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| <p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">July 17, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C./Mandy Woodland Commission Co-counsel</p> <p>Jackie Brazil Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Darlene Russell. Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Blair Pritchett. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p> | <p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBITS P-1842 THROUGH P-1847 CANCELLED Pg. 4 EXHIBITS RE-ENTERED AS C-0174 THROUGH C-0179 Pg. EXHIBIT P-2330 Pg. 120 EXHIBITS P-2332 THROUGH P-2337 Pg. 120 EXHIBITS C-0180 AND C-0181 Pg. 219</p> |
| <p style="text-align: center;">TABLE OF CONTENTS</p> <p>MS. MARY BUTLER - RESUMES THE STAND</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 4 - 104 Examination by Jennifer Newbury Pgs. 104 - 114 Examination by Daniel Simmons Pgs. 114 - 118</p> <p>DR. DANIEL FONTAINE - SWORN</p> <p>Examination by Bernard Coffey, Q.C. Pgs. 118 - 396</p> <p>Certificate</p> | <p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER: 2 Q. Please be seated. Ms. Chaytor. 3 MS. MARY BUTLER, RESUMES STAND, EXAMINATION BY MS. SANDRA 4 CHAYTOR (CONT'D) 5 CHAYTOR, Q.C.: 6 Q. Good morning, Commissioner. Good morning, Ms. 7 Butler. 8 MS. BUTLER: 9 A. Good morning. 10 CHAYTOR, Q.C.: 11 Q. Commissioner, there were a number of exhibits 12 entered yesterday as P exhibits and I'm going 13 to ask that those exhibits be cancelled and we 14 enter them as C exhibits. They are pathology 15 records with names redacted, but just to be on 16 the side of caution, we'll have them entered 17 as C exhibits instead. And those are P- 1842 18 through to P-1847 inclusive, and the new 19 numbers will be C-0174, C-0175, C-0176, C- 20 0177, C-0178 and C-0179. 21 THE COMMISSIONER: 22 Q. All right then, P-1842 through to 1847 23 cancelled and they become C-0174, 75, 76, 77, 24 78 and 79. 25 EXHIBITS P-1842 THROUGH P-1847 CANCELLED</p> |

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1 EXHIBITS RE-ENTERED AND MARKED AS C-0174 THROUGH C-0179

2 CHAYTOR, Q.C.:

3 Q. Yes, not necessarily in that order though,

4 Commissioner. I can give you which become

5 which, if that's helpful. It may be helpful

6 to counsel actually because they can make the

7 changes on their documents.

8 THE COMMISSIONER:

9 Q. Yes, but won't we produce them as C forms to

10 people?

11 CHAYTOR, Q.C.:

12 Q. We will produce them as C forms, yes, but I

13 will be referring to them this morning.

14 THE COMMISSIONER:

15 Q. Oh, okay.

16 CHAYTOR, Q.C.:

17 Q. And they may not have them. What I'll do is

18 when I bring the exhibit up, I will indicate

19 which it was, the original number.

20 THE COMMISSIONER:

21 Q. All right, thank you.

22 CHAYTOR, Q.C.:

23 Q. If we could have, please, Registrar, 2173,

24 page 60? Ms. Butler, when we finished up

25 yesterday, I was taking you through a number

Page 6

1 of pages in this exhibit. You'll recall this

2 exhibit is a list of request forms for ER/PR

3 testing in 2003.

4 MS. BUTLER:

5 A. Yes.

6 CHAYTOR, Q.C.:

7 Q. And on this particular form, which is the

8 requisition, looks like it came in from Dr.

9 Dankwa on April 10th, 2003, and the test was

10 carried out by you on May 2nd, 2003 and I take

11 it this would be a repeat on May 30th, 2003?

12 MS. BUTLER:

13 A. Yes.

14 CHAYTOR, Q.C.:

15 Q. And it's written here "tissue washing off."

16 Is that your handwriting?

17 MS. BUTLER:

18 A. That's mine.

19 CHAYTOR, Q.C.:

20 Q. Okay. Now it's not signed again on May 30th,

21 but is that your writing?

22 MS. BUTLER:

23 A. That's my writing again, yes.

24 CHAYTOR, Q.C.:

25 Q. So you repeated the test later on in the

Page 7

1 month?

2 MS. BUTLER:

3 A. Later on, yes.

4 CHAYTOR, Q.C.:

5 Q. Okay, and then at page 62 of the exhibit, we

6 have a request from--can you--the doctor's

7 name here, is it Dr. Luer?

8 MS. BUTLER:

9 A. I think so.

10 CHAYTOR, Q.C.:

11 Q. May 15th, 2003, and this is for estrogen as

12 well as HER2/neu?

13 MS. BUTLER:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. And this one is--the ER/PR is done May 26th

17 '03 and then the HER2/neu is May 30th. So in

18 this case where we see your name signed twice,

19 it's two different tests?

20 MS. BUTLER:

21 A. Two different tests.

22 CHAYTOR, Q.C.:

23 Q. Okay, and if that were to be the case, you

24 would write in the second test or the second

25 test would also be indicated up in the--would

Page 8

1 be circled in the index, I take it?

2 MS. BUTLER:

3 A. I think so, yes.

4 CHAYTOR, Q.C.:

5 Q. Okay. Then on the back of that form, we have

6 June 5th, 2003 in the corner. So I take it

7 that's when you sent it back?

8 MS. BUTLER:

9 A. That's when I sent it, yes.

10 CHAYTOR, Q.C.:

11 Q. And what does it mean to have a check mark and

12 the number 50?

13 MS. BUTLER:

14 A. Whenever you sent out a case, you had to sign

15 it off the system.

16 CHAYTOR, Q.C.:

17 Q. What's the significance of the 50? What does

18 50 mean? What's the significance?

19 MS. BUTLER:

20 A. That's S-O, signed out.

21 CHAYTOR, Q.C.:

22 Q. Oh, that's signed out, thank you. There you

23 go, learned something new today.

24 MS. BUTLER:

25 A. Always had to have reminders.

Page 9

1 CHAYTOR, Q.C.:
 2 Q. So that's what you would normally do on the
 3 back of your form when it's signed out?
 4 MS. BUTLER:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and then if we look at 68, this is
 8 another test for Dr. Luer, and I believe it's
 9 March 20th, 2003?
 10 MS. BUTLER:
 11 A. Um-hm.
 12 CHAYTOR, Q.C.:
 13 Q. And HER2/neu is crossed off and estrogen and
 14 progesterone is still circled, and the
 15 original test is done by Mr. Simms, March 26th
 16 '03, and then we have your signature for May
 17 2nd, 2003?
 18 MS. BUTLER:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. So would that have been a repeat of the ER/PR?
 22 MS. BUTLER:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. And then you did the HER2/neu on May 30th, 2003?

Page 10

1 MS. BUTLER:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And on this form again, you've indicated
 5 checked by Dr. Ejeckam?
 6 MS. BUTLER:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. So in May of--on May 2nd, 2003, this is your
 10 writing?
 11 MS. BUTLER:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. It was checked by Dr. Ejeckam?
 15 MS. BUTLER:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And again, that meant that he checked all the
 19 slides?
 20 MS. BUTLER:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. Not just the control slides?
 24 MS. BUTLER:
 25 A. Yes.

Page 11

1 CHAYTOR, Q.C.:
 2 Q. On May 2nd, and we see up here in the corner,
 3 it's indicated that it was a repeat.
 4 MS. BUTLER:
 5 A. Repeat, yes.
 6 CHAYTOR, Q.C.:
 7 Q. So that's a repeat from the March test?
 8 MS. BUTLER:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. If we could have, please, Registrar, page 78?
 12 Page 78 has written at the top "repeat with
 13 control on slide" and this is, I think--the
 14 dates are difficult to see on this. Would it
 15 be June or March of '03? Not sure?
 16 MS. BUTLER:
 17 A. I'm not sure.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, and I don't know if you can read this or
 20 not. Is this your handwriting?
 21 MS. BUTLER:
 22 A. No.
 23 CHAYTOR, Q.C.:
 24 Q. It says "the staining on the test" and then
 25 there's something, not sure what's written

Page 12

1 there.
 2 MS. BUTLER:
 3 A. No. It's something about, I think, Pat
 4 wanted--I'm not sure if that's only started--
 5 I'm not sure of the date line when we started
 6 putting controls on the slides.
 7 CHAYTOR, Q.C.:
 8 Q. That seems to be -
 9 MS. BUTLER:
 10 A. But I think she may have requested that I put
 11 a control on the slide, so she could compare
 12 it all on the one slide.
 13 CHAYTOR, Q.C.:
 14 Q. And which pathologist is that?
 15 MS. BUTLER:
 16 A. Dr. Pat Wadden.
 17 CHAYTOR, Q.C.:
 18 Q. Dr. Pat Wadden, okay. So this may have
 19 predated, in 2003, this may have predated the
 20 actual practice which eventually evolved of
 21 putting your control, positive control, on the
 22 patient slide?
 23 MS. BUTLER:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

Page 13

1 Q. But she had asked "repeat with control on
 2 slide." She had asked that that happen at
 3 this point in time?
 4 MS. BUTLER:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and that is--is that your writing
 8 "repeat with control on slide"?
 9 MS. BUTLER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. Okay, and you recall Dr. Wadden requesting
 13 that?
 14 MS. BUTLER:
 15 A. I remember her requesting that.
 16 CHAYTOR, Q.C.:
 17 Q. Did any other doctors request that?
 18 MS. BUTLER:
 19 A. No.
 20 CHAYTOR, Q.C.:
 21 Q. And did she ever request it again? Is that
 22 then what she wanted for her cases?
 23 MS. BUTLER:
 24 A. I think she was having some issue with this
 25 case and she wanted to see it all, everything

Page 14

1 together.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. Now, Ms. Butler, we spent a fair bit of
 4 time yesterday going through your worksheets
 5 and the work that you were doing with Dr.
 6 Ejeckam back in 2003, and took you through
 7 quite a number of repeats that were done in
 8 that time period of tests.
 9 MS. BUTLER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. ER/PR tests. As a result of your efforts and
 13 Dr. Ejeckam's efforts, did it ever come to
 14 your attention as to whether or not any
 15 repeats of the test resulted in changed
 16 results for the patients?
 17 MS. BUTLER:
 18 A. He never discussed that part with me.
 19 CHAYTOR, Q.C.:
 20 Q. You didn't know the outcome of any of your
 21 work?
 22 MS. BUTLER:
 23 A. No.
 24 CHAYTOR, Q.C.:
 25 Q. Okay, and whether or not there was any then

Page 15

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

Page 16

1 MS. BUTLER:
 2 A. (Unintelligible) be--date line I can't -
 3 CHAYTOR, Q.C.:
 4 Q. Well, it's not something I take it you've
 5 heard in the past -
 6 MS. BUTLER:
 7 A. No, I haven't.
 8 CHAYTOR, Q.C.:
 9 Q. You didn't hear it this year?
 10 MS. BUTLER:
 11 A. No, no.
 12 CHAYTOR, Q.C.:
 13 Q. Was it around the time that you became aware
 14 of the issues about ER/PR in 2005?
 15 MS. BUTLER:
 16 A. I think with me it was just much later,
 17 because I didn't really get into things.
 18 CHAYTOR, Q.C.:
 19 Q. So later than that?
 20 MS. BUTLER:
 21 A. I didn't get into discussions on, and like e-
 22 mails and that, I didn't bother too much. I
 23 just knew that there was things happening, but
 24 I never got into them. Just did my work when
 25 they requested it.

Page 17

1 CHAYTOR, Q.C.:

2 Q. Yes, and in terms of what did you understand

3 when Mr. Dyer talked to you about an index

4 case? What did you understand that to mean?

5 MS. BUTLER:

6 A. Well, it took me a while to understand it,

7 because I never got into not knowing--didn't

8 know much about the reporting end of my work.

9 So I just knew something--to me, something had

10 happened that wasn't good.

11 CHAYTOR, Q.C.:

12 Q. So did you understand that it was--in

13 referring to someone as an index patient, we

14 understand that meant it was a patient whose

15 test had changed on repeating.

16 MS. BUTLER:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. Her ER/PR testing -

20 MS. BUTLER:

21 A. Had changed.

22 CHAYTOR, Q.C.:

23 Q. Yes, okay. If we could look, please, at the

24 same exhibit, 2173, page 56? And this is May

25 23rd, 2003. So we understand from the

Page 18

1 documentation we have that ER/PR would have

2 resumed, but this is shortly after Dr.

3 Ejeckam's adjustments, and you carried out

4 this test. I guess that's the same date, May

5 23rd.

6 MS. BUTLER:

7 A. Looks like 29th.

8 CHAYTOR, Q.C.:

9 Q. 29th maybe, okay, and this is request by Dr.

10 Ford Elms or pathologist is Dr. Ford Elms.

11 MS. BUTLER:

12 A. Yes.

13 CHAYTOR, Q.C.:

14 Q. And the surgical number of this patient is an

15 '02 case, and written over here it says

16 "repeat ER/PR requested by Dr. Zaidi."

17 MS. BUTLER:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. Do you know who Dr. Zaidi is?

21 MS. BUTLER:

22 A. Not right now, no.

23 CHAYTOR, Q.C.:

24 Q. Do you know that if -

25 MS. BUTLER:

Page 19

1 A. He's an outside pathologist.

2 CHAYTOR, Q.C.:

3 Q. Is he a pathologist?

4 MS. BUTLER:

5 A. No, I don't know. Maybe he's a -

6 CHAYTOR, Q.C.:

7 Q. Or is he an oncologist?

8 MS. BUTLER:

9 A. - oncologist.

10 CHAYTOR, Q.C.:

11 Q. Oncologist, I believe, yes, okay. So how

12 usual was that to have a repeat requested by

13 an oncologist?

14 MS. BUTLER:

15 A. Unusual.

16 CHAYTOR, Q.C.:

17 Q. Unusual. And if we could look, please, at

18 2190, page 20? And if you remember the

19 surgical number being 5231-02, page 20, this

20 is the right page? Right here, sorry, line

21 15, 5231-03. You've indicated '03, but this

22 is a May 29th run. So do you believe that

23 should be '02?

24 MS. BUTLER:

25 A. '02.

Page 20

1 CHAYTOR, Q.C.:

2 Q. That should be an '02, so that's an error.

3 MS. BUTLER:

4 A. I guess I was writing all '03s and I just

5 continued.

6 CHAYTOR, Q.C.:

7 Q. With '03, right, okay. So that would be the

8 same test that was requested to be repeated by

9 Dr. Zaidi?

10 MS. BUTLER:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. Okay, and you ran that in your May 29th B

14 batch?

15 MS. BUTLER:

16 A. Yes.

17 CHAYTOR, Q.C.:

18 Q. And if we could look then, please, at Exhibit

19 C-0074 (actual exhibit called up and

20 referenced was C-0174)? And this was

21 originally P-1843, and if--and you see the

22 surgical number here again, SS5231, an '02

23 case, so same number?

24 MS. BUTLER:

25 A. Yes.

Page 21

1 CHAYTOR, Q.C.:

2 Q. And on page four of the--this is a pathology

3 report. We'll see it's Dr. Elms who was the

4 pathologist involved in the case.

5 MS. BUTLER:

6 A. Right.

7 CHAYTOR, Q.C.:

8 Q. And we'll see that there was an addendum two

9 entered, August 29th 2002, signed off by Dr.

10 Elms on that date indicating

11 "immunohistochemical staining for progesterone

12 receptors is positive in approximately 15

13 percent of lesional cells.

14 Immunohistochemical staining for estrogen

15 receptors is negative."

16 MS. BUTLER:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. And then signed off by Dr. Elms on June 11th,

20 2003, keeping in mind you did the test on May

21 29th, and it indicates "at the request of Dr.

22 Zaidi, immunohistochemical staining for

23 estrogen and progesterone receptors has been

24 repeated. Estrogen receptors show faint

25 positivity in approximately 10 to 15 of

Page 22

1 lesional cells. Progesterone receptors are

2 unequivocally positive in approximately 75

3 percent of lesional cells." So this appears

4 to be the pathology report following from your

5 retest on May 29th.

6 MS. BUTLER:

7 A. Yes.

8 CHAYTOR, Q.C.:

9 Q. Yes. So any change in the result for this

10 particular patient in 2003, that was never

11 discussed with you?

12 MS. BUTLER:

13 A. No.

14 CHAYTOR, Q.C.:

15 Q. And not brought to your attention?

16 MS. BUTLER:

17 A. No.

18 CHAYTOR, Q.C.:

19 Q. If we could look at, please, P-2190, page 11?

20 And again, Ms. Butler, this is back to your

21 worksheets of the work that you were doing in

22 that time frame with Dr. Ejeckam.

23 MS. BUTLER:

24 A. Okay.

25 CHAYTOR, Q.C.:

Page 23

1 Q. And the case that I'd like you to look at this

2 time is this one here at line 30, or 29,

3 sorry, slide 29, and it's S4821-03, and then

4 if we go ahead to page 16, and I believe I

5 brought your attention to this yesterday, that

6 that case was repeated, slide 13, 4821-03. So

7 it was repeated then on May 7th '03 after

8 ER/PR has resumed.

9 MS. BUTLER:

10 A. Yes.

11 CHAYTOR, Q.C.:

12 Q. And if we could look, please, then at C-0175.

13 We see the surgical number here. Just a

14 reminder to others that this was originally P-

15 1842, and the new exhibit number is C-0175.

16 You'll see that here's the same specimen

17 number, and if we look at the addendums,

18 addendum #1 which was entered, I believe, May

19 6th, 2003, "When compared to controls the

20 specimen is negative for HER-2-neu, ER, and

21 PR". Addendum #2 entered May 9th, 2003, and

22 again bearing in mind, I believe, our retest

23 was May 7th and signed by Dr. Morris-Larkin,

24 "The ER and PR were repeated due to quality

25 assurance issues. The repeated stains show

Page 24

1 the following; ER positive in 80 percent of

2 the cells, PR positive in 10 percent of the

3 cells. This replaces the previous report.

4 Phoned the Cancer Clinic voice mail on May

5 9th, 2003". Again, Ms. Butler, the fact of

6 any patient having had a change in result in

7 their ER/PR testing in 2003 resulting from

8 retesting carried out by you and Dr. Ejeckam,

9 that was never brought to your attention?

10 MS. BUTLER:

11 A. No.

12 CHAYTOR, Q.C.:

13 Q. When did you learn that there was an ER/PR

14 issue as we've come to call it?

15 MS. BUTLER:

16 A. I guess when he approached me about just doing

17 extra work. At that time there. So I guess I

18 should have known something was going on

19 there.

20 CHAYTOR, Q.C.:

21 Q. So when would that have been, when were you

22 asked to do extra work?

23 MS. BUTLER:

24 A. Just your dates on the screen there in that

25 '03 period, that's when I look at that date

Page 25

1 when I did all the controls.
 2 CHAYTOR, Q.C.:
 3 Q. So in 2003, you became aware that there was
 4 something with ER?
 5 MS. BUTLER:
 6 A. Something going on that I had to do a lot of
 7 extra work.
 8 CHAYTOR, Q.C.:
 9 Q. And whether or not there were any changes to
 10 patient's results, that wasn't brought to your
 11 attention?
 12 MS. BUTLER:
 13 A. No.
 14 CHAYTOR, Q.C.:
 15 Q. But you knew there was something up?
 16 MS. BUTLER:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. And then when in 2005 did it again come -- was
 20 there anything else then brought to your
 21 attention about ER/PR after these adjustments
 22 in 2003 up until the summer or spring of 2005?
 23 Did you hear anything else about any concerns
 24 about ER/PR testing?
 25 MS. BUTLER:

Page 26

1 A. No, it seemed like when I -- when we went
 2 through that period of "x" number of weeks
 3 just working on it, we had made some changes
 4 and then it just seemed to go away.
 5 CHAYTOR, Q.C.:
 6 Q. So things were quiet then on the ER/PR front?
 7 MS. BUTLER:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. For some time?
 11 MS. BUTLER:
 12 A. Some time.
 13 CHAYTOR, Q.C.:
 14 Q. And then when did you next hear about it in
 15 terms of the issue then that unfolds in 2005?
 16 When were you made aware of that?
 17 MS. BUTLER:
 18 A. I can't -- I really can't say.
 19 CHAYTOR, Q.C.:
 20 Q. Did you learn about it in -- well, we know
 21 there was a memo sent out to the technologists
 22 in August of 2005 by Dr. Cook?
 23 MS. BUTLER:
 24 A. I would say my knowledge came about -- I'm
 25 sure we discussed it in the lab or something

Page 27

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

Page 28

1 Q. Were you aware of retests taking place then in
 2 2005 in the Ventana machine throughout
 3 June/July of 2005?
 4 MS. BUTLER:
 5 A. Again I'm not really sure. I know something
 6 was going on, but again I can't recall it
 7 totally.
 8 CHAYTOR, Q.C.:
 9 Q. I take it, it wasn't the same as what you had
 10 experienced in 2003 when you were aware that
 11 you were asked to do extra work in 2003?
 12 MS. BUTLER:
 13 A. No, because I was involved more with the DAKO
 14 machine and Ken and Barry were more involved
 15 with the Ventana machine.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. So there was no extra work asked of you
 18 in 2005?
 19 MS. BUTLER:
 20 A. No, not me.
 21 CHAYTOR, Q.C.:
 22 Q. In that time period. If we could look,
 23 please, at P-0506. I believe we have a typed
 24 version. These are notes, Ms. Butler, of Dr.
 25 Williams and he's been kind enough to have

Page 29

1 them typed for us. July 15th, 2005, and this
 2 is a meeting of Mr. Gulliver, Drs. Cook and
 3 Williams, and it refers to a number of things
 4 here that were happening at that time period,
 5 and it refers to, "Reviewed meeting of July
 6 14th, 2005, re; identifying all patients and
 7 getting tests done as soon as possible. Plan;
 8 pull one to two people to start process and
 9 assign", and I think that should be "assign
 10 Mary to cutting and testing only". We believe
 11 that refers to yourself, Mary Butler.

12 MS. BUTLER:
 13 A. Yes.

14 CHAYTOR, Q.C.:
 15 Q. Do you recall that happening in the middle of
 16 July, 2005, that you were assigned to cutting
 17 and testing?

18 MS. BUTLER:
 19 A. I remember doing a lot of cutting.

20 CHAYTOR, Q.C.:
 21 Q. In that time period, and was that a change in
 22 your regular duties?

23 MS. BUTLER:
 24 A. No, well, we'd always have our -- you know
 25 what I mean, we'd always rotate cut, machine,

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1 kidney biopsies.

2 CHAYTOR, Q.C.:
 3 Q. Now this would be for the breast tests. This
 4 would be for, specifically we understand, for
 5 the retesting of ER/PR?

6 MS. BUTLER:
 7 A. I remember, like, maybe cutting them. I'm not
 8 sure about the testing them. I can't remember
 9 being -- when I was down on -- this would be
 10 Ventana time, right?

11 CHAYTOR, Q.C.:
 12 Q. Yes, this is Ventana time. So were you --

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

17 CHAYTOR, Q.C.:
 18 Q. So you don't remember anyone coming to you,
 19 taking you out of your normal rotation and
 20 asking you to do cutting and testing only?

21 MS. BUTLER:
 22 A. I can't remember doing that.

23 CHAYTOR, Q.C.:
 24 Q. Okay. If we could look at P-0516, please, and
 25 again these are notes from Dr. Williams and

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

12 MS. BUTLER:
 13 A. Mostly what I had to do there, I think, was
 14 just retrieve as many cases as I -- whatever
 15 cases they requested from the Health Science
 16 that were on our site to have them sent to
 17 her.

18 CHAYTOR, Q.C.:
 19 Q. So you were asked to identify and retrieve
 20 blocks, is that right?

21 MS. BUTLER:
 22 A. I was given numbers and then I had to retrieve
 23 those numbers and I had to send slides and
 24 blocks over to St. Clare's.

25 CHAYTOR, Q.C.:

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

2 MS. BUTLER:
 3 A. Yes.

4 CHAYTOR, Q.C.:
 5 Q. And how long did that go on? Did that go on
 6 for a period of weeks, months?

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

13 CHAYTOR, Q.C.:
 14 Q. Okay, and so you would -- Dr. Carter would
 15 provide you with a list of surgical numbers?

16 MS. BUTLER:
 17 A. Just the surgical numbers, yes.

18 CHAYTOR, Q.C.:
 19 Q. And then you would find those blocks and
 20 arrange to have them sent to her at St.
 21 Clare's?

22 MS. BUTLER:
 23 A. Yes.

24 CHAYTOR, Q.C.:
 25 Q. Okay, and were you involved in getting any

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|---|--|
| <p>1 tests done on those blocks?</p> <p>2 MS. BUTLER:</p> <p>3 A. Not that I'm aware of. Mostly I can remember</p> <p>4 collecting blocks, but if she was getting</p> <p>5 numbers, someone had to perform the tests.</p> <p>6 CHAYTOR, Q.C.:</p> <p>7 Q. Okay.</p> <p>8 MS. BUTLER:</p> <p>9 A. Not necessarily being me.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. And did anyone explain to you why you were</p> <p>12 doing that, why you were getting these blocks</p> <p>13 for Dr. Carter?</p> <p>14 MS. BUTLER:</p> <p>15 A. I was just thinking that it was -- I assumed</p> <p>16 that -- we knew that this ER/PR situation was</p> <p>17 going on and that she was doing some work.</p> <p>18 She was considered a breast specialist.</p> <p>19 CHAYTOR, Q.C.:</p> <p>20 Q. So you were aware at that point in time there</p> <p>21 was an issue with ER/PR?</p> <p>22 MS. BUTLER:</p> <p>23 A. Yes, I'm sure I was.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. But you have no recollection of what you were</p> | <p>1 CHAYTOR, Q.C.:</p> <p>2 Q. So was there anything, in particular, in this</p> <p>3 time period that stands out as being you're</p> <p>4 really having to work a lot of extra hours?</p> <p>5 MS. BUTLER:</p> <p>6 A. Just that we, you know, with doing the extra</p> <p>7 breast work on top of all of our other work.</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. Okay. In early August, 2005, a representative</p> <p>10 from Ventana visited the lab, Carole</p> <p>11 Quevillon.</p> <p>12 MS. BUTLER:</p> <p>13 A. I never knew her last name. I called her</p> <p>14 Carole.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. That's okay, I struggle with it too. So you</p> <p>17 were aware she was there?</p> <p>18 MS. BUTLER:</p> <p>19 A. Yes.</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. Okay, and did you meet with her while she was</p> <p>22 there?</p> <p>23 MS. BUTLER:</p> <p>24 A. I was present in the lab while she was there,</p> <p>25 yes.</p> |
| <p>1 told or who told you what the issue was?</p> <p>2 MS. BUTLER:</p> <p>3 A. No.</p> <p>4 CHAYTOR, Q.C.:</p> <p>5 Q. Did this involved -- this work that you did</p> <p>6 for Dr. Carter, did that involve overtime for</p> <p>7 you, were you having to work extra hours or</p> <p>8 was that fitted in in your regular day?</p> <p>9 MS. BUTLER:</p> <p>10 A. Fitting in, but I'm sure overtime was involved</p> <p>11 too.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. Some overtime involved?</p> <p>14 MS. BUTLER:</p> <p>15 A. I would say, yes.</p> <p>16 CHAYTOR, Q.C.:</p> <p>17 Q. Okay.</p> <p>18 MS. BUTLER:</p> <p>19 A. Overtime seemed to be the name of the game</p> <p>20 with our work.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. And that was the norm for you that you would</p> <p>23 at times have to work overtime?</p> <p>24 MS. BUTLER:</p> <p>25 A. Yes.</p> | <p>1 CHAYTOR, Q.C.:</p> <p>2 Q. So she didn't have individual meeting with you</p> <p>3 as such?</p> <p>4 MS. BUTLER:</p> <p>5 A. No, she just did her thing with the machine.</p> <p>6 CHAYTOR, Q.C.:</p> <p>7 Q. And what did you understand was the purpose of</p> <p>8 her visit on that occasion?</p> <p>9 MS. BUTLER:</p> <p>10 A. I'm not sure. Maybe I thought it was -- I'm</p> <p>11 not sure, but I knew it was attached to the</p> <p>12 issue, or if she was maintenance or -- I'm not</p> <p>13 really sure. She used to come to do our</p> <p>14 maintenance as well sometimes, and we could</p> <p>15 talk to her about where she knew the Ventana</p> <p>16 so well. She would give us pointers and</p> <p>17 things.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. So she would come in from time to time and do</p> <p>20 that in any event?</p> <p>21 MS. BUTLER:</p> <p>22 A. Um.</p> <p>23 CHAYTOR, Q.C.:</p> <p>24 Q. And were you told the outcome of her visit or</p> <p>25 her review in August of 2005?</p> |

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1 MS. BUTLER:
 2 A. No.
 3 CHAYTOR, Q.C.:
 4 Q. Were you made aware that she had some issues
 5 with maintenance on the Ventana machine?
 6 MS. BUTLER:
 7 A. Maintenance, I'm going to say yes because we
 8 always had a little bit of -- we always found
 9 it hard to fit in our maintenance because we
 10 wouldn't stop our work long enough to do our
 11 maintenance.
 12 CHAYTOR, Q.C.:
 13 Q. Tell me about that. So sometimes the
 14 maintenance didn't get done?
 15 MS. BUTLER:
 16 A. Occasionally when -- like, we did our daily
 17 maintenance on a regular basis. Every day
 18 actually you'd sign it off in the computer.
 19 Then the -- I think we had to do it daily,
 20 monthly, quarterly.
 21 CHAYTOR, Q.C.:
 22 Q. Okay.
 23 MS. BUTLER:
 24 A. So the monthly -- I think we managed to do the
 25 monthly a fair amount, quarterly, and then she

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1 had to do the last maintenance. So she'd be
 2 able to look in the computer and tell if the
 3 maintenance was done on the machine or not.
 4 CHAYTOR, Q.C.:
 5 Q. So after she attended in August, 2005, was the
 6 maintenance schedule then strictly adhered to?
 7 MS. BUTLER:
 8 A. I'm not going to say strictly, no.
 9 CHAYTOR, Q.C.:
 10 Q. There were still times it was missed?
 11 MS. BUTLER:
 12 A. We were trying. There were still times when
 13 we were -- we were programmed, I will call it,
 14 to get our work done, and we wouldn't -- we
 15 should have paid attention to stopping more to
 16 do maintenance.
 17 CHAYTOR, Q.C.:
 18 Q. Okay.
 19 MS. BUTLER:
 20 A. We were fortunate the machine was fine,
 21 nothing ever happened.
 22 CHAYTOR, Q.C.:
 23 Q. Okay, to your knowledge that would be?
 24 MS. BUTLER:
 25 A. To my knowledge, yes.

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1 CHAYTOR, Q.C.:
 2 Q. And I take it, was that the same in the DAKO
 3 days at well in terms of not finding the time
 4 to stop you work to make sure maintenance was
 5 carried out?
 6 MS. BUTLER:
 7 A. Maintenance on DAKO was performed -- I think
 8 she only had so many tests and you had to do
 9 your cleaning there, and --
 10 CHAYTOR, Q.C.:
 11 Q. And was that done?
 12 MS. BUTLER:
 13 A. And then the maintenance on the machine was
 14 done by the outside department, biomedical
 15 department, I think it might have been.
 16 CHAYTOR, Q.C.:
 17 Q. Okay.
 18 MS. BUTLER:
 19 A. And they came down yearly because the tags
 20 used to be on the machine saying when they
 21 came.
 22 CHAYTOR, Q.C.:
 23 Q. They came annually, did they, to do a
 24 maintenance check?
 25 MS. BUTLER:

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1 A. Maintenance, yeah.
 2 CHAYTOR, Q.C.:
 3 Q. So you as a technologist would do cleaning on
 4 a regular basis, though?
 5 MS. BUTLER:
 6 A. Yes, on a regular basis.
 7 CHAYTOR, Q.C.:
 8 Q. And was that always done when it was supposed
 9 to be done?
 10 MS. BUTLER:
 11 A. Yes, because we couldn't do -- she would stop
 12 and we couldn't go on with our work.
 13 CHAYTOR, Q.C.:
 14 Q. So the machine actually wouldn't continue?
 15 MS. BUTLER:
 16 A. She had a number of tests and once she reached
 17 that number, she wouldn't let you continue.
 18 CHAYTOR, Q.C.:
 19 Q. So that was the safety check built into that
 20 machine. If we could look, please, at P-0559.
 21 Ms Butler, this is a memo of Dr. Cook, August
 22 8th, 2005, which went to Mr. Gulliver, Mr.
 23 Dyer, and the three IHC technologists,
 24 including yourself. Do you recall did you
 25 receive this memo?

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1 MS. BUTLER:
 2 A. It was in the lab because we put it up on the
 3 wall.
 4 CHAYTOR, Q.C.:
 5 Q. So did you personally get a copy or was it
 6 posted in the lab?
 7 MS. BUTLER:
 8 A. It was posted in the lab.
 9 CHAYTOR, Q.C.:
 10 Q. And did --
 11 MS. BUTLER:
 12 A. Someone received it, one of the three, and
 13 then we put it on the wall.
 14 CHAYTOR, Q.C.:
 15 Q. So one of the three of you received it and
 16 posted it in the lab?
 17 MS. BUTLER:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And did any -- so were you there when the memo
 21 was received, did it come with any other
 22 discussion around it?
 23 MS. BUTLER:
 24 A. I'm sure there was a discussion, but --
 25 CHAYTOR, Q.C.:

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1 Q. Amongst the technologists?
 2 MS. BUTLER:
 3 A. Among the technologists. You know what I
 4 mean, if you work together, you know you're
 5 going to discuss things.
 6 CHAYTOR, Q.C.:
 7 Q. I'm just wondering if anyone ever who
 8 delivered the memo to you explained the
 9 background or the context of the memo to the
 10 technologists?
 11 MS. BUTLER:
 12 A. I'm not sure other than again Barry usually
 13 showed up in our lab when things were
 14 happening.
 15 CHAYTOR, Q.C.:
 16 Q. And what did you understand from this memo
 17 from a technical perspective was to happen
 18 with respect to ER/PR testing on a go-forward
 19 basis?
 20 MS. BUTLER:
 21 A. I think we were just supposed to -- no, that
 22 was the pathologist. I think we just had to -
 23 - we still had to keep doing them.
 24 CHAYTOR, Q.C.:
 25 Q. So you continued to do ER/PR testing?

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1 MS. BUTLER:
 2 A. Continued to do them, yes.
 3 CHAYTOR, Q.C.:
 4 Q. And did anyone ever come and tell you
 5 otherwise to stop making the slides?
 6 MS. BUTLER:
 7 A. No, because I think they still have those
 8 slides in the fridge.
 9 CHAYTOR, Q.C.:
 10 Q. So you and Les and Ken continued on with your
 11 regular rotations in IHC until you --
 12 continued on with your work in terms of doing
 13 the ER/PR testing?
 14 MS. BUTLER:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. What do you next recall then? After you
 18 received this memo, you're continuing on as
 19 normal in terms of the technical side of the
 20 testing. What do you next recall, what was
 21 your involvement with the ER/PR issue? Do you
 22 have any other direct involvement?
 23 MS. BUTLER:
 24 A. Mostly in the lab--I don't know, we continued
 25 our three-way, you know, like how we did our

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

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1 A. They say we had a meeting in Barry's office.
 2 I can't recall it, but I can remember her in
 3 the lab with us all the time.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, but you don't recall the presentation
 6 that she did on Barry's computer?
 7 MS. BUTLER:
 8 A. I can't remember it much. I'm sure I must
 9 have been there.
 10 CHAYTOR, Q.C.:
 11 Q. But you don't--that doesn't stick out in your
 12 mind.
 13 MS. BUTLER:
 14 A. It doesn't stick out in my mind for some
 15 reason.
 16 CHAYTOR, Q.C.:
 17 Q. So whether or not, I guess you're not able to
 18 tell me whether or not you found it to be of
 19 use or a good learning experience for you.
 20 MS. BUTLER:
 21 A. I found with Trish being in the lab, she was
 22 able to point out some things and started
 23 making me think about doing different things
 24 in our lab.
 25 CHAYTOR, Q.C.:

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1 Q. Okay, so the couple of days she spent with
 2 you, you found that there were things that she
 3 made--that were of use to you?
 4 MS. BUTLER:
 5 A. Yes, I found her, you know, she was sort of--
 6 she was sort of helpful and she used to always
 7 say "I didn't come here to tear you apart or
 8 anything, but to help you." I remember her
 9 saying those things.
 10 CHAYTOR, Q.C.:
 11 Q. And you did find that it was helpful?
 12 MS. BUTLER:
 13 A. Yes, very.
 14 CHAYTOR, Q.C.:
 15 Q. Very helpful. And I understand that you also
 16 had an opportunity to go then to Mount Sinai
 17 in January of 2006.
 18 MS. BUTLER:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. So a few months later you went to Mount Sinai
 22 and stayed there for a couple of weeks
 23 training?
 24 MS. BUTLER:
 25 A. Observing more than training.

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1 CHAYTOR, Q.C.:
 2 Q. Okay, what was the purpose of that visit?
 3 MS. BUTLER:
 4 A. I went to see about formalin, just to check
 5 out mainly with the formalin and to -
 6 CHAYTOR, Q.C.:
 7 Q. The formalin?
 8 MS. BUTLER:
 9 A. Just look at how they did their--receiving
 10 their specimens and how long maybe they were
 11 keeping their specimens and -
 12 CHAYTOR, Q.C.:
 13 Q. And what was it about the formalin that you
 14 were observing?
 15 MS. BUTLER:
 16 A. Just to see if our lab was sort of comparable
 17 to their lab, you know, keeping it and how
 18 long we left our specimens.
 19 CHAYTOR, Q.C.:
 20 Q. Oh, okay, so how long the specimens would be
 21 in the fixative, in the formalin?
 22 MS. BUTLER:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. And were you making inquiries as to the type

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1 of formalin they were using and, was that one
 2 of the issues?
 3 MS. BUTLER:
 4 A. I didn't pay attention to the type, other than
 5 it was neutral buffered formalin, as it goes,
 6 when you say "type", company maybe, but it was
 7 neutral buffered formalin.
 8 CHAYTOR, Q.C.:
 9 Q. So at that point in time the Health Sciences
 10 was using commercial formalin.
 11 MS. BUTLER:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. Do you recall the days when you used to make
 15 your own formalin?
 16 MS. BUTLER:
 17 A. Yes, we had to make our own buffered formalin
 18 ourselves, yes.
 19 CHAYTOR, Q.C.:
 20 Q. And when did that stop?
 21 MS. BUTLER:
 22 A. Barry should be able to tell you that more
 23 than -
 24 CHAYTOR, Q.C.:
 25 Q. Barry would know, okay. And you don't know

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1 whether it had stopped prior to 2005?
 2 MS. BUTLER:
 3 A. No, I don't.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, I'll ask then Mr. Dyer about that. So
 6 at Mount Sinai then, you made inquiries and
 7 observations as to practices regarding
 8 fixation, I take it?
 9 MS. BUTLER:
 10 A. Yes, fixation and then I was supposed to just
 11 oversee or just watch the different things
 12 they did in their lab, go to the IHC lab and
 13 just pay attention to, like, how they
 14 documented things.
 15 CHAYTOR, Q.C.:
 16 Q. So what did you understand was the purpose of
 17 your visit there?
 18 MS. BUTLER:
 19 A. Well we were very, we weren't good at
 20 documentation, so I understood it was more
 21 about how they did their documentation and to
 22 try and bring back some things to help us out
 23 with moving ahead with our documentation.
 24 CHAYTOR, Q.C.:
 25 Q. Okay, and I take it from documentation, you

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1 mean things like we've already discussed about
 2 documenting that you're maintaining your
 3 equipment, those kinds of things.
 4 MS. BUTLER:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Did it also include documentation such as SOP,
 8 standard operating procedures?
 9 MS. BUTLER:
 10 A. SOPs, yes.
 11 CHAYTOR, Q.C.:
 12 Q. So this was an effort to learn how, what
 13 standard operating procedures they had in
 14 place and how you could adopt your own?
 15 MS. BUTLER:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And did you, the whole two weeks that
 19 you were there, were you in the IHC lab or the
 20 entire pathology lab?
 21 MS. BUTLER:
 22 A. I was in the--combination, I was in both, IHC
 23 so many days and then I would go out into the
 24 main lab and I was in where the, where the PAS
 25 do their work, that's when you received the

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

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1 CHAYTOR, Q.C.:
 2 Q. So that part wasn't of much use because you
 3 were on a different system.
 4 MS. BUTLER:
 5 A. On a different system.
 6 CHAYTOR, Q.C.:
 7 Q. And I take it the issues around what happens
 8 to the specimen prior to it being put into the
 9 machine, up to that point in time certainly
 10 would be of use?
 11 MS. BUTLER:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. And if we could look then, please, at P-1848?
 15 And this is entitled "Mary Butler, Mount
 16 Sinai, January 8th to 21st, '06"?
 17 MS. BUTLER:
 18 A. Uh-hm.
 19 CHAYTOR, Q.C.:
 20 Q. And is this your document?
 21 MS. BUTLER:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. And there's 12 pages here. So you wrote this,
 25 did you?

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1 MS. BUTLER:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And when did you write this?
 5 MS. BUTLER:
 6 A. I'm not sure, sometime after I came back
 7 because I do have a weakness with having to
 8 write, put things on paper, so it took me a
 9 little while.
 10 CHAYTOR, Q.C.:
 11 Q. And did you have to submit this--so it took
 12 you a while after?
 13 MS. BUTLER:
 14 A. A while, yes.
 15 CHAYTOR, Q.C.:
 16 Q. Did you have to submit it to anyone?
 17 MS. BUTLER:
 18 A. We had a--Dr. Ejeckam wanted--well Ken was
 19 away and myself, and he wanted Les to--I think
 20 we had to present it to the pathologists.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and you indicate that the purpose of
 23 your visit was threefold: the fixation
 24 protocol, QA, and documentation activities for
 25 immunohistochemistry routine, where time

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1 permits." What does that mean, "where time
 2 permits"?)
 3 MS. BUTLER:
 4 A. Mainly to be in the IHC lab and then what
 5 extra time was left over, to go out into the
 6 routine lab.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, so this means routine lab.
 9 MS. BUTLER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. "Lines of communication with key
 13 pathologists." And what was it that you were--
 14 -what were you trying to learn or observe in
 15 that respect?
 16 MS. BUTLER:
 17 A. To see how, you know, if their slides went out
 18 to different pathologists or how they
 19 interacted with their different pathologists.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and was there any concern about that
 22 then in your lab?
 23 MS. BUTLER:
 24 A. No.
 25 CHAYTOR, Q.C.:

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

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1 MS. BUTLER:
 2 A. They're similar.
 3 CHAYTOR, Q.C.:
 4 Q. So it was nothing that stood out as being
 5 different to you?
 6 MS. BUTLER:
 7 A. No, well the only thing that stood out as a
 8 little difference was I used to see that their
 9 doctors used to come in with their PAs and
 10 they'd have a discussion around their day's
 11 work on the beginning. I think that's
 12 happened--since we've developed our PAs, I
 13 think that's sort of happening now.
 14 CHAYTOR, Q.C.:
 15 Q. That's happening now, is it? Okay, and
 16 there's no indication here, though, about any
 17 times for a fixation, how long specimens
 18 should be left?
 19 MS. BUTLER:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. But was that part of the fixation procedure
 23 and policy at Mount Sinai?
 24 MS. BUTLER:
 25 A. Yeah, they had it in a, I can't remember it

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1 now, but they had it in their SOPs.
 2 CHAYTOR, Q.C.:
 3 Q. Yes.
 4 MS. BUTLER:
 5 A. And every--they had SOPs, like at different
 6 stations they had their SOPs.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, and I take it at the time that wasn't
 9 happening in the Health Sciences?
 10 MS. BUTLER:
 11 A. No.
 12 CHAYTOR, Q.C.:
 13 Q. The QA and documentation activities for
 14 immunohistochemistry and routine lab are
 15 outlined in a manual and practice as follows."
 16 Where was that manual kept? Was that also
 17 kept in the document stations in the lab, the
 18 manual about QA?
 19 MS. BUTLER:
 20 A. QA and immunohistochemistry, she had all her
 21 own in there and the routine lab had all their
 22 own.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. "All sections of the department must
 25 have procedure manuals and all staff is

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1 expected to read and sign off to verify an
 2 understanding of the purpose, policies and
 3 procedures of the pathology lab."
 4 MS. BUTLER:
 5 A. Yes, they used to--you'd look in their books,
 6 in those manuals and you'd see that they all
 7 had signed. And any updates and everything
 8 occurred, that would be there, changes would
 9 be dated and signed as well.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and had that been happening at the
 12 Health Sciences?
 13 MS. BUTLER:
 14 A. No.
 15 CHAYTOR, Q.C.:
 16 Q. And now that you have a--we've seen a manual
 17 with policies and procedures, most of which
 18 were adopted this year.
 19 MS. BUTLER:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. Is that now a practice?
 23 MS. BUTLER:
 24 A. It's now moving ahead, yes.
 25 CHAYTOR, Q.C.:

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1 Q. I'm sorry?
 2 MS. BUTLER:
 3 A. It's now moving ahead and things are starting
 4 to work out with the SOPs.
 5 CHAYTOR, Q.C.:
 6 Q. Have you had to sign off and indicate that you
 7 understand the purpose of the policies and the
 8 procedures?
 9 MS. BUTLER:
 10 A. I haven't been keeping up on it because where
 11 I was going to retire, I never--because I
 12 started coming out of the lab.
 13 CHAYTOR, Q.C.:
 14 Q. Do you know whether or not others have done
 15 that?
 16 MS. BUTLER:
 17 A. Yeah, I think the others are doing it. Now I--
 18 -maybe I'm--after we came back, started to
 19 develop some of those books with the, like,
 20 corrective action books, antibodies and all
 21 that, now I filled out those, helped start
 22 filling out those books.
 23 CHAYTOR, Q.C.:
 24 Q. So if there was any, you mean if there was any
 25 corrective action undertaken, you would

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1 document it?
 2 MS. BUTLER:
 3 A. Document.
 4 CHAYTOR, Q.C.:
 5 Q. So you were following the procedure.
 6 MS. BUTLER:
 7 A. Yes, yes.
 8 CHAYTOR, Q.C.:
 9 Q. But you hadn't signed off saying -
 10 MS. BUTLER:
 11 A. I can't remember signing off.
 12 CHAYTOR, Q.C.:
 13 Q. - that you read it and understood it.
 14 MS. BUTLER:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. So is this your recommendation that three
 18 manuals should be developed?
 19 MS. BUTLER:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. And that was your recommendation coming out of
 23 Mount Sinai?
 24 MS. BUTLER:
 25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. One for grossing, specimen entry; statement

3 for grossing of all tissues processing and

4 pathological procedures required; all

5 antibodies and ancillary products must be

6 documented and assessed for validation." And

7 then, I'm not sure, but the next number I see

8 here is three, so perhaps that's--it says

9 "there are three manuals" -

10 MS. BUTLER:

11 A. Three, okay.

12 CHAYTOR, Q.C.:

13 Q. What's that?

14 MS. BUTLER:

15 A. Yeah, I'm not sure, it's been awhile.

16 CHAYTOR, Q.C.:

17 Q. All right, and these were antibody technical

18 information for all antibodies and you go on

19 from there, "all control tissues must be

20 validated and documented".

21 MS. BUTLER:

22 A. Uh-hm.

23 CHAYTOR, Q.C.:

24 Q. Had that been happening in any event?

25 MS. BUTLER:

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1 A. We had been trying to validate but we had no

2 one, no pathologist to help us to finish off

3 the process.

4 CHAYTOR, Q.C.:

5 Q. And I take it it wasn't being documented, if

6 it wasn't being validated, there was no

7 documentation.

8 MS. BUTLER:

9 A. No documentation.

10 CHAYTOR, Q.C.:

11 Q. And control documentation you indicate "will

12 include verification of positivity, negativity

13 of controls and signed off. Record of quality

14 issues with immunohistochemical staining to

15 include the date of occurrence, issue

16 specimen, corrective action and date

17 completed. Tissue control bank offers the

18 pathologist the ability to document tissues

19 that are positive for specific antibodies and

20 immunofluorescence." These ideas, Ms. Butler,

21 was this taken directly from what Mount Sinai

22 was doing?

23 MS. BUTLER:

24 A. Yes.

25 CHAYTOR, Q.C.:

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1 Q. And the lines of communications with key

2 pathologists are assessed through a

3 pathologist designate in charge of the

4 immunohistochemistry lab." So that's how they

5 were doing it at Mount Sinai. I take it they

6 had a pathologist in charge of the

7 immunohistochemistry lab.

8 MS. BUTLER:

9 A. Yes.

10 CHAYTOR, Q.C.:

11 Q. And any communication from other pathologists

12 would go through that person?

13 MS. BUTLER:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. "The technologist has the freedom and ability

17 to consult with a subspecialty pathologist

18 about a specific antibody, but the designate

19 pathologist in charge will make the final

20 decision on all issues."

21 MS. BUTLER:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. And then you indicate a separate manual then

25 for the body of the lab and the third one, I

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1 guess, the third manual you were recommending

2 was for "immunohistochemistry lab which should

3 contain the following"--and then you have a

4 list.

5 MS. BUTLER:

6 A. Yes.

7 CHAYTOR, Q.C.:

8 Q. And again this is taken from Mount Sinai's

9 information, is it?

10 MS. BUTLER:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. "All mechanical equipment must be checked and

14 documented daily. The following charts are

15 being created." And what did you mean by

16 that, the following charts are being created?

17 Was that within the Health Science at that

18 point in time?

19 MS. BUTLER:

20 A. I'm not--I'm thinking yes, because we did

21 create a lot of--when I came back, she

22 provided me with charts that she used and then

23 we adapted them to our lab.

24 CHAYTOR, Q.C.:

25 Q. So prior to that, your visit in January of

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1 2006, did you have a daily temperature chart
 2 for your water baths, your ovens, your
 3 refrigerators? Did you have such daily
 4 temperature charts?
 5 MS. BUTLER:
 6 A. No, the only--we didn't have charts, no.
 7 CHAYTOR, Q.C.:
 8 Q. Did you have any record, whether you call it a
 9 chart or not, was there any record of -
 10 MS. BUTLER:
 11 A. Like we test our water baths and make sure
 12 they were at temperatures every day, our oven
 13 had a thermometer in it which we checked every
 14 day. The refrigerator -
 15 CHAYTOR, Q.C.:
 16 Q. There was no documentation -
 17 MS. BUTLER:
 18 A. No documentation, we just, I guess, visually.
 19 CHAYTOR, Q.C.:
 20 Q. And nothing anyone had to sign off verifying
 21 in fact they had done that?
 22 MS. BUTLER:
 23 A. No.
 24 CHAYTOR, Q.C.:
 25 Q. And again "The pH standardization chart will

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1 include the standards for QC, check the
 2 deionized water and buffer solutions", that's
 3 new, I take it, as well?
 4 MS. BUTLER:
 5 A. It's new, but we used to always pH any
 6 solutions we made up and needed to be pH'd,
 7 we'd pH them when they were made up.
 8 CHAYTOR, Q.C.:
 9 Q. But again, there was no documentation that
 10 that was taking place?
 11 MS. BUTLER:
 12 A. No.
 13 CHAYTOR, Q.C.:
 14 Q. And here it looks like we have a chart,
 15 ancillary products, prepared in house.
 16 MS. BUTLER:
 17 A. Yes, those came from Mount Sinai.
 18 CHAYTOR, Q.C.:
 19 Q. It's from Mount Sinai.
 20 MS. BUTLER:
 21 A. So, we either use--we just adopted some that
 22 looked very similar and started filling in--we
 23 used as many as we could after I came back.
 24 That's how we started off and then we started
 25 improving on it.

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1 CHAYTOR, Q.C.:
 2 Q. And this is a temperature chart.
 3 MS. BUTLER:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. So, did you adopt this or something similar to
 7 this? And this would be for your bath, water
 8 bath, your refrigerator, your oven and so on.
 9 MS. BUTLER:
 10 A. I think, yeah, at first we used to do it
 11 individually and then we combined it all
 12 together.
 13 CHAYTOR, Q.C.:
 14 Q. To something like this?
 15 MS. BUTLER:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And on the form, would have the appropriate
 19 temperatures, was that done?
 20 MS. BUTLER:
 21 A. Yes, daily.
 22 CHAYTOR, Q.C.:
 23 Q. So, your form right now would have the
 24 appropriate temperatures should be?
 25 MS. BUTLER:

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1 A. Every day someone is supposed to go in and
 2 check there, the temperatures of everything
 3 before they start their work.
 4 CHAYTOR, Q.C.:
 5 Q. And then you date it and you sign your
 6 initials.
 7 MS. BUTLER:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And is that every technologists? So, the fact
 11 that Mary Butler did it, does that mean that
 12 Ken Green doesn't have to do it?
 13 MS. BUTLER:
 14 A. If you were cutting, you might--you'd be the
 15 one that would check. I'm not sure how they
 16 do it now, but when I was in the lab, if I was
 17 cutting, I'd check my oven, my water bath and
 18 whoever, maybe was on the stainer might make
 19 sure, the refrigerator.
 20 CHAYTOR, Q.C.:
 21 Q. So, the rule was that if you used it, you had
 22 to check the temperatures.
 23 MS. BUTLER:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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

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1 for a whole week we might, say, oh, we're
 2 checking one temperature, we might as well do
 3 it all and have it done.
 4 CHAYTOR, Q.C.:
 5 Q. And those are daily though, aren't they?
 6 MS. BUTLER:
 7 A. Daily, yes.
 8 CHAYTOR, Q.C.:
 9 Q. And this form here in terms of detection
 10 systems, lot numbers, expiry date, received,
 11 open, acceptable, the lab technicians -
 12 MS. BUTLER:
 13 A. This one here, I don't this we utilized that
 14 one.
 15 CHAYTOR, Q.C.:
 16 Q. Didn't use that?
 17 MS. BUTLER:
 18 A. I don't think so.
 19 CHAYTOR, Q.C.:
 20 Q. Did you have a similar form for keeping track
 21 of lots numbers of antibodies?
 22 MS. BUTLER:
 23 A. Well, the machine, our Ventana machine kept
 24 track of all of, and we could print it all
 25 off. And then when everything came in, it was

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1 kept, but I can't remember other that our
 2 machine keeping track of all of this for us.
 3 But now we have a binder called an ancillary
 4 binder, that's other things.
 5 CHAYTOR, Q.C.:
 6 Q. And here's an antibody -
 7 MS. BUTLER:
 8 A. It's taking a while now to--when you stop
 9 using something, you start losing your
 10 abilities, right. Your antibody, I remember
 11 that one.
 12 CHAYTOR, Q.C.:
 13 Q. Antibody, you remember this one. And did you
 14 adopt a similar form to that? That's at page
 15 nine of the exhibit.
 16 MS. BUTLER:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. So, this would keep track of the lot number of
 20 the antibody?
 21 MS. BUTLER:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. The expiry date, date received, date opened.
 25 MS. BUTLER:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. And what would acceptable mean?
 4 MS. BUTLER:
 5 A. Your pH, whether or not your pH was in the
 6 right range.
 7 CHAYTOR, Q.C.:
 8 Q. Okay.
 9 MS. BUTLER:
 10 A. This is all the information about the
 11 antibodies.
 12 CHAYTOR, Q.C.:
 13 Q. Antibody technical information.
 14 MS. BUTLER:
 15 A. Um-hm.
 16 CHAYTOR, Q.C.:
 17 Q. And did you create a similar sheet or start
 18 using a similar sheet as this?
 19 MS. BUTLER:
 20 A. A similar sheet.
 21 CHAYTOR, Q.C.:
 22 Q. And this is a document control
 23 immunohistopathology laboratory record of
 24 quality issues.
 25 MS. BUTLER:

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|--|---|
| <p>1 A. Issues, yes.</p> <p>2 CHAYTOR, Q.C.:</p> <p>3 Q. So, I take it this would be similar to any</p> <p>4 correction action.</p> <p>5 MS. BUTLER:</p> <p>6 A. Yes.</p> <p>7 CHAYTOR, Q.C.:</p> <p>8 Q. And the correction action log which was</p> <p>9 adopted.</p> <p>10 MS. BUTLER:</p> <p>11 A. Yes.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. And this is their worksheet which would be</p> <p>14 similar, I take it to the worksheets we looked</p> <p>15 at for you?</p> <p>16 MS. BUTLER:</p> <p>17 A. Yes, we have our own. We still kept--you</p> <p>18 didn't change your worksheets?</p> <p>19 MS. BUTLER:</p> <p>20 A. No, we just kept our own variation of our</p> <p>21 worksheets.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. So, the format that we've looked at here in P-</p> <p>24 2190, that's still the format that's used.</p> <p>25 MS. BUTLER:</p> | <p>1 Q. Had you ever been to any conference or course</p> <p>2 on IHC?</p> <p>3 MS. BUTLER:</p> <p>4 A. When I'd go to the national conventions with</p> <p>5 our--our own national conventions. I'd attend</p> <p>6 whatever IHC lectures and that they offered.</p> <p>7 CHAYTOR, Q.C.:</p> <p>8 Q. And over the course of your career, how often</p> <p>9 was that?</p> <p>10 MS. BUTLER:</p> <p>11 A. I've been to a fair--I was trying to remember</p> <p>12 when I started going, but I can't, but I'd say</p> <p>13 I've been to at least ten.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. At least ten?</p> <p>16 MS. BUTLER:</p> <p>17 A. At least ten of them.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. And how many of those would have dealt with</p> <p>20 IHC?</p> <p>21 MS. BUTLER:</p> <p>22 A. That I can't remember because I'm not sure my</p> <p>23 date line of when I started.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. And the one that you went to in 2006, did you</p> |
| <p>1 A. With the Ventana, you'd see a sheet of paper</p> <p>2 sort of divided up, up in four. Run one and</p> <p>3 then everything--run two -</p> <p>4 CHAYTOR, Q.C.:</p> <p>5 Q. Okay. So, those, of course, were for the</p> <p>6 DAKO, is 48.</p> <p>7 MS. BUTLER:</p> <p>8 A. The 1 to 48 were DAKO.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. Okay. Other than your time then at Mount</p> <p>11 Sinai, did you also receive any further</p> <p>12 training in IHC?</p> <p>13 MS. BUTLER:</p> <p>14 A. Other than going to some conferences.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. And I believe you went to a conference in</p> <p>17 Arizona in 2006.</p> <p>18 MS. BUTLER:</p> <p>19 A. I went to the NHS, yes.</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. Okay. And had you ever gone to such a</p> <p>22 conference or course before?</p> <p>23 MS. BUTLER:</p> <p>24 A. Not the NHS, no.</p> <p>25 CHAYTOR, Q.C.:</p> | <p>1 find that to be beneficial?</p> <p>2 MS. BUTLER:</p> <p>3 A. Very.</p> <p>4 CHAYTOR, Q.C.:</p> <p>5 Q. Okay. And tell us about that, what did you</p> <p>6 think about that course?</p> <p>7 MS. BUTLER:</p> <p>8 A. I just thought I would have--my reaction was I</p> <p>9 would have loved to have a lot of this</p> <p>10 information years ago.</p> <p>11 CHAYTOR, Q.C.:</p> <p>12 Q. Ms. Butler, I asked you about the reviews by</p> <p>13 Dr. Banerjee and Ms. Wegrynowski and you said</p> <p>14 that you recall being in the lab with Ms.</p> <p>15 Wegrynowski while she was there. Did you</p> <p>16 actually get to meet Dr. Banerjee?</p> <p>17 MS. BUTLER:</p> <p>18 A. I actually met him, yes.</p> <p>19 CHAYTOR, Q.C.:</p> <p>20 Q. Okay. And did he ask any questions of you?</p> <p>21 Did you have any discussions with him?</p> <p>22 MS. BUTLER:</p> <p>23 A. No, he just walked into the lab and just did</p> <p>24 an overview of the lab.</p> <p>25 CHAYTOR, Q.C.:</p> |

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1 Q. Okay. So, he didn't ask anything of you. You
 2 just met him to say hello kind of thing.
 3 MS. BUTLER:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. You weren't part of his review process?
 7 MS. BUTLER:
 8 A. No, just when a strange person comes in your
 9 lab, you sort of ask who they are.
 10 CHAYTOR, Q.C.:
 11 Q. And did he ask to see any particular equipment
 12 or what did he do while he was there?
 13 MS. BUTLER:
 14 A. I can't remember other than just meeting him
 15 and someone was showing him around and they
 16 did whatever.
 17 CHAYTOR, Q.C.:
 18 Q. And do you remember who was showing him
 19 around?
 20 MS. BUTLER:
 21 A. No, I can't remember now. It might have been
 22 one of the pathologists, but not really sure.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. And after, in particular, Ms.
 25 Wegrynowski's review, did you ever see her

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1 report?
 2 MS. BUTLER:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. Were you ever told the outcome of her review?
 6 MS. BUTLER:
 7 A. Only lately.
 8 CHAYTOR, Q.C.:
 9 Q. Only lately?
 10 MS. BUTLER:
 11 A. Only lately.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. And when you say lately, do you mean
 14 since the Inquiry has started?
 15 MS. BUTLER:
 16 A. Since the Inquiry started, yes.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And have you then, in that time period
 19 since seen her reports, she actually did two
 20 reports.
 21 MS. BUTLER:
 22 A. Yes, I've seen them since.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. And did you meet with her when she came
 25 back the second time in 2006?

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

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

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1 technical staff at a suitable time, if
 2 interested. A log book is available in the
 3 reporting room to record all problems".
 4 Back in September 2002, so this would
 5 have been the same year that you worked with
 6 Dr. Ejeckam on the ER/PR and other stains, are
 7 you the senior technologist who attended is
 8 lecture on quality assurance?
 9 MS. BUTLER:
 10 A. I think that I was. I remember being to one
 11 lecture when he had all the techs, he wanted
 12 all the techs to show him different things
 13 that could happen to different slides, you
 14 know, different scenarios on what could happen
 15 to slides, and just different things that
 16 would happen in your pathology lab.
 17 CHAYTOR, Q.C.:
 18 Q. So, in this process he actually showed you
 19 slides and what could happen to the slides.
 20 MS. BUTLER:
 21 A. Yes. And I think this is--I remember having
 22 that and I'm wondering if this is the same
 23 one.
 24 CHAYTOR, Q.C.:
 25 Q. Do you recall being the only person at the

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1 lecture?
 2 MS. BUTLER:
 3 A. Yes, because I don't think Barry was around at
 4 the time.
 5 CHAYTOR, Q.C.:
 6 Q. Okay.
 7 MS. BUTLER:
 8 A. And I was interest in what he, usually when
 9 they had something to say, I used to like to
 10 hear it, just to see if what I was thinking
 11 was the same way they were thinking on
 12 different issues like blocks and slides and
 13 stuff like that.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And do you recall some of the things
 16 that Dr. Ejeckam pointed out at that time?
 17 MS. BUTLER:
 18 A. Just different things in cutting, how slides
 19 would look if you cut them wrong, or if you
 20 didn't go deep enough or if you didn't cut a
 21 good section how it wouldn't be--not good for
 22 the pathologist for reading, things like that.
 23 CHAYTOR, Q.C.:
 24 Q. And was there any issue of cutting a block
 25 which had tumour and normal tissue? Was there

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1 any issue of that discussed?
 2 MS. BUTLER:
 3 A. No, this was just an overall lecture on any
 4 block or what could happen to anything in the
 5 lab.
 6 CHAYTOR, Q.C.:
 7 Q. And was there any attention paid, in this
 8 lecture, to external controls or -
 9 MS. BUTLER:
 10 A. Oh no.
 11 CHAYTOR, Q.C.:
 12 Q. Nothing like that, it was cutting.
 13 MS. BUTLER:
 14 A. This is just basically your basic lab, your
 15 start of your histology lab, nothing to do
 16 with IHC.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. Nothing to do with IHC?
 19 MS. BUTLER:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. Earlier, I believe yesterday and you've
 23 mentioned today that you're not, in the last
 24 few months, have not actually been in the lab
 25 working. And instead, you've been working for

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1 Mr. Dyer in helping organize and catalogue
 2 slides, that kind of thing. So, that's been
 3 for, I take it that was for getting the
 4 retests ready and sending off to Mount Sinai.
 5 MS. BUTLER:
 6 A. Yes, and different -
 7 CHAYTOR, Q.C.:
 8 Q. That would have been concluded though. So,
 9 I'm just wondering what it is that you would
 10 have been doing in the last few months.
 11 MS. BUTLER:
 12 A. Just mostly getting slides ready to go out
 13 when other people requested them, like the
 14 different lawyers, I guess, wanted materials.
 15 CHAYTOR, Q.C.:
 16 Q. And so other than organizing and cataloguing
 17 the slides, have you been doing any data
 18 management or any record keeping, anything
 19 like that?
 20 MS. BUTLER:
 21 A. Trying to keep all my ER/PR things so that I
 22 know how to--if I had to go look for other
 23 things, I'd know where to find them and just
 24 keeping all this in order. So, when they want
 25 some further testing sent off to Mount Sinai

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1 to get it ready and keep it, so that they know
 2 where it's to.
 3 CHAYTOR, Q.C.:
 4 Q. I guess, I'm just trying to get a sense about
 5 exactly what it is you're doing. Did you run
 6 into any difficulties in trying to, for
 7 example, organize or retrieve slides? Did you
 8 have any problems?
 9 MS. BUTLER:
 10 A. Well, you find a lot of things missing out of
 11 our files.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. So, you found slides missing?
 14 MS. BUTLER:
 15 A. You do find, you know, you do and then you
 16 have to go different routes. Generally, I'm
 17 pretty good at tracing things down.
 18 CHAYTOR, Q.C.:
 19 Q. And where did you tend to have to look to
 20 trace things down?
 21 MS. BUTLER:
 22 A. Well, like over the years we have a lot of
 23 research going on in our hospital. So, then
 24 you'd have to, you know, you take your blocks
 25 and they may have been gone missing from a

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1 research project, but then they may have been
 2 in a lab, but may have not been returned to
 3 the files. So, you just have to sort of
 4 connect things to try to locate your blocks
 5 and slides.
 6 CHAYTOR, Q.C.:
 7 Q. Wouldn't there be a record of that? If
 8 somebody had taken blocks or slides, would
 9 there be a record that Dr. So And So has these
 10 blocks or slides?
 11 MS. BUTLER:
 12 A. Earlier years there wasn't and then we
 13 realized that with so much research ongoing,
 14 that we had to start informing them that they
 15 had to put notes in the files saying where
 16 things were. So, certain years there wasn't.
 17 CHAYTOR, Q.C.:
 18 Q. So, when did that start? When did the notes
 19 start appearing, around what year?
 20 MS. BUTLER:
 21 A. I'm not going to be able to tell you a date
 22 line. I remember one of the date lines might
 23 be Dr. Robb, when Dr. Robb was with us, his
 24 lab started doing it.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And other than for research purposes,
 2 did you find that there were pathologists
 3 coming and taking slides or blocks or
 4 requesting that things be taken?
 5 MS. BUTLER:
 6 A. Over my lifetime with pathology, they'd come
 7 in and take things. Then later on in years we
 8 started getting more of a handle on it and
 9 realizing that we should know where everything
 10 is in our files and we're responsible for our
 11 files. So, we should know, but it's something
 12 that needs a, still needs work to it because
 13 we don't have good slide storage.
 14 CHAYTOR, Q.C.:
 15 Q. And while you were trying to catalogue and
 16 organize the slides and blocks, were you still
 17 encountering people coming and requesting to
 18 remove slides and blocks?
 19 MS. BUTLER:
 20 A. No, mostly us then. It would come down to
 21 mostly me and a couple of other, like Judy
 22 Quinlan, I saw her name mentioned and another
 23 worker at St. Clare's, he'd retrieve things.
 24 CHAYTOR, Q.C.:
 25 Q. Were you able to track down everything?

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1 MS. BUTLER:
 2 A. I don't think we accomplished everything, no.
 3 CHAYTOR, Q.C.:
 4 Q. So, there were still slides missing?
 5 MS. BUTLER:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. And blocks missing?
 9 MS. BUTLER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. And if we could look please at P-0114?
 13 And just before I leave that, the idea though
 14 of slides or blocks being missing, we know, of
 15 course, blocks were able to produced for
 16 everyone who was retested obviously because
 17 retests were carried out on those individuals.
 18 Are you aware of any patient that hasn't been
 19 retested because no block could be found for
 20 that person?
 21 MS. BUTLER:
 22 A. No, I'm not aware of it.
 23 CHAYTOR, Q.C.:
 24 Q. So, it's no concern in that regard?
 25 MS. BUTLER:

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1 A. No.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. We have here P-0114 and this is a
 4 document entitled feedback from
 5 immunohistochemistry technologists, May 29th,
 6 2007. And this would be a little bit over a
 7 year ago. Do you remember having any
 8 discussions with anyone as to any concern you
 9 may? If you just want to read down through
 10 the types of concerns, expressed concerns
 11 related to co-ordination of quality assurance
 12 activities for the entire immunohistochemical
 13 service and expressed concerns regarding
 14 communication and then there's sub-bullets
 15 under those. Does this look familiar to you,
 16 Ms. Butler?
 17 MS. BUTLER:
 18 A. It doesn't look familiar right now.
 19 CHAYTOR, Q.C.:
 20 Q. Sorry?
 21 MS. BUTLER:
 22 A. It doesn't look familiar right now.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. And the issues that are discussed
 25 there, do you recall, for example, do you

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1 recall Heather Predham ever coming to you and
 2 asking for any feedback?
 3 MS. BUTLER:
 4 A. Heather Predham, I can remember her being in
 5 the lab. I can remember being present when
 6 she was there, but I can't remember her actual
 7 -
 8 CHAYTOR, Q.C.:
 9 Q. So, do you recall the purpose of her visit to
 10 find out whether or not there were any
 11 concerns of the technologists, with respect
 12 to, in particular, those two issues?
 13 MS. BUTLER:
 14 A. They're talking there about recommended
 15 training for technologists re: controls--never
 16 ever heard of that.
 17 CHAYTOR, Q.C.:
 18 Q. So, it says, "the vast majority of IHC SOPs
 19 were not signed off. The ER/PR one had been
 20 completed. No knowledge of feedback re:
 21 external proficiency testing, no knowledge of
 22 overall action plan or status of same". Were
 23 these any concerns that you had at the time or
 24 would have voiced?
 25 MS. BUTLER:

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

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1 CHAYTOR, Q.C.:
 2 Q. And "requests for documentation are coming in
 3 without the knowledge of manager". Were you
 4 aware that or was that happening, to your
 5 knowledge?
 6 MS. BUTLER:
 7 A. "Requests for documentations", I'd sort of
 8 have to know what documentations in order to -
 9 CHAYTOR, Q.C.:
 10 Q. To be able to answer that.
 11 MS. BUTLER:
 12 A. - be able to answer it.
 13 CHAYTOR, Q.C.:
 14 Q. "ER/PR retesting started without the knowledge
 15 of manager and manager was informed by the
 16 technologist after the fact". Were you aware
 17 that happened?
 18 MS. BUTLER:
 19 A. I'm thinking yes, because I always had the
 20 feeling that Barry was never kept--he was
 21 never informed by people involved. They'd
 22 always come to us and just demand things of us
 23 and then we'd wonder why he didn't know.
 24 CHAYTOR, Q.C.:
 25 Q. So, who would be coming and demanding things

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

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

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

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

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1 commented on anything or -- our positive
 2 control which we could site and see was
 3 positive, and then send it to the pathologist.
 4 If they didn't come back with any problems, we
 5 couldn't fix anything not knowing that there
 6 was a problem.
 7 CHAYTOR, Q.C.:
 8 Q. So no one brought any issue -- if there was an
 9 issue with your process, nobody brought that
 10 to your attention?
 11 MS. BUTLER:
 12 A. No.
 13 CHAYTOR, Q.C.:
 14 Q. And other than you indicated yesterday Dr.
 15 Ejeckam on one occasion indicated his internal
 16 control wasn't working, did any other
 17 pathologist ever make such a concern known to
 18 you?
 19 MS. BUTLER:
 20 A. I'm thinking no because I just remember Dr.
 21 Ejeckam because he'd point out -- and he had a
 22 habit of he'd take you to his office and he
 23 would show you areas of slides with -- mainly
 24 with other IHCs, he'd point it out and say,
 25 and then he'd talk to you as if sometimes you

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1 had to -- well, he talked to you on a doctor
 2 level, and then he'd realize he wasn't -- you
 3 couldn't connect a lot, you could just only
 4 connect with what you understood about your
 5 stain and what you read in your data sheets,
 6 but not having been trained in the basis of
 7 it, you couldn't go on. So they had a habit
 8 of talking over our heads, I guess, and not
 9 realizing they were doing it.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and was that true of Dr. Ejeckam as
 12 well?
 13 MS. BUTLER:
 14 A. Dr. Ejeckam could be like it at times, and
 15 then he was a little bit difficult to
 16 understand as well. You had to get past his
 17 dialect type thing.
 18 CHAYTOR, Q.C.:
 19 Q. I'm just about done. There's one point,
 20 though, I'd like to clarify with you, and 2173
 21 -- if we could have 2173, please. These are
 22 the requisition or request forms for the time
 23 period of 2003 that we looked at yesterday and
 24 again today, and -- okay, around page five,
 25 please, Registrar. Some of those forms we

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1 looked at have indicated on them "Checked by
 2 Dr. Ejeckam", and this one again on April 28th
 3 says, "Checked by Dr. Ejeckam". This one is
 4 checked by Dr. Ejeckam, and into -- these are
 5 all April 28th, they're all checked by Dr.
 6 Ejeckam. Again April 30th. Then May 2nd,
 7 "Checked by Dr. Ejeckam", and this May 2nd
 8 doesn't indicate that it's checked by Dr.
 9 Ejeckam, but this one here is checked by Dr.
 10 Ejeckam for the same date. Again for the same
 11 date, "Checked by Dr. Ejeckam". The same with
 12 that one at page 23, page 24, same date,
 13 "Checked by Dr. Ejeckam". I think I've
 14 covered that with you yesterday, but what did
 15 you understand Dr. Ejeckam was checking?
 16 MS. BUTLER:
 17 A. I would say -- well, I would say he was
 18 checking our controls plus his own internal
 19 controls, I would say.
 20 CHAYTOR, Q.C.:
 21 Q. And even though he's not the pathologist
 22 involved in these cases, he was looking at all
 23 the slides?
 24 MS. BUTLER:
 25 A. He was looking at all the slides -- I would

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1 say he was because when we were testing there,
 2 he did have cases from all over.
 3 CHAYTOR, Q.C.:
 4 Q. Yes. We'll see that that goes on, May 5th,
 5 goes on for some time.
 6 MS. BUTLER:
 7 A. So I'm thinking he didn't want anything to go
 8 out at that time until he checked them in that
 9 period of time until he was satisfied that
 10 everything was happening the way he wanted it
 11 to happen.
 12 CHAYTOR, Q.C.:
 13 Q. And then as of May 7th, I don't see that
 14 recorded any more. May 8th, we do have a
 15 "Checked by Dr. Ejeckam", but not May 7th. So
 16 why is it that sometimes he'd be checking and
 17 other times not?
 18 MS. BUTLER:
 19 A. I think he was checking all the time. It's
 20 just sometimes I was --
 21 CHAYTOR, Q.C.:
 22 Q. And you recorded some of them and you didn't
 23 others?
 24 MS. BUTLER:
 25 A. And some I didn't.

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1 CHAYTOR, Q.C.:

2 Q. And do you know how long that went on through

3 2003?

4 MS. BUTLER:

5 A. That he was checking those?

6 CHAYTOR, Q.C.:

7 Q. Yes.

8 MS. BUTLER:

9 A. No.

10 CHAYTOR, Q.C.:

11 Q. Okay, and so if it's written on the bottom, he

12 definitely checked it, but even if it's not

13 written there, he may have still checked the

14 case?

15 MS. BUTLER:

16 A. Yes.

17 CHAYTOR, Q.C.:

18 Q. So May 26th, for example, it's not written

19 there, but he may still have been checking

20 your --

21 MS. BUTLER:

22 A. He may still have checked it, yes, he may, and

23 then it may have come to a point that he was

24 satisfied with it and he might have let it go

25 to the actual reading pathologist.

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1 CHAYTOR, Q.C.:

2 Q. I'm just going to check my notes here for a

3 moment, Ms. Butler. Maybe we could go back,

4 please, to -- there's one other thing on that

5 exhibit, 2173 at page 13. On dates such as

6 this, and this is one of the cases in which

7 there was a retest, and it's written "ER/PR

8 checked by Dr. Ejeckam". Was that, do you

9 know, and I think it says something "Include

10 controls, please" maybe or -- you've got two

11 different dates there, the test run on April

12 30th and again on May 2nd. Did Dr. Ejeckam

13 check both dates or was it just one?

14 MS. BUTLER:

15 A. I'm thinking maybe just -- maybe just one

16 maybe, but I'm not really sure.

17 CHAYTOR, Q.C.:

18 Q. So you can't tell us what that would mean,

19 whether he checked April 30th or May 2nd or

20 both?

21 MS. BUTLER:

22 A. No.

23 CHAYTOR, Q.C.:

24 Q. Those are all my questions, Ms. Butler, unless

25 there's anything else that you think would be

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1 helpful for the Commissioner to know, if

2 there's anything I haven't asked you, but that

3 it is relevant to looking into this matter and

4 will be helpful for the Commissioner.

5 MS. BUTLER:

6 A. No, I think a lot of things were covered.

7 CHAYTOR, Q.C.:

8 Q. Is there anything else you can think of?

9 MS. BUTLER:

10 A. I can't think of anything right now.

11 CHAYTOR, Q.C.:

12 Q. And I'm sure some of the other lawyers may

13 have some questions for you, so thank you.

14 MS. BUTLER:

15 A. Thank you.

16 COMMISSIONER:

17 Q. Ms. Brazil?

18 MS. BRAZIL:

19 Q. I have no questions for this witness,

20 Commissioner.

21 COMMISSIONER:

22 Q. Thank you. Mr. Browne?

23 MR. BROWNE:

24 Q. No questions, thank you, Commissioner. Thank

25 you, Ms. Butler.

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1 COMMISSIONER:

2 Q. Mr. Pritchett.

3 MR. PRITCHETT:

4 Q. No questions for this witness.

5 COMMISSIONER:

6 Q. All right then. Ms. Newbury.

7 MS. MARY BUTLER, EXAMINATION BY MS. JENNIFER NEWBURY

8 MS. NEWBURY:

9 Q. Good morning, Ms. Butler. My name is Jennifer

10 Newbury. I represent the Canadian Cancer

11 Society, Newfoundland and Labrador Division.

12 I just have a couple of questions for you this

13 morning. First of all, about your visit to

14 Mount Sinai Hospital for training in January

15 of 2006, I understand this morning that you

16 indicated what your understanding of the

17 purpose of that visit was, and I'm wondering,

18 upon your arrival at Mount Sinai, did you have

19 any different appreciation as to what you

20 would be doing while you were there? Were the

21 activities that you did at Mount Sinai

22 consistent with what you understood you would

23 be doing?

24 MS. BUTLER:

25 A. I just went for -- it wasn't for training. It

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1 was just observation.
 2 MS. NEWBURY:
 3 Q. Observation, okay, and were you involved in
 4 starting to develop standard operating
 5 procedures, actually sitting down to do that
 6 exercise while you were still at Mount Sinai?
 7 MS. BUTLER:
 8 A. It was -- I was thinking I may have been going
 9 to start, but I didn't, and Ken Green started
 10 doing the SOPs.
 11 MS. NEWBURY:
 12 Q. Okay. That was when you returned there, but
 13 was there any effort while you were at Mount
 14 Sinai to start to, I guess, begin that
 15 exercise?
 16 MS. BUTLER:
 17 A. I just read over a lot of theirs to get ideas.
 18 MS. NEWBURY:
 19 Q. And had you ever been involved in doing
 20 anything of that nature before going to Mount
 21 Sinai?
 22 MS. BUTLER:
 23 A. No, it was a new venture for me.
 24 MS. NEWBURY:
 25 Q. And before you left to go to Mount Sinai, did

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1 you think that you would at any point, either
 2 during that trip or when you returned, did you
 3 think that you would ever be involved in
 4 writing standard operating procedures?
 5 MS. BUTLER:
 6 A. I was thinking it was a possibility.
 7 MS. NEWBURY:
 8 Q. Okay. Is that something that came into your
 9 mind yourself or did anyone indicate that that
 10 would be?
 11 MS. BUTLER:
 12 A. No, but I guess where they considered I was
 13 senior technologist, maybe I would like to do
 14 it.
 15 MS. NEWBURY:
 16 Q. Okay, and I understood from Ms. Wegrynowski
 17 when she was working with you -- I understood
 18 from her evidence that she thought that you
 19 were starting to develop standard operating
 20 procedures there, but there was some
 21 indication --
 22 MS. BUTLER:
 23 A. At her hospital?
 24 MS. NEWBURY:
 25 Q. At Mount Sinai.

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1 MS. BUTLER:
 2 A. She had wanted me to go in the first day I was
 3 there to try to write things, and, like, the
 4 SOPs and that. I wasn't comfortable doing
 5 that. I just wanted to observe and come back
 6 and try to develop it, but I think I realized
 7 it was out of my scope and I had to get a lot
 8 of help in computer things, I needed more --
 9 MS. NEWBURY:
 10 Q. Okay.
 11 MS. BUTLER:
 12 A. More update.
 13 MS. NEWBURY:
 14 Q. She'd indicated that she thought it was a
 15 computer issue and I think she indicated
 16 Microsoft Word was something you weren't
 17 familiar with?
 18 MS. BUTLER:
 19 A. Yes, I needed to get some computer --
 20 MS. NEWBURY:
 21 Q. Was that the primary impediment or was there
 22 any concern about the actual writing process
 23 itself?
 24 MS. BUTLER:
 25 A. No, I just needed to learn to deal with paper

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1 things, and I wasn't good at a paper trail, so
 2 I would have had a learning curve there to
 3 accomplish.
 4 MS. NEWBURY:
 5 Q. I think you had indicated when the Ventana
 6 equipment was brought in to Eastern Health,
 7 you also had a little uneasiness about using
 8 the computer?
 9 MS. BUTLER:
 10 A. I've always had an uneasiness with computers
 11 all my life. It's been a stumbling block for
 12 me until I get comfortable with learning the
 13 procedures.
 14 MS. NEWBURY:
 15 Q. Sure, and you did develop that comfort level
 16 after a couple of weeks or months?
 17 MS. BUTLER:
 18 A. Very much so, yes.
 19 MS. NEWBURY:
 20 Q. And I take it that given the timing that you
 21 were in high school, and that period of time
 22 that you attended trade school, that computers
 23 were not being taught as part of the
 24 curriculum at that time?
 25 MS. BUTLER:

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1 A. No.
 2 MS. NEWBURY:
 3 Q. Have you ever had any computer training
 4 provided to you or have you taken your own
 5 courses since commencing work?
 6 MS. BUTLER:
 7 A. No. I've had some -- you could attend any you
 8 wanted to in the hospital.
 9 MS. NEWBURY:
 10 Q. Okay.
 11 MS. BUTLER:
 12 A. I've had basic when the computers came in at
 13 the hospital and things like that, but mostly
 14 applying to your own individual stations that
 15 you're working on.
 16 MS. NEWBURY:
 17 Q. Okay, just for the --
 18 MS. BUTLER:
 19 A. I even have a computer home now that I tossed
 20 aside, just not interested in it right now.
 21 MS. NEWBURY:
 22 Q. Okay, and so you think that you could have
 23 done more computer courses through the --
 24 through Eastern Health?
 25 MS. BUTLER:

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1 A. It wouldn't have been a problem.
 2 MS. NEWBURY:
 3 Q. Okay, it's just something that you didn't
 4 particularly have an interest in?
 5 MS. BUTLER:
 6 A. No.
 7 MS. NEWBURY:
 8 Q. And given the nature of your position, do you
 9 think more familiarity with the computers
 10 would have been beneficial to you, or do you
 11 think you had a comfort level learning what
 12 you needed to know?
 13 MS. BUTLER:
 14 A. No, I just liked to learn what I needed to
 15 know on a need to know basis.
 16 MS. NEWBURY:
 17 Q. And looking back now on your training session
 18 or your observation session, I guess, at Mount
 19 Sinai Hospital, would you have any
 20 recommendations as to how that experience
 21 might have been improved for you or was it,
 22 you know, a totally successful experience for
 23 you? Do you have any tips or recommendations
 24 for what future technologists might do?
 25 MS. BUTLER:

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1 A. I would have liked to -- I would have been
 2 able to work more with her SOPs if she had to
 3 be a little -- I wasn't allowed to take any of
 4 her SOPs, I had to develop my own.
 5 MS. NEWBURY:
 6 Q. Okay.
 7 MS. BUTLER:
 8 A. I think if I had to have copies -- some
 9 hospitals will let you have their SOPs and
 10 then you can sort of make it as a project and
 11 work with it, and then adapt it to your own
 12 hospital, but I wasn't given that.
 13 MS. NEWBURY:
 14 Q. So if you could have taken that and worked on
 15 it in your own time and space --
 16 MS. BUTLER:
 17 A. Time -- I could have done it that way.
 18 MS. NEWBURY:
 19 Q. Okay, and is there anything else about the
 20 experience that you might have found useful?
 21 MS. BUTLER:
 22 A. I found very useful with the other parts of
 23 the lab. I went to PA, and looking at their
 24 PA programs, and looking at the other part of
 25 their labs. They were good.

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

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1 MS. NEWBURY:
 2 Q. Were you aware -- I guess, just from being in
 3 the vicinity of Ken Green and his work
 4 regarding the testing that had resumed in
 5 February, 2007, you were aware of that, I take
 6 it?
 7 MS. BUTLER:
 8 A. I'm pretty well sure I should have been.
 9 MS. NEWBURY:
 10 Q. Were you aware of any quality assurance
 11 testing involving Mount Sinai during that
 12 period of time?
 13 MS. BUTLER:
 14 A. Mount Sinai? I'm going to say no. There's
 15 nothing coming to mind right now.
 16 MS. NEWBURY:
 17 Q. Okay. Thank you, those are all the questions
 18 I have.
 19 COMMISSIONER:
 20 Q. Thank you. Ms. Taylor?
 21 MS. TAYLOR:
 22 Q. No questions, Commissioner.
 23 COMMISSIONER:
 24 Q. Mr. Pike?
 25 MR. PIKE:

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1 Q. No questions.
 2 COMMISSIONER:
 3 Q. Mr. Simmons?
 4 MR. SIMMONS:
 5 Q. Commissioner, it's about time for the break.
 6 I'm not sure if I'll have any questions at
 7 all, but --
 8 COMMISSIONER:
 9 Q. Do you want to take the break to think about
 10 it?
 11 MR. SIMMONS:
 12 Q. Okay.
 13 COMMISSIONER:
 14 Q. All right. We'll take the morning break.
 15 (BREAK)
 16 THE COMMISSIONER:
 17 Q. Mr. Simmons?
 18 MS. MARY BUTLER, EXAMINATION BY MR. DANIEL SIMMONS
 19 MR. SIMMONS:
 20 Q. Thank you, Commissioner. Ms. Butler, I have
 21 only one thing that I wanted to ask you about,
 22 and we'll just bring up, for reference,
 23 Exhibit P-2190, please? These were the
 24 worksheets that you went through in some
 25 detail with Ms. Chaytor, and they begin on

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

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1 one person, then you keep things more
 2 consistent.
 3 MR. SIMMONS:
 4 Q. Okay, and we've heard that, at this time, at
 5 the beginning of April '03, was when Peggy
 6 Welsh left?
 7 MS. BUTLER:
 8 A. She was starting--she never left until the end
 9 of that month.
 10 MR. SIMMONS:
 11 Q. And Les Simms was new?
 12 MS. BUTLER:
 13 A. Yes.
 14 MR. SIMMONS:
 15 Q. And Ken Green had been there since sometime in
 16 2002?
 17 MS. BUTLER:
 18 A. Yes.
 19 MR. SIMMONS:
 20 Q. So do you know whether or not, during this
 21 five-week period when you were doing this IHC
 22 testing, do you know whether Mr. Green rotated
 23 into the immunohistochemical lab at any point
 24 in that time period?
 25 MS. BUTLER:

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1 A. I'm thinking not, because I'm thinking that I
 2 was put there to do the work. Someone asked
 3 me to do the work.
 4 MR. SIMMONS:
 5 Q. So that it's--would it be fair to assume then
 6 that it's most likely that during this period
 7 in which Dr. Ejeckam was directing the
 8 testing, that you were probably the only
 9 technologist in the lab doing the IHC testing
 10 at that time?
 11 MS. BUTLER:
 12 A. Yes.
 13 MR. SIMMONS:
 14 Q. Okay, fine. Thank you very much.
 15 MS. BUTLER:
 16 A. Thank you.
 17 THE COMMISSIONER:
 18 Q. Thank you, Mr. Simmons. Is there anything
 19 arising?
 20 CHAYTOR, Q.C.:
 21 Q. No, nothing arising.
 22 THE COMMISSIONER:
 23 Q. All right. Thank you very much, Ms. Butler,
 24 for your assistance.
 25 MS. BUTLER:

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1 A. Thank you.
 2 THE COMMISSIONER:
 3 Q. Yes, we have another witness ready?
 4 COFFEY, Q.C.:
 5 Q. Yes, Commissioner, Dr. Daniel Fontaine.
 6 THE COMMISSIONER:
 7 Q. All right. I think they've gone to get him.
 8 COFFEY, Q.C.:
 9 Q. Yes.
 10 DR. DANIEL FONTAINE, SWORN, EXAMINATION BY BERNARD
 11 COFFEY, Q.C.
 12 REGISTRAR:
 13 Q. Would you please state and spell your complete
 14 name for the Commission?
 15 DR. FONTAINE:
 16 A. Daniel Fontaine, D-A-N-I-E-L F-O-N-T-A-I-N-E
 17 REGISTRAR:
 18 Q. Thank you.
 19 COFFEY, Q.C.:
 20 Q. Now, Doctor, I'm going to ask you to--I'm
 21 going to have to ask you to do something
 22 that's perhaps out of character for you, and
 23 that is to raise your voice.
 24 DR. FONTAINE:
 25 A. Speak up.

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

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1 Q. Okay. So it's Exhibits 2330?
 2 COFFEY, Q.C.:
 3 Q. Yes, and -
 4 THE COMMISSIONER:
 5 Q. 2332 through to 2337?
 6 COFFEY, Q.C.:
 7 Q. Inclusive, thank you.
 8 THE COMMISSIONER:
 9 Q. Entered, thank you.
 10 EXHIBIT ENTERED AND MARKED P-2330
 11 EXHIBITS ENTERED AND MARKED P-2332 THROUGH P-2337
 12 COFFEY, Q.C.:
 13 Q. Thank you, Commissioner. If we could bring
 14 up, when you're ready, Registrar, Exhibit P-
 15 2330, please? Doctor, I understand that this
 16 is your--this document, it's a redacted, but
 17 this is your curriculum vitae?
 18 DR. FONTAINE:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. Okay, Doctor, I'm going to ask you, please, to
 22 outline for the Commissioner your educational
 23 and professional background?
 24 DR. FONTAINE:
 25 A. Okay. In 1985, I entered a diploma program of

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1 cytotechnology and became a lab technologist,
 2 practised in New Brunswick for several years.
 3 I then returned to school, went to University
 4 of New Brunswick where I was working on a
 5 Bachelor's Degree. Then I was accepted into
 6 medical school at Memorial, finishing in 1998.
 7 I then went on to Halifax to commence a five-
 8 year residency program in anatomical
 9 pathology.
 10 COFFEY, Q.C.:
 11 Q. And you finished that in?
 12 DR. FONTAINE:
 13 A. In 2003.
 14 COFFEY, Q.C.:
 15 Q. And Doctor, since 2003, what have you been
 16 doing?
 17 DR. FONTAINE:
 18 A. I've been practising at the Health Care
 19 Corporation or Eastern Health in Newfoundland
 20 with several interruptions of doing some locum
 21 work in New Brunswick.
 22 COFFEY, Q.C.:
 23 Q. And Doctor, I understand that you're a member
 24 of the--or a fellow of the Royal College of
 25 Physicians and Surgeons of Canada?

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1 DR. FONTAINE:
 2 A. That's correct.
 3 COFFEY, Q.C.:
 4 Q. And you became so in 2003?
 5 DR. FONTAINE:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Doctor, in your career before becoming or
 9 going to university to become and eventually
 10 end up as a physician, what did you do before?
 11 DR. FONTAINE:
 12 A. I was a technologist, a cytotechnologist,
 13 which is in the realm of diagnostic cytology.
 14 COFFEY, Q.C.:
 15 Q. A cytotechnologist?
 16 DR. FONTAINE:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. And could you briefly outline for the
 20 Commissioner what that involves?
 21 DR. FONTAINE:
 22 A. It's primarily involved with detection of
 23 cancer. The majority of our work is with PAP
 24 smears, probably comprises approximately 80
 25 percent of what we do. The remainder is what

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1 we call non-gynecological specimens, again,
 2 different cancers and involving with their
 3 diagnosis.
 4 COFFEY, Q.C.:
 5 Q. And that's cytology?
 6 DR. FONTAINE:
 7 A. That's cytology, yes.
 8 COFFEY, Q.C.:
 9 Q. Now as a--then, in your training as a
 10 physician, particularly your training as a
 11 pathology--during your training as a pathology
 12 resident in Halifax, did you acquire any
 13 particular training in relation to cytology,
 14 compared to your fellow physicians?
 15 DR. FONTAINE:
 16 A. Not so much additional training, because I had
 17 training prior to going into that field, but
 18 there was a mandatory three-month rotation in
 19 cytology. I did complete a two-month elective
 20 here in Newfoundland in my residency training
 21 as well, in cytology.
 22 COFFEY, Q.C.:
 23 Q. Doctor, so I gather that you have a particular
 24 interest in the cytology aspects of pathology?
 25 DR. FONTAINE:

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1 A. Correct.
 2 COFFEY, Q.C.:
 3 Q. And you've been involved in that since, in
 4 particular since finishing your residency
 5 program?
 6 DR. FONTAINE:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. What I'd like to ask you about is your
 10 exposure to immunohistochemistry. First of
 11 all, if you can recall what, if any, exposure
 12 you would have had as a medical student, first
 13 of all, as an undergraduate medical student?
 14 DR. FONTAINE:
 15 A. Undergraduate medical student, I would say I
 16 knew about immunohistochemistry as a
 17 cytotechnologist, but -
 18 COFFEY, Q.C.:
 19 Q. Yes, because you happened to be a
 20 technologist.
 21 DR. FONTAINE:
 22 A. - only for that, because of that training. As
 23 far as a medical student, it would only be if
 24 I was to ask a question related to that and I
 25 would not have been so inclined.

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1 COFFEY, Q.C.:

2 Q. And you trained at the medical school at

3 Memorial University between 1994 and 1998?

4 DR. FONTAINE:

5 A. Yes.

6 COFFEY, Q.C.:

7 Q. Doctor, and you did, as you've indicated, a

8 residency from 1998 through, I gather, 2003?

9 DR. FONTAINE:

10 A. That's correct.

11 COFFEY, Q.C.:

12 Q. Was that connected with Dalhousie University's

13 medical program?

14 DR. FONTAINE:

15 A. Yes.

16 COFFEY, Q.C.:

17 Q. Based in Halifax?

18 DR. FONTAINE:

19 A. Yes.

20 COFFEY, Q.C.:

21 Q. And would that involve exposure to hospitals

22 other than in Halifax?

23 DR. FONTAINE:

24 A. Yes. I spent a three-month rotation in St.

25 John, New Brunswick, and I also did a six-

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1 month elective here in St. John's.

2 COFFEY, Q.C.:

3 Q. In relation to--I want to ask you then about

4 in the period from '98 through 2003, your

5 residency program in pathology. What, if any,

6 exposure did you have to immunohistochemistry

7 then?

8 DR. FONTAINE:

9 A. As part of the training in Halifax, we had a

10 half day in pathology, if you will, where

11 special topics relating to different aspects

12 of pathology would be discussed. As part of

13 that, we did have Dr. Geoffrey Rowden. He was

14 a basic science researcher who was looking

15 into immunohistochemical techniques and

16 methods. So he would have given us several

17 one-hour lectures on the basics of

18 immunohistochemistry.

19 COFFEY, Q.C.:

20 Q. So several one-hour lectures on the science?

21 DR. FONTAINE:

22 A. On the science behind, yes.

23 COFFEY, Q.C.:

24 Q. And he would have been connected with

25 Dalhousie University?

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1 DR. FONTAINE:

2 A. Correct.

3 COFFEY, Q.C.:

4 Q. Did you have any other exposure to

5 immunohistochemistry?

6 DR. FONTAINE:

7 A. As part of our sign out in pathology, we would

8 often be ordering immunohistochemistry as part

9 of our learning and training experience.

10 COFFEY, Q.C.:

11 Q. And when in your residency program would that

12 sort of ordering of the tests begin and how

13 would the sign out occur?

14 DR. FONTAINE:

15 A. It's actually from day one, as soon as you

16 came across a case. Whether you would

17 actually be ordering it yourself or you would

18 be discussing with attending pathologists and

19 you'd have a discussion relating to if immuno

20 could be helpful with a case. So more or less

21 right from day one.

22 COFFEY, Q.C.:

23 Q. And that would be as, I take it, as you came

24 across cases?

25 DR. FONTAINE:

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1 A. Correct.

2 COFFEY, Q.C.:

3 Q. If a particular IHC test was thought to be

4 useful or potentially useful, it would be

5 ordered?

6 DR. FONTAINE:

7 A. Correct.

8 COFFEY, Q.C.:

9 Q. Either by yourself as a resident or you would

10 watch an attending physician?

11 DR. FONTAINE:

12 A. That's correct.

13 COFFEY, Q.C.:

14 Q. A senior resident or a pathologist, in fact,

15 order it?

16 DR. FONTAINE:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. And presumably come to some understanding

20 about why it's being done?

21 DR. FONTAINE:

22 A. Why are you ordering this, yes.

23 COFFEY, Q.C.:

24 Q. Doctor, was there any other--was there any

25 formal training, other than what you've

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1 described, in relation to
 2 immunohistochemistry? Like what actually goes
 3 on in the immunohistochemistry lab or the
 4 laboratory concerning immunohistochemistry? I
 5 appreciate you had been a technologist
 6 yourself.
 7 DR. FONTAINE:
 8 A. Correct.
 9 COFFEY, Q.C.:
 10 Q. I'm asking you, kind of leaving that aside and
 11 looking back on it, what, if any, exposure as
 12 a resident in pathology would you have to the
 13 IHC processes in the lab itself?
 14 DR. FONTAINE:
 15 A. Short of the discussions that you would have
 16 with the pathologist and the different issues-
 17 -because again, Dr. Rowden would be speaking
 18 to the basics, again as part of those half-day
 19 presentations, immuno would be discussed in
 20 relation to particular subjects. So how
 21 immuno could help you with there. So those
 22 would be sort of the formal. There'd be a lot
 23 more informal present--or talks, if you will,
 24 corridor chats with technologists and having
 25 those discussions. But for as far as formal

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1 processes, it would be more or less limited to
 2 those academic half-day presentations.
 3 COFFEY, Q.C.:
 4 Q. Doctor, then throughout your residency then,
 5 as time went on over the period, would you be
 6 exposed to--or how would you, if at all, be
 7 exposed to, from what you would understand to
 8 be a technologist's perspective, the problems
 9 associated or potential problems associated
 10 with IHC testing? You're in kind of a unique
 11 situation as a former technologist.
 12 DR. FONTAINE:
 13 A. Correct.
 14 COFFEY, Q.C.:
 15 Q. But as a resident, how, if at all, would you
 16 become aware of the problems that
 17 technologists might be having doing IHC
 18 staining or processing in providing
 19 appropriate slides for yourselves as
 20 physicians? Would you ever become aware of
 21 that, and if so, how?
 22 DR. FONTAINE:
 23 A. Again, through discussion with the
 24 technologists themselves. If you found a
 25 particular issue, you could go and have that

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1 discussion. There would often be quite open
 2 discussion with the attending pathologists and
 3 they may ask you, as part of your training, to
 4 go and discuss it with the technologist.
 5 COFFEY, Q.C.:
 6 Q. In particular, in relation to the Commission,
 7 we are interested, of course, in ER and PR IHC
 8 processes. When you started your residency in
 9 Halifax, what process was being utilized there
 10 to ascertain the ER and PR status of breast
 11 tumours?
 12 DR. FONTAINE:
 13 A. It was immunohistochemical techniques.
 14 COFFEY, Q.C.:
 15 Q. And in Halifax at the time, do you recall
 16 which, if any particular lab was doing the IHC
 17 testing in that area?
 18 DR. FONTAINE:
 19 A. It was the lab that, the VG lab essentially,
 20 because they had amalgamated their lab
 21 services to one lab for Halifax. So it was
 22 all being done on site.
 23 COFFEY, Q.C.:
 24 Q. In the one building?
 25 DR. FONTAINE:

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1 A. Yes, one building.
 2 COFFEY, Q.C.:
 3 Q. So I'll ask you then, in terms of ER and PR,
 4 do you recall your initial exposure to that
 5 and how you learned about it as time went on?
 6 If you can just tell the Commissioner what you
 7 recall about it?
 8 DR. FONTAINE:
 9 A. Again, when I first started training in
 10 Halifax, Dr. Penny Barnes, who was the breast
 11 pathologist, had just returned from
 12 Nottingham, England, from fellowship training.
 13 So she had additional training in breast. So
 14 we would often have, again, these sessions and
 15 she would be presenting some of these sessions
 16 and discussing issues particular to ER/PR.
 17 Again, if you were selected to be signing out
 18 with Dr. Barnes, because she would get more of
 19 the breast cases. Again, the way that the
 20 practice was in Halifax, there was
 21 subspecialty preference streaming, if you will
 22 with cases. So there would be preference given
 23 to breast cases to Dr. Barnes. So you knew if
 24 you were signing out with Dr. Barnes, you
 25 would tend to see more of these ER/PR cases.

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1 COFFEY, Q.C.:

2 Q. Did you have occasion to do so?

3 DR. FONTAINE:

4 A. Yes, I did.

5 COFFEY, Q.C.:

6 Q. And how much, in terms of the time frame that

7 that might involve? How often would you have

8 been exposed to signing out cases with Dr.

9 Barnes?

10 DR. FONTAINE:

11 A. It would probably depend on the rota,

12 depending on how many residents are there and

13 how many staff pathologists were there as

14 well, and again the availability of Dr.

15 Barnes. Now again, I should state that other

16 pathologists were signing out ER/PR as well,

17 but I felt that I concentrated on what Dr.

18 Barnes was telling me, looking at that as

19 being the most recent information.

20 COFFEY, Q.C.:

21 Q. And then are you able to give the Commissioner

22 any kind of sense of how many ER and PR cases

23 you would have been involved in as a resident?

24 DR. FONTAINE:

25 A. As a resident, because that would have been

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1 over the course of four years, it would range

2 in the hundreds, like couple of hundred cases,

3 I would say.

4 COFFEY, Q.C.:

5 Q. Of?

6 DR. FONTAINE:

7 A. Of ER/PR.

8 COFFEY, Q.C.:

9 Q. ER/PR

10 DR. FONTAINE:

11 A. Breast cancer cases, yes.

12 COFFEY, Q.C.:

13 Q. And what, if anything, do you recall about

14 being told or taught or at the time, I take

15 it, you would also, if you were so inclined,

16 read about yourself -

17 DR. FONTAINE:

18 A. Oh yes.

19 COFFEY, Q.C.:

20 Q. - the strengths and weaknesses of that

21 procedure, the potential pitfalls, things to

22 look out for, how would--what do you recall

23 about that?

24 DR. FONTAINE:

25 A. I would come across that--it depended--in

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1 talking with Dr. Barnes, it was a different

2 thing when you talked to different

3 pathologists. Different pathologists had

4 different views on the reproducibility of

5 immunohistochemistry, and even more so when it

6 came to ER/PR because you could get some

7 differing results if you were to repeat, even

8 on the same block, as has been discussed in

9 the course of the Inquiry, and that was well

10 known amongst pathologists. So it was one of

11 these things that it wouldn't be unexpected to

12 see, and again, when we consider the

13 interpretation as well, as being fairly loose,

14 if you will.

15 COFFEY, Q.C.:

16 Q. Loose in what sense?

17 DR. FONTAINE:

18 A. Interpretative, more or less the standards.

19 You were not counting cells. There were other

20 areas in pathology where you would actually

21 count cells and give percentages. Where in

22 ER/PR, you would more or less eyeball the

23 amount of tumour that is staining and then

24 give a percentage from that end.

25 COFFEY, Q.C.:

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1 Q. Could you just explain to the Commissioner

2 then, the differences between what you were

3 doing in ER/PR and cell counting?

4 DR. FONTAINE:

5 A. Cell counting actually didn't apply. It would

6 apply more to counting for mitotic figures.

7 Again, not so much for immunohistochemistry.

8 I've not seen another immuno that is so

9 specific that you would count cells. So I use

10 that as a comparative that is something else

11 that we would use in histology, not so much in

12 immuno. So again, it would be more looking

13 for mitotic counts, we would actually count a

14 number of cells, you'd count a hundred cells

15 and then you would give a percentage from

16 there, or protein high power fields.

17 COFFEY, Q.C.:

18 Q. And ER/PR, perhaps you could just explain then

19 to the Commissioner, by the time you finished

20 up in Halifax, finished your residency, what

21 was your understanding of the appropriate way

22 to approach ER and PR?

23 DR. FONTAINE:

24 A. That it was necessary to report ER/PR on every

25 case of breast cancer and that it would

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1 determine whether a patient would be eligible
 2 for Tamoxifen or not. My training was you
 3 would report a percentage, that you would not
 4 determine whether it was positive or negative,
 5 beyond that, you would always tend to report
 6 the percentages.
 7 COFFEY, Q.C.:
 8 Q. So, for example, in your senior year as a
 9 resident, I take it in fact you were a chief
 10 resident -
 11 DR. FONTAINE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. At one point. As the chief resident, if you
 15 ordered an ER and PR for a breast cancer
 16 patient, how would you go about choosing it?
 17 Could you perhaps just describe for the
 18 Commissioner what you were taught in Halifax
 19 as to the appropriate approach to take, like
 20 literally step by step, what would you do?
 21 DR. FONTAINE:
 22 A. So essentially once we would receive--do you
 23 want me to start from the grossing?
 24 COFFEY, Q.C.:
 25 Q. Yes.

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1 DR. FONTAINE:
 2 A. So essentially once we receive the gross,
 3 depending on the type of specimen, it may need
 4 orientation to that and depending on the
 5 specimen itself. Once that was determined,
 6 there would be a description given, it would
 7 be fixed if necessary, and again described
 8 again, and if any special procedures needed to
 9 be undertaken, they would be done. Then we
 10 would select areas for sampling. Important to
 11 include tumour and adjacent tissue.
 12 COFFEY, Q.C.:
 13 Q. Adjacent normal tissue?
 14 DR. FONTAINE:
 15 A. Normal tissue or what appeared to be normal
 16 tissue.
 17 COFFEY, Q.C.:
 18 Q. Yes.
 19 DR. FONTAINE:
 20 A. So then those slides would be handed off and
 21 processed, we would receive the slides the
 22 next day. Following, they would be cut,
 23 stained and then we would receive them for
 24 interpretation. Once we would look at the
 25 slides, we would select an appropriate block,

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1 which would have an internal control and
 2 select that block for -
 3 COFFEY, Q.C.:
 4 Q. And these slides are H&E slides?
 5 DR. FONTAINE:
 6 A. These are H&E slides, so selecting from that
 7 H&E slide, we would pick the one block that
 8 would have internal control and that would be
 9 selected for estrogen and progesterone
 10 staining.
 11 COFFEY, Q.C.:
 12 Q. And then what would happen?
 13 DR. FONTAINE:
 14 A. That would be sent for staining, then we would
 15 receive that, and then there would be an
 16 interpretation. Again, do you want me to
 17 speak to the resident -
 18 COFFEY, Q.C.:
 19 Q. Yeah, how would you go about the--yes, if you
 20 would please?
 21 DR. FONTAINE:
 22 A. Right, so in both times, as a more junior
 23 resident, what would happen is you would be
 24 sitting with the staff person and discussing
 25 the case. So you would be looking at the

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1 ER/PR and making a percentage determination
 2 from there and discussing some particular
 3 issues. Again you would look at the controls
 4 to see if the--external controls and the
 5 internal controls had worked to validate the
 6 run and the tissue itself. Then we'd have a
 7 discussion as to, well, what percentage do you
 8 think this is? What percentage do you think
 9 this is? So there'd be a bit of guess work,
 10 you would try to guess what the pathologist
 11 was going to say, so you'd hedge your bets.
 12 COFFEY, Q.C.:
 13 Q. This is as a junior -
 14 DR. FONTAINE:
 15 A. This is as a junior resident, so you're sort
 16 of trying to, you want to be in the ballpark,
 17 if you will. And then as you become more
 18 senior, you then do it on your own, so you're
 19 actually looking at the slides, you'll order
 20 the stains, examine the slides yourself,
 21 create a report and then hand it to the staff
 22 pathologist, who then would come back and tell
 23 you if they have made any corrections to that.
 24 COFFEY, Q.C.:
 25 Q. Now in doing this or arriving at a percentage

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1 in your senior residency, what physical and/or
 2 mental processes would you go through to
 3 determine that?
 4 DR. FONTAINE:
 5 A. I'd be looking at the tissue -
 6 COFFEY, Q.C.:
 7 Q. You'd get the stained slides back.
 8 DR. FONTAINE:
 9 A. Right, so I now have the slides, so I'd look
 10 at them under the microscope and my tendency
 11 was to look at them at low power, objective,
 12 and get a sense of, okay, did the stains work?
 13 So you want to make sure that your internal
 14 control and your external controls have
 15 actually worked.
 16 COFFEY, Q.C.:
 17 Q. And so, they work if what happens?
 18 DR. FONTAINE:
 19 A. If they're staining brown and there's nuclear
 20 staining, so again, when we think of
 21 immunoperoxidase, the pathologist who had this
 22 sort of imposed on them, if you will, like to
 23 refer to them as brown stains. You may have
 24 heard of this through the process of the
 25 inquiry. Essentially that is just saying

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1 they're labelled with a brown chromogen, so it
 2 does not tell you what the stain actually is,
 3 and then beyond that, you need to know where
 4 the antigen is localized. And it's very
 5 important with ER/PR. As to my mind, this was
 6 the first stain that I remember being an
 7 exclusive nuclear stain and this was one thing
 8 that I found with pathologists, again, this
 9 was relatively new. I don't know if it was
 10 common knowledge because we would have
 11 discussions and I would see some pathologists
 12 interpreting cytoplasmic staining as being
 13 positive.
 14 COFFEY, Q.C.:
 15 Q. For ER/PR?
 16 DR. FONTAINE:
 17 A. For ER/PR in Halifax. It wasn't common, but
 18 it would happen. They would say, because
 19 again, that would shift the percentages. They
 20 would see some cytoplasmic staining and say
 21 that was positive. Then we'd have a
 22 discussion as to, well, I've been told that
 23 it's only nuclear.
 24 COFFEY, Q.C.:
 25 Q. Dr. Barnes had told me -

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1 DR. FONTAINE:
 2 A. Dr. Barnes says, exactly.
 3 COFFEY, Q.C.:
 4 Q. Go ahead, Doctor, so you'd be looking, as you
 5 told the Commissioner, you were trained to
 6 look for the staining of the controls nuclear
 7 staining, brown staining of the external
 8 controls and the internal control tissue.
 9 DR. FONTAINE:
 10 A. Correct.
 11 COFFEY, Q.C.:
 12 Q. What would you then do, assuming, I take it
 13 that both stained.
 14 DR. FONTAINE:
 15 A. Now that I've recognized that both stained, so
 16 I'm comfortable that I can interpret this
 17 stain. I would then look at the entire tumour
 18 from that end and see how much of this tumour
 19 is staining. Again, keeping in mind that
 20 there are some pit falls because you can get
 21 antibody trapping, that's not actually true
 22 staining, if you will, so you're always, edge
 23 artifacts and all these things, so you're
 24 always sort of thinking is there a preference
 25 to certain area of the tumour itself where you

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1 will see more of the clones, or is it a
 2 diffused weak positivity, et cetera, et
 3 cetera.
 4 COFFEY, Q.C.:
 5 Q. Spread throughout the tumour tissue.
 6 DR. FONTAINE:
 7 A. Spread throughout the tumour and all those
 8 things, and then from that, then you would
 9 make a determination as to what percentage of
 10 these nuclei are actually staining.
 11 COFFEY, Q.C.:
 12 Q. Were you taught any particular method to go
 13 about doing that?
 14 DR. FONTAINE:
 15 A. No, it was more or less eyeballed, best to use
 16 the entire field, the entire tumour. Again,
 17 when we're talking fields, I would go to low
 18 power and try to make an assessment of overall
 19 how much of this tissue was actually staining
 20 with this antibody.
 21 COFFEY, Q.C.:
 22 Q. When you say go to low power, what actually
 23 physically is that?
 24 DR. FONTAINE:
 25 A. Right, because as you use the microscope, you

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1 have different objectives, so if you look at a
 2 microscope, there are these turning wheels, if
 3 you will, so you can look at tissues at
 4 different levels of magnification. So these
 5 objectives correlate back to levels of
 6 magnification. A two times or four times
 7 magnification is what we call low power; a ten
 8 or twenty is medium power and a 40 is a high
 9 power examination. So basically using those
 10 different fields. So what we would say was go
 11 to the lowest power objective and you can get
 12 a sense of how much of this bigger overall
 13 view, if you will. Sometimes you can pick up a
 14 tissue and just look at it and say this is
 15 going to be positive, but then you still need
 16 to firm that it is localized to the nucleus
 17 and that it's not cytoplasmic staining.
 18 COFFEY, Q.C.:
 19 Q. You can't just see that with your eyes?
 20 DR. FONTAINE:
 21 A. You can't just see it without a microscope.
 22 COFFEY, Q.C.:
 23 Q. And then low power, I take it you're seeing
 24 more of the tumour?
 25 DR. FONTAINE:

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1 A. Correct.
 2 COFFEY, Q.C.:
 3 Q. And as the power increases, you're seeing a
 4 narrower or smaller and smaller area of the
 5 tumour?
 6 DR. FONTAINE:
 7 A. Correct.
 8 COFFEY, Q.C.:
 9 Q. Doctor, what were you taught in Halifax about
 10 any situation where the external control, from
 11 your perspective, did not stain?
 12 DR. FONTAINE:
 13 A. If the external control did not stain, that
 14 run was invalid.
 15 THE COMMISSIONER:
 16 Q. I'm sorry, I -
 17 DR. FONTAINE:
 18 A. Sorry was invalid.
 19 COFFEY, Q.C.:
 20 Q. And what would then happen?
 21 DR. FONTAINE:
 22 A. That would be process to repeat.
 23 COFFEY, Q.C.:
 24 Q. And I take it the technologist would be
 25 requested to repeat.

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1 DR. FONTAINE:
 2 A. Correct.
 3 COFFEY, Q.C.:
 4 Q. And would they be advised that -
 5 DR. FONTAINE:
 6 A. They would know because once they would
 7 receive that, they would say, well there's
 8 already one ordered on this, because they had
 9 a process of being able to know that there was
 10 already an ER/PR ordered on this case.
 11 COFFEY, Q.C.:
 12 Q. So if you saw an external control, for your
 13 ER/PR case, and it didn't work, you would send
 14 it -
 15 DR. FONTAINE:
 16 A. I would send it back for a repeat.
 17 COFFEY, Q.C.:
 18 Q. Repeat. And they understood that, for the
 19 whole process again, to create the ER and PR
 20 slides?
 21 DR. FONTAINE:
 22 A. Correct.
 23 COFFEY, Q.C.:
 24 Q. Do you recall, Doctor, do you recall that
 25 happening at all?

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1 DR. FONTAINE:
 2 A. In Halifax?
 3 COFFEY, Q.C.:
 4 Q. In Halifax, yes, external controls did not
 5 stain?
 6 DR. FONTAINE:
 7 A. It did happen, yes.
 8 COFFEY, Q.C.:
 9 Q. Would it be, do you recall, was it a common
 10 place or -
 11 DR. FONTAINE:
 12 A. Not a commonplace thing, so it's not
 13 exceptional, but I wouldn't say it was one of
 14 these exceptional rare events, but it would
 15 happen.
 16 COFFEY, Q.C.:
 17 Q. And did you ever become aware while you were
 18 there of any explanations for why, like
 19 yesterday's external control didn't stain for
 20 you? Would it be explained to you afterwards
 21 as to why that had come about?
 22 DR. FONTAINE:
 23 A. Not specifically, we would more or less, look,
 24 something must have gone wrong with the
 25 process, as I'm sure you have heard, there are

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

10 COFFEY, Q.C.:
 11 Q. And the internal controls, I've asked you
 12 about the external control, what about
 13 internal controls if they didn't stain for a
 14 particular case? What, if anything, would you
 15 do then?

16 DR. FONTAINE:
 17 A. The same thing, it would be repeated.

18 COFFEY, Q.C.:
 19 Q. And if it came back the second time?

20 DR. FONTAINE:
 21 A. As negative?

22 COFFEY, Q.C.:
 23 Q. Yes, as negative.

24 COFFEY, Q.C.:
 25 Q. Then there would be a question of, okay, this

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

9 COFFEY, Q.C.:
 10 Q. Doctor, thinking back on your residency
 11 training, did that occasionally happen, that
 12 it wouldn't stain the second time?

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

20 COFFEY, Q.C.:
 21 Q. If an internal control for a particular block,
 22 internal controls failed the second time, that
 23 would occasion discussion, as it were amongst
 24 -
 25 DR. FONTAINE:

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1 A. That would trigger more investigation.

2 COFFEY, Q.C.:
 3 Q. Do you recall what, if any, investigation in
 4 that regard revealed? Did you get an
 5 explanation as to why it had failed the second
 6 time?

7 DR. FONTAINE:
 8 A. The time that I'm familiar with was actually,
 9 just as I mentioned, we picked another block
 10 and the internal control worked in that
 11 situation. So we ascribed it to being that
 12 block in particular obviously had some issue
 13 within that block itself.

14 COFFEY, Q.C.:
 15 Q. Doctor, looking back on that particular
 16 instance that you recall and thinking back on
 17 the first two sets of slides, like the first
 18 one that failed, internal control and the
 19 second one, was there anything that you could
 20 see on the slide itself, like in the tissue
 21 that you could see on the slide that would
 22 alert you to, other than the fact that it
 23 hadn't stained appropriately--what you
 24 expected, was there anything else about the
 25 slide?

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1 DR. FONTAINE:
 2 A. In that case in particular?

3 COFFEY, Q.C.:
 4 Q. Yes.

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

14 COFFEY, Q.C.:
 15 Q. As much as the other block -

16 DR. FONTAINE:
 17 A. As the other block.

18 COFFEY, Q.C.:
 19 Q. As the tissue in the other block.

20 DR. FONTAINE:
 21 A. Correct.

22 COFFEY, Q.C.:
 23 Q. So, Doctor, if the internal control didn't
 24 stain as expected, I'll use the word "failed"
 25 okay, advisedly, would the entire run be

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1 redone or just that particular patient's?
 2 DR. FONTAINE:
 3 A. Depending on the external control has worked?
 4 COFFEY, Q.C.:
 5 Q. No, no, the internal control I'm asking about.
 6 The external control worked.
 7 DR. FONTAINE:
 8 A. The question then becomes has the external
 9 control worked.
 10 COFFEY, Q.C.:
 11 Q. Yes, if the external control worked, then you
 12 would just redo the single patients?
 13 DR. FONTAINE:
 14 A. As long as it was that single patient that was
 15 affected, because again, if all the other
 16 internal controls had failed -
 17 COFFEY, Q.C.:
 18 Q. In the other patients.
 19 DR. FONTAINE:
 20 A. In the other patients, then we have a problem.
 21 But if it was isolated to that one instance,
 22 no.
 23 COFFEY, Q.C.:
 24 Q. You would retest that one -
 25 DR. FONTAINE:

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1 A. We're retest that one.
 2 COFFEY, Q.C.:
 3 Q. So we're clear, but if the external control
 4 failed -
 5 DR. FONTAINE:
 6 A. Then we have to repeat the run.
 7 COFFEY, Q.C.:
 8 Q. How many external controls would be run with a
 9 particular run?
 10 DR. FONTAINE:
 11 A. Again, that was, as much as the inquiry has
 12 heard, there's been change here, much like the
 13 same in Halifax, there was changes then as
 14 well, because when I first started, it was a
 15 batch control. There would be one case run
 16 with the entire batch, to validate the batch
 17 and then it came to the point where the
 18 pathologist wanted to see it on the slide. So
 19 it would actually be put on the slide itself.
 20 COFFEY, Q.C.:
 21 Q. Do you recall when that transition occurred to
 22 the external control tissue being put on the
 23 slide, on the patient slide?
 24 DR. FONTAINE:
 25 A. It was late in my training, but I can't speak

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1 to the specific times, but I would anticipate
 2 late 2000 to potentially mid 2002.
 3 COFFEY, Q.C.:
 4 Q. Well, Doctor, when there were--you had a
 5 problem with the external control not
 6 staining, would you have to record that?
 7 Document it?
 8 DR. FONTAINE:
 9 A. Myself?
 10 COFFEY, Q.C.:
 11 Q. Yes.
 12 DR. FONTAINE:
 13 A. I would not, no.
 14 COFFEY, Q.C.:
 15 Q. How would you then order a rerun?
 16 DR. FONTAINE:
 17 A. I would just reorder ER/PR and then often
 18 times what I would put in parenthesis is
 19 "repeat", so that, cluing off the
 20 technologists, but my impression was that the
 21 technologists would know it was a repeat.
 22 Again, when I first started training, they
 23 were batching estrogen progesterone from that
 24 point.
 25 COFFEY, Q.C.:

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1 Q. So if the external control failed, you'd note
 2 it in your own head, but you wouldn't have to
 3 record it anywhere?
 4 DR. FONTAINE:
 5 A. No, it would just be recorded on the
 6 requisition asking for ER/PR retesting.
 7 COFFEY, Q.C.:
 8 Q. Would you says "external control failed" or -
 9 DR. FONTAINE:
 10 A. Sometimes I would, I can't say that I did it
 11 every time.
 12 COFFEY, Q.C.:
 13 Q. Sometimes you might note it and even if you
 14 didn't note it, was it your understanding that
 15 the technologists would assume the external
 16 controls failed or how would they know the
 17 difference between internal and external
 18 controls? I'm trying to get some sense of -
 19 DR. FONTAINE:
 20 A. Right, I think that as our knowledge
 21 developed, if you will, from these things and
 22 it was important for them to have feedback as
 23 well. And oftentimes they would come and ask
 24 you what was going on as well.
 25 COFFEY, Q.C.:

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1 Q. Why the repeat.
 2 DR. FONTAINE:
 3 A. Why are you repeating this, because again, it
 4 was on their watch, if you will, they took
 5 pride in this and they wanted to know why, why
 6 was this happening.
 7 COFFEY, Q.C.:
 8 Q. And if the internal control on a patient's
 9 tissue, internal controls from your
 10 perspective failed, would you have to note
 11 that anywhere? Document that?
 12 DR. FONTAINE:
 13 A. No, again, the same process. I would be more
 14 inclined to notify them that the internal
 15 control, if the external control had worked, I
 16 would be more inclined to tell them that it
 17 was an internal control problem, because
 18 again, it was not a frequent event.
 19 THE COMMISSIONER:
 20 Q. In the days when the external control was on a
 21 separate slide -
 22 DR. FONTAINE:
 23 A. Yes.
 24 THE COMMISSIONER:
 25 Q. Was there some kind of a pre-examination of

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1 whether or not the external control had worked
 2 before it got to you, as a pathologist?
 3 DR. FONTAINE:
 4 A. Yes.
 5 THE COMMISSIONER:
 6 Q. So was that a technologist doing that or a
 7 head pathologist in a lab or a person who got
 8 the bad duty and had to do it that week or
 9 something?
 10 DR. FONTAINE:
 11 A. It was more or less the technologist would
 12 take a look at it and it would be available
 13 for the pathologist to review.
 14 COFFEY, Q.C.:
 15 Q. Was it documented anywhere, like when you
 16 would get your slides and the external control
 17 slide, would it be documented anywhere already
 18 that the external control worked?
 19 DR. FONTAINE:
 20 A. I'm not aware of there being a formal
 21 document, but I can't speak to that
 22 specifically, but -
 23 COFFEY, Q.C.:
 24 Q. Now, Doctor, the reporting of ER/PR during
 25 your residency, how were you taught to do

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1 that?
 2 DR. FONTAINE:
 3 A. The tendency was report a percentage and that
 4 was what I adopted as routine practice. You
 5 reported the percentage and you left the
 6 decision making then to the oncologist.
 7 COFFEY, Q.C.:
 8 Q. As to what they would make of -
 9 DR. FONTAINE:
 10 A. Make of that interpretation, correct.
 11 COFFEY, Q.C.:
 12 Q. So if, for example, if the percentage was
 13 zero, would you use zero?
 14 DR. FONTAINE:
 15 A. I may say negative, but I would expect that I
 16 would have used zero percent as well.
 17 COFFEY, Q.C.:
 18 Q. And if there was, so it would either be,
 19 meaning complete absence of nuclear staining.
 20 DR. FONTAINE:
 21 A. Correct, yes.
 22 COFFEY, Q.C.:
 23 Q. You would use either zero or negative to mean
 24 zero?
 25 DR. FONTAINE:

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1 A. Correct.
 2 COFFEY, Q.C.:
 3 Q. And any other percentage figure, like one
 4 through a hundred would be just a percentage?
 5 DR. FONTAINE:
 6 A. Correct.
 7 COFFEY, Q.C.:
 8 Q. Doctor, in your residency, in your time in
 9 Halifax in your residency, how much
 10 interaction would there be on a routine basis
 11 between the pathologist and oncologist?
 12 DR. FONTAINE:
 13 A. We had--are you speaking specifically to
 14 breast?
 15 COFFEY, Q.C.:
 16 Q. Yes.
 17 DR. FONTAINE:
 18 A. There was a bi-weekly breast oncology group,
 19 if you will, where the oncologist and the
 20 pathologist would sit and discuss cases.
 21 COFFEY, Q.C.:
 22 Q. And was that during the whole time you were
 23 there?
 24 DR. FONTAINE:
 25 A. It more or less was initiated by Dr. Barnes,

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1 so it wasn't there when I first started, but I
 2 can't say when it actually started, but it was
 3 fairly early on in the process.
 4 COFFEY, Q.C.:
 5 Q. Yours and presumably shortly after she
 6 arrived.
 7 DR. FONTAINE:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. It would be instituted. From your
 11 perspective, were pathologists, if they run a
 12 rotation, expected to show up?
 13 DR. FONTAINE:
 14 A. As a general -
 15 COFFEY, Q.C.:
 16 Q. As a resident.
 17 DR. FONTAINE:
 18 A. As a resident, they were expected to show up,
 19 yes.
 20 COFFEY, Q.C.:
 21 Q. And what was your observation about the
 22 frequency of attendance of staff pathologists?
 23 DR. FONTAINE:
 24 A. It was more or less run by Dr. Barnes, but the
 25 attending pathologists would rarely, if ever,

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1 show up to that round.
 2 COFFEY, Q.C.:
 3 Q. So it would be Dr. Barnes as in effect the
 4 staff breast pathologist, in effect, the
 5 residents, pathology residents and
 6 oncologists?
 7 DR. FONTAINE:
 8 A. I should back up because there were other
 9 pathologists doing breasts as well, so Dr.
 10 McIntosh would show up as well from the
 11 pathology end, but for as far as the other
 12 pathologists, they would not attend regularly.
 13 COFFEY, Q.C.:
 14 Q. And what about the oncologists?
 15 DR. FONTAINE:
 16 A. The oncologists, again, it was a preference
 17 towards those treating breast cancers, so Dr.
 18 Rayson, Daniel Rayson would attend those
 19 rounds quite frequently.
 20 COFFEY, Q.C.:
 21 Q. During those bi-weekly meetings, would there
 22 sometimes be discussions of staining of the
 23 slides, if there were problems or perceived to
 24 be problems?
 25 DR. FONTAINE:

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1 A. Not that I remember specifically, again, it
 2 would be more or less about different
 3 parameters with the cases, from that end. It
 4 would be more discussing the clinical end and
 5 then the pathology would present. Often
 6 times, we often look at pathology reports as
 7 being that's what it is, and it's never
 8 questioned beyond that. I think that's
 9 changing and as a result of this, we'll
 10 certainly be suspect.
 11 COFFEY, Q.C.:
 12 Q. Doctor, the technologists or any
 13 representative of technologists ever come to
 14 such meetings?
 15 DR. FONTAINE:
 16 A. I can't say--when I was there, I did not see a
 17 technologist.
 18 COFFEY, Q.C.:
 19 Q. Would there be, while you were resident, were
 20 there any kind of formal, semi formal routine
 21 meetings between the pathologists and the
 22 technologists?
 23 DR. FONTAINE:
 24 A. We did have occasional rounds involved with
 25 the technologists. The administration of the

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1 day was trying to get and foster relationships
 2 between the technologists and pathologists.
 3 Again, it would be more a single pathologist
 4 talking about their subspecialty with the
 5 technologist. So it wouldn't really be all
 6 pathologists and all technologists together,
 7 but it would be as that subspecialty group
 8 went through.
 9 COFFEY, Q.C.:
 10 Q. And in terms of IHC itself, was there anyone
 11 in particular in the Dalhousie program or the
 12 Halifax hospital system there, any particular
 13 pathologists or pathologist who, I mean, if
 14 you looked around, as it were, amongst you,
 15 everybody would agree that he or she is the
 16 go-to person for IHC or in fact was in charge
 17 of IHC?
 18 DR. FONTAINE:
 19 A. No individual was in charge of IHC. The IHC
 20 responsibility was more or less delegated to
 21 the subspecialty groups for their own
 22 particular interests. So if they had
 23 particular issues, they would take it up with
 24 the technologists performing immuno.
 25 COFFEY, Q.C.:

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1 Q. So subspecialty groups, for example Dr.
 2 Barnes.
 3 DR. FONTAINE:
 4 A. Correct.
 5 COFFEY, Q.C.:
 6 Q. If there was a breast pathology -
 7 DR. FONTAINE:
 8 A. If there was a breast issue.
 9 COFFEY, Q.C.:
 10 Q. A breast issue involving staining, HER2/neu,
 11 ER/PR and whatever else might be appropriate,
 12 it would be expected that Dr. Barnes, if there
 13 was a concern expressed or she had her own
 14 concern, would deal with the technologists?
 15 DR. FONTAINE:
 16 A. Correct.
 17 COFFEY, Q.C.:
 18 Q. And neuropathology, the same thing, I take it,
 19 in effect.
 20 DR. FONTAINE:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And any other subspecialty?
 24 DR. FONTAINE:
 25 A. Uro pathology and, yes.

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1 COFFEY, Q.C.:
 2 Q. In terms of the overall, IHC as kind of an
 3 overall--because we have now, Dr. Elms, and
 4 I'm thinking about the equivalent of Dr. Elms?
 5 DR. FONTAINE:
 6 A. Not in a formal sense as much as what we see
 7 here. There was one individual who was sort
 8 of the knower of all, so any time there was an
 9 issue in pathology, he would be consulted on
 10 anything because he was just one of these very
 11 well rounded individuals. But to say that he
 12 was the overseer of immunohistochemistry, no.
 13 COFFEY, Q.C.:
 14 Q. That wouldn't be.
 15 DR. FONTAINE:
 16 A. That would not be.
 17 COFFEY, Q.C.:
 18 Q. Doctor, if we could, please Registrar, exhibit
 19 P-1600. Now, Doctor, this is a--it's a
 20 document entitled "Eastern Health Pathologist
 21 Staff Turn Over" and it was revised July 10th,
 22 2007 and your name is there, third from the
 23 top.
 24 DR. FONTAINE:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. You're listed as an incumbent, start date,
 3 June 19th, 2003 and the heading is
 4 "Termination Date". And there's a blank
 5 space, so was it June 19th, 2003 that you
 6 started here in St. John's as a staff
 7 pathologist?
 8 DR. FONTAINE:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. And, Doctor, when you came to work in St.
 12 John's, where were you stationed, which
 13 hospital?
 14 DR. FONTAINE:
 15 A. Primarily at the Health Science site but with
 16 responsibilities at the Miller Centre where
 17 cytology is performed.
 18 COFFEY, Q.C.:
 19 Q. And when you came to St. John's, what
 20 technically was your position in the sense
 21 were you part of the medical school staff?
 22 DR. FONTAINE:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. And who you actually associated with?

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1 DR. FONTAINE:
 2 A. So I came in as the GFT, so as a university
 3 position, so I had responsibilities to the
 4 university and to the clinical practice as
 5 well.
 6 COFFEY, Q.C.:
 7 Q. And was there any understanding at that time
 8 as to the proportion, the division of
 9 responsibility or the amount of your time
 10 you'd spend doing each different -
 11 DR. FONTAINE:
 12 A. The way it was explained to me, it was a .8
 13 appointment for clinical and a .2 appointment
 14 for teaching or university functions, if you
 15 will.
 16 COFFEY, Q.C.:
 17 Q. So that would be 80 percent of your time.
 18 DR. FONTAINE:
 19 A. 80 percent, clinical.
 20 COFFEY, Q.C.:
 21 Q. And 20 percent teaching?
 22 DR. FONTAINE:
 23 A. Correct.
 24 COFFEY, Q.C.:
 25 Q. Research.

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1 DR. FONTAINE:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. And was there any particular type of pathology
 5 that you were supposed to be engaged in?
 6 DR. FONTAINE:
 7 A. I was being groomed, if you will, towards
 8 cytology. When I came, there was no director
 9 for cytopathology, so they were more or less
 10 grooming me, if you will, so I can get my feet
 11 wet with the anticipation that I would take
 12 over as director in cytology.
 13 COFFEY, Q.C.:
 14 Q. Now did that happen?
 15 DR. FONTAINE:
 16 A. Yes, it did.
 17 COFFEY, Q.C.:
 18 Q. And when did you become director of cytology?
 19 DR. FONTAINE:
 20 A. I believe it was April 1st of 2004, so
 21 approximately 9 months into the position.
 22 COFFEY, Q.C.:
 23 Q. Now you were at the General Hospital site.
 24 DR. FONTAINE:
 25 A. Yes.

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

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. Doctor, were you made aware of any of this
 4 when you first arrived in St. John's and the
 5 fact that this had been going on before you
 6 arrived?
 7 DR. FONTAINE:
 8 A. No.
 9 COFFEY, Q.C.:
 10 Q. And in fact, was almost concurrently going on
 11 looking at the last memo?
 12 DR. FONTAINE:
 13 A. Looking at the timelines, I mean, yeah. No, I
 14 did not know of these letters' existence.
 15 COFFEY, Q.C.:
 16 Q. Or the subject matter, I take it?
 17 DR. FONTAINE:
 18 A. No.
 19 COFFEY, Q.C.:
 20 Q. Because it's one thing to have seen the memos
 21 or somebody actually speaks about the memos,
 22 which is one thing, but the actual subject
 23 matter, which is, for example, the April 4th,
 24 2003 memo, the fact that Dr. Ejeckam had
 25 described these eight stains that remain

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1 "unreliable, erratic and therefore unhelpful
 2 for diagnostic purposes" as of April 4, 2003,
 3 by the time you arrived and really got going,
 4 perhaps by July of 2003, you'd be certainly
 5 into your job by then?
 6 DR. FONTAINE:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. There was no one at work talking about --
 10 DR. FONTAINE:
 11 A. No.
 12 COFFEY, Q.C.:
 13 Q. Scuttlebutt kind of talking, you know, over
 14 coffee or whatever?
 15 DR. FONTAINE:
 16 A. No. No, not as the issue that it's presented
 17 as here.
 18 COFFEY, Q.C.:
 19 Q. Was there any discussion at that time in the
 20 summer of '03, in the fall of '03, that you
 21 heard or participated in involving the quality
 22 of the staining, IHC staining?
 23 DR. FONTAINE:
 24 A. Again thinking of it, IHC staining itself, it
 25 was an issue that was always discussed in

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1 Halifax, and it was discussed when I came
 2 here, and it's been discussed with colleagues
 3 as well that -- I just thought of it was just
 4 sort of your garden variety unhappiness with
 5 immuno, if you will. I didn't see it as being
 6 abnormal or particular to the St. John's lab.
 7 COFFEY, Q.C.:
 8 Q. So there was --
 9 DR. FONTAINE:
 10 A. I had heard -- there were pathologists, but
 11 pathologists talk about IHC all the time.
 12 It's one of these things that's shop talk, if
 13 you will. So it's sort of the low level -- not
 14 knowing about these letters, I didn't know the
 15 letters were written, but the discussions did
 16 not seem out of what I'd been exposed to in
 17 other places.
 18 COFFEY, Q.C.:
 19 Q. So what sorts of -- what sorts of things had
 20 you heard in Halifax, and again I take it you
 21 were hearing much the same thing when you
 22 arrived in St. John's?
 23 DR. FONTAINE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. The first, you know, say, six months you were
 2 here?
 3 DR. FONTAINE:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. What sorts of complaints or concerns would
 7 pathologists voice about IHC staining?
 8 DR. FONTAINE:
 9 A. Again much the issue that we spoke of with
 10 external controls, internal controls, that
 11 they wouldn't work, and it's one of these
 12 accepted practises. Sometimes the stains
 13 don't work. If you're looking for it, then
 14 just reorder and take it from there, but you
 15 would like -- you would feel much more
 16 comfortable if it was always working, and then
 17 you'd get a bit of a sense of uneasiness, if
 18 you will, when occasionally it doesn't work
 19 and you have to ask yourself, well, why didn't
 20 this work. Again if -- going back to the
 21 process, it could be any one of those steps,
 22 and you hope that it's a unique situation and
 23 you don't see trends that develop from that.
 24 COFFEY, Q.C.:
 25 Q. Do you know if in Halifax while you were a

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1 resident, they were keeping track of --
 2 statistically keeping track of things?
 3 DR. FONTAINE:
 4 A. Not that I was aware of.
 5 COFFEY, Q.C.:
 6 Q. Now in St. John's when you arrived and
 7 throughout 2003, would there be discussion
 8 about fixation problems in relation to IHC
 9 staining?
 10 DR. FONTAINE:
 11 A. No more than what I was hearing in Halifax, if
 12 you will.
 13 COFFEY, Q.C.:
 14 Q. So from your perspective --
 15 DR. FONTAINE:
 16 A. I didn't see --
 17 COFFEY, Q.C.:
 18 Q. You spent four to five years in Halifax?
 19 DR. FONTAINE:
 20 A. Correct.
 21 COFFEY, Q.C.:
 22 Q. And arriving in St. John's --
 23 DR. FONTAINE:
 24 A. And what I was seeing on the ground was no
 25 different than what I was experiencing in

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1 Halifax.
 2 COFFEY, Q.C.:
 3 Q. Doctor, this May 2nd, 2003 memo which begins
 4 at page two of P-0113, it's addressed to
 5 Pathologists, HSC, St. Clare's, and out of
 6 town hospitals from Dr. Ejeckam, the subject
 7 is ER/PR immunohistochemical stains, did you
 8 see this back in 2003?
 9 DR. FONTAINE:
 10 A. No.
 11 COFFEY, Q.C.:
 12 Q. Have you since seen it?
 13 DR. FONTAINE:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. And when would you have first seen this, do
 17 you think?
 18 DR. FONTAINE:
 19 A. I think it would have been perhaps at the time
 20 of my deposition.
 21 COFFEY, Q.C.:
 22 Q. Okay, when -- I take it when you were
 23 interviewed by the -- by myself and Ms.
 24 Chaytor?
 25 DR. FONTAINE:

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1 A. Correct.
 2 COFFEY, Q.C.:
 3 Q. So, Doctor, having had a chance in 2007/2008,
 4 that time frame to review this, were you aware
 5 of -- you weren't aware of the memo, but were
 6 you aware of the contents of these sorts of
 7 things, these concerns about IHC -- I'm sorry,
 8 ER/PR stains? Were you familiar with this,
 9 the idea that there's concern possibly with
 10 delayed fixation, over fixation, under
 11 fixation?
 12 DR. FONTAINE:
 13 A. These would have been addressed in Dr.
 14 Rowden's lectures with immunohistochemistry.
 15 COFFEY, Q.C.:
 16 Q. Back --
 17 DR. FONTAINE:
 18 A. Back in my days of residency.
 19 COFFEY, Q.C.:
 20 Q. Your early residency?
 21 DR. FONTAINE:
 22 A. Correct.
 23 DR. FONTAINE:
 24 A. And, for example, paragraph two here, the fact
 25 that "ER/PR false negative results increase in

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1 core biopsies. Where possible, restrict the
 2 request to excision biopsies", would you have
 3 been aware of that?
 4 DR. FONTAINE:
 5 A. Not so much -- that's a controversial area.
 6 COFFEY, Q.C.:
 7 Q. And, I take it, there's differences of opinion
 8 with the results?
 9 DR. FONTAINE:
 10 A. There's differences of opinions with this, but
 11 I was aware that that did exist.
 12 COFFEY, Q.C.:
 13 Q. As a --
 14 DR. FONTAINE:
 15 A. As a potential confounding variable.
 16 COFFEY, Q.C.:
 17 Q. The reference to in paragraph three, "Check
 18 normal breast acini in your sections as
 19 internal controls", you were aware of that?
 20 DR. FONTAINE:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. From your residency days. Paragraph four, "In
 24 carcinoma of the breast, most PR positive
 25 tumours are also ER positive, however, 10

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1 percent of PR positive tumours are ER
 2 negative", and would you have been aware of
 3 that?
 4 DR. FONTAINE:
 5 A. Yes. I can specifically remember Dr. Barnes
 6 pointing that out, and I know it's a
 7 contention with a lot of breast pathologists
 8 in the ability to explain that. It does
 9 exist.
 10 COFFEY, Q.C.:
 11 Q. About the actual phenomena, and explaining the
 12 phenomena?
 13 DR. FONTAINE:
 14 A. Explaining it because the progesterone
 15 receptor works through the estrogen receptor,
 16 so there's a lot of people who've had the
 17 belief that that shouldn't exist, but it does,
 18 and we have to deal with that.
 19 COFFEY, Q.C.:
 20 Q. Here, Doctor, if -- so coming out of your
 21 training then, the idea that only one in ten
 22 breast tumours would show up as PR positive,
 23 ER negative?
 24 DR. FONTAINE:
 25 A. Right.

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1 COFFEY, Q.C.:
 2 Q. Would you have been aware of that coming out
 3 of your training then?
 4 DR. FONTAINE:
 5 A. I don't know if I would have specifically
 6 known it was 10 percent. I knew it was a rare
 7 event.
 8 COFFEY, Q.C.:
 9 Q. Rare.
 10 DR. FONTAINE:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. And that's more what I'm getting at, what
 14 actual percentage?
 15 DR. FONTAINE:
 16 A. Percentage, I just knew it was a rare event.
 17 COFFEY, Q.C.:
 18 Q. So as a pathologist then finishing your
 19 residency and coming to St. John's, when you
 20 would look or would order an ER/PR test and
 21 get the results, bearing in mind what you were
 22 seeing --
 23 DR. FONTAINE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. From your perspective, would you compare that
 2 with kind of your expectations as to how
 3 common the result you had arrived at? For
 4 example, if you call a tumour PR positive, ER
 5 negative --
 6 DR. FONTAINE:
 7 A. Right.
 8 COFFEY, Q.C.:
 9 Q. Would it cross your mind that this is a
 10 relatively rare tumour if it falls into that
 11 category?
 12 DR. FONTAINE:
 13 A. It would cross my mind because I knew it was
 14 an issue because it had been discussed several
 15 times in my training as to the phenomenon, and
 16 it was one of these things that I knew it was
 17 difficult to explain and an area of
 18 controversy in breast pathology, but I knew it
 19 did happen.
 20 COFFEY, Q.C.:
 21 Q. And so if you would come across a tumour
 22 result that fell into these kind of rare
 23 categories, this happens to be one of them?
 24 DR. FONTAINE:
 25 A. Correct.

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1 COFFEY, Q.C.:
 2 Q. Another example, I'll use it with you now
 3 because we'll see it on the next -- actually
 4 going to the next page, ER positive tumours,
 5 paragraph seven.
 6 DR. FONTAINE:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. And Dr. Ejeckam has listed tubular, mucinous,
 10 papillary, ductal low nuclear grade, and he
 11 has indicated to the Commissioner he should
 12 have included lobular.
 13 DR. FONTAINE:
 14 A. Lobular.
 15 COFFEY, Q.C.:
 16 Q. As well, lobular invasive.
 17 DR. FONTAINE:
 18 A. Correct.
 19 COFFEY, Q.C.:
 20 Q. Doctor, if you saw -- again you had classified
 21 a tumour as tubular, and yet you were seeing
 22 it as ER negative, would that strike you as
 23 strange and, therefore, cause you to --
 24 DR. FONTAINE:
 25 A. It would strike me as strange, but I know it's

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1 possible, but again as a one event, no, it
 2 wouldn't trigger alarm bells, but if I saw
 3 that repeatedly, yes, it could trigger
 4 something might be going on here.
 5 COFFEY, Q.C.:
 6 Q. I take it, in any case you'd be looking,
 7 though, at the external controls?
 8 DR. FONTAINE:
 9 A. Correct.
 10 COFFEY, Q.C.:
 11 Q. And the internal controls?
 12 DR. FONTAINE:
 13 A. Right.
 14 COFFEY, Q.C.:
 15 Q. Regardless of what --
 16 DR. FONTAINE:
 17 A. Exactly, because feeling that as long as the
 18 external and internal controls have worked,
 19 and this tumour is again negative, because it
 20 does happen. We do know that there is a
 21 certain population that do have this finding.
 22 COFFEY, Q.C.:
 23 Q. The idea that certain tumours, certain types
 24 of tumour will tend to be ER positive, were
 25 you aware of that during your residency?

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1 DR. FONTAINE:
 2 A. Yes, because with the better differentiated
 3 tumours, if you will, the ones that look more
 4 like normal epithelium, if you will, they were
 5 known to be ER positive.
 6 COFFEY, Q.C.:
 7 Q. And so this information contained in paragraph
 8 eight, would you have been aware of that as a
 9 resident?
 10 DR. FONTAINE:
 11 A. Yes, and again there are exceptions to those
 12 rules. In medicine, we never make 100s or 0
 13 percents.
 14 COFFEY, Q.C.:
 15 Q. Doctor, here in paragraph five, there's a
 16 reference to reporting ER/PR, several formulae
 17 are in the literature and he spells them out
 18 here.
 19 DR. FONTAINE:
 20 A. Right.
 21 COFFEY, Q.C.:
 22 Q. ER positive, greater or equal to 5 percent, ER
 23 positive, 10 percent, ER positive, 1 percent,
 24 and then he refers to this consensus statement
 25 in 2000.

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1 DR. FONTAINE:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Would you have been exposed to this sort of
 5 information in your residency?
 6 DR. FONTAINE:
 7 A. I was aware of it as part of my training, yes.
 8 I don't know about 2000, but I know it came up
 9 as part of my -- as I was going towards my
 10 exams, I became aware of that.
 11 COFFEY, Q.C.:
 12 Q. The idea that there were different views as to
 13 what constituted positivity?
 14 DR. FONTAINE:
 15 A. Definitely, yes.
 16 COFFEY, Q.C.:
 17 Q. From your perspective as a pathologist, if
 18 you're reporting percentages, did it matter?
 19 DR. FONTAINE:
 20 A. That was how I was trained, and this was
 21 exactly why Dr. Barnes was reporting
 22 percentages, and had that discussion.
 23 COFFEY, Q.C.:
 24 Q. Put down a percentage?
 25 DR. FONTAINE:

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1 A. Put down a percentage and leave it to the --
 2 COFFEY, Q.C.:
 3 Q. And leave it to the oncologist to make up
 4 their mind?
 5 DR. FONTAINE:
 6 A. Correct, because it's probably going to keep
 7 changing.
 8 COFFEY, Q.C.:
 9 Q. The idea in paragraph six here, "Higher
 10 staining intensity does not reflect better
 11 results. This is a function of staining
 12 procedure and may alter. All cytoplasmic
 13 staining in ER and PR immunostain are to be
 14 considered as negative", and that last
 15 sentence you've already told us you were aware
 16 of that?
 17 DR. FONTAINE:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. How about the first two sentences?
 21 DR. FONTAINE:
 22 A. Oh, definitely. The higher staining intensity
 23 does not reflect better results. It's just --
 24 it just speaks to the fact that you've coated
 25 it more, if you will, so it's just amplified

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

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1 won't find it.
 2 COFFEY, Q.C.:
 3 Q. Doctor, if we could, please -- and Doctor, you
 4 settled in in the middle of 2003 in St.
 5 John's. How much breast pathology would you
 6 be involved in?
 7 DR. FONTAINE:
 8 A. Breast was not really my area of sub-specialty
 9 because when I'd heard that Dr. Carter was
 10 coming, I was more than happy to show her
 11 anything I had related to breast. Coming out
 12 of residency, my primary interest was more in
 13 cytology. I was exposed -- it would probably
 14 constitute about two to three percent of
 15 practice, I imagine.
 16 COFFEY, Q.C.:
 17 Q. If you could just look back, please, at
 18 Exhibit P-1600. Doctor, here looking down
 19 this page is a listing of pathologists. Dr.
 20 Carter is the sixth from the bottom and it
 21 shows her start date here is August 16th,
 22 2004?
 23 DR. FONTAINE:
 24 A. Yes, because I believe she actually started as
 25 locum before that.

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1 COFFEY, Q.C.:
 2 Q. Before that?
 3 DR. FONTAINE:
 4 A. Yeah.
 5 COFFEY, Q.C.:
 6 Q. But when you learned then that she had taken a
 7 position here in St. John's, you understood
 8 she was a breast -- she had a sub-specialty in
 9 breast pathology?
 10 DR. FONTAINE:
 11 A. Right, I had recognized that when she was a
 12 locum.
 13 COFFEY, Q.C.:
 14 Q. And from your perspective, you were pleased, I
 15 take it, to have her here?
 16 DR. FONTAINE:
 17 A. Very much so.
 18 COFFEY, Q.C.:
 19 Q. If we could, please, Exhibit P-1576. Doctor,
 20 this is a -- that's an agenda, a Division of
 21 Anatomical Pathology pathologists meeting at
 22 the General Hospital site, September 24th,
 23 2003, and, Doctor, these are the minutes
 24 themselves. Present are a number of
 25 physicians, including Dr. Ejeckam, Dr. Carter,

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

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

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1 Q. Would there be meetings or would just you'd
 2 run into him?
 3 DR. FONTAINE:
 4 A. You'd sort of run into him from that end, but
 5 if there were an issue, he was very
 6 approachable.
 7 COFFEY, Q.C.:
 8 Q. And I've noticed here, Dr. S. Parai was there?
 9 DR. FONTAINE:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. Dr. Parai, I understand, was the site chief of
 13 the day?
 14 DR. FONTAINE:
 15 A. That's correct.
 16 COFFEY, Q.C.:
 17 Q. What, if any, interaction would you have with
 18 the site chief, in his capacity as site chief?
 19 DR. FONTAINE:
 20 A. I knew he was the site chief and if I had any
 21 issues I could bring them up with him.
 22 COFFEY, Q.C.:
 23 Q. And what sorts of things might -
 24 DR. FONTAINE:
 25 A. Again, much like the issues if I saw something

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1 that was of concern, like if I saw repeated
 2 negative internal control, I know that I could
 3 take it up with him or something to that
 4 effect.
 5 COFFEY, Q.C.:
 6 Q. And here I see, Dr. Ejeckam is listed here as
 7 well.
 8 DR. FONTAINE:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. Doctor, I take it he was another staff
 12 pathologist?
 13 DR. FONTAINE:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. Did you have any understanding that he had any
 17 particular interest in IHC?
 18 DR. FONTAINE:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. And where did you first--when did you first
 22 learn that?
 23 DR. FONTAINE:
 24 A. I can't remember specifically, but--because
 25 when I heard that Dr. Ejeckam was coming,

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1 because again, through the process of
 2 recruitment, because I had done some training
 3 here, the clinical chief, Dr. Haegert, had
 4 mentioned that there was a pathologist coming
 5 from Dohar who had extensive experience and
 6 had an interest in immunochemistry as well.
 7 COFFEY, Q.C.:
 8 Q. Doctor, now the six-month, I think you said
 9 you did a rotation in St. John's?
 10 DR. FONTAINE:
 11 A. I did a rotation for six months.
 12 COFFEY, Q.C.:
 13 Q. Six months in St. John's?
 14 DR. FONTAINE:
 15 A. That's correct.
 16 COFFEY, Q.C.:
 17 Q. Do you recall when that was?
 18 DR. FONTAINE:
 19 A. That would have been 2002, June of 2002 to
 20 December of 2003.
 21 COFFEY, Q.C.:
 22 Q. Okay.
 23 DR. FONTAINE:
 24 A. Or 2002, I'm sorry, yes, so it was just six
 25 months.

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1 COFFEY, Q.C.:
 2 Q. June '02 to December '02.
 3 DR. FONTAINE:
 4 A. June '02 to December '02.
 5 COFFEY, Q.C.:
 6 Q. The last half of 2002.
 7 DR. FONTAINE:
 8 A. Correct.
 9 COFFEY, Q.C.:
 10 Q. Would you have done any ER and PR reporting at
 11 that time?
 12 DR. FONTAINE:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. During that time frame?
 16 DR. FONTAINE:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. This particular six-month rotation was for
 20 what?
 21 DR. FONTAINE:
 22 A. What I did was essentially look at--I was
 23 evaluating the lab with the consideration of
 24 coming here for employment. So what I did was
 25 two-month rotation at the Health Sciences site

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1 and then a two-month rotation at St. Clare's,
 2 and then a two-month rotation at the Miller
 3 Centre.
 4 COFFEY, Q.C.:
 5 Q. Now the ER and PR testing that you would have
 6 been exposed to in 2002 here in St. John's, do
 7 you recall anything about that, any problems
 8 associated with it, or anything coming to your
 9 attention?
 10 DR. FONTAINE:
 11 A. From what I saw from what I came from Halifax,
 12 what I was doing was no different than what I
 13 was seeing there.
 14 COFFEY, Q.C.:
 15 Q. So, and Dr. Haegert would have been the
 16 clinical chief--no, discipline chair?
 17 DR. FONTAINE:
 18 A. Exactly. I'm never sure of the exact titles,
 19 but I know that he was in transition at that
 20 time. So I think he was just leaving when I
 21 came in, in June.
 22 COFFEY, Q.C.:
 23 Q. So he would be clinical chief then. In fact,
 24 he was, because that was -
 25 DR. FONTAINE:

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1 A. Right, and then Dr. Cook was coming in as
 2 acting.
 3 COFFEY, Q.C.:
 4 Q. And it was during discussions with Dr. Haegert
 5 you recall being told that there was a
 6 physician coming from Dohar?
 7 DR. FONTAINE:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Who had some experience with IHC?
 11 DR. FONTAINE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. And in what context would that have come up?
 15 DR. FONTAINE:
 16 A. I guess as a recruitment strategy perhaps,
 17 just saying about how there were constantly
 18 people coming here as well.
 19 COFFEY, Q.C.:
 20 Q. Trying to entice you, for example, or make it
 21 more -
 22 DR. FONTAINE:
 23 A. You could take it as that, I guess.
 24 COFFEY, Q.C.:
 25 Q. Dr. Haegert would be, in effect, saying to you

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

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1 think it was because there were a number of
 2 openings at the time and it was to say that
 3 here's what we are recruiting and we are
 4 actively recruiting, but not so much the fact
 5 that it was direct IHC. I was much more
 6 interested in that there was going to be a
 7 breast subspecialist present.
 8 COFFEY, Q.C.:
 9 Q. And why is that?
 10 DR. FONTAINE:
 11 A. Because of my experience with these issues,
 12 because I've known that this has always been a
 13 test that's been fraught with difficulties.
 14 COFFEY, Q.C.:
 15 Q. And you had known that from Halifax, your days
 16 in Halifax?
 17 DR. FONTAINE:
 18 A. Correct.
 19 COFFEY, Q.C.:
 20 Q. Now Doctor, looking at this particular--these
 21 minutes of September 24th, 2003, paragraph
 22 3.2, "QA program. A final QA program will be
 23 completed soon after a final meeting with Dr.
 24 Cook and Barry Dyer. However, the present
 25 practice of mentioning the name of the

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

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

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

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

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1 A. Or that she would look at them.
 2 COFFEY, Q.C.:
 3 Q. Look at them, and I'm going to ask you about
 4 that, okay. What was -
 5 DR. FONTAINE:
 6 A. Because with the idea that potentially we
 7 could move towards that subspecialization,
 8 t h a t - - b e c a u s e u l t i m a t e l y , w i t h
 9 subspecialization, that she would be doing the
 10 lion's share of breast cases. It's not just--
 11 so we used sort of ER/PR, HER2 as a launch
 12 point to plant the seed, if you will, to then
 13 move to the fact that she would actually be
 14 handling the majority of the breast cancer
 15 cases.
 16 COFFEY, Q.C.:
 17 Q. Not unlike Doctor--the doctor in Halifax,
 18 Doctor -
 19 DR. FONTAINE:
 20 A. Correct, Dr. Barnes.
 21 COFFEY, Q.C.:
 22 Q. Dr. Barnes.
 23 DR. FONTAINE:
 24 A. Right. So it's sort of a subtle way of trying
 25 to introduce the Halifax model, if you will.

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1 COFFEY, Q.C.:

2 Q. And we've just noted, she started, formally

3 started, like in a full-time position in

4 August 2004?

5 DR. FONTAINE:

6 A. Correct.

7 COFFEY, Q.C.:

8 Q. So this is, in effect, really effectually just

9 two weeks -

10 DR. FONTAINE:

11 A. Shortly thereafter. I didn't wait too long to

12 get--to discuss things.

13 COFFEY, Q.C.:

14 Q. So you would have discussed this with her

15 before, during her -

16 DR. FONTAINE:

17 A. Yes, we had discussions prior to this.

18 COFFEY, Q.C.:

19 Q. During her locums?

20 DR. FONTAINE:

21 A. That's correct.

22 COFFEY, Q.C.:

23 Q. And what were you met with? What was the

24 response?

25 DR. FONTAINE:

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1 A. There was some resistance, as you can see in

2 the minutes. I think there was reluctance

3 within the group and again, to speak to the

4 group themselves, but my sense was that they

5 were concerned that if we moved to

6 subspecialization, as you can see, there'd

7 been a tremendous turnover of pathologists and

8 they were worried that, "sure, you'll take

9 over this subspecialty and then you'll leave."

10 COFFEY, Q.C.:

11 Q. And what was the complaint then?

12 DR. FONTAINE:

13 A. Then we'd be doing it again. We would then

14 have to take it back on, so -

15 COFFEY, Q.C.:

16 Q. And the down--what was the problem with that?

17 What was the expressed problem? I'm not

18 suggesting that there was.

19 DR. FONTAINE:

20 A. I guess that there would be a loss of that

21 expertise, as in that was the concern.

22 COFFEY, Q.C.:

23 Q. That six months or a year might pass, or two

24 years -

25 DR. FONTAINE:

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1 A. Or it could be five, not knowing how long this

2 could be.

3 COFFEY, Q.C.:

4 Q. A particular subspecialist might stay.

5 DR. FONTAINE:

6 A. A particular subspecialty, yeah. The

7 generalist approach was what had been the

8 status.

9 COFFEY, Q.C.:

10 Q. Now Doctor, here at this meeting, there were--

11 when we look back at page one, I'm sorry,

12 apologize. There are ten of you, I believe.

13 DR. FONTAINE:

14 A. Yes.

15 COFFEY, Q.C.:

16 Q. You're a proponent of the idea, so that leaves

17 nine, and do you recall, like was it uniform

18 amongst the nine or was there -

19 DR. FONTAINE:

20 A. There were some individuals who it didn't

21 really matter because they were going to be

22 retiring soon. So they didn't--they weren't

23 too concerned either way. But specific names,

24 I can't speak to--there wasn't one person

25 standing up and saying, "oh no, there's no way

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1 we can do this." It wouldn't be just one

2 individual, no.

3 COFFEY, Q.C.:

4 Q. And so just again, looking back then at the

5 actual minutes, I want to get, for the

6 Commissioner, some sense of what actually went

7 on. Was this the only time that you raised

8 this?

9 DR. FONTAINE:

10 A. No.

11 COFFEY, Q.C.:

12 Q. Did you -

13 DR. FONTAINE:

14 A. This was something that I would often talk

15 about, because my thing was my specialty

16 interest was cytology, and I had made it very

17 clear that that was where I wanted to be from

18 that end. Now for as far as Dr. Carter, you'd

19 have to speak to her specifically of how much

20 she addressed that with other people, but I

21 would not use Dr. Carter and say that Dr.

22 Carter wants to do this. I would just push my

23 own--other than this point.

24 COFFEY, Q.C.:

25 Q. I was going to ask you, this one time that you

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1 were, in effect, being a proponent of what Dr.
 2 Carter had in mind, this is the one time this
 3 happened, that you raised this at the General
 4 Hospital?
 5 DR. FONTAINE:
 6 A. In -
 7 COFFEY, Q.C.:
 8 Q. For Dr. Carter, on Dr. Carter's behalf?
 9 DR. FONTAINE:
 10 A. For Dr. Carter. I may have used her name in
 11 other circles, but this would be, I think,
 12 probably the only time I mentioned it formally
 13 to that end.
 14 COFFEY, Q.C.:
 15 Q. Doctor, was it sold, do you recall, or you
 16 tried to sell it at the time, from the
 17 perspective of she was just going to look at
 18 the HER2/neu, ER/PR slides and wouldn't report
 19 them?
 20 DR. FONTAINE:
 21 A. Correct.
 22 COFFEY, Q.C.:
 23 Q. That was it. That was all that was said?
 24 DR. FONTAINE:
 25 A. That was all that was, sort of -

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1 COFFEY, Q.C.:
 2 Q. As opposed to, "I'm telling you this, but -
 3 DR. FONTAINE:
 4 A. I'm sort of testing the waters, if you will.
 5 COFFEY, Q.C.:
 6 Q. The response was what? So what I'm getting at
 7 is this, it would seem, frankly, what would
 8 the problem be with somebody looking at your
 9 slides? I mean, you know, "so what, somebody
 10 wants to look at them. If they're my slides,
 11 I will report them. But in the meantime, if
 12 you want to look at them, Doctor, you're--
 13 because you're interested, sure, you're
 14 welcome to." So I'm just curious about, for
 15 the Commissioner's perspective, of what was
 16 going on here? What did you get the sense in
 17 the room? Were people talking about "we don't
 18 want subspecialization"?
 19 DR. FONTAINE:
 20 A. There was a want for generalized, general
 21 pathologists. That this notion of
 22 subspecialty pathology was not welcome here,
 23 if you will.
 24 COFFEY, Q.C.:
 25 Q. What I'm getting at is did the opponents in

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1 the room, did they see through what you were
 2 doing, which is in effect, and raise it with
 3 you, the fact that what you really want here,
 4 where you're going--where Carter wants to go
 5 with this is subspecialization. Did that come
 6 up during the conversation?
 7 DR. FONTAINE:
 8 A. I can't remember specifically if that was, but
 9 I know that there was just resistance. I
 10 don't think it was so much specifically to the
 11 ER/PR. It was more this resistance to
 12 subspecialization. So there might have been
 13 some issue tracking. The way that it's
 14 minuted may not necessarily reflect the fact
 15 that "oh, it's ER/PR and HER2." That it's
 16 more the fact of subspecialization, not so
 17 much the specific of ER/PR, more towards the
 18 subspecialization. So I don't know that it's
 19 specific to ER/PR. Again, I think it's more
 20 general that it applies to the fact of
 21 subspecialization, and this was sort of a way
 22 to introduce that idea because there was much
 23 more discussion than what is minuted here.
 24 This didn't just sort of come up and then die,
 25 if you will. There was a bit more discussion,

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1 but my sense was that it was not just the fact
 2 of HER2, ER/PR. It was more the notion of
 3 subspecialization.
 4 THE COMMISSIONER:
 5 Q. I just want to pursue that for a moment.
 6 DR. FONTAINE:
 7 A. Yes.
 8 THE COMMISSIONER:
 9 Q. Is it that--it seems to me that there are two
 10 different things here. One is that the person
 11 who might be quite happy, for example, to give
 12 up having to deal with issues having to do
 13 with breast cancer might say "boy, this is a
 14 great thing, because I won't have to do that,
 15 and I really don't like doing that branch." I
 16 can't imagine that there's any profession
 17 where there isn't a branch of it that people
 18 don't like doing. And the other is the idea
 19 that you mentioned before and which I think
 20 has been mentioned by Dr. Cook when he was
 21 here and that is the turnover was so great
 22 that you might find yourself having lost a
 23 skill that's all of a sudden somebody comes
 24 along and says you have to pick up again.
 25 DR. FONTAINE:

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1 A. Exactly.
 2 THE COMMISSIONER:
 3 Q. Was that the kind of debate?
 4 DR. FONTAINE:
 5 A. Yes, more or less, because I know I certainly
 6 came from the camp of I was happy to have my
 7 breast cancers from--what you've described
 8 from the beginning, and then from the opposing
 9 side was more the notion--because if we look
 10 at the history of what had happened here with
 11 Dr. Khalifa, he was taking on the role of that
 12 staining and then left. When he left, it went
 13 to the pathologists, and I think they
 14 remembered that and said "but, we have to keep
 15 our skills."
 16 COFFEY, Q.C.:
 17 Q. Exhibit P-1921, please? This is an MAC
 18 minutes of October 20th, 2004, Doctor. At
 19 page four, you're mentioned there at the
 20 bottom as associate to active staff,
 21 laboratory medicine program, division of
 22 cytopathology, September 19th, 2004 to April
 23 1, 2007. I take it this was your appointment?
 24 DR. FONTAINE:
 25 A. I assume, yes.

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

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

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

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1 COFFEY, Q.C.:

2 Q. And I take it then that--because this would

3 have come up from time to time?

4 DR. FONTAINE:

5 A. No, this was a constant issue.

6 COFFEY, Q.C.:

7 Q. It was constant.

8 DR. FONTAINE:

9 A. Yes.

10 COFFEY, Q.C.:

11 Q. And did it ever come to fruition?

12 DR. FONTAINE:

13 A. Yes.

14 COFFEY, Q.C.:

15 Q. And when did that finally happen?

16 DR. FONTAINE:

17 A. Can't remember the date specifically, but it

18 would have been in the realm of 2006, I think

19 in the summer of 2006, and where we acquired

20 four pathology assistants.

21 COFFEY, Q.C.:

22 Q. From your perspective, has that made any

23 difference?

24 DR. FONTAINE:

25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. In terms of your work, and what, if anything,

3 have you noticed about what difference it's

4 made?

5 DR. FONTAINE:

6 A. I know that it frees up the pathologist's time

7 much more to attend to other duties.

8 COFFEY, Q.C.:

9 Q. How about the actual blocks or tissue in

10 blocks and staining and the slides and so on,

11 has it made any difference, do you think?

12 DR. FONTAINE:

13 A. Again, I do cytology now.

14 COFFEY, Q.C.:

15 Q. Yes.

16 DR. FONTAINE:

17 A. I don't actually look at slides from histology

18 so much. In the time that I was there,

19 because again, remember that the pathology

20 assistant is always under the advice of the

21 pathologist. There's still a pathologist

22 available for consultation and review of

23 cases. To that end, and again, I should

24 remind you that what I was seeing was--would

25 have been the cases that I had grossed. So in

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1 the acquisition of pathology assistants, I

2 didn't notice any significant differences, but

3 I knew that the gross room was running more

4 efficiently.

5 COFFEY, Q.C.:

6 Q. If we could then, after lunch, Commissioner.

7 THE COMMISSIONER:

8 Q. Yes, we'll reconvene at ten after two.

9 COFFEY, Q.C.:

10 Q. Thank you.

11 (LUNCH BREAK)

12 THE COMMISSIONER:

13 Q. Mr. Coffey.

14 COFFEY, Q.C.:

15 Q. Thank you, Commissioner. Doctor, if we could,

16 please, Doctor, there's--actually, there are

17 two new exhibits, Commissioner, Exhibit C-0180

18 and C-0181.

19 THE COMMISSIONER:

20 Q. 0180 and 0181?

21 COFFEY, Q.C.:

22 Q. Yes, please. Okay, entered?

23 THE COMMISSIONER:

24 Q. Yes.

25 EXHIBITS ENTERED AND MARKED C-0180 AND C-0181

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1 COFFEY, Q.C.:

2 Q. Thank you, Commissioner. If we could open,

3 please, Exhibit C-0181, please? Now Doctor,

4 this is a redacted copy of a pathology report

5 for a particular patient. The surgical number

6 is 03-SU17521 and if you look down through it,

7 you'll see your own name at various times as

8 the pathologist involved.

9 DR. FONTAINE:

10 A. Yes.

11 COFFEY, Q.C.:

12 Q. What I wanted to ask you about was this, go

13 here to addendum number one on the first page,

14 and I gather that that would mean that

15 05/01/04, which would be January 5th, 2004?

16 DR. FONTAINE:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. And you've noted here "staining for HER2/neu

20 was performed and is interpreted as negative."

21 DR. FONTAINE:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. And then we go on to the main body of the

25 report, which I take it is here under the--

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1 you've got it described here under diagnosis?
 2 DR. FONTAINE:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. And number one, lymph nodes, and number two,
 6 breast biopsy left, and you've diagnosed it as
 7 infiltrating ductal carcinoma.
 8 DR. FONTAINE:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. And it goes on, you go on from there and you
 12 say "progesterone receptor weakly positive.
 13 Estrogen receptor negative."
 14 DR. FONTAINE:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. And "see tumour summary" and when we look
 18 here, just going into the next page, Doctor,
 19 there's an entry here, right here, signature
 20 on file?
 21 DR. FONTAINE:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. And this would be December 16th '03?
 25 DR. FONTAINE:

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

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1 DR. FONTAINE:
 2 A. Correct.
 3 COFFEY, Q.C.:
 4 Q. Now Doctor, just on this, and just so the
 5 Commissioner gets some sense of this. Under
 6 gross for this particular patient, that
 7 section -
 8 DR. FONTAINE:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. - there's dictated by another physician.
 12 DR. FONTAINE:
 13 A. Dr. Chandrakanth, yes, he would be--he's a
 14 resident at the time.
 15 COFFEY, Q.C.:
 16 Q. So I wanted to ask you about that, in terms of
 17 this, because sometimes if we see this, this
 18 sort of practice.
 19 DR. FONTAINE:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. How would that work then?
 23 DR. FONTAINE:
 24 A. Essentially Dr. Chandrakanth would have been
 25 assigned to my day of grossing, if you will,

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

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1 to that end. So as an editing, because that
 2 time line would not be congruent with this
 3 signing out of that case.
 4 COFFEY, Q.C.:
 5 Q. On the 16th?
 6 DR. FONTAINE:
 7 A. On the same day, that's right, because again,
 8 remembering the process. There would have had
 9 to have been blocks taken. So I would have
 10 gone through it. Because again, we would have
 11 gone over this together and I would have had
 12 recollection of what we saw grossly. So it
 13 wouldn't be uncommon to change some of the
 14 gross.
 15 COFFEY, Q.C.:
 16 Q. And you referred to that, in fact in Halifax
 17 even, you said that that, at times, would
 18 happen?
 19 DR. FONTAINE:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Here then, and just so the Commissioner again
 23 has some sense of this, as you indicated, when
 24 you went to finally sign off on this as the
 25 attending physician on December 16th, if you

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1 saw fit when you were reviewing your
 2 resident's work as dictated by him and as
 3 typed up, if you wanted to make an amendment,
 4 you would do it?
 5 DR. FONTAINE:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Before the actual signing off occurs?
 9 DR. FONTAINE:
 10 A. Correct.
 11 COFFEY, Q.C.:
 12 Q. Now Doctor, when you want to insert an
 13 addendum, such as is here, addendum number
 14 one, and then in this particular patient's
 15 case, there's an addendum two and three.
 16 DR. FONTAINE:
 17 A. Correct.
 18 COFFEY, Q.C.:
 19 Q. When you go to do that in the Meditec system
 20 at the General Hospital, can you insert the
 21 addendum anywhere within the body of the text
 22 or are you limited to kind of going one--you
 23 know, addendum number one is the next thing at
 24 the beginning of the report?
 25 DR. FONTAINE:

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1 A. Chronologically in line, if you will.
 2 COFFEY, Q.C.:
 3 Q. Does the system allow you to--could you put an
 4 addendum, for example, if you'd wanted to, for
 5 some reason wanted to type it in beginning, I
 6 don't know, after clinical history, say, would
 7 you have been able -
 8 DR. FONTAINE:
 9 A. I don't believe so. I've never tried to do
 10 so, but there are direct fields that are--when
 11 you actually sit at the Meditec, they will
 12 line numbered fields. So I'm not aware that
 13 you can actually change the--but maybe you
 14 can, but I'm not aware.
 15 COFFEY, Q.C.:
 16 Q. It's not your practice to do so?
 17 DR. FONTAINE:
 18 A. It's not my practice.
 19 COFFEY, Q.C.:
 20 Q. You're just simply--you sign off as you did
 21 here on page three of this exhibit.
 22 DR. FONTAINE:
 23 A. Right.
 24 COFFEY, Q.C.:
 25 Q. Right there, and then when you want to enter

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1 an addendum, as you did on the first page of
 2 the exhibit, addendum number one goes in.
 3 DR. FONTAINE:
 4 A. Right.
 5 COFFEY, Q.C.:
 6 Q. And then go, we go on to the second page here,
 7 we can see your actual sign off of that.
 8 DR. FONTAINE:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. January 5th '04, your HER2/neu.
 12 DR. FONTAINE:
 13 A. Yes. Because again, when you go to do
 14 addendums, the field comes up in the Meditec
 15 system just as addendum, and I believe that
 16 the system then assigns it addendum number
 17 one, number two, number three, as it is
 18 entered chronologically.
 19 COFFEY, Q.C.:
 20 Q. This particular patient, there was an addendum
 21 number two entered August 13th, 2004 and then
 22 signed off by you that day.
 23 DR. FONTAINE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. And it says "Addendum number two. At the
 2 request of Dr. Zaidi -
 3 DR. FONTAINE:
 4 A. Zaidi.
 5 COFFEY, Q.C.:
 6 Q. - A. Zaidi, the progesterone receptor stain is
 7 reviewed and is interpreted as involving less
 8 than ten percent of neoplastic cells and is
 9 weakly positive when compared with the
 10 internal control of the adjacent normal breast
 11 tissue."
 12 DR. FONTAINE:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. What's--and again, I'm not particularly
 16 interested in this particular patient so much
 17 as what was going on here generally, in the
 18 sense of being requested and it's now six to
 19 seven months after your initial report.
 20 DR. FONTAINE:
 21 A. Exactly.
 22 COFFEY, Q.C.:
 23 Q. You're being approached--Dr. Zaidi, I take it,
 24 is an oncologist?
 25 DR. FONTAINE:

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1 A. Correct.
 2 COFFEY, Q.C.:
 3 Q. So what would this sort of process involve?
 4 DR. FONTAINE:
 5 A. Well, I remember this case specifically.
 6 COFFEY, Q.C.:
 7 Q. Okay.
 8 DR. FONTAINE:
 9 A. Because it was, to me, such an exceptional
 10 case and that's why I remember it. I received
 11 a phone call from Dr. Zaidi in and around that
 12 time. He asked--because if you go back to the
 13 diagnosis, you'll read that I actually entered
 14 as -
 15 COFFEY, Q.C.:
 16 Q. There you go.
 17 DR. FONTAINE:
 18 A. - progesterone receptor weakly positive.
 19 COFFEY, Q.C.:
 20 Q. Yes.
 21 DR. FONTAINE:
 22 A. Because I remember when he spoke to me and he
 23 said "what do you mean by weakly positive?"
 24 and I mentioned to him, I said "well, what is
 25 the percentage?" and he said "the percentage

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

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1 nuclear, but it's not as strong as what we
 2 would see in the internal control, if you
 3 will. So again, it's weakly positive in that
 4 sense, and when I look at when I signed that
 5 case off, I must have been expecting to go
 6 back and review that, because it was my
 7 practice to enter percentages, but it was one
 8 I must have missed, and when Dr. Zaidi called,
 9 I specifically remember that case.
 10 COFFEY, Q.C.:
 11 Q. Now Doctor, in this particular case -
 12 THE COMMISSIONER:
 13 Q. Just a point I want to make sure I understand
 14 on this business of when you're saying weakly
 15 positive compared to internal control.
 16 DR. FONTAINE:
 17 A. Right.
 18 THE COMMISSIONER:
 19 Q. So do I take it at that juncture, you are, in
 20 fact, looking at strength of staining?
 21 DR. FONTAINE:
 22 A. Correct, the intensity.
 23 THE COMMISSIONER:
 24 Q. Well, what's--intensity meaning?
 25 DR. FONTAINE:

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1 A. So the intensity, so the amount of brown -
 2 THE COMMISSIONER:
 3 Q. The amount of brown or the strength of the
 4 brown?
 5 DR. FONTAINE:
 6 A. The strength of the brown, if you will.
 7 THE COMMISSIONER:
 8 Q. Do you know what I mean?
 9 DR. FONTAINE:
 10 A. Exactly, so that the -
 11 THE COMMISSIONER:
 12 Q. Depth of colour?
 13 DR. FONTAINE:
 14 A. The depth of colour would be the best, yes.
 15 THE COMMISSIONER:
 16 Q. All right. So in your process, you, when
 17 comparing the internal control and the nuclei
 18 -
 19 DR. FONTAINE:
 20 A. Nuclei, yes.
 21 THE COMMISSIONER:
 22 Q. - for that purpose, you will compare the depth
 23 of the colour on the internal control with
 24 that in the tumour?
 25 DR. FONTAINE:

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1 A. Correct. Oftentimes what you would do is--
 2 because you're essentially looking at the
 3 internal control as your standard. You would
 4 expect that that's--that's what my level would
 5 be. Because sometimes if we have what we
 6 consider background, we may actually subtract
 7 background staining from what we would expect
 8 to be true staining.
 9 THE COMMISSIONER:
 10 Q. Okay.
 11 DR. FONTAINE:
 12 A. So we're always looking at intensities as well
 13 to say is this more intense, less intense,
 14 from what is there and the thinking behind
 15 that is that it may reflect the level of
 16 antigen to that end.
 17 THE COMMISSIONER:
 18 Q. Okay, thank you.
 19 COFFEY, Q.C.:
 20 Q. Doctor, I'm going to come back to this one
 21 later.
 22 DR. FONTAINE:
 23 A. Okay.
 24 COFFEY, Q.C.:
 25 Q. The addendum number three, because I want to

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1 ask you about that in the context of kind of
 2 the larger, what was otherwise going on. So
 3 that was in 2004. After your arrival in St.
 4 John's in June of '03 and then continuing on,
 5 obviously this is now August of '04 and really
 6 into '05, continuing right on until, for
 7 example, you became the site chief.
 8 DR. FONTAINE:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. We'll talk about in a minute, in '05.
 12 DR. FONTAINE:
 13 A. That's right.
 14 COFFEY, Q.C.:
 15 Q. Do you recall there ever being discussions
 16 amongst the pathologists at the General
 17 Hospital about internal controls, staining of
 18 internal controls from ER/PR?
 19 DR. FONTAINE:
 20 A. Not specifically, no.
 21 COFFEY, Q.C.:
 22 Q. IHC staining, yes.
 23 DR. FONTAINE:
 24 A. IHC staining, yes, because I had had more
 25 discussion about prostates, but not so much

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1 about the ER/PR specifically.
 2 COFFEY, Q.C.:
 3 Q. And the prostate, in that context, what did
 4 that involve?
 5 DR. FONTAINE:
 6 A. Again, with prostate, we'll look for internal
 7 controls as well. I had noticed and others
 8 had noticed as well, that sometimes the
 9 internal control would not stain. We would
 10 repeat that stain and the internal control
 11 would work, again, as a one instance. I did
 12 not have occasion to have repeated negative
 13 internal controls in my time in St. John's.
 14 COFFEY, Q.C.:
 15 Q. You mean repeated in the sense of twice for
 16 the same patient?
 17 DR. FONTAINE:
 18 A. Correct.
 19 COFFEY, Q.C.:
 20 Q. If there was a failure -
 21 DR. FONTAINE:
 22 A. If there was a failure on the first time, it
 23 did convert, if you will.
 24 COFFEY, Q.C.:
 25 Q. The internal control converted, as it were, on

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1 the second one?

2 DR. FONTAINE:

3 A. Correct, yes.

4 COFFEY, Q.C.:

5 Q. Doctor, during the discussions you had with

6 your fellow physicians concerning the prostate

7 IHC tests, at that time, do you recall anybody

8 referring back to the fact that well, Dr.

9 Ejeckam was somehow involved in the spring of

10 '03 with at least one prostate stain?

11 DR. FONTAINE:

12 A. No, that was not brought up.

13 COFFEY, Q.C.:

14 Q. Like no one's kind of harkened back to "well,

15 you know, Gershon was dealing with that a year

16 ago"?

17 DR. FONTAINE:

18 A. No, as far as I was aware, I didn't know it

19 had existed, so I didn't know it was an issue,

20 and it looked like it was resolved, looking

21 now at the documentation.

22 COFFEY, Q.C.:

23 Q. Do you recall, in particular, which stain was-

24 -for a period of, you know, at least for a

25 particular period, you recall it being

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1 discussed while you were here, involving

2 prostate, which particular stain it was?

3 DR. FONTAINE:

4 A. It would be the high molecular weight keratin.

5 COFFEY, Q.C.:

6 Q. Which is?

7 DR. FONTAINE:

8 A. 34 Beta

9 COFFEY, Q.C.:

10 Q. 34 beta, which is?

11 DR. FONTAINE:

12 A. 34 beta epsilon 12.

13 COFFEY, Q.C.:

14 Q. Which is the one that--one of the ones that is

15 referred to in those eight that Dr. Ejeckam -

16 DR. FONTAINE:

17 A. I believe it's the first one, looking at the

18 one from this morning.

19 COFFEY, Q.C.:

20 Q. So during the--I appreciate you weren't here

21 on April 4th, 2003.

22 DR. FONTAINE:

23 A. That's correct.

24 COFFEY, Q.C.:

25 Q. But after you started in June of '03, between

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1 then and your time as site chief in April '05,

2 at some point in that time frame, there was

3 discussion amongst the pathologists about the

4 fact that--you called it for -

5 DR. FONTAINE:

6 A. High molecular weight keratin or 34 beta.

7 COFFEY, Q.C.:

8 Q. 34 beta, yes. Is not stain--"I had an

9 internal control of 34 beta didn't stain. I

10 had it redone, and it stained" and

11 occasionally amongst yourselves, you'd talk

12 about that?

13 DR. FONTAINE:

14 A. Very occasionally, again, and it was not

15 unique to here. I'd had experience in Halifax

16 with the same issue, so I did not see that it

17 was--it was not a repeated problem.

18 COFFEY, Q.C.:

19 Q. Do you recall, Doctor, when it was that that

20 came up, in that period between June of '03

21 and -

22 DR. FONTAINE:

23 A. No.

24 COFFEY, Q.C.:

25 Q. Okay, just some time in -

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1 DR. FONTAINE:

2 A. It would be sometime, and it was not only 34

3 beta. I'm sure there were other stains as

4 well that we had discussion on. It's one of

5 these things that that's the nature of

6 immunohistochemistry.

7 COFFEY, Q.C.:

8 Q. And it's just the one that happens to stand

9 out in your mind now?

10 DR. FONTAINE:

11 A. Correct.

12 COFFEY, Q.C.:

13 Q. Exhibit P-2333, please? Doctor, I just bring

14 this up here. It's laboratory division

15 managers meeting of April 12th, 2005, page

16 five of the exhibit, paragraph F, under new

17 business. "Site chief pathology, HSC Dr. D.

18 Fontaine is the new site chief for pathology

19 at the Health Sciences Centre, effective April

20 1st."

21 DR. FONTAINE:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. So you had replaced Dr. -

25 DR. FONTAINE:

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1 A. Parai.
 2 COFFEY, Q.C.:
 3 Q. - Parai?
 4 DR. FONTAINE:
 5 A. Dr. S. Parai, yes.
 6 COFFEY, Q.C.:
 7 Q. As site chief, what did you understand your
 8 duties to be?
 9 DR. FONTAINE:
 10 A. Again -
 11 COFFEY, Q.C.:
 12 Q. At the General Hospital?
 13 DR. FONTAINE:
 14 A. At the General Hospital site, it was to sort
 15 of address any issues that would have been
 16 raised by the medical staff there.
 17 COFFEY, Q.C.:
 18 Q. Any issues, medical issues. I take it that
 19 would cover what, the entire range of -
 20 DR. FONTAINE:
 21 A. It could be. I mean, to myself, it was never
 22 really defined from that end, but it was
 23 issues as they arise and then I could consult
 24 with Dr. Cook, who was, I believe, then
 25 appointed as the clinical chief.

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1 COFFEY, Q.C.:
 2 Q. Yes, he was still clinical chief at the time.
 3 Doctor, was there a job description for the
 4 site chief's position that you knew of when
 5 you took over?
 6 DR. FONTAINE:
 7 A. I don't remember ever receiving one.
 8 COFFEY, Q.C.:
 9 Q. And then you've described to the Commissioner
 10 how when you first signed on in St. John's it
 11 was 80 clinical, 20 teaching?
 12 DR. FONTAINE:
 13 A. Correct.
 14 COFFEY, Q.C.:
 15 Q. Had that changed before you became site chief?
 16 DR. FONTAINE:
 17 A. Yes, because I'd become the cytology director.
 18 So there was .2 division there. So
 19 essentially I had a .2 or 20 percent
 20 appointment for my administrative duties for
 21 the Director of Cytopathology, and then I was
 22 reduced to a 60 percent --
 23 COFFEY, Q.C.:
 24 Q. For clinical?
 25 DR. FONTAINE:

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1 A. For clinical, and then taking this one meant -
 2 - now again I never received any formal
 3 documentation, but it was assumed that there
 4 would be another 20 percent to the
 5 administrative responsibilities as the site
 6 chief for Health Sciences.
 7 COFFEY, Q.C.:
 8 Q. So it would be -- from April 1, 2005, onward
 9 without any formal documentation --
 10 DR. FONTAINE:
 11 A. Correct.
 12 COFFEY, Q.C.:
 13 Q. Your understanding --
 14 DR. FONTAINE:
 15 A. Sort of the understanding that --
 16 COFFEY, Q.C.:
 17 Q. The informal arrangement was 40 percent for
 18 you clinical, 20 cytology --
 19 DR. FONTAINE:
 20 A. Correct.
 21 COFFEY, Q.C.:
 22 Q. Cytology chief, 20 site chief, and 20
 23 teaching?
 24 DR. FONTAINE:
 25 A. Correct.

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1 COFFEY, Q.C.:
 2 Q. Teaching and research.
 3 DR. FONTAINE:
 4 A. University responsibilities, yes.
 5 COFFEY, Q.C.:
 6 Q. Doctor, can you tell the Commissioner how does
 7 that actually work itself out? Is there --
 8 DR. FONTAINE:
 9 A. Well, you've seen the numbers. We've not had
 10 that many bodies on the ground, and in a
 11 position of leadership, I couldn't just say,
 12 well, I want 40 percent. So I would be
 13 responsible for making the call schedule, and
 14 as physicians we tend to take on a bit more
 15 than we should, if you will. So I would take
 16 on more clinical responsibilities. That was
 17 the priority.
 18 COFFEY, Q.C.:
 19 Q. So the adjustment in theory for clinical 40,
 20 50, 60, 70, whatever it is --
 21 DR. FONTAINE:
 22 A. Right.
 23 COFFEY, Q.C.:
 24 Q. Would be adjusted on the basis of the call
 25 schedule, I take it, generally?

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1 DR. FONTAINE:
 2 A. Correct.
 3 COFFEY, Q.C.:
 4 Q. And whatever the total amount of call, if
 5 you're 100 percent clinical, then you do the
 6 full clinical allotment for 100 percent?
 7 DR. FONTAINE:
 8 A. Correct.
 9 COFFEY, Q.C.:
 10 Q. And if it's 80 percent, then you're on call 80
 11 percent of a 100 percent equivalent?
 12 DR. FONTAINE:
 13 A. Correct.
 14 COFFEY, Q.C.:
 15 Q. Is that --
 16 DR. FONTAINE:
 17 A. Or you would do the workload of -- taking the
 18 100 percent, you would be required to do 80
 19 percent.
 20 COFFEY, Q.C.:
 21 Q. Of the workload?
 22 DR. FONTAINE:
 23 A. Of the clinical workload.
 24 COFFEY, Q.C.:
 25 Q. Now in terms of divvying up the clinical

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1 workload just so the Commissioner understands
 2 this, in a practical way, how does it get
 3 divvied up, on the basis of how much call is
 4 given or what, or how many patients are
 5 assigned? How does it work?
 6 DR. FONTAINE:
 7 A. The way it worked at that time at the Health
 8 Sciences because again I was also juggling
 9 with cytology, so cytology needed to be
 10 covered as well, it worked quite well in the
 11 sense that you had these divisions as 20
 12 percent because it represented one day of a
 13 100 percent schedule, looking at a five day
 14 work week. So it would represent one day. So
 15 essentially you could assign somebody as
 16 having that equivalent. Now when we went to
 17 make up the schedules, we would put
 18 individuals on the schedule and that would be
 19 their workload for that day, and then
 20 depending on how many pathologists were there
 21 at that time, that would determine how often
 22 you should be on call if you're 100 percent
 23 divvied up from that, and then you would just
 24 do the math from there and that would
 25 determine how often somebody should be on

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1 call.
 2 COFFEY, Q.C.:
 3 Q. I'll just explore this a little bit with you
 4 now. When you first arrived, for example, in
 5 2003 and really up until you took over and
 6 after you became site chief, leaving aside
 7 your particular situation because I appreciate
 8 you were divvied up a number of different ways
 9 --
 10 DR. FONTAINE:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. But a person who was 100 percent clinical,
 14 what could they expect then? Assuming the
 15 place was fully staffed at the time, assuming
 16 it was for the moment --
 17 DR. FONTAINE:
 18 A. Uh-hm.
 19 COFFEY, Q.C.:
 20 Q. Assuming it was, what would they routinely
 21 expect and then I'll ask you about because of
 22 the lack of staff.
 23 DR. FONTAINE:
 24 A. Right. So essentially if -- and again that's
 25 a hypothetical because it never happened while

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

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|---|---|
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| <p>1 that day, that's whatever came in the door</p> <p>2 that day?</p> <p>3 DR. FONTAINE:</p> <p>4 A. That's correct.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. Is that pathologist until they hit 75 cases?</p> <p>7 DR. FONTAINE:</p> <p>8 A. Until they hit 75 cases, and when you made up</p> <p>9 the schedule you would consider how many</p> <p>10 pathologists are then available, and then you</p> <p>11 would work it from there. Then for the next</p> <p>12 cycle, you would consider who is on a</p> <p>13 university appointment, who has other</p> <p>14 responsibilities who have protected time, and</p> <p>15 then just sort of doing the math from there.</p> <p>16 So the first cycle would be somebody would be</p> <p>17 on every day, and then from that end you would</p> <p>18 stagger off those who were 100 percent, those</p> <p>19 who might be 80 percent, and those who might</p> <p>20 be other appointments.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Now, Doctor, if you were one of those who was</p> <p>23 100 percent clinical --</p> <p>24 DR. FONTAINE:</p> <p>25 A. Yes.</p> | <p>1 you were fully staffed. That didn't happen</p> <p>2 very often in my time.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. But the idea would be that whatever came</p> <p>5 through the door on that particular day you</p> <p>6 were on call as a staff pathologist, that</p> <p>7 would be yours?</p> <p>8 DR. FONTAINE:</p> <p>9 A. That's yours.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. It would be your cases --</p> <p>12 DR. FONTAINE:</p> <p>13 A. Correct.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. To deal with, and then depending upon the</p> <p>16 staffing levels overall, and whether or not</p> <p>17 you were 100 or 80 or 60 --</p> <p>18 DR. FONTAINE:</p> <p>19 A. Would determine how frequent --</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. How often you would have to be back, but you</p> <p>22 might be back within six working days, back on</p> <p>23 the bench?</p> <p>24 DR. FONTAINE:</p> <p>25 A. Correct.</p> |
| Page 250 | Page 252 |
| <p>1 COFFEY, Q.C.:</p> <p>2 Q. You, and particularly day one, you took</p> <p>3 everything that came through the door and say</p> <p>4 you happened to get your 72 or 75, you were at</p> <p>5 the cap --</p> <p>6 DR. FONTAINE:</p> <p>7 A. Yes.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. When -- at what point then would you get to</p> <p>10 deal with those cases?</p> <p>11 DR. FONTAINE:</p> <p>12 A. You would have the amount of time until you</p> <p>13 were back on the surgical bench.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. And how long would that be?</p> <p>16 DR. FONTAINE:</p> <p>17 A. It would vary as to the staff that you had</p> <p>18 available.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. On average?</p> <p>21 DR. FONTAINE:</p> <p>22 A. On average, it would probably be in the</p> <p>23 vicinity of six to seven. So once every week</p> <p>24 and a half. So you'd have approximately seven</p> <p>25 days -- you could have as much as ten days if</p> | <p>1 COFFEY, Q.C.:</p> <p>2 Q. To take up another round of cases?</p> <p>3 DR. FONTAINE:</p> <p>4 A. Exactly.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. Or it might be as long as ten days?</p> <p>7 DR. FONTAINE:</p> <p>8 A. Correct.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Or even longer?</p> <p>11 DR. FONTAINE:</p> <p>12 A. Or even longer, and again because there is</p> <p>13 that variability of -- there would be the</p> <p>14 variability from day to day. There may be</p> <p>15 cases you would -- days you would only receive</p> <p>16 50 cases, and then there are other days that</p> <p>17 you receive 75.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. On a day that you got 50 --</p> <p>20 DR. FONTAINE:</p> <p>21 A. You'd still have the same amount of time that</p> <p>22 you have to do 75. It would not be taken into</p> <p>23 consideration. The group had agreed that this</p> <p>24 is how it was going to be, and it was luck of</p> <p>25 the draw, if you will.</p> |

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1 COFFEY, Q.C.:

2 Q. And, Doctor --

3 COMMISSIONER:

4 Q. Did the arrangement work out, in any event?

5 DR. FONTAINE:

6 A. It seemed to. It was quite surprising that it

7 would because at the end of the year once you

8 actually did the overall statistics, again --

9 but for the most part.

10 COFFEY, Q.C.:

11 Q. Doctor, a final point on this, were there any

12 particular sorts of cases that if you happened

13 to be the person on the bench that day, as it

14 were, on call or on the bench, would you -- as

15 a pathologist, would there be some cases of a

16 certain type that you wouldn't get because --

17 DR. FONTAINE:

18 A. It depended on what was going on in the

19 operating room or what would come from

20 outside.

21 COFFEY, Q.C.:

22 Q. But are there some -- was there any kind of

23 sub-specialization going on in the sense of

24 certain types of cases would end up with

25 another pathologist because he or she --

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1 DR. FONTAINE:

2 A. No.

3 COFFEY, Q.C.:

4 Q. Had a --

5 DR. FONTAINE:

6 A. Not at that time, no. There was no initiative

7 towards that. It as agreed -- although I

8 should -- no, there was renal cases would be

9 routed to Dr. Fernandez, and some of them --

10 medical lung cases would be routed to Dr.

11 Chittal, so there would -- and neuropathology

12 again was a special sub-specialty. So again

13 looking at that, there was some level of sub-

14 specialization in existence.

15 COFFEY, Q.C.:

16 Q. So that if I was a generalist, as it were, and

17 it was my day and a renal pathology came in,

18 it might not come to me, it might actually --

19 or it might end up with Dr. Fernandez?

20 DR. FONTAINE:

21 A. Right, if Dr. Fernandez was on vacation,

22 you'll be left with it.

23 COFFEY, Q.C.:

24 Q. But if she was around?

25 DR. FONTAINE:

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1 A. If she was available and had no other reason

2 to not take the case, she would take the case.

3 COFFEY, Q.C.:

4 Q. Now I take it then as you envisaged it, and

5 you discussed this before lunch, you were

6 telling the Commissioner about it, you kind of

7 envisioned -- at least you had -- for example,

8 with breast pathology and Dr. Carter,

9 potentially the breast cases, things that

10 evolved the way you envisaged perhaps, that

11 they would have ended up all being redirected

12 from the pathologist on call as it were, or on

13 the bench that day, out to Dr. Carter? That

14 would be the idea?

15 DR. FONTAINE:

16 A. That would be sort of how we did things in

17 Halifax, if you will, that there would be some

18 sub-specialty screening. It would not be only

19 breast, it would be all other cases as -- GI

20 would go to a certain group of pathologists,

21 GU would go to certain pathologists.

22 COFFEY, Q.C.:

23 Q. Doctor, you took over as -- I gather, as site

24 chief, April 1st, 2005.

25 DR. FONTAINE:

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1 A. Yes.

2 COFFEY, Q.C.:

3 Q. Were you aware of any potential problems with

4 estrogen receptors, progesterone receptor

5 testing come to your attention before that?

6 DR. FONTAINE:

7 A. It comes up shortly thereafter, but at the

8 time I did not know.

9 COFFEY, Q.C.:

10 Q. No.

11 DR. FONTAINE:

12 A. No.

13 COFFEY, Q.C.:

14 Q. Doctor, when did you first become aware of

15 what ultimately has brought us here as a

16 problem?

17 DR. FONTAINE:

18 A. I've tried to remember when did I actually

19 recognize -- I can certainly speak to the fact

20 that I did not know on April 1st because I

21 don't think I would have been stepping into

22 this position recognizing the magnitude of

23 this, but on that -- it was probably in June

24 thereof. I'd heard some grumblings, but again

25 -- because there was always this rumour mill,

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1 so people speak, small labs, it's hard to do
 2 anything that people don't know what's going
 3 on, but I would struggle to give you a
 4 specific time, but it would probably have been
 5 in late May, early June, time frame.
 6 COFFEY, Q.C.:
 7 Q. Do you recall who you heard it from at first
 8 and what was said to you?
 9 DR. FONTAINE:
 10 A. No, again I can't remember specifically, but I
 11 know that there were a lot of grumblings
 12 within the lab.
 13 COFFEY, Q.C.:
 14 Q. And grumblings in the sense of -- by
 15 pathologists?
 16 DR. FONTAINE:
 17 A. Pathologists and technologists. Again there
 18 was this move afoot, not really knowing -- I
 19 knew there was some uncertainty as to was
 20 there a problem, and then we weren't really
 21 sure if it was a problem. I knew there was
 22 something being done, but when it actually
 23 came to full attention that, oh, we do have a
 24 problem, I can't remember specifically when
 25 that date would have been.

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1 COMMISSIONER:
 2 Q. Can you be a little more specific at about at
 3 what stage things were when you learned about
 4 it? I'm just wondering --
 5 DR. FONTAINE:
 6 A. The stage?
 7 COFFEY, Q.C.:
 8 Q. How much, for example, retesting had gone on
 9 before you knew about it?
 10 DR. FONTAINE:
 11 A. Right. Because I had heard the rumours of
 12 this index case and there was a lot of talk of
 13 that, and then it was -- I was aware there was
 14 retesting ongoing, did not really appreciate
 15 what the magnitude of that was or what the
 16 results of that were. I knew there was
 17 something afoot, but did not realize the
 18 magnitude of it. Does that --
 19 COFFEY, Q.C.:
 20 Q. So when you refer to index case --
 21 COMMISSIONER:
 22 Q. Which index case?
 23 DR. FONTAINE:
 24 A. Yes, which one.
 25 COMMISSIONER:

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1 Q. The other thing is that I would like you to
 2 also address -- I'll leave Mr. Coffey to go
 3 down that road with you, but you were then
 4 site chief.
 5 DR. FONTAINE:
 6 A. I'm sorry?
 7 COMMISSIONER:
 8 Q. You were then site chief?
 9 DR. FONTAINE:
 10 A. Yes, when it all came to --
 11 COMMISSIONER:
 12 Q. Yes, but it seems to me then there had been
 13 some progress down the path of starting to
 14 investigate this --
 15 DR. FONTAINE:
 16 A. By the time I came.
 17 COMMISSIONER:
 18 Q. Before you, as site chief, knew about it?
 19 DR. FONTAINE:
 20 A. Yes.
 21 COMMISSIONER:
 22 Q. And shouldn't the site chief have been told
 23 about it?
 24 DR. FONTAINE:
 25 A. I think it was that they didn't really

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1 appreciate the magnitude of the problem, but
 2 again you'd have to ask those individuals
 3 specifically, but I did not know or fully
 4 aware of what was going on.
 5 COMMISSIONER:
 6 Q. Well, let me put it this way, in your
 7 understanding of the role of a site chief,
 8 would it --
 9 DR. FONTAINE:
 10 A. I would have expected to know.
 11 COMMISSIONER:
 12 Q. Yes, you would have expected --
 13 DR. FONTAINE:
 14 A. I would have expected to be aware.
 15 COMMISSIONER:
 16 Q. Somebody to sort of knock on your door and
 17 say, guess what.
 18 DR. FONTAINE:
 19 A. Guess what's going on here.
 20 COMMISSIONER:
 21 Q. This is going on, it may be big, it may be
 22 little, we'll let you know, but it's going on?
 23 DR. FONTAINE:
 24 A. Especially considering it was happening at the
 25 site that I was the site chief of.

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1 COMMISSIONER:
 2 Q. Uh-hm.
 3 DR. FONTAINE:
 4 A. Yes.
 5 COMMISSIONER:
 6 Q. Okay.
 7 COFFEY, Q.C.:
 8 Q. Doctor, what had you heard about the index
 9 case initially in 2005?
 10 DR. FONTAINE:
 11 A. I had heard that there was a lobular carcinoma
 12 that had converted.
 13 COFFEY, Q.C.:
 14 Q. What, if any, significance did that have? I
 15 mean, I take it that that's gone from negative
 16 to positive?
 17 DR. FONTAINE:
 18 A. Correct.
 19 COFFEY, Q.C.:
 20 Q. You heard that in what context?
 21 DR. FONTAINE:
 22 A. I just heard that there was a conversion from
 23 that and it was being looked into beyond that,
 24 and again considering the climate that we had
 25 just changed technologies, and there was the

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1 question of how much of that has to play into
 2 this conversion.
 3 COFFEY, Q.C.:
 4 Q. So it was couched in terms of -- when you
 5 first heard about it, there has been a
 6 conversion?
 7 DR. FONTAINE:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Lobular, and in hearing that, I take it, in
 11 your world lobular --
 12 DR. FONTAINE:
 13 A. It's one case.
 14 COFFEY, Q.C.:
 15 Q. Yes, the relatively rare negative --
 16 DR. FONTAINE:
 17 A. Right.
 18 COFFEY, Q.C.:
 19 Q. Conversion perhaps then not unexpected in the
 20 sense of it probably should have been -- it
 21 would be expected to be positive to start?
 22 DR. FONTAINE:
 23 A. Right, yes.
 24 COFFEY, Q.C.:
 25 Q. But a new machine --

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1 DR. FONTAINE:
 2 A. New machine, new technology, what does this
 3 really mean, so take it to the next step.
 4 COFFEY, Q.C.:
 5 Q. So you understood then that this had happened,
 6 you understood that there was investigation
 7 being conducted?
 8 DR. FONTAINE:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. Did you understand who that was being done by?
 12 DR. FONTAINE:
 13 A. My understanding was that it was Dr. Carter
 14 and Dr. Cook.
 15 COFFEY, Q.C.:
 16 Q. And the patient, were you told the patient's
 17 name?
 18 DR. FONTAINE:
 19 A. Eventually, I did, yes.
 20 COFFEY, Q.C.:
 21 Q. So at first --
 22 DR. FONTAINE:
 23 A. At first I didn't.
 24 COFFEY, Q.C.:
 25 Q. Peggy Deane's name wasn't being bandied around

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1 initially?
 2 DR. FONTAINE:
 3 A. No.
 4 COFFEY, Q.C.:
 5 Q. At least to you, anyway?
 6 DR. FONTAINE:
 7 A. Not to myself, no.
 8 COFFEY, Q.C.:
 9 Q. When did you become aware that it was Ms.
 10 Deane?
 11 DR. FONTAINE:
 12 A. I can't remember specifically, but it was
 13 before the inquiry. I can say that.
 14 COFFEY, Q.C.:
 15 Q. Oh, this is -- but it would have been after
 16 this had all --
 17 DR. FONTAINE:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. Gotten out into the media and so on.
 21 DR. FONTAINE:
 22 A. Even before that.
 23 COFFEY, Q.C.:
 24 Q. Before that. So sometime between being --
 25 DR. FONTAINE:

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1 A. Being identified as the index, and before the
 2 release.
 3 COFFEY, Q.C.:
 4 Q. It went public.
 5 DR. FONTAINE:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Someone identified the patient as being Ms.
 9 Deane?
 10 DR. FONTAINE:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. Did you make any inquiries when you first
 14 heard about it, I mean, in the sense of, look,
 15 there's an index case, I understand Don and
 16 Bev are investigating it? Did you make any
 17 inquiries of them or anybody else as to --
 18 DR. FONTAINE:
 19 A. No, I figured that they were taking care of
 20 that. They were looking into it, and I would
 21 be kept abreast as the developments came
 22 forth.
 23 COFFEY, Q.C.:
 24 Q. Exhibit P-0492, please. Actually, if I could,
 25 please, I apologize, just before we get to

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

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1 DR. FONTAINE:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. When did you first see a copy of this letter?
 5 DR. FONTAINE:
 6 A. I could almost say this is the first time I'm
 7 seeing it here now.
 8 COFFEY, Q.C.:
 9 Q. But certainly I take it in your role as site
 10 chief, it wasn't brought to your attention?
 11 DR. FONTAINE:
 12 A. I did not -- no, I did not see this.
 13 COFFEY, Q.C.:
 14 Q. That's what I'm --
 15 DR. FONTAINE:
 16 A. No, I did not see this as site chief. I mean,
 17 it would -- if I've seen this, again we've
 18 looked at so many documents, but it's not
 19 something that I saw as site chief.
 20 COFFEY, Q.C.:
 21 Q. And would it have been -- if you have seen
 22 this, it's since the Commission was
 23 established?
 24 DR. FONTAINE:
 25 A. Correct.

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1 COFFEY, Q.C.:
 2 Q. In this province.
 3 DR. FONTAINE:
 4 A. Yes, I think this is the first time that I see
 5 this.
 6 COFFEY, Q.C.:
 7 Q. Now, Doctor, this letter makes reference to
 8 the index--well what we have been, up to this
 9 point, certainly, describing as the index
 10 case.
 11 DR. FONTAINE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. And the requested two other patients with
 15 infiltrating lobular be retested, did any one
 16 at that time, while you were site chief in
 17 May, June, July, August and so on of '05,
 18 bring to your attention this concern about
 19 infiltrating lobular having been originally
 20 negative, some reported as negative and they
 21 should be positive and -
 22 DR. FONTAINE:
 23 A. Not to me, no.
 24 COFFEY, Q.C.:
 25 Q. Not to yourself.

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1 DR. FONTAINE:
 2 A. No.
 3 COFFEY, Q.C.:
 4 Q. Doctor, here on the third page there are four
 5 recommendations listed by Dr. Cook. The
 6 immediate establishment of external
 7 proficiency testing and monitoring program for
 8 immunoperoxidase testing; establishment of a
 9 separate immunoperoxidase service with at
 10 least three technologists solely dedicated to
 11 it, with separate testing facilities; the
 12 training of immunoperoxidase technologists in
 13 a major immuno referral lab and continuing CME
 14 funding for those immunotechnologists. Now at
 15 that point in time, this is May of '05 or June
 16 of '05, did anybody approach you at that time,
 17 you know, concerning this sort of subject
 18 matter?
 19 DR. FONTAINE:
 20 A. There's a good chance that Dr. Cook and myself
 21 might have discussed this at some -
 22 COFFEY, Q.C.:
 23 Q. As the summer went on into the fall.
 24 DR. FONTAINE:
 25 A. I know we've had discussions about this, yes,

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1 and again, on top of that with pathology
 2 assistants as well, and myself.
 3 COFFEY, Q.C.:
 4 Q. Now, Doctor, as the site chief at the Health
 5 Sciences Centre or the General Hospital, we're
 6 using that term interchangeably or those terms
 7 interchangeably, the immunohistochemical
 8 testing that was going on, the processing that
 9 was going on in Newfoundland at the time was
 10 all centered in the General Hospital?
 11 DR. FONTAINE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. As a site chief, did you understand that you
 15 were responsible--were you talking on the
 16 responsibility for that part of the lab?
 17 DR. FONTAINE:
 18 A. That would be my impression, yes.
 19 COFFEY, Q.C.:
 20 Q. And it was your impression, I take it then,
 21 that your predecessor, Dr. Parai, would have
 22 had a commensurate responsibility for it?
 23 DR. FONTAINE:
 24 A. Correct.
 25 COFFEY, Q.C.:

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1 Q. Here, and one final point in this letter, the
 2 last paragraph on page two says "In early
 3 2003, Dr. Gershon Ejeckam, our point man for
 4 immunoperoxidase testing at the General
 5 Hospital site, discontinued testing of the
 6 ER/PR receptors with the manual method for a
 7 six week period" and it goes on from there.
 8 The idea of describing Dr. Ejeckam in May of
 9 2005 as "our point man for immunoperoxidase
 10 testing at the General Hospital site".
 11 DR. FONTAINE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. As the site chief, would that be the sort of--
 15 would you have characterized Dr. Ejeckam at
 16 that time as the -
 17 DR. FONTAINE:
 18 A. Yes, because he had the interest and was
 19 communicating with the technologists. He was
 20 certainly the person that the pathologists
 21 would consult with when they had immuno
 22 issues.
 23 COFFEY, Q.C.:
 24 Q. So certainly, because you come in June of '03,
 25 and certainly by May of '05, you had quite a

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1 period of time before May of '05 to figure out
 2 that Dr. Gershon Ejeckam -
 3 DR. FONTAINE:
 4 A. He's declared himself much earlier than this.
 5 COFFEY, Q.C.:
 6 Q. He's occupied the position, as it were.
 7 DR. FONTAINE:
 8 A. Yes, but the position doesn't exist.
 9 COFFEY, Q.C.:
 10 Q. Exactly, but de facto, if he's reproached by
 11 the technologists, he's fulfilling that role?
 12 DR. FONTAINE:
 13 A. Correct.
 14 COFFEY, Q.C.:
 15 Q. If we could now, Exhibit P-0492? Doctor, this
 16 is a memo from June 14th, 2005 from Dr. Cook,
 17 it's to all laboratory directors, and you're
 18 included, you're first listed.
 19 DR. FONTAINE:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. And your counterparts across or throughout the
 23 province. It's estrogen and progesterone
 24 receptors and Dr. Cook writes, "We are aware
 25 of a number of negative estrogen and

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1 progesterone receptors that have converted on
 2 repeat testing with our new Ventana.
 3 Benchmark immunoperoxidase testing"--and he
 4 goes on about that, and he says "Presently we
 5 are in the process of retesting all negative
 6 ER and PRs for that particular year. I am
 7 requesting that you forward all negative ERs
 8 and PRs for the year 2002 to Barry Dyer. I
 9 also ask you to submit the reports, original
 10 ER/PR slides, including controls, as well as
 11 H&E slides and paraffin blocks. We will
 12 repeat all ER and PR receptors with the
 13 Ventana and forward the results to you."
 14 DR. FONTAINE:
 15 A. Right.
 16 COFFEY, Q.C.:
 17 Q. And you can contact either Dr. Cook or Dr.
 18 Carter. Now, had you know at the time that
 19 this memo was coming?
 20 DR. FONTAINE:
 21 A. I can't say that I knew the memo was coming,
 22 but I knew it was being dealt with by Dr. Cook
 23 and Mr. Dyer.
 24 COFFEY, Q.C.:
 25 Q. And, Doctor, did you act upon this memo in any

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1 way? Did you have to do anything?
 2 DR. FONTAINE:
 3 A. No, when I got the memo, I was under the
 4 impression this was already done for our site.
 5 I may have checked with Mr. Dyer, but I can't
 6 remember specifically, but my impression was
 7 that it was already taking place for our site.
 8 COFFEY, Q.C.:
 9 Q. That would be in the process of identifying
 10 the ER and PR negatives for that particular
 11 year.
 12 DR. FONTAINE:
 13 A. Correct, yes. It was initiative from our
 14 site, so -
 15 COFFEY, Q.C.:
 16 Q. From your perspective, kind of addressing this
 17 matter was in whose hands?
 18 DR. FONTAINE:
 19 A. It was already dealt with was my impression.
 20 COFFEY, Q.C.:
 21 Q. In the overall manner, the responsibility for
 22 dealing with it was whose?
 23 DR. FONTAINE:
 24 A. I saw that Dr. Cook was already taking that
 25 lead and in consultation with Dr. Carter.

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1 COFFEY, Q.C.:
 2 Q. If I could, please, Exhibit P-0493 please?
 3 Doctor, this is a letter of June 14th, 2005,
 4 same date, it's from Dr.--I'll show it to you,
 5 it's Dr. Cook. It's to Dr. Williams,
 6 "Preliminary update on false negative results
 7 for estrogen and progesterone receptors." And
 8 in effect, this is a report by Dr. Cook to Dr.
 9 Williams as to kind of the current status or
 10 it's an update up to that point. He even
 11 identifies here, in the middle of the first
 12 paragraph, "It also seems that most of the
 13 negative ER/PR results started sometime around
 14 June 24, 2002." He goes on from there.
 15 Doctor, did you ever receive a copy of this?
 16 DR. FONTAINE:
 17 A. No.
 18 COFFEY, Q.C.:
 19 Q. The sort of subject matter involving, like
 20 identifying the total number of cases from
 21 '02, the positivity rate which is spelled out
 22 here to be about, if I remember correctly -
 23 DR. FONTAINE:
 24 A. Fifty percent.
 25 COFFEY, Q.C.:

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1 Q. Yeah, a negative rate of fifty percent, which
 2 is what he's identified here.
 3 DR. FONTAINE:
 4 A. Right.
 5 COFFEY, Q.C.:
 6 Q. Having set above the 160, ER/PR cases, 50
 7 percent reported in '02 as ER/PR negative.
 8 Were you made or brought into that kind of
 9 loop at the time as to what was going on with
 10 this?
 11 DR. FONTAINE:
 12 A. No. This is the first I've seen of this.
 13 COFFEY, Q.C.:
 14 Q. And I appreciate it, the first you've seen of
 15 it of the letter, but as well, I take it, the
 16 actual information -
 17 DR. FONTAINE:
 18 A. Of the numbers.
 19 COFFEY, Q.C.:
 20 Q. The numbers and -
 21 DR. FONTAINE:
 22 A. Of a fifty percent, that's the first I heard
 23 of a fifty percent. I've heard a number of
 24 different numbers, but not that one.
 25 COFFEY, Q.C.:

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1 Q. If we could please, Exhibit P-0495 please?
 2 Doctor, this is a, well it's a fax coversheet
 3 from Dr. Cook--I'm sorry, from Dr. Carter,
 4 June 30th, 2005 on her behalf to Dr. Williams
 5 and she's faxing him a letter, this version is
 6 redacted, June 29th, 2005 and it's addressed
 7 to Dr. Joy McCarthy. "As per our previous
 8 discussions repeat ER and PR has been carried
 9 out on the following patients, initially
 10 identified as estrogen receptor negative. The
 11 results are as follows"--and there are 25, if
 12 I recall correctly, use the number we've been
 13 using here, listed here and about 16 of them
 14 have been described as converted, that's the
 15 number, that's the way some of the witnesses
 16 have described it. Were you aware, like in
 17 late June or early July that on this first
 18 run, as it were, the first wave of retests for
 19 the Ventana, the first wave of 25, that 16 of
 20 them had converted?
 21 DR. FONTAINE:
 22 A. I didn't know the specific numbers, but I knew
 23 there was a significant conversion rate.
 24 COFFEY, Q.C.:
 25 Q. Do you recall where you learned that from?

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1 DR. FONTAINE:
 2 A. It would have been in a verbal conversation,
 3 most likely from Dr. Cook.
 4 COFFEY, Q.C.:
 5 Q. Doctor, do you recall then the first time you
 6 attended a meeting in relation to the ER/PR
 7 matter?
 8 DR. FONTAINE:
 9 A. A formal meeting?
 10 COFFEY, Q.C.:
 11 Q. Start with that first.
 12 DR. FONTAINE:
 13 A. Okay, I guess it would be in August,
 14 July/August, I would think, sometime around
 15 that timeline.
 16 COFFEY, Q.C.:
 17 Q. Do you recall who, generally who was there,
 18 like specifically or generally who was there?
 19 DR. FONTAINE:
 20 A. Only from the discussions that have been
 21 coming up as a result of the inquiry. Like,
 22 if you would have asked me that before I saw
 23 some of the documents, I would say no, I
 24 wouldn't be able to, but I've seen documents
 25 since that time that, there were several

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1 pathologists, both from the Health Science's
 2 site and the St. Clare's site.
 3 COFFEY, Q.C.:
 4 Q. Okay, so this is the meeting of pathologists
 5 and I'll be taking you to that, I have one of
 6 August 5, I believe.
 7 DR. FONTAINE:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. And I think Dr. Cook testified and in fact,
 11 has testified here about having had two
 12 meetings, one of August 5 and one of, several
 13 days before that.
 14 DR. FONTAINE:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. But other than that kind of meeting of
 18 pathologists, you know, how about any others,
 19 like to actually deal with the ER/PR matter in
 20 a procedural way.
 21 DR. FONTAINE:
 22 A. That I would have been involved with?
 23 COFFEY, Q.C.:
 24 Q. Yes.
 25 DR. FONTAINE:

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1 A. As site chief you mean?
 2 COFFEY, Q.C.:
 3 Q. As site chief, yes.
 4 DR. FONTAINE:
 5 A. No.
 6 COFFEY, Q.C.:
 7 Q. Because what we've--the Commissioner has
 8 heard, of course, a lot of evidence about
 9 people attending meetings, you know, in the
 10 hospital, even in the Confederation Building,
 11 you know, different meetings here or there.
 12 DR. FONTAINE:
 13 A. Right.
 14 COFFEY, Q.C.:
 15 Q. But as a site chief, you were not invited
 16 along to them.
 17 DR. FONTAINE:
 18 A. No, I saw this as, for the pathology
 19 involvement that it was Dr. Cook and Dr.
 20 Carter taking the lead.
 21 COFFEY, Q.C.:
 22 Q. If we could, please, Exhibit P-0504? Now,
 23 Doctor, these just happen to be minutes of
 24 laboratory--they're entitled "Laboratory
 25 Medicine, July 14th, 2005 meeting notes."

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1 Present are Ms. Heather Predham, Don Cook, Bob
 2 Williams and Terry Gulliver. Issue discussed
 3 is ER/PR receptor results.
 4 DR. FONTAINE:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. I understand from evidence we've heard already
 8 that the lab leadership team, as it were, was
 9 Dr. Williams, Dr. Cook, as clinical chief -
 10 DR. FONTAINE:
 11 A. That's correct.
 12 COFFEY, Q.C.:
 13 Q. And Terry Gulliver as program director.
 14 DR. FONTAINE:
 15 A. Correct.
 16 COFFEY, Q.C.:
 17 Q. What, if any, relationship did you as site
 18 chief have to that group?
 19 DR. FONTAINE:
 20 A. I could consult with either Mr. Gulliver or
 21 Mr. Cook with issues that would be brought up
 22 at this, within this group and I also had the
 23 ability to talk to Dr. Williams directly as
 24 well.
 25 COFFEY, Q.C.:

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1 Q. But you wouldn't attend their meetings, I take
 2 it, routinely or have copies of their minutes
 3 or -
 4 DR. FONTAINE:
 5 A. No, no.
 6 COFFEY, Q.C.:
 7 Q. If you had a problem, you knew who they were,
 8 you could go to them.
 9 DR. FONTAINE:
 10 A. I knew who they were and then they would bring
 11 it to their meeting and then report back to
 12 me.
 13 COFFEY, Q.C.:
 14 Q. And conversely if they had a problem with -
 15 DR. FONTAINE:
 16 A. With anything that was going on, exactly.
 17 COFFEY, Q.C.:
 18 Q. They could approach you.
 19 DR. FONTAINE:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Exhibit P-0069 please? Dr. Fontaine, this is
 23 a letter of July 14th, 205, it's addressed to
 24 Dr. Cook. You will see it's from Dr. Carter,
 25 copied to Dr. Williams and I want you to look

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1 at the first part of this, glance your eye
 2 down to the first paragraph and at the second,
 3 you'll see that, and this has been described
 4 as kind of a proposal by Dr. Carter to Dr.
 5 Cook to conduct, in effect, a full review of
 6 the cases between 1997 and 2003 or '04.
 7 DR. FONTAINE:
 8 A. Right.
 9 COFFEY, Q.C.:
 10 Q. Okay. When did you first become aware that
 11 Dr. Carter was proposing to undertake such a
 12 full scale review?
 13 DR. FONTAINE:
 14 A. I heard, really I wasn't involved with what
 15 the process was, to that end, I heard
 16 grumblings or rumours that that was going to
 17 be undertaken, but the full bore of how this
 18 was going to happen, I just found out since
 19 the inquiry has been -
 20 COFFEY, Q.C.:
 21 Q. Okay, underway.
 22 DR. FONTAINE:
 23 A. Underway.
 24 COFFEY, Q.C.:
 25 Q. And I take it then, you did not receive a copy

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1 of the letter?
 2 DR. FONTAINE:
 3 A. No.
 4 COFFEY, Q.C.:
 5 Q. If I could, please, Exhibit P-0532 please?
 6 And Doctor, these are handwritten notes dated
 7 July 28th, 2005 of Dr. Cook in which he noted,
 8 "spoke to Dan Fontaine, to begin negative
 9 controls for ER and PR"?
 10 DR. FONTAINE:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. Do you recall -
 14 DR. FONTAINE:
 15 A. No, because actually I'm not a proponent of
 16 negative controls.
 17 COFFEY, Q.C.:
 18 Q. And in the context here, if I could, Exhibit
 19 P-0076 please? And, Doctor, this is a memo to
 20 all pathologists, pathology residents,
 21 Department of Pathology, St. John's hospitals,
 22 Eastern Health. It's from Drs. Cook and
 23 Carter, July 28th, 2005 re: "optimal
 24 assessment and reporting of hormone receptor
 25 status in infiltrating carcinoma." And we

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1 look at this, "when ordering and reporting
 2 ER/PR status and infiltrating carcinoma of the
 3 breast: one to eight"--actually one to nine.
 4 Do you recall receiving this? And I'm not
 5 suggesting you did receive it.
 6 DR. FONTAINE:
 7 A. It doesn't look familiar I can say. I may
 8 have received it, but it's not one that stands
 9 out in my mind.
 10 COFFEY, Q.C.:
 11 Q. And I say that because a signed copy, we don't
 12 have a signed copy, that's why I -
 13 DR. FONTAINE:
 14 A. Yeah, it doesn't look familiar.
 15 COFFEY, Q.C.:
 16 Q. And in particular, Doctor, in the context
 17 here, bearing in mind the context, this is
 18 July 28th, 2005, by then you would have known
 19 there had been a number of conversions,
 20 certainly on the Ventana.
 21 DR. FONTAINE:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. And you would have known there was certainly a
 25 large scale investigation going on, of some

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1 sort.
 2 DR. FONTAINE:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. And if you had gotten then, do you think a
 6 memo from Drs. Cook and Carter who were the
 7 organizers of the investigation, you
 8 understood were the organizers of it.
 9 DR. FONTAINE:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. Spelling out nine different steps to look out
 13 for, to be aware of, in relation to ER and PR,
 14 do you think that would, might you have
 15 recalled that?
 16 DR. FONTAINE:
 17 A. I think I would.
 18 COFFEY, Q.C.:
 19 Q. It's the sort of thing, in the circumstances
 20 it would kind of stand out, wouldn't it, in
 21 terms of two people most heavily involved in
 22 doing an investigation -
 23 DR. FONTAINE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Significant investigation and suddenly you got
 2 a memo from them.
 3 DR. FONTAINE:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. With nine steps related -
 7 DR. FONTAINE:
 8 A. We would have to go through this and then have
 9 an action plan from that end, yes.
 10 COFFEY, Q.C.:
 11 Q. Because at this point in time, the testing was
 12 still going on in St. John's.
 13 DR. FONTAINE:
 14 A. Correct
 15 COFFEY, Q.C.:
 16 Q. ER/PR.
 17 DR. FONTAINE:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. Exhibit P-534, please.
 21 THE COMMISSIONER:
 22 Q. Mr. Coffey, before you go on, when you were
 23 showing the witness P-0532 that was the
 24 reference to beginning negative controls. I
 25 understood Dr. Fontaine to start a statement -

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1 COFFEY, Q.C.:
 2 Q. He's not a proponent.
 3 THE COMMISSIONER:
 4 Q. - not being a proponent.
 5 DR. FONTAINE:
 6 A. I'm not a proponent.
 7 THE COMMISSIONER:
 8 Q. And you said no and I wasn't sure whether that
 9 -
 10 DR. FONTAINE:
 11 A. I didn't say no, I guess the -
 12 THE COMMISSIONER:
 13 Q. I wasn't sure what that meant in this context.
 14 COFFEY, Q.C.:
 15 Q. You go ahead.
 16 DR. FONTAINE:
 17 A. I guess there could have been the discussion
 18 to begin negative controls, but I wasn't under
 19 the impression that he was asking me to do it.
 20 We may have had that discussion. I don't
 21 remember there being a directive associated
 22 with that. I'm not saying the conversation
 23 wouldn't have taken place, but -
 24 THE COMMISSIONER:
 25 Q. But you can be clear that you did not begin

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1 negative control at this point, I presume?
 2 DR. FONTAINE:
 3 A. It was not my initiative, no.
 4 THE COMMISSIONER:
 5 Q. Yes, okay.
 6 COFFEY, Q.C.:
 7 Q. Your answer then was you didn't do it at the
 8 time.
 9 DR. FONTAINE:
 10 A. I didn't go with the direction of--I did not
 11 get the impression that it was going to be a
 12 directive.
 13 COFFEY, Q.C.:
 14 Q. Did you have any--how do you feel about, in
 15 this context, negative controls?
 16 DR. FONTAINE:
 17 A. Again, there's a wide opinion, if you -
 18 COFFEY, Q.C.:
 19 Q. Because I think you indicated you're not a
 20 proponent either.
 21 DR. FONTAINE:
 22 A. Right.
 23 COFFEY, Q.C.:
 24 Q. So, I'll ask you about that now, perhaps you
 25 can explain that -

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1 DR. FONTAINE:
 2 A. Because again when I look at it for the
 3 negative--there is built in negative control
 4 in our tissues, in essence, that we don't
 5 expect certain cell to stain. And if they
 6 don't stain, then that is a built in internal
 7 negative control, if you will.
 8 COFFEY, Q.C.:
 9 Q. And if they do stain -
 10 DR. FONTAINE:
 11 A. Then you've got a problem, if you will.
 12 COFFEY, Q.C.:
 13 Q. Okay.
 14 DR. FONTAINE:
 15 A. Exactly.
 16 COFFEY, Q.C.:
 17 Q. Is that true in breast tissue?
 18 DR. FONTAINE:
 19 A. To speak to breast tissue specifically, it's
 20 not my area of expertise, but I'm not aware of
 21 something. But I know there is a school of
 22 thought that ascribes to that belief. And the
 23 same with other immunohistochemistry.
 24 COFFEY, Q.C.:
 25 Q. And if the context at the time, if it had been

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

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

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1 COFFEY, Q.C.:

2 Q. HER2.

3 DR. FONTAINE:

4 A. Yes, sorry, yes HER2/neu.

5 COFFEY, Q.C.:

6 Q. And HER2 overall, but that's the point, I take

7 it, of having enough tissue there.

8 DR. FONTAINE:

9 A. Correct, yes.

10 COFFEY, Q.C.:

11 Q. That very reason.

12 DR. FONTAINE:

13 A. Yes.

14 COFFEY, Q.C.:

15 Q. And in this context though it would also, I

16 take it, if it's being done, it refers to here

17 as well -

18 DR. FONTAINE:

19 A. The importance of internal control.

20 COFFEY, Q.C.:

21 Q. Yes. Also here, for both hormone receptor

22 testing and HER2/neu.

23 DR. FONTAINE:

24 A. Yes.

25 COFFEY, Q.C.:

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1 Q. So, if the block contains normal tissue for

2 HER2/neu purposes, it would also act as a

3 positive internal control for hormone.

4 DR. FONTAINE:

5 A. Correct.

6 COFFEY, Q.C.:

7 Q. But that was not new to you either at the

8 time?

9 DR. FONTAINE:

10 A. No.

11 COFFEY, Q.C.:

12 Q. You were aware of this.

13 DR. FONTAINE:

14 A. I was aware of this, yes.

15 COFFEY, Q.C.:

16 Q. At the time you received this, Doctor, and I

17 take it you did receive it?

18 DR. FONTAINE:

19 A. Yes.

20 COFFEY, Q.C.:

21 Q. Did you reflect upon why that was asserted? I

22 mean, your world, there'd be no necessity to

23 tell you that.

24 DR. FONTAINE:

25 A. Right. And I think this is the thing that we

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1 have to consider here as well and it's because

2 immunohistochemistry is sort of thrown in at

3 pathologists. You've heard a number of

4 stories about education pieces and whatnot.

5 Of the day and if this was brought in without

6 education, it's as it states, as a reminder,

7 is the thing. So, for those who wouldn't know

8 this, it would be new information, but it

9 would be expected that as a reminder for those

10 who are choosing these blocks.

11 COFFEY, Q.C.:

12 Q. If you're already doing a carry on as -

13 DR. FONTAINE:

14 A. Carry on, exactly, but if you don't know, you

15 better start doing it.

16 COFFEY, Q.C.:

17 Q. - you had been; if you're not, you -

18 DR. FONTAINE:

19 A. Exactly.

20 COFFEY, Q.C.:

21 Q. Exhibit P-2095 please. I'm sorry, page 22,

22 please. Doctor, here this is a memo from Dr.

23 Cook to all pathologists, I take it, in the

24 division of anatomical pathology which would

25 be throughout Eastern, St. John's Eastern

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1 Health anyway.

2 DR. FONTAINE:

3 A. Yes.

4 COFFEY, Q.C.:

5 Q. August 2 '05, resource individual for

6 immunohistochemistry and he says, "Dr. Gershon

7 Ejeckam is currently our resource person for

8 immunohistochemistry. All inquiries regarding

9 immunohistochemistry should be referred to Dr.

10 Ejeckam. In the event that Dr. Ejeckam is not

11 available, all inquiries will be referred to

12 the site chief, General Hospital site, who is

13 currently Dr. Dan Fontaine."

14 DR. FONTAINE:

15 A. Yes.

16 COFFEY, Q.C.:

17 Q. Were you aware that this was going out?

18 DR. FONTAINE:

19 A. Yes

20 COFFEY, Q.C.:

21 Q. And what were you told by Dr. Cook about this?

22 DR. FONTAINE:

23 A. Essentially if Dr. Ejeckam was unavailable

24 that the responsibility would fall to me. As

25 site chief, I accepted that that would be part

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1 of my responsibility, knowing that Dr. Ejeckam
 2 was in place, but this was more or less a
 3 formalization of an already existing
 4 agreement.
 5 COFFEY, Q.C.:
 6 Q. Now in this context, inquiries regarding
 7 immunohistochemistry, all inquiries, what did
 8 you understand was going on here in the sense
 9 of what sorts of inquiries would you get?
 10 What might you get as a result of this sort of
 11 a memo?
 12 DR. FONTAINE:
 13 A. I would expect that that would relate to
 14 issues regarding external control failures,
 15 internal control failures, inconsistent
 16 staining, these kinds of issues.
 17 COFFEY, Q.C.:
 18 Q. I take it concerns or complaints by
 19 pathologists about the staining?
 20 DR. FONTAINE:
 21 A. Correct.
 22 COFFEY, Q.C.:
 23 Q. The stains.
 24 DR. FONTAINE:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. Exhibit P-0555 please? Now, Doctor, this is a
 3 document we received from Dr. Cook, it's
 4 apparently Dr. Cook's handwriting. Meeting of
 5 pathologists, Dr. Dan Fontaine, Dr. Lynn
 6 Morris-Larkin, Dr. M. Parai, Pirzada, Baron -
 7 DR. FONTAINE:
 8 A. Bibi Naghibi, yes.
 9 COFFEY, Q.C.:
 10 Q. And Dr. Cook, August 5, 2005, 3:00 p.m.
 11 DR. FONTAINE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. And this is a typed document, the actual body
 15 of it.
 16 DR. FONTAINE:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. Do you know who prepared this or how this came
 20 about? How it came to be prepared?
 21 DR. FONTAINE:
 22 A. I can--no.
 23 COFFEY, Q.C.:
 24 Q. Well, I'll ask you then, the meeting of August
 25 5, did you attend it?

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1 DR. FONTAINE:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Okay. How did you come to attend the meeting?
 5 DR. FONTAINE:
 6 A. Dr. Cook notified us. The best I can figure
 7 is that this was Dr. Cook putting this
 8 together.
 9 COFFEY, Q.C.:
 10 Q. And it begins by saying, "this is a list of
 11 some concerns which have emerged during
 12 conversations about the current problem.
 13 Included are some of our suggestions about how
 14 to approach this. It's important that we work
 15 together and support each other's department.
 16 Important features of the ongoing process
 17 should include and it lists a number of them.
 18 Co-operation, transparency, communication,
 19 dissemination of information as the process
 20 evolves, avoidance of finger pointing to other
 21 individuals or a group of individuals, input
 22 into the procedure and quality control and
 23 assurance initiatives surrounding it. We
 24 should ensure that no bias is introduced into
 25 the ongoing study. If the purpose is to

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1 compare methods, then the following are
 2 important features", and it goes on to list
 3 them.
 4 Now, and toward the bottom there's a
 5 reference to "we should not be working in an
 6 environment where pathologists feel they are
 7 being criticized for past performances. Avoid
 8 generalized statements such as 'pathologists
 9 don't know how to report the ER/PR'. 'A single
 10 pathologist has repeatedly reported the ER/PR
 11 incorrectly'. 'Keeping statistics on
 12 individual pathologists'. These statements as
 13 well as loud discussions around the issue in
 14 corridors with high public traffic are
 15 threatening and demoralizing. We all assume
 16 that we are the pathologists being referred to
 17 however anonymously. This issue concerns
 18 pathologists outside the Health Care
 19 Corporation and they also need to be informed
 20 and re-assured. The process is proceeding at
 21 a fair and productive manner".
 22 Now, Doctor, you came, I take it, to go
 23 to this meeting because Dr. Cook asked people
 24 to come.
 25 DR. FONTAINE:

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1 A. Yes, that's correct.
 2 COFFEY, Q.C.:
 3 Q. What did you understand the purpose was?
 4 DR. FONTAINE:
 5 A. I just think because there was a lot of
 6 rumours going around. Nobody really knew what
 7 was the true story as it stood. So, it was
 8 more or less to have a chance for individuals
 9 to raise their issue, should they have any.
 10 COFFEY, Q.C.:
 11 Q. And what happened at the meeting?
 12 DR. FONTAINE:
 13 A. There was a lot of fear and anxiety related to
 14 this issue because there was a lot of, again,
 15 like we see, there were a lot of statements
 16 being made, a lot of finger pointing, if you
 17 will. Was it a technology issue? Was it a
 18 pathology issue? We really didn't know the
 19 scope of the problem either.
 20 COFFEY, Q.C.:
 21 Q. So that, I take it, was the circumstances
 22 leading up to the meeting itself.
 23 DR. FONTAINE:
 24 A. Yes, there was a lot of anxiety related,
 25 amongst the pathologists. I can't remember

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1 specifically if it was a called for meeting,
 2 but I know there was a lot of unrest within
 3 the pathology community.
 4 COFFEY, Q.C.:
 5 Q. And the purpose then in having the meeting you
 6 understood was what?
 7 DR. FONTAINE:
 8 A. Was to have a chance to air out some of these
 9 issues and find out what is really going on
 10 here.
 11 COFFEY, Q.C.:
 12 Q. What then happened at the meeting?
 13 DR. FONTAINE:
 14 A. Do you remember the specifics, I can try to
 15 recall that there was some discussion as to
 16 there was a significant conversion. There was
 17 an issue and there was going to be a mass
 18 retesting from that. From that end then the
 19 pathologists were concerned that was somebody
 20 going to be singled out and finger pointing
 21 and looking at that.
 22 COFFEY, Q.C.:
 23 Q. Because in the middle of this there are
 24 references to persons conducting the study do
 25 not need to know which pathologists signed the

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1 report original.
 2 DR. FONTAINE:
 3 A. Right. There was a lot of discussion as to--
 4 because for those who would do the study, the
 5 pathologists wanted to know that there was
 6 going to be blinding, so that there wouldn't
 7 be an interpretative bias introduced by, so
 8 that a pathologist would be singled out as
 9 being more of the road, because the concern
 10 also was that if the person doing the review
 11 knew who it was might interpret things
 12 differently. That was the concern.
 13 COFFEY, Q.C.:
 14 Q. And what was understood at the time as to what
 15 the ongoing study was?
 16 DR. FONTAINE:
 17 A. I think at this time it was understood that
 18 there was a significant conversion and there
 19 was going to be the retrospective look and see
 20 how big of an issue was this and how far back
 21 does it go.
 22 COFFEY, Q.C.:
 23 Q. I take it the person then bringing information
 24 to the meeting, and I've looked at the list of
 25 participants, was Dr. Cook.

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1 DR. FONTAINE:
 2 A. Yes, he would be, in essence, chairing the
 3 meeting, if you would.
 4 COFFEY, Q.C.:
 5 Q. He's the one who would know about what studies
 6 were going on and what was proposed.
 7 DR. FONTAINE:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. And was the upshot of the meeting in the sense
 11 of the outcome of it, in a sense of, was there
 12 kind of a consensus, everybody agree to
 13 disagree or what?
 14 DR. FONTAINE:
 15 A. There's a lot of that in pathology and I think
 16 people felt better because they felt some of
 17 their concerns were being addressed, that it
 18 was not intended to be a witch hunt. We just
 19 wanted to get retesting. We found that there
 20 was an issue and we wanted to find out what
 21 was the scope of that issue.
 22 COFFEY, Q.C.:
 23 Q. At that meeting, was it apparent by the time
 24 the meeting ended, from Dr. Cook, was it
 25 apparent that there had been a number of

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1 conversions?
 2 DR. FONTAINE:
 3 A. Yes. I think that had been--that's probably
 4 what spawned the meeting, is that people
 5 recognized that there was a significant
 6 conversion and then what was being done about
 7 it.
 8 COFFEY, Q.C.:
 9 Q. Doctor, it's your understanding then, before
 10 the meeting and going into it and during it
 11 that at least some pathologists wanted or were
 12 concerned about the original reporting
 13 pathologist in any individual case being
 14 identified.
 15 DR. FONTAINE:
 16 A. Correct.
 17 COFFEY, Q.C.:
 18 Q. And with respect to that, did you have any
 19 understanding, come to any understanding as to
 20 what their concern was? I mean, if it turns
 21 out that you reported a case zero/zero or
 22 negative/negative and it turns out that on
 23 retest it was 80/80, what was your
 24 understanding about--what was their concern
 25 about it? Obviously, it might have

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1 implications for patient.
 2 DR. FONTAINE:
 3 A. I think that was more--the implication for
 4 patient care. You'd have to speak to the
 5 individuals themselves. I know for myself it
 6 was--I didn't see that as an issue. I
 7 thought, it's the patient first. If I have a
 8 conversion, then I have to resolve what that
 9 is. And people were frightened that there
 10 might be a bias towards reporting, if you
 11 would in that if somebody knew that it was an
 12 individual, there might be a selection for
 13 singling out an individual.
 14 COFFEY, Q.C.:
 15 Q. Somebody might be singled out as the person
 16 who had most of the conversions or all of the
 17 conversions, that sort of thing or -
 18 DR. FONTAINE:
 19 A. Or that the interpreting individual would see
 20 who that person was and that may introduce
 21 bias in that they may--because again, this is
 22 an interpretive skill. And the concern was
 23 that if they saw the name and then looked at
 24 the slide, they may not be as objective as
 25 they would be.

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1 COFFEY, Q.C.:
 2 Q. And were there any assurances given that that
 3 would be addressed?
 4 DR. FONTAINE:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. So, Dr. Cook -
 8 DR. FONTAINE:
 9 A. Dr. Cook addressed what--the conclusion was
 10 that the individuals names would be redacted
 11 on the review.
 12 COFFEY, Q.C.:
 13 Q. Mr. Coffey, wherever you can find a spot,
 14 we'll take the afternoon break.
 15 COFFEY, Q.C.:
 16 Q. Okay. If we could please, Exhibit P-0556.
 17 Doctor, this is a draft of a letter of August
 18 5, 2005. It was originally intended to go to
 19 Dr. Williams. It would have been from Dr.
 20 Cook. He drafted it. He says, "both Dr. Dan
 21 Fontaine and myself met with Heather Predham
 22 today to discuss the issue of technologists
 23 and interaction with pathologists in regard to
 24 immunoperoxidase staining. Following that
 25 discussion, I would like to make the following

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1 recommendations". And he talks then about the
 2 establishment of a separate immunoperoxidase
 3 service and so on with at least three
 4 technologists solely dedicate to it.
 5 DR. FONTAINE:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. And he talks then about the, from his
 9 perspective, perhaps more appropriate training
 10 or at least hiring of people for this
 11 particular function.
 12 DR. FONTAINE:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. Do you recall discussing this with Ms. Predham
 16 and Dr. Cook, discussions -
 17 DR. FONTAINE:
 18 A. Not specifically, but I do remember having
 19 discussions around these issues with these
 20 individuals.
 21 COFFEY, Q.C.:
 22 Q. And do you recall generally what it was about,
 23 the nature of those discussions?
 24 DR. FONTAINE:
 25 A. It would have been around this issue of

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1 getting dedicated technologists for
 2 immunoperoxidase lab. Again, there were a
 3 number of discussions that we had because this
 4 was always on issue, if you will, but to say
 5 that I can remember this specific discussion,
 6 I don't remember, but I know this was the
 7 flair of many discussions that we had.
 8 COFFEY, Q.C.:
 9 Q. Thank you, Commissioner.
 10 THE COMMISSIONER:
 11 Q. We'll take the afternoon break.
 12 (RECESS)
 13 THE COMMISSIONER:
 14 Q. Please be seated. Mr. Coffey.
 15 COFFEY, Q.C.:
 16 Q. Thank you, Commissioner. Registrar, Exhibit
 17 P-0079, please. Now Doctor, this is a letter
 18 dated August 2, 2005. It's to Dr. Cook, it's
 19 from Dr. Carter and this is a letter where
 20 she--is copied to Dr. Williams--she advises
 21 Dr. Cook that she wishes to withdraw from her
 22 organizational role in the investigation of
 23 the problem with ER/PR testing at the Health
 24 Sciences Centre, St. John's from 1997 to 2004.
 25 Were you made aware, did you become aware that

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1 Dr. Cook, that Dr. Carter had so withdrawn?
 2 DR. FONTAINE:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. And how did you become aware of that?
 6 DR. FONTAINE:
 7 A. Basically Dr. Cook approached me about taking
 8 up where Dr. Carter would have left off.
 9 COFFEY, Q.C.:
 10 Q. And what were you being asked to do and what
 11 did you agree to do?
 12 DR. FONTAINE:
 13 A. Well, there was a discussion--I couldn't
 14 really get a sense of why Dr. Carter had
 15 resigned from this role and my impression was
 16 the fact to look at slides and determine which
 17 blocks, or to select blocks with internal
 18 control provided the original block that the
 19 estrogen/progesterone receptor would have been
 20 ordered on would not be available, they could
 21 pick an alternate block and this would be the
 22 alternate block with internal controls. So I
 23 would be charged with looking at slides and
 24 determining which blocks would serve as
 25 alternates.

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1 COFFEY, Q.C.:
 2 Q. And would you be involved at all in screening
 3 to see if the original block, in fact, had
 4 normal tissue on it?
 5 DR. FONTAINE:
 6 A. I did not -
 7 COFFEY, Q.C.:
 8 Q. Assuming it was available.
 9 DR. FONTAINE:
 10 A. I would not look at the original block.
 11 COFFEY, Q.C.:
 12 Q. The slide for the original -
 13 DR. FONTAINE:
 14 A. I'm sorry, the original slide, that's correct,
 15 yes. No, I would not look at the original
 16 slide.
 17 COFFEY, Q.C.:
 18 Q. So your involvement, you understood from when
 19 Dr. Cook approached you about this was to be
 20 limited to, in those instances where the
 21 original block is not available -
 22 DR. FONTAINE:
 23 A. Correct.
 24 COFFEY, Q.C.:
 25 Q. - the original block on which ER and PR was

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1 conducted, that the patient's surgical number
 2 would be identified?
 3 DR. FONTAINE:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. And you would be charged then with looking at
 7 the H & E slides for the other blocks,
 8 whichever ones might be available, and based
 9 upon that, picking the block, from your
 10 perspective that best fit the bill of having
 11 tumour and normal tissue on it?
 12 DR. FONTAINE:
 13 A. Correct.
 14 COFFEY, Q.C.:
 15 Q. To conduct the retest?
 16 DR. FONTAINE:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. But for those for which the original block was
 20 available, you understood that was just going
 21 to be the original block was going to be
 22 processed and sent off?
 23 DR. FONTAINE:
 24 A. They would just select the original block,
 25 that's correct. That was my understanding.

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1 COFFEY, Q.C.:

2 Q. Okay, and what then happened, Doctor, in

3 relation to that?

4 DR. FONTAINE:

5 A. So in around this time, I was presented with a

6 spreadsheet with the surgical numbers and it

7 was identified which block the ER/PR was

8 ordered on originally. So I would know which

9 slide it had been ordered on, and would then

10 look at all the other slides to select an

11 appropriate alternate. So sometimes it would-

12 -I would only need to look at one slide. In

13 other cases, I would have to look at several

14 slides.

15 COFFEY, Q.C.:

16 Q. And I take it, for many patients, you wouldn't

17 have to look at any slides at all?

18 DR. FONTAINE:

19 A. I would still look--always, in every case that

20 I was presented, I would pick an alternate

21 block.

22 COFFEY, Q.C.:

23 Q. An alternate block, okay, but if you weren't

24 being asked to pick an alternate block, you

25 didn't look at--if an alternate block wasn't

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1 being used, you weren't asked to look at the

2 case?

3 DR. FONTAINE:

4 A. I don't--I wasn't aware that there were other

5 cases that had alternate blocks. So every

6 case that I went through, that I was presented

7 with, I would select an alternate block.

8 COFFEY, Q.C.:

9 Q. An alternate block?

10 DR. FONTAINE:

11 A. Yes.

12 COFFEY, Q.C.:

13 Q. What I'm getting at is this, is that you were

14 only tasked to look at cases for which an

15 alternate block was required?

16 DR. FONTAINE:

17 A. I assume so. All I did, I just--what I was

18 presented with, I would look and select an

19 alternate block for every case I was

20 presented.

21 COFFEY, Q.C.:

22 Q. An alternate block, okay. Here's an example.

23 I'll just bring up Exhibit P-0573. Now

24 Doctor, these are handwritten notes of Dr.

25 Williams, but he has provided typed versions

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1 of them. This particular one is August 17th,

2 2005. It involves a meeting involving Dr.

3 Williams and Mr. Gulliver, but first bullet

4 says "all blocks pulled and reviewed at

5 General site by Dr. Dan Fontaine."

6 DR. FONTAINE:

7 A. Yes.

8 COFFEY, Q.C.:

9 Q. And "now waiting to send off for 1999 to first

10 three years--three months" I'm sorry, "of

11 2004." So "all blocks pulled and reviewed at

12 General site by Dr. Dan Fontaine."

13 DR. FONTAINE:

14 A. I hadn't actually pulled the slides, but I had

15 reviewed them, yes.

16 COFFEY, Q.C.:

17 Q. I take it that was all slides that you were

18 asked to review?

19 DR. FONTAINE:

20 A. Correct.

21 COFFEY, Q.C.:

22 Q. As opposed to all slides for blocks that were

23 going to Mount Sinai? See, what I'm getting

24 at is this, we understand, and correct me if

25 I'm wrong -

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1 DR. FONTAINE:

2 A. Okay.

3 COFFEY, Q.C.:

4 Q. - we understand that, you know, there were

5 thousands of pathology reports printed out,

6 okay, and of those, a certain number were

7 identified as involving estrogen and

8 progesterone testing.

9 DR. FONTAINE:

10 A. Correct.

11 COFFEY, Q.C.:

12 Q. And of those, those that might be considered

13 negative results, negative ER results in the

14 beginning, the original test, that those

15 patients were identified and the surgical

16 numbers identified and the thought was, the

17 intention was that they would be all sent off

18 to Mount Sinai, a block for each individual

19 patient.

20 DR. FONTAINE:

21 A. Correct.

22 COFFEY, Q.C.:

23 Q. Okay. You understood that--or did you

24 understand that the intention was, where

25 possible, that the block on which the original

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1 ER and PR test was done -
 2 DR. FONTAINE:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. - was going to be sent to Mount Sinai?
 6 DR. FONTAINE:
 7 A. That would be the--and provided that slide was
 8 not available, my impression -
 9 COFFEY, Q.C.:
 10 Q. Oh no, provided -
 11 DR. FONTAINE:
 12 A. Okay.
 13 COFFEY, Q.C.:
 14 Q. - if it was available.
 15 DR. FONTAINE:
 16 A. If it was available, my impression was that
 17 the block that I've chosen would not be sent.
 18 It would not be pulled.
 19 COFFEY, Q.C.:
 20 Q. Okay.
 21 DR. FONTAINE:
 22 A. Correct.
 23 COFFEY, Q.C.:
 24 Q. So, and this is what I wanted to ask you
 25 about. In your review, were you looking at

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1 the original ER and PR slides -
 2 DR. FONTAINE:
 3 A. No.
 4 COFFEY, Q.C.:
 5 Q. - that were--and the corresponding H & E slide
 6 for that original ER and PR slide?
 7 DR. FONTAINE:
 8 A. Those would be the only slides I would not
 9 look at.
 10 COFFEY, Q.C.:
 11 Q. Okay. So you were tasked with, for all the
 12 patients identified to you, their surgical
 13 numbers, to find an alternate block for each
 14 of those that was identified to you?
 15 DR. FONTAINE:
 16 A. Correct.
 17 COFFEY, Q.C.:
 18 Q. An appropriate alternate block?
 19 DR. FONTAINE:
 20 A. An appropriate, exactly, when available,
 21 appropriate with an internal control.
 22 COFFEY, Q.C.:
 23 Q. How long were you involved in that effort,
 24 Doctor?
 25 DR. FONTAINE:

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1 A. I don't remember the specific time frame. I
 2 do remember Dr. Williams coming down and
 3 seeing--because I would just basically receive
 4 these folders of slides and then just go
 5 through them as they were presented on the
 6 spreadsheet, and it would have been--it was a
 7 significant amount of time, but I can't
 8 remember. Again, I just thought that I had a
 9 task to do and did it. I don't remember the
 10 specific time lines. But it was a significant
 11 endeavour.
 12 COFFEY, Q.C.:
 13 Q. And the slides in question, were you looking
 14 at slides from outside St. John's, as well as
 15 St. John's?
 16 DR. FONTAINE:
 17 A. Only in St. John's.
 18 COFFEY, Q.C.:
 19 Q. Only St. John's slides?
 20 DR. FONTAINE:
 21 A. That's correct.
 22 COFFEY, Q.C.:
 23 Q. And did you have to in any way--you had to
 24 identify the particular slides and
 25 corresponding block?

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1 DR. FONTAINE:
 2 A. Correct. I was given a spreadsheet with the
 3 corresponding numbers and then on the
 4 spreadsheet it would say which one the ER/PR
 5 had been done on. So I would be able to
 6 identify, so I wouldn't look at that slide,
 7 and then I would look at other slides to
 8 select an alternate.
 9 COFFEY, Q.C.:
 10 Q. And did you--you would signify that, I take
 11 it, having made your choice, done your
 12 examination, made your choice, you'd write
 13 that in the sheet?
 14 DR. FONTAINE:
 15 A. I would write it in the spreadsheet.
 16 COFFEY, Q.C.:
 17 Q. Who did you give the spreadsheets back to?
 18 DR. FONTAINE:
 19 A. Mr. Barry Dyer.
 20 COFFEY, Q.C.:
 21 Q. Did you have any other involvement in the
 22 retesting process, in terms of -
 23 DR. FONTAINE:
 24 A. In what respect?
 25 COFFEY, Q.C.:

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

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1 order ERS and PRs on the respective cases,
 2 fill out the IHC request form and forward this
 3 to the technologist. The ER and PR
 4 immunohistochemical stain will simultaneously
 5 be processed by our technologists and sent
 6 back to the ordering pathologist. Once these
 7 stains are received, the ordering pathologist
 8 will give an interpretation using the enclosed
 9 form and forward this to Dr. Carter. That
 10 report is not to be released within the
 11 hospital information system."
 12 Now Doctor, I take it that this is the
 13 notification to yourself and your fellow
 14 pathologists that the current and ongoing
 15 cases, testing in St. John's was going to be
 16 suspended for a period of time?
 17 DR. FONTAINE:
 18 A. Correct.
 19 COFFEY, Q.C.:
 20 Q. Had you known this was coming?
 21 DR. FONTAINE:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. And you'd learned that from?
 25 DR. FONTAINE:

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1 A. I knew it at the time because there was this
 2 talk of if we have a significant issue, we
 3 better find out what it is before we actually
 4 continue doing this. So we better get to the
 5 bottom of what's going on here. There was
 6 question could it be a problem with the new
 7 technology. We didn't really know, have a
 8 good handle on what the true issue was.
 9 COFFEY, Q.C.:
 10 Q. Doctor, you understood, in the meantime
 11 though, I take it, that the Ventana Benchmark
 12 system was being utilized for all the other
 13 IHC stains?
 14 DR. FONTAINE:
 15 A. Correct.
 16 COFFEY, Q.C.:
 17 Q. So at the time, and I take it there would have
 18 been upwards of a hundred or more around that
 19 time?
 20 DR. FONTAINE:
 21 A. Easily.
 22 COFFEY, Q.C.:
 23 Q. Easily, you say. Was there any discussion at
 24 the time about well, you know, if there's a
 25 problem with the machine, if indeed there was

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1 really a problem with the machine itself, why
 2 would it be limited to ER/PR and why can we
 3 continue to use it for the other hundred odd
 4 stains? Was that discussed?
 5 DR. FONTAINE:
 6 A. Not to my recollection. I mean, there was
 7 discussion amongst different individuals as to
 8 why that was, but it was never beyond that.
 9 It never really came as a discussion point at
 10 a meeting or anything to that end.
 11 COFFEY, Q.C.:
 12 Q. At the time, did you have any thoughts
 13 yourself on that, in that regard? I take it
 14 you were comfortable with continuing with the
 15 IHC staining for everything else?
 16 DR. FONTAINE:
 17 A. I felt comfortable with the IHC staining and
 18 with the new technology, I was quite
 19 comfortable with the new technology as well.
 20 The product that I was seeing, I was quite
 21 comfortable with.
 22 COFFEY, Q.C.:
 23 Q. Sorry, I interrupted you. You were about to
 24 say--I asked you what--did you have any
 25 thoughts yourself at the time?

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1 DR. FONTAINE:
 2 A. To be honest with you, I looked at this as
 3 that was the decision and again, my feeling
 4 with breast is they're the experts in this
 5 area. That's their decision. I'll go with
 6 it.
 7 COFFEY, Q.C.:
 8 Q. Doctor, and I take it then, you know, when you
 9 were on call, did your turn on call, while
 10 working a particular day at the bench, you
 11 would order your own ER and PR as a result of
 12 this?
 13 DR. FONTAINE:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. For your patient.
 17 DR. FONTAINE:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. And this idea that you would continue to fill
 21 out the form, the IHC form, send it to the
 22 technologist.
 23 DR. FONTAINE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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

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

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1 COFFEY, Q.C.:
 2 Q. And so if they were coming back, as it points
 3 out here, the idea was it was going to come
 4 back to Dr. Carter and it would be entered
 5 into the system?
 6 DR. FONTAINE:
 7 A. Correct.
 8 COFFEY, Q.C.:
 9 Q. So having ordered the test, the results would
 10 not -
 11 DR. FONTAINE:
 12 A. Come back to you.
 13 COFFEY, Q.C.:
 14 Q. - according to this, would not come back to
 15 you as the individual ordering?
 16 DR. FONTAINE:
 17 A. That's correct.
 18 COFFEY, Q.C.:
 19 Q. Exhibit P-1939, please? Doctor, this is a
 20 memo from Dr. Cook to yourself and Maria
 21 Tracey. I take it she works with the
 22 perioperative program?
 23 DR. FONTAINE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. As program director, August 23rd, 2005, and
 2 Dr. Cook writes "I am requesting that all
 3 mastectomy specimens be placed in a large
 4 container completely immersed in ten percent
 5 formalin. Specimens should be immediately
 6 forwarded to the pathology lab where the
 7 breast tumour is appropriately sectioned to
 8 allow for even permeation and fixation by
 9 formalin. Cases should not be left overnight
 10 or over the weekend unsectioned as this may
 11 interfere with proper fixation of tissue."
 12 And "for cases that occur after normal working
 13 hours, the pathologist on call should be
 14 notified. Please make every attempt to have
 15 these--to ensure these cases are done early in
 16 the day and submitted to the lab before four
 17 p.m." Do you recall receiving this particular
 18 copy?
 19 DR. FONTAINE:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. And did you--well, first of all, I'll ask you,
 23 why was it sent to you?
 24 DR. FONTAINE:
 25 A. Because it had been identified as one of the

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1 contributing issues, if you will, because
 2 again, we were talking about IHC and again, in
 3 speaking to IHC, fixation becomes an issue.
 4 It was not common practice, but sometimes you
 5 would receive specimens that would not be
 6 completely immersed in formalin. So it was to
 7 let the OR know that this was a practice that
 8 should be averted when possible.
 9 COFFEY, Q.C.:
 10 Q. Did you get any feedback on that?
 11 DR. FONTAINE:
 12 A. On this issue specifically?
 13 COFFEY, Q.C.:
 14 Q. Yes.
 15 DR. FONTAINE:
 16 A. In what respect?
 17 COFFEY, Q.C.:
 18 Q. Well, from the surgical program.
 19 DR. FONTAINE:
 20 A. Where it wasn't addressed to me, I think it
 21 would have probably been back to Dr. Cook, but
 22 I didn't receive anything, no.
 23 COFFEY, Q.C.:
 24 Q. Okay. Exhibit P-0561, please? Actually, no,
 25 I'm going to--I'll leave that. Instead,

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1 Exhibit P-0590? Doctor, this is a memo of
 2 September 6th, 2005, to all laboratory
 3 directors. You're listed as the first one.
 4 It's from Dr. Cook, September 6th '05, ERs and
 5 PRs is the subject matter, and Dr. Cook writes
 6 "I wish to advise you that we are doing a
 7 review of our ER and PR. I expect to have
 8 more information within the next few weeks and
 9 will keep you updated. Please note the
 10 following points" and then he requests that
 11 the lab directors "forward all ER negative
 12 cases on primary breast lesions, independent
 13 of PR status, from May '97 to March 31/04 to
 14 Barry Dyer," and then he talks about the
 15 various classifications of what constitutes
 16 negative. "From January 1, 2001, ER negative
 17 is defined as ten percent or less. From May
 18 '97 to December 2000, ER negative is defined
 19 as 30 percent or less."
 20 Now Doctor, were you consulted about the
 21 utilization of these figures as cutoffs?
 22 DR. FONTAINE:
 23 A. No.
 24 COFFEY, Q.C.:
 25 Q. Did you have any understanding, as the

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1 laboratory director, when you received this?
 2 DR. FONTAINE:
 3 A. Yes, I knew that there were these cutoffs. I
 4 knew that they existed.
 5 COFFEY, Q.C.:
 6 Q. And did you have any understanding as to how
 7 they were arrived at, in the sense of the time
 8 frames that were being utilized and the
 9 numbers?
 10 DR. FONTAINE:
 11 A. I've come to appreciate that.
 12 COFFEY, Q.C.:
 13 Q. Since?
 14 DR. FONTAINE:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. But how about at the time?
 18 DR. FONTAINE:
 19 A. At the time, I knew there was, but the
 20 specific numbers, I wasn't so familiar with,
 21 but I knew that there had been a change in the
 22 numerical assignment of negatives over that
 23 period of time.
 24 COFFEY, Q.C.:
 25 Q. And what have you come to understand since

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1 then?

2 DR. FONTAINE:

3 A. In what respect?

4 COFFEY, Q.C.:

5 Q. In the sense of the fact that these numbers -

6 DR. FONTAINE:

7 A. That these numbers would represent the times

8 that are represented as being cutoffs where

9 certain reports may be defined as negative or

10 positive, as a result of these cutoff

11 percentages.

12 COFFEY, Q.C.:

13 Q. And you've learned that from whom since, or

14 your understanding since has come from where?

15 Have you sat down and had oncologists explain

16 it to you or pathologists explain it to you,

17 in terms of how they arrived at this?

18 DR. FONTAINE:

19 A. Yes, because I seen a note from, I believe it

20 was Dr. Khalifa, about the 30 percent and the

21 reference from that point as well, and I knew

22 there were a number of different references

23 from that. I knew they existed, but the

24 specific numbers again had escaped me.

25 COFFEY, Q.C.:

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1 Q. Have you ever made any investigation yourself

2 as to the appropriateness or otherwise of

3 those numbers and those particular time

4 frames?

5 DR. FONTAINE:

6 A. So much to go to read the journals, if you

7 wish?

8 COFFEY, Q.C.:

9 Q. Yes, yourself.

10 DR. FONTAINE:

11 A. I've never read the specific journals, but I

12 know that those are the conclusions and other

13 colleagues have discussed that in discussions

14 with them. I guess these were national

15 standards and international standards for the

16 day.

17 COFFEY, Q.C.:

18 Q. From your perspective, I take it, as a

19 pathologist, I mean, you were trained in fact-

20 -you were in training, in fact, around the

21 time--training as a resident -

22 DR. FONTAINE:

23 A. And again, remembering -

24 COFFEY, Q.C.:

25 Q. - during this change over period.

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1 DR. FONTAINE:

2 A. - the practice, the practice in Halifax, again

3 was to report percentages and much--looking

4 back at this now, I see why Dr. Barnes was so

5 adamant about talking about percentages rather

6 than giving the declaration of positive or

7 negative without qualification.

8 COFFEY, Q.C.:

9 Q. If we could, please, Exhibit P-1953? Now

10 Doctor, this is a Division of Anatomical

11 Pathology, minutes of a pathologists meeting

12 of the General Hospital. It's October 4th

13 2005. Number of physicians present, listed

14 as present, including yourself, the last one

15 there.

16 DR. FONTAINE:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. The meeting was called to order by yourself,

20 as I take it you were the site chief.

21 DR. FONTAINE:

22 A. I was site chief at the time.

23 COFFEY, Q.C.:

24 Q. And approval of the earlier minutes, business

25 arising, and then paragraph 3.2 on the second

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1 page, "update on ER/PR status." It reads "as

2 all are aware, the media has gotten a hold of

3 this issue. We are still in the process of

4 determining how extensive this problem is. In

5 view of this discussion with Dr. Cook, he has

6 appointed--in view of this," yeah, "discussion

7 with Dr. Cook, he has appointed Dr. Beverley

8 Carter as the point person for HER2/neu

9 testing. With this in mind, there was some

10 sentiment from the pathologists that Dr.

11 Carter should review all breast cases with a

12 backup person to cover in her absence. A

13 letter to this effect will be sent to Dr. Cook

14 stating the opinion of the pathologists at

15 this site and this will be discussed with Dr.

16 Carter as well" and then there's a reference

17 to an update on the pathology assistants.

18 DR. FONTAINE:

19 A. Yes.

20 COFFEY, Q.C.:

21 Q. And on surgical sign out. I wanted to ask

22 you, Doctor, first of all, in terms of the

23 ER/PR status matter, I take it then, if this

24 is October of '05 and you had raised this back

25 in September of '04 with your colleagues, Dr.

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1 Carter's request that perhaps she could look
 2 at HER2/neu, ER and PR.
 3 DR. FONTAINE:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. And it had met with at least resistance from
 7 some of them anyway. You recall telling the
 8 Commissioner about that.
 9 DR. FONTAINE:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. This is 13 months later. Has the opposition
 13 or resistance -
 14 DR. FONTAINE:
 15 A. Sentiment has somewhat changed.
 16 COFFEY, Q.C.:
 17 Q. - lessened or evaporated?
 18 DR. FONTAINE:
 19 A. Yes, yes.
 20 COFFEY, Q.C.:
 21 Q. It has changed.
 22 DR. FONTAINE:
 23 A. I think it's changed.
 24 COFFEY, Q.C.:
 25 Q. And what, from your perspective, looking at

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

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

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1 approaches.
 2 DR. FONTAINE:
 3 A. Correct.
 4 COFFEY, Q.C.:
 5 Q. Depending upon how they were trained?
 6 DR. FONTAINE:
 7 A. That's correct.
 8 COFFEY, Q.C.:
 9 Q. And the idea would be that to draft written
 10 policies and have them distributed to
 11 particular pathologists who had expertise
 12 perhaps or an interest in a particular area?
 13 DR. FONTAINE:
 14 A. Correct. This is the way we do things here.
 15 COFFEY, Q.C.:
 16 Q. And kind of get a consensus, as it were?
 17 DR. FONTAINE:
 18 A. Correct.
 19 COFFEY, Q.C.:
 20 Q. And then --
 21 DR. FONTAINE:
 22 A. And then adopt within the group and recognize
 23 this is best practice.
 24 COFFEY, Q.C.:
 25 Q. Had that sort of approach existed in Halifax?

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1 DR. FONTAINE:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. In your training?
 5 DR. FONTAINE:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. This -- a written policy as to how --
 9 DR. FONTAINE:
 10 A. It was in process. Again when I was in
 11 Halifax, there was a new divisional chief who
 12 was very forward thinking, and when she came
 13 in and recognized there was no policy and
 14 procedure manual in place, instituted one from
 15 that end. It took a significant amount of
 16 time, but it was in process when I left
 17 Halifax in 2003.
 18 COFFEY, Q.C.:
 19 Q. Now, Doctor, this initiative certainly talked
 20 about here in October of '05, how far did it
 21 get?
 22 DR. FONTAINE:
 23 A. It didn't get very far. Unfortunately, there
 24 were a number of other pressing issues, and
 25 again the work needed to be done. This is an

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1 endeavour that takes a lot of time and it was
 2 also difficult to find individuals who would
 3 be the point people for these. So it never
 4 even got so far as to designation of
 5 pathologists to different areas,
 6 unfortunately.
 7 COFFEY, Q.C.:
 8 Q. And to this day, it hasn't been concluded?
 9 DR. FONTAINE:
 10 A. Not to my knowledge, but --
 11 COFFEY, Q.C.:
 12 Q. How far has it gotten?
 13 DR. FONTAINE:
 14 Q. I know it's been worked on. I know there are
 15 several groups who have -- I know with the
 16 breast that this does exist to this end, and
 17 some other groups have made -- have gotten so
 18 far as to have drafts, but I'm not aware of
 19 where the entire process sits as of this date.
 20 COFFEY, Q.C.:
 21 Q. And that would be a written policy and
 22 procedure manual for grossing of particular
 23 types of tissue?
 24 DR. FONTAINE:
 25 A. That's correct.

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

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

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1 A. Yes.

2 COFFEY, Q.C.:

3 Q. With the pathologists at the General. Was

4 there -- before it went public or even just

5 after it went public in October of '05, had

6 Dr. Cook in the meantime met with you again as

7 a group to let you know where things were?

8 DR. FONTAINE:

9 A. I can't remember specifically, but there were

10 a number of meetings going on, more or less

11 impromptu meetings and addressing -- sort of

12 trying to put out fires as they came up.

13 COFFEY, Q.C.:

14 Q. What I'm trying to get at is --

15 DR. FONTAINE:

16 A. Nothing too --

17 COFFEY, Q.C.:

18 Q. How much, as a group, were you kept apprised

19 of what was going on from day to day or week

20 to week?

21 DR. FONTAINE:

22 A. The communication was a bit lacking, but I

23 think it was also that there wasn't that much

24 information because if we asked for updates,

25 it was essentially there wasn't really

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1 anything to report. That information was slow

2 to come back as well. So it was -- it was a

3 very trying time.

4 COFFEY, Q.C.:

5 Q. Were you contacted by any pathologists from

6 outside St. John's about this?

7 DR. FONTAINE:

8 A. Not about this particular --

9 COFFEY, Q.C.:

10 Q. Not about this matter?

11 DR. FONTAINE:

12 A. No.

13 COFFEY, Q.C.:

14 Q. Again looking at the September 21st, 2005,

15 letter, page two of Exhibit P-1288, Doctor,

16 this is your letter it's two pages long.

17 DR. FONTAINE:

18 A. Yes.

19 COFFEY, Q.C.:

20 Q. Copied to Drs. Cook and Williams. You're

21 writing to Mr. Gulliver. How was it that you

22 came to write this letter, what prompted you

23 to do so?

24 DR. FONTAINE:

25 A. Again if you consider the timelines, I've

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1 completed my review of the slides at this

2 time, and I saw that -- just looking at

3 everything that was going on, there was an

4 issue with immunohistochemistry, there was an

5 issue with fixation, so these two issues were

6 addressed in this letter because I felt if

7 fixation is not addressed, the

8 immunohistochemical issue may not be resolved

9 either. Again thinking back to the earlier

10 statements that I made, fixation is key to

11 this process.

12 COFFEY, Q.C.:

13 Q. And so you wanted what then of Mr. Gulliver in

14 relation to the fixation?

15 DR. FONTAINE:

16 A. With fixation, it was -- again you'll see in

17 the second line in the second paragraph where

18 I make reference to the fact that there is a

19 variety of practice patterns involving various

20 pathologists to which there is no standardized

21 approach to grossing of specimens, and this

22 would be best remedied by the introduction of

23 pathology assistants into the program. So I

24 sort of saw that that was a way that we could,

25 in essence, standardize our gross room, take

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1 the pathologists out of the gross room. They

2 had their practises, and the way to unify

3 those practises was to bring other people in

4 and get that moving, and again making the

5 statement that this was the standard of

6 practise at other tertiary care academic

7 centres.

8 COFFEY, Q.C.:

9 Q. In fact, you -- the second last sentence of

10 the second paragraph says, "This could be

11 achieved with a standardized grossing policy

12 and procedure manual".

13 DR. FONTAINE:

14 A. Right.

15 COFFEY, Q.C.:

16 Q. "To which the department pathologists have

17 indicated consensus to move into this

18 direction", which is brought up in your

19 meeting of October 4th?

20 DR. FONTAINE:

21 A. Correct.

22 COFFEY, Q.C.:

23 Q. So by way of addressing then the fixation

24 issue such as it can be through the grossing

25 process, you're urging Mr. Gulliver to follow

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1 the pathology assistants path?
 2 DR. FONTAINE:
 3 A. Correct.
 4 COFFEY, Q.C.:
 5 Q. With a written policy for the grossing
 6 procedures?
 7 DR. FONTAINE:
 8 A. First bringing in the pathology assistants. So
 9 it was first acquiring those pathology
 10 assistants and then having protocols for them
 11 to follow.
 12 COFFEY, Q.C.:
 13 Q. So that's the second paragraph of your letter.
 14 The first paragraph, I take it, is directed at
 15 the idea that a dedicated immunohistochemical
 16 lab is essential?
 17 DR. FONTAINE:
 18 A. Correct.
 19 COFFEY, Q.C.:
 20 Q. And you wanted dedicated technologists?
 21 DR. FONTAINE:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. So up to this point in time, September of '05,
 25 there still were not dedicated technologists?

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1 DR. FONTAINE:
 2 A. That's correct, and again you can see that I
 3 stated --
 4 COFFEY, Q.C.:
 5 Q. You state two dedicated, at least two?
 6 DR. FONTAINE:
 7 A. Minimum of two.
 8 COFFEY, Q.C.:
 9 Q. Yes.
 10 DR. FONTAINE:
 11 A. And again looking at -- being responsible for
 12 this lab and this lab is responsible for the
 13 provincial volume, that this really speaks to
 14 the patients of Newfoundland and Labrador.
 15 COFFEY, Q.C.:
 16 Q. Doctor, you -- the last two sentences of the
 17 first paragraph say, "As site chief, I feel it
 18 is imperative that we have this dedicated
 19 service to ensure quality to the patients of
 20 Newfoundland and Labrador. I would not
 21 support continuing performance of
 22 immunohistochemical staining at this site
 23 should these recommendations not be followed".
 24 DR. FONTAINE:
 25 A. Right.

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1 COFFEY, Q.C.:
 2 Q. I take it, Doctor, that now it's apparent that
 3 eventually they were followed because there
 4 were dedicated technologists eventually
 5 assigned?
 6 DR. FONTAINE:
 7 A. That's correct.
 8 COFFEY, Q.C.:
 9 Q. Doctor, was this hyperbole or was this, in
 10 fact, actually your honestly held view at the
 11 time that if you're not going to have
 12 dedicated technologists to IHC, should they be
 13 involved at all?
 14 DR. FONTAINE:
 15 A. It wasn't my own view alone. I discussed this
 16 with Dr. Ejeckam many times as well.
 17 COFFEY, Q.C.:
 18 Q. And --
 19 DR. FONTAINE:
 20 A. And other pathologists as well. We all felt
 21 that it was important that you needed to have
 22 dedicated -- that this would be their sole
 23 performance of duty, it was important, and
 24 they could have the resources afforded to them
 25 as well.

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

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1 apprised of the progress that is made in
 2 addressing these concerns. I want to thank
 3 you for your interest in this issue. I look
 4 forward to your ongoing participation". Now,
 5 Doctor, having written to Mr. Gulliver and
 6 received this response from Mr. Gulliver, did
 7 you actually think or feel that there was
 8 going to be any resistance from Mr. Gulliver
 9 to the idea of dedicated technologists?
 10 DR. FONTAINE:
 11 A. I didn't get the impression there was. We'd
 12 had discussion -- I think this was in his
 13 spectrum of desire as well.
 14 COFFEY, Q.C.:
 15 Q. It wasn't so much -- your letter wasn't
 16 written so much as you had to actually
 17 convince him?
 18 DR. FONTAINE:
 19 A. No, no, it wasn't going to be a very difficult
 20 argument. We'd had discussion and felt -- had
 21 similar views.
 22 COFFEY, Q.C.:
 23 Q. If we could, please, Exhibit P-0637. Now this
 24 is a letter of October 13th, 2005, addressed
 25 by Dr. Cook to Dr. Ejeckam. It's copied to a

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1 number of individuals, including yourself.
 2 DR. FONTAINE:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. And it tells Dr. Ejeckam that Dr. Cook
 6 appreciates his continuing role in overseeing
 7 the immunoperoxidase service and he says, "We
 8 are in the process of developing a specialized
 9 service with a technologist solely dedicated
 10 in immunohistochemical technique". So I take
 11 it that certainly addressed one of your
 12 concerns?
 13 DR. FONTAINE:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. And he says, "It's agreed, you", that is Dr.
 17 Ejeckam, "will oversee all aspects of the
 18 immunoperoxidase operation, have direct
 19 supervision over the technologist involved in
 20 the service. You will also provide direction
 21 to all pathologists involved in
 22 immunoperoxidase interpretation. In areas
 23 where we hope to develop sub-specialized
 24 service, there will obviously be consultation
 25 between you and the appropriate pathologists

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1 on immunoperoxidase staining. If you feel
 2 there's any deviation, you should report this
 3 immediately to the clinical chief and the VP
 4 medical". Now, Doctor, in relation to the IHC
 5 matter, was this, in effect, a significant
 6 change?
 7 DR. FONTAINE:
 8 A. From what was happening before?
 9 COFFEY, Q.C.:
 10 Q. Yes, in terms of --
 11 DR. FONTAINE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. The idea that Dr. Ejeckam would be --
 15 DR. FONTAINE:
 16 A. He had been taking the lead in this, so again
 17 more or less a formalization from that end.
 18 COFFEY, Q.C.:
 19 Q. Here, though it says "Direct supervision over
 20 the technologist involved in the service".
 21 DR. FONTAINE:
 22 A. Right.
 23 COFFEY, Q.C.:
 24 Q. "And also provide direction to all
 25 pathologists involved in immunoperoxidase

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1 interpretation". I take it -- was that new?
 2 DR. FONTAINE:
 3 A. I wouldn't think it was. I would think that
 4 he was always there. I knew if I had immuno
 5 issue, I knew his door was open and -- open
 6 for discussion. So I don't think the
 7 pathologists would see that as a new
 8 statement.
 9 COFFEY, Q.C.:
 10 Q. Or as an imposition on them? From their
 11 perspective, this was just --
 12 DR. FONTAINE:
 13 A. It was available.
 14 COFFEY, Q.C.:
 15 Q. This was kind of codifying or documenting
 16 something, a state of affairs that, from your
 17 perspective, already existed?
 18 DR. FONTAINE:
 19 A. Was understood.
 20 COFFEY, Q.C.:
 21 Q. Understood. Now, Doctor, in Exhibit P-0619,
 22 we'd seen the reference to the leader in
 23 pathology at BC Cancer Institute. That would
 24 be Dr. Banerjee.
 25 DR. FONTAINE:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. And Trish Wegrynowski from Mount Sinai.
 4 DR. FONTAINE:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. Had you known that they were coming to St.
 8 John's in September of 2005?
 9 DR. FONTAINE:
 10 A. I can't speak to the specific dates. I knew
 11 they were coming because I was actually
 12 meeting with Dr. Banerjee as part of his
 13 visit. Now Ms. Wegrynowski, I was aware there
 14 was somebody coming to review the technology
 15 end of things, but I can't speak to specific
 16 dates, but it would have been in around that
 17 time, I would expect.
 18 COFFEY, Q.C.:
 19 Q. Did you meet with Trish Wegrynowski when she
 20 was here?
 21 DR. FONTAINE:
 22 A. No, I did not, no.
 23 COFFEY, Q.C.:
 24 Q. I take it you weren't asked to?
 25 DR. FONTAINE:

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1 A. No.
 2 COFFEY, Q.C.:
 3 Q. How about during her exit interview?
 4 DR. FONTAINE:
 5 A. No.
 6 COFFEY, Q.C.:
 7 Q. You did, though, meet with Dr. Banerjee in
 8 September of 2005?
 9 DR. FONTAINE:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. Why was it you -- how did you come to meet
 13 with him, what happened?
 14 DR. FONTAINE:
 15 A. He -- so he would have been given -- as part
 16 of his visit, he would have been given an
 17 itinerary and I had an hour meeting with him.
 18 COFFEY, Q.C.:
 19 Q. In your capacity as what?
 20 DR. FONTAINE:
 21 A. In capacity as site chief for the Health
 22 Sciences.
 23 COFFEY, Q.C.:
 24 Q. And do you recall what was discussed at the
 25 time?

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1 DR. FONTAINE:
 2 A. Oh, yes, we discussed a lot of the issues.
 3 What I actually asked was, so what were your
 4 findings, and then I just sort of compared to
 5 what I -- what my views were.
 6 COFFEY, Q.C.:
 7 Q. So what were you told at the time by him?
 8 DR. FONTAINE:
 9 A. That -- much like what's in his report, that
 10 fixation was an issue and that was identified.
 11 COFFEY, Q.C.:
 12 Q. If we could, please, Exhibit P-0046, please.
 13 Doctor, this is a letter of -- well, it begins
 14 -- the first page is a letter of October 17th,
 15 2005, to Dr. Cook. It's from Dr. Banerjee.
 16 It's a cover letter.
 17 DR. FONTAINE:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. That accompanied his report. Page two of the
 21 exhibit is the title page of the report,
 22 October 17th, 2005, and the report is only
 23 several pages long, the main body of the text.
 24 Doctor, in the report under -- he says,
 25 "Reviewed a number of cases from the

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

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1 that -- was this the sort of thing you
 2 discussed with him?
 3 DR. FONTAINE:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. Number three?
 7 DR. FONTAINE:
 8 A. Yes, well actually looking at it now, we did
 9 discuss the issue of internal controls as
 10 well.
 11 COFFEY, Q.C.:
 12 Q. Yes, which is the fourth one, "inadequate or
 13 no attention is being paid by the reporting
 14 pathologist to the status of internal
 15 controls, to the inappropriate exclusive
 16 reliance and external positive controls." I
 17 wanted to ask you, before I get to that,
 18 Doctor, the first two things, the fact that
 19 the DAKO system, in his view, it's unlikely
 20 that it was faulty and the Ventana being too
 21 sensitive, there was no evidence of that. Was
 22 that discussed with Dr. Banerjee, the fact
 23 that--he wasn't attributing it to machinery.
 24 DR. FONTAINE:
 25 A. No, that's right.

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1 COFFEY, Q.C.:
 2 Q. Had he let you know that?
 3 DR. FONTAINE:
 4 A. We did talk a bit about that because there was
 5 that question of is it a technical issue, is
 6 it really switching platforms, is that really
 7 the issue. And we sort of had discussions
 8 around that.
 9 COFFEY, Q.C.:
 10 Q. He conveyed to you what?
 11 DR. FONTAINE:
 12 A. He conveyed to me that it didn't seem to be
 13 the issue and I agreed, it didn't seem to be
 14 in my view either.
 15 COFFEY, Q.C.:
 16 Q. Now this reference to, number 3, "inadequate
 17 attention paid by the gross pathologist to the
 18 thickness of tissue slices."
 19 DR. FONTAINE:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. I take it that that relates to the whole idea
 23 of the grossing procedure.
 24 DR. FONTAINE:
 25 A. Correct.

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1 COFFEY, Q.C.:
 2 Q. And the lack of consistency or agreed
 3 approach.
 4 DR. FONTAINE:
 5 A. Correct.
 6 COFFEY, Q.C.:
 7 Q. Which you were trying to remedy with a written
 8 protocol?
 9 DR. FONTAINE:
 10 A. Trying.
 11 COFFEY, Q.C.:
 12 Q. Suggesting.
 13 DR. FONTAINE:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. In your meeting earlier in October, the
 17 meeting in October. The idea of trying to, as
 18 well, address the issue of fixation per se,
 19 because he goes on "quality and adequacy of
 20 fixation".
 21 DR. FONTAINE:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. As the site chief, so much as that part of the
 25 matter, quality and adequacy of fixation that

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1 occurred outside the lab.
 2 DR. FONTAINE:
 3 A. Before we received -
 4 COFFEY, Q.C.:
 5 Q. Yeah, before you ever got the tissue at all,
 6 how much influence as site chief would you
 7 have on that or could you have on it?
 8 DR. FONTAINE:
 9 A. That would be an issue I'd likely take up with
 10 Dr. Cook, that I would take it to the next
 11 level to have that discussion at that level.
 12 I'm not, again, it's a small hospital, but I
 13 don't have that much interaction with the OR
 14 staff. In other departments, there would be
 15 more, more likely that I would just contact
 16 that individual directly, but for an issue
 17 like this, I would look at it as a clinical
 18 chief.
 19 COFFEY, Q.C.:
 20 Q. Now, what is numbered here, four and six,
 21 because there is no number five here, I take
 22 it No. 6 referencing inappropriate choice of
 23 blocks with no representative normal ductal
 24 epithelium is just a way of saying that there
 25 is no -

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1 DR. FONTAINE:
 2 A. Internal control.
 3 COFFEY, Q.C.:
 4 Q. Internal control.
 5 DR. FONTAINE:
 6 A. Correct.
 7 COFFEY, Q.C.:
 8 Q. And four then deals with the matter of
 9 internal controls as well. Were you surprised
 10 by that at the time that Dr. Banerjee raised
 11 that with you, the fact that some of the
 12 slides he looked at had no normal tissue on
 13 and your practice in Halifax and here in St.
 14 John's when we looked at that '04 particular
 15 one I just happened to pull, the pathology
 16 report we looked at earlier.
 17 DR. FONTAINE:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. You were certainly aware of the importance of
 21 internal controls -
 22 DR. FONTAINE:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. Having the tissue and -

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

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

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1 very striking statement, again, considering
 2 the timelines.
 3 COFFEY, Q.C.:
 4 Q. Here, Doctor, in the first page of text of Dr.
 5 Banerjee's report is the beginning of a
 6 background, the incident problem case, he
 7 concludes that paragraph under the second
 8 heading "Four other patients previously tested
 9 in 2002 were also retested and all tested
 10 positive with the Ventana. This led to a
 11 review of other 57 cases reported in 2002 as
 12 negative which on retesting on the Ventana,
 13 resulted in a high conversion rate from
 14 negative to positive, 67 percent"--38 out of
 15 57, I'm sorry, 67 percent.
 16 DR. FONTAINE:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. So and again, I'm not suggesting necessarily
 20 that all the ones that did not have internal
 21 controls are 2002 cases.
 22 DR. FONTAINE:
 23 A. Right.
 24 COFFEY, Q.C.:
 25 Q. But certainly reading the report, it's

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1 apparent that perhaps a number of them were
 2 2002. Now in '02, by the time you left
 3 Halifax, the idea of using internal controls
 4 for ER and PR was well known, I mean, in your
 5 training.
 6 DR. FONTAINE:
 7 A. In my training, but again, remember this is
 8 Dr. Barnes -
 9 COFFEY, Q.C.:
 10 Q. The pathologist who may have trained before
 11 your time might not have been as aware -
 12 DR. FONTAINE:
 13 A. I wouldn't expect them to be aware of that
 14 issue, because again, Dr. Barnes was fresh
 15 from her fellowship training in Nottingham at
 16 the U.K, so I can't speak to what would have
 17 been the knowledge base prior to that, but I
 18 know coming in, I was quite fortunate in that
 19 sense to have had that experience.
 20 COFFEY, Q.C.:
 21 Q. Doctor, have you ever looked in textbooks as
 22 to, that would deal with this kind of subject
 23 matter and do they actually spell out that you
 24 should be using internal controls?
 25 DR. FONTAINE:

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1 A. There is, just as a general rule, if there's
 2 internal control available because it's not
 3 only specifically to breast, again it's
 4 prostrate, if there is a tissue that has it
 5 available, you're best to select a block that
 6 has internal control. So in this day and age,
 7 yes, I would expect, but again, leading up to
 8 my exam and reading textbooks at the time, it
 9 was not something that was commonly placed in
 10 textbooks at that day.
 11 COFFEY, Q.C.:
 12 Q. You were preparing for your exams, I take it,
 13 in -
 14 DR. FONTAINE:
 15 A. In 2002/2003. Again, it would be more in the
 16 journals, so again we expect, textbooks have a
 17 delay, so the textbooks of today would
 18 certainly have that information.
 19 COFFEY, Q.C.:
 20 Q. So the journals then, I take it, it would have
 21 been apparent in your days as a resident, in
 22 the journals, if somebody went to look to find
 23 out how to do this properly -
 24 DR. FONTAINE:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. You could easily enough figure it out as a
 3 pathologist?
 4 DR. FONTAINE:
 5 A. You could find it in--yes.
 6 COFFEY, Q.C.:
 7 Q. Exhibit P-0047 please? This is Patricia
 8 Wegrynowski's report, Doctor. Did you at the
 9 time as site chief receive a copy of this in
 10 November of '05?
 11 DR. FONTAINE:
 12 A. No.
 13 COFFEY, Q.C.:
 14 Q. Now, Doctor Banerjee's report, P-0046, did you
 15 see a copy of that in 2005?
 16 DR. FONTAINE:
 17 A. No.
 18 COFFEY, Q.C.:
 19 Q. Did you ever get read the contents of it?
 20 Were you ever told the contents of it?
 21 DR. FONTAINE:
 22 A. We were told the contents at a meeting with
 23 Dr. Cook, so there was a staff meeting where
 24 he read out the recommendations, but we were
 25 not allowed to actually look at the document

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1 per se.
 2 COFFEY, Q.C.:
 3 Q. Read the recommendations, did he read the
 4 actual body of the report as well?
 5 DR. FONTAINE:
 6 A. I can't remember specifically if I read--I was
 7 more concerned with the recommendations
 8 because I think that's what I remember more
 9 vividly.
 10 COFFEY, Q.C.:
 11 Q. Now, Doctor, do you recall when it was that
 12 Dr. Cook held that meeting?
 13 DR. FONTAINE:
 14 A. I can't say, no, for a specific--I know it
 15 would have been after I had met with Dr.
 16 Banerjee, obviously, but it was probably in
 17 the timeline of one or two months following.
 18 COFFEY, Q.C.:
 19 Q. Following Dr. Banerjee's visit?
 20 DR. FONTAINE:
 21 A. Yes or perhaps even longer.
 22 COFFEY, Q.C.:
 23 Q. What was the reaction--I take it this is with
 24 the Health Science's Centre pathologists?
 25 DR. FONTAINE:

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1 A. Correct.
 2 COFFEY, Q.C.:
 3 Q. What was the reaction?
 4 DR. FONTAINE:
 5 A. I think people were a bit concerned by the
 6 fact that it identified issues that could have
 7 been related to practice.
 8 COFFEY, Q.C.:
 9 Q. And what did they say about it, do you recall?
 10 DR. FONTAINE:
 11 A. Not specifically, what would you be looking
 12 for?
 13 COFFEY, Q.C.:
 14 Q. Well in the sense of, I'm just trying to get
 15 the Commissioner to get some sense of, if
 16 you're kind of told the results of what we see
 17 to be Banerjee's report -
 18 DR. FONTAINE:
 19 A. There was more silence, I guess, after the
 20 discussion, it was more of a silence, there
 21 weren't people shouting up and down, and
 22 saying oh no, that's not what it is. It was
 23 more of a silence and just sort of trying to
 24 take it all in.
 25 COFFEY, Q.C.:

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

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1 personal and professional toll" and you wish
 2 to concentrate your efforts on cytopathology
 3 and research and you're thinking at the time
 4 about relocating and you're going to give
 5 notice "I will resign my position as site
 6 chief as of the 1st of January and hope it
 7 doesn't place too much inconvenience on the
 8 department." So, Doctor, I take it that by
 9 the end of November that you were tired?
 10 DR. FONTAINE:
 11 A. I was getting a bit--essentially because I
 12 came into this not expecting what was going to
 13 fall on my lap, if you will, and again, the
 14 notion of pick your battles. There were a lot
 15 of issues that I was trying to move forward in
 16 cytopathology as well, so this wasn't in
 17 isolation. I was trying to acquire liquid
 18 based technology for the cytopathology lab, so
 19 and the research efforts were ongoing as well,
 20 so I just found that it was just better that
 21 somebody else take the lead in this situation.
 22 COFFEY, Q.C.:
 23 Q. What were the staffing levels from the time
 24 April 1, '05, you took over until the end of
 25 '05, when you were going to resign as site

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

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1 Cook, October 13th, 2005. The Commissioner
 2 has seen this before, I'm just wondering, were
 3 you given a copy of this?
 4 DR. FONTAINE:
 5 A. It's very familiar, I'm sure I have a copy of
 6 this.
 7 COFFEY, Q.C.:
 8 Q. And this would have been in your--you would
 9 have received this as site chief at the time?
 10 DR. FONTAINE:
 11 A. Yes, I would believe, yes.
 12 COFFEY, Q.C.:
 13 Q. Objective 1.2, "The objective of this proposal
 14 is to identify the requirements needed to
 15 implement a complex quality assurance program
 16 for the immunohistochemistry lab, ensuring
 17 that we provide a standardized and reliable
 18 service equivalent to the Mount Sinai
 19 reference lab in Toronto. I take it that the
 20 scope of this proposal includes a review of
 21 all the components of the IHC service, from
 22 grossing specimen to pathologist
 23 interpretation." So the idea, you would
 24 receive this as a report as to what they
 25 planned to do?

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1 DR. FONTAINE:
 2 A. Yes, correct.
 3 COFFEY, Q.C.:
 4 Q. Exhibit P-2334. Doctor, this is a memo of
 5 November 16th, 2005 from Maria Tracey, program
 6 director of the surgical program from
 7 yourself, as site chief. And policy regarding
 8 mastectomy specimens at Health Sciences Centre
 9 and you say "all mastectomy specimens must be
 10 placed in a large container, completely
 11 immersed in 10 percent formalin, the ideal
 12 volume of formalin to specimen is 10 to 1.
 13 And you talk then about what should be done
 14 about it, including the reference to cases
 15 should not be left overnight or on the weekend
 16 unsectioned.
 17 DR. FONTAINE:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. And what should happen if it happens outside
 21 regular hours. Why was it that you, why was
 22 it necessary to send this to Marie Tracey on
 23 November 16th, 2005?
 24 DR. FONTAINE:
 25 A. Again, if you think back to the exhibit with

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1 Dr. Cook's, it's more or less a mirror of this
 2 and this is more or less now a policy because
 3 where the other one was a letter, we sort of
 4 said, well, let's put this as a policy
 5 regarding this. So this is now our policy and
 6 there was a case where this happened and the
 7 pathologist on call was difficult to get a
 8 hold of and that's why you'll see, if you go
 9 back to the other exhibit, the--if this is
 10 still unsuccessful, the clinical chief of
 11 laboratory medicine, so that's a bit different
 12 than what the original, the way the original
 13 would have said the pathologist on call, so
 14 this was a bit more explicit directive for the
 15 surgical program in case they couldn't get
 16 hold of the on call pathologist.
 17 COFFEY, Q.C.:
 18 Q. So was there a policy then before this, a
 19 written policy or is this -
 20 DR. FONTAINE:
 21 A. The written policy would have been the letter
 22 that Dr. Cook would have sent to Maria Tracey.
 23 COFFEY, Q.C.:
 24 Q. Back in August.
 25 DR. FONTAINE:

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1 A. Whether it was--it didn't state that it was a
 2 policy, but it was a letter that was sent, so
 3 they would have been notified, but whether you
 4 want to call it a formal policy.
 5 COFFEY, Q.C.:
 6 Q. So here, Doctor, I take it then in mid
 7 November, was this done, sent by you at Dr.
 8 Cook's request or was this something you took
 9 upon yourself?
 10 DR. FONTAINE:
 11 A. I guess it would have been both in
 12 consultation with Dr. Cook, giving them
 13 directive as well, to make sure that we have,
 14 we've explicitly stated it's not enough to
 15 just call the pathologist on call and just
 16 say, well if they don't call back, what do you
 17 do? So now you try calling them at home and
 18 if that's unsuccessful, then you call the
 19 clinical chief.
 20 COFFEY, Q.C.:
 21 Q. So, Doctor, by the time--did you leave then at
 22 the end, as site chief, at the end of 2005?
 23 DR. FONTAINE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Did you ever subsequently take on the role of
 2 a site chief or the equivalent? I'm not
 3 suggesting you did, I'm just -
 4 DR. FONTAINE:
 5 A. No, I stayed away from that, I thought, well
 6 the first time I got into it, this broke, I
 7 thought, I don't want to get back into that.
 8 I was concentrating on cytopathology.
 9 COFFEY, Q.C.:
 10 Q. Now, Doctor, in the meantime then, by the time
 11 2005 ended, did you have any involvement that
 12 we haven't covered in relation to ER/PR that I
 13 haven't talked to you about?
 14 DR. FONTAINE:
 15 A. None that comes to mind. I mean, my role was
 16 more or less as site chief, I wrote a couple
 17 of letters from that end, but I saw that the
 18 lion's share, the decisions being made were
 19 coming from Drs. Cook and Carter, from the
 20 pathology aspect.
 21 COFFEY, Q.C.:
 22 Q. Now here, if we could please, Exhibit P-2044?
 23 Just before I, I don't forget to ask you about
 24 it, I'll ask you now. Doctor, the
 25 Commissioner has heard a fair amount of

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1 evidence about communication with patients and
 2 you know, with the timing of it and what
 3 should or shouldn't be done. Were you ever
 4 consulted about that?
 5 DR. FONTAINE:
 6 A. No.
 7 COFFEY, Q.C.:
 8 Q. And I take it, I'm asking in the context as
 9 site chief.
 10 DR. FONTAINE:
 11 A. No, that's correct, no.
 12 COFFEY, Q.C.:
 13 Q. Did you ever offer an opinion on it?
 14 DR. FONTAINE:
 15 A. No.
 16 COFFEY, Q.C.:
 17 Q. Here, Doctor, P-2044, February 1st, 2006 memo
 18 from Dr. Cook, it's to a number of
 19 individuals, including yourself.
 20 DR. FONTAINE:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. Now these other individuals are in the main,
 24 the site chiefs, as it were, for pathology.
 25 DR. FONTAINE:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. Or the equivalent title, other than Dr.
 4 Williams throughout the province. It's ER/PR
 5 reports from Mount Sinai and he says, "We have
 6 received most of the reports from Mount Sinai
 7 regarding ER/PR review process" and he talks
 8 about them being on Excel spreadsheets and
 9 the fact that he's going to prepare individual
 10 reports, that is Dr. Cook is. Why were you
 11 sent this, do you know?
 12 DR. FONTAINE:
 13 A. I don't know, I think it was just for
 14 completion, but I actually never received any
 15 reports or, like the results on Excel
 16 spreadsheets, so I think it was just more for
 17 completion.
 18 COFFEY, Q.C.:
 19 Q. So do you know when you were replaced as site
 20 chief, I understood you resigned as of the end
 21 -
 22 DR. FONTAINE:
 23 A. That's right.
 24 COFFEY, Q.C.:
 25 Q. Do you know who replaced you and if so, when?

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1 DR. FONTAINE:
 2 A. Dr. Morris-Larkin and it would have been
 3 shortly around the time of January 1st, I
 4 believe was the date. Again, it was a fairly
 5 loose timeline, but I can't remember
 6 specifically if the transition went for
 7 February 1st, but again, to speak to this
 8 issue here, that would have been something
 9 that I don't expect we would have seen.
 10 Anyways, I'd be surprised if my predecessor--
 11 or my successor would have received that. I'm
 12 not sure, but I can't speak--it's Dr. Morris
 13 Larkin.
 14 COFFEY, Q.C.:
 15 Q. Okay, and you would have understood--you
 16 understood at the time this was kind of being
 17 sent to you bearing in mind the names of the
 18 other individuals because you had been site
 19 chief at -
 20 DR. FONTAINE:
 21 A. Correct.
 22 COFFEY, Q.C.:
 23 Q. - at the earlier time.
 24 DR. FONTAINE:
 25 A. At the time, exactly.

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1 COFFEY, Q.C.:

2 Q. At the time did you see that you had any

3 responsibility arising out of this from your

4 perspective?

5 DR. FONTAINE:

6 A. No, I mean, I think because it fell--that

7 would have been already taken care of at our

8 institution.

9 COFFEY, Q.C.:

10 Q. Exhibit P-1748 please? Doctor, these are

11 handwritten notes, I believe of Dr. Cook,

12 February 8th, 2006. It's a meeting at the

13 Health Sciences Centre, meeting regarding

14 update and implementation of ER and PR.

15 Present are Drs. Cook, Ejeckam, Carter and

16 Fontaine, Mr. Gulliver, Mr. Dyer, Mr. Simms,

17 Ken Green and Mary Butler. Do you recall

18 attending this meeting and if so, why you were

19 there? This is February 8th.

20 DR. FONTAINE:

21 A. I'm trying to think of, because at this time--

22 yeah, because I was on my way out at this

23 point.

24 COFFEY, Q.C.:

25 Q. It says "Meeting started with both Ken Green

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1 and Mary giving written reports of their

2 experiences in Mount Sinai, Mary, that is, and

3 in Montreal, Jewish General, Ken. Ken brought

4 back information from Montreal and types of

5 antibodies used and protocols." Then it goes

6 on some length about that and it says "Drs.

7 Carter and Ejeckam commented on the staining

8 for ERs and PRs seem to be good correlations

9 and reproducibility with ER results in

10 comparison with Mount Sinai, less so for PR.

11 All agreed that implementation date of March

12 31, 2006 seems feasible. General discussion

13 followed, including the prospect of bringing

14 in digital microscopy with image analysis."

15 And it goes on from there. Do you recall why

16 it was that you were at this meeting?

17 DR. FONTAINE:

18 A. I don't specifically remember this meeting, to

19 tell you the truth.

20 COFFEY, Q.C.:

21 Q. And again I'm only assuming you were there

22 because you were listed.

23 DR. FONTAINE:

24 A. Right.

25 COFFEY, Q.C.:

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1 Q. That doesn't necessarily mean --

2 DR. FONTAINE:

3 A. I don't actually remember being at this

4 meeting. I've been at meetings where some of

5 these issues were discussed, but I don't

6 remember these individuals at a meeting with

7 myself.

8 COFFEY, Q.C.:

9 Q. And by this point in time, that is early

10 February, 2006, you know, what if any

11 involvement did you have then in your

12 professional role with this aspect of the

13 matter?

14 DR. FONTAINE:

15 A. Again just thinking back -- because my

16 resignation came in --

17 COFFEY, Q.C.:

18 Q. Well, it says your resignation came -- you

19 planned to resign effective the end of the

20 year.

21 DR. FONTAINE:

22 A. The end of the year, yes.

23 COFFEY, Q.C.:

24 Q. Now whether you did or not that's --

25 DR. FONTAINE:

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1 A. Because I did put my resignation on for

2 February.

3 COFFEY, Q.C.:

4 Q. So it's possible that this is just really a

5 carry over?

6 DR. FONTAINE:

7 A. Yes, quite possible, because I know I did get

8 to a point where I had decided that I was

9 going to be leaving and that was in February

10 where I would no longer be in the employment

11 of Eastern Health. I don't remember this

12 meeting specifically, no.

13 COFFEY, Q.C.:

14 Q. Exhibit P-1590. Doctor, it's a fax coversheet

15 of the attached memo to Drs. Fontaine,

16 Ejeckam, Mr. Gulliver and Mr. Dyer, from

17 Dr. Cook, March 6th, 2006, implementation of

18 new immunohistochemical antibodies, "All new

19 antibodies that are requested by pathologists

20 for immunoperoxidase service have to be

21 approved by the chief pathologist overseeing

22 immunohistochemistry. No new antibodies will

23 enter the system until they're signed off on

24 the protocol form by the pathologist

25 overseeing the IHC service". So, Doctor, do

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1 you know if -- even why you were sent this; if
 2 you did receive it, why?
 3 DR. FONTAINE:
 4 A. It doesn't strike me any -- I mean, it's not
 5 one that I would have been particularly
 6 overwhelmed with, but I don't know if I --
 7 because for a period of time again, I did take
 8 over as the director for immunohistochemistry
 9 as well.
 10 COFFEY, Q.C.:
 11 Q. Now it's around this time, this is in March of
 12 '06 that Dr. Ejeckam is planning on leaving?
 13 DR. FONTAINE:
 14 A. Right.
 15 COFFEY, Q.C.:
 16 Q. He's going to leave in April of '06.
 17 DR. FONTAINE:
 18 A. Okay.
 19 COFFEY, Q.C.:
 20 Q. So when did you get involved then in terms of
 21 being director of immunohistochemistry?
 22 DR. FONTAINE:
 23 A. When Dr. Ejeckam left, that's when I sort of
 24 stepped in, if you will.
 25 COFFEY, Q.C.:

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1 Q. And in leaving as site chief, were you ever
 2 asked to create a job description?
 3 DR. FONTAINE:
 4 A. No.
 5 COFFEY, Q.C.:
 6 Q. Now, Doctor, if we could, please, Exhibit P-
 7 2068. Doctor, these are minutes of Discipline
 8 Laboratory Medicine meeting of March 28th,
 9 2006. There are a number of people in
 10 attendance, including yourself listed there,
 11 and under "New business - Quality Assurance",
 12 there's a reference to Dr. Denic having
 13 thanked Dr. Cook for all his work and
 14 implementation of the new quality assurance
 15 program was discussed at length, and Dr.
 16 Beverley Carter will act as manager, and it
 17 goes on from there to talk about that. Why
 18 would you have been attending this?
 19 DR. FONTAINE:
 20 A. Now that I think about it, because I probably
 21 only served resignation in April. The more I'm
 22 thinking about this now, when I actually left
 23 the position, because the timelines are
 24 somewhat blurry for me, but that would be my
 25 recollection now, looking at it that I'm

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1 staying on this long because this timeline is
 2 quite different than what I remember. Again
 3 the years have become a bit blurred, if you
 4 will.
 5 COMMISSIONER:
 6 Q. So are you saying you were still acting as
 7 site chief?
 8 DR. FONTAINE:
 9 A. I think I was still acting as site chief in
 10 this capacity, yes, yes, because I think when
 11 -- looking at it now, I believe that it would
 12 have been around April because whether there
 13 was a replacement forthcoming, I can't speak
 14 to you specifically, but it looks like that I
 15 would still have been in that position.
 16 COFFEY, Q.C.:
 17 Q. So, Doctor, I take it then it's in that
 18 capacity then that you would have been
 19 attending this meeting?
 20 DR. FONTAINE:
 21 A. I believe so, yes.
 22 COFFEY, Q.C.:
 23 Q. Now the initiative here, this QA initiative
 24 that Dr. Carter is going to head up, I take it
 25 that that had -- had that been going on for

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1 some period of time before this?
 2 DR. FONTAINE:
 3 A. There was a lot of discussion as to that being
 4 brought to fruition.
 5 COFFEY, Q.C.:
 6 Q. How far had it advanced, do you know?
 7 DR. FONTAINE:
 8 A. So far as to have Dr. Carter being the
 9 manager. So this was -- this was now going to
 10 happen.
 11 COFFEY, Q.C.:
 12 Q. If we could, please, Exhibit P-2076.
 13 COMMISSIONER:
 14 Q. Mr. Coffey, when you find a spot.
 15 COFFEY, Q.C.:
 16 Q. Yes. Now this is a letter of April 24th,
 17 2006. It's from Dr. Denic to Dr. Elms
 18 regarding his appointment of Assistant
 19 Director of Immunohistochemistry Department,
 20 St. John's Hospitals, Eastern Health, and Dr.
 21 Denic, as clinical chief says it gives him
 22 great pleasure to appoint Dr. Elms as
 23 Assistant Director of Immunohistochemistry
 24 Department. He continues on, "Along with Dr.
 25 Dan Fontaine, Director of Immunohistochemistry

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1 Department, you will take on and assume
 2 responsibility for the services provided with
 3 a goal of achieving excellence in the field of
 4 immunohistochemistry" and this happens to be
 5 copied to Drs. Williams, Fontaine, Carter, and
 6 Mr. Gulliver. So that when Dr. Elms came on
 7 as assistant director, you were already --
 8 DR. FONTAINE:
 9 A. Right, after Dr. Ejeckam had left, I was -- I
 10 had gained that appointment as well.
 11 COFFEY, Q.C.:
 12 Q. Now, Doctor, you remained as Director of
 13 Immunohistochemistry for how long?
 14 DR. FONTAINE:
 15 A. Not very long, because I know as Dr. Elms came
 16 on stream, I was fairly quick releasing myself
 17 from that role.
 18 COFFEY, Q.C.:
 19 Q. And at the time -- I mean, how long would you
 20 have been, do you think, director?
 21 DR. FONTAINE:
 22 A. It would have been from the time that Dr.
 23 Ejeckam would have resigned -- sorry, retired?
 24 COFFEY, Q.C.:
 25 Q. Retired.

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1 DR. FONTAINE:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Which we understand is April certainly of 2006
 5 he was gone. He left during that month. So
 6 you would have remained, though, as director
 7 for about how long?
 8 DR. FONTAINE:
 9 A. What's the date on --
 10 COFFEY, Q.C.:
 11 Q. That's April 24th, 2006.
 12 DR. FONTAINE:
 13 A. It would be fairly short order. I would say
 14 within that next month.
 15 COFFEY, Q.C.:
 16 Q. So then as director what, if any, involvement
 17 did you have in the IHC service in a practical
 18 way during that short period of time you were
 19 the director?
 20 DR. FONTAINE:
 21 A. Again trying to optimize and serving as a
 22 point person, optimizing antibodies as they
 23 came on stream. Should a new antibody become
 24 available, it would be to work that antibody
 25 up to make it optimized.

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1 COFFEY, Q.C.:
 2 Q. And if you could, just before we finish then,
 3 that involved what?
 4 DR. FONTAINE:
 5 A. Essentially working with the technologists to
 6 look at different concentrations, antigen
 7 retrieval times, different parameters with the
 8 immunohistochemistry for development of
 9 protocol that we could use to optimize the
 10 antibody.
 11 COFFEY, Q.C.:
 12 Q. Now did you -- had you had any actual training
 13 in a technological sense, formal training
 14 involving IHC?
 15 DR. FONTAINE:
 16 A. Not beyond --
 17 COFFEY, Q.C.:
 18 Q. Other than what you've already told us about?
 19 DR. FONTAINE:
 20 A. Not beyond what I've already told you about,
 21 the academic or the -- in my residency.
 22 COFFEY, Q.C.:
 23 Q. And tomorrow morning, Commissioner, I will not
 24 be long. Thank you.
 25 UPON CONCLUSION

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1 CERTIFICATE
 2 I, Judy Moss, hereby certify that the foregoing is
 3 a true and correct transcript in the matter of the
 4 Commission of Inquiry on Hormone Receptor Testing,
 5 heard on the 17th day of July, A.D., 2008 before
 6 the Honourable Justice Margaret A. Cameron,
 7 Commissioner, at the Commission of Inquiry, St.
 8 John's, Newfoundland and Labrador and was
 9 transcribed by me to the best of my ability by
 10 means of a sound apparatus.
 11 Dated at St. John's, Newfoundland and Labrador
 12 this 17th day of July, A.D., 2008
 13 Judy Moss

Inquiry on Hormone Receptor Testing

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Inquiry on Hormone Receptor Testing

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