Did you get an explanation as to why it had failed the second time?

DR. FONTAINE:

A. The time that I'm familiar with was actually, just as I mentioned, we picked another block and the internal control worked in that situation. So we ascribed it to being that block in particular obviously had some issue within that block itself.

COFFEY, Q.C.:

Q. Doctor, looking back on that particular instance that you recall and thinking back on the first two sets of slides, like the first one that failed, internal control and the second one, was there anything that you could see on the slide itself, like in the tissue that you could see on the slide that would alert you to, other than the fact that it hadn't stained appropriately--what you expected, was there anything else about the slide?

Page 152

DR. FONTAINE:

A. In that case in particular?

COFFEY, Q.C.:

Q. Yes.

DR. FONTAINE:

A. No. Thinking back, because to look at it morphologically or under the H&E slide, there wasn't anything in particular that made that slide look different than the other block and that was a bit of a mystery. What we figured it was, was potentially that that was not as well fixed, that it was more likely that it was not exposed to formalin.

COFFEY, Q.C.:

Q. As much as the other block -

DR. FONTAINE:

A. As the other block.

COFFEY, Q.C.:

Q. As the tissue in the other block.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. So, Doctor, if the internal control didn't stain as expected, I'll use the word "failed" okay, advisedly, would the entire run be

Page 153

redone or just that particular patient's?
DR. FONTAINE:
A. Depending on the external control has worked?
COFFEY, Q.C.:
Q. No, no, the internal control I'm asking about. The external control worked.
DR. FONTAINE:
A. The question then becomes has the external control worked.
COFFEY, Q.C.:
Q. Yes, if the external control worked, then you would just redo the single patients?
DR. FONTAINE:
A. As long as it was that single patient that was affected, because again, if all the other internal controls had failed -
COFFEY, Q.C.:
Q. In the other patients.
DR. FONTAINE:
A. In the other patients, then we have a problem. But if it was isolated to that one instance, no.
COFFEY, Q.C.:
Q. You would retest that one -
DR. FONTAINE:

Page 154

A. We're retest that one.
COFFEY, Q.C.:
Q. So we're clear, but if the external control failed -
DR. FONTAINE:
A. Then we have to repeat the run.
COFFEY, Q.C.:
Q. How many external controls would be run with a particular run?
DR. FONTAINE:
A. Again, that was, as much as the inquiry has heard, there's been change here, much like the same in Halifax, there was changes then as well, because when I first started, it was a batch control. There would be one case run with the entire batch, to validate the batch and then it came to the point where the pathologist wanted to see it on the slide. So it would actually be put on the slide itself.
COFFEY, Q.C.:
Q. Do you recall when that transition occurred to the external control tissue being put on the slide, on the patient slide?
DR. FONTAINE:
A. It was late in my training, but I can't speak

Page 155

to the specific times, but I would anticipate late 2000 to potentially mid 2002.
COFFEY, Q.C.:
Q. Well, Doctor, when there were--you had a problem with the external control not staining, would you have to record that? Document it?
DR. FONTAINE:
A. Myself?
COFFEY, Q.C.:
Q. Yes.
DR. FONTAINE:
A. I would not, no.
COFFEY, Q.C.:
Q. How would you then order a rerun?
DR. FONTAINE:
A. I would just reorder ER/PR and then often times what I would put in parenthesis is "repeat", so that, cluing off the technologists, but my impression was that the technologists would know it was a repeat. Again, when I first started training, they were batching estrogen progesterone from that point.
COFFEY, Q.C.:

Page 156

Q. So if the external control failed, you'd note it in your own head, but you wouldn't have to record it anywhere?
DR. FONTAINE:
A. No, it would just be recorded on the requisition asking for ER/PR retesting.
COFFEY, Q.C.:
Q. Would you says "external control failed" or -
DR. FONTAINE:
A. Sometimes I would, I can't say that I did it every time.
COFFEY, Q.C.:
Q. Sometimes you might note it and even if you didn't note it, was it your understanding that the technologists would assume the external controls failed or how would they know the difference between internal and external controls? I'm trying to get some sense of -
DR. FONTAINE:
A. Right, I think that as our knowledge developed, if you will, from these things and it was important for them to have feedback as well. And oftentimes they would come and ask you what was going on as well.
COFFEY, Q.C.:

Page 157

Q. Why the repeat.
DR. FONTAINE:
A. Why are you repeating this, because again, it was on their watch, if you will, they took pride in this and they wanted to know why, why was this happening.
COFFEY, Q.C.:
Q. And if the internal control on a patient's tissue, internal controls from your perspective failed, would you have to note that anywhere? Document that?
DR. FONTAINE:
A. No, again, the same process. I would be more inclined to notify them that the internal control, if the external control had worked, I would be more inclined to tell them that it was an internal control problem, because again, it was not a frequent event.
THE COMMISSIONER:
Q. In the days when the external control was on a separate slide -
DR. FONTAINE:
A. Yes.
THE COMMISSIONER:
Q. Was there some kind of a pre-examination of

Page 158

whether or not the external control had worked before it got to you, as a pathologist?
DR. FONTAINE:
A. Yes.
THE COMMISSIONER:
Q. So was that a technologist doing that or a head pathologist in a lab or a person who got the bad duty and had to do it that week or something?
DR. FONTAINE:
A. It was more or less the technologist would take a look at it and it would be available for the pathologist to review.
COFFEY, Q.C.:
Q. Was it documented anywhere, like when you would get your slides and the external control slide, would it be documented anywhere already that the external control worked?
DR. FONTAINE:
A. I'm not aware of there being a formal document, but I can't speak to that specifically, but -
COFFEY, Q.C.:
Q. Now, Doctor, the reporting of ER/PR during your residency, how were you taught to do

Page 159

that?
DR. FONTAINE:
A. The tendency was report a percentage and that was what I adopted as routine practice. You reported the percentage and you left the decision making then to the oncologist.
COFFEY, Q.C.:
Q. As to what they would make of -
DR. FONTAINE:
A. Make of that interpretation, correct.
COFFEY, Q.C.:
Q. So if, for example, if the percentage was zero, would you use zero?
DR. FONTAINE:
A. I may say negative, but I would expect that I would have used zero percent as well.
COFFEY, Q.C.:
Q. And if there was, so it would either be, meaning complete absence of nuclear staining.
DR. FONTAINE:
A. Correct, yes.
COFFEY, Q.C.:
Q. You would use either zero or negative to mean zero?
DR. FONTAINE:

Page 160

A. Correct.
COFFEY, Q.C.:
Q. And any other percentage figure, like one through a hundred would be just a percentage?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Doctor, in your residency, in your time in Halifax in your residency, how much interaction would there be on a routine basis between the pathologist and oncologist?
DR. FONTAINE:
A. We had--are you speaking specifically to breast?
COFFEY, Q.C.:
Q. Yes.
DR. FONTAINE:
A. There was a bi-weekly breast oncology group, if you will, where the oncologist and the pathologist would sit and discuss cases.
COFFEY, Q.C.:
Q. And was that during the whole time you were there?
DR. FONTAINE:
A. It more or less was initiated by Dr. Barnes,

Page 161

so it wasn't there when I first started, but I can't say when it actually started, but it was fairly early on in the process.

COFFEY, Q.C.:

Q. Yours and presumably shortly after she arrived.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. It would be instituted. From your perspective, were pathologists, if they run a rotation, expected to show up?

DR. FONTAINE:

A. As a general -

COFFEY, Q.C.:

Q. As a resident.

DR. FONTAINE:

A. As a resident, they were expected to show up, yes.

COFFEY, Q.C.:

Q. And what was your observation about the frequency of attendance of staff pathologists?

DR. FONTAINE:

A. It was more or less run by Dr. Barnes, but the attending pathologists would rarely, if ever,

Page 162

show up to that round.

COFFEY, Q.C.:

Q. So it would be Dr. Barnes as in effect the staff breast pathologist, in effect, the residents, pathology residents and oncologists?

DR. FONTAINE:

A. I should back up because there were other pathologists doing breasts as well, so Dr. McIntosh would show up as well from the pathology end, but for as far as the other pathologists, they would not attend regularly.

COFFEY, Q.C.:

Q. And what about the oncologists?

DR. FONTAINE:

A. The oncologists, again, it was a preference towards those treating breast cancers, so Dr. Rayson, Daniel Rayson would attend those rounds quite frequently.

COFFEY, Q.C.:

Q. During those bi-weekly meetings, would there sometimes be discussions of staining of the slides, if there were problems or perceived to be problems?

DR. FONTAINE:

Page 163

A. Not that I remember specifically, again, it would be more or less about different parameters with the cases, from that end. It would be more discussing the clinical end and then the pathology would present. Often times, we often look at pathology reports as being that's what it is, and it's never questioned beyond that. I think that's changing and as a result of this, we'll certainly be suspect.

COFFEY, Q.C.:

Q. Doctor, the technologists or any representative of technologists ever come to such meetings?

DR. FONTAINE:

A. I can't say--when I was there, I did not see a technologist.

COFFEY, Q.C.:

Q. Would there be, while you were resident, were there any kind of formal, semi formal routine meetings between the pathologists and the technologists?

DR. FONTAINE:

A. We did have occasional rounds involved with the technologists. The administration of the

Page 164

day was trying to get and foster relationships between the technologists and pathologists. Again, it would be more a single pathologist talking about their subspecialty with the technologist. So it wouldn't really be all pathologists and all technologists together, but it would be as that subspecialty group went through.

COFFEY, Q.C.:

Q. And in terms of IHC itself, was there anyone in particular in the Dalhousie program or the Halifax hospital system there, any particular pathologists or pathologist who, I mean, if you looked around, as it were, amongst you, everybody would agree that he or she is the go-to person for IHC or in fact was in charge of IHC?

DR. FONTAINE:

A. No individual was in charge of IHC. The IHC responsibility was more or less delegated to the subspecialty groups for their own particular interests. So if they had particular issues, they would take it up with the technologists performing immuno.

COFFEY, Q.C.:

Page 165

Q. So subspecialty groups, for example Dr. Barnes.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. If there was a breast pathology -
DR. FONTAINE:
A. If there was a breast issue.
COFFEY, Q.C.:
Q. A breast issue involving staining, HER2/neu, ER/PR and whatever else might be appropriate, it would be expected that Dr. Barnes, if there was a concern expressed or she had her own concern, would deal with the technologists?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And neuropathology, the same thing, I take it, in effect.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And any other subspecialty?
DR. FONTAINE:
A. Uropathology and, yes.

Page 166

COFFEY, Q.C.:
Q. In terms of the overall, IHC as kind of an overall--because we have now, Dr. Elms, and I'm thinking about the equivalent of Dr. Elms?
DR. FONTAINE:
A. Not in a formal sense as much as what we see here. There was one individual who was sort of the knower of all, so any time there was an issue in pathology, he would be consulted on anything because he was just one of these very well rounded individuals. But to say that he was the overseer of immunohistochemistry, no.
COFFEY, Q.C.:
Q. That wouldn't be.
DR. FONTAINE:
A. That would not be.
COFFEY, Q.C.:
Q. Doctor, if we could, please Registrar, exhibit P-1600. Now, Doctor, this is a--it's a document entitled "Eastern Health Pathologist Staff Turn Over" and it was revised July 10th, 2007 and your name is there, third from the top.
DR. FONTAINE:
A. Yes.

Page 167

COFFEY, Q.C.:
Q. You're listed as an incumbent, start date, June 19th, 2003 and the heading is "Termination Date". And there's a blank space, so was it June 19th, 2003 that you started here in St. John's as a staff pathologist?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And, Doctor, when you came to work in St. John's, where were you stationed, which hospital?
DR. FONTAINE:
A. Primarily at the Health Science site but with responsibilities at the Miller Centre where cytology is performed.
COFFEY, Q.C.:
Q. And when you came to St. John's, what technically was your position in the sense were you part of the medical school staff?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And who you actually associated with?

Page 168

DR. FONTAINE:
A. So I came in as the GFT, so as a university position, so I had responsibilities to the university and to the clinical practice as well.
COFFEY, Q.C.:
Q. And was there any understanding at that time as to the proportion, the division of responsibility or the amount of your time you'd spend doing each different -
DR. FONTAINE:
A. The way it was explained to me, it was a .8 appointment for clinical and a .2 appointment for teaching or university functions, if you will.
COFFEY, Q.C.:
Q. So that would be 80 percent of your time.
DR. FONTAINE:
A. 80 percent, clinical.
COFFEY, Q.C.:
Q. And 20 percent teaching?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Research.

Page 169

DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And was there any particular type of pathology that you were supposed to be engaged in?
DR. FONTAINE:
A. I was being groomed, if you will, towards cytology. When I came, there was no director for cytopathology, so they were more or less grooming me, if you will, so I can get my feet wet with the anticipation that I would take over as director in cytology.
COFFEY, Q.C.:
Q. Now did that happen?
DR. FONTAINE:
A. Yes, it did.
COFFEY, Q.C.:
Q. And when did you become director of cytology?
DR. FONTAINE:
A. I believe it was April 1st of 2004, so approximately 9 months into the position.
COFFEY, Q.C.:
Q. Now you were at the General Hospital site.
DR. FONTAINE:
A. Yes.

Page 170

COFFEY, Q.C.:
Q. You first started work there then, did you actually begin June 19th?
DR. FONTAINE:
A. It was shortly thereafter because there was an orientation, a hospital orientation and on the ground working, I'm sure, within that week.
COFFEY, Q.C.:
Q. Now, Doctor, do you recall--as it turns out, it just happens to be June 19th. If we could bring up, please, Exhibit P-0113? Now, Doctor, I'm going to ask you about a couple of these, but Dr. Ejeckam's memo actually to Terry Gulliver is dated June 19th, 2003, and the Commissioner has seen this before. And it's copied to Dr. Desmond Robb, Dr. Cook, Dr. Parai and Mr. Dyer. Sir, when you first arrived in St. John's in the summer of 2003 and went to work, this refers to--Dr. Ejeckam there is referring to, of course, concerns about IHC staining in St. John's and going back to April 4th, he would have suspended the usage for a period of time of these eight antibodies that are listed in the second line.
DR. FONTAINE:

Page 171

A. Yes.
COFFEY, Q.C.:
Q. Doctor, were you made aware of any of this when you first arrived in St. John's and the fact that this had been going on before you arrived?
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. And in fact, was almost concurrently going on looking at the last memo?
DR. FONTAINE:
A. Looking at the timelines, I mean, yeah. No, I did not know of these letters' existence.
COFFEY, Q.C.:
Q. Or the subject matter, I take it?
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Because it's one thing to have seen the memos or somebody actually speaks about the memos, which is one thing, but the actual subject matter, which is, for example, the April 4th, 2003 memo, the fact that Dr. Ejeckam had described these eight stains that remain

Page 172

"unreliable, erratic and therefore unhelpful for diagnostic purposes" as of April 4, 2003, by the time you arrived and really got going, perhaps by July of 2003, you'd be certainly into your job by then?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. There was no one at work talking about --
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Scuttlebutt kind of talking, you know, over coffee or whatever?
DR. FONTAINE:
A. No. No, not as the issue that it's presented as here.
COFFEY, Q.C.:
Q. Was there any discussion at that time in the summer of '03, in the fall of '03, that you heard or participated in involving the quality of the staining, IHC staining?
DR. FONTAINE:
A. Again thinking of it, IHC staining itself, it was an issue that was always discussed in

Page 173

Halifax, and it was discussed when I came here, and it's been discussed with colleagues as well that -- I just thought of it was just sort of your garden variety unhappiness with immuno, if you will. I didn't see it as being abnormal or particular to the St. John's lab.

COFFEY, Q.C.:

Q. So there was --

DR. FONTAINE:

A. I had heard -- there were pathologists, but pathologists talk about IHC all the time. It's one of these things that's shop talk, if you will. So it's sort of the low level -- not knowing about these letters, I didn't know the letters were written, but the discussions did not seem out of what I'd been exposed to in other places.

COFFEY, Q.C.:

Q. So what sorts of -- what sorts of things had you heard in Halifax, and again I take it you were hearing much the same thing when you arrived in St. John's?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Page 174

Q. The first, you know, say, six months you were here?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. What sorts of complaints or concerns would pathologists voice about IHC staining?

DR. FONTAINE:

A. Again much the issue that we spoke of with external controls, internal controls, that they wouldn't work, and it's one of these accepted practises. Sometimes the stains don't work. If you're looking for it, then just reorder and take it from there, but you would like -- you would feel much more comfortable if it was always working, and then you'd get a bit of a sense of uneasiness, if you will, when occasionally it doesn't work and you have to ask yourself, well, why didn't this work. Again if -- going back to the process, it could be any one of those steps, and you hope that it's a unique situation and you don't see trends that develop from that.

COFFEY, Q.C.:

Q. Do you know if in Halifax while you were a

Page 175

resident, they were keeping track of -- statistically keeping track of things?

DR. FONTAINE:

A. Not that I was aware of.

COFFEY, Q.C.:

Q. Now in St. John's when you arrived and throughout 2003, would there be discussion about fixation problems in relation to IHC staining?

DR. FONTAINE:

A. No more than what I was hearing in Halifax, if you will.

COFFEY, Q.C.:

Q. So from your perspective --

DR. FONTAINE:

A. I didn't see --

COFFEY, Q.C.:

Q. You spent four to five years in Halifax?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. And arriving in St. John's --

DR. FONTAINE:

A. And what I was seeing on the ground was no different than what I was experiencing in

Page 176

Halifax.

COFFEY, Q.C.:

Q. Doctor, this May 2nd, 2003 memo which begins at page two of P-0113, it's addressed to Pathologists, HSC, St. Clare's, and out of town hospitals from Dr. Ejeckam, the subject is ER/PR immunohistochemical stains, did you see this back in 2003?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. Have you since seen it?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And when would you have first seen this, do you think?

DR. FONTAINE:

A. I think it would have been perhaps at the time of my deposition.

COFFEY, Q.C.:

Q. Okay, when -- I take it when you were interviewed by the -- by myself and Ms. Chaytor?

DR. FONTAINE:

Page 177

A. Correct.
COFFEY, Q.C.:
Q. So, Doctor, having had a chance in 2007/2008, that time frame to review this, were you aware of -- you weren't aware of the memo, but were you aware of the contents of these sorts of things, these concerns about IHC -- I'm sorry, ER/PR stains? Were you familiar with this, the idea that there's concern possibly with delayed fixation, over fixation, under fixation?
DR. FONTAINE:
A. These would have been addressed in Dr. Rowden's lectures with immunohistochemistry.
COFFEY, Q.C.:
Q. Back --
DR. FONTAINE:
A. Back in my days of residency.
COFFEY, Q.C.:
Q. Your early residency?
DR. FONTAINE:
A. Correct.
DR. FONTAINE:
A. And, for example, paragraph two here, the fact that "ER/PR false negative results increase in

Page 178

core biopsies. Where possible, restrict the request to excision biopsies", would you have been aware of that?
DR. FONTAINE:
A. Not so much -- that's a controversial area.
COFFEY, Q.C.:
Q. And, I take it, there's differences of opinion with the results?
DR. FONTAINE:
A. There's differences of opinions with this, but I was aware that that did exist.
COFFEY, Q.C.:
Q. As a --
DR. FONTAINE:
A. As a potential confounding variable.
COFFEY, Q.C.:
Q. The reference to in paragraph three, "Check normal breast acini in your sections as internal controls", you were aware of that?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. From your residency days. Paragraph four, "In carcinoma of the breast, most PR positive tumours are also ER positive, however, 10

Page 179

percent of PR positive tumours are ER negative", and would you have been aware of that?
DR. FONTAINE:
A. Yes. I can specifically remember Dr. Barnes pointing that out, and I know it's a contention with a lot of breast pathologists in the ability to explain that. It does exist.
COFFEY, Q.C.:
Q. About the actual phenomena, and explaining the phenomena?
DR. FONTAINE:
A. Explaining it because the progesterone receptor works through the estrogen receptor, so there's a lot of people who've had the belief that that shouldn't exist, but it does, and we have to deal with that.
COFFEY, Q.C.:
Q. Here, Doctor, if -- so coming out of your training then, the idea that only one in ten breast tumours would show up as PR positive, ER negative?
DR. FONTAINE:
A. Right.

Page 180

COFFEY, Q.C.:
Q. Would you have been aware of that coming out of your training then?
DR. FONTAINE:
A. I don't know if I would have specifically known it was 10 percent. I knew it was a rare event.
COFFEY, Q.C.:
Q. Rare.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And that's more what I'm getting at, what actual percentage?
DR. FONTAINE:
A. Percentage, I just knew it was a rare event.
COFFEY, Q.C.:
Q. So as a pathologist then finishing your residency and coming to St. John's, when you would look or would order an ER/PR test and get the results, bearing in mind what you were seeing --
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:

Page 181

Q. From your perspective, would you compare that with kind of your expectations as to how common the result you had arrived at? For example, if you call a tumour PR positive, ER negative --

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. Would it cross your mind that this is a relatively rare tumour if it falls into that category?

DR. FONTAINE:

A. It would cross my mind because I knew it was an issue because it had been discussed several times in my training as to the phenomenon, and it was one of these things that I knew it was difficult to explain and an area of controversy in breast pathology, but I knew it did happen.

COFFEY, Q.C.:

Q. And so if you would come across a tumour result that fell into these kind of rare categories, this happens to be one of them?

DR. FONTAINE:

A. Correct.

Page 182

COFFEY, Q.C.:

Q. Another example, I'll use it with you now because we'll see it on the next -- actually going to the next page, ER positive tumours, paragraph seven.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And Dr. Ejeckam has listed tubular, mucinous, papillary, ductal low nuclear grade, and he has indicated to the Commissioner he should have included lobular.

DR. FONTAINE:

A. Lobular.

COFFEY, Q.C.:

Q. As well, lobular invasive.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. Doctor, if you saw -- again you had classified a tumour as tubular, and yet you were seeing it as ER negative, would that strike you as strange and, therefore, cause you to --

DR. FONTAINE:

A. It would strike me as strange, but I know it's possible, but again as a one event, no, it wouldn't trigger alarm bells, but if I saw that repeatedly, yes, it could trigger something might be going on here.

Page 183

COFFEY, Q.C.:

Q. I take it, in any case you'd be looking, though, at the external controls?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. And the internal controls?

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. Regardless of what --

DR. FONTAINE:

A. Exactly, because feeling that as long as the external and internal controls have worked, and this tumour is again negative, because it does happen. We do know that there is a certain population that do have this finding.

COFFEY, Q.C.:

Q. The idea that certain tumours, certain types of tumour will tend to be ER positive, were you aware of that during your residency?

Page 184

DR. FONTAINE:

A. Yes, because with the better differentiated tumours, if you will, the ones that look more like normal epithelium, if you will, they were known to be ER positive.

COFFEY, Q.C.:

Q. And so this information contained in paragraph eight, would you have been aware of that as a resident?

DR. FONTAINE:

A. Yes, and again there are exceptions to those rules. In medicine, we never make 100s or 0 percents.

COFFEY, Q.C.:

Q. Doctor, here in paragraph five, there's a reference to reporting ER/PR, several formulae are in the literature and he spells them out here.

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. ER positive, greater or equal to 5 percent, ER positive, 10 percent, ER positive, 1 percent, and then he refers to this consensus statement in 2000.

Page 185

DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Would you have been exposed to this sort of information in your residency?
DR. FONTAINE:
A. I was aware of it as part of my training, yes. I don't know about 2000, but I know it came up as part of my -- as I was going towards my exams, I became aware of that.
COFFEY, Q.C.:
Q. The idea that there were different views as to what constituted positivity?
DR. FONTAINE:
A. Definitely, yes.
COFFEY, Q.C.:
Q. From your perspective as a pathologist, if you're reporting percentages, did it matter?
DR. FONTAINE:
A. That was how I was trained, and this was exactly why Dr. Barnes was reporting percentages, and had that discussion.
COFFEY, Q.C.:
Q. Put down a percentage?
DR. FONTAINE:

Page 186

A. Put down a percentage and leave it to the --
COFFEY, Q.C.:
Q. And leave it to the oncologist to make up their mind?
DR. FONTAINE:
A. Correct, because it's probably going to keep changing.
COFFEY, Q.C.:
Q. The idea in paragraph six here, "Higher staining intensity does not reflect better results. This is a function of staining procedure and may alter. All cytoplasmic staining in ER and PR immunostain are to be considered as negative", and that last sentence you've already told us you were aware of that?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. How about the first two sentences?
DR. FONTAINE:
A. Oh, definitely. The higher staining intensity does not reflect better results. It's just -- it just speaks to the fact that you've coated it more, if you will, so it's just amplified

Page 187

the intensity.
COFFEY, Q.C.:
Q. And you would have been aware of that as a resident?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Doctor, in your training in relation to ER and PR testing, IHC testing, were there any particular things coming out of your residency that you understood you had to look for? I'm ordering an ER and PR test, and you've taken us through the external controls, internal controls, but in terms of were these type of tests susceptible to particular problems unique to them, and, for example if fixation is an issue?
DR. FONTAINE:
A. Fixation would -- it would be the same for all tissues because again that's paramount to the immunohistochemical process. If you don't have good antigen presentation, which is key to fixation, then you're not going to have good immunohistochemistry. So again if what you're looking for is not well presented, you

Page 188

won't find it.
COFFEY, Q.C.:
Q. Doctor, if we could, please -- and Doctor, you settled in in the middle of 2003 in St. John's. How much breast pathology would you be involved in?
DR. FONTAINE:
A. Breast was not really my area of sub-specialty because when I'd heard that Dr. Carter was coming, I was more than happy to show her anything I had related to breast. Coming out of residency, my primary interest was more in cytology. I was exposed -- it would probably constitute about two to three percent of practice, I imagine.
COFFEY, Q.C.:
Q. If you could just look back, please, at Exhibit P-1600. Doctor, here looking down this page is a listing of pathologists. Dr. Carter is the sixth from the bottom and it shows her start date here is August 16th, 2004?
DR. FONTAINE:
A. Yes, because I believe she actually started as locum before that.

Page 189

COFFEY, Q.C.:
Q. Before that?
DR. FONTAINE:
A. Yeah.
COFFEY, Q.C.:
Q. But when you learned then that she had taken a position here in St. John's, you understood she was a breast -- she had a sub-specialty in breast pathology?
DR. FONTAINE:
A. Right, I had recognized that when she was a locum.
COFFEY, Q.C.:
Q. And from your perspective, you were pleased, I take it, to have her here?
DR. FONTAINE:
A. Very much so.
COFFEY, Q.C.:
Q. If we could, please, Exhibit P-1576. Doctor, this is a -- that's an agenda, a Division of Anatomical Pathology pathologists meeting at the General Hospital site, September 24th, 2003, and, Doctor, these are the minutes themselves. Present are a number of physicians, including Dr. Ejeckam, Dr. Carter,

Page 190

Dr. Barron, Dr. Fontaine, yourself, and Dr. Parai. Could you tell the Commissioner then -- I take it that -- of course, this is September and you'd only arrived in June, what these sorts of meetings were about because we've seen a number of minutes of them over the years? What do these meetings involve? From your perspective, what were their purpose?
DR. FONTAINE:
A. So these are the site meetings, if you will, for the Health Sciences. So it's a chance for the pathologists to get together and discuss issues relating to the practice of pathology at the Health Sciences site, and a chance to update on any changes or any issues that might be coming up in the department.
COFFEY, Q.C.:
Q. And I take it that this -- were these routinely scheduled?
DR. FONTAINE:
A. Pretty --
COFFEY, Q.C.:
Q. Was there a set schedule or --
DR. FONTAINE:

Page 191

A. Not a set schedule per se, but they would come up as needed every couple of months.
COFFEY, Q.C.:
Q. And Doctor, the purpose then was to discuss, I think, I gather, anything connected with pathology within that site?
DR. FONTAINE:
A. Issues for that site, that's correct.
COFFEY, Q.C.:
Q. Now here I've noticed that Dr. Cook is not listed here. He would have been the clinical chief at the time?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. What, if any, involvement, you know, in that era, in your first year or two, or in fact, yes, in St. John's, what, if any, contact would you have with the clinical chief?
DR. FONTAINE:
A. He was available. So he would often be over at the Health Sciences site. So it was not uncommon to see him at least once a week over at our site.
COFFEY, Q.C.:

Page 192

Q. Would there be meetings or would just you'd run into him?
DR. FONTAINE:
A. You'd sort of run into him from that end, but if there were an issue, he was very approachable.
COFFEY, Q.C.:
Q. And I've noticed here, Dr. S. Parai was there?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Dr. Parai, I understand, was the site chief of the day?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. What, if any, interaction would you have with the site chief, in his capacity as site chief?
DR. FONTAINE:
A. I knew he was the site chief and if I had any issues I could bring them up with him.
COFFEY, Q.C.:
Q. And what sorts of things might -
DR. FONTAINE:
A. Again, much like the issues if I saw something

Page 193

that was of concern, like if I saw repeated negative internal control, I know that I could take it up with him or something to that effect.

COFFEY, Q.C.:

Q. And here I see, Dr. Ejeckam is listed here as well.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Doctor, I take it he was another staff pathologist?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Did you have any understanding that he had any particular interest in IHC?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And where did you first--when did you first learn that?

DR. FONTAINE:

A. I can't remember specifically, but--because when I heard that Dr. Ejeckam was coming,

Page 194

because again, through the process of recruitment, because I had done some training here, the clinical chief, Dr. Haegert, had mentioned that there was a pathologist coming from Dohar who had extensive experience and had an interest in immunochemistry as well.

COFFEY, Q.C.:

Q. Doctor, now the six-month, I think you said you did a rotation in St. John's?

DR. FONTAINE:

A. I did a rotation for six months.

COFFEY, Q.C.:

Q. Six months in St. John's?

DR. FONTAINE:

A. That's correct.

COFFEY, Q.C.:

Q. Do you recall when that was?

DR. FONTAINE:

A. That would have been 2002, June of 2002 to December of 2003.

COFFEY, Q.C.:

Q. Okay.

DR. FONTAINE:

A. Or 2002, I'm sorry, yes, so it was just six months.

Page 195

COFFEY, Q.C.:

Q. June '02 to December '02.

DR. FONTAINE:

A. June '02 to December '02.

COFFEY, Q.C.:

Q. The last half of 2002.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. Would you have done any ER and PR reporting at that time?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. During that time frame?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. This particular six-month rotation was for what?

DR. FONTAINE:

A. What I did was essentially look at--I was evaluating the lab with the consideration of coming here for employment. So what I did was two-month rotation at the Health Sciences site

Page 196

and then a two-month rotation at St. Clare's, and then a two-month rotation at the Miller Centre.

COFFEY, Q.C.:

Q. Now the ER and PR testing that you would have been exposed to in 2002 here in St. John's, do you recall anything about that, any problems associated with it, or anything coming to your attention?

DR. FONTAINE:

A. From what I saw from what I came from Halifax, what I was doing was no different than what I was seeing there.

COFFEY, Q.C.:

Q. So, and Dr. Haegert would have been the clinical chief--no, discipline chair?

DR. FONTAINE:

A. Exactly. I'm never sure of the exact titles, but I know that he was in transition at that time. So I think he was just leaving when I came in, in June.

COFFEY, Q.C.:

Q. So he would be clinical chief then. In fact, he was, because that was -

DR. FONTAINE:

Page 197

A. Right, and then Dr. Cook was coming in as acting.
COFFEY, Q.C.:
Q. And it was during discussions with Dr. Haegert you recall being told that there was a physician coming from Dohar?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Who had some experience with IHC?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And in what context would that have come up?
DR. FONTAINE:
A. I guess as a recruitment strategy perhaps, just saying about how there were constantly people coming here as well.
COFFEY, Q.C.:
Q. Trying to entice you, for example, or make it more -
DR. FONTAINE:
A. You could take it as that, I guess.
COFFEY, Q.C.:
Q. Dr. Haegert would be, in effect, saying to you

Page 198

"look, you know, it's not a bad place to work, and in fact, we do have a gentleman coming, a Dr. Ejeckam coming out of Dohar -
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. - and he knows a certain amount about IHC."
DR. FONTAINE:
A. And they knew him because in talking to people, he had worked within the system. So people knew who he was and people had good things to say about him.
COFFEY, Q.C.:
Q. And the idea that a particular pathologist might come with a demonstrated interest in IHC, would--why would that make it such a situation be more of interest to somebody like yourself?
DR. FONTAINE:
A. Don't think it was so much that he was IHC. It was that here's somebody who has a lot of experience, you can learn from, and that the department is going to benefit from his presence. So we're still able to recruit individuals. It wasn't really more or less--I

Page 199

think it was because there were a number of openings at the time and it was to say that here's what we are recruiting and we are actively recruiting, but not so much the fact that it was direct IHC. I was much more interested in that there was going to be a breast subspecialist present.
COFFEY, Q.C.:
Q. And why is that?
DR. FONTAINE:
A. Because of my experience with these issues, because I've known that this has always been a test that's been fraught with difficulties.
COFFEY, Q.C.:
Q. And you had known that from Halifax, your days in Halifax?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Now Doctor, looking at this particular--these minutes of September 24th, 2003, paragraph 3.2, "QA program. A final QA program will be completed soon after a final meeting with Dr. Cook and Barry Dyer. However, the present practice of mentioning the name of the

Page 200

consulting pathologist in the microscopic description will continue." Do you recall what this QA program was about? Like what was the state of the QA program when you arrived in St. John's? Perhaps that the easier way to deal with it. What, if any, quality assurance program was there in pathology here?
DR. FONTAINE:
A. There was subscription to--there'd be checklist samples whereby there's--and the American Society of Clinical Pathologists actually send specimen or--well, the cases, so essentially they'll send H & E slides out with a known reference diagnosis and then there'll be a selected--so it's unknown to the institution that it's sent to, and then we would sit and look at these slides and make a determination of what the response was. We'd send in our reply and then we'd get a fax back of what the accepted reply was. So that was ongoing. But other than that, I wasn't really aware of a full QA program.
COFFEY, Q.C.:
Q. And how about compared to Halifax, what you'd come out of in Halifax? Was there -

Page 201

DR. FONTAINE:
A. They were starting with a formalized QA program, where they would actually sit and review frozen section diagnosis per se. So again, they were at their infancy with QA as well.
COFFEY, Q.C.:
Q. Doctor, here, paragraph 4.1 on page three, there's a reference to "laboratory technical quality. This was discussed with Barry Dyer, Terry Gulliver and Dr. D. Cook. Discussion included the technical quality of the slides, error of labelling, floater and others. Some of these issues have been documented. Dr. G. Ejeckam has given a lecture on quality assurance of the laboratory which was attended by one senior technologist. This program is available for all the lab technical staff at a suitable time, if interested. A log book is available in the reporting room to record all problems."
So Doctor, I refer you to that because I take it then that at this meeting on September 24th, 2003, would you have gotten any sense that Dr. Ejeckam is in particular involved

Page 202

with IHC or the laboratory, you know, technical -
DR. FONTAINE:
A. My sense was that he was interested in IHC, more or less from the get-go, if you will, because I can't remember specifically when I first started, but I know that he certainly took the lead in IHC.
COFFEY, Q.C.:
Q. Exhibit P-1393, please? Doctor, this is a Division of Anatomical Pathology pathologists, General Hospital site pathologists meeting, the minutes of September 1st, 2004, and the listing of those present includes yourself.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And actually there are ten of you listed there, and ask you about was paragraph 3.6 on page three of the exhibit, and it says "HER2/neu, ER and PR immunostaining" and it's under the heading business arising, and it reads "Dr. D. Fontaine" which would be yourself, "did mention that Dr. Bev Carter, B. Carter, would like to review all the new

Page 203

HER2/neu, ER and PR immunostaining before returning to the reporting pathologist. Some members of the division expressed that this is unnecessary and they will continue reporting their own cases." Now Doctor, what can you recall about how this came up? How did this come up as -
DR. FONTAINE:
A. Well, Dr. Carter and myself had had numerous discussions about moving towards subspecialization. I had an interest in cytology. She had a breast fellowship. So we had several discussions regarding this, and I thought it would be worth mentioning, after discussion with Dr. Carter, that we should float this idea and see what the response would be.
COFFEY, Q.C.:
Q. So what happened? Float the idea of what, that she would do all the HER2/neu, ER/PR or -
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. She'd report them all?
DR. FONTAINE:

Page 204

A. Or that she would look at them.
COFFEY, Q.C.:
Q. Look at them, and I'm going to ask you about that, okay. What was -
DR. FONTAINE:
A. Because with the idea that potentially we could move towards that subspecialization, that--because ultimately, with subspecialization, that she would be doing the lion's share of breast cases. It's not just--so we used sort of ER/PR, HER2 as a launch point to plant the seed, if you will, to then move to the fact that she would actually be handling the majority of the breast cancer cases.
COFFEY, Q.C.:
Q. Not unlike Doctor--the doctor in Halifax, Doctor -
DR. FONTAINE:
A. Correct, Dr. Barnes.
COFFEY, Q.C.:
Q. Dr. Barnes.
DR. FONTAINE:
A. Right. So it's sort of a subtle way of trying to introduce the Halifax model, if you will.

Page 205

COFFEY, Q.C.:
Q. And we've just noted, she started, formally started, like in a full-time position in August 2004?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. So this is, in effect, really effectually just two weeks -
DR. FONTAINE:
A. Shortly thereafter. I didn't wait too long to get--to discuss things.
COFFEY, Q.C.:
Q. So you would have discussed this with her before, during her -
DR. FONTAINE:
A. Yes, we had discussions prior to this.
COFFEY, Q.C.:
Q. During her locums?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. And what were you met with? What was the response?
DR. FONTAINE:

Page 206

A. There was some resistance, as you can see in the minutes. I think there was reluctance within the group and again, to speak to the group themselves, but my sense was that they were concerned that if we moved to subspecialization, as you can see, there'd been a tremendous turnover of pathologists and they were worried that, "sure, you'll take over this subspecialty and then you'll leave."
COFFEY, Q.C.:
Q. And what was the complaint then?
DR. FONTAINE:
A. Then we'd be doing it again. We would then have to take it back on, so -
COFFEY, Q.C.:
Q. And the down--what was the problem with that? What was the expressed problem? I'm not suggesting that there was.
DR. FONTAINE:
A. I guess that there would be a loss of that expertise, as in that was the concern.
COFFEY, Q.C.:
Q. That six months or a year might pass, or two years -
DR. FONTAINE:

Page 207

A. Or it could be five, not knowing how long this could be.
COFFEY, Q.C.:
Q. A particular subspecialist might stay.
DR. FONTAINE:
A. A particular subspecialty, yeah. The generalist approach was what had been the status.
COFFEY, Q.C.:
Q. Now Doctor, here at this meeting, there were--when we look back at page one, I'm sorry, apologize. There are ten of you, I believe.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. You're a proponent of the idea, so that leaves nine, and do you recall, like was it uniform amongst the nine or was there -
DR. FONTAINE:
A. There were some individuals who it didn't really matter because they were going to be retiring soon. So they didn't--they weren't too concerned either way. But specific names, I can't speak to--there wasn't one person standing up and saying, "oh no, there's no way

Page 208

we can do this." It wouldn't be just one individual, no.
COFFEY, Q.C.:
Q. And so just again, looking back then at the actual minutes, I want to get, for the Commissioner, some sense of what actually went on. Was this the only time that you raised this?
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Did you -
DR. FONTAINE:
A. This was something that I would often talk about, because my thing was my specialty interest was cytology, and I had made it very clear that that was where I wanted to be from that end. Now for as far as Dr. Carter, you'd have to speak to her specifically of how much she addressed that with other people, but I would not use Dr. Carter and say that Dr. Carter wants to do this. I would just push my own--other than this point.
COFFEY, Q.C.:
Q. I was going to ask you, this one time that you

Page 209

were, in effect, being a proponent of what Dr. Carter had in mind, this is the one time this happened, that you raised this at the General Hospital?

DR. FONTAINE:

A. In -

COFFEY, Q.C.:

Q. For Dr. Carter, on Dr. Carter's behalf?

DR. FONTAINE:

A. For Dr. Carter. I may have used her name in other circles, but this would be, I think, probably the only time I mentioned it formally to that end.

COFFEY, Q.C.:

Q. Doctor, was it sold, do you recall, or you tried to sell it at the time, from the perspective of she was just going to look at the HER2/neu, ER/PR slides and wouldn't report them?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. That was it. That was all that was said?

DR. FONTAINE:

A. That was all that was, sort of -

Page 210

COFFEY, Q.C.:

Q. As opposed to, "I'm telling you this, but -

DR. FONTAINE:

A. I'm sort of testing the waters, if you will.

COFFEY, Q.C.:

Q. The response was what? So what I'm getting at is this, it would seem, frankly, what would the problem be with somebody looking at your slides? I mean, you know, "so what, somebody wants to look at them. If they're my slides, I will report them. But in the meantime, if you want to look at them, Doctor, you're-- because you're interested, sure, you're welcome to." So I'm just curious about, for the Commissioner's perspective, of what was going on here? What did you get the sense in the room? Were people talking about "we don't want subspecialization"?

DR. FONTAINE:

A. There was a want for generalized, general pathologists. That this notion of subspecialty pathology was not welcome here, if you will.

COFFEY, Q.C.:

Q. What I'm getting at is did the opponents in the room, did they see through what you were doing, which is in effect, and raise it with you, the fact that what you really want here, where you're going--where Carter wants to go with this is subspecialization. Did that come up during the conversation?

DR. FONTAINE:

A. I can't remember specifically if that was, but I know that there was just resistance. I don't think it was so much specifically to the ER/PR. It was more this resistance to subspecialization. So there might have been some issue tracking. The way that it's minuted may not necessarily reflect the fact that "oh, it's ER/PR and HER2." That it's more the fact of subspecialization, not so much the specific of ER/PR, more towards the subspecialization. So I don't know that it's specific to ER/PR. Again, I think it's more general that it applies to the fact of subspecialization, and this was sort of a way to introduce that idea because there was much more discussion than what is minuted here. This didn't just sort of come up and then die, if you will. There was a bit more discussion,

Page 212

but my sense was that it was not just the fact of HER2, ER/PR. It was more the notion of subspecialization.

THE COMMISSIONER:

Q. I just want to pursue that for a moment.

DR. FONTAINE:

A. Yes.

THE COMMISSIONER:

Q. Is it that--it seems to me that there are two different things here. One is that the person who might be quite happy, for example, to give up having to deal with issues having to do with breast cancer might say "boy, this is a great thing, because I won't have to do that, and I really don't like doing that branch." I can't imagine that there's any profession where there isn't a branch of it that people don't like doing. And the other is the idea that you mentioned before and which I think has been mentioned by Dr. Cook when he was here and that is the turnover was so great that you might find yourself having lost a skill that's all of a sudden somebody comes along and says you have to pick up again.

DR. FONTAINE:

Page 213

A. Exactly.
THE COMMISSIONER:
Q. Was that the kind of debate?
DR. FONTAINE:
A. Yes, more or less, because I know I certainly came from the camp of I was happy to have my breast cancers from--what you've described from the beginning, and then from the opposing side was more the notion--because if we look at the history of what had happened here with Dr. Khalifa, he was taking on the role of that staining and then left. When he left, it went to the pathologists, and I think they remembered that and said "but, we have to keep our skills."
COFFEY, Q.C.:
Q. Exhibit P-1921, please? This is an MAC minutes of October 20th, 2004, Doctor. At page four, you're mentioned there at the bottom as associate to active staff, laboratory medicine program, division of cytopathology, September 19th, 2004 to April 1, 2007. I take it this was your appointment?
DR. FONTAINE:
A. I assume, yes.

Page 214

COFFEY, Q.C.:
Q. Okay. So you would move, I take it, having spent a certain amount of time as an associate to a full-time member, I take it.
DR. FONTAINE:
A. I guess. I mean, I'm not--I just looked at it that I didn't see that as a significant--now I did receive a letter from Dr. Williams. I just put it on my bulletin board and kept doing what I did.
THE COMMISSIONER:
Q. Mr. Coffey, wherever you can (inaudible).
COFFEY, Q.C.:
Q. Yes. If we could, please, Exhibit P-1583? Doctor, this is, again, it's minutes of a Division of Anatomical Pathology, General Hospital, meeting of November 2nd, 2004, and ask you about, Doctor, here is page two--I'm sorry, page three, new business, pathology assistant. There's a reference here, "there was much discussion on this issue," and I should go back, to be clear here. You're listed there as one of the participants.
DR. FONTAINE:
A. Yes.

Page 215

COFFEY, Q.C.:
Q. "Pathology assistants. It was agreed by pathologists that this issue should be brought to the attention of the VP Medical Services. Dr. Robb will write to Dr. Williams recommending pathology assistants, as per the Royal College recommendation. It was also pointed out that the Anatomical Pathology division is earning over 100,000 a year by billing for technical work. It is expected that some of the money should be given to the pathology budget to hire pathology assistants." What do you recall about the impetus or the initiative trying to obtain pathology assistants, from the time you arrived in St. John's?
DR. FONTAINE:
A. I know it had always been an issue with Dr. Cook as well, because if you go back to the Hay report, they had identified that as an issue, and also looking at the national scene, most of the academic institutions were moving towards acquisition of pathology assistants from that end. So it was always an issue, and we were just looking at ways of being able to

Page 216

bring that in to St. John's.
COFFEY, Q.C.:
Q. Was it perceived to be a desirable development?
DR. FONTAINE:
A. Very much so, yes.
COFFEY, Q.C.:
Q. And why is that?
DR. FONTAINE:
A. Well, the pathology assistant sort of takes control of the gross room, if you will. They are the experts in that domain. Again, when we look at training of residents, when you're a resident actually what you end up doing is you're often left in the gross room and that's where your primary responsibility is, because grossing is not one of your most favoured duties by a pathologist. It's time consuming, but again, if you remember, it's the part that's got to be done properly, because it's the most important part, but yet it's often relegated off to the individuals who are still training, if you will. So it's one of those issues that is seen as it's necessary but it can be done by other individuals.

Page 217

COFFEY, Q.C.:
Q. And I take it then that--because this would have come up from time to time?
DR. FONTAINE:
A. No, this was a constant issue.
COFFEY, Q.C.:
Q. It was constant.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And did it ever come to fruition?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And when did that finally happen?
DR. FONTAINE:
A. Can't remember the date specifically, but it would have been in the realm of 2006, I think in the summer of 2006, and where we acquired four pathology assistants.
COFFEY, Q.C.:
Q. From your perspective, has that made any difference?
DR. FONTAINE:
A. Yes.

Page 218

COFFEY, Q.C.:
Q. In terms of your work, and what, if anything, have you noticed about what difference it's made?
DR. FONTAINE:
A. I know that it frees up the pathologist's time much more to attend to other duties.
COFFEY, Q.C.:
Q. How about the actual blocks or tissue in blocks and staining and the slides and so on, has it made any difference, do you think?
DR. FONTAINE:
A. Again, I do cytology now.
COFFEY, Q.C.:
Q. Yes.
DR. FONTAINE:
A. I don't actually look at slides from histology so much. In the time that I was there, because again, remember that the pathology assistant is always under the advice of the pathologist. There's still a pathologist available for consultation and review of cases. To that end, and again, I should remind you that what I was seeing was--would have been the cases that I had grossed. So in

Page 219

the acquisition of pathology assistants, I didn't notice any significant differences, but I knew that the gross room was running more efficiently.
COFFEY, Q.C.:
Q. If we could then, after lunch, Commissioner.
THE COMMISSIONER:
Q. Yes, we'll reconvene at ten after two.
COFFEY, Q.C.:
Q. Thank you.
(LUNCH BREAK)
THE COMMISSIONER:
Q. Mr. Coffey.
COFFEY, Q.C.:
Q. Thank you, Commissioner. Doctor, if we could, please, Doctor, there's--actually, there are two new exhibits, Commissioner, Exhibit C-0180 and C-0181.
THE COMMISSIONER:
Q. 0180 and 0181?
COFFEY, Q.C.:
Q. Yes, please. Okay, entered?
THE COMMISSIONER:
Q. Yes.
EXHIBITS ENTERED AND MARKED C-0180 AND C-0181

Page 220

COFFEY, Q.C.:
Q. Thank you, Commissioner. If we could open, please, Exhibit C-0181, please? Now Doctor, this is a redacted copy of a pathology report for a particular patient. The surgical number is 03-SU17521 and if you look down through it, you'll see your own name at various times as the pathologist involved.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. What I wanted to ask you about was this, go here to addendum number one on the first page, and I gather that that would mean that 05/01/04, which would be January 5th, 2004?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And you've noted here "staining for HER2/neu was performed and is interpreted as negative."
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And then we go on to the main body of the report, which I take it is here under the--

Page 221

you've got it described here under diagnosis?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And number one, lymph nodes, and number two, breast biopsy left, and you've diagnosed it as infiltrating ductal carcinoma.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And it goes on, you go on from there and you say "progesterone receptor weakly positive. Estrogen receptor negative."
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And "see tumour summary" and when we look here, just going into the next page, Doctor, there's an entry here, right here, signature on file?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And this would be December 16th '03?
DR. FONTAINE:

Page 222

A. Yes.
COFFEY, Q.C.:
Q. Now Doctor, can you tell us, please, and you can just look through this, of course. You can take the mouse there and scroll up and down. Tell us, please, when you would have reported the estrogen receptor negative and PR weakly positive?
DR. FONTAINE:
A. I expect that would have been on the day that I did the microscopy on 16/12/03, because that would be when the diagnosis would have been made. My practice was to wait for the estrogen progesterone receptor and sign that as a completed case, rather than report the-- and then report the estrogen receptor as an addendum.
COFFEY, Q.C.:
Q. That's right.
DR. FONTAINE:
A. So then I would report the HER2 as an addendum.
COFFEY, Q.C.:
Q. And that's what we just saw there in addendum number one on this particular one.

Page 223

DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Now Doctor, just on this, and just so the Commissioner gets some sense of this. Under gross for this particular patient, that section -
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. - there's dictated by another physician.
DR. FONTAINE:
A. Dr. Chandrakanth, yes, he would be--he's a resident at the time.
COFFEY, Q.C.:
Q. So I wanted to ask you about that, in terms of this, because sometimes if we see this, this sort of practice.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. How would that work then?
DR. FONTAINE:
A. Essentially Dr. Chandrakanth would have been assigned to my day of grossing, if you will,

Page 224

and so he would handle either the majority of cases, depending on his--where he was in his training, I may give him some of my gross to do and I would do the remainder, and then I would expect him to work those cases up, if you will. So this would have been a case that we would have gone through and then he would have taken over from there and grossed to that end.
COFFEY, Q.C.:
Q. Doctor, again, perhaps this is just a matter of formatting. So he would have done that and then December 16th, '03, there would have been--I take it the computer somehow or another enters the time?
DR. FONTAINE:
A. Right. When I see that, because what's interesting there, what I don't understand is that there's a 16/12/03 as when my signature goes on file for the microscopy.
COFFEY, Q.C.:
Q. Yes.
DR. FONTAINE:
A. So I'm not sure if that actually--I must have made some type of a correction in his report

Page 225

to that end. So as an editing, because that time line would not be congruent with this signing out of that case.

COFFEY, Q.C.:

Q. On the 16th?

DR. FONTAINE:

A. On the same day, that's right, because again, remembering the process. There would have had to have been blocks taken. So I would have gone through it. Because again, we would have gone over this together and I would have had recollection of what we saw grossly. So it wouldn't be uncommon to change some of the gross.

COFFEY, Q.C.:

Q. And you referred to that, in fact in Halifax even, you said that that, at times, would happen?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Here then, and just so the Commissioner again has some sense of this, as you indicated, when you went to finally sign off on this as the attending physician on December 16th, if you

Page 226

saw fit when you were reviewing your resident's work as dictated by him and as typed up, if you wanted to make an amendment, you would do it?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Before the actual signing off occurs?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. Now Doctor, when you want to insert an addendum, such as is here, addendum number one, and then in this particular patient's case, there's an addendum two and three.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. When you go to do that in the Meditec system at the General Hospital, can you insert the addendum anywhere within the body of the text or are you limited to kind of going one--you know, addendum number one is the next thing at the beginning of the report?

DR. FONTAINE:

Page 227

A. Chronologically in line, if you will.

COFFEY, Q.C.:

Q. Does the system allow you to--could you put an addendum, for example, if you'd wanted to, for some reason wanted to type it in beginning, I don't know, after clinical history, say, would you have been able -

DR. FONTAINE:

A. I don't believe so. I've never tried to do so, but there are direct fields that are--when you actually sit at the Meditec, they will line numbered fields. So I'm not aware that you can actually change the--but maybe you can, but I'm not aware.

COFFEY, Q.C.:

Q. It's not your practice to do so?

DR. FONTAINE:

A. It's not my practice.

COFFEY, Q.C.:

Q. You're just simply--you sign off as you did here on page three of this exhibit.

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. Right there, and then when you want to enter

Page 228

an addendum, as you did on the first page of the exhibit, addendum number one goes in.

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. And then go, we go on to the second page here, we can see your actual sign off of that.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. January 5th '04, your HER2/neu.

DR. FONTAINE:

A. Yes. Because again, when you go to do addendums, the field comes up in the Meditec system just as addendum, and I believe that the system then assigns it addendum number one, number two, number three, as it is entered chronologically.

COFFEY, Q.C.:

Q. This particular patient, there was an addendum number two entered August 13th, 2004 and then signed off by you that day.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Page 229

Q. And it says "Addendum number two. At the request of Dr. Zaidi -
DR. FONTAINE:
A. Zaidi.
COFFEY, Q.C.:
Q. - A. Zaidi, the progesterone receptor stain is reviewed and is interpreted as involving less than ten percent of neoplastic cells and is weakly positive when compared with the internal control of the adjacent normal breast tissue."
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. What's--and again, I'm not particularly interested in this particular patient so much as what was going on here generally, in the sense of being requested and it's now six to seven months after your initial report.
DR. FONTAINE:
A. Exactly.
COFFEY, Q.C.:
Q. You're being approached--Dr. Zaidi, I take it, is an oncologist?
DR. FONTAINE:

Page 230

A. Correct.
COFFEY, Q.C.:
Q. So what would this sort of process involve?
DR. FONTAINE:
A. Well, I remember this case specifically.
COFFEY, Q.C.:
Q. Okay.
DR. FONTAINE:
A. Because it was, to me, such an exceptional case and that's why I remember it. I received a phone call from Dr. Zaidi in and around that time. He asked--because if you go back to the diagnosis, you'll read that I actually entered as -
COFFEY, Q.C.:
Q. There you go.
DR. FONTAINE:
A. - progesterone receptor weakly positive.
COFFEY, Q.C.:
Q. Yes.
DR. FONTAINE:
A. Because I remember when he spoke to me and he said "what do you mean by weakly positive?" and I mentioned to him, I said "well, what is the percentage?" and he said "the percentage

Page 231

is not reported there" and I was a bit taken aback, if you will, because my practice was to enter percentages, and I said "are you sure this is my report?" and he said "yes." "Well, let me get back to you on that count." So I went back, reviewed the slides, and in that review, you'll see my diagnosis as addendum number two, where I found that there was less than ten percent staining of the neoplastic cells, and weakly positive when compared to the internal control.
COFFEY, Q.C.:
Q. And a comment such as you've made there "is weakly positive when compared with the internal control of the adjacent normal breast tissue," which I take it is the internal control you've described to the Commissioner before lunch.
DR. FONTAINE:
A. Correct, that's right.
COFFEY, Q.C.:
Q. What does "weakly positive when compared with" mean here in this context?
DR. FONTAINE:
A. Again, it's not as intense. The staining is

Page 232

nuclear, but it's not as strong as what we would see in the internal control, if you will. So again, it's weakly positive in that sense, and when I look at when I signed that case off, I must have been expecting to go back and review that, because it was my practice to enter percentages, but it was one I must have missed, and when Dr. Zaidi called, I specifically remember that case.
COFFEY, Q.C.:
Q. Now Doctor, in this particular case -
THE COMMISSIONER:
Q. Just a point I want to make sure I understand on this business of when you're saying weakly positive compared to internal control.
DR. FONTAINE:
A. Right.
THE COMMISSIONER:
Q. So do I take it at that juncture, you are, in fact, looking at strength of staining?
DR. FONTAINE:
A. Correct, the intensity.
THE COMMISSIONER:
Q. Well, what's--intensity meaning?
DR. FONTAINE:

Page 233

A. So the intensity, so the amount of brown -
THE COMMISSIONER:
Q. The amount of brown or the strength of the brown?
DR. FONTAINE:
A. The strength of the brown, if you will.
THE COMMISSIONER:
Q. Do you know what I mean?
DR. FONTAINE:
A. Exactly, so that the -
THE COMMISSIONER:
Q. Depth of colour?
DR. FONTAINE:
A. The depth of colour would be the best, yes.
THE COMMISSIONER:
Q. All right. So in your process, you, when comparing the internal control and the nuclei -
DR. FONTAINE:
A. Nuclei, yes.
THE COMMISSIONER:
Q. - for that purpose, you will compare the depth of the colour on the internal control with that in the tumour?
DR. FONTAINE:

Page 234

A. Correct. Oftentimes what you would do is--because you're essentially looking at the internal control as your standard. You would expect that that's--that's what my level would be. Because sometimes if we have what we consider background, we may actually subtract background staining from what we would expect to be true staining.
THE COMMISSIONER:
Q. Okay.
DR. FONTAINE:
A. So we're always looking at intensities as well to say is this more intense, less intense, from what is there and the thinking behind that is that it may reflect the level of antigen to that end.
THE COMMISSIONER:
Q. Okay, thank you.
COFFEY, Q.C.:
Q. Doctor, I'm going to come back to this one later.
DR. FONTAINE:
A. Okay.
COFFEY, Q.C.:
Q. The addendum number three, because I want to

Page 235

ask you about that in the context of kind of the larger, what was otherwise going on. So that was in 2004. After your arrival in St. John's in June of '03 and then continuing on, obviously this is now August of '04 and really into '05, continuing right on until, for example, you became the site chief.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. We'll talk about in a minute, in '05.
DR. FONTAINE:
A. That's right.
COFFEY, Q.C.:
Q. Do you recall there ever being discussions amongst the pathologists at the General Hospital about internal controls, staining of internal controls from ER/PR?
DR. FONTAINE:
A. Not specifically, no.
COFFEY, Q.C.:
Q. IHC staining, yes.
DR. FONTAINE:
A. IHC staining, yes, because I had had more discussion about prostates, but not so much

Page 236

about the ER/PR specifically.
COFFEY, Q.C.:
Q. And the prostate, in that context, what did that involve?
DR. FONTAINE:
A. Again, with prostate, we'll look for internal controls as well. I had noticed and others had noticed as well, that sometimes the internal control would not stain. We would repeat that stain and the internal control would work, again, as a one instance. I did not have occasion to have repeated negative internal controls in my time in St. John's.
COFFEY, Q.C.:
Q. You mean repeated in the sense of twice for the same patient?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. If there was a failure -
DR. FONTAINE:
A. If there was a failure on the first time, it did convert, if you will.
COFFEY, Q.C.:
Q. The internal control converted, as it were, on

Page 237

the second one?
DR. FONTAINE:
A. Correct, yes.
COFFEY, Q.C.:
Q. Doctor, during the discussions you had with your fellow physicians concerning the prostate IHC tests, at that time, do you recall anybody referring back to the fact that well, Dr. Ejeckam was somehow involved in the spring of ’03 with at least one prostate stain?
DR. FONTAINE:
A. No, that was not brought up.
COFFEY, Q.C.:
Q. Like no one’s kind of harkened back to "well, you know, Gershon was dealing with that a year ago"?
DR. FONTAINE:
A. No, as far as I was aware, I didn’t know it had existed, so I didn’t know it was an issue, and it looked like it was resolved, looking now at the documentation.
COFFEY, Q.C.:
Q. Do you recall, in particular, which stain was--for a period of, you know, at least for a particular period, you recall it being

Page 238

discussed while you were here, involving prostate, which particular stain it was?
DR. FONTAINE:
A. It would be the high molecular weight keratin.
COFFEY, Q.C.:
Q. Which is?
DR. FONTAINE:
A. 34 Beta
COFFEY, Q.C.:
Q. 34 beta, which is?
DR. FONTAINE:
A. 34 beta epsilon 12.
COFFEY, Q.C.:
Q. Which is the one that--one of the ones that is referred to in those eight that Dr. Ejeckam -
DR. FONTAINE:
A. I believe it’s the first one, looking at the one from this morning.
COFFEY, Q.C.:
Q. So during the--I appreciate you weren’t here on April 4th, 2003.
DR. FONTAINE:
A. That’s correct.
COFFEY, Q.C.:
Q. But after you started in June of ’03, between

Page 239

then and your time as site chief in April ’05, at some point in that time frame, there was discussion amongst the pathologists about the fact that--you called it for -
DR. FONTAINE:
A. High molecular weight keratin or 34 beta.
COFFEY, Q.C.:
Q. 34 beta, yes. Is not stain--"I had an internal control of 34 beta didn’t stain. I had it redone, and it stained" and occasionally amongst yourselves, you’d talk about that?
DR. FONTAINE:
A. Very occasionally, again, and it was not unique to here. I’d had experience in Halifax with the same issue, so I did not see that it was--it was not a repeated problem.
COFFEY, Q.C.:
Q. Do you recall, Doctor, when it was that that came up, in that period between June of ’03 and -
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Okay, just some time in -

Page 240

DR. FONTAINE:
A. It would be sometime, and it was not only 34 beta. I’m sure there were other stains as well that we had discussion on. It’s one of these things that that’s the nature of immunohistochemistry.
COFFEY, Q.C.:
Q. And it’s just the one that happens to stand out in your mind now?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Exhibit P-2333, please? Doctor, I just bring this up here. It’s laboratory division managers meeting of April 12th, 2005, page five of the exhibit, paragraph F, under new business. "Site chief pathology, HSC. Dr. D. Fontaine is the new site chief for pathology at the Health Sciences Centre, effective April 1st."
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. So you had replaced Dr. -
DR. FONTAINE:

Page 241

A. Parai.
COFFEY, Q.C.:
Q. - Parai?
DR. FONTAINE:
A. Dr. S. Parai, yes.
COFFEY, Q.C.:
Q. As site chief, what did you understand your duties to be?
DR. FONTAINE:
A. Again -
COFFEY, Q.C.:
Q. At the General Hospital?
DR. FONTAINE:
A. At the General Hospital site, it was to sort of address any issues that would have been raised by the medical staff there.
COFFEY, Q.C.:
Q. Any issues, medical issues. I take it that would cover what, the entire range of -
DR. FONTAINE:
A. It could be. I mean, to myself, it was never really defined from that end, but it was issues as they arise and then I could consult with Dr. Cook, who was, I believe, then appointed as the clinical chief.

Page 242

COFFEY, Q.C.:
Q. Yes, he was still clinical chief at the time. Doctor, was there a job description for the site chief's position that you knew of when you took over?
DR. FONTAINE:
A. I don't remember ever receiving one.
COFFEY, Q.C.:
Q. And then you've described to the Commissioner how when you first signed on in St. John's it was 80 clinical, 20 teaching?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Had that changed before you became site chief?
DR. FONTAINE:
A. Yes, because I'd become the cytology director. So there was .2 division there. So essentially I had a .2 or 20 percent appointment for my administrative duties for the Director of Cytopathology, and then I was reduced to a 60 percent --
COFFEY, Q.C.:
Q. For clinical?
DR. FONTAINE:

Page 243

A. For clinical, and then taking this one meant -- now again I never received any formal documentation, but it was assumed that there would be another 20 percent to the administrative responsibilities as the site chief for Health Sciences.
COFFEY, Q.C.:
Q. So it would be -- from April 1, 2005, onward without any formal documentation --
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Your understanding --
DR. FONTAINE:
A. Sort of the understanding that --
COFFEY, Q.C.:
Q. The informal arrangement was 40 percent for you clinical, 20 cytology --
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Cytology chief, 20 site chief, and 20 teaching?
DR. FONTAINE:
A. Correct.

Page 244

COFFEY, Q.C.:
Q. Teaching and research.
DR. FONTAINE:
A. University responsibilities, yes.
COFFEY, Q.C.:
Q. Doctor, can you tell the Commissioner how does that actually work itself out? Is there --
DR. FONTAINE:
A. Well, you've seen the numbers. We've not had that many bodies on the ground, and in a position of leadership, I couldn't just say, well, I want 40 percent. So I would be responsible for making the call schedule, and as physicians we tend to take on a bit more than we should, if you will. So I would take on more clinical responsibilities. That was the priority.
COFFEY, Q.C.:
Q. So the adjustment in theory for clinical 40, 50, 60, 70, whatever it is --
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:
Q. Would be adjusted on the basis of the call schedule, I take it, generally?

Page 245

DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And whatever the total amount of call, if you're 100 percent clinical, then you do the full clinical allotment for 100 percent?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And if it's 80 percent, then you're on call 80 percent of a 100 percent equivalent?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Is that --
DR. FONTAINE:
A. Or you would do the workload of -- taking the 100 percent, you would be required to do 80 percent.
COFFEY, Q.C.:
Q. Of the workload?
DR. FONTAINE:
A. Of the clinical workload.
COFFEY, Q.C.:
Q. Now in terms of divvying up the clinical

Page 246

workload just so the Commissioner understands this, in a practical way, how does it get divvied up, on the basis of how much call is given or what, or how many patients are assigned? How does it work?
DR. FONTAINE:
A. The way it worked at that time at the Health Sciences because again I was also juggling with cytology, so cytology needed to be covered as well, it worked quite well in the sense that you had these divisions as 20 percent because it represented one day of a 100 percent schedule, looking at a five day work week. So it would represent one day. So essentially you could assign somebody as having that equivalent. Now when we went to make up the schedules, we would put individuals on the schedule and that would be their workload for that day, and then depending on how many pathologists were there at that time, that would determine how often you should be on call if you're 100 percent divvied up from that, and then you would just do the math from there and that would determine how often somebody should be on

Page 247

call.
COFFEY, Q.C.:
Q. I'll just explore this a little bit with you now. When you first arrived, for example, in 2003 and really up until you took over and after you became site chief, leaving aside your particular situation because I appreciate you were divvied up a number of different ways --
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:
Q. But a person who was 100 percent clinical, what could they expect then? Assuming the place was fully staffed at the time, assuming it was for the moment --
DR. FONTAINE:
A. Uh-hm.
COFFEY, Q.C.:
Q. Assuming it was, what would they routinely expect and then I'll ask you about because of the lack of staff.
DR. FONTAINE:
A. Right. So essentially if -- and again that's a hypothetical because it never happened while

Page 248

I was there, but the fact -- so if you have somebody who is 100 percent, you would take the call schedule and see, okay, this individual I expect is going to be on equivalent -- because again it would never work evenly from that end because on the other side, I was actually trying to work towards this each day getting an allotment because then it made the math much easier. The way that we were currently practising was you could get up to 75 cases in a day, so you could get 75 cases in one day, and that's where you would be kept. So anything above 75 would go to the next day. Routinely you'd be looking at somewhere in the 55 to 60 cases per day. So it wasn't -- you wouldn't hit 75 every day.
COFFEY, Q.C.:
Q. So if you were -- you would get 65 to 75 cases, capped at 75?
DR. FONTAINE:
A. Capped at 75.
COFFEY, Q.C.:
Q. And you would -- you in the context here as a pathologist and the person would be on call

Page 249

that day, that's whatever came in the door that day?

DR. FONTAINE:

A. That's correct.

COFFEY, Q.C.:

Q. Is that pathologist until they hit 75 cases?

DR. FONTAINE:

A. Until they hit 75 cases, and when you made up the schedule you would consider how many pathologists are then available, and then you would work it from there. Then for the next cycle, you would consider who is on a university appointment, who has other responsibilities who have protected time, and then just sort of doing the math from there. So the first cycle would be somebody would be on every day, and then from that end you would stagger off those who were 100 percent, those who might be 80 percent, and those who might be other appointments.

COFFEY, Q.C.:

Q. Now, Doctor, if you were one of those who was 100 percent clinical --

DR. FONTAINE:

A. Yes.

Page 250

COFFEY, Q.C.:

Q. You, and particularly day one, you took everything that came through the door and say you happened to get your 72 or 75, you were at the cap --

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. When -- at what point then would you get to deal with those cases?

DR. FONTAINE:

A. You would have the amount of time until you were back on the surgical bench.

COFFEY, Q.C.:

Q. And how long would that be?

DR. FONTAINE:

A. It would vary as to the staff that you had available.

COFFEY, Q.C.:

Q. On average?

DR. FONTAINE:

A. On average, it would probably be in the vicinity of six to seven. So once every week and a half. So you'd have approximately seven days -- you could have as much as ten days if

Page 251

you were fully staffed. That didn't happen very often in my time.

COFFEY, Q.C.:

Q. But the idea would be that whatever came through the door on that particular day you were on call as a staff pathologist, that would be yours?

DR. FONTAINE:

A. That's yours.

COFFEY, Q.C.:

Q. It would be your cases --

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. To deal with, and then depending upon the staffing levels overall, and whether or not you were 100 or 80 or 60 --

DR. FONTAINE:

A. Would determine how frequent --

COFFEY, Q.C.:

Q. How often you would have to be back, but you might be back within six working days, back on the bench?

DR. FONTAINE:

A. Correct.

Page 252

COFFEY, Q.C.:

Q. To take up another round of cases?

DR. FONTAINE:

A. Exactly.

COFFEY, Q.C.:

Q. Or it might be as long as ten days?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. Or even longer?

DR. FONTAINE:

A. Or even longer, and again because there is that variability of -- there would be the variability from day to day. There may be cases you would -- days you would only receive 50 cases, and then there are other days that you receive 75.

COFFEY, Q.C.:

Q. On a day that you got 50 --

DR. FONTAINE:

A. You'd still have the same amount of time that you have to do 75. It would not be taken into consideration. The group had agreed that this is how it was going to be, and it was luck of the draw, if you will.

Page 253

COFFEY, Q.C.:
Q. And, Doctor --
COMMISSIONER:
Q. Did the arrangement work out, in any event?
DR. FONTAINE:
A. It seemed to. It was quite surprising that it would because at the end of the year once you actually did the overall statistics, again -- but for the most part.
COFFEY, Q.C.:
Q. Doctor, a final point on this, were there any particular sorts of cases that if you happened to be the person on the bench that day, as it were, on call or on the bench, would you -- as a pathologist, would there be some cases of a certain type that you wouldn't get because --
DR. FONTAINE:
A. It depended on what was going on in the operating room or what would come from outside.
COFFEY, Q.C.:
Q. But are there some -- was there any kind of sub-specialization going on in the sense of certain types of cases would end up with another pathologist because he or she --

Page 254

DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Had a --
DR. FONTAINE:
A. Not at that time, no. There was no initiative towards that. It as agreed -- although I should -- no, there was renal cases would be routed to Dr. Fernandez, and some of them -- medical lung cases would be routed to Dr. Chittal, so there would -- and neuropathology again was a special sub-specialty. So again looking at that, there was some level of sub-specialization in existence.
COFFEY, Q.C.:
Q. So that if I was a generalist, as it were, and it was my day and a renal pathology came in, it might not come to me, it might actually -- or it might end up with Dr. Fernandez?
DR. FONTAINE:
A. Right, if Dr. Fernandez was on vacation, you'll be left with it.
COFFEY, Q.C.:
Q. But if she was around?
DR. FONTAINE:

Page 255

A. If she was available and had no other reason to not take the case, she would take the case.
COFFEY, Q.C.:
Q. Now I take it then as you envisaged it, and you discussed this before lunch, you were telling the Commissioner about it, you kind of envisioned -- at least you had -- for example, with breast pathology and Dr. Carter, potentially the breast cases, things that evolved the way you envisaged perhaps, that they would have ended up all being redirected from the pathologist on call as it were, or on the bench that day, out to Dr. Carter? That would be the idea?
DR. FONTAINE:
A. That would be sort of how we did things in Halifax, if you will, that there would be some sub-specialty screening. It would not be only breast, it would be all other cases as -- GI would go to a certain group of pathologists, GU would go to certain pathologists.
COFFEY, Q.C.:
Q. Doctor, you took over as -- I gather, as site chief, April 1st, 2005.
DR. FONTAINE:

Page 256

A. Yes.
COFFEY, Q.C.:
Q. Were you aware of any potential problems with estrogen receptors, progesterone receptor testing come to your attention before that?
DR. FONTAINE:
A. It comes up shortly thereafter, but at the time I did not know.
COFFEY, Q.C.:
Q. No.
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Doctor, when did you first become aware of what ultimately has brought us here as a problem?
DR. FONTAINE:
A. I've tried to remember when did I actually recognize -- I can certainly speak to the fact that I did not know on April 1st because I don't think I would have been stepping into this position recognizing the magnitude of this, but on that -- it was probably in June thereof. I'd heard some grumblings, but again -- because there was always this rumour mill,

Page 257

so people speak, small labs, it's hard to do anything that people don't know what's going on, but I would struggle to give you a specific time, but it would probably have been in late May, early June, time frame.

COFFEY, Q.C.:

Q. Do you recall who you heard it from at first and what was said to you?

DR. FONTAINE:

A. No, again I can't remember specifically, but I know that there were a lot of grumblings within the lab.

COFFEY, Q.C.:

Q. And grumblings in the sense of -- by pathologists?

DR. FONTAINE:

A. Pathologists and technologists. Again there was this move afoot, not really knowing -- I knew there was some uncertainty as to was there a problem, and then we weren't really sure if it was a problem. I knew there was something being done, but when it actually came to full attention that, oh, we do have a problem, I can't remember specifically when that date would have been.

Page 258

COMMISSIONER:

Q. Can you be a little more specific at about at what stage things were when you learned about it? I'm just wondering --

DR. FONTAINE:

A. The stage?

COFFEY, Q.C.:

Q. How much, for example, retesting had gone on before you knew about it?

DR. FONTAINE:

A. Right. Because I had heard the rumours of this index case and there was a lot of talk of that, and then it was -- I was aware there was retesting ongoing, did not really appreciate what the magnitude of that was or what the results of that were. I knew there was something afoot, but did not realize the magnitude of it. Does that --

COFFEY, Q.C.:

Q. So when you refer to index case --

COMMISSIONER:

Q. Which index case?

DR. FONTAINE:

A. Yes, which one.

COMMISSIONER:

Page 259

Q. The other thing is that I would like you to also address -- I'll leave Mr. Coffey to go down that road with you, but you were then site chief.

DR. FONTAINE:

A. I'm sorry?

COMMISSIONER:

Q. You were then site chief?

DR. FONTAINE:

A. Yes, when it all came to --

COMMISSIONER:

Q. Yes, but it seems to me then there had been some progress down the path of starting to investigate this --

DR. FONTAINE:

A. By the time I came.

COMMISSIONER:

Q. Before you, as site chief, knew about it?

DR. FONTAINE:

A. Yes.

COMMISSIONER:

Q. And shouldn't the site chief have been told about it?

DR. FONTAINE:

A. I think it was that they didn't really

Page 260

appreciate the magnitude of the problem, but again you'd have to ask those individuals specifically, but I did not know or fully aware of what was going on.

COMMISSIONER:

Q. Well, let me put it this way, in your understanding of the role of a site chief, would it --

DR. FONTAINE:

A. I would have expected to know.

COMMISSIONER:

Q. Yes, you would have expected --

DR. FONTAINE:

A. I would have expected to be aware.

COMMISSIONER:

Q. Somebody to sort of knock on your door and say, guess what.

DR. FONTAINE:

A. Guess what's going on here.

COMMISSIONER:

Q. This is going on, it may be big, it may be little, we'll let you know, but it's going on?

DR. FONTAINE:

A. Especially considering it was happening at the site that I was the site chief of.

Page 261

COMMISSIONER:
Q. Uh-hm.
DR. FONTAINE:
A. Yes.
COMMISSIONER:
Q. Okay.
COFFEY, Q.C.:
Q. Doctor, what had you heard about the index case initially in 2005?
DR. FONTAINE:
A. I had heard that there was a lobular carcinoma that had converted.
COFFEY, Q.C.:
Q. What, if any, significance did that have? I mean, I take it that that's gone from negative to positive?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. You heard that in what context?
DR. FONTAINE:
A. I just heard that there was a conversion from that and it was being looked into beyond that, and again considering the climate that we had just changed technologies, and there was the

Page 262

question of how much of that has to play into this conversion.
COFFEY, Q.C.:
Q. So it was couched in terms of -- when you first heard about it, there has been a conversion?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Lobular, and in hearing that, I take it, in your world lobular --
DR. FONTAINE:
A. It's one case.
COFFEY, Q.C.:
Q. Yes, the relatively rare negative --
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:
Q. Conversion perhaps then not unexpected in the sense of it probably should have been -- it would be expected to be positive to start?
DR. FONTAINE:
A. Right, yes.
COFFEY, Q.C.:
Q. But a new machine --

Page 263

DR. FONTAINE:
A. New machine, new technology, what does this really mean, so take it to the next step.
COFFEY, Q.C.:
Q. So you understood then that this had happened, you understood that there was investigation being conducted?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Did you understand who that was being done by?
DR. FONTAINE:
A. My understanding was that it was Dr. Carter and Dr. Cook.
COFFEY, Q.C.:
Q. And the patient, were you told the patient's name?
DR. FONTAINE:
A. Eventually, I did, yes.
COFFEY, Q.C.:
Q. So at first --
DR. FONTAINE:
A. At first I didn't.
COFFEY, Q.C.:
Q. Peggy Deane's name wasn't being bandied around

Page 264

initially?
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. At least to you, anyway?
DR. FONTAINE:
A. Not to myself, no.
COFFEY, Q.C.:
Q. When did you become aware that it was Ms. Deane?
DR. FONTAINE:
A. I can't remember specifically, but it was before the inquiry. I can say that.
COFFEY, Q.C.:
Q. Oh, this is -- but it would have been after this had all --
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Gotten out into the media and so on.
DR. FONTAINE:
A. Even before that.
COFFEY, Q.C.:
Q. Before that. So sometime between being --
DR. FONTAINE:

Page 265

A. Being identified as the index, and before the release.
COFFEY, Q.C.:
Q. It went public.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Someone identified the patient as being Ms. Deane?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Did you make any inquiries when you first heard about it, I mean, in the sense of, look, there's an index case, I understand Don and Bev are investigating it? Did you make any inquiries of them or anybody else as to --
DR. FONTAINE:
A. No, I figured that they were taking care of that. They were looking into it, and I would be kept abreast as the developments came forth.
COFFEY, Q.C.:
Q. Exhibit P-0492, please. Actually, if I could, please, I apologize, just before we get to

Page 266

that, Exhibit P-0067, please, first. Now, Doctor, this is a letter of May 24th, 2005. It's to Dr. Williams, it's from Dr. Cook. The Commissioner has seen it a number of times. The subject matter of it is, "False negative results for estrogen and progesterone receptors, ER and PR", and it refers to Dr. Cook on May 11th received a phone call from Dr. Joy McCarthy informing him of an ER/PR reported negative is a patient with infiltrating lobular carcinoma diagnosed and retested in May of '05. The ER/PR is reported strongly positive. Dr. McCarthy expressed concern over what appears to be a high rate of infiltrating lobular carcinomas that were reported as ER/PR negative. She stated usually 95 percent of lobular carcinomas are ER/PR positive, while 5 percent are negative. She requested that two other patients with infiltrating lobular carcinoma who were reported as ER and PR negative in '02 be retested". Now, Doctor, and there's a reference to May 17th, 2005, meeting between Drs. Cook, Carter, Barry Dyer, and Drs. McCarthy and Laing.

Page 267

DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. When did you first see a copy of this letter?
DR. FONTAINE:
A. I could almost say this is the first time I'm seeing it here now.
COFFEY, Q.C.:
Q. But certainly I take it in your role as site chief, it wasn't brought to your attention?
DR. FONTAINE:
A. I did not -- no, I did not see this.
COFFEY, Q.C.:
Q. That's what I'm --
DR. FONTAINE:
A. No, I did not see this as site chief. I mean, it would -- if I've seen this, again we've looked at so many documents, but it's not something that I saw as site chief.
COFFEY, Q.C.:
Q. And would it have been -- if you have seen this, it's since the Commission was established?
DR. FONTAINE:
A. Correct.

Page 268

COFFEY, Q.C.:
Q. In this province.
DR. FONTAINE:
A. Yes, I think this is the first time that I see this.
COFFEY, Q.C.:
Q. Now, Doctor, this letter makes reference to the index--well what we have been, up to this point, certainly, describing as the index case.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And the requested two other patients with infiltrating lobular be retested, did any one at that time, while you were site chief in May, June, July, August and so on of '05, bring to your attention this concern about infiltrating lobular having been originally negative, some reported as negative and they should be positive and -
DR. FONTAINE:
A. Not to me, no.
COFFEY, Q.C.:
Q. Not to yourself.

Page 269

DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Doctor, here on the third page there are four recommendations listed by Dr. Cook. The immediate establishment of external proficiency testing and monitoring program for immunoperoxidase testing; establishment of a separate immunoperoxidase service with at least three technologists solely dedicated to it, with separate testing facilities; the training of immunoperoxidase technologists in a major immuno referral lab and continuing CME funding for those immunotechnologists. Now at that point in time, this is May of ’05 or June of ’05, did anybody approach you at that time, you know, concerning this sort of subject matter?
DR. FONTAINE:
A. There’s a good chance that Dr. Cook and myself might have discussed this at some -
COFFEY, Q.C.:
Q. As the summer went on into the fall.
DR. FONTAINE:
A. I know we’ve had discussions about this, yes,

Page 270

and again, on top of that with pathology assistants as well, and myself.
COFFEY, Q.C.:
Q. Now, Doctor, as the site chief at the Health Sciences Centre or the General Hospital, we’re using that term interchangeably or those terms interchangeably, the immunohistochemical testing that was going on, the processing that was going on in Newfoundland at the time was all centered in the General Hospital?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. As a site chief, did you understand that you were responsible--were you talking on the responsibility for that part of the lab?
DR. FONTAINE:
A. That would be my impression, yes.
COFFEY, Q.C.:
Q. And it was your impression, I take it then, that your predecessor, Dr. Parai, would have had a commensurate responsibility for it?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:

Page 271

Q. Here, and one final point in this letter, the last paragraph on page two says "In early 2003, Dr. Gershon Ejeckam, our point man for immunoperoxidase testing at the General Hospital site, discontinued testing of the ER/PR receptors with the manual method for a six week period" and it goes on from there. The idea of describing Dr. Ejeckam in May of 2005 as "our point man for immunoperoxidase testing at the General Hospital site".
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. As the site chief, would that be the sort of--would you have characterized Dr. Ejeckam at that time as the -
DR. FONTAINE:
A. Yes, because he had the interest and was communicating with the technologists. He was certainly the person that the pathologists would consult with when they had immuno issues.
COFFEY, Q.C.:
Q. So certainly, because you come in June of ’03, and certainly by May of ’05, you had quite a

Page 272

period of time before May of ’05 to figure out that Dr. Gershon Ejeckam -
DR. FONTAINE:
A. He’s declared himself much earlier than this.
COFFEY, Q.C.:
Q. He’s occupied the position, as it were.
DR. FONTAINE:
A. Yes, but the position doesn’t exist.
COFFEY, Q.C.:
Q. Exactly, but de facto, if he’s reproached by the technologists, he’s fulfilling that role?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. If we could now, Exhibit P-0492? Doctor, this is a memo from June 14th, 2005 from Dr. Cook, it’s to all laboratory directors, and you’re included, you’re first listed.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And your counterparts across or throughout the province. It’s estrogen and progesterone receptors and Dr. Cook writes, "We are aware of a number of negative estrogen and

Page 273

progesterone receptors that have converted on repeat testing with our new Ventana. Benchmark immunoperoxidase testing"--and he goes on about that, and he says "Presently we are in the process of retesting all negative ER and PRs for that particular year. I am requesting that you forward all negative ERs and PRs for the year 2002 to Barry Dyer. I also ask you to submit the reports, original ER/PR slides, including controls, as well as H&E slides and paraffin blocks. We will repeat all ER and PR receptors with the Ventana and forward the results to you."

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. And you can contact either Dr. Cook or Dr. Carter. Now, had you know at the time that this memo was coming?

DR. FONTAINE:

A. I can't say that I knew the memo was coming, but I knew it was being dealt with by Dr. Cook and Mr. Dyer.

COFFEY, Q.C.:

Q. And, Doctor, did you act upon this memo in any

Page 274

way? Did you have to do anything?

DR. FONTAINE:

A. No, when I got the memo, I was under the impression this was already done for our site. I may have checked with Mr. Dyer, but I can't remember specifically, but my impression was that it was already taking place for our site.

COFFEY, Q.C.:

Q. That would be in the process of identifying the ER and PR negatives for that particular year.

DR. FONTAINE:

A. Correct, yes. It was initiative from our site, so -

COFFEY, Q.C.:

Q. From your perspective, kind of addressing this matter was in whose hands?

DR. FONTAINE:

A. It was already dealt with was my impression.

COFFEY, Q.C.:

Q. In the overall manner, the responsibility for dealing with it was whose?

DR. FONTAINE:

A. I saw that Dr. Cook was already taking that lead and in consultation with Dr. Carter.

Page 275

COFFEY, Q.C.:

Q. If I could, please, Exhibit P-0493 please? Doctor, this is a letter of June 14th, 2005, same date, it's from Dr.--I'll show it to you, it's Dr. Cook. It's to Dr. Williams, "Preliminary update on false negative results for estrogen and progesterone receptors." And in effect, this is a report by Dr. Cook to Dr. Williams as to kind of the current status or it's an update up to that point. He even identifies here, in the middle of the first paragraph, "It also seems that most of the negative ER/PR results started sometime around June 24, 2002." He goes on from there. Doctor, did you ever receive a copy of this?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. The sort of subject matter involving, like identifying the total number of cases from '02, the positivity rate which is spelled out here to be about, if I remember correctly -

DR. FONTAINE:

A. Fifty percent.

COFFEY, Q.C.:

Page 276

Q. Yeah, a negative rate of fifty percent, which is what he's identified here.

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. Having set above the 160, ER/PR cases, 50 percent reported in '02 as ER/PR negative. Were you made or brought into that kind of loop at the time as to what was going on with this?

DR. FONTAINE:

A. No. This is the first I've seen of this.

COFFEY, Q.C.:

Q. And I appreciate it, the first you've seen of it of the letter, but as well, I take it, the actual information -

DR. FONTAINE:

A. Of the numbers.

COFFEY, Q.C.:

Q. The numbers and -

DR. FONTAINE:

A. Of a fifty percent, that's the first I heard of a fifty percent. I've heard a number of different numbers, but not that one.

COFFEY, Q.C.:

Page 277

Q. If we could please, Exhibit P-0495 please? Doctor, this is a, well it's a fax coversheet from Dr. Cook--I'm sorry, from Dr. Carter, June 30th, 2005 on her behalf to Dr. Williams and she's faxing him a letter, this version is redacted, June 29th, 2005 and it's addressed to Dr. Joy McCarthy. "As per our previous discussions repeat ER and PR has been carried out on the following patients, initially identified as estrogen receptor negative. The results are as follows"--and there are 25, if I recall correctly, use the number we've been using here, listed here and about 16 of them have been described as converted, that's the number, that's the way some of the witnesses have described it. Were you aware, like in late June or early July that on this first run, as it were, the first wave of retests for the Ventana, the first wave of 25, that 16 of them had converted?

DR. FONTAINE:

A. I didn't know the specific numbers, but I knew there was a significant conversion rate.

COFFEY, Q.C.:

Q. Do you recall where you learned that from?

Page 278

DR. FONTAINE:

A. It would have been in a verbal conversation, most likely from Dr. Cook.

COFFEY, Q.C.:

Q. Doctor, do you recall then the first time you attended a meeting in relation to the ER/PR matter?

DR. FONTAINE:

A. A formal meeting?

COFFEY, Q.C.:

Q. Start with that first.

DR. FONTAINE:

A. Okay, I guess it would be in August, July/August, I would think, sometime around that timeline.

COFFEY, Q.C.:

Q. Do you recall who, generally who was there, like specifically or generally who was there?

DR. FONTAINE:

A. Only from the discussions that have been coming up as a result of the inquiry. Like, if you would have asked me that before I saw some of the documents, I would say no, I wouldn't be able to, but I've seen documents since that time that, there were several

Page 279

pathologists, both from the Health Science's site and the St. Clare's site.

COFFEY, Q.C.:

Q. Okay, so this is the meeting of pathologists and I'll be taking you to that, I have one of August 5, I believe.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And I think Dr. Cook testified and in fact, has testified here about having had two meetings, one of August 5 and one of, several days before that.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. But other than that kind of meeting of pathologists, you know, how about any others, like to actually deal with the ER/PR matter in a procedural way.

DR. FONTAINE:

A. That I would have been involved with?

COFFEY, Q.C.:

Q. Yes.

DR. FONTAINE:

Page 280

A. As site chief you mean?

COFFEY, Q.C.:

Q. As site chief, yes.

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. Because what we've--the Commissioner has heard, of course, a lot of evidence about people attending meetings, you know, in the hospital, even in the Confederation Building, you know, different meetings here or there.

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. But as a site chief, you were not invited along to them.

DR. FONTAINE:

A. No, I saw this as, for the pathology involvement that it was Dr. Cook and Dr. Carter taking the lead.

COFFEY, Q.C.:

Q. If we could, please, Exhibit P-0504? Now, Doctor, these just happen to be minutes of laboratory--they're entitled "Laboratory Medicine, July 14th, 2005 meeting notes."

Page 281

Present are Ms. Heather Predham, Don Cook, Bob Williams and Terry Gulliver. Issue discussed is ER/PR receptor results.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. I understand from evidence we've heard already that the lab leadership team, as it were, was Dr. Williams, Dr. Cook, as clinical chief -

DR. FONTAINE:

A. That's correct.

COFFEY, Q.C.:

Q. And Terry Gulliver as program director.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. What, if any, relationship did you as site chief have to that group?

DR. FONTAINE:

A. I could consult with either Mr. Gulliver or Mr. Cook with issues that would be brought up at this, within this group and I also had the ability to talk to Dr. Williams directly as well.

COFFEY, Q.C.:

Page 282

Q. But you wouldn't attend their meetings, I take it, routinely or have copies of their minutes or -

DR. FONTAINE:

A. No, no.

COFFEY, Q.C.:

Q. If you had a problem, you knew who they were, you could go to them.

DR. FONTAINE:

A. I knew who they were and then they would bring it to their meeting and then report back to me.

COFFEY, Q.C.:

Q. And conversely if they had a problem with -

DR. FONTAINE:

A. With anything that was going on, exactly.

COFFEY, Q.C.:

Q. They could approach you.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Exhibit P-0069 please? Dr. Fontaine, this is a letter of July 14th, 205, it's addressed to Dr. Cook. You will see it's from Dr. Carter, copied to Dr. Williams and I want you to look

Page 283

at the first part of this, glance your eye down to the first paragraph and at the second, you'll see that, and this has been described as kind of a proposal by Dr. Carter to Dr. Cook to conduct, in effect, a full review of the cases between 1997 and 2003 or '04.

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. Okay. When did you first become aware that Dr. Carter was proposing to undertake such a full scale review?

DR. FONTAINE:

A. I heard, really I wasn't involved with what the process was, to that end, I heard grumblings or rumours that that was going to be undertaken, but the full bore of how this was going to happen, I just found out since the inquiry has been -

COFFEY, Q.C.:

Q. Okay, underway.

DR. FONTAINE:

A. Underway.

COFFEY, Q.C.:

Q. And I take it then, you did not receive a copy

Page 284

of the letter?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. If I could, please, Exhibit P-0532 please? And Doctor, these are handwritten notes dated July 28th, 2005 of Dr. Cook in which he noted, "spoke to Dan Fontaine, to begin negative controls for ER and PR"?

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. Do you recall -

DR. FONTAINE:

A. No, because actually I'm not a proponent of negative controls.

COFFEY, Q.C.:

Q. And in the context here, if I could, Exhibit P-0076 please? And, Doctor, this is a memo to all pathologists, pathology residents, Department of Pathology, St. John's hospitals, Eastern Health. It's from Drs. Cook and Carter, July 28th, 2005 re: "optimal assessment and reporting of hormone receptor status in infiltrating carcinoma." And we

Page 285

look at this, "when ordering and reporting ER/PR status and infiltrating carcinoma of the breast: one to eight"--actually one to nine. Do you recall receiving this? And I'm not suggesting you did receive it.

DR. FONTAINE:

A. It doesn't look familiar I can say. I may have received it, but it's not one that stands out in my mind.

COFFEY, Q.C.:

Q. And I say that because a signed copy, we don't have a signed copy, that's why I -

DR. FONTAINE:

A. Yeah, it doesn't look familiar.

COFFEY, Q.C.:

Q. And in particular, Doctor, in the context here, bearing in mind the context, this is July 28th, 2005, by then you would have known there had been a number of conversions, certainly on the Ventana.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And you would have known there was certainly a large scale investigation going on, of some

Page 286

sort.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And if you had gotten then, do you think a memo from Drs. Cook and Carter who were the organizers of the investigation, you understood were the organizers of it.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Spelling out nine different steps to look out for, to be aware of, in relation to ER and PR, do you think that would, might you have recalled that?

DR. FONTAINE:

A. I think I would.

COFFEY, Q.C.:

Q. It's the sort of thing, in the circumstances it would kind of stand out, wouldn't it, in terms of two people most heavily involved in doing an investigation -

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Page 287

Q. Significant investigation and suddenly you got a memo from them.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. With nine steps related -

DR. FONTAINE:

A. We would have to go through this and then have an action plan from that end, yes.

COFFEY, Q.C.:

Q. Because at this point in time, the testing was still going on in St. John's.

DR. FONTAINE:

A. Correct

COFFEY, Q.C.:

Q. ER/PR.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Exhibit P-534, please.

THE COMMISSIONER:

Q. Mr. Coffey, before you go on, when you were showing the witness P-0532 that was the reference to beginning negative controls. I understood Dr. Fontaine to start a statement -

Page 288

COFFEY, Q.C.:

Q. He's not a proponent.

THE COMMISSIONER:

Q. - not being a proponent.

DR. FONTAINE:

A. I'm not a proponent.

THE COMMISSIONER:

Q. And you said no and I wasn't sure whether that -

DR. FONTAINE:

A. I didn't say no, I guess the -

THE COMMISSIONER:

Q. I wasn't sure what that meant in this context.

COFFEY, Q.C.:

Q. You go ahead.

DR. FONTAINE:

A. I guess there could have been the discussion to begin negative controls, but I wasn't under the impression that he was asking me to do it. We may have had that discussion. I don't remember there being a directive associated with that. I'm not saying the conversation wouldn't have taken place, but -

THE COMMISSIONER:

Q. But you can be clear that you did not begin

Page 289

negative control at this point, I presume?
DR. FONTAINE:
A. It was not my initiative, no.
THE COMMISSIONER:
Q. Yes, okay.
COFFEY, Q.C.:
Q. Your answer then was you didn't do it at the time.
DR. FONTAINE:
A. I didn't go with the direction of--I did not get the impression that it was going to be a directive.
COFFEY, Q.C.:
Q. Did you have any--how do you feel about, in this context, negative controls?
DR. FONTAINE:
A. Again, there's a wide opinion, if you -
COFFEY, Q.C.:
Q. Because I think you indicated you're not a proponent either.
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:
Q. So, I'll ask you about that now, perhaps you can explain that -

Page 290

DR. FONTAINE:
A. Because again when I look at it for the negative--there is built in negative control in our tissues, in essence, that we don't expect certain cell to stain. And if they don't stain, then that is a built in internal negative control, if you will.
COFFEY, Q.C.:
Q. And if they do stain -
DR. FONTAINE:
A. Then you've got a problem, if you will.
COFFEY, Q.C.:
Q. Okay.
DR. FONTAINE:
A. Exactly.
COFFEY, Q.C.:
Q. Is that true in breast tissue?
DR. FONTAINE:
A. To speak to breast tissue specifically, it's not my area of expertise, but I'm not aware of something. But I know there is a school of thought that ascribes to that belief. And the same with other immunohistochemistry.
COFFEY, Q.C.:
Q. And if the context at the time, if it had been

Page 291

going to be taken out and instituted as a policy, I take it, that that's something that would have been taken up with Bev Carter.
DR. FONTAINE:
A. Correct, that's my impression, yes.
COFFEY, Q.C.:
Q. And if Dr. Carter, at the time, took the position or said to you, look Dan, this is the way we should go for the following reasons.
DR. FONTAINE:
A. Much like the exhibit you had just shown, if that came out as--I would think that would have been more likely to act on, the nine step, because it does state in that nine step to talk about negative controls. I'm not such a proponent that I would be, no, we can't do this, kind of thing. I would go along with--because again, Bev is the expert in that area.
COFFEY, Q.C.:
Q. Exhibit P-0534, please. Doctor, this is a memo from Dr. Cook of July 28th, 2005. It's to, again, all pathologists in St. John's as well as yourself in capacity as lab director and the other lab directors. It involves HER2/neu. And in the very end of it--I'm not

Page 292

going to take you through the first part of it, but concludes by saying, "as a reminder when choosing blocks to send for both hormone receptor testing and HER2/neu testing, please select a section that contains both tumour and normal or benign epithelium. The normal and/or benign epithelium acts as an internal control for immunohistochemical staining".
Now, the information contained in those three lines, was that news to you at the time?
DR. FONTAINE:
A. No, you would expect the internal control to be negative, in a case like that. So, that would be--to answer your question previously that that is something unique to breast.
THE COMMISSIONER:
Q. I'm sorry, that is?
DR. FONTAINE:
A. Unique to breast, in that it's a negative control from that. So, you would not expect to see staining in the normal -
COFFEY, Q.C.:
Q. For which type of stain?
DR. FONTAINE:
A. HER2.

Page 293

COFFEY, Q.C.:
Q. HER2.
DR. FONTAINE:
A. Yes, sorry, yes HER2/neu.
COFFEY, Q.C.:
Q. And HER2 overall, but that's the point, I take it, of having enough tissue there.
DR. FONTAINE:
A. Correct, yes.
COFFEY, Q.C.:
Q. That very reason.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And in this context though it would also, I take it, if it's being done, it refers to here as well -
DR. FONTAINE:
A. The importance of internal control.
COFFEY, Q.C.:
Q. Yes. Also here, for both hormone receptor testing and HER2/neu.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:

Page 294

Q. So, if the block contains normal tissue for HER2/neu purposes, it would also act as a positive internal control for hormone.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. But that was not new to you either at the time?
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. You were aware of this.
DR. FONTAINE:
A. I was aware of this, yes.
COFFEY, Q.C.:
Q. At the time you received this, Doctor, and I take it you did receive it?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Did you reflect upon why that was asserted? I mean, your world, there'd be no necessity to tell you that.
DR. FONTAINE:
A. Right. And I think this is the thing that we

Page 295

have to consider here as well and it's because immunohistochemistry is sort of thrown in at pathologists. You've heard a number of stories about education pieces and whatnot. Of the day and if this was brought in without education, it's as it states, as a reminder, is the thing. So, for those who wouldn't know this, it would be new information, but it would be expected that as a reminder for those who are choosing these blocks.
COFFEY, Q.C.:
Q. If you're already doing a carry on as -
DR. FONTAINE:
A. Carry on, exactly, but if you don't know, you better start doing it.
COFFEY, Q.C.:
Q. - you had been; if you're not, you -
DR. FONTAINE:
A. Exactly.
COFFEY, Q.C.:
Q. Exhibit P-2095 please. I'm sorry, page 22, please. Doctor, here this is a memo from Dr. Cook to all pathologists, I take it, in the division of anatomical pathology which would be throughout Eastern, St. John's Eastern

Page 296

Health anyway.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. August 2 '05, resource individual for immunohistochemistry and he says, "Dr. Gershon Ejeckam is currently our resource person for immunohistochemistry. All inquiries regarding immunohistochemistry should be referred to Dr. Ejeckam. In the event that Dr. Ejeckam is not available, all inquiries will be referred to the site chief, General Hospital site, who is currently Dr. Dan Fontaine."
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Were you aware that this was going out?
DR. FONTAINE:
A. Yes
COFFEY, Q.C.:
Q. And what were you told by Dr. Cook about this?
DR. FONTAINE:
A. Essentially if Dr. Ejeckam was unavailable that the responsibility would fall to me. As site chief, I accepted that that would be part

Page 297

of my responsibility, knowing that Dr. Ejeckam was in place, but this was more or less a formalization of an already existing agreement.

COFFEY, Q.C.:

Q. Now in this context, inquiries regarding immunohistochemistry, all inquiries, what did you understand was going on here in the sense of what sorts of inquiries would you get? What might you get as a result of this sort of a memo?

DR. FONTAINE:

A. I would expect that that would relate to issues regarding external control failures, internal control failures, inconsistent staining, these kinds of issues.

COFFEY, Q.C.:

Q. I take it concerns or complaints by pathologists about the staining?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. The stains.

DR. FONTAINE:

A. Yes.

Page 298

COFFEY, Q.C.:

Q. Exhibit P-0555 please? Now, Doctor, this is a document we received from Dr. Cook, it's apparently Dr. Cook's handwriting. Meeting of pathologists, Dr. Dan Fontaine, Dr. Lynn Morris-Larkin, Dr. M. Parai, Pirzada, Baron -

DR. FONTAINE:

A. Bibi Naghibi, yes.

COFFEY, Q.C.:

Q. And Dr. Cook, August 5, 2005, 3:00 p.m.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And this is a typed document, the actual body of it.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Do you know who prepared this or how this came about? How it came to be prepared?

DR. FONTAINE:

A. I can--no.

COFFEY, Q.C.:

Q. Well, I'll ask you then, the meeting of August 5, did you attend it?

Page 299

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Okay. How did you come to attend the meeting?

DR. FONTAINE:

A. Dr. Cook notified us. The best I can figure is that this was Dr. Cook putting this together.

COFFEY, Q.C.:

Q. And it begins by saying, "this is a list of some concerns which have emerged during conversations about the current problem. Included are some of our suggestions about how to approach this. It's important that we work together and support each other's department. Important features of the ongoing process should include and it lists a number of them. Co-operation, transparency, communication, dissemination of information as the process evolves, avoidance of finger pointing to other individuals or a group of individuals, input into the procedure and quality control and assurance initiatives surrounding it. We should ensure that no bias is introduced into the ongoing study. If the purpose is to

Page 300

compare methods, then the following are important features", and it goes on to list them.

Now, and toward the bottom there's a reference to "we should not be working in an environment where pathologists feel they are being criticized for past performances. Avoid generalized statements such as 'pathologists don't know how to report the ER/PR'. 'A single pathologist has repeatedly reported the ER/PR incorrectly'. 'Keeping statistics on individual pathologists'. These statements as well as loud discussions around the issue in corridors with high public traffic are threatening and demoralizing. We all assume that we are the pathologists being referred to however anonymously. This issue concerns pathologists outside the Health Care Corporation and they also need to be informed and re-assured. The process is proceeding at a fair and productive manner".

Now, Doctor, you came, I take it, to go to this meeting because Dr. Cook asked people to come.

DR. FONTAINE:

Page 301

A. Yes, that's correct.
COFFEY, Q.C.:
Q. What did you understand the purpose was?
DR. FONTAINE:
A. I just think because there was a lot of rumours going around. Nobody really knew what was the true story as it stood. So, it was more or less to have a chance for individuals to raise their issue, should they have any.
COFFEY, Q.C.:
Q. And what happened at the meeting?
DR. FONTAINE:
A. There was a lot of fear and anxiety related to this issue because there was a lot of, again, like we see, there were a lot of statements being made, a lot of finger pointing, if you will. Was it a technology issue? Was it a pathology issue? We really didn't know the scope of the problem either.
COFFEY, Q.C.:
Q. So that, I take it, was the circumstances leading up to the meeting itself.
DR. FONTAINE:
A. Yes, there was a lot of anxiety related, amongst the pathologists. I can't remember

Page 302

specifically if it was a called for meeting, but I know there was a lot of unrest within the pathology community.
COFFEY, Q.C.:
Q. And the purpose then in having the meeting you understood was what?
DR. FONTAINE:
A. Was to have a chance to air out some of these issues and find out what is really going on here.
COFFEY, Q.C.:
Q. What then happened at the meeting?
DR. FONTAINE:
A. Do you remember the specifics, I can try to recall that there was some discussion as to there was a significant conversion. There was an issue and there was going to be a mass retesting from that. From that end then the pathologists were concerned that was somebody going to be singled out and finger pointing and looking at that.
COFFEY, Q.C.:
Q. Because in the middle of this there are references to persons conducting the study do not need to know which pathologists signed the

Page 303

report original.
DR. FONTAINE:
A. Right. There was a lot of discussion as to-- because for those who would do the study, the pathologists wanted to know that there was going to be blinding, so that there wouldn't be an interpretative bias introduced by, so that a pathologist would be singled out as being more of the road, because the concern also was that if the person doing the review knew who it was might interpret things differently. That was the concern.
COFFEY, Q.C.:
Q. And what was understood at the time as to what the ongoing study was?
DR. FONTAINE:
A. I think at this time it was understood that there was a significant conversion and there was going to be the retrospective look and see how big of an issue was this and how far back does it go.
COFFEY, Q.C.:
Q. I take it the person then bringing information to the meeting, and I've looked at the list of participants, was Dr. Cook.

Page 304

DR. FONTAINE:
A. Yes, he would be, in essence, chairing the meeting, if you would.
COFFEY, Q.C.:
Q. He's the one who would know about what studies were going on and what was proposed.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And was the upshot of the meeting in the sense of the outcome of it, in a sense of, was there kind of a consensus, everybody agree to disagree or what?
DR. FONTAINE:
A. There's a lot of that in pathology and I think people felt better because they felt some of their concerns were being addressed, that it was not intended to be a witch hunt. We just wanted to get retesting. We found that there was an issue and we wanted to find out what was the scope of that issue.
COFFEY, Q.C.:
Q. At that meeting, was it apparent by the time the meeting ended, from Dr. Cook, was it apparent that there had been a number of

Page 305

conversions?
DR. FONTAINE:
A. Yes. I think that had been--that's probably what spawned the meeting, is that people recognized that there was a significant conversion and then what was being done about it.
COFFEY, Q.C.:
Q. Doctor, it's your understanding then, before the meeting and going into it and during it that at least some pathologists wanted or were concerned about the original reporting pathologist in any individual case being identified.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And with respect to that, did you have any understanding, come to any understanding as to what their concern was? I mean, if it turns out that you reported a case zero/zero or negative/negative and it turns out that on retest it was 80/80, what was your understanding about--what was their concern about it? Obviously, it might have

Page 306

implications for patient.
DR. FONTAINE:
A. I think that was more--the implication for patient care. You'd have to speak to the individuals themselves. I know for myself it was--I didn't see that as an issue. I thought, it's the patient first. If I have a conversion, then I have to resolve what that is. And people were frightened that there might be a bias towards reporting, if you would in that if somebody knew that it was an individual, there might be a selection for singling out an individual.
COFFEY, Q.C.:
Q. Somebody might be singled out as the person who had most of the conversions or all of the conversions, that sort of thing or -
DR. FONTAINE:
A. Or that the interpreting individual would see who that person was and that may introduce bias in that they may--because again, this is an interpretive skill. And the concern was that if they saw the name and then looked at the slide, they may not be as objective as they would be.

Page 307

COFFEY, Q.C.:
Q. And were there any assurances given that that would be addressed?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. So, Dr. Cook -
DR. FONTAINE:
A. Dr. Cook addressed what--the conclusion was that the individuals names would be redacted on the review.
COFFEY, Q.C.:
Q. Mr. Coffey, wherever you can find a spot, we'll take the afternoon break.
COFFEY, Q.C.:
Q. Okay. If we could please, Exhibit P-0556. Doctor, this is a draft of a letter of August 5, 2005. It was originally intended to go to Dr. Williams. It would have been from Dr. Cook. He drafted it. He says, "both Dr. Dan Fontaine and myself met with Heather Predham today to discuss the issue of technologists and interaction with pathologists in regard to immunoperoxidase staining. Following that discussion, I would like to make the following

Page 308

recommendations". And he talks then about the establishment of a separate immunoperoxidase service and so on with at least three technologists solely dedicate to it.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And he talks then about the, from his perspective, perhaps more appropriate training or at least hiring of people for this particular function.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Do you recall discussing this with Ms. Predham and Dr. Cook, discussions -
DR. FONTAINE:
A. Not specifically, but I do remember having discussions around these issues with these individuals.
COFFEY, Q.C.:
Q. And do you recall generally what it was about, the nature of those discussions?
DR. FONTAINE:
A. It would have been around this issue of

Page 309

getting dedicated technologists for immunoperoxidase lab. Again, there were a number of discussions that we had because this was always on issue, if you will, but to say that I can remember this specific discussion, I don't remember, but I know this was the flair of many discussions that we had.

COFFEY, Q.C.:

Q. Thank you, Commissioner.

THE COMMISSIONER:

Q. We'll take the afternoon break.

(RECESS)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey.

COFFEY, Q.C.:

Q. Thank you, Commissioner. Registrar, Exhibit P-0079, please. Now Doctor, this is a letter dated August 2, 2005. It's to Dr. Cook, it's from Dr. Carter and this is a letter where she--is copied to Dr. Williams--she advises Dr. Cook that she wishes to withdraw from her organizational role in the investigation of the problem with ER/PR testing at the Health Sciences Centre, St. John's from 1997 to 2004. Were you made aware, did you become aware that

Page 310

Dr. Cook, that Dr. Carter had so withdrawn?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And how did you become aware of that?

DR. FONTAINE:

A. Basically Dr. Cook approached me about taking up where Dr. Carter would have left off.

COFFEY, Q.C.:

Q. And what were you being asked to do and what did you agree to do?

DR. FONTAINE:

A. Well, there was a discussion--I couldn't really get a sense of why Dr. Carter had resigned from this role and my impression was the fact to look at slides and determine which blocks, or to select blocks with internal control provided the original block that the estrogen/progesterone receptor would have been ordered on would not be available, they could pick an alternate block and this would be the alternate block with internal controls. So I would be charged with looking at slides and determining which blocks would serve as alternates.

Page 311

COFFEY, Q.C.:

Q. And would you be involved at all in screening to see if the original block, in fact, had normal tissue on it?

DR. FONTAINE:

A. I did not -

COFFEY, Q.C.:

Q. Assuming it was available.

DR. FONTAINE:

A. I would not look at the original block.

COFFEY, Q.C.:

Q. The slide for the original -

DR. FONTAINE:

A. I'm sorry, the original slide, that's correct, yes. No, I would not look at the original slide.

COFFEY, Q.C.:

Q. So your involvement, you understood from when Dr. Cook approached you about this was to be limited to, in those instances where the original block is not available -

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. - the original block on which ER and PR was

Page 312

conducted, that the patient's surgical number would be identified?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And you would be charged then with looking at the H & E slides for the other blocks, whichever ones might be available, and based upon that, picking the block, from your perspective that best fit the bill of having tumour and normal tissue on it?

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. To conduct the retest?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. But for those for which the original block was available, you understood that was just going to be the original block was going to be processed and sent off?

DR. FONTAINE:

A. They would just select the original block, that's correct. That was my understanding.

Page 313

COFFEY, Q.C.:
Q. Okay, and what then happened, Doctor, in relation to that?
DR. FONTAINE:
A. So in around this time, I was presented with a spreadsheet with the surgical numbers and it was identified which block the ER/PR was ordered on originally. So I would know which slide it had been ordered on, and would then look at all the other slides to select an appropriate alternate. So sometimes it would--I would only need to look at one slide. In other cases, I would have to look at several slides.
COFFEY, Q.C.:
Q. And I take it, for many patients, you wouldn't have to look at any slides at all?
DR. FONTAINE:
A. I would still look--always, in every case that I was presented, I would pick an alternate block.
COFFEY, Q.C.:
Q. An alternate block, okay, but if you weren't being asked to pick an alternate block, you didn't look at--if an alternate block wasn't

Page 314

being used, you weren't asked to look at the case?
DR. FONTAINE:
A. I don't--I wasn't aware that there were other cases that had alternate blocks. So every case that I went through, that I was presented with, I would select an alternate block.
COFFEY, Q.C.:
Q. An alternate block?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. What I'm getting at is this, is that you were only tasked to look at cases for which an alternate block was required?
DR. FONTAINE:
A. I assume so. All I did, I just--what I was presented with, I would look and select an alternate block for every case I was presented.
COFFEY, Q.C.:
Q. An alternate block, okay. Here's an example. I'll just bring up Exhibit P-0573. Now Doctor, these are handwritten notes of Dr. Williams, but he has provided typed versions

Page 315

of them. This particular one is August 17th, 2005. It involves a meeting involving Dr. Williams and Mr. Gulliver, but first bullet says "all blocks pulled and reviewed at General site by Dr. Dan Fontaine."
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And "now waiting to send off for 1999 to first three years--three months" I'm sorry, "of 2004." So "all blocks pulled and reviewed at General site by Dr. Dan Fontaine."
DR. FONTAINE:
A. I hadn't actually pulled the slides, but I had reviewed them, yes.
COFFEY, Q.C.:
Q. I take it that was all slides that you were asked to review?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. As opposed to all slides for blocks that were going to Mount Sinai? See, what I'm getting at is this, we understand, and correct me if I'm wrong -

Page 316

DR. FONTAINE:
A. Okay.
COFFEY, Q.C.:
Q. - we understand that, you know, there were thousands of pathology reports printed out, okay, and of those, a certain number were identified as involving estrogen and progesterone testing.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And of those, those that might be considered negative results, negative ER results in the beginning, the original test, that those patients were identified and the surgical numbers identified and the thought was, the intention was that they would be all sent off to Mount Sinai, a block for each individual patient.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Okay. You understood that--or did you understand that the intention was, where possible, that the block on which the original

Page 317

ER and PR test was done -
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. - was going to be sent to Mount Sinai?
DR. FONTAINE:
A. That would be the--and provided that slide was not available, my impression -
COFFEY, Q.C.:
Q. Oh no, provided -
DR. FONTAINE:
A. Okay.
COFFEY, Q.C.:
Q. - if it was available.
DR. FONTAINE:
A. If it was available, my impression was that the block that I've chosen would not be sent. It would not be pulled.
COFFEY, Q.C.:
Q. Okay.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. So, and this is what I wanted to ask you about. In your review, were you looking at

Page 318

the original ER and PR slides -
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. - that were--and the corresponding H & E slide for that original ER and PR slide?
DR. FONTAINE:
A. Those would be the only slides I would not look at.
COFFEY, Q.C.:
Q. Okay. So you were tasked with, for all the patients identified to you, their surgical numbers, to find an alternate block for each of those that was identified to you?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. An appropriate alternate block?
DR. FONTAINE:
A. An appropriate, exactly, when available, appropriate with an internal control.
COFFEY, Q.C.:
Q. How long were you involved in that effort, Doctor?
DR. FONTAINE:

Page 319

A. I don't remember the specific time frame. I do remember Dr. Williams coming down and seeing--because I would just basically receive these folders of slides and then just go through them as they were presented on the spreadsheet, and it would have been--it was a significant amount of time, but I can't remember. Again, I just thought that I had a task to do and did it. I don't remember the specific time lines. But it was a significant endeavour.
COFFEY, Q.C.:
Q. And the slides in question, were you looking at slides from outside St. John's, as well as St. John's?
DR. FONTAINE:
A. Only in St. John's.
COFFEY, Q.C.:
Q. Only St. John's slides?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. And did you have to in any way--you had to identify the particular slides and corresponding block?

Page 320

DR. FONTAINE:
A. Correct. I was given a spreadsheet with the corresponding numbers and then on the spreadsheet it would say which one the ER/PR had been done on. So I would be able to identify, so I wouldn't look at that slide, and then I would look at other slides to select an alternate.
COFFEY, Q.C.:
Q. And did you--you would signify that, I take it, having made your choice, done your examination, made your choice, you'd write that in the sheet?
DR. FONTAINE:
A. I would write it in the spreadsheet.
COFFEY, Q.C.:
Q. Who did you give the spreadsheets back to?
DR. FONTAINE:
A. Mr. Barry Dyer.
COFFEY, Q.C.:
Q. Did you have any other involvement in the retesting process, in terms of -
DR. FONTAINE:
A. In what respect?
COFFEY, Q.C.:

Page 321

Q. Well, I'm just asking in any respect.
DR. FONTAINE:
A. Not that comes to mind, no.
COFFEY, Q.C.:
Q. You're identifying -
DR. FONTAINE:
A. No, this was what I did. This was my involvement, to my eye.
COFFEY, Q.C.:
Q. Exhibit P-0560, please? Doctor, this is a memo to all pathologists, St. John's hospitals, Eastern Health, from Dr. Cook, clinical chief, August 8th, 2005. It's re: ER and PR on current cases, and he writes "there will be a hold on reporting of ER and PRs by all pathologists in the Division of Anatomical Pathology, St. John's hospitals, Eastern Health" and goes on to say that "all ERs and PRs will be forwarded to Mount Sinai Hospital for immunohistochemical processing and reporting. The reports will be returned to Dr. Carter and released into the hospital information system. Hard copies of these reports will be forwarded to the appropriate physician. All pathologists will continue to

Page 322

order ERs and PRs on the respective cases, fill out the IHC request form and forward this to the technologist. The ER and PR immunohistochemical stain will simultaneously be processed by our technologists and sent back to the ordering pathologist. Once these stains are received, the ordering pathologist will give an interpretation using the enclosed form and forward this to Dr. Carter. That report is not to be released within the hospital information system."

Now Doctor, I take it that this is the notification to yourself and your fellow pathologists that the current and ongoing cases, testing in St. John's was going to be suspended for a period of time?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Had you known this was coming?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And you'd learned that from?
DR. FONTAINE:

Page 323

A. I knew it at the time because there was this talk of if we have a significant issue, we better find out what it is before we actually continue doing this. So we better get to the bottom of what's going on here. There was question could it be a problem with the new technology. We didn't really know, have a good handle on what the true issue was.
COFFEY, Q.C.:
Q. Doctor, you understood, in the meantime though, I take it, that the Ventana Benchmark system was being utilized for all the other IHC stains?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. So at the time, and I take it there would have been upwards of a hundred or more around that time?
DR. FONTAINE:
A. Easily.
COFFEY, Q.C.:
Q. Easily, you say. Was there any discussion at the time about well, you know, if there's a problem with the machine, if indeed there was

Page 324

really a problem with the machine itself, why would it be limited to ER/PR and why can we continue to use it for the other hundred odd stains? Was that discussed?
DR. FONTAINE:
A. Not to my recollection. I mean, there was discussion amongst different individuals as to why that was, but it was never beyond that. It never really came as a discussion point at a meeting or anything to that end.
COFFEY, Q.C.:
Q. At the time, did you have any thoughts yourself on that, in that regard? I take it you were comfortable with continuing with the IHC staining for everything else?
DR. FONTAINE:
A. I felt comfortable with the IHC staining and with the new technology, I was quite comfortable with the new technology as well. The product that I was seeing, I was quite comfortable with.
COFFEY, Q.C.:
Q. Sorry, I interrupted you. You were about to say--I asked you what--did you have any thoughts yourself at the time?

Page 325

DR. FONTAINE:
A. To be honest with you, I looked at this as that was the decision and again, my feeling with breast is they're the experts in this area. That's their decision. I'll go with it.
COFFEY, Q.C.:
Q. Doctor, and I take it then, you know, when you were on call, did your turn on call, while working a particular day at the bench, you would order your own ER and PR as a result of this?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. For your patient.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And this idea that you would continue to fill out the form, the IHC form, send it to the technologist.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:

Page 326

Q. That did happen as time went on?
DR. FONTAINE:
A. I believe, yes.
COFFEY, Q.C.:
Q. "The ER/PR IHC stain will be processed by our technologist and sent back the slides to the ordering pathologist." Did that happen? It's number -
DR. FONTAINE:
A. Yes, I'm trying to remember specifically, because again, it would--my experience was that it would be as if I was signing out a case like this. It was never brought to my attention beyond that again. Around this time as well, I'm sort of doing more cytology. So I'm not doing as much surgical sign out, but my impression is, yes, that was the way things were being done.
COFFEY, Q.C.:
Q. It was certainly being planned?
DR. FONTAINE:
A. It was being planned.
COFFEY, Q.C.:
Q. And whether it actually occurred or not, do you know if in fact you ever did process any

Page 327

case? Because you're not supposed to sign these out, I take it.
DR. FONTAINE:
A. No, exactly. I think that was the general message here was "don't sign them out" and then there was a lot of discussion as well, should we even be looking at them, and to speak to it specifically, I don't ever remember looking, in my own practice, at cases after that, because I was under the impression that we would send them to Mount Sinai.
COFFEY, Q.C.:
Q. Doctor, when cases would come back for a particular patient throughout August, September, October, those patients that you might have ordered an ER/PR test done and it ended up being done at Mount Sinai?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Would the results come back to you as the ordering pathologist?
DR. FONTAINE:
A. In my practice, I don't--I never received a report from Mount Sinai on my cases.

Page 328

COFFEY, Q.C.:
Q. And so if they were coming back, as it points out here, the idea was it was going to come back to Dr. Carter and it would be entered into the system?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. So having ordered the test, the results would not -
DR. FONTAINE:
A. Come back to you.
COFFEY, Q.C.:
Q. - according to this, would not come back to you as the individual ordering?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. Exhibit P-1939, please? Doctor, this is a memo from Dr. Cook to yourself and Maria Tracey. I take it she works with the perioperative program?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:

Page 329

Q. As program director, August 23rd, 2005, and Dr. Cook writes "I am requesting that all mastectomy specimens be placed in a large container completely immersed in ten percent formalin. Specimens should be immediately forwarded to the pathology lab where the breast tumour is appropriately sectioned to allow for even permeation and fixation by formalin. Cases should not be left overnight or over the weekend unsectioned as this may interfere with proper fixation of tissue." And "for cases that occur after normal working hours, the pathologist on call should be notified. Please make every attempt to have these--to ensure these cases are done early in the day and submitted to the lab before four p.m." Do you recall receiving this particular copy?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And did you--well, first of all, I'll ask you, why was it sent to you?

DR. FONTAINE:

A. Because it had been identified as one of the

Page 330

contributing issues, if you will, because again, we were talking about IHC and again, in speaking to IHC, fixation becomes an issue. It was not common practice, but sometimes you would receive specimens that would not be completely immersed in formalin. So it was to let the OR know that this was a practice that should be averted when possible.

COFFEY, Q.C.:

Q. Did you get any feedback on that?

DR. FONTAINE:

A. On this issue specifically?

COFFEY, Q.C.:

Q. Yes.

DR. FONTAINE:

A. In what respect?

COFFEY, Q.C.:

Q. Well, from the surgical program.

DR. FONTAINE:

A. Where it wasn't addressed to me, I think it would have probably been back to Dr. Cook, but I didn't receive anything, no.

COFFEY, Q.C.:

Q. Okay. Exhibit P-0561, please? Actually, no, I'm going to--I'll leave that. Instead,

Page 331

Exhibit P-0590? Doctor, this is a memo of September 6th, 2005, to all laboratory directors. You're listed as the first one. It's from Dr. Cook, September 6th '05, ERs and PRs is the subject matter, and Dr. Cook writes "I wish to advise you that we are doing a review of our ER and PR. I expect to have more information within the next few weeks and will keep you updated. Please note the following points" and then he requests that the lab directors "forward all ER negative cases on primary breast lesions, independent of PR status, from May '97 to March 31/04 to Barry Dyer," and then he talks about the various classifications of what constitutes negative. "From January 1, 2001, ER negative is defined as ten percent or less. From May '97 to December 2000, ER negative is defined as 30 percent or less."

Now Doctor, were you consulted about the utilization of these figures as cutoffs?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. Did you have any understanding, as the

Page 332

laboratory director, when you received this?

DR. FONTAINE:

A. Yes, I knew that there were these cutoffs. I knew that they existed.

COFFEY, Q.C.:

Q. And did you have any understanding as to how they were arrived at, in the sense of the time frames that were being utilized and the numbers?

DR. FONTAINE:

A. I've come to appreciate that.

COFFEY, Q.C.:

Q. Since?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. But how about at the time?

DR. FONTAINE:

A. At the time, I knew there was, but the specific numbers, I wasn't so familiar with, but I knew that there had been a change in the numerical assignment of negatives over that period of time.

COFFEY, Q.C.:

Q. And what have you come to understand since

Page 333

then?
DR. FONTAINE:
A. In what respect?
COFFEY, Q.C.:
Q. In the sense of the fact that these numbers -
DR. FONTAINE:
A. That these numbers would represent the times that are represented as being cutoffs where certain reports may be defined as negative or positive, as a result of these cutoff percentages.
COFFEY, Q.C.:
Q. And you've learned that from whom since, or your understanding since has come from where? Have you sat down and had oncologists explain it to you or pathologists explain it to you, in terms of how they arrived at this?
DR. FONTAINE:
A. Yes, because I seen a note from, I believe it was Dr. Khalifa, about the 30 percent and the reference from that point as well, and I knew there were a number of different references from that. I knew they existed, but the specific numbers again had escaped me.
COFFEY, Q.C.:

Page 334

Q. Have you ever made any investigation yourself as to the appropriateness or otherwise of those numbers and those particular time frames?
DR. FONTAINE:
A. So much to go to read the journals, if you wish?
COFFEY, Q.C.:
Q. Yes, yourself.
DR. FONTAINE:
A. I've never read the specific journals, but I know that those are the conclusions and other colleagues have discussed that in discussions with them. I guess these were national standards and international standards for the day.
COFFEY, Q.C.:
Q. From your perspective, I take it, as a pathologist, I mean, you were trained in fact--you were in training, in fact, around the time--training as a resident -
DR. FONTAINE:
A. And again, remembering -
COFFEY, Q.C.:
Q. - during this change over period.

Page 335

DR. FONTAINE:
A. - the practice, the practice in Halifax, again was to report percentages and much--looking back at this now, I see why Dr. Barnes was so adamant about talking about percentages rather than giving the declaration of positive or negative without qualification.
COFFEY, Q.C.:
Q. If we could, please, Exhibit P-1953? Now Doctor, this is a Division of Anatomical Pathology, minutes of a pathologists meeting of the General Hospital. It's October 4th 2005. Number of physicians present, listed as present, including yourself, the last one there.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. The meeting was called to order by yourself, as I take it you were the site chief.
DR. FONTAINE:
A. I was site chief at the time.
COFFEY, Q.C.:
Q. And approval of the earlier minutes, business arising, and then paragraph 3.2 on the second

Page 336

page, "update on ER/PR status." It reads "as all are aware, the media has gotten a hold of this issue. We are still in the process of determining how extensive this problem is. In view of this discussion with Dr. Cook, he has appointed--in view of this," yeah, "discussion with Dr. Cook, he has appointed Dr. Beverley Carter as the point person for HER2/neu testing. With this in mind, there was some sentiment from the pathologists that Dr. Carter should review all breast cases with a backup person to cover in her absence. A letter to this effect will be sent to Dr. Cook stating the opinion of the pathologists at this site and this will be discussed with Dr. Carter as well" and then there's a reference to an update on the pathology assistants.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And on surgical sign out. I wanted to ask you, Doctor, first of all, in terms of the ER/PR status matter, I take it then, if this is October of '05 and you had raised this back in September of '04 with your colleagues, Dr.

Page 337

Carter's request that perhaps she could look at HER2/neu, ER and PR.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And it had met with at least resistance from some of them anyway. You recall telling the Commissioner about that.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. This is 13 months later. Has the opposition or resistance -
DR. FONTAINE:
A. Sentiment has somewhat changed.
COFFEY, Q.C.:
Q. - lessened or evaporated?
DR. FONTAINE:
A. Yes, yes.
COFFEY, Q.C.:
Q. It has changed.
DR. FONTAINE:
A. I think it's changed.
COFFEY, Q.C.:
Q. And what, from your perspective, looking at

Page 338

this, what practically had changed?
DR. FONTAINE:
A. I think the sentiment of the notion that an issue like this could be addressed, again we could see trends if one individual was--and it was recognized to be a quality issue by the group in that trends such as ER/PR, if there was a drift such as tumours that we would expect to be positive are repeatedly negative, if you have a smaller group of dedicated people looking at something and I think people were just of the right mind set at that time then to move towards that, and with everything that was going on, it seemed to make sense, if you will.
COFFEY, Q.C.:
Q. Doctor, here, under new business, "4.1. Policy and Procedure Manual for grossing."
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. "Dr. D. Fontaine," that's yourself, "discussed with the group the intent to formulate a policy and procedure manual. This will be a draft circulated--there will be," I'm sorry,

Page 339

"a draft circulated shortly and specific pathologists will be assigned to different areas. With this in mind, the individuals will be responsible for certain areas of grossing. Once this has been completed, the document will be reassembled and distributed for approval from the group. This is expected to occur before the end of the year." Now Doctor, what was this about?
DR. FONTAINE:
A. This was the notion that we should have policies in place for grossing, that essentially when a specimen comes down, it should be handled the same way every day by all the individual pathologists, and so there would be continuity to that end.
COFFEY, Q.C.:
Q. I take it, Doctor, that as of this point in time, October '05, there was no such written policy?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. And in the absence of such a written policy, I take it different pathologists used different

Page 340

approaches.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. Depending upon how they were trained?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. And the idea would be that to draft written policies and have them distributed to particular pathologists who had expertise perhaps or an interest in a particular area?
DR. FONTAINE:
A. Correct. This is the way we do things here.
COFFEY, Q.C.:
Q. And kind of get a consensus, as it were?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And then --
DR. FONTAINE:
A. And then adopt within the group and recognize this is best practice.
COFFEY, Q.C.:
Q. Had that sort of approach existed in Halifax?

Page 341

DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. In your training?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. This -- a written policy as to how --
DR. FONTAINE:
A. It was in process. Again when I was in Halifax, there was a new divisional chief who was very forward thinking, and when she came in and recognized there was no policy and procedure manual in place, instituted one from that end. It took a significant amount of time, but it was in process when I left Halifax in 2003.
COFFEY, Q.C.:
Q. Now, Doctor, this initiative certainly talked about here in October of '05, how far did it get?
DR. FONTAINE:
A. It didn't get very far. Unfortunately, there were a number of other pressing issues, and again the work needed to be done. This is an

Page 342

endeavour that takes a lot of time and it was also difficult to find individuals who would be the point people for these. So it never even got so far as to designation of pathologists to different areas, unfortunately.
COFFEY, Q.C.:
Q. And to this day, it hasn't been concluded?
DR. FONTAINE:
A. Not to my knowledge, but --
COFFEY, Q.C.:
Q. How far has it gotten?
DR. FONTAINE:
Q. I know it's been worked on. I know there are several groups who have -- I know with the breast that this does exist to this end, and some other groups have made -- have gotten so far as to have drafts, but I'm not aware of where the entire process sits as of this date.
COFFEY, Q.C.:
Q. And that would be a written policy and procedure manual for grossing of particular types of tissue?
DR. FONTAINE:
A. That's correct.

Page 343

COFFEY, Q.C.:
Q. Breast tissue, for example?
DR. FONTAINE:
A. Correct. What -- what we would sort of use would be the pages of -- the back pages. If somebody was looking for something, again with the residents in mind, they could use that as their reference manual.
COFFEY, Q.C.:
Q. Exhibit P-1288, please. Now, Doctor, by this point in time -- well, this goes back to September 21st and I'll ask you about this in a moment because you'll see on the second page of this your letter of September 21st.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. To Mr. Gulliver, but the exhibit we were just looking at, that meeting of October 4th, it makes reference to the fact that the media has gotten a hold of the issue is the way it's described in the minutes. What was the reaction amongst the pathologists, do you recall, to the fact that this had gone public?
DR. FONTAINE:

Page 344

A. There was a lot of anxiety. There was again that whole notion of people were talking about us and we didn't really know what the magnitude of the problem was. There were all kinds of numbers being thrown about, yet we didn't -- we still didn't have a handle on what was the issue here.
COFFEY, Q.C.:
Q. Now you were the site chief for the General.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Were other pathologists at the General, for example, coming to you and asking what's going on, what do you know, Dan, in terms of --
DR. FONTAINE:
A. They wouldn't come to me. They would be more -- recognizing that I wasn't really a key player in this whole process, so they would be looking more to Dr. Cook to feed back that information.
COFFEY, Q.C.:
Q. Now you indicated that on August 5th, Dr. Cook had met -- we looked at that earlier.
DR. FONTAINE:

Page 345

A. Yes.
COFFEY, Q.C.:
Q. With the pathologists at the General. Was there -- before it went public or even just after it went public in October of '05, had Dr. Cook in the meantime met with you again as a group to let you know where things were?
DR. FONTAINE:
A. I can't remember specifically, but there were a number of meetings going on, more or less impromptu meetings and addressing -- sort of trying to put out fires as they came up.
COFFEY, Q.C.:
Q. What I'm trying to get at is --
DR. FONTAINE:
A. Nothing too --
COFFEY, Q.C.:
Q. How much, as a group, were you kept apprised of what was going on from day to day or week to week?
DR. FONTAINE:
A. The communication was a bit lacking, but I think it was also that there wasn't that much information because if we asked for updates, it was essentially there wasn't really

Page 346

anything to report. That information was slow to come back as well. So it was -- it was a very trying time.
COFFEY, Q.C.:
Q. Were you contacted by any pathologists from outside St. John's about this?
DR. FONTAINE:
A. Not about this particular --
COFFEY, Q.C.:
Q. Not about this matter?
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. Again looking at the September 21st, 2005, letter, page two of Exhibit P-1288, Doctor, this is your letter it's two pages long.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Copied to Drs. Cook and Williams. You're writing to Mr. Gulliver. How was it that you came to write this letter, what prompted you to do so?
DR. FONTAINE:
A. Again if you consider the timelines, I've

Page 347

completed my review of the slides at this time, and I saw that -- just looking at everything that was going on, there was an issue with immunohistochemistry, there was an issue with fixation, so these two issues were addressed in this letter because I felt if fixation is not addressed, the immunohistochemical issue may not be resolved either. Again thinking back to the earlier statements that I made, fixation is key to this process.
COFFEY, Q.C.:
Q. And so you wanted what then of Mr. Gulliver in relation to the fixation?
DR. FONTAINE:
A. With fixation, it was -- again you'll see in the second line in the second paragraph where I make reference to the fact that there is a variety of practice patterns involving various pathologists to which there is no standardized approach to grossing of specimens, and this would be best remedied by the introduction of pathology assistants into the program. So I sort of saw that that was a way that we could, in essence, standardize our gross room, take

Page 348

the pathologists out of the gross room. They had their practises, and the way to unify those practises was to bring other people in and get that moving, and again making the statement that this was the standard of practise at other tertiary care academic centres.
COFFEY, Q.C.:
Q. In fact, you -- the second last sentence of the second paragraph says, "This could be achieved with a standardized grossing policy and procedure manual".
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:
Q. "To which the department pathologists have indicated consensus to move into this direction", which is brought up in your meeting of October 4th?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. So by way of addressing then the fixation issue such as it can be through the grossing process, you're urging Mr. Gulliver to follow

Page 349

the pathology assistants path?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. With a written policy for the grossing procedures?
DR. FONTAINE:
A. First bringing in the pathology assistants. So it was first acquiring those pathology assistants and then having protocols for them to follow.
COFFEY, Q.C.:
Q. So that's the second paragraph of your letter. The first paragraph, I take it, is directed at the idea that a dedicated immunohistochemical lab is essential?
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And you wanted dedicated technologists?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. So up to this point in time, September of '05, there still were not dedicated technologists?

Page 350

DR. FONTAINE:
A. That's correct, and again you can see that I stated --
COFFEY, Q.C.:
Q. You state two dedicated, at least two?
DR. FONTAINE:
A. Minimum of two.
COFFEY, Q.C.:
Q. Yes.
DR. FONTAINE:
A. And again looking at -- being responsible for this lab and this lab is responsible for the provincial volume, that this really speaks to the patients of Newfoundland and Labrador.
COFFEY, Q.C.:
Q. Doctor, you -- the last two sentences of the first paragraph say, "As site chief, I feel it is imperative that we have this dedicated service to ensure quality to the patients of Newfoundland and Labrador. I would not support continuing performance of immunohistochemical staining at this site should these recommendations not be followed".
DR. FONTAINE:
A. Right.

Page 351

COFFEY, Q.C.:
Q. I take it, Doctor, that now it's apparent that eventually they were followed because there were dedicated technologists eventually assigned?
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. Doctor, was this hyperbole or was this, in fact, actually your honestly held view at the time that if you're not going to have dedicated technologists to IHC, should they be involved at all?
DR. FONTAINE:
A. It wasn't my own view alone. I discussed this with Dr. Ejeckam many times as well.
COFFEY, Q.C.:
Q. And --
DR. FONTAINE:
A. And other pathologists as well. We all felt that it was important that you needed to have dedicated -- that this would be their sole performance of duty, it was important, and they could have the resources afforded to them as well.

Page 352

COFFEY, Q.C.:
Q. Exhibit P-0619, please. This is a letter of October 4th, 2005, from Mr. Gulliver to yourself. He's responding to your letter.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Of September 21st, the one we just looked at, concerning recent problems experienced with IHC staining specifically regarding ER and PR, and he says, "As you are aware, we've had an external quality review performed by the leader in Pathology at the BC Cancer Institute, and the Chief Technologist of the Immunohistochemistry Section of Mount Sinai Hospital. Dr. Cook, Williams, and myself have received a preliminary assessment at our debriefing session with both these consultants. Their recommendations will be all encompassing, and currently Dr. Cook and myself are putting together a strategy to deal with the issues they referenced. The recommendations that we will be pursuing will encompass the issues that are outlined in your letter. I'm sure Dr. Cook will keep you

Page 353

apprised of the progress that is made in addressing these concerns. I want to thank you for your interest in this issue. I look forward to your ongoing participation". Now, Doctor, having written to Mr. Gulliver and received this response from Mr. Gulliver, did you actually think or feel that there was going to be any resistance from Mr. Gulliver to the idea of dedicated technologists?

DR. FONTAINE:

A. I didn't get the impression there was. We'd had discussion -- I think this was in his spectrum of desire as well.

COFFEY, Q.C.:

Q. It wasn't so much -- your letter wasn't written so much as you had to actually convince him?

DR. FONTAINE:

A. No, no, it wasn't going to be a very difficult argument. We'd had discussion and felt -- had similar views.

COFFEY, Q.C.:

Q. If we could, please, Exhibit P-0637. Now this is a letter of October 13th, 2005, addressed by Dr. Cook to Dr. Ejeckam. It's copied to a

Page 354

number of individuals, including yourself.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And it tells Dr. Ejeckam that Dr. Cook appreciates his continuing role in overseeing the immunoperoxidase service and he says, "We are in the process of developing a specialized service with a technologist solely dedicated in immunohistochemical technique". So I take it that certainly addressed one of your concerns?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And he says, "It's agreed, you", that is Dr. Ejeckam, "will oversee all aspects of the immunoperoxidase operation, have direct supervision over the technologist involved in the service. You will also provide direction to all pathologists involved in immunoperoxidase interpretation. In areas where we hope to develop sub-specialized service, there will obviously be consultation between you and the appropriate pathologists

Page 355

on immunoperoxidase staining. If you feel there's any deviation, you should report this immediately to the clinical chief and the VP medical". Now, Doctor, in relation to the IHC matter, was this, in effect, a significant change?

DR. FONTAINE:

A. From what was happening before?

COFFEY, Q.C.:

Q. Yes, in terms of --

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. The idea that Dr. Ejeckam would be --

DR. FONTAINE:

A. He had been taking the lead in this, so again more or less a formalization from that end.

COFFEY, Q.C.:

Q. Here, though it says "Direct supervision over the technologist involved in the service".

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. "And also provide direction to all pathologists involved in immunoperoxidase

Page 356

interpretation". I take it -- was that new?

DR. FONTAINE:

A. I wouldn't think it was. I would think that he was always there. I knew if I had immuno issue, I knew his door was open and -- open for discussion. So I don't think the pathologists would see that as a new statement.

COFFEY, Q.C.:

Q. Or as an imposition on them? From their perspective, this was just --

DR. FONTAINE:

A. It was available.

COFFEY, Q.C.:

Q. This was kind of codifying or documenting something, a state of affairs that, from your perspective, already existed?

DR. FONTAINE:

A. Was understood.

COFFEY, Q.C.:

Q. Understood. Now, Doctor, in Exhibit P-0619, we'd seen the reference to the leader in pathology at BC Cancer Institute. That would be Dr. Banerjee.

DR. FONTAINE:

Page 357

A. Yes.
COFFEY, Q.C.:
Q. And Trish Wegrynowski from Mount Sinai.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Had you known that they were coming to St. John's in September of 2005?
DR. FONTAINE:
A. I can't speak to the specific dates. I knew they were coming because I was actually meeting with Dr. Banerjee as part of his visit. Now Ms. Wegrynowski, I was aware there was somebody coming to review the technology end of things, but I can't speak to specific dates, but it would have been in around that time, I would expect.
COFFEY, Q.C.:
Q. Did you meet with Trish Wegrynowski when she was here?
DR. FONTAINE:
A. No, I did not, no.
COFFEY, Q.C.:
Q. I take it you weren't asked to?
DR. FONTAINE:

Page 358

A. No.
COFFEY, Q.C.:
Q. How about during her exit interview?
DR. FONTAINE:
A. No.
COFFEY, Q.C.:
Q. You did, though, meet with Dr. Banerjee in September of 2005?
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Why was it you -- how did you come to meet with him, what happened?
DR. FONTAINE:
A. He -- so he would have been given -- as part of his visit, he would have been given an itinerary and I had an hour meeting with him.
COFFEY, Q.C.:
Q. In your capacity as what?
DR. FONTAINE:
A. In capacity as site chief for the Health Sciences.
COFFEY, Q.C.:
Q. And do you recall what was discussed at the time?

Page 359

DR. FONTAINE:
A. Oh, yes, we discussed a lot of the issues. What I actually asked was, so what were your findings, and then I just sort of compared to what I -- what my views were.
COFFEY, Q.C.:
Q. So what were you told at the time by him?
DR. FONTAINE:
A. That -- much like what's in his report, that fixation was an issue and that was identified.
COFFEY, Q.C.:
Q. If we could, please, Exhibit P-0046, please. Doctor, this is a letter of -- well, it begins -- the first page is a letter of October 17th, 2005, to Dr. Cook. It's from Dr. Banerjee. It's a cover letter.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. That accompanied his report. Page two of the exhibit is the title page of the report, October 17th, 2005, and the report is only several pages long, the main body of the text. Doctor, in the report under -- he says, "Reviewed a number of cases from the

Page 360

retrospective testing set with Dr. Cook. All the cases that converted from negative to positive by switching platforms had one or more of the following characteristics. One, poor fixation", and you just referred to that, "Two, negative internal controls. Normal ductal epithelium when present was completely negative, or absent internal controls, there was no normal ductal epithelium present to evaluate".
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. And then on the next page under the heading "Conclusions about the reasons for test failure", it says, is the DAKO System faulty, and he says that's unlikely; is the Ventana System too sensitive, and he says there's no evidence that that's so. Then he says, "Is there a problem with tissue fixation", and "there appears to be inadequate attention paid by the grossing pathologist to the thickness of tissue slices, quality and adequacy of fixation, and there's no standardized fixation protocol that everyone adheres to". I take it

Page 361

that -- was this the sort of thing you discussed with him?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Number three?

DR. FONTAINE:

A. Yes, well actually looking at it now, we did discuss the issue of internal controls as well.

COFFEY, Q.C.:

Q. Yes, which is the fourth one, "inadequate or no attention is being paid by the reporting pathologist to the status of internal controls, to the inappropriate exclusive reliance and external positive controls." I wanted to ask you, before I get to that, Doctor, the first two things, the fact that the DAKO system, in his view, it's unlikely that it was faulty and the Ventana being too sensitive, there was no evidence of that. Was that discussed with Dr. Banerjee, the fact that--he wasn't attributing it to machinery.

DR. FONTAINE:

A. No, that's right.

Page 362

COFFEY, Q.C.:

Q. Had he let you know that?

DR. FONTAINE:

A. We did talk a bit about that because there was that question of is it a technical issue, is it really switching platforms, is that really the issue. And we sort of had discussions around that.

COFFEY, Q.C.:

Q. He conveyed to you what?

DR. FONTAINE:

A. He conveyed to me that it didn't seem to be the issue and I agreed, it didn't seem to be in my view either.

COFFEY, Q.C.:

Q. Now this reference to, number 3, "inadequate attention paid by the gross pathologist to the thickness of tissue slices."

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. I take it that that relates to the whole idea of the grossing procedure.

DR. FONTAINE:

A. Correct.

Page 363

COFFEY, Q.C.:

Q. And the lack of consistency or agreed approach.

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. Which you were trying to remedy with a written protocol?

DR. FONTAINE:

A. Trying.

COFFEY, Q.C.:

Q. Suggesting.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. In your meeting earlier in October, the meeting in October. The idea of trying to, as well, address the issue of fixation per se, because he goes on "quality and adequacy of fixation".

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. As the site chief, so much as that part of the matter, quality and adequacy of fixation that

Page 364

occurred outside the lab.

DR. FONTAINE:

A. Before we received -

COFFEY, Q.C.:

Q. Yeah, before you ever got the tissue at all, how much influence as site chief would you have on that or could you have on it?

DR. FONTAINE:

A. That would be an issue I'd likely take up with Dr. Cook, that I would take it to the next level to have that discussion at that level. I'm not, again, it's a small hospital, but I don't have that much interaction with the OR staff. In other departments, there would be more, more likely that I would just contact that individual directly, but for an issue like this, I would look at it as a clinical chief.

COFFEY, Q.C.:

Q. Now, what is numbered here, four and six, because there is no number five here, I take it No. 6 referencing inappropriate choice of blocks with no representative normal ductal epithelium is just a way of saying that there is no -

Page 365

DR. FONTAINE:
A. Internal control.
COFFEY, Q.C.:
Q. Internal control.
DR. FONTAINE:
A. Correct.
COFFEY, Q.C.:
Q. And four then deals with the matter of internal controls as well. Were you surprised by that at the time that Dr. Banerjee raised that with you, the fact that some of the slides he looked at had no normal tissue on and your practice in Halifax and here in St. John's when we looked at that '04 particular one I just happened to pull, the pathology report we looked at earlier.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. You were certainly aware of the importance of internal controls -
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. Having the tissue and -

Page 366

DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. So the fact that apparently some slides were being made without internal controls or they were there and were being reported, but they weren't stained.
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:
Q. And you described the process, you go through having it redone. Were you surprised by that when Dr. Banerjee raised that with you?
DR. FONTAINE:
A. Not really, because again, the timelines are important here. This is information that may have been gained after the recognition of this is an issue; in other words, we now know to look for internal controls, but back in 1997, I wouldn't say that it was a standard that everybody would be looking for internal controls. So again, we have to keep it in context with where we are, so if--and again, I did not pay attention, it was something that I did notice in my review as well. When I went

Page 367

to pick, because you'll remember when I picked the alternate blocks, there were instances where there were no--there was no opportunity to give internal control because there were no sections that have internal control within them, so that was an issue. The lack of recognition of the importance of internal controls, again, not really surprised considering the timelines with this, as well, like looking at--I wouldn't say it was common knowledge in 1997 and again, even up to when I trained, because again, in the Halifax experience because I could speak to, again, like you pointed out with the importance of the number of cut offs, those again came in my training period. The interpretation was an issue as well at that same time period because there were instances when I would be sitting with pathologists at the microscope and telling them about the importance of internal controls and they were not aware of that.
COFFEY, Q.C.:
Q. They were not.
DR. FONTAINE:
A. So that is not a--although it may seem like a

Page 368

very striking statement, again, considering the timelines.
COFFEY, Q.C.:
Q. Here, Doctor, in the first page of text of Dr. Banerjee's report is the beginning of a background, the incident problem case, he concludes that paragraph under the second heading "Four other patients previously tested in 2002 were also retested and all tested positive with the Ventana. This led to a review of other 57 cases reported in 2002 as negative which on retesting on the Ventana, resulted in a high conversion rate from negative to positive, 67 percent"--38 out of 57, I'm sorry, 67 percent.
DR. FONTAINE:
A. Yes.
COFFEY, Q.C.:
Q. So and again, I'm not suggesting necessarily that all the ones that did not have internal controls are 2002 cases.
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:
Q. But certainly reading the report, it's

Page 369

apparent that perhaps a number of them were 2002. Now in '02, by the time you left Halifax, the idea of using internal controls for ER and PR was well known, I mean, in your training.

DR. FONTAINE:

A. In my training, but again, remember this is Dr. Barnes -

COFFEY, Q.C.:

Q. The pathologist who may have trained before your time might not have been as aware -

DR. FONTAINE:

A. I wouldn't expect them to be aware of that issue, because again, Dr. Barnes was fresh from her fellowship training in Nottingham at the U.K, so I can't speak to what would have been the knowledge base prior to that, but I know coming in, I was quite fortunate in that sense to have had that experience.

COFFEY, Q.C.:

Q. Doctor, have you ever looked in textbooks as to, that would deal with this kind of subject matter and do they actually spell out that you should be using internal controls?

DR. FONTAINE:

Page 370

A. There is, just as a general rule, if there's internal control available because it's not only specifically to breast, again it's prostrate, if there is a tissue that has it available, you're best to select a block that has internal control. So in this day and age, yes, I would expect, but again, leading up to my exam and reading textbooks at the time, it was not something that was commonly placed in textbooks at that day.

COFFEY, Q.C.:

Q. You were preparing for your exams, I take it, in -

DR. FONTAINE:

A. In 2002/2003. Again, it would be more in the journals, so again we expect, textbooks have a delay, so the textbooks of today would certainly have that information.

COFFEY, Q.C.:

Q. So the journals then, I take it, it would have been apparent in your days as a resident, in the journals, if somebody went to look to find out how to do this properly -

DR. FONTAINE:

A. Yes.

Page 371

COFFEY, Q.C.:

Q. You could easily enough figure it out as a pathologist?

DR. FONTAINE:

A. You could find it in--yes.

COFFEY, Q.C.:

Q. Exhibit P-0047 please? This is Patricia Wegrynowski's report, Doctor. Did you at the time as site chief receive a copy of this in November of '05?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. Now, Doctor Banerjee's report, P-0046, did you see a copy of that in 2005?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. Did you ever get read the contents of it? Were you ever told the contents of it?

DR. FONTAINE:

A. We were told the contents at a meeting with Dr. Cook, so there was a staff meeting where he read out the recommendations, but we were not allowed to actually look at the document

Page 372

per se.

COFFEY, Q.C.:

Q. Read the recommendations, did he read the actual body of the report as well?

DR. FONTAINE:

A. I can't remember specifically if I read--I was more concerned with the recommendations because I think that's what I remember more vividly.

COFFEY, Q.C.:

Q. Now, Doctor, do you recall when it was that Dr. Cook held that meeting?

DR. FONTAINE:

A. I can't say, no, for a specific--I know it would have been after I had met with Dr. Banerjee, obviously, but it was probably in the timeline of one or two months following.

COFFEY, Q.C.:

Q. Following Dr. Banerjee's visit?

DR. FONTAINE:

A. Yes or perhaps even longer.

COFFEY, Q.C.:

Q. What was the reaction--I take it this is with the Health Science's Centre pathologists?

DR. FONTAINE:

Page 373

A. Correct.
COFFEY, Q.C.:
Q. What was the reaction?
DR. FONTAINE:
A. I think people were a bit concerned by the fact that it identified issues that could have been related to practice.
COFFEY, Q.C.:
Q. And what did they say about it, do you recall?
DR. FONTAINE:
A. Not specifically, what would you be looking for?
COFFEY, Q.C.:
Q. Well in the sense of, I'm just trying to get the Commissioner to get some sense of, if you're kind of told the results of what we see to be Banerjee's report -
DR. FONTAINE:
A. There was more silence, I guess, after the discussion, it was more of a silence, there weren't people shouting up and down, and saying oh no, that's not what it is. It was more of a silence and just sort of trying to take it all in.
COFFEY, Q.C.:

Page 374

Q. And people's reaction was not to project, no, that's not so.
DR. FONTAINE:
A. That's correct.
COFFEY, Q.C.:
Q. It was just kind of accepted or at least didn't protest it.
DR. FONTAINE:
A. No, that's correct.
COFFEY, Q.C.:
Q. Exhibit P-2024 please? And in terms of Trish Wegrynowski's report, I take it you didn't see it. Were you generally told what she'd found?
DR. FONTAINE:
A. I had come to recognize some of the issues, I know some of the technologists had mentioned some issues that were brought forth by Ms. Wegrynowski but the detailed specifics, no.
COFFEY, Q.C.:
Q. This is a letter of November 26th, 2005 from yourself to Dr. Cook, it's copied to a number of individuals. "I write to inform you of my decision to resign as site chief of the Health Science's Centre"--and you indicate, "the events of the past few months have taken a

Page 375

personal and professional toll" and you wish to concentrate your efforts on cytopathology and research and you're thinking at the time about relocating and you're going to give notice "I will resign my position as site chief as of the 1st of January and hope it doesn't place too much inconvenience on the department." So, Doctor, I take it that by the end of November that you were tired?
DR. FONTAINE:
A. I was getting a bit--essentially because I came into this not expecting what was going to fall on my lap, if you will, and again, the notion of pick your battles. There were a lot of issues that I was trying to move forward in cytopathology as well, so this wasn't in isolation. I was trying to acquire liquid based technology for the cytopathology lab, so and the research efforts were ongoing as well, so I just found that it was just better that somebody else take the lead in this situation.
COFFEY, Q.C.:
Q. What were the staffing levels from the time April 1, '05, you took over until the end of '05, when you were going to resign as site

Page 376

chief? Do you recall -
DR. FONTAINE:
A. I don't really recall specifically, but I know that we had had individuals apply and then there was some--there was another individual left and again, around this timeline, I can't remember to speak to the specifics, but there was a number of retirements that came to fruition in this timeframe as well. These were individuals who had been with the department for very long periods of time and my feeling was it's going to be a very rough road ahead because we're going to have difficulty recruiting. These were people who had stayed here for a long time and had served as tolerants, if you will, throughout the storm, because as you've heard there had been a number of people who rotated through this department, if you will.
COFFEY, Q.C.:
Q. Exhibit P-0121 please? Doctor, this is a document entitled "Review of Immunohistochemistry Lab, General Hospital Site, St. John's, Eastern Health", prepared for Dr. Williams by Terry Gulliver and Dr.

Page 377

Cook, October 13th, 2005. The Commissioner has seen this before, I'm just wondering, were you given a copy of this?

DR. FONTAINE:

A. It's very familiar, I'm sure I have a copy of this.

COFFEY, Q.C.:

Q. And this would have been in your--you would have received this as site chief at the time?

DR. FONTAINE:

A. Yes, I would believe, yes.

COFFEY, Q.C.:

Q. Objective 1.2, "The objective of this proposal is to identify the requirements needed to implement a complex quality assurance program for the immunohistochemistry lab, ensuring that we provide a standardized and reliable service equivalent to the Mount Sinai reference lab in Toronto. I take it that the scope of this proposal includes a review of all the components of the IHC service, from grossing specimen to pathologist interpretation." So the idea, you would receive this as a report as to what they planned to do?

Page 378

DR. FONTAINE:

A. Yes, correct.

COFFEY, Q.C.:

Q. Exhibit P-2334. Doctor, this is a memo of November 16th, 2005 from Maria Tracey, program director of the surgical program from yourself, as site chief. And policy regarding mastectomy specimens at Health Sciences Centre and you say "all mastectomy specimens must be placed in a large container, completely immersed in 10 percent formalin, the ideal volume of formalin to specimen is 10 to 1. And you talk then about what should be done about it, including the reference to cases should not be left overnight or on the weekend unsectioned.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. And what should happen if it happens outside regular hours. Why was it that you, why was it necessary to send this to Marie Tracey on November 16th, 2005?

DR. FONTAINE:

A. Again, if you think back to the exhibit with

Page 379

Dr. Cook's, it's more or less a mirror of this and this is more or less now a policy because where the other one was a letter, we sort of said, well, let's put this as a policy regarding this. So this is now our policy and there was a case where this happened and the pathologist on call was difficult to get a hold of and that's why you'll see, if you go back to the other exhibit, the--if this is still unsuccessful, the clinical chief of laboratory medicine, so that's a bit different than what the original, the way the original would have said the pathologist on call, so this was a bit more explicit directive for the surgical program in case they couldn't get hold of the on call pathologist.

COFFEY, Q.C.:

Q. So was there a policy then before this, a written policy or is this -

DR. FONTAINE:

A. The written policy would have been the letter that Dr. Cook would have sent to Maria Tracey.

COFFEY, Q.C.:

Q. Back in August.

DR. FONTAINE:

Page 380

A. Whether it was--it didn't state that it was a policy, but it was a letter that was sent, so they would have been notified, but whether you want to call it a formal policy.

COFFEY, Q.C.:

Q. So here, Doctor, I take it then in mid November, was this done, sent by you at Dr. Cook's request or was this something you took upon yourself?

DR. FONTAINE:

A. I guess it would have been both in consultation with Dr. Cook, giving them directive as well, to make sure that we have, we've explicitly stated it's not enough to just call the pathologist on call and just say, well if they don't call back, what do you do? So now you try calling them at home and if that's unsuccessful, then you call the clinical chief.

COFFEY, Q.C.:

Q. So, Doctor, by the time--did you leave then at the end, as site chief, at the end of 2005?

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Page 381

Q. Did you ever subsequently take on the role of a site chief or the equivalent? I'm not suggesting you did, I'm just -

DR. FONTAINE:

A. No, I stayed away from that, I thought, well the first time I got into it, this broke, I thought, I don't want to get back into that. I was concentrating on cytopathology.

COFFEY, Q.C.:

Q. Now, Doctor, in the meantime then, by the time 2005 ended, did you have any involvement that we haven't covered in relation to ER/PR that I haven't talked to you about?

DR. FONTAINE:

A. None that comes to mind. I mean, my role was more or less as site chief, I wrote a couple of letters from that end, but I saw that the lion's share, the decisions being made were coming from Drs. Cook and Carter, from the pathology aspect.

COFFEY, Q.C.:

Q. Now here, if we could please, Exhibit P-2044? Just before I, I don't forget to ask you about it, I'll ask you now. Doctor, the Commissioner has heard a fair amount of

Page 382

evidence about communication with patients and you know, with the timing of it and what should or shouldn't be done. Were you ever consulted about that?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. And I take it, I'm asking in the context as site chief.

DR. FONTAINE:

A. No, that's correct, no.

COFFEY, Q.C.:

Q. Did you ever offer an opinion on it?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. Here, Doctor, P-2044, February 1st, 2006 memo from Dr. Cook, it's to a number of individuals, including yourself.

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Now these other individuals are in the main, the site chiefs, as it were, for pathology.

DR. FONTAINE:

Page 383

A. Yes.

COFFEY, Q.C.:

Q. Or the equivalent title, other than Dr. Williams throughout the province. It's ER/PR reports from Mount Sinai and he says, "We have received most of the reports from Mount Sinai regarding ER/PR review process" and he talks about them being on Excel spreadhsheets and the fact that he's going to prepare individual reports, that is Dr. Cook is. Why were you sent this, do you know?

DR. FONTAINE:

A. I don't know, I think it was just for completion, but I actually never received any reports or, like the results on Excel spreadsheets, so I think it was just more for completion.

COFFEY, Q.C.:

Q. So do you know when you were replaced as site chief, I understood you resigned as of the end -

DR. FONTAINE:

A. That's right.

COFFEY, Q.C.:

Q. Do you know who replaced you and if so, when?

Page 384

DR. FONTAINE:

A. Dr. Morris-Larkin and it would have been shortly around the time of January 1st, I believe was the date. Again, it was a fairly loose timeline, but I can't remember specifically if the transition went for February 1st, but again, to speak to this issue here, that would have been something that I don't expect we would have seen. Anyways, I'd be surprised if my predecessor-- or my successor would have received that. I'm not sure, but I can't speak--it's Dr. Morris Larkin.

COFFEY, Q.C.:

Q. Okay, and you would have understood--you understood at the time this was kind of being sent to you bearing in mind the names of the other individuals because you had been site chief at -

DR. FONTAINE:

A. Correct.

COFFEY, Q.C.:

Q. - at the earlier time.

DR. FONTAINE:

A. At the time, exactly.

Page 385

COFFEY, Q.C.:
Q. At the time did you see that you had any responsibility arising out of this from your perspective?
DR. FONTAINE:
A. No, I mean, I think because it fell--that would have been already taken care of at our institution.
COFFEY, Q.C.:
Q. Exhibit P-1748 please? Doctor, these are handwritten notes, I believe of Dr. Cook, February 8th, 2006. It's a meeting at the Health Sciences Centre, meeting regarding update and implementation of ER and PR. Present are Drs. Cook, Ejeckam, Carter and Fontaine, Mr. Gulliver, Mr. Dyer, Mr. Simms, Ken Green and Mary Butler. Do you recall attending this meeting and if so, why you were there? This is February 8th.
DR. FONTAINE:
A. I'm trying to think of, because at this time-- yeah, because I was on my way out at this point.
COFFEY, Q.C.:
Q. It says "Meeting started with both Ken Green

Page 386

and Mary giving written reports of their experiences in Mount Sinai, Mary, that is, and in Montreal, Jewish General, Ken. Ken brought back information from Montreal and types of antibodies used and protocols." Then it goes on some length about that and it says "Drs. Carter and Ejeckam commented on the staining for ERs and PRs seem to be good correlations and reproducibility with ER results in comparison with Mount Sinai, less so for PR. All agreed that implementation date of March 31, 2006 seems feasible. General discussion followed, including the prospect of bringing in digital microscopy with image analysis." And it goes on from there. Do you recall why it was that you were at this meeting?
DR. FONTAINE:
A. I don't specifically remember this meeting, to tell you the truth.
COFFEY, Q.C.:
Q. And again I'm only assuming you were there because you were listed.
DR. FONTAINE:
A. Right.
COFFEY, Q.C.:

Page 387

Q. That doesn't necessarily mean --
DR. FONTAINE:
A. I don't actually remember being at this meeting. I've been at meetings where some of these issues were discussed, but I don't remember these individuals at a meeting with myself.
COFFEY, Q.C.:
Q. And by this point in time, that is early February, 2006, you know, what if any involvement did you have then in your professional role with this aspect of the matter?
DR. FONTAINE:
A. Again just thinking back -- because my resignation came in --
COFFEY, Q.C.:
Q. Well, it says your resignation came -- you planned to resign effective the end of the year.
DR. FONTAINE:
A. The end of the year, yes.
COFFEY, Q.C.:
Q. Now whether you did or not that's --
DR. FONTAINE:

Page 388

A. Because I did put my resignation on for February.
COFFEY, Q.C.:
Q. So it's possible that this is just really a carry over?
DR. FONTAINE:
A. Yes, quite possible, because I know I did get to a point where I had decided that I was going to be leaving and that was in February where I would no longer be in the employment of Eastern Health. I don't remember this meeting specifically, no.
COFFEY, Q.C.:
Q. Exhibit P-1590. Doctor, it's a fax coversheet of the attached memo to Drs. Fontaine, Ejeckam, Mr. Gulliver and Mr. Dyer, from Dr.Cook, March 6th, 2006, implementation of new immunohistochemical antibodies, "All new antibodies that are requested by pathologists for immunoperoxidase service have to be approved by the chief pathologist overseeing immunohistochemistry. No new antibodies will enter the system until they're signed off on the protocol form by the pathologist overseeing the IHC service". So, Doctor, do

Page 389

you know if -- even why you were sent this; if you did receive it, why?

DR. FONTAINE:

A. It doesn't strike me any -- I mean, it's not one that I would have been particularly overwhelmed with, but I don't know if I -- because for a period of time again, I did take over as the director for immunohistochemistry as well.

COFFEY, Q.C.:

Q. Now it's around this time, this is in March of '06 that Dr. Ejeckam is planning on leaving?

DR. FONTAINE:

A. Right.

COFFEY, Q.C.:

Q. He's going to leave in April of '06.

DR. FONTAINE:

A. Okay.

COFFEY, Q.C.:

Q. So when did you get involved then in terms of being director of immunohistochemistry?

DR. FONTAINE:

A. When Dr. Ejeckam left, that's when I sort of stepped in, if you will.

COFFEY, Q.C.:

Page 390

Q. And in leaving as site chief, were you ever asked to create a job description?

DR. FONTAINE:

A. No.

COFFEY, Q.C.:

Q. Now, Doctor, if we could, please, Exhibit P-2068. Doctor, these are minutes of Discipline Laboratory Medicine meeting of March 28th, 2006. There are a number of people in attendance, including yourself listed there, and under "New business - Quality Assurance", there's a reference to Dr. Denic having thanked Dr. Cook for all his work and implementation of the new quality assurance program was discussed at length, and Dr. Beverley Carter will act as manager, and it goes on from there to talk about that. Why would you have been attending this?

DR. FONTAINE:

A. Now that I think about it, because I probably only served resignation in April. The more I'm thinking about this now, when I actually left the position, because the timelines are somewhat blurry for me, but that would be my recollection now, looking at it that I'm

Page 391

staying on this long because this timeline is quite different than what I remember. Again the years have become a bit blurred, if you will.

COMMISSIONER:

Q. So are you saying you were still acting as site chief?

DR. FONTAINE:

A. I think I was still acting as site chief in this capacity, yes, yes, because I think when -- looking at it now, I believe that it would have been around April because whether there was a replacement forthcoming, I can't speak to you specifically, but it looks like that I would still have been in that position.

COFFEY, Q.C.:

Q. So, Doctor, I take it then it's in that capacity then that you would have been attending this meeting?

DR. FONTAINE:

A. I believe so, yes.

COFFEY, Q.C.:

Q. Now the initiative here, this QA initiative that Dr. Carter is going to head up, I take it that that had -- had that been going on for

Page 392

some period of time before this?

DR. FONTAINE:

A. There was a lot of discussion as to that being brought to fruition.

COFFEY, Q.C.:

Q. How far had it advanced, do you know?

DR. FONTAINE:

A. So far as to have Dr. Carter being the manager. So this was -- this was now going to happen.

COFFEY, Q.C.:

Q. If we could, please, Exhibit P-2076.

COMMISSIONER:

Q. Mr. Coffey, when you find a spot.

COFFEY, Q.C.:

Q. Yes. Now this is a letter of April 24th, 2006. It's from Dr. Denic to Dr. Elms regarding his appointment of Assistant Director of Immunohistochemistry Department, St. John's Hospitals, Eastern Health, and Dr. Denic, as clinical chief says it gives him great pleasure to appoint Dr. Elms as Assistant Director of Immunohistochemistry Department. He continues on, "Along with Dr. Dan Fontaine, Director of Immunohistochemistry

Page 393

Department, you will take on and assume responsibility for the services provided with a goal of achieving excellence in the field of immunohistochemistry" and this happens to be copied to Drs. Williams, Fontaine, Carter, and Mr. Gulliver. So that when Dr. Elms came on as assistant director, you were already --

DR. FONTAINE:

A. Right, after Dr. Ejeckam had left, I was -- I had gained that appointment as well.

COFFEY, Q.C.:

Q. Now, Doctor, you remained as Director of Immunohistochemistry for how long?

DR. FONTAINE:

A. Not very long, because I know as Dr. Elms came on stream, I was fairly quick releasing myself from that role.

COFFEY, Q.C.:

Q. And at the time -- I mean, how long would you have been, do you think, director?

DR. FONTAINE:

A. It would have been from the time that Dr. Ejeckam would have resigned -- sorry, retired?

COFFEY, Q.C.:

Q. Retired.

Page 394

DR. FONTAINE:

A. Yes.

COFFEY, Q.C.:

Q. Which we understand is April certainly of 2006 he was gone. He left during that month. So you would have remained, though, as director for about how long?

DR. FONTAINE:

A. What's the date on --

COFFEY, Q.C.:

Q. That's April 24th, 2006.

DR. FONTAINE:

A. It would be fairly short order. I would say within that next month.

COFFEY, Q.C.:

Q. So then as director what, if any, involvement did you have in the IHC service in a practical way during that short period of time you were the director?

DR. FONTAINE:

A. Again trying to optimize and serving as a point person, optimizing antibodies as they came on stream. Should a new antibody become available, it would be to work that antibody up to make it optimized.

Page 395

COFFEY, Q.C.:

Q. And if you could, just before we finish then, that involved what?

DR. FONTAINE:

A. Essentially working with the technologists to look at different concentrations, antigen retrieval times, different parameters with the immunohistochemistry for development of protocol that we could use to optimize the antibody.

COFFEY, Q.C.:

Q. Now did you -- had you had any actual training in a technological sense, formal training involving IHC?

DR. FONTAINE:

A. Not beyond --

COFFEY, Q.C.:

Q. Other than what you've already told us about?

DR. FONTAINE:

A. Not beyond what I've already told you about, the academic or the -- in my residency.

COFFEY, Q.C.:

Q. And tomorrow morning, Commissioner, I will not be long. Thank you.

UPON CONCLUSION

Page 396

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 17th 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 17th day of July, A.D., 2008

Judy Moss

-F-

-G-

-H-

-N-

-O-

-P-

-Q-

Q.C./Mandy [1] 1:7

QA [13] 53:24 57:13,18 57:20 91:5 199:22,22 200:3,4,22 201:2,5 391:23

QC [1] 66:1

qualification [1] 335:7

quality [24] 23:24 62:13 72:24 80:17,19,23 81:8 89:11 113:10 172:21 200:6 201:10,12,15 299:22 338:6 350:19 352:12 360:23 363:19,25 377:15 390:11,14

quarterly [2] 37:20,25

questioned [1] 163:8

questions [14] 15:8 76:20 95:19 102:24 103:13,19,24 104:4,12 113:17,22 114:1,6 150:1

Quevillon [1] 35:11

quick [1] 393:16

quiet [1] 26:6

Quinlan [2] 32:12 87:22

quite [13] 14:7 96:9 131:1 162:19 212:11 246:10 253:6 271:25 324:18,20 369:18 388:7 391:2

-R-