COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

MARCH 25, 2008

Appearances:

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

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

Rolf Pritchard .... Her Majesty in Right of NL

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

Chesley Crosbie, Q.C. .... Members of the Breast Cancer
.... Testing Class Action
Ms. Darlene Russell .... Co-counsel

Jennifer Newbury ..... Canadian Cancer Society (NL Division)

David Eaton, Q.C. .... Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

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1 THE COMMISSIONER:
2 Q. Good morning. Please be seated. Mr. Coffey?
3 COFFEY, Q.C.:
4 Q. Thank you. Commissioner, the next witness is
5 Dr. Robert Deane.
6 THE COMMISSIONER:
7 Q. Swear the witness, please?
8 DR. ROBERT DEANE (SWORN) EXAMINATION BY BERNARD COFFEY,
9 Q.C.
10 REGISTRAR:
11 Q. Would you please state and spell your complete
12 name for the Commission?
13 DR. DEANE:
14 A. Dr. Robert Deane, D-E-A-N-E.
15 REGISTRAR:
16 Q. Thank you, sir.
17 COFFEY, Q.C.:
18 Q. Thank you. Good morning, Doctor. Doctor, can
19 you tell us, please, where you're from?
20 DR. DEANE:
21 A. I'm originally from South Africa.
22 COFFEY, Q.C.:
23 Q. And you're a physician?
24 DR. DEANE:
25 A. Yes.

1 COFFEY, Q.C.:
2 Q. Could you tell us, please, what type of
3 physician you are?
4 DR. DEANE:
5 A. I'm a paediatric orthopaedic surgeon at the
6 Janeway Hospital.
7 COFFEY, Q.C.:
8 Q. And how long have you been at--how long have
9 you been with the Janeway Hospital?
10 DR. DEANE:
11 A. About 20 years.
12 COFFEY, Q.C.:
13 Q. And could you tell us, please, I take it then
14 that you were at the Janeway Hospital when it
15 was on the old Janeway site?
16 DR. DEANE:
17 A. Yes, indeed.
18 COFFEY, Q.C.:
19 Q. In the extreme east end of St. John's and
20 followed the Janeway to the General Hospital
21 site?
22 DR. DEANE:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Doctor, I understand at one time you were

1 married?
2 DR. DEANE:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. And what was your wife's name?
6 DR. DEANE:
7 A. Peggy.
8 COFFEY, Q.C.:
9 Q. That was Margaret Peggy Deane?
10 DR. DEANE:
11 A. Well, they called her Peggy.
12 COFFEY, Q.C.:
13 Q. Peggy, yes.
14 DR. DEANE:
15 A. Short for Margaret, yeah.
16 COFFEY, Q.C.:
17 Q. And how long were you married?
18 DR. DEANE:
19 A. We were married in '92.
20 COFFEY, Q.C.:
21 Q. And what was Peggy's occupation?
22 DR. DEANE:
23 A. She was a nurse in the emergency department at
24 the Janeway and she was there until our son
25 was born and then she took a part-time job in

1 the x-ray department.
2 COFFEY, Q.C.:
3 Q. And approximately when was that?
4 DR. DEANE:
5 A. That was in '98.
6 COFFEY, Q.C.:
7 Q. Now I understand that--I will refer to her as
8 Peggy, if I might?
9 DR. DEANE:
10 A. Sure.
11 COFFEY, Q.C.:
12 Q. I understand that Peggy developed breast
13 cancer?
14 DR. DEANE:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Could you tell us, please, about what you
18 recall about that?
19 DR. DEANE:
20 A. She had a lump in her breast and she went for
21 an ultrasound, it was actually repeat
22 ultrasound and it looked rather suspicious for
23 malignancy, so they biopsied it.
24 COFFEY, Q.C.:
25 Q. Do you recall what year that was?

1 DR. DEANE:
2 A. It was 2002.
3 COFFEY, Q.C.:
4 Q. And so there was a biopsy done. You can go
5 ahead.
6 DR. DEANE:
7 A. It was a needle biopsy and that biopsy
8 actually suggested it was probably carcinoma.
9 And in fact, ductal carcinoma was that biopsy,
10 which was subsequently changed. Following
11 that, of course, they did an open biopsy and
12 took out a lump which was actually a little
13 larger than we thought it was, it was about
14 three centimetres. And that confirmed the
15 diagnosis of carcinoma, but that showed
16 lobular carcinoma.
17 COFFEY, Q.C.:
18 Q. And what happened then in terms of her
19 treatment?
20 DR. DEANE:
21 A. Well, she had a mastectomy and they did a node
22 dissection. The nodes appeared to be
23 uninvolved, but microscopically it was shown
24 that three of the nodes, in fact, were
25 involved and had tumor spread to them.

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1 Following that they did a CT scan to see if
2 there was tumor elsewhere and they found a 1.2
3 centimetre lesion in her liver. Now, this was
4 biopsied and it was confirmed that this was
5 metastatic carcinoma, as well.
6 COFFEY, Q.C.:
7 Q. Then what happened in terms of her treatment?
8 DR. DEANE:
9 A. Well, she was started on her treatment. She
10 was started on the FAC, which is the sort of
11 standard initial three chemotherapeutic agents
12 that they use for breast cancer, and she was
13 on these until she could no longer tolerate
14 them.
15 COFFEY, Q.C.:
16 Q. I take it you have records -
17 DR. DEANE:
18 A. I've got a little bit of a chronology of the
19 events so that it makes it easier for me to
20 remember the dates of the exact treatments
21 because these ingredients, these medications
22 all have rather complicated long names that I
23 don't necessarily recall all that well. But,
24 yes, they did the lumpectomy 21st of June, ' 02
25 and then they found invasive lobular

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1 carcinoma, three by 1.2 by one centimetres.
2 It was extensive. They didn't seen any
3 lymphatic invasion, but they did find nodes
4 involved, and as I'd already mentioned, the
5 lesion in the liver which was, she had a
6 needle biopsy done by a radiologist.
7 COFFEY, Q.C.:
8 Q. Now, sir, when your wife was initially
9 diagnosed, I take it that you and her, because
10 of her background as a nurse, did you do any
11 research at the time yourself?
12 DR. DEANE:
13 A. Well, we certainly read up on the disease and
14 the condition, yes.
15 COFFEY, Q.C.:
16 Q. Okay. And what -
17 DR. DEANE:
18 A. We were actually given a book by the cancer
19 centre, the H. Bliss Murphy Cancer Centre gave
20 us two little booklets on breast cancer, which
21 are, one was produced by the group in
22 Vancouver for patients to read, and I found
23 them very, very useful.
24 COFFEY, Q.C.:
25 Q. And what was your understanding after your

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1 initial education, you know, in -
2 DR. DEANE:
3 A. Well, she had stage 4 breast cancer and the
4 prognosis is dismal.
5 COFFEY, Q.C.:
6 Q. You've indicated that the initial line of
7 treatment after the surgery was, you
8 understood, FAC?
9 DR. DEANE:
10 A. Yes, FAC, and she was on that for five months.
11 She had eight cycles, which I think is the
12 standard. And she was responding. And in
13 fact, the small little lesion which was there,
14 we did a repeat CAT scan and it looked as if
15 it might have shrunk a little bit. It was
16 only a millimetre or so. So you know, it's
17 within margins of error, but it certainly
18 looked as if it was a little smaller. So it
19 looked as if the FAC had done something.
20 COFFEY, Q.C.:
21 Q. And that would be the lesion on her liver?
22 DR. DEANE:
23 A. That's the lesion on the liver, yes.
24 COFFEY, Q.C.:
25 Q. Who was Peggy's medical oncologist?

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1 DR. DEANE:
2 A. Dr. Kara Laing.
3 COFFEY, Q.C.:
4 Q. And so had you and Peggy known Dr. Kara Laing
5 before Peggy got ill?
6 DR. DEANE:
7 A. No.
8 COFFEY, Q.C.:
9 Q. Okay, so you met her after Peggy was
10 diagnosed?
11 DR. DEANE:
12 A. Yes, I just knew who she was and met her like
13 once or twice occasionally, socially, but not,
14 didn't really know her.
15 COFFEY, Q.C.:
16 Q. So after Peggy was diagnosed in the middle of
17 2002?
18 DR. DEANE:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. Yourself and Peggy would have met Dr. Laing
22 and this would be after the surgery, but it
23 would be Dr. Laing then who would have
24 discussed and prescribed the course of
25 treatment, the FAC?

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1 DR. DEANE:
2 A. Sure. Actually, the way it worked out during
3 the course of her treatment is Dr. Laing went
4 on maternity leave and then Dr. Joy McCarthy
5 took over. And I don't know whether this was
6 by design or just by happen stances, but one,
7 Dr. Laing had her child and then came back and
8 then Joy had her child and came back. And
9 they just planned it exactly right that the
10 one finished on maternity leave when the other
11 one went and had her baby, so it worked out
12 very well. So the two of them sort of
13 interdigitated or whatever the word is,
14 overlapped.
15 COFFEY, Q.C.:
16 Q. And handled Peggy's treatment?
17 DR. DEANE:
18 A. They handled Peggy's treatment, yes.
19 COFFEY, Q.C.:
20 Q. You've indicated that Peggy had the FAC
21 treatment for, your understanding is for about
22 five months?
23 DR. DEANE:
24 A. Yes, five months, which was eight cycles,
25 yeah.

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1 COFFEY, Q.C.:
2 Q. And you say you had a PET scan done in
3 Hamilton?
4 DR. DEANE:
5 A. Yes, we wanted to know if this lesion was
6 active or not. I mean, you see something on a
7 CAT scan, you don't know if it's actually, if
8 there's any metabolic activity there, whether
9 it's alive or if it's just a dead nodule. And
10 the PET scan, the intent was to answer that
11 question. So, we went off to Hamilton and had
12 the PET scan and that showed no activity. But
13 the radiologist that performed the PET scan
14 warned us that lobular carcinoma doesn't
15 always show up as active. It's actually a
16 rather nasty form of breast cancer because it
17 doesn't show on mammograms and it doesn't show
18 on ultrasound. So it kind of slips through
19 the net. And it also doesn't show on PET
20 scan.
21 So anyway, she had the PET scan, it
22 showed no activity, so we thought, well,
23 that's a very encouraging sign. But
24 unfortunately, three months later the repeat
25 CT scan showed this lesion to be about 17

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1 millimetres in diameter, so clearly it was
2 growing and the PET scan was, in fact,
3 misleading, which is what we'd been warned.
4 COFFEY, Q.C.:
5 Q. And then what happened?
6 DR. DEANE:
7 A. Well, she carried on with her chemo, of
8 course, all along. Yeah, we had the PET scan
9 in '03, January. We also asked about radio
10 frequency ablation, but breast cancer is a
11 systemic disease, really, once it's spread,
12 it's microscopic lesions throughout the body
13 and ablating a single lesion really is
14 pointless because there are other lesions
15 elsewhere. And they said it's not
16 appropriate. They put a small radio frequency
17 down under ultrasound into the centre of the
18 lesion in the liver and then the intense heat
19 and vibration generated by the radio frequency
20 probe will destroy the lesion. So it's a nice
21 neat little way to just get at that single
22 lesion and destroy it. And at the time it
23 seemed like an attractive option and we--this
24 is part of our research. But I'm an
25 orthopaedic surgeon and it soon became obvious

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1 to me that my knowledge of how to treat cancer
2 is rudimentary. And we investigated that
3 option.
4 COFFEY, Q.C.:
5 Q. Yes.
6 DR. DEANE:
7 A. We thought about having it done at Toronto,
8 but we were told it was--it made no sense, it
9 was not going to be a good, good option. So
10 that was bit of a disappointment, but anyway,
11 we carried on. By May there was an increased
12 number of liver metastases and then she put
13 her on Taxane and Capecitabine, and that was
14 started. And that was awful stuff.
15 COFFEY, Q.C.:
16 Q. What was the effect on Peggy?
17 DR. DEANE:
18 A. Oh, she had many of these. She started to
19 really bad reaction, she was--of course, she
20 lost her hair, she really lost that from the
21 previous chemo. She lost her sense of taste;
22 she couldn't taste any food. And she enjoyed
23 a good meal, so she couldn't taste anything,
24 you know. And, oh, she had to dip her fingers
25 in ice, little bowls of ice during the chemo

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1 because of the burning sensation. She just
2 felt tired, exhausted, run down. And it
3 affected her mood, as well, as you'd expect.
4 COFFEY, Q.C.:
5 Q. Yes.
6 DR. DEANE:
7 A. So it was dreadful stuff. You know, even
8 though she reacted badly, she wanted to
9 continue with that. And then the disease
10 started to spread. And in August she had
11 radiotherapy to her spine when the disease has
12 spread to the spine. The liver mets,
13 metastases seemed to be improving a little bit
14 in October. And she was on Taxatine and she
15 reacted really badly in October, so they
16 stopped it. Would you like me to carry on?
17 COFFEY, Q.C.:
18 Q. Before you do, so we're now well into '03,
19 really, into the fall?
20 DR. DEANE:
21 A. Yeah, middle of '03.
22 COFFEY, Q.C.:
23 Q. Middle of '03?
24 DR. DEANE:
25 A. Fall of '03, yeah.

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1 COFFEY, Q.C.:
2 Q. Now up to this point in time, which is about a
3 year?
4 DR. DEANE:
5 A. Um-hm.
6 COFFEY, Q.C.:
7 Q. Just over a year since your wife's diagnosis.
8 Had her ER/PR status and the idea of using
9 Tamoxifen, had it ever come up during that
10 year?
11 DR. DEANE:
12 A. Not at that stage. I mean, we were told she
13 as ER negative and that, you know, Tamoxifen
14 wouldn't work, it's as simple as that. If
15 you're ER negative--I'd actually, I think it
16 was about in October when we were starting to
17 run out of options. You know, once you've had
18 several different forms of chemo and you're
19 starting to run out of options, I said, "Is it
20 worth trying?" And she said, "If she's ER
21 negative, it's pointless. You're just wasting
22 time because it's not going to work and you
23 could be getting something else." So and that
24 made sense.
25 COFFEY, Q.C.:

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1 Q. So you would have had this--Peggy had
2 undergone at least a number of different forms
3 of chemo?
4 DR. DEANE:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. None of them had worked.
8 DR. DEANE:
9 A. Well, they worked to varying degree.
10 COFFEY, Q.C.:
11 Q. Yes.
12 DR. DEANE:
13 A. But the side effects were so dreadful that we
14 had to stop them, yeah.
15 COFFEY, Q.C.:
16 Q. I withdraw that. Not that they hadn't worked,
17 but they could not be continued with?
18 DR. DEANE:
19 A. That's, yes, yes.
20 COFFEY, Q.C.:
21 Q. And you raised the issue of potentially trying
22 Tamoxifen, you would have raised that with Dr.
23 Laing or Dr. McCarthy or one of the two?
24 DR. DEANE:
25 A. Yeah, it was at about the time I said, "Would

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1 you be offended if we went to another centre
2 for another opinion?" And Dr. Laing actually
3 welcomed it, she said, "Absolutely."
4 COFFEY, Q.C.:
5 Q. So the issue of Tamoxifen, though, you would
6 have raised it with one of the two
7 oncologists?
8 DR. DEANE:
9 A. I don't know whether I first--we went to see
10 Dr. Maureen Trudeau.
11 COFFEY, Q.C.:
12 Q. Okay.
13 DR. DEANE:
14 A. Who is actually, well, she is the breast
15 cancer, the best in Canada and she's a world
16 authority. She's recognized worldwide as a
17 real expert on breast cancer. She's as good
18 as you'll get. And we went to see her to see
19 if there was any additional treatment. And I
20 might have raised the issue of Tamoxifen with
21 her and got the same answer that I got from
22 Dr. Laing, that it doesn't--if they're
23 estrogen receptor negative, it's not going to
24 do anything.
25 COFFEY, Q.C.:

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1 Q. Okay. So the idea, though, of using,
2 potentially trying Tamoxifen certainly crossed
3 your mind at one point through -
4 DR. DEANE:
5 A. Well, I guess when you start to get a little
6 desperate, you'll try anything.
7 COFFEY, Q.C.:
8 Q. Yes. And the explanations that you were given
9 for not, or the explanation you were given for
10 not doing it because she was ER negative?
11 DR. DEANE:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Made sense to you, so.
15 DR. DEANE:
16 A. Well, it seems to be the standard thinking,
17 and it's not--I didn't think it was
18 controversial. I mean, you know, some areas
19 of medicine are controversial, but this seemed
20 to be fairly clear cut. And especially if
21 we'd heard it from Dr. Maureen Trudeau and
22 from Dr. Laing and Dr. McCarthy, well, there
23 is it.
24 COFFEY, Q.C.:
25 Q. There it is.

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1 DR. DEANE:
2 A. Who am I to argue?
3 COFFEY, Q.C.:
4 Q. Doctor, you've referred to the fact that Peggy
5 did consult with Margaret (sic.) Trudeau?
6 DR. DEANE:
7 A. Yes.
8 UNKNOWN SPEAKER:
9 Q. Maureen Trudeau.
10 DR. DEANE:
11 A. Maureen Trudeau, yes.
12 COFFEY, Q.C.:
13 Q. Maureen Trudeau, sorry -
14 DR. DEANE:
15 A. Sorry, did I say Margaret? Margaret, we're
16 getting--yes, yes.
17 COFFEY, Q.C.:
18 Q. It's the Ms fool me up. It's Maureen Trudeau.
19 DR. DEANE:
20 A. Maureen, yes.
21 COFFEY, Q.C.:
22 Q. Maureen Trudeau.
23 DR. DEANE:
24 A. I might have said Margaret, I can't -
25 THE COMMISSIONER:

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1 Q. No, I think you did say Maureen.
2 DR. DEANE:
3 A. Thank you.
4 COFFEY, Q.C.:
5 Q. Maureen, you got it right, Doctor. Doctor, do
6 you recall when that was?
7 DR. DEANE:
8 A. November of '03, Sunnybrook Regional Cancer
9 Centre, Toronto.
10 COFFEY, Q.C.:
11 Q. So as you indicated, it's about a year, just
12 beyond -
13 DR. DEANE:
14 A. Just over a year post diagnosis, yeah. And it
15 was shortly after this that Kara Laing went on
16 maternity leave and Dr. Joy McCarthy came off
17 maternity leave, perfectly timed. And
18 actually, Dr. Trudeau, I must say, did an
19 extremely thorough job. She was aware of the
20 pathology, she knew she had lobular carcinoma
21 and she was also aware of the receptor status,
22 which is worthy of note.
23 COFFEY, Q.C.:
24 Q. And I take it with hindsight it's worthy of
25 note now?

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1 DR. DEANE:
2 A. Yes, very much so, yeah. You know, I think it
3 needs to be pointed out to the Commission that
4 Dr. Trudeau, Dr. Laing, Dr. McCarthy all, you
5 know, were aware of this and it was obviously
6 it didn't jump out at them that there was an
7 issue.
8 COFFEY, Q.C.:
9 Q. And that is the fact that your wife had been
10 diagnosed with lobular, invasive lobular
11 carcinoma?
12 DR. DEANE:
13 A. Yeah.
14 COFFEY, Q.C.:
15 Q. And yet her status, ER status was negative?
16 DR. DEANE:
17 A. Was negative.
18 COFFEY, Q.C.:
19 Q. Right. And -
20 DR. DEANE:
21 A. And it is actually not just Dr. Trudeau, we
22 saw several people. There were two fellows
23 that saw us and then Dr. Trudeau, so.
24 COFFEY, Q.C.:
25 Q. That would be in Sunnybrook?

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1 DR. DEANE:
2 A. In Sunnybrook.
3 COFFEY, Q.C.:
4 Q. Yes.
5 DR. DEANE:
6 A. They spent a couple of hours going over her
7 case and they went through her chart very
8 thoroughly.
9 COFFEY, Q.C.:
10 Q. And the significance of that will become
11 apparent a little bit later in the morning,
12 Commissioner. So yourself and Peggy had
13 visited Sunnybrook?
14 DR. DEANE:
15 A. Um-hm.
16 COFFEY, Q.C.:
17 Q. Maureen Trudeau. What do you recall about
18 what advice, if any, Dr. Trudeau had?
19 DR. DEANE:
20 A. Well, she commended Dr. Laing. She said,
21 "She's done exactly what I would do. She's
22 done--our treatment would be absolutely no
23 different than what you've had in St. John's."
24 And said basically, "I've got nothing to add.
25 Unfortunately, I can't recommend any

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1 additional treatment to chemo. What you've
2 got is what I would have done. And nice to
3 have met you, but I'm afraid we can't offer
4 you anything additional."
5 COFFEY, Q.C.:
6 Q. Okay. So you then returned to St. John's?
7 DR. DEANE:
8 A. Yeah.
9 COFFEY, Q.C.:
10 Q. And then how did Peggy's treatment progress
11 from there?
12 DR. DEANE:
13 A. I'm sure, as you know, with cancer it's just,
14 it's just bad news after bad news after bad
15 news. She went on to Xeloda, which was a nice
16 little reprieve, and I think it was about
17 this time, it was Peggy's--one of the nurses
18 in the cancer centre said, "This is Peggy's
19 drug," and sure it was, because the disease
20 became static. And that gave her about eight
21 or nine months. She was--had few side
22 effects. Her whole demeanour and energy level
23 and mood picked up. She didn't have any pain.
24 The tumor didn't grow. It was wonderful. It
25 was a great little reprieve and that lasted

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1 and it was fantastic. But unfortunately, with
2 all these chemo agents, they only last for a
3 certain period of time and then those few
4 resistant cells that were just a tiny little
5 spec gradually grow and you know, they kicked
6 in and the tumor started to grow again. And
7 it was about this point when we were starting
8 to run out of options. They put her on one
9 other medication and--yes, she had a
10 reasonable quality of life during '04. That
11 was they started the Xeloda at the end of '03,
12 and that was, that was good. And
13 unfortunately, it started to spread. It then
14 spread to the peritoneal cavity and the lungs.
15 And I remember she had lesions in the lungs.
16 And we went over to Corner Brook. She was a
17 very tough lady and very determined. We were
18 in the hotel and we were lying in bed and I
19 could hear this fluid sloshing around as she
20 turned over in her sleep. I said, "Peggy, you
21 got fluid in your lungs. We got to go and get
22 an x-ray." She said, "I'm not being x-rayed
23 in Corner Brook. I want to go home." She
24 drove home knowing there was fluid in her
25 lungs, all the way from Corner Brook. She

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1 wouldn't fly, she wanted to be with her
2 family. She was very--it was very important
3 to her. We got to St. John's, it was almost
4 two litres of fluid in her left lung. We
5 drained it out and, of course, she felt, it
6 felt a lot better, a lot more energy. And we
7 tried a different chemo. And at that point we
8 had been on a trip, just the two of us, we
9 left the kids behind, we'd been on a trip to
10 New York, and at the hotel we were staying in
11 in New York--Peggy wanted to get the most out
12 of life before she passed away. She wanted to
13 live life to the full. Said, "Let's go to New
14 York." I said, "Fine. Why not? That's what
15 you want." And we met this--there was a
16 cancer conference on and I was going down the
17 elevator and I noticed on someone's name tag--
18 Peggy wasn't with me, she was actually quite,
19 quite exhausted as we'd been out for the
20 morning and she was lying down for the
21 afternoon. And the name tag was a lady's
22 name, Sloan-Kettering Institute, which is the
23 world's, probably the world's most
24 prestigious, that and the Mayo Clinic, it's
25 certainly up there, Cancer Centre. And

1 Sunnybrook is also up there; don't get me
2 wrong. And she was a breast cancer
3 specialist, so I kind of cornered her and
4 said, "Look, my wife's got breast cancer. Do
5 you have anything there that's experimental or
6 new on the horizon? We don't mind travelling
7 down here if there's anything out there." She
8 mentioned one or two trials that were going
9 on, I said, "Well, we'd like to partake."
10 Anyway, I got back and I thought, I'd better
11 share this with Dr. Kara Laing.
12 COFFEY, Q.C.:
13 Q. This is back to St. John's?
14 DR. DEANE:
15 A. Yes. You know, I didn't want to go behind her
16 back. And I mentioned this conversation. And
17 she said, "Well, I'm going to a breast cancer
18 conference in the near future and I will
19 certainly ask around." So she asked another
20 physician, I forget his name for a moment.
21 COFFEY, Q.C.:
22 Q. If I'm--Cliff Hudis?
23 DR. DEANE:
24 A. That's it, yes.
25 COFFEY, Q.C.:

1 Q. H-U-D-I-S.
2 DR. DEANE:
3 A. Yeah, she bumped into, also from the Sloan-
4 Kettering Institute. And they had just done a
5 review of their estrogen receptor status and
6 had noted that if you--if you had lobular
7 carcinoma, the odds are of having ER negative
8 were low, almost--he'd actually never seen a
9 case, but I believe the figure is somewhere
10 like 92 percent. So if you've got ER negative
11 and you're lobular, you know, there's an
12 issue. Which sort of surprised us because
13 certainly Dr. Maureen Trudeau hadn't commented
14 on this and none of our own oncologists were
15 aware of it. So I think this was following a
16 review that they had done in Sloan-Kettering
17 of their own. You know how they do
18 retrospective studies on these topics.
19 Anyway, he suggested we retest the estrogen
20 receptors. So Peggy's estrogen -
21 COFFEY, Q.C.:
22 Q. The he would be Dr. Hudus?
23 DR. DEANE:
24 A. Yes, absolutely, yeah.
25 COFFEY, Q.C.:

1 Q. And what--you've said about--other than
2 meeting the doctor in the elevator.
3 DR. DEANE:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. From, with the Sloan-Kettering name tag on the
7 lady you spoke with, the communication with
8 Dr. Hudus.
9 DR. DEANE:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And what Dr. Hudus, you've recounted what you
13 understood he said.
14 DR. DEANE:
15 A. Yeah.
16 COFFEY, Q.C.:
17 Q. You learned that from Dr. Laing?
18 DR. DEANE:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. DEANE:
23 A. Yeah, she said that we should retest her
24 estrogen receptor status.
25 COFFEY, Q.C.:

1 Q. Dr. Hudus suggested that?
2 DR. DEANE:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Okay.
6 DR. DEANE:
7 A. So they retested it. And we actually went off
8 to Cuba on a holiday. This was going to be
9 our last holiday as a family. And -
10 COFFEY, Q.C.:
11 Q. So if I could, just I'm to put this in a
12 temporal context, okay. Your holiday to Cuba,
13 I understand, was, began on May 3rd or 4th of
14 2005?
15 DR. DEANE:
16 A. Yeah, yeah, that sounds right.
17 COFFEY, Q.C.:
18 Q. And the idea of retesting the status of, or
19 the ER status of Peggy's tumor tissue had
20 occurred before Cuba?
21 DR. DEANE:
22 A. Shortly before then, yeah.
23 COFFEY, Q.C.:
24 Q. Okay.
25 DR. DEANE:

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1 A. I would guess somewhere in April of '05 we had
2 that conversation.
3 COFFEY, Q.C.:
4 Q. And we do have, and I will be referring to
5 certain documents that, records of the
6 hospital that certainly do deal with some of
7 these things and the timing of them. But, as
8 ill as Peggy was, I take it, that in May she
9 wanted to go to--or before May, but certainly
10 by the beginning of May you were going Cuba?
11 DR. DEANE:
12 A. That's right. In fact, it was before we went
13 to Cuba that we were told that her estrogen
14 receptor status had changed.
15 COFFEY, Q.C.:
16 Q. Do you recall how that came about?
17 DR. DEANE:
18 A. She as admitted--we'd planned this vacation to
19 Cuba which -
20 COFFEY, Q.C.:
21 Q. I'll be asking you about that in a minute,
22 okay.
23 DR. DEANE:
24 A. All right.
25 COFFEY, Q.C.:

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1 Q. How it turned out.
2 DR. DEANE:
3 A. And one of the, one of the problems was that
4 she had this fluid in her lungs which kept re-
5 accumulating. And my worst nightmare was that
6 we'd be on some beach in Cuba and her lungs
7 would fill up with fluid and there'd be very
8 little we could do about it. Anyway, they did
9 a pleuradisis, which is they stick the inner
10 and outer layer of the pleura together so that
11 there's no space for the fluid to collect.
12 And they did two or three attempts until they
13 got it right and then the pleuradisis was
14 effective so that there could be no re-
15 accumulation of fluid there. She had a
16 metastases at the base of her lung, so this is
17 where the fluid was coming from, but if you
18 prevented the fluid from re-accumulating,
19 she'd be all right. So we did that and it was
20 during one of those admissions for a
21 pleuradisis that the team came. And I can't
22 remember the exact date but it must have been
23 somewhere in April, early April that they told
24 us she was estrogen receptor positive.
25 COFFEY, Q.C.:

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1 Q. Now who is the team, who is that?
2 DR. DEANE:
3 A. Well that was Kara Laing, Joy McCarthy and
4 Jonathan Greenland. And I suppose they came,
5 all three of them, which was a little unusual,
6 but they probably were on their way to some
7 rounds or to a meeting of some kind, I don't
8 know, or maybe they just came together for to
9 give each other moral support. I certainly
10 know, and fortunately for me it's a very rare
11 occurrence, but every now and then I look at
12 an x-ray and I see what looks like a
13 malignancy and then we discuss it and before
14 you even say one word to the parents you make
15 damn sure you know what you're dealing with.
16 COFFEY, Q.C.:
17 Q. Yes.
18 DR. DEANE:
19 A. And usually you biopsy it first. But when I
20 discuss this with patients, I certainly like
21 to have an oncologist with me because, trust
22 me, they are far better at breaking bad news
23 to parents than I am. And you often get stuck
24 for words. I mean, you tell them in as nice a
25 way as you possibly can the diagnosis and you

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1 run out of stuff to say. And if you've got--
2 they're wonderful people, oncologists, and I
3 don't know how they do their job. But they
4 usually have an appropriate something to say.
5 It's very difficult. And I must say, Kara
6 Laing was, was really, really good at this.
7 She's--and Joy. They were both fantastic. I
8 mean, they knew how to break bad news, how to
9 comfort way better than I could, how to
10 comfort Peggy and how to just say it right and
11 do it right. Fantastic at their job and I
12 don't know how they do it. But, anyway,
13 that's, I'm getting off topic, sorry.
14 COFFEY, Q.C.:
15 Q. No, in terms of--because I think it's
16 important in this context for the Commissioner
17 to get a sense of how these things unfold.
18 DR. DEANE:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. You remember -
22 DR. DEANE:
23 A. I don't know whether they've -
24 COFFEY, Q.C.:
25 Q. Yes. Do you remember where this happened,

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1 where you were first, where you were when you
2 were first told about the change in ER status?
3 DR. DEANE:
4 A. Peggy was an in-patient and we were in the
5 ward and I was sitting next to her.
6 COFFEY, Q.C.:
7 Q. Sitting on her bed?
8 DR. DEANE:
9 A. Sitting on the bed.
10 COFFEY, Q.C.:
11 Q. Okay. And what happened?
12 DR. DEANE:
13 A. And the three of them came in and they said,
14 "You'd better sit down." I said, "Well," and
15 I didn't know what was coming, but by this
16 stage, you know, how much more bad news can
17 you get. It was in her lungs. It was in her
18 bowel. She had the ascites fluid in the fluid
19 in the abdomen. She had pleural effusions.
20 It was in her spine. Her liver was just full
21 of metastases. It was everywhere. It was
22 overwhelming, and this was just before our
23 vacation in Cuba, and I really--I had a lot of
24 trepidation about going on this holiday. I
25 thought, you know, "what happens if we're in

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1 Cuba and she passes away? What are we going
2 to do? What do I do with the kids?" you know,
3 but anyway -
4 COFFEY, Q.C.:
5 Q. I take it you had three young children at the
6 time?
7 DR. DEANE:
8 A. Three young children.
9 COFFEY, Q.C.:
10 Q. Understand.
11 DR. DEANE:
12 A. She was determined, and she was a strong
13 woman, very strong woman, and she decided she
14 wanted to go.
15 COFFEY, Q.C.:
16 Q. So you're sitting--one of the three of them
17 has suggested you sit down, bad news.
18 DR. DEANE:
19 A. Yes, and they told us she's estrogen receptor-
20 -they've retested--"we've retested your
21 specimen on the advice of this specialist in
22 Sloan-Kettering and you're positive," and that
23 was a big shock. I think this was the first
24 time that they--at least my understanding is
25 that this was the first--this is the case why

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1 we're here now, you know. It was due to this
2 finding and I'm told that Peggy was the index
3 case.
4 COFFEY, Q.C.:
5 Q. And that phrase, the index case, or I believe
6 she is at times referred to, within Eastern
7 Health's own documentation, as the index
8 patient in this case.
9 DR. DEANE:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. So they told you this. Dr. McCarthy and Dr.
13 Laing, you've already described their
14 occupations. Dr. Greenland, Jonathan
15 Greenland, who was he?
16 DR. DEANE:
17 A. He was a--he does the radiation, radiation
18 oncologist I think is his correct title, and
19 Peggy gives the--thank you. Sorry, Kara Laing
20 and Joy give chemo and he does the radiation.
21 COFFEY, Q.C.:
22 Q. Radiation, okay.
23 DR. DEANE:
24 A. And she'd already had radiation as part of her
25 treatment, you know, they combined the two.

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1 COFFEY, Q.C.:
2 Q. So Jonathan Greenland, Dr. Greenland was part
3 of the team that was treating her?
4 DR. DEANE:
5 A. Sure.
6 COFFEY, Q.C.:
7 Q. Okay, and they, between them, indicated to you
8 that there had been a retest at the suggestion
9 of Dr. Hudus and the result was she was
10 positive?
11 DR. DEANE:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Estrogen positive, the tumor was. Was there
15 any further discussion at that point about how
16 that could have happened and the implications
17 for Peggy's treatment?
18 DR. DEANE:
19 A. At that stage, I don't think they knew where
20 the problem was. They just said "there's a
21 problem in the lab and we don't know what the
22 problem is," and I didn't get mad at them
23 because they're only the messengers and they
24 weren't responsible for the mistake. They
25 were just giving me the news.

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1 COFFEY, Q.C.:
2 Q. Yes.
3 DR. DEANE:
4 A. And they'd obviously discussed it before they
5 walked in the room, because they had their
6 treatment plan all ready to go.
7 COFFEY, Q.C.:
8 Q. Okay, so -
9 DR. DEANE:
10 A. Which is how it should be.
11 COFFEY, Q.C.:
12 Q. - so what did they tell you then about the
13 treatment plan?
14 DR. DEANE:
15 A. Well, unfortunately, Peggy's disease had
16 advanced to such a point that I don't know
17 that anything, any--there was anything that
18 you could offer, and I said "well, isn't it
19 worth a try?" and they said "yeah, it is." So
20 they started her on the Tamoxifen and she was
21 on it for a period of time and it seemed to be
22 effective because it--the ascites, the fluid
23 in her abdomen didn't reaccumulate and the
24 fluid in her lungs didn't reaccumulate, and it
25 seemed from that that the Tamoxifen was

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1 effective. But of course, the disease was so
2 disseminated and overwhelming, and I must say,
3 when Peggy got the news, well, she was on pain
4 medication at the time, she was on morphine,
5 and she was pretty--you know, she was pretty
6 well out of it. So she didn't react as I
7 thought she would, but we just left it at
8 that. We said "well, let's try it. We don't
9 know where the problem is or why there's a
10 problem." All we did know is it's not Kara
11 Laing, Joy McCarthy or Jonathan Greenland
12 who's responsible for the problem. They're
13 just the messengers and they're just giving us
14 the news.
15 So they told us they'd try the Tamoxifen,
16 which they did, and it seemed to work. But
17 because we were going away, there's this flare
18 phenomenon which I don't fully understand, but
19 you get a lot of pain and you get breakdown of
20 metabolites and because of the tumor kills,
21 etcetera, you get what's called a flare and if
22 we were going away to Cuba, it wasn't a good
23 idea to be on this stuff because if we got a
24 flare in Cuba, we'd be in trouble. So we
25 stopped it, and we went off on our holiday and

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1 we had a wonderful holiday. My worst
2 nightmare never happened. Peggy was in good
3 spirits. She had a great time, had good
4 friends with us there, and that was
5 excellent.
6 COFFEY, Q.C.:
7 Q. I take it the idea for the holiday in Cuba
8 with her friends, yourself and your children
9 was her idea?
10 DR. DEANE:
11 A. She wanted to live life to the fullest. What
12 little she had left, she wanted to make the
13 most of, and she was determined, and she did.
14 She didn't let this disease get the better of
15 her. She said "I'm having one more holiday
16 with my kids. I don't care what happens," and
17 that's what we did.
18 COFFEY, Q.C.:
19 Q. Now with respect to the type of cancer, not
20 the hormone status of the tumor, but the type
21 of cancer, you've indicated that you had
22 understood that it was lobular invasive
23 carcinoma.
24 DR. DEANE:
25 A. Yeah, yeah.

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1 COFFEY, Q.C.:
2 Q. Has that ever been brought into question?
3 DR. DEANE:
4 A. I subsequently found out that when they found
5 the change in receptor status, at the time I
6 didn't know this, and when they found the
7 change in receptor status, they looked at the
8 whole thing. They re-looked at everything.
9 COFFEY, Q.C.:
10 Q. Who told you this?
11 DR. DEANE:
12 A. I don't know, but I know it was re-looked at.
13 COFFEY, Q.C.:
14 Q. Okay.
15 DR. DEANE:
16 A. And they reevaluated it and they felt that it
17 wasn't--well, it was always a mixed--if you
18 look at the original histology report, it was
19 a mixed tumor. It was mixed, ductal and
20 lobular, and it was predominantly lobular, and
21 they then said it's--you know, "it's more
22 ductal than we thought."
23 COFFEY, Q.C.:
24 Q. And the they, you don't know who the -
25 DR. DEANE:

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1 A. I think it was only looked at by Dr. Laing and
2 Dr. Elms Ford, who's the pathologist. They re
3 sort of looked at it. I don't even know if
4 Dr. Laing looked at it, because she's an
5 oncologist and, you know, that's not part of
6 her domain. You know, she's not a specialist
7 in pathology. I don't know if it was sent
8 away or not. I think it was just looked at
9 here. You may have more information than me
10 on that. But that's not really the issue
11 because she was estrogen receptor positive,
12 and it means that she could have had the
13 Tamoxifen earlier had we known, and that might
14 have made a significant difference to her
15 prognosis or, you know, who knows what would
16 have happened, but she seemed to have a good
17 response to the Tamoxifen when we did use it,
18 and when we got back from Cuba, they were
19 scared of this flare phenomenon, which I don't
20 entirely understand, and so better to ask them
21 about it, but they decided not to go back to
22 the Tamoxifen, and by then, Peggy was--I won't
23 say she was--you know, the disease was pretty
24 overwhelming. She was very ill.
25 COFFEY, Q.C.:

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1 Q. This would be mid way through May?
2 DR. DEANE:
3 A. Yeah, towards the end of May, yeah. They also
4 put her on Zoladex, which shuts down the
5 ovaries, which helps to boost the effects of
6 the Tamoxifen.
7 COFFEY, Q.C.:
8 Q. Now you referred to Dr. Elms. His name is Dr.
9 Ford Elms, a pathologist.
10 DR. DEANE:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Did you ever speak with Dr. Elms about this
14 matter yourself?
15 DR. DEANE:
16 A. No.
17 COFFEY, Q.C.:
18 Q. So any information about ductal carcinoma,
19 invasive carcinoma, whether it's predominantly
20 one as opposed to the other, any change in
21 view on that, you wouldn't have gotten from
22 him?
23 DR. DEANE:
24 A. No.
25 COFFEY, Q.C.:

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1 Q. You would have had to have gotten it from Dr.
2 Laing?
3 DR. DEANE:
4 A. Yeah. Well, the reports -
5 COFFEY, Q.C.:
6 Q. And the reports themselves we have, okay.
7 DR. DEANE:
8 A. Yes, I had access to the reports.
9 COFFEY, Q.C.:
10 Q. Yes.
11 DR. DEANE:
12 A. Being a physician, we do, yeah.
13 COFFEY, Q.C.:
14 Q. Now Doctor, the retesting of the tumor tissue
15 that occurred in 2005, were you told in 2005
16 where the retest occurred physically?
17 DR. DEANE:
18 A. No.
19 COFFEY, Q.C.:
20 Q. So, at the time, they said that she had been
21 retested.
22 DR. DEANE:
23 A. That's it.
24 COFFEY, Q.C.:
25 Q. And the result was different?

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1 DR. DEANE:
2 A. Yeah.
3 COFFEY, Q.C.:
4 Q. But where that retest, whether it occurred
5 here or elsewhere, you weren't told?
6 DR. DEANE:
7 A. No.
8 COFFEY, Q.C.:
9 Q. Okay.
10 DR. DEANE:
11 A. To me, it didn't matter.
12 COFFEY, Q.C.:
13 Q. Sure.
14 DR. DEANE:
15 A. What matters is that she had switched from
16 negative to positive.
17 COFFEY, Q.C.:
18 Q. Sir, I take it then that as the spring and we
19 entered the summer of 2005, Peggy's disease
20 progressed?
21 DR. DEANE:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. And when did she pass away?
25 DR. DEANE:

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1 A. 5th of August '05.
2 COFFEY, Q.C.:
3 Q. Not so much the day that you were initially
4 told about the change in status, because I
5 appreciate that ER status, I appreciate that
6 was probably in a context, it takes some time
7 to process the implications.
8 DR. DEANE:
9 A. Yeah.
10 COFFEY, Q.C.:
11 Q. Could you tell us please, you know, as the
12 time went on how you felt about it?
13 DR. DEANE:
14 A. Well, we realized that obviously she--if we'd
15 known about the--if it had been diagnosed
16 positive from the get-go, the whole course of
17 the disease would probably have been a lot
18 better and she probably wouldn't have had to
19 endure the types of chemo that she had. My
20 understanding is that the response to
21 Tamoxifen is variable.
22 COFFEY, Q.C.:
23 Q. Yes.
24 DR. DEANE:
25 A. She seemed to respond well and it depends on

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1 the tumor's biology, and her particular tumor
2 seemed to be fairly responsive to the
3 Tamoxifen, so how long it would have been
4 effective, we don't know. We'll never know,
5 but I think it would have certainly improved
6 her prognosis significantly.
7 COFFEY, Q.C.:
8 Q. And in terms of the idea of, or the
9 characterization of the change from negative
10 status to positive status, the fact that it
11 was originally called as a negative, how was
12 that characterized to you when it was first
13 conveyed to you? Was it, I'll use the word
14 "mistake," was the word "mistake" used? I
15 think you referred earlier to the mistake was
16 in the lab.
17 DR. DEANE:
18 A. Yeah, I think they told us that the--they
19 didn't really know what the reason was.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. DEANE:
23 A. Possibly the re-agents, I think it was
24 mentioned that they had faulty re-agents.
25 They weren't sure. At that time, I don't

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1 think they knew.
2 COFFEY, Q.C.:
3 Q. Sure.
4 DR. DEANE:
5 A. They just said "there's been a change in
6 status. We've retested it as a result of our
7 conversations with this man in Sloan-Kettering
8 and there's a change in status," and that's
9 basically it, and they then went on to talk
10 about the chemo and, I mean, it was a great
11 shock, a huge shock. I don't think Peggy
12 actually--as I say, she was pretty well out of
13 it. They'd given her fairly heavy sedation.
14 COFFEY, Q.C.:
15 Q. Sure.
16 DR. DEANE:
17 A. She was--I won't say semi-comatose, but she
18 was pretty drowsy.
19 COFFEY, Q.C.:
20 Q. That was at the time you -
21 DR. DEANE:
22 A. Actually the time they told us.
23 COFFEY, Q.C.:
24 Q. And then, I take it during her vacation, she
25 would have been aware of this when she was on

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1 vacation in Cuba. She was more interested in
2 -
3 DR. DEANE:
4 A. She was more interested in having a holiday
5 than anything else. We didn't talk about it
6 at all, in fact, on the vacation. It was a
7 taboo subject.
8 COFFEY, Q.C.:
9 Q. Did you speak about it afterward?
10 DR. DEANE:
11 A. Yeah, not a lot though. At that stage, she
12 was getting towards palliation and that was
13 the focus. You deal with what's happening at
14 the time. You can't--I don't want to sound
15 callous, but I mean, you deal with what's
16 happening. You got enough on your plate at
17 that time, coping with the pain and the
18 fusions and the--she had this perineal
19 dialysis because the kidneys started to shut
20 down, and you just--it's a lot on the go and
21 pain control was probably our main focus at
22 the time.
23 COFFEY, Q.C.:
24 Q. Yes. Commissioner, I'm going to ask,
25 Commissioner, that Exhibits C-0155 through C-

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1 0172 inclusive be entered.
2 THE COMMISSIONER:
3 Q. Entered.
4 EXHIBITS ENTERED AND MARKED EXHIBITS C-0155 THROUGH C-
5 0172
6 COFFEY, Q.C.:
7 Q. Thank you, Commissioner.
8 THE COMMISSIONER:
9 Q. Dr. Deane, you will have both a paper copy of
10 any exhibits that will be referred to, and as
11 well, they'll come up on the screen in front
12 of you when counsel refer to them.
13 COFFEY, Q.C.:
14 Q. Doctor, you'll see that--and both in the paper
15 and when an exhibit comes up on the screen,
16 there's--the exhibit number is in the top
17 centre of the page.
18 DR. DEANE:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. You'll see it stamped there, and the page
22 number.
23 DR. DEANE:
24 A. That's where they got it from, C-0155.
25 COFFEY, Q.C.:

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1 Q. Yes, if you could, please, C-01--Registrar, C-
2 0155.
3 DR. DEANE:
4 A. Page one, yes, and -
5 COFFEY, Q.C.:
6 Q. Now this, Doctor, is a pathology report, a
7 laboratory report from the Health Care
8 Corporation of St. John's for Peggy Deane.
9 The specimen is CS766-02, received June 13th,
10 2002. The history is that it's a mass right
11 breast, not cyst, and the cytology final
12 diagnosis is highly suspicious of malignancy
13 ductal carcinoma, and Dr. Vaze goes on to say
14 "a tissue biopsy is recommended to confirm the
15 diagnosis." So this really is the beginning.
16 DR. DEANE:
17 A. This is where there has been a bit of a switch
18 from ductal to lobular back to ductal.
19 COFFEY, Q.C.:
20 Q. Yes.
21 DR. DEANE:
22 A. And this is the original one was ductal, yes.
23 COFFEY, Q.C.:
24 Q. So that -
25 DR. DEANE:

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1 A. But it's a mixed tumor, so you know, it's not
2 as bad as it sounds.
3 COFFEY, Q.C.:
4 Q. So that was -
5 DR. DEANE:
6 A. I guess that was a needle biopsy, so they
7 probably--the needle hit a little small
8 pocket, which was predominantly ductal. If
9 the needle had been, say, a centimetre away
10 from that, they might have hit lobular. So
11 it's a mixed tumor. That's what--that's how I
12 interpret that.
13 COFFEY, Q.C.:
14 Q. Understand. If I could, please, Exhibit C-
15 0156, please, Registrar? Now, this is a
16 three-page report and it has--if I could,
17 please, and it's toward the bottom of the
18 page, in fact, you'll note that there are date
19 stamps on it, June 15th, 2005. It's on all
20 three pages. I'm just going to go back to the
21 first page, and it's a report, St. Clare's
22 Mercy Hospital. It's for Peggy Deane. It
23 relates to specimen number 02-SS4884, which is
24 right here, and it's received June 21st, 2002,
25 and the surgeon is Dr. David Pace. I take it

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1 that was Peggy's surgeon?
2 DR. DEANE:
3 A. Yes, correct.
4 COFFEY, Q.C.:
5 Q. And the comments that are made, "our case was
6 verbally discussed by phone with Dr. David
7 Pace, Wednesday, June 26th, 2002 at 4:15
8 p.m.," and then there are a number of
9 addendum. I'm going to skip over those to
10 start, and let me see, back up a bit here to
11 the second page, please, Commissioner, and
12 under pathological interpretation -
13 DR. DEANE:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. - there's a--it's described as a "mass right
17 breast excisional biopsy, invasive lobular
18 carcinoma. Widespread lobular carcinoma in
19 situ. Lateral inferior margin focally
20 involved and please see tumor summary," and of
21 course, the tumor summary is right below that,
22 right here, on the bottom left-hand side of
23 the page, and it says "breast right, specimen
24 excisional biopsy, tumor infiltrating lobular
25 carcinoma," and it goes on at some length, on

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1 into the next page, and under microscopy, it
2 indicates "sections show a tumor comprised of
3 infiltrating lobular carcinoma" and it goes
4 on, Dr. Elms does, it's Ford Elms, because
5 there's an entry there at the bottom, he had
6 signed off on this June 27, 2002, and he goes
7 on under the description of what he saw under
8 the microscope in some detail here.
9 Partway through it, he notes
10 "approximately 50 percent of the tumor is
11 comprised of lobular carcinoma in situ. For
12 the most part, this is typical lobular
13 carcinoma in situ with numerous distended
14 terminal ductal lobular units, having
15 cytological appearance with cells having a
16 cytological appearance which is
17 distinguishable from that of the invasive
18 component. However the carcinoma in situ
19 contains a more cribriform pattern such as the
20 one in DCIS. The inferior lateral margin is
21 focally involved by tumor," and then he
22 finally ends with the comment, "for the most
23 part, this tumor is comprised of a mixture of
24 lobular carcinoma in situ with invasive
25 lobular carcinoma. It is noted that both the

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1 in situ as well as the invasive components in
2 areas attain a somewhat ductal appearance.
3 However, this is not a predominant"--I'm
4 sorry, "this is not a prominent finding."
5 So that was the diagnosis recorded by Dr.
6 Elms at the end of June of 2002, and if you
7 look back to page two of this -
8 THE COMMISSIONER:
9 Q. So this particular exhibit that we're now
10 looking at would be the exhibit giving us the
11 pathological--pathology, sorry, pathology
12 report following the surgery, as opposed to
13 the first one which dealt with the report
14 following the biopsy?
15 DR. DEANE:
16 A. Correct.
17 COFFEY, Q.C.:
18 Q. That's my understanding, Commissioner. On
19 page two of C-0156, the addendum number one,
20 which is really in the middle of the page,
21 right here, the addendum was entered July 8th,
22 2002, signed off on July 10th, 2002, and it
23 reads "immunohistochemical staining for
24 estrogen and progesterone receptors shows weak
25 staining for progesterone receptors in less

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1 than ten percent of lesional cells. Negative
2 staining for estrogen receptors." So that was
3 in the initial ER/PR report for Peggy's tumor,
4 and if we could just go up, for the sake of,
5 in this context, completeness, addendum number
6 two, which is entered August 21st '02, right
7 here. It's "immunohistochemical staining for
8 HER-2 neu is negative," and that was entered
9 by Dr. Elms on August 21st, 2002. So in the
10 summer of 2002, they were apparently the
11 interpretations and the tests done. I'm going
12 to come back to addendum three, which is on
13 page one eventually or later on.
14 If I could, please, Registrar, Exhibit C-
15 0159? Now this is a first assessment summary
16 on Newfoundland Cancer Treatment and Research
17 Foundation letterhead for Peggy Deane dated
18 24th of July 2002, and it is a three-page
19 report or assessment. Just go to the final
20 page here. It's Dr. Laing. She is then the
21 Acting Director of Medical Oncology. And the
22 diagnosis, Dr. Deane, it's "Stage IV,
23 particular type of infiltrating lobular
24 carcinoma of the right breast. Status post
25 right modified radical mastectomy, July 2002.

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1 Biopsy proven liver metastases. ER/PR
2 negative. HER-2 neu pending," because then
3 that wasn't until August that the HER-2 neu
4 result was available, and I'm just going to
5 take you through small portions of this. The
6 reason seen is noted to be "this 43-year-old
7 lady from St. John's was seen at the request
8 of Dr. Pace for consideration of systemic
9 therapy for recently diagnosed metastatic
10 carcinoma of the breast. Mrs. Deane first
11 noticed a mass in her right breast in the fall
12 of 2000. Ultrasound, mammogram at that time
13 were both negative. The mass persisted, but
14 did not change in size until the spring of
15 2002 when adjacent to this, she was aware of
16 another mass which enlarged over a few
17 months". I'm going to go to the last line of
18 that paragraph. "A mammogram confirmed the
19 suspicion of malignancy and fine needle
20 aspirate was suggestive of a ductal
21 carcinoma", which is what you described -
22 (DR. DEANE'S CELL PHONE RINGS)
23 DR. DEANE:
24 A. If it's all right, can I -
25 COFFEY, Q.C.:

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1 Q. Sure.
2 DR. DEANE:
3 A. It's a text message, I'll read it later.
4 COFFEY, Q.C.:
5 Q. Okay. Thank you, Doctor. Doctor, one thing
6 of note here is that--and I do appreciate that
7 you'd indicated when you first spoke about
8 your wife's experience with breast cancer,
9 that she originally actually had a mass before
10 2002, she recognized one going back to 2000, I
11 take it.
12 DR. DEANE:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. So, this accurately reflects your wife's
16 medical history.
17 DR. DEANE:
18 A. Correct.
19 COFFEY, Q.C.:
20 Q. Third paragraph indicates "She went on to have
21 an excisional biopsy on June 21, 2002 which
22 revealed a 3 centimetre invasive lobular
23 carcinoma with no evidence of lymphatic or
24 vascular invasion. Margin was positive
25 focally. Tumor was both estrogen and

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1 progesterone receptor negative. She went on
2 to have a completion modified radical
3 mastectomy on July 4, 2002 with no evidence of
4 residual disease within the breast. But three
5 out of eight lymph nodes were involved with
6 metastatic spread." And the next page,
7 please, there we are. "Staging investigations
8 included a CT scan of the chest, abdomen and
9 pelvis which showed a suspicious area in the
10 liver. This was biopsied yesterday and the
11 pathology has come back to show metastatic
12 lobular carcinoma, bone scan is negative."
13 And it notes that Peggy and yourself are
14 obviously distraught with the news at the
15 time.
16 Under "Diagnosis" which is on the third
17 page. As you recall it, diagnosis was Stage
18 4. "Invasive lobular carcinoma, ER/PR
19 negative". And in terms of the disposition,
20 what Dr. Laing has recorded is, "this lady
21 presents with metastatic breast cancer at the
22 time of initial diagnosis. This has been
23 confirmed by a biopsy of the liver.
24 Unfortunately, this is not a curable
25 situation, however she is a young woman with

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1 an excellent performance status and low bulk
2 of metastatic disease. The only evidence of
3 distance spread being the one nodule in the
4 liver. As she is ER/PR negative, our
5 treatment will include palliative
6 chemotherapy. She and her husband had a lot
7 of good questions today and metastatic breast
8 cancer is a very systemic disease and there is
9 no evidence that localized treatment of the
10 liver or surgical resection of this met will
11 improve her outcome". And the middle of the
12 next paragraph, she notes, "she would like to
13 start a chemotherapy in August, so I've booked
14 her to come on Friday, August 9 for her first
15 cycle. Side effects and rationale of
16 treatment have been reviewed. And if she
17 continues, I will obtain a pathology review to
18 determine the grade of this tumor and also
19 HER-2 neu status and she will be a candidate
20 for Herceptin therapy. In the future, should
21 she be an overexpressor of HER-2 neu. I plan
22 to give her three cycles of FAC chemotherapy
23 and then we will repeat the CT scan of the
24 abdomen to assess her response." So, I take
25 it that that summarizes your recollection?

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1 DR. DEANE:
2 A. Yes. Yes, we pursued the option of local
3 resection of that met in the liver and, you
4 know, had been told about radiofrequency
5 ablation, but as she says there in her notes
6 and it's exactly what they told us when we
7 went to Hamilton and Toronto, that it's a
8 systemic disease, by the time it's got to the
9 liver, it's everywhere, so it's really
10 pointless.
11 COFFEY, Q.C.:
12 Q. Doctor, there are a number of other pathology
13 reports here involving different biopsies.
14 I'm not going to take you through those. I
15 would, though, ask C-0161 please, Registrar?
16 And this is a final surgical report. It's
17 labelled Health Sciences Centre for Peggy
18 Deane, specimen is 02 SU: 10253, it's dated
19 July 23rd, 2002 and the diagnosis is biopsy of
20 liver and metastatic carcinoma, consistent
21 with origin from a primary in the breast and
22 in fact, it's signed off by Dr. Desmond Robb,
23 at the bottom of the page there on July 25th,
24 2002. He ends with a comment, "These features
25 are consistent with metastatic carcinoma

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1 arising from a primary in the breast." This
2 was a confirmation, I take it, that this was
3 the metastases from the breast?
4 DR. DEANE:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. If I could please, Registrar, Exhibit C-0162
8 and Doctor, these are progress notes for
9 Doctor--or signed by Dr. J. McCarthy. They
10 are for Peggy Deane and the clinical
11 diagnosis, of course, is invasive lobular
12 carcinoma, right breast. Dated 21 of
13 November, 2003, Medical Oncology Clinic and
14 again, this is, of course, more than a year
15 into your wife's treatment. The diagnosis,
16 Dr. McCarthy notes "metastatic breast cancer
17 with liver and bony mets. Had eight cycles of
18 FAC chemotherapy and progressed at the end and
19 did not tolerate Taxotere"--and I'm in the
20 same position you are with the pronunciation
21 of that drug, Doctor--"Capecitabine, so she
22 was switched to Taxotere alone. She has had
23 seven cycles of Taxotere and unfortunately
24 progressed." And again, as you are a
25 physician, the idea of "progressed" here,

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1 because we haven't--I've referred to it in
2 reading and in other charts, progression in
3 this means that the disease has gotten worse?
4 DR. DEANE:
5 A. Yes, and it's various different things,
6 increase in size, maybe on a CAT scan or
7 accumulation of fluid or increasing symptoms,
8 whatever, it encompasses a bunch of things.
9 COFFEY, Q.C.:
10 Q. And in this context, progress is not good.
11 DR. DEANE:
12 A. No.
13 COFFEY, Q.C.:
14 Q. Dr. McCarthy goes on to say, "Peggy is seen
15 today in follow-up. I saw her last week as
16 well in my office and we had a long chat about
17 the fact that she has progressed. Her liver
18 nodules are more numerous and some of them
19 have enlarged. She is quite devastated with
20 this news. We had a long chat about where to
21 go from here and we do not have any trials
22 available here that I can offer here that are
23 currently open; thus, we have decided to go
24 ahead with Xeloda. She would like to see an
25 oncologist on the mainland just so that she

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1 feels that she has exhausted every other
2 possibility; thus I have contacted Dr. Trudeau
3 and hopefully we can get an appointment with
4 her soon." And then it ends with "Plan: We
5 will go ahead with a single agent, Xeloda and
6 the side effects were explained to her. I
7 will repeat a CAT scan after three cycles and
8 I will try and arrange for an appointment with
9 Dr. Trudeau as soon as possible." This is
10 November 23rd, 2003 and you will note in fact
11 that it's dictated by Dr. McCarthy on that
12 same day. If you turn, please, to Exhibit C-
13 0163, one will see that Dr. McCarthy was as
14 good as her word because on November 21st,
15 2003, this is a letter signed by her. It's
16 two pages long and it's addressed to Dr.
17 Maureen Trudeau at Sunnybrook, and it relates
18 to your wife. And the letter, I'm not going
19 to--I'm just going to read portions of it and
20 the first page is "Dear Dr. Trudeau: Thank
21 you very much for agreeing to see Margaret
22 Peggy Deane, an unfortunate 45 year-old lady
23 who presented with metastatic breast cancer
24 last year." Further down, she describes it
25 some length, your wife's situation and her

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1 treatment up to that point. Midway through
2 the paragraph, just past that point, Dr.
3 McCarthy notes, "I should note that she is
4 ER/PR negative." And she goes on to say, "She
5 initially responded to both FAC and Taxotere
6 and then progressed while on them. As I said
7 before, she has never had a chemotherapy break
8 for any amount of time. I saw her last week
9 for the last CT scan results and obviously she
10 and her husband are devastated. We have
11 decided to place her on Xeloda and since we
12 did not have any clinical trials open here
13 that would be available to her." She goes on
14 to say in the bottom paragraph, she notes "We
15 started Xeloda today. She would like to come
16 and meet with you just to discuss any further
17 possible options. She has three small
18 children, ages 10, 8 and 5 and I did not feel
19 it necessary for her to spend much time away
20 from home if a worthwhile clinical trial was
21 not available." And she goes on then to
22 conclude with "We will forward all of her most
23 recent test results, pathology and OR reports
24 to you." So they were sending it all to
25 Maureen Trudeau. If we could, please

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1 Registrar, Exhibit C-0164. This is a three-
2 page document. It's a report from Sunnybrook
3 and Women's College Health Sciences Centre in
4 Toronto. It's entitled "History and
5 Physical", the patient name is Margaret Deane.
6 Service date is 16th of December, 2003 and on
7 the third page it's noted to be a report of
8 Dr. M. Trudeau, division of medical oncology,
9 hematology and also S. Verma, M.D. for
10 clinical fellow. And it's carboned to Drs.
11 Pace, Grandy and McCarthy. And one will note
12 there are a number of date stamps, February
13 10th, 2004 and February 12th, 2004 at the
14 bottom of the pages. I understand then that
15 this is the report that would have come,
16 Doctor, as a result of yourself and Peggy's
17 visit to Dr. Trudeau?
18 DR. DEANE:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. And Doctor, so it's your memory that not only
22 did Peggy see Dr. Trudeau, but also two or
23 three fellows as well?
24 DR. DEANE:
25 A. Yes, I don't know all of their status. Dr.

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1 Verma was certainly very prominent and Dr.
2 Trudeau and the others might have been
3 residents or they may have been fellows, I
4 didn't get into that.
5 COFFEY, Q.C.:
6 Q. And in this report and Dr. Trudeau notes "This
7 45 year old female was seen in our clinic
8 today." And midway through that first
9 paragraph, she notes: "She underwent an
10 incisional biopsy on June 21st, 2002 which
11 showed a three centimeter invasive lobular
12 incarcinoma with positive margins and
13 subsequent to that on July 4, 2002, she had a
14 modified radical mastectomy and lymph node
15 dissection indicating three of eight lymph
16 nodes to be involved with cancer. Subsequent
17 to the surgery the patient had a CT scan of
18 the abdomen which documented metastatic
19 disease to be present in the liver. And
20 toward the bottom of that first text, if I
21 could, there's a paragraph here that begins,
22 "As far as imaging is concerned, we know that
23 the disease is present in the liver and the
24 pleural nodules, as well as the bone. With
25 respect to bony mets, she had radiation

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1 treatment from T-12 to L-3 in August of 2003.
2 The tumor is ER and PR negative and HER-2 neu
3 negative." Which you did note in speaking
4 about this earlier?
5 DR. DEANE:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. That Dr. Trudeau was aware of the lobular
9 invasive and the ER/PR negative status.
10 DR. DEANE:
11 A. Correct, as was her fellow and other two, so -
12 COFFEY, Q.C.:
13 Q. And there was nothing said at that time about
14 any inconsistency in that regard?
15 DR. DEANE:
16 A. No. She did recommend--I recall now she
17 recommended this other regime, these other
18 medications and -
19 COFFEY, Q.C.:
20 Q. That's later on in the report.
21 DR. DEANE:
22 A. (Unintelligible) MP and try cyclophosamide and
23 a methotrexate again. But when Joy McCarthy
24 put her on to Xeloda, we had such an excellent
25 response that this all became irrelevant.

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1 Xeloda was fantastic.
2 COFFEY, Q.C.:
3 Q. And with Dr. Trudeau, on page two, because
4 you've read ahead here, under "Impression and
5 Plan: Mrs. Deane is a pleasant 45 year old
6 lady with metastatic breast cancer to her
7 liver, and pleura and bones. She comes here
8 today for further opinion regarding any
9 clinical trials. It appears to us that her
10 malignancy does respond to chemotherapy and
11 she appears to have a good response while on
12 treatment and progressive disease soon after
13 treatment." And as one reads down through
14 that, there were, as you've noted just now,
15 certain potential future treatment options set
16 forth by Dr. Trudeau.
17 DR. DEANE:
18 A. Uh-hm.
19 COFFEY, Q.C.:
20 Q. She concludes at the bottom of the page, "We
21 also had discussions regarding a bone marrow
22 transplant in this setting. There is no
23 evidence of transplant being effective in
24 patients with metastatic breast cancer which
25 we could suggest at the present time." I take

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1 it that that idea was raised?
2 DR. DEANE:
3 A. We didn't raise it, but I guess they just
4 covered that off as one of the options,
5 covering all bases, yeah.
6 COFFEY, Q.C.:
7 Q. And in a third page, Dr. Trudeau concludes
8 with, "It's a pleasure to meet Mrs. Deane.
9 She will have further care as per Dr.
10 McCarthy. I will be more to happy to see her
11 in the future. If there are any further
12 questions or concerns.." So I understand from
13 that then, that this was Dr. Trudeau's review,
14 possible suggestions?
15 DR. DEANE:
16 A. She basically said that there is nothing that
17 we would do in Toronto that you haven't
18 already had done in St. John's and was very
19 complimentary of the care we had received
20 here.
21 COFFEY, Q.C.:
22 Q. After this, which would be--this is December
23 2003 and the report itself is apparently, it
24 looks like received, date stamp is early or
25 mid February, 2004. Was there any subsequent

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1 contact with Dr. Trudeau or Sunnybrook?
2 DR. DEANE:
3 A. No, we were quite satisfied that every bit of
4 advice and treatment that we had gotten here
5 was as good as it was going to be in Toronto,
6 so there was no need to travel again. We had
7 also been to Hamilton for advice and had been
8 in contact with somebody who did ultrasound
9 ablation in Toronto, so we certainly--and we
10 also discussed her case with somebody in
11 Sloan-Kettering, so we had certainly shopped
12 around and I don't think we felt that the
13 treatment here was lacking.
14 COFFEY, Q.C.:
15 Q. If we could please, Registrar, Exhibit C-0166,
16 this is progress notes for Margaret Deane, 7th
17 of May, 2004, Medical Oncology Clinic by Dr.
18 Azadi, medical oncologist.
19 DR. DEANE:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. And Doctor notes in the second paragraph,
23 "Peggy continues to do reasonably well. I am
24 seeing her for the first time in Dr. Laing's
25 absence, but she has no major complaints

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1 today." And under "Assessment and Plan", it's
2 noted "we will continue with Xeloda for the
3 time being" and other potential scans or scans
4 that are going to be done are noted. And the
5 Doctor notes, "She will come back to see Dr.
6 Laing in three weeks' time." Now if we could
7 please, Registrar, Exhibit C-0167. This,
8 Doctor, is a form on Health Care Corporation
9 letterhead. It's a discharge summary. The
10 admission date is April 12th, 2005; the
11 discharge date, April 20th, 2005. The
12 attending physician is noted to be Dr. Stewart
13 Rorke and do you know who Dr. Rorke is?
14 DR. DEANE:
15 A. Oh yes, he's a medical oncologist.
16 COFFEY, Q.C.:
17 Q. Medical oncologist. I take it he at times -
18 DR. DEANE:
19 A. He was involved in her care as well, but not
20 to the extent that the other three were.
21 COFFEY, Q.C.:
22 Q. Now, Doctor, here the diagnosis is right
23 pleural effusion with metastatic breast
24 cancer, which I take it is consistent with
25 your memory of that stay in April?

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1 DR. DEANE:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. And why Peggy was being treated for. The
5 history of present illness, Doctor, this is a
6 sort of form that when you look at the very
7 bottom of the second page, is signed by Dr.
8 Rorke. The dictated date is October 5th,
9 2005, transcribed November 24th, 2005 and
10 apparently stamped, whatever those stamps mean
11 on December 16th, '05 and January 5th, '06.
12 But Dr. Rorke notes here that, under "History
13 of Present Illness: This 46 year old woman
14 was well known to our service. She as
15 admitted for symptoms relating to her
16 metastatic breast cancer. She was suffering
17 from shortness of breath relating to her
18 recurrent right pleural effusion." And he
19 refers to the Paytell (phonetic) catheter is
20 placed and other treatment. "Her shortness of
21 breath settled and she was able to be weaned
22 off oxygen on April 16th, 2005. Repeat
23 testing of her ER/PR receptor status had
24 changed its status to ER/PR positive and thus,
25 she was started on treatment with Tamoxifen

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1 and also given Zoladex injections after
2 laboratory parameter showed she was pre-
3 menopausal." And under discharge medications,
4 No. 9 notes: Tamoxifen, 20 milligrams daily.
5 If we could go on, "In follow up -
6 THE COMMISSIONER:
7 Q. Mr. Coffey, just while this question is in my
8 head, Dr. Deane, do you recall for what period
9 of time Mrs. Deane would have been on
10 Tamoxifen?
11 DR. DEANE:
12 A. They started it about this time, which would
13 have been, what have we got, the 17th of April
14 here, and they discontinued it, it was only
15 for a few weeks, but I don't have that
16 documentation ready to have, but it's about
17 that.
18 THE COMMISSIONER:
19 Q. It wasn't a long period of time?
20 DR. DEANE:
21 A. No, they stopped it because we were going to
22 Cuba and they didn't want her on the Tamoxifen
23 while we were out of sight, in case we ran
24 into problems.
25 THE COMMISSIONER:

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1 Q. Okay.
2 DR. DEANE:
3 A. So I think it was done as a precautionary--
4 they discontinued it as a precaution against
5 us, you know, getting into further problems on
6 holiday.
7 THE COMMISSIONER:
8 Q. And then I think you said earlier when you
9 came back, the decision was that she should be
10 put back on it.
11 DR. DEANE:
12 A. Yeah, and I can't give you the precise
13 rationale behind it, but they had their
14 reasons and I had a lot of respect and I
15 repeat the word "respect" for Dr. Laing's
16 opinion and she said it was not advisable, so
17 I said, I'll go with that.
18 COFFEY, Q.C.:
19 Q. And Commissioner, there are notes that I will
20 be referring to that will deal with the issue
21 or address the issue, according to the chart
22 of Tamoxifen and its usage.
23 THE COMMISSIONER:
24 Q. Yes.
25 COFFEY, Q.C.:

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1 Q. So under follow-up in C-0167 on the second
2 page, Dr. Rorke notes, "She was discharged
3 home with follow-up plans with Dr. Laing and
4 also a follow-up assessment with Dr. Greenland
5 for consideration of further radiotherapy."
6 Okay. If I could please, Registrar, Exhibit
7 C-0168. Now this is a one-page document, it's
8 on Bliss Murphy Cancer Centre letterhead, it's
9 for Margaret Dean. Clinical diagnosis is
10 invasive lobular carcinoma, right breast.
11 Progress notes dated 3 May, 2005, Medical
12 Oncology Clinic and dictated but not read by
13 Dr. Laing, Director of Medical Oncology.
14 There are portions of this I'm going to refer
15 to, Dr. Deane. The diagnosis is metastatic
16 carcinoma of the breast. "Peggy comes back
17 today. She is getting ready to go to Cuba
18 tomorrow. She had about 1.5 litres of fluid
19 drained from her abdomen about ten days ago.
20 She had a repeat ultrasound yesterday which
21 showed a very slight pocket of fluid still
22 there." And she goes on then, and there is a
23 note on the third last line that "she takes
24 the Morphine for break-through, which is
25 keeping things under control. Her appetite

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1 has actually been fairly good and overall she
2 says that she has felt better than she has in
3 the last five months." Dr. Laing goes on, "I
4 had sent an e-mail to Dr. Clifford Hudus in
5 the United States asking him if he had any
6 trials that Peggy might be eligible for. He
7 commented that it would be unusual for a
8 lobular carcinoma to be PR/ER negative. For
9 this reason, I had asked for her pathology to
10 be reviewed and interestingly, it came back
11 saying it was a ductal cancer, but when they
12 did stain her for ER/PR, it was positive for
13 both. Because of this, we started Peggy on
14 Tamoxifen as she still had evidence of
15 estrodal level, which would put her in the pre
16 menopausal range, although she has not had a
17 period for some time. She has been tolerating
18 the Tamoxifen well with no difficulties." And
19 she goes on to describe then her observations
20 in terms of her examination of her that day.
21 And the plan is noted to be: "Peggy is going
22 to go on her holiday. She has everything that
23 she needs, including some IV fluids, her pain
24 medications and her usual medications. She
25 will be back in town on May 11th, 2005 and I

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1 have booked her to come and see me on May 13th
2 in my Friday clinic. I will be on call on
3 that time and I told her that if there are any
4 difficulties when she comes back from Cuba,
5 she can come directly to the Emergency Room
6 and we can look after her then, if needed. I
7 am hopeful that she will get some response to
8 the Tamoxifen and I have started her on an
9 LH/RH agonist at the same time, just knowing
10 that at some point we may consider adding in
11 Femara. We need to have her ovaries
12 suppressed before this." So, Doctor, in terms
13 of what's recorded here, does that accord with
14 -
15 DR. DEANE:
16 A. Actually, Commissioner, I think I was slightly
17 in error. I notice here on the 1st of June,
18 which is after we got back from Cuba, she was
19 on Tamoxifen still.
20 COFFEY, Q.C.:
21 Q. And I will get to that and I appreciate -
22 DR. DEANE:
23 A. So she was on it a little longer than I
24 stated, yes.
25 COFFEY, Q.C.:

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1 Q. In terms of May 3rd, 2005, Exhibit C-0168, the
2 references here to Dr. Hudus, the interaction
3 with Dr. Hudus and what at least Dr. Laing
4 told you about it, is that consistent with
5 what you remember about it?
6 DR. DEANE:
7 A. Pretty well. I know she went the extra mile
8 for us, yes, we asked if she would see if
9 there was anything else that could be done and
10 she contacted this doctor at Sloan-Kettering
11 and this is obviously the result of that
12 effort that she made on our behalf.
13 COFFEY, Q.C.:
14 Q. If we could, please Registrar, Exhibit C-0156,
15 there was a portion of it that I didn't
16 address the first time through. This is the
17 pathology report, St. Clare's Mercy Hospital
18 for Peggy Deane. It's for specimen number 02
19 SS: 4884, do you see that Doctor?
20 DR. DEANE:
21 A. What page are we on?
22 COFFEY, Q.C.:
23 Q. It's on page one of Exhibit C-0156, it's right
24 towards the beginning. Do you have that?
25 DR. DEANE:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Great. Now this is the same report that when
4 you go to the second page it, we looked at
5 this earlier, the second page is the one that
6 has the pathological interpretation describes
7 the tumor and tumor summary as infiltrating
8 lobular carcinoma and we go on to the third
9 page, microscopy, the one that says "sections
10 show a tumor comprised of infiltrating lobular
11 carcinoma", and it goes on from there. And at
12 the bottom, I had referred you to this
13 earlier, the comment: "For the most part,
14 this tumor is comprised of a mixture of
15 lobular carcinoma in situ with invasive
16 lobular carcinoma. It is noted that both the
17 in situ as well as invasive components in
18 areas attained has somewhat ductal appearance,
19 however this is not a prominent finding." And
20 this is signed off by Dr. Ford Elms, June
21 27th, 2002. This is back, it would be at the
22 time of your wife's initial diagnosis. If we
23 go back to the first page, there is under the
24 heading right here, "Addendum" which is in
25 white lettering against a black background.

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1 It reads Addendum No. 3 entered May 31st, 2005
2 at, I understand that would be 1528 hours.
3 It's signed by Dr. Ford Elms on May 31st,
4 2005. The addendum is signed using a
5 signature on file and it reads,
6 "Immunohistochemical staining for ER and PR
7 has been repeated on this tissue using Ventana
8 automated system. Stains for both receptors
9 are positive." And I stand to be corrected,
10 but I believe an examination of those three
11 pages would show that that's the only
12 reference to the retesting and the ER and PR
13 in the pathology report.
14 DR. DEANE:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Were you ever told what the percentage of
18 positivity was on the retesting?
19 DR. DEANE:
20 A. No, they just said her estrogen receptor
21 status has changed, they were going to try
22 Tamoxifen.
23 COFFEY, Q.C.:
24 Q. They didn't--you weren't given an actual
25 figure.

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1 DR. DEANE:
2 A. No. I might have been, but I don't recall and
3 that's all I know.
4 COFFEY, Q.C.:
5 Q. Sure, and it's not recorded here, I know that,
6 but if you were given a figure, you don't
7 recall it?
8 DR. DEANE:
9 A. No.
10 THE COMMISSIONER:
11 Q. Mr. Coffey, is this a convenient place to take
12 a morning break?
13 COFFEY, Q.C.:
14 Q. Yes, it would be. Thank you Commissioner.
15 THE COMMISSIONER:
16 Q. All right, we'll do that then.
17 (RECESS)
18 THE COMMISSIONER:
19 Q. Please be seated. Mr. Coffey.
20 COFFEY, Q.C.:
21 Q. Thank you, Commissioner. Now, Doctor, if we
22 could Register please, Exhibit C-0169. Now
23 Doctor, these are progress notes for Peggy
24 dated June 1, 2005. Two pages long, the notes
25 are those of Dr. Laing and they are just some

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1 portions of this I wish to refer you to.
2 Diagnosis is metastatic carcinoma of the
3 breast. Extensive disease to the lung, liver,
4 bones. Presently on Tamoxifen and Zoladex,
5 multiple previous chemotherapies. Recently
6 found to be ER positive and previously thought
7 to be ER negative. And she notes, "Peggy
8 returns to clinic today. Overall she is doing
9 okay." So I take it then, Doctor, this was
10 the situation just over two weeks after your
11 vacation?
12 DR. DEANE:
13 A. Yes, that's right.
14 COFFEY, Q.C.:
15 Q. And the second page under "Plan", Dr. Laing
16 notes in the first line, "Certainly I think
17 the Tamoxifen has to be working because I do
18 not have any other explanation for the failure
19 reaccumulation of the ascites and pleural
20 fluids, even though we did a pleural
21 synthesis, I do not think it would be
22 successful enough to stop the fluid from
23 reaccumulating. She feels better overall. I
24 suspect she may have had disease in these
25 areas in her bones previously and the symptoms

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1 may be a flare. She has been on the Tamoxifen
2 now for six weeks. She has also had two shots
3 of Zoladex." And she goes on then to say, "I
4 discussed with her and her husband today,
5 again the rationale for putting her on
6 Zoladex. It is twofold, one is that some
7 studies in patients with metastatic breast
8 cancer who are pre-menopausal and ER positive
9 have shown an increased benefit to giving
10 Tamoxifen and Zoladex together. The second
11 issue is that at some point she is going to
12 progress on the Tamoxifen and then we will be
13 ready to treat her with Femara and we won't
14 have to worry about the fact that she is pre-
15 menopausal because the Zoladex will make her
16 post-menopausal. I do not plan to switch her
17 to Femara, however, until I have clear
18 evidence that the Tamoxifen is not working. I
19 do not think that is the case at present."
20 And she concludes by saying, "She will go
21 ahead with the radiation and stay on the
22 Tamoxifen and Zoladex and I will see her back
23 in a couple of weeks and I am going to get a
24 CT scan in the interim." So that was the
25 situation, Doctor, at the beginning of June,

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1 apparently Peggy was then on Tamoxifen.
2 DR. DEANE:
3 A. Correct. I was previously wrong. They did
4 carry on with the Tamoxifen after our return
5 from Cuba and there was a concern about the
6 flare phenomenon that she refers to.
7 COFFEY, Q.C.:
8 Q. Yes, she does, in fact in terms of Exhibit C-
9 0169, because you did recall really from
10 memory earlier this morning, the concern about
11 flare and under "Impressions" at the bottom of
12 that first page of 0169, "no reaccumulation of
13 pleural or peritoneal fluid, improved clinical
14 symptoms aside from bone pain." And then she
15 notes at the top of the next page, "I wonder
16 if these bony things may be a flare
17 phenomena." So there was a concern, as your
18 memory of that is certainly accurate.
19 DR. DEANE:
20 A. Yes, she got the numbness in her chin. She
21 had a lesion in her jaw and this might have
22 been precipitated, the numbness may have been
23 precipitated by the Tamoxifen. I think it
24 produces edema and swelling of the lesion and
25 then it produces pressure on the nerve. You'd

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1 have to ask her about that. I'm not an expert
2 and I probably shouldn't say too much. Yeah,
3 but it certainly seemed for a time that the
4 Tamoxifen was effective. It's too bad we
5 didn't use it earlier.
6 COFFEY, Q.C.:
7 Q. Yes. And in fact, as your memory or
8 understanding of it is that Tamoxifen, at
9 least for a short period of time was
10 effective.
11 DR. DEANE:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And when you look at page two of 0169, Dr.
15 Laing does note in the first line, "Certainly
16 I think the Tamoxifen has to be working."
17 DR. DEANE:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. As of that point, bearing in mind the advanced
21 stage of the disease that your wife was
22 suffering form.
23 DR. DEANE:
24 A. Unfortunately at this point in time, basically
25 too late, but it did help to some extent.

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1 COFFEY, Q.C.:
2 Q. Registrar, Exhibit C-0170, please? These are
3 progress notes of Dr. McCarthy for the 4th of
4 July, 2005 for Margaret Dean, Medical Oncology
5 Clinic. And under "Diagnosis", Dr. McCarthy
6 has noted "metastatic carcinoma of the breast,
7 lung, liver, bone and lymph nodes, recently
8 found to be ER/PR positive and still on
9 Tamoxifen and Zoladex." And she continues on
10 from there, under "Plan, it's noted "Peggy
11 does not want to come in the hospital, but
12 would like to have everything done as an
13 outpatient. I will send her for a chest x-ray
14 and blood work today and Dr. Collingwood has
15 kindly agreed to do an ultrasound tomorrow to
16 see if there are any ascites to be drained and
17 to see if she has new bladder and distention."
18 And she continues on in the next page then
19 about the care that is anticipated to be
20 required. If I could please, Registrar,
21 Exhibit C-0171. Now this is a two-page
22 letter, Doctor, it's from Dr. Jonathan
23 Greenland who signs it on the second page,
24 radiation oncology. And Dr. Greenland has
25 addressed it to Dr. Elizabeth Mate-Downer.

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1 Who is Doctor Downer, do you recall?
2 DR. DEANE:
3 A. Her family doctor, yes.
4 COFFEY, Q.C.:
5 Q. And in this letter, Dr. Greenland is letting,
6 I take it, Dr. Downer know of what Peggy's
7 situation is and by this point in time they
8 were talking about palliative care, as you've
9 noted earlier that she was in that stage.
10 DR. DEANE:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. In the beginning of July. Here at one point
14 on the ER/PR, first page of the letter, Dr.
15 Greenland in the fourth paragraph says, "More
16 recently on pathology review, her tumor was
17 found to be ER/PR positive, whereas previously
18 it had been called ER/PR negative. This did
19 open up a couple of other therapeutic options
20 for her in the form of hormonal therapy. She
21 was started on Tamoxifen with good results
22 initially a few months ago; however, has since
23 progressed and will switch to second line
24 Femara therapy. Unfortunately this progressed
25 despite this line of treatment as well. There

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1 are not any other systemic antineoplastic
2 options available to her at the moment." And
3 the second page, Dr. Greenland notes that your
4 wife is near the end of her disease process
5 and he had discussed the matter frankly with
6 both her and yourself. He concludes by noting
7 the short-term plan for her is to go home;
8 however, she will likely have to come back in
9 the hospital over time. It is going to reach
10 the point where there won't be any point in
11 her being admitted to an acute care hospital.
12 And Dr. Greenland advises Dr. Downer that she
13 can contact either himself of Dr. Laing. And
14 I take it then, sir, that within a month, your
15 wife was dead?
16 DR. DEANE:
17 A. Correct.
18 COFFEY, Q.C.:
19 Q. Doctor, I asked if you have ever spoken with
20 Dr. Elms and you indicated "no." Have you
21 ever spoken with any other pathologist about
22 this?
23 DR. DEANE:
24 A. No. All my communication has been through the
25 oncologists. It seems that the oncologists

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1 have to break the news to their patients,
2 which is a tough job. The pathologists
3 generally--well, they never called me. I
4 often get calls from the pathologists at the
5 Janeway Hospital regarding patients, but I
6 never had a call from any of the pathologists
7 at the Health Sciences Centre.
8 COFFEY, Q.C.:
9 Q. In relation to this matter?
10 DR. DEANE:
11 A. In relation to this matter, no.
12 COFFEY, Q.C.:
13 Q. Now, Doctor, you've indicated that in April of
14 2005 you were advised that the tumor tissue
15 from Peggy had been retested for ER/PR status
16 and you were advised that the status had
17 changed, and you've indicated as well that at
18 the time you didn't--weren't told where it was
19 retested?
20 DR. DEANE:
21 A. No.
22 COFFEY, Q.C.:
23 Q. But based upon the pathology report we looked
24 at just a little while ago, before the break,
25 I believe, Dr. Ford Elms on May 31st, 2005,

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1 reported it as the ER/PR status had changed.
2 DR. DEANE:
3 A. Correct.
4 COFFEY, Q.C.:
5 Q. Suggesting that it was probably retested
6 locally?
7 DR. DEANE:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. And there'll be more evidence on that. Do you
11 know if Peggy's tumor tissue has ever been
12 retested at Mount Sinai?
13 DR. DEANE:
14 A. I don't know where it was all done. I just
15 know it was retested.
16 COFFEY, Q.C.:
17 Q. Okay. Has anyone ever advised you that it was
18 retested at Mount Sinai?
19 DR. DEANE:
20 A. No.
21 COFFEY, Q.C.:
22 Q. Doctor, has anyone from Eastern Health or any
23 of the physicians who treated your wife told
24 you what may have happened to cause or
25 contribute to the discrepancy in her ER

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1 testing between 2002 and 2005?
2 DR. DEANE:
3 A. No. When we were told of the change in her
4 receptor status, certainly the three
5 oncologists were apologetic, but at that time,
6 they had only just--Peggy was the index case.
7 They'd only just found the change, and so they
8 didn't know what the problem was. They just
9 knew there was a problem, and so they didn't
10 elaborate, and that's quite understandably the
11 case.
12 COFFEY, Q.C.:
13 Q. Sure.
14 DR. DEANE:
15 A. Since then, well, it's up to the Commission to
16 find out where the problem was. It would be
17 inappropriate for me to comment. I have my
18 ideas, but they're best left unsaid.
19 COFFEY, Q.C.:
20 Q. And in terms of that, it's not like, for
21 example, in your case, I take it you are a
22 minimum of five, probably six or seven days a
23 week, in the General Hospital facility.
24 You're easily found.
25 DR. DEANE:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Since your wife passed away in August of 2005,
4 has anyone from Eastern Health come to you and
5 spoken to you about the ER/PR result that she
6 had originally and the change and the possible
7 reason or reasons for it?
8 DR. DEANE:
9 A. Nobody from management. Dr. Kara Laing and
10 Dr. Joy McCarthy told me of the status.
11 COFFEY, Q.C.:
12 Q. Sure.
13 DR. DEANE:
14 A. Not a great deal of detail as to why the error
15 occurred and where it occurred.
16 COFFEY, Q.C.:
17 Q. And I appreciate that initially, but since
18 August 2005, since your wife's death, has
19 anyone spoken to you about it?
20 DR. DEANE:
21 A. I'm aware there were a lot of problems in the
22 laboratory.
23 COFFEY, Q.C.:
24 Q. Yes, you're aware of that?
25 DR. DEANE:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. And I mean in a--not so much in a, you know,
4 having a cup of coffee in the cafeteria
5 situation. I mean in a -
6 DR. DEANE:
7 A. Nobody has formally come and apologized to me
8 from Eastern Health, none of the
9 administration or CEO or anything like that,
10 no.
11 COFFEY, Q.C.:
12 Q. Okay. Someone--no one who you, in the
13 context, thought of and perceived to be
14 officially representing Eastern Health in that
15 regard?
16 DR. DEANE:
17 A. No.
18 COFFEY, Q.C.:
19 Q. So they haven't--no one has apologized to you
20 or expressed any regret to you?
21 DR. DEANE:
22 A. No.
23 COFFEY, Q.C.:
24 Q. Has anyone from Eastern Health or any of the
25 physicians involved expressed to you any

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1 acceptance of responsibility for what
2 happened?
3 DR. DEANE:
4 A. Not really. I mean, the oncologists told me
5 about it, but they're not responsible for the
6 problem.
7 COFFEY, Q.C.:
8 Q. Yes.
9 DR. DEANE:
10 A. But so, they apologized but not on their own
11 behalf, on behalf of the others.
12 COFFEY, Q.C.:
13 Q. Has anyone from Eastern Health offered you any
14 follow-up meeting or any meeting at all to
15 discuss this issue?
16 DR. DEANE:
17 A. No.
18 COFFEY, Q.C.:
19 Q. Has anyone from Eastern Health or any of the
20 physicians that you understand were involved
21 or potentially involved in this outlined to
22 you any plan that might exist that's intended
23 to rectify the harm and prevent recurrence of
24 this problem?
25 DR. DEANE:

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1 A. Well, I'm aware that there are problems which
2 are being dealt with, but no one's
3 specifically come and told me or outlined it
4 to me.
5 COFFEY, Q.C.:
6 Q. And I appreciate that, no one's come to you?
7 DR. DEANE:
8 A. No.
9 COFFEY, Q.C.:
10 Q. And no one has--I take it then no one has, in
11 fact, explained to you what the cause or
12 causes might have been?
13 DR. DEANE:
14 A. No.
15 COFFEY, Q.C.:
16 Q. Doctor, Peggy died in August of 2005. This
17 did not become a matter known generally
18 publicly until October 2nd, 2005. That's a
19 matter of public record. The Independent
20 published--Independent newspaper published a
21 story, and then there was--it was dealt with
22 in the media at various points over the years
23 that followed. Do you have any thoughts or
24 observations about Eastern Health's approach
25 to this?

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1 DR. DEANE:
2 A. Well, there certainly has been a delay in
3 disclosure. A certain amount of delay is
4 acceptable because you have to get all your
5 facts together and your ducks in a row before
6 you go in front of the media, get all your
7 information correct. Stories we're hearing in
8 the press right now, there's been a lot of
9 delays in informing patients of this problem,
10 which certainly seemed rather excessive, if
11 the patients' accounts are correct. I'm very
12 glad that the problem is getting the attention
13 it has got and I think Peggy would be pleased
14 to know that some good has come out of this,
15 that the problem will be rectified. I know
16 she felt very strongly about that. She said
17 "at least I hope anyone in the future don't
18 have to go through this." So from her
19 perspective, certainly, you know, I'm glad
20 that this has happened. I'm glad we're here,
21 and I think it's largely due to her case that
22 we are here. I know that there have been
23 problems prior to her and that the system was
24 aware of problems in the lab. I wish we had
25 known. We would have had it independently

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1 tested elsewhere.
2 COFFEY, Q.C.:
3 Q. These problems you're referring to, I take it,
4 are the 2003 Dr. Ejeckam memos?
5 DR. DEANE:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. And that's a matter of public record.
9 DR. DEANE:
10 A. Yes, and I only found out about that
11 subsequent to her passing.
12 COFFEY, Q.C.:
13 Q. Subsequent to her death, okay. That was when
14 you first heard of that?
15 DR. DEANE:
16 A. Yes. I'd never heard of the Dr. Ejeckam memos
17 and his warnings. I wish I had known because
18 I think we would have got an independent test,
19 certainly got independent opinions on her
20 management and we just--you accept the
21 results. They are what they are and you
22 accept them at face value. I mean, I guess if
23 I look at an x-ray, I don't question the
24 technique of the x-ray tech. I don't say "how
25 many milliamps and kilovolts did you use? How

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1 far from the limb was the x-ray machine?" and
2 so on. You just look at the x-ray and you
3 take it for what it is. Presumably that's,
4 you know, what the oncologists did. They've
5 had to work with the information they're
6 given.
7 COFFEY, Q.C.:
8 Q. And it's your view then that if, in 2005--
9 well, in 2002 or certainly in 2003, if you'd
10 become aware of the concerns expressed by Dr.
11 Ejeckam in '03, you might have, at that point,
12 and probably would have, in fact, questioned
13 the pathology reports that your wife had
14 gotten in 2002?
15 DR. DEANE:
16 A. We would have probably got it tested
17 elsewhere.
18 COFFEY, Q.C.:
19 Q. And you didn't--and just so we're clear, you
20 did not become aware of Dr. Ejeckam's memos or
21 expressions of concern that apparently were
22 made in 2003 until after August 2005?
23 DR. DEANE:
24 A. Correct.
25 COFFEY, Q.C.:

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1 Q. Any other thoughts, Doctor? If there's
2 anything further you wish to add?
3 DR. DEANE:
4 A. I don't know where this is all going. I mean,
5 there's a lot of material still to come.
6 There's a lot of -
7 THE COMMISSIONER:
8 Q. So I'm told.
9 DR. DEANE:
10 A. It's going to be a long inquiry. One of my--
11 one of the--I was out of town recently and
12 picked up quite a lot of different reports of
13 the media, and I was somewhat dismayed to see
14 Dr. Laing and Dr. McCarthy's name in
15 editorials because they have done--they've
16 done an excellent job and they were really--
17 they're some of the finest physicians I've
18 ever met. They're not only compassionate and
19 caring, but they're smart. They're wonderful
20 doctors and I just hope this province doesn't
21 lose them, because they're great people. I
22 don't know whose fault or what the problem was
23 in the lab. I know they're under staffed,
24 under paid, overworked, under appreciated, and
25 I hope Eastern Health doesn't dump them. I

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1 hope they take care of their physicians. It
2 doesn't excuse what's happened. It's up to
3 you to find out exactly where the problem
4 arose and why, and it seems to be a very
5 technical thing, which it would be
6 inappropriate for me to comment on,
7 technicalities of it.
8 One other little observation which I
9 probably--I don't know if it's appropriate to
10 share, but when I worked in the old Janeway,
11 quality assurance was a much more--physicians
12 were more involved in it. I used to get a
13 little note every quarter, "Dear Doctor,
14 please find enclosed your infection rate," and
15 you know, "you've had 0.85 infections in this
16 last quarter. The average for your specialty
17 is" such and such. So you'd know if you were-
18 -if you had more than the normal number of
19 infections or less than the normal number of
20 infections. So you kind of got some feedback
21 as to how you were doing, and they had a very
22 active quality assurance committee and there
23 were a number of physicians on it, and since
24 we moved to the new site, with amalgamation
25 and economies of scale, that was dropped. So

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1 I don't know if quality assurance is quite as-
2 -it's changed and perhaps communication
3 between physicians and quality assurance
4 committees is not what it used to be. That's
5 one change I've noticed and I thought might be
6 worthy of comment.
7 They used to come up with other things
8 like our length of stay. My length of stay was
9 higher than the national average, and I was
10 asked to explain that, and I said "well, you
11 know, we have patients in Goose Bay and in St.
12 Anthony. We're not in Etobicoke where you can
13 just send them home and they can come back
14 tomorrow if there's a problem. We hang on to
15 them longer," and they accepted that, but you
16 know, there was a process in place.
17 It doesn't seem to be--it's not the same.
18 Now I know the new infection control nurse,
19 and I've worked with her for 20 years, and
20 she's excellent, so it's not to say that
21 they're not good people in quality assurance,
22 but maybe they're spread a bit more thinly. I
23 don't know, and that's, I guess, part of what
24 you will look at down the road. I don't get
25 the impression there was a lot of quality

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1 assurance in that lab.
2 THE COMMISSIONER:
3 Q. So are you suggesting that a component of
4 quality assurance has to be communication
5 with, I would presume, others involved but
6 certainly with the physicians involved?
7 DR. DEANE:
8 A. Yes.
9 THE COMMISSIONER:
10 Q. So that you are conscious of those factors
11 which lead to a quality product, if you will?
12 DR. DEANE:
13 A. Yes.
14 THE COMMISSIONER:
15 Q. And if something that's happening that
16 indicates that perhaps other measures should
17 be taken or things haven't been going right
18 for the last quarter, at least when you're
19 advised, you can take corrective measures?
20 DR. DEANE:
21 A. Yeah. I think you should know if there's a
22 problem and somebody should be--you don't want
23 big brother breathing down--you know,
24 breathing down your neck over your shoulder,
25 but it has changed and it wasn't--it was a

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1 very positive process, you know. It wasn't
2 offensive. It was just simply these are your
3 stats, and everybody has numbers. I just
4 noticed that's changed.
5 THE COMMISSIONER:
6 Q. Okay.
7 DR. DEANE:
8 A. The other thing is I think that physicians are
9 probably getting--a lot of decisions are not
10 made by physicians that used to be and we
11 probably have less control of the purse
12 strings in decision making, yet we're still
13 responsible if things go wrong. You know,
14 we're held accountable. It may not
15 necessarily be that we are responsible. But,
16 I'm thinking of the laboratory. I mean,
17 they're working under very tough
18 circumstances, and perhaps somebody from
19 Eastern Health should be looking at that
20 situation and, you know, try and make their
21 life easier for them.
22 THE COMMISSIONER:
23 Q. When you're talking about tough circumstances,
24 are you referring to the numbers or -
25 DR. DEANE:

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1 A. Yes, I mean, there's a high turnover in that
2 lab. People obviously are not happy. They
3 can make a lot more money in Ontario. So
4 they're working under--and they're overworked.
5 I don't think, you know, the positions are all
6 filled. So there's a shortage and that's
7 probably part of why this problem has arisen,
8 and I think also physician training. You
9 know, maybe they don't get time to get to
10 conferences and maybe they should be funded to
11 go to conferences, you know, keep up with new
12 developments. I don't want to speak too much
13 out of turn because -
14 COFFEY, Q.C.:
15 Q. But I did ask if there were any thoughts that
16 you'd had. You had now a number of years
17 actually to think about this.
18 DR. DEANE:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. And to watch it unfold, and you are somebody
22 who is not directly, as a physician involved,
23 but you do work on the inside, as it were,
24 within Eastern Health.
25 DR. DEANE:

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1 A. I suppose there's one other thing, having been
2 a little bit involved in quality assurance,
3 and I don't know if it's appropriate for me to
4 relate an experience to you. When I was an
5 intern, one of the surgeons I was working with
6 had a particularly high infection rate, way
7 above what was acceptable, and they then
8 looked at all the other surgeons in that
9 operating room, and this was in South Africa,
10 it's called operating theatre, and they found
11 that all their infection rates were high and
12 initially they blamed the original surgeon,
13 and said "well, he's doing a lousy job." But
14 then when they found that they were all high,
15 they said "there's something here in the
16 system." They then looked at the nurses and
17 said "are they cleaning the instruments
18 properly? Are they sterilizing them
19 properly?" And it got into a bit of an
20 argument between nurses and doctors, which was
21 unusual in those days, but it got a little
22 ugly. They then found that actually there was
23 a temperature gauge in the autoclave that was
24 defective and they also found a dead seagull
25 in the air intake to the air conditioning of

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1 the operating room. Well, they got rid of the
2 seagull and they fixed the autoclave and the
3 problem resolved, but nobody was at fault. So
4 sometimes there are systemic problems.
5 Particularly, I think, if you got one
6 physician with a high infection rate and
7 everybody else is okay, well then, he's got a
8 problem. But if everybody's doing something
9 wrong, then there's a systemic problem. It's
10 in the system, and that's, I guess, it's just,
11 the message I'm saying, if it was one
12 pathologist who's doing all the false ER
13 tests, then he's got a problem. But if it's
14 all of them, then you have a system problem.
15 That's how I see it. Now this is for you to
16 evaluate and decide down the road.
17 COFFEY, Q.C.:
18 Q. And Doctor, in terms of that, I take it,
19 because you've told us that Eastern Health and
20 nobody from Eastern Health has actually
21 informed you or spoken to you about what, if
22 anything, is known about what caused the
23 problem, they haven't actually told you
24 anything like that?
25 DR. DEANE:

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1 A. No.
2 COFFEY, Q.C.:
3 Q. And you've not read any reports or anything
4 that purport at least to deal with or to
5 address what caused this?
6 DR. DEANE:
7 A. No. I'm aware of that there have been reviews
8 of the pathology divisions and there are
9 issues there.
10 COFFEY, Q.C.:
11 Q. Okay.
12 DR. DEANE:
13 A. But it's not appropriate for me to comment.
14 COFFEY, Q.C.:
15 Q. I appreciate that, Doctor. Is there anything
16 further?
17 DR. DEANE:
18 A. I don't think so, no.
19 COFFEY, Q.C.:
20 Q. Okay. They're the questions I have. I don't
21 know if other counsel have any, Commissioner.
22 I'll step aside here.
23 THE COMMISSIONER:
24 Q. Mr. Pritchard?
25 MR. PRITCHARD:

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1 A. Dr. Deane, thank you for your evidence.
2 Commissioner, I have no questions.
3 THE COMMISSIONER:
4 Q. Mr. Simmons?
5 MR. SIMMONS:
6 Q. I have no questions either. Thank you very
7 much, Dr. Deane.
8 THE COMMISSIONER:
9 Q. Mr. Browne?
10 MR. BROWNE:
11 Q. Good morning, Dr. Deane. I deeply appreciate
12 your evidence here this morning.
13 MS. O'DEA:
14 Q. Thank you, Dr. Deane. We have no questions.
15 THE COMMISSIONER:
16 Q. Ms. Newbury?
17 MS. NEWBURY:
18 Q. Thank you, Dr. Deane. No questions of Dr.
19 Deane.
20 THE COMMISSIONER:
21 Q. Mr. Crosbie?
22 CROSBIE, Q.C.:
23 Q. No questions, thank you.
24 THE COMMISSIONER:
25 Q. Thank you. Thank you very much, Dr. Deane. I

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1 do appreciate you coming here today to give us
2 the story of you and your wife and your
3 journey and your views on what has occurred
4 and what should be done.
5 DR. DEANE:
6 A. Thank you.
7 THE COMMISSIONER:
8 Q. Thank you.
9 COFFEY, Q.C.:
10 Q. Just a moment, Commissioner, please.
11 THE COMMISSIONER:
12 Q. Yes, of course.
13 COFFEY, Q.C.:
14 Q. Just checking on the availability of a
15 witness, Commissioner.
16 THE COMMISSIONER:
17 Q. All right.
18 COFFEY, Q.C.:
19 Q. Thank you.
20 THE COMMISSIONER:
21 Q. Do you -
22 COFFEY, Q.C.:
23 Q. Can we take a break for a couple of minutes?
24 THE COMMISSIONER:
25 Q. Do you want to take a break while you do that?

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1 COFFEY, Q.C.:
2 Q. Thank you very much.
3 THE COMMISSIONER:
4 Q. Yes, all right. We'll take five minutes. You
5 can let me know when you're ready.
6 COFFEY, Q.C.:
7 Q. Thank you, Commissioner.
8 (BREAK)
9 THE COMMISSIONER:
10 Q. Ms. Chaytor?
11 CHAYTOR, Q.C.:
12 Q. Thank you, Commissioner. Our next witness is
13 Geraldine Rogers. Registrar, I would ask,
14 please, if you would have Ms. Rogers sworn or
15 affirmed.
16 MS. GERALDINE ROGERS, AFFIRMED, EXAMINATION BY SANDRA
17 CHAYTOR, Q.C.
18 REGISTRAR:
19 Q. Would you please state and spell your complete
20 name for the Commission?
21 MS. ROGERS:
22 A. It's Augusta Maria Geraldine Rogers, A-U-G-U-
23 S-T-A M-A-R-I-A G-E-R-A-L-D-I-N-E R-O-G-E-R-S
24 CHAYTOR, Q.C.:
25 Q. I promise the questions get simpler. Good

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1 morning, Ms. Rogers. Please take a seat.
2 THE COMMISSIONER:
3 Q. Good morning, and now make yourself
4 comfortable there.
5 MS. ROGERS:
6 A. Thank you.
7 CHAYTOR, Q.C.:
8 Q. Thank you for joining us and thank you for
9 accommodating our change in scheduling today.
10 Commissioner, the documents that we will be
11 referring to today during Ms. Rogers' evidence
12 are the documents from her medical chart,
13 which are C exhibits, C No. 0071 and C-0116
14 through to C-0144 inclusively. As well, we
15 have a number of P exhibits for Ms. Rogers,
16 and those are exhibits number P-0009 through
17 to P-0016 inclusively. I would ask, please,
18 that these documents be entered as exhibits.
19 THE COMMISSIONER:
20 Q. So entered.
21 EXHIBIT ENTERED AND MARKED EXHIBIT C-0071
22 EXHIBITS ENTERED AND MARKED EXHIBITS C-0116 THROUGH C-
23 0144
24 EXHIBITS ENTERED AND MARKED EXHIBIT P-0009 THROUGH P-0016
25 CHAYTOR, Q.C.:

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1 Q. Thank you, and Ms. Rogers, those documents
2 will be displayed on the screen in front of
3 you or you can refer to the book, whichever
4 you're more comfortable with.
5 MS. ROGERS:
6 A. Thank you.
7 CHAYTOR, Q.C.:
8 Q. Ms. Rogers, perhaps we could begin, you could
9 just tell us a little bit about yourself, your
10 date of birth, where you're from and your
11 employment background.
12 MS. ROGERS:
13 A. I was born August 17th, 1956 in the lovely
14 town of Corner Brook, Newfoundland. For the
15 past 26 years, I've been a documentary film
16 maker.
17 CHAYTOR, Q.C.:
18 Q. And where do you currently reside?
19 MS. ROGERS:
20 A. I currently reside in St. John's.
21 CHAYTOR, Q.C.:
22 Q. Okay, and we understand that you are a breast
23 cancer patient?
24 MS. ROGERS:
25 A. I have been, yes.

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1 CHAYTOR, Q.C.:
2 Q. Yes, and when were you diagnosed with breast
3 cancer and where did that diagnosis take
4 place?
5 MS. ROGERS:
6 A. I was diagnosed with breast cancer in July--in
7 June of 1999 in Carbonear. My physician was
8 Dr. Paul Heneghan and I had--after an initial-
9 -I had a surgical biopsy of my left breast and
10 then I had a modified radical mastectomy, July
11 2nd, 1999. I was told I had infiltrating
12 ductal carcinoma of the left breast and that I
13 was Stage II B. I then was referred to the
14 Bliss Murphy Cancer Centre in St. John's.
15 CHAYTOR, Q.C.:
16 Q. Okay, and whose care did you come under at the
17 Cancer Centre?
18 MS. ROGERS:
19 A. The amazing, incredible Dr. Kara Laing and I
20 believe I was her first patient when she
21 returned to the province.
22 CHAYTOR, Q.C.:
23 Q. Is that right? At the time of your diagnosis,
24 Ms. Rogers, do you know whether there was an
25 ER/PR test carried out?

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1 MS. ROGERS:
2 A. At the time of my initial diagnosis, I did not
3 know. However, when I met with Dr. Laing, I
4 never really--I received a copy of my
5 pathology, but there was no ER/PR information
6 on that pathology that came as result of my
7 mastectomy, and she told me that I was ER
8 positive. Pardon me, that I was PR positive,
9 ER negative.
10 CHAYTOR, Q.C.:
11 Q. Okay. So Dr. Laing advised you of that?
12 MS. ROGERS:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. Okay.
16 MS. ROGERS:
17 A. So I underwent six months of chemotherapy. I
18 did CEF. After that, I did five weeks of
19 radiation therapy.
20 CHAYTOR, Q.C.:
21 Q. Okay. So what did you understand the
22 significance of being ER negative PR
23 positivity, what did you understand the
24 significance of that to be to your treatment?
25 MS. ROGERS:

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1 A. Well, I knew that the protocol, if you were ER
2 positive, that the protocol would be to take
3 Tamoxifen after chemo and radiation. I wasn't
4 ER positive. I was told I wasn't ER positive,
5 so I didn't take Tamoxifen.
6 CHAYTOR, Q.C.:
7 Q. You were PR positive?
8 MS. ROGERS:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. Were you advised of the percentage of PR
12 positivity?
13 MS. ROGERS:
14 A. I believe I was advised that I was PR positive
15 70 percent.
16 CHAYTOR, Q.C.:
17 Q. So you continued then with six months of
18 chemotherapy?
19 MS. ROGERS:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. Followed by five weeks of radiation?
23 MS. ROGERS:
24 A. That's right.
25 CHAYTOR, Q.C.:

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1 Q. And then what happened in terms of your care?
2 MS. ROGERS:
3 A. Then Dr. Laing suggested that I consider
4 Tamoxifen. I, however, we discussed it a lot.
5 I also consulted with another doctor, because
6 it wasn't the standard protocol to take
7 Tamoxifen if you were ER negative. I came from
8 a family with a strong history of heart
9 disease on both sides of my family, I had
10 chemotherapy that could possibly affect my
11 heart, I had radiation that also could
12 possibly affect my heart. The side effects of
13 Tamoxifen, one of them is the possibility of
14 affecting your heart. So after careful
15 consideration and discussion with Dr. Laing
16 and then with Dr. Susan Love, who is perhaps
17 one of the--quite a recognized breast cancer
18 expert in the world, she advised me to not
19 take the Tamoxifen, that I then chose not to
20 take the Tamoxifen based on the pathology that
21 I had.
22 CHAYTOR, Q.C.:
23 Q. Yes. And Dr. Susan Love, is, where does she
24 practice?
25 MS. ROGERS:

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1 A. In California.
2 CHAYTOR, Q.C.:
3 Q. Okay. And how did you come to consult with
4 Dr. Love?
5 MS. ROGERS:
6 A. She's written a book called "Dr. Susan Love's
7 Breast Book" which is basically the breast
8 cancer survivor's Bible and handbook. She is
9 a breast cancer researcher, as well. So I
10 knew of her work, so I contacted her.
11 CHAYTOR, Q.C.:
12 Q. Okay. And her advice to you was the fact that
13 you were ER negative but PR positive, that you
14 not take Tamoxifen?
15 MS. ROGERS:
16 A. And based upon other factors in my life and
17 the staging of the cancer and the tumor,
18 that's what she suggested, yes.
19 CHAYTOR, Q.C.:
20 Q. Okay, and what was Dr. Laing's advice?
21 MS. ROGERS:
22 A. She felt, well, you know, that perhaps
23 Tamoxifen would have been one more thing that
24 might help me, but there was--it wasn't
25 definitive and that it wasn't protocol.

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1 CHAYTOR, Q.C.:
2 Q. So she was okay with your ultimate decision?
3 MS. ROGERS:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. Based on your pathology at that point in time?
7 MS. ROGERS:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. Okay. Registrar, if we could be shown,
11 please, Exhibit C-0117? Ms. Rogers, C-0117,
12 we understand this is the pathology report.
13 And you'll see it's from your left breast
14 biopsy?
15 MS. ROGERS:
16 A. Um-hm.
17 CHAYTOR, Q.C.:
18 Q. And the date is June 18th, 1999, Dr. Heneghan
19 is referred to. And your tumor, your tumor is
20 identified as being infiltrating ductal
21 carcinoma, moderately well differentiated is
22 the grade. And then page 2, the addendum
23 report indicates, "Estrogen receptors
24 negative, progesterone receptors positive, 60
25 to 70 percent of cells." And the pathologist

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1 is noted to be Dr. G. Baker. And the date,
2 1999/06/30, so June 30th, 1999. So this is
3 consistent with your understanding at the time
4 of your ER/PR status?
5 MS. ROGERS:
6 A. Yes. I've never seen this particular
7 pathology report. The pathology report that I
8 saw was after my mastectomy. So -
9 CHAYTOR, Q.C.:
10 Q. We have that one here, as well.
11 MS. ROGERS:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. And actually, this particular document, the
15 addendum we just referred to, we're just
16 seeing that ourselves for the first time in
17 the past hour. This was--the first page, I
18 believe, you would have seen before from your
19 breast, your left breast biopsy. But the page
20 actually with your addendum, the addendum
21 report with your ER/PR, that's the page I
22 would take it you haven't seen before?
23 MS. ROGERS:
24 A. No, I haven't seen either of them before.
25 CHAYTOR, Q.C.:

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1 Q. Okay. If we go back and look at the pathology
2 number, S1181-99 at the top right corner, the
3 first page, June 18th, 1999. And then we
4 scroll down to the second page, again it's
5 June 18th, 1999, S1181-99. And it appears
6 then that the ER/PR report is done with
7 respect to your biopsy sample, because this
8 would have been the date, is it not, for your
9 biopsy sample?
10 MS. ROGERS:
11 A. That's right.
12 CHAYTOR, Q.C.:
13 Q. Yes. Your mastectomy would have been later, I
14 believe, beginning of July?
15 MS. ROGERS:
16 A. That's right, yes.
17 CHAYTOR, Q.C.:
18 Q. Yes, okay. Thank you. If we could have then,
19 please, Registrar, Exhibit C-0118? And this
20 would have been the document then that you're
21 more familiar with then, Ms. Rogers?
22 MS. ROGERS:
23 A. That's right.
24 CHAYTOR, Q.C.:
25 Q. Your operation date is July 2nd, 1999 and this

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1 is the Department of Laboratory Medicine,
2 Carbonear General Hospital. And the pathology
3 number in the top right corner is now S1290-99
4 and your name. And this is your--the filing
5 diagnosis is breast left mastectomy. Residual
6 infiltration infiltrating carcinoma, see
7 approximately tumor size in the micro. And it
8 continues on from there. And if we look to
9 the left of this, you'll see some handwriting
10 in the left margin, which appears to be ER
11 negative, PR positive. And again, that's
12 consistent with what you would have been
13 advised at the time?
14 MS. ROGERS:
15 A. That's right. However, the copy of the
16 pathology that I received did not have the ER
17 negative, PR positive written on it.
18 CHAYTOR, Q.C.:
19 Q. Okay.
20 MS. ROGERS:
21 A. So this must have been added after.
22 CHAYTOR, Q.C.:
23 Q. And when did you receive your pathology
24 report?
25 MS. ROGERS:

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1 A. I received it, I think I received it from Dr.
2 Paul Heneghan, so perhaps before the ER/Pr
3 status was determined, I'm not sure.
4 CHAYTOR, Q.C.:
5 Q. Okay.
6 MS. ROGERS:
7 A. I don't know.
8 CHAYTOR, Q.C.:
9 Q. So it would have been shortly after your
10 surgery in July of 1999?
11 MS. ROGERS:
12 A. Yes. I asked for a copy of my pathology
13 before going to the cancer centre.
14 CHAYTOR, Q.C.:
15 Q. And so it may have been sometime after that
16 before the ER/PR test was performed, which we
17 understand would have been the case -
18 MS. ROGERS:
19 A. Perhaps.
20 CHAYTOR, Q.C.:
21 Q. - it would have been some time, some time
22 delay. Okay. Okay, Registrar, please,
23 Exhibit C No. 0119? Now, Ms. Rogers, this is
24 a letter then from the Avalon Health Care
25 Institutions Board written by your physician

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1 there, Dr. Paul Heneghan to Dr. Ralph George
2 at the Health Sciences Centre. Who is Dr.
3 George?
4 MS. ROGERS:
5 A. Dr. George is a surgeon who--Dr. Paul Heneghan
6 was the surgeon, was my surgeon who did the
7 mastectomy and then he referred me to Dr.
8 Ralph George.
9 CHAYTOR, Q.C.:
10 Q. Okay.
11 MS. ROGERS:
12 A. Who is also an oncologist surgeon, surgical
13 oncologist.
14 CHAYTOR, Q.C.:
15 Q. And this has been written, I believe this date
16 is July 8th, 1999. And he's writing to Dr.
17 George thanking him for agreeing to see you
18 and providing some background as to your
19 disease. And he indicates here, "Her estrogen
20 receptors are negative. She has positive
21 progesterone receptors, 60 to 70 percent of
22 cells. I will include this, as well." And so
23 this is the information being forwarded on in
24 the referral of your care?
25 MS. ROGERS:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. 0120, please, Registrar? And this is a first
4 assessment summary, July 16th, 1999,
5 pertaining to your care. And Newfoundland
6 Cancer Treatment and Research Foundation. And
7 on the second page we see that this is
8 dictated but not read by a Dr. J. Younus. Do
9 you recall your first visit to the cancer
10 clinic being seen by Dr. Younus?
11 MS. ROGERS:
12 A. Vaguely.
13 CHAYTOR, Q.C.:
14 Q. Okay.
15 MS. ROGERS:
16 A. Vaguely. I do know that I knew that Dr. Kara
17 Laing was coming and that she was going to be
18 the breast cancer expert and that I had asked
19 if I could wait and see her. So I have a
20 vague recollection of seeing Dr. Younus.
21 CHAYTOR, Q.C.:
22 Q. Okay. And again, this is July 6th, 1999. And
23 there's the diagnosis of moderately
24 differentiated ductal carcinoma, left breast.
25 Continues on down through your history of

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1 present illness and it refers to your ER/PR.
2 And Dr. Younus is writing, "Although I do not
3 have the ER/PR officially, I was told by Dr.
4 George and by the letter from the primary
5 physician that it was ER negative but PR
6 positive about 60 to 70 percent." So again,
7 that's consistent with what you were told?
8 MS. ROGERS:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. And with the documentation that we've now
12 looked at. And under "Assessment and Plan"
13 Dr. Younus has recorded, "Her ER was negative
14 and PR was positive. I have discussed in
15 detail about the chemotherapy that she should
16 receive in an adjuvant setting." So do you
17 recall discussing your treatment options with
18 Dr. Younus on this day?
19 MS. ROGERS:
20 A. Vaguely.
21 CHAYTOR, Q.C.:
22 Q. Vaguely, okay. Was there any discussion of
23 Tamoxifen or hormonal treatment on this date?
24 MS. ROGERS:
25 A. I don't recall, I don't think so.

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1 CHAYTOR, Q.C.:
2 Q. Okay. C-0121, please? And I believe this may
3 be your first visit then with Dr. Laing. This
4 is a--these are progress notes, August 6th,
5 1999, medical oncology clinic. And at the
6 bottom we see that it is Dr. K. Laing who has
7 signed. So would that be in keeping with your
8 recollection that it was around the beginning
9 of August?
10 MS. ROGERS:
11 A. That's right, yes.
12 CHAYTOR, Q.C.:
13 Q. Okay. And again the diagnosis is stage 2,
14 moderately differentiated ductal carcinoma of
15 the left breast. And she's seeing you post
16 left mastectomy. And if we look at the end of
17 this report, she notes that you had four lymph
18 nodes involved. "She will require referral
19 for radiation therapy upon the completion of
20 her chemotherapy. She had concerns about
21 taking adjuvant Tamoxifen and this will be
22 discussed further towards the end of her
23 chemotherapy." What were your concerns, Ms.
24 Rogers, about the Tamoxifen, is that the heart
25 complications that you've referred to earlier?

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1 MS. ROGERS:
2 A. Well, Tamoxifen is a nasty drug and cancer is
3 a nasty disease. And one doesn't want to take
4 Tamoxifen unless we know that the benefit far
5 outweigh the negative.
6 CHAYTOR, Q.C.:
7 Q. And your first visit with Dr. Laing you
8 discussed those concerns that you had on that
9 first visit?
10 MS. ROGERS:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. Okay. 0122. And again, Ms. Rogers, this is a
14 visit with Dr. Laing, January 4th, 2000,
15 medical oncology clinic. Your diagnosis is
16 moderately differentiated ductal carcinoma
17 left breast. And you'll see that it's node
18 positive carcinoma of the left breast,
19 receiving adjuvant CEF chemotherapy. ER
20 negative, PR positive. And again, it's Dr.
21 Laing. Dr. Laing concludes this report with
22 stating, "I'd like to see her back in six
23 weeks time. At that point she should be
24 started the radiation. I will talk to her
25 further about Tamoxifen at that point." So I

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1 take it at this point in time no decision had
2 been made as to whether or not you would take
3 Tamoxifen?
4 MS. ROGERS:
5 A. No. And my experience with Dr. Laing on that
6 point was that she was very respectful and was
7 very open to my being involved in my health
8 care process and that she was wonderful, just
9 wonderful.
10 CHAYTOR, Q.C.:
11 Q. Okay. Can we have C-0123? And these are
12 progress notes again, March 28th, 2000,
13 medical oncology clinic. And your diagnosis
14 again, stage 2, moderately differentiated
15 ductal carcinoma of the left breast, breast,
16 sorry. And this is being written by Dr. Kara
17 Laing. And she indicates here, "Geri returns
18 to clinic today for review. She had finished
19 her chemotherapy." So you're now done your
20 chemo at this point?
21 MS. ROGERS:
22 A. That's right, yes.
23 CHAYTOR, Q.C.:
24 Q. And you're presently receiving radiation?
25 MS. ROGERS:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. And overall tolerating it fairly well. The
4 plan at this point in time, "I'm going to,"
5 and I guess the word "review" is missing there
6 or "see" "Geri back in about a month. We will
7 talk about Tamoxifen further. She is ER
8 negative but PR positive. She is going to
9 consider whether or not she wishes to take
10 Tamoxifen and we have discussed this at length
11 today." So this is now March 28th, 2000.
12 MS. ROGERS:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. The end of March. And you're having a lengthy
16 discussion with Dr. Laing at this point in
17 time as to whether or not you should take
18 Tamoxifen?
19 MS. ROGERS:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. Or consider Tamoxifen. Yes, okay. And do you
23 recall what the discussion would be about?
24 MS. ROGERS:
25 A. It would be about whether or not--what--

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1 whether or not it would help in terms of
2 staving off any recurrence. Also because of
3 the strong history of breast cancer in my
4 family, that I had three aunts with breast
5 cancer and subsequently, well, we didn't know
6 that at the time, my mother and my sister were
7 both diagnosed with breast cancer. So it was
8 again because it wasn't the protocol, it was a
9 bit of a gamble whether or not to take it.
10 CHAYTOR, Q.C.:
11 Q. Okay. So what did Dr. Laing advise you in
12 terms of PR positivity and whether or not
13 that, in fact, may be treated by Tamoxifen,
14 were you--was there any discussion along those
15 lines?
16 MS. ROGERS:
17 A. That there was a possibility but that really
18 that Tamoxifen was used for somebody who was
19 ER positive.
20 CHAYTOR, Q.C.:
21 Q. Okay. So was the nature of your discussion
22 with Dr. Laing, did she--was she trying to
23 encourage you to take the Tamoxifen?
24 MS. ROGERS:
25 A. I think we were looking at it as an option.

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1 CHAYTOR, Q.C.:
2 Q. So it wasn't a situation where you were
3 reluctant but Dr. Laing was trying to
4 encourage you?
5 MS. ROGERS:
6 A. I was reluctant, I was reluctant to take
7 chemo, I was reluctant to take radiation. Who
8 wouldn't be? Except that's, we know that
9 that's the protocol and that's the best that
10 we have, so I took the chemo and I took the
11 radiation because that was the protocol. The
12 Tamoxifen for me was a very grey area.
13 CHAYTOR, Q.C.:
14 Q. In terms of someone being ER negative and PR
15 positive?
16 MS. ROGERS:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. Okay. Thank you. C-0125, please? You're
20 seen back then by Dr. Laing on May 12th, 2000.
21 Dr. Laing. And the diagnosis is actually in
22 the heading this time, moderately
23 differentiated ductal carcinoma left breast.
24 And it refers to your chemotherapy having been
25 completed January, 2000 and adjuvant

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1 radiation, ER negative and PR positive. "We
2 talked today about the role of Tamoxifen in PR
3 positive patients. She brought along some
4 literature from the internet." And then down
5 the next, the plan paragraph, "Geri and I have
6 had a lengthy discussion about Tamoxifen.
7 There certainly is evidence of benefit in PR
8 positive women, although this is less. She's
9 agreeable to try it, however she has--if she
10 has difficulty, I won't be opposed to
11 discontinuing it. I have asked her to see her
12 family physician, Dr. Peacock" and it goes on
13 from there. So do you recall this discussion
14 with Dr. Laing?
15 MS. ROGERS:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. And on that date did you decide to take a
19 prescription for Tamoxifen?
20 MS. ROGERS:
21 A. I did.
22 CHAYTOR, Q.C.:
23 Q. Okay. So tell us about that, what do you
24 recall?
25 MS. ROGERS:

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1 A. Well, I decided that I would take the
2 prescription so that I would have it. I
3 wanted to do a little more research and I
4 wanted to consult also with Dr. Susan Love.
5 And then after that I decided not to take it.
6 CHAYTOR, Q.C.:
7 Q. Okay. So you left this day after a lengthy
8 discussion with Dr. Laing and you took the
9 prescription and then you had a further--or
10 you had your first discussion with Dr. Susan
11 Love?
12 MS. ROGERS:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. Okay. 0124, please? And this, I believe, Ms.
16 Rogers, is the prescription that you took that
17 day from the cancer clinic, May 13th, 2000.
18 And it refers to Tamoxifen. So that's in
19 keeping with your recollection?
20 MS. ROGERS:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. 0126, please, Registrar? Another progress
24 notes from Dr. Laing. And this is August
25 11th, 2000. And again, we see your diagnosis

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1 which include ER negative, PR positive and
2 then it says, "Not taking Tamoxifen." "Geri
3 returns to clinic today for her regular
4 follow-up. When I last saw her, we discussed
5 at length Tamoxifen. She has decided not to
6 take this. She is too worried about its side
7 effects. I think given the fact that she is
8 ER negative and only about 20 to 25 percent PR
9 positive that this is okay." So do you recall
10 this discussion on this day when you go back
11 to see Dr. Laing after having decided not to
12 take the Tamoxifen?
13 MS. ROGERS:
14 A. Yes, I do. But I do not recall a drop in the
15 PR.
16 CHAYTOR, Q.C.:
17 Q. Yes. That was my next question for you. Do
18 you recall any discussion about being only 20
19 to 25 percent PR positive?
20 MS. ROGERS:
21 A. I don't recall that.
22 CHAYTOR, Q.C.:
23 Q. And we've seen your pathology report and the
24 addendum which refers to you being 60 to 70
25 percent PR positive, and the correspondence

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1 from Carbonear from Dr. Heneghan to Dr. George
2 which again repeated the 60 to 70. But this
3 is the first point in your chart where we see
4 a 20 to 25 percent PR positivity?
5 MS. ROGERS:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. Do you have any explanation or any knowledge
9 of how that happened?
10 MS. ROGERS:
11 A. I'd not seen it before until this was
12 presented to me by co-counsel.
13 CHAYTOR, Q.C.:
14 Q. Yes, okay. And you don't remember that being
15 discussed as the figure with Dr. Laing in -
16 MS. ROGERS:
17 A. No.
18 CHAYTOR, Q.C.:
19 Q. - August, 2000?
20 MS. ROGERS:
21 A. I can only assume it's a clerical error.
22 CHAYTOR, Q.C.:
23 Q. Okay. And you made, in any event, you made
24 your decision to not take the Tamoxifen
25 knowing that you were 60 to 70 percent PR

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1 positive?
2 MS. ROGERS:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. Okay. 0127, please? This progress note is
6 now January 8th, 2001. And this continues to
7 refer--this is Dr. Laing, as well. And this
8 continues to refer to you being ER negative
9 and now PR low positivity, "Not on Tamoxifen."
10 And again, I take it there was no discussion
11 with you about your positivity levels after
12 your decision on--to not take the Tamoxifen?
13 MS. ROGERS:
14 A. I don't recall that at all, no.
15 CHAYTOR, Q.C.:
16 Q. C-0128, please? This is April 6th, 2001, the
17 medical oncology clinic, progress notes for
18 Dr. Laing. And again, under diagnosis, refers
19 to ER negative and PR low positivity, not on
20 Tamoxifen, and again just confirms that you
21 are not on Tamoxifen in the body of the
22 progress note.
23 0131, please. Again, this is a progress
24 note, Medical Oncology Clinic, November 22nd,
25 2002, seen by Dr. Laing, I believe. Yes, Dr.

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1 Laing, and again, it continues under diagnosis
2 to refer to ER negative and low PR positivity
3 and "not on Tamoxifen. From the point of view
4 of breast cancer, she has no symptoms to
5 suggest recurrent disease. She is going to
6 have a prophylactic mastectomy on the right
7 side next week under Dr. Kwan's care." And
8 then on the bottom of the page, "if there is
9 any abnormality in her mastectomy specimen, I
10 will see her sooner. If not, I will recheck
11 her in six months."
12 So Ms. Rogers, what happens after this
13 visit then, November 22nd, 2002?
14 MS. ROGERS:
15 A. I did have a second mastectomy. Dr. Kwan was
16 my surgeon and my pathology came back as
17 infiltrating ductal carcinoma in situ.
18 CHAYTOR, Q.C.:
19 Q. Okay, and where was that surgery carried out?
20 MS. ROGERS:
21 A. At St. Clare's in St. John's.
22 CHAYTOR, Q.C.:
23 Q. Perhaps we could look then at C-0116, and it's
24 page two of that exhibit, Registrar, and I
25 believe, Ms. Rogers, this is the pathology

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1 report following your right breast mastectomy.
2 The date of the specimen being received -
3 MS. ROGERS:
4 A. 116?
5 CHAYTOR, Q.C.:
6 Q. 0116, page two. November 26th, 2002, and
7 right breast mastectomy, and it indicates that
8 fibrosytic change, one small focus of, I
9 believe that should be low grade ductal
10 carcinoma in situ, margins uninvolved, 12
11 lymph nodes and all were free or malignant
12 disease.
13 MS. ROGERS:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. And under microscopy, it again refers to the
17 low grade ductal carcinoma in situ. Okay?
18 MS. ROGERS:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. So that's consistent with the diagnosis that
22 you were given at the time that you recall?
23 MS. ROGERS:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. If we could go back then, please, to 133, and
2 this is July 17th, 2003. Seen in the Medical
3 Oncology Clinic by Dr. McCarthy. So I take it
4 sometimes Dr. McCarthy would fill in for Dr.
5 Laing?
6 MS. ROGERS:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. But Dr. Laing was your primary oncologist?
10 MS. ROGERS:
11 A. That's right.
12 CHAYTOR, Q.C.:
13 Q. Yes, okay, and under diagnosis, Dr. McCarthy
14 has recorded you're moderately differentiated
15 ductal carcinoma of your left breast as well
16 as infiltrating ductal carcinoma in situ right
17 breast. So you're seen by Dr. McCarthy
18 following your right breast surgery?
19 MS. ROGERS:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. And again, she indicates ER negative, PR
23 positive and "refused Tamoxifen post right
24 prophylactic mastectomy. Strong family
25 history of breast cancer." Do you know

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1 whether or not there was any ER/PR test
2 carried out with respect to your right breast?
3 MS. ROGERS:
4 A. I do not know.
5 CHAYTOR, Q.C.:
6 Q. And we don't see it. I don't see it in your
7 records, so you don't know.
8 MS. ROGERS:
9 A. I don't know.
10 CHAYTOR, Q.C.:
11 Q. Did you have any discussion with any of your
12 physicians at that time about whether or not
13 that had taken place?
14 MS. ROGERS:
15 A. I don't believe I did, no.
16 CHAYTOR, Q.C.:
17 Q. And you don't recall it coming up in your
18 discussion with Dr. McCarthy on that day when
19 you see her?
20 MS. ROGERS:
21 A. No.
22 CHAYTOR, Q.C.:
23 Q. And there's certainly no record of it in the
24 progress notes, and do you have any knowledge
25 as to whether or not ER/PR tests would be

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1 carried out on that type of cancer?
2 MS. ROGERS:
3 A. I don't know.
4 CHAYTOR, Q.C.:
5 Q. Okay.
6 THE COMMISSIONER:
7 Q. Ms. Chaytor, whatever point is convenient for
8 you, we will take the luncheon break.
9 CHAYTOR, Q.C.:
10 Q. That's fine. This is good for me. Is it fine
11 for you, Ms. Rogers?
12 MS. ROGERS:
13 A. Yes.
14 THE COMMISSIONER:
15 Q. Return at 2:00, if that's all right for
16 everybody.
17 CHAYTOR, Q.C.:
18 Q. Thank you.
19 THE COMMISSIONER:
20 Q. Thank you.
21 (LUNCH BREAK)
22 THE COMMISSIONER:
23 Q. Please be seated.
24 CHAYTOR, Q.C.:
25 Q. Commissioner, Mr. Rogers is here.

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1 THE COMMISSIONER:
2 Q. Welcome, Mr. Rogers.
3 MR. ROGERS:
4 Q. Good day. Madame Justice, I'm here as
5 personal counsel for one of the witnesses,
6 Geri Rogers, here today.
7 THE COMMISSIONER:
8 Q. Okay then.
9 MR. ROGERS:
10 Q. Thank you.
11 THE COMMISSIONER:
12 Q. Thank you. Now, Ms. Rogers?
13 CHAYTOR, Q.C.:
14 Q. Ms. Rogers?
15 REGISTRAR:
16 Q. She's on her way.
17 CHAYTOR, Q.C.:
18 Q. Okay.
19 THE COMMISSIONER:
20 Q. She's on her way, okay. Ms. Chaytor, would
21 you refresh my memory about which exhibit I
22 should have opened?
23 CHAYTOR, Q.C.:
24 Q. I think we had left off -
25 REGISTRAR:

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1 Q. 0134.
2 CHAYTOR, Q.C.:
3 Q. Thank you.
4 THE COMMISSIONER:
5 Q. Thank you.
6 CHAYTOR, Q.C.:
7 Q. And the next one I'll be referring to is 0135.
8 THE COMMISSIONER:
9 Q. Now, Ms. Rogers, we'll continue.
10 MS. ROGERS:
11 A. Thank you.
12 CHAYTOR, Q.C.:
13 Q. Good afternoon.
14 MS. ROGERS:
15 A. Good afternoon. I'm just adjusting my chair.
16 I seem to be going a little -
17 THE COMMISSIONER:
18 Q. Make yourself comfortable.
19 CHAYTOR, Q.C.:
20 Q. There you go. Ms. Rogers, this morning I was
21 canvassing some of your portions of your chart
22 and you had made your decision not to take
23 Tamoxifen on the basis of your original
24 pathology -
25 MS. ROGERS:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. - which indicated you were ER negative. If
4 you had been aware at the time of making that
5 decision that you were in fact ER positive,
6 would your decision have been different?
7 MS. ROGERS:
8 A. Absolutely I would have taken Tamoxifen.
9 CHAYTOR, Q.C.:
10 Q. I'd like to turn now then and ask you some
11 questions about how you first learned about
12 the retesting process on ER/PR. So perhaps
13 you could tell us, when did you learn and how
14 did you learn that there was retesting taking
15 place of ER/PR in the province, not
16 specifically your own case, but generally that
17 this issue was unfolding?
18 MS. ROGERS:
19 A. The first information I heard was through the
20 article in The Independent, and then all of
21 the following media after that article. I
22 wasn't contacted by anybody, so I basically
23 found information out through the media.
24 CHAYTOR, Q.C.:
25 Q. And how do you feel about learning about this

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1 issue through the media?
2 MS. ROGERS:
3 A. I don't think that the media is the ideal
4 place for me to get my health care
5 information. I was quite astounded actually.
6 However, I'm resourceful, so I started phoning
7 and I phoned the Department of Health and I
8 said "I'm looking for information about the
9 retesting on the ER/PR breast cancer
10 retesting," and -
11 CHAYTOR, Q.C.:
12 Q. Do you know who you spoke with at the
13 Department of Health?
14 MS. ROGERS:
15 A. No, I would phone and then somebody would say
16 "well, maybe try this number," and then I
17 would try another number. I made a number of
18 calls, and I guess this was before there was
19 actually a number, a specific number
20 identified and set aside for patients to call.
21 CHAYTOR, Q.C.:
22 Q. So we know that first article that you
23 referred to from The Independent, that was
24 published October 2nd, 2005.
25 MS. ROGERS:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. So these inquiries that you're referring to
4 and the phone calls to the Department of
5 Health, those would have taken place shortly
6 after that?
7 MS. ROGERS:
8 A. That's right, yes.
9 CHAYTOR, Q.C.:
10 Q. So in October 2005?
11 MS. ROGERS:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. And did anyone from--anyone return any of your
15 phone calls or did you end up speaking with
16 anyone about this issue?
17 MS. ROGERS:
18 A. No. No, and then I was contacted by the media
19 to give comment on the situation. So I called
20 Dr. Kara Laing and left messages. I phoned
21 her a few times and left messages and I also
22 phoned George Tilley's office and left
23 messages. I believe it was George Tilley I
24 called, and in all those situations, I said
25 that I had been approached by the media to

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1 comment and that I didn't know what was going
2 on. All I had to go by was what I heard in
3 the media, and I said that I didn't--I know
4 that there are a lot of people who are
5 frightened and confused and I didn't want to
6 make it worse, and I would appreciate if
7 somebody could call me back, inform me on
8 what's going on so that I could help rather
9 than--to help give some clarity and to see
10 what was going on, because I didn't want to
11 make it worse. Somehow we needed information
12 about what was going on.
13 CHAYTOR, Q.C.:
14 Q. And did anyone from Eastern Health call you
15 back?
16 MS. ROGERS:
17 A. No.
18 CHAYTOR, Q.C.:
19 Q. Did Dr. Laing call you back?
20 MS. ROGERS:
21 A. Dr. Laing didn't call me back, which was
22 unusual and out of character. Dr. Laing has
23 always been totally accessible to me and has
24 just given me such wonderful care and has
25 always been open to answer any of my questions

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1 or queries about my own health care, but no,
2 nobody called me back at that time.
3 CHAYTOR, Q.C.:
4 Q. And did you make it clear in the messages that
5 you were leaving for these people that you
6 were calling regarding the retesting of ER/PR?
7 MS. ROGERS:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. Were you ever asked by Eastern Health
11 permission to have your sample retested?
12 MS. ROGERS:
13 A. No.
14 CHAYTOR, Q.C.:
15 Q. Do you feel you should have been?
16 MS. ROGERS:
17 A. I would like to have been informed, yes.
18 CHAYTOR, Q.C.:
19 Q. Ms. Rogers, we understand that this did break
20 in the media, as you've indicated, and that
21 patients, up to that point in time, there
22 hadn't been disclosure to you, for example, as
23 a patient. If the reason for not telling
24 patients at the time of the retesting was
25 ongoing was to basically spare the patients

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1 stress in the interim while waiting for the
2 test results to come back, do you have any
3 comment as to that as a valid reason for
4 holding off on patient contact or patient
5 notification?
6 MS. ROGERS:
7 A. Nobody from Eastern Health ever contacted me
8 and still--and then finally when all the
9 retests were back, I got a call from the media
10 once again because I had done a lot of media,
11 I had a lot of media requests all through this
12 whole process. The media called me and asked
13 me if my tests were back, and I said "I don't
14 know." So I called the patient number to see
15 if my tests were back.
16 CHAYTOR, Q.C.:
17 Q. So at this point in time, there has been a
18 patient number published?
19 MS. ROGERS:
20 A. Yes, and this was quite far on in the process.
21 I had already seen Dr. Kara Laing for what was
22 a regular scheduled check up and I said to
23 her, "do you know if I will be retested?" She
24 said "yours will be retested," and she said,
25 "I'm 99 percent sure that will probably come

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1 back that you are in fact ER positive."
2 CHAYTOR, Q.C.:
3 Q. And Ms. Rogers, when did this meeting with Dr.
4 Laing take place, do you recall?
5 MS. ROGERS:
6 A. I'm not sure of the date.
7 CHAYTOR, Q.C.:
8 Q. So it's sometime after October 2005, the -
9 MS. ROGERS:
10 A. Yeah, I think it was -
11 CHAYTOR, Q.C.:
12 Q. - the issue came out in the media.
13 MS. ROGERS:
14 A. - I think it was in around December.
15 CHAYTOR, Q.C.:
16 Q. December, okay.
17 MS. ROGERS:
18 A. December, late November, early December 2005.
19 CHAYTOR, Q.C.:
20 Q. And in the meantime, the interim period from
21 October to December is when you had been
22 making your inquiries, your phone calls?
23 MS. ROGERS:
24 A. That's right.
25 CHAYTOR, Q.C.:

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1 Q. Okay, and then you had your regular scheduled
2 appointment in December with Dr. Laing?
3 MS. ROGERS:
4 A. That's right, yes, and so she told me that she
5 was 99 percent sure that mine would come back
6 as ER positive.
7 CHAYTOR, Q.C.:
8 Q. Okay.
9 MS. ROGERS:
10 A. And I -
11 CHAYTOR, Q.C.:
12 Q. Maybe we'll look then--sorry, go ahead.
13 MS. ROGERS:
14 A. And I asked her why Eastern Health didn't
15 notify us.
16 CHAYTOR, Q.C.:
17 Q. Yes.
18 MS. ROGERS:
19 A. And I asked her why nobody returned my calls,
20 and she said that she had wanted Eastern
21 Health to contact the patients, and I couldn't
22 understand the rationale that it was to save
23 people stress. I said, you know, "it's not
24 1955. It's 2005 and we're grown adult women.
25 Many who have been--who've had surgery, who've

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1 had horrible chemotherapy, who've gone through
2 radiation, and that we're adults, and we're
3 smart, and we take part in our health care.
4 We have to make decisions," and Dr. Kara Laing
5 was one of the doctors who respected that so
6 much too.
7 CHAYTOR, Q.C.:
8 Q. So Dr. Laing told you that she had wanted the
9 patients to be notified that the retesting was
10 taking place, but -
11 MS. ROGERS:
12 A. And I know--sorry, go ahead.
13 CHAYTOR, Q.C.:
14 Q. I'm sorry. That's correct?
15 MS. ROGERS:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. And who did she indicate had made the decision
19 not to contact the patients?
20 MS. ROGERS:
21 A. We didn't talk about that further, because I
22 felt that that was probably a delicate thing
23 for her to talk to me about that.
24 CHAYTOR, Q.C.:
25 Q. And who did you understand, from your

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1 discussion with her, had made that decision?
2 MS. ROGERS:
3 A. I assumed that there was a committee that had
4 been struck to deal with this.
5 CHAYTOR, Q.C.:
6 Q. Okay.
7 MS. ROGERS:
8 A. After--so she told me that my samples had been
9 sent off. I wasn't anxious or nervous. I knew
10 that there'd been a mess up and that so, then
11 you just move forward and deal with it. Then
12 the media called me to say that all the
13 samples were back and had I heard, and I said
14 "no, I haven't." So then I started calling
15 again, and I didn't call the Cancer Clinic
16 because they're really busy there. They're so
17 busy there. Sometimes when I go for my
18 appointments, my appointment might be at 10:30
19 in the morning and I'll see my doctor at 1:30
20 or 2. That means she hasn't had lunch, that
21 she's been seeing patients all the way
22 through. So you don't want to call unless
23 there's something important. So I called the
24 numbers identified by Eastern Health and left
25 messages, and no one got back to me. So when

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1 the media called me back, I said "I don't
2 know. I don't have that information." So
3 finally, I called Honourable John Ottenheimer,
4 who was the Minister of Health at the time,
5 and I said to him that "I have been treated
6 with utmost respect and dignity and compassion
7 and professionalism through my whole treatment
8 of cancer, except for this particular issue,"
9 and I said--I told him how badly I felt we'd
10 all been treated by Eastern Health, the fact
11 that nobody communicated with us, and I said
12 to him that I wanted to know what the results
13 were. I wanted somebody to speak to me, and
14 to speak to me within 24 hours, and so I got -
15 CHAYTOR, Q.C.:
16 Q. So when was this discussion? When did you
17 make your phone call to Minister Ottenheimer?
18 MS. ROGERS:
19 A. That was when all the results were back in,
20 whenever that was.
21 CHAYTOR, Q.C.:
22 Q. So probably January 2006, around that time
23 period?
24 MS. ROGERS:
25 A. Probably, yeah. So about 45 minutes later,

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1 Kara Laing called me and she was in Texas at a
2 conference.
3 CHAYTOR, Q.C.:
4 Q. So 45 minutes after speaking with Minister
5 Ottenheimer?
6 MS. ROGERS:
7 A. Yeah, and she called me and she said "yes,
8 your results are back," and we both sort of
9 had a laugh and she said "I'll be back in town
10 soon" and that in fact, my results had changed
11 and I was ER positive, and that we would--that
12 she would make an appointment when she got
13 back and we'd see each other, and I was fine
14 with that.
15 CHAYTOR, Q.C.:
16 Q. So you learned--Dr. Laing called you back and
17 she was out of the country?
18 MS. ROGERS:
19 A. Yes, from Texas, yes.
20 CHAYTOR, Q.C.:
21 Q. From Texas, and -
22 MS. ROGERS:
23 A. And then -
24 CHAYTOR, Q.C.:
25 Q. - she knew that you had spoken with Minister

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1 Ottenheimer?
2 MS. ROGERS:
3 A. I assume so. Somebody tracked her down, I
4 guess. And then, finally the patient--the
5 contact patient for Eastern Health called me
6 and she apologized for not having called me
7 any other time, but she said that her role was
8 to speak to patients whose ER status hadn't
9 changed, and that because my ER status had
10 changed that in those cases that the doctors
11 would contact the patients, and then I asked
12 her, why had they--why did Eastern Health
13 never call me back and why didn't Eastern
14 Health speak directly to the women who were
15 involved, because there was so much confusion.
16 There was so much fear, and which I think
17 mistrust grew out of that as well, and she
18 said "well, we didn't want to frighten women,"
19 and I said again, you know, it makes no sense.
20 It's--we're adults who take part in our health
21 care, and that, in fact, what they did was
22 exactly the opposite. They caused fear. They
23 caused confusion. They caused mistrust. They
24 caused unnecessary anxiety, and I think--and
25 that, basically that was the bulk of our

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1 conversation.
2 CHAYTOR, Q.C.:
3 Q. That was your discussion with the patient
4 relations officer. Do you know who that is or
5 was?
6 MS. ROGERS:
7 A. I think it was Nancy Parsons.
8 CHAYTOR, Q.C.:
9 Q. Nancy Parsons, okay, and again, this
10 conversation with her took place after you
11 have spoken with Minister Ottenheimer?
12 MS. ROGERS:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. And after you've spoken with Dr. Kara Laing?
16 MS. ROGERS:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. I'm just going to backtrack a little then and
20 -
21 MS. ROGERS:
22 A. The other thing that she had said was "well,
23 we didn't know how--there was so many people,"
24 and I said "well, it was only a 1,000." She
25 said "well, we didn't know, you know, we

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1 couldn't have contacted everyone," and I said
2 "well, if I had a car from Ford and there was
3 a recall, they'd find me," and then she said
4 "well"--I said, "but we all have MCP numbers,"
5 and she said "well, but some people have
6 moved. Well, but for the most part, then they
7 have other health care numbers. We could be
8 found. All it would take would be a letter,
9 just a letter at least explaining what was
10 going on, because if we're only getting our
11 information through the media, what if I don't
12 watch the news Thursday night. Does that mean
13 I'm out of luck?"
14 CHAYTOR, Q.C.:
15 Q. Okay, Ms. Rogers, now I'm going to take you
16 back through some of that, looking at your
17 documents. So if we could look at C-0135, and
18 this is back to December 2005 and it's a
19 progress note of an appointment with Dr.
20 Laing, and this is dated December 6th, 2005,
21 Medical Oncology Clinic, dictated but not read
22 by Dr. Laing. Your diagnosis is indicated and
23 again, we see "ER negative, PR positive, but
24 did not take Tamoxifen. Geraldine was seen by
25 me in follow up on December 17th, 2004. At

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1 that time, she was well with no symptoms or
2 evidence or recurrence on physical
3 examination." I take it you're at a one-year
4 interval at this point in time, are you?
5 MS. ROGERS:
6 A. That's right, yes.
7 CHAYTOR, Q.C.:
8 Q. So she had previously seen you the year
9 before. And then if we could have 0136
10 please? And this, you believe it was in
11 December 2005 that Dr. Laing spoke to you
12 about the issue of the retesting, is that
13 right?
14 MS. ROGERS:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. Yes, okay. The next progress note at 0136 is
18 dated the same date, so we see December 6th,
19 2005, and this progress note is dictated but
20 not read by Dr. Laing. First of all, Ms.
21 Rogers, do you have any explanation or know
22 why there would be two progress notes for the
23 same date?
24 MS. ROGERS:
25 A. No, I do not.

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1 CHAYTOR, Q.C.:
2 Q. Okay, and this progress -
3 MS. ROGERS:
4 A. But they're on different letterhead.
5 CHAYTOR, Q.C.:
6 Q. No, if we could go back, please, 0135.
7 MS. ROGERS:
8 A. Oh, I'm sorry, I'm looking at two different
9 ones. I'm sorry.
10 CHAYTOR, Q.C.:
11 Q. Yes, same letterhead. This is a progress note
12 from the Dr. H. Bliss Murphy Cancer Centre.
13 MS. ROGERS:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. Okay, and this one, on the first one that I
17 referred you to, 0135, is a very short note,
18 diagnosis and a plan. "She will see me again
19 in one year." And then if we could go forward
20 again, please, to 0136, this is a longer note,
21 and again "ER negative and PR positive on
22 initial testing. The patient did not take
23 Tamoxifen. Geraldine comes back to clinic. I
24 have not seen her in a year. She has been
25 well overall. She was initially ER negative

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1 and PR positive. On retesting, a lot of
2 patients with this profile have come back as
3 ER and PR positive. Her retesting has been
4 sent off, but I do not have the results yet.
5 I did talk to her about Tamoxifen initially
6 but she was not keen to take it then. She
7 tells me that she is still not now, but she
8 would consider Arimidex, and she is post-
9 menopausal, so this would be an option." And
10 under plan, "I have told her that I will let
11 her know as soon as I get the ER/PR testing
12 back. If she is positive, we will consider
13 Arimidex. I will continue to follow her on an
14 annual basis." But if she starts you on the
15 Arimidex, you'll be seen sooner than a year.
16 So this particular note of December 6th,
17 2005, does this accurately capture your
18 discussion that you recall in December of 2005
19 with Dr. Laing about the retesting?
20 MS. ROGERS:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. Okay, so the plan at this point in time, Dr.
24 Laing says that "a lot of patients with this
25 profile, ER negative and PR positive, have

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1 come back as ER and PR positive."
2 MS. ROGERS:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. Did Dr. Laing discuss that with you?
6 MS. ROGERS:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. Okay, and what had she been noticing? What
10 did she tell you?
11 MS. ROGERS:
12 A. That she was 99 percent sure that my test
13 would come back changed.
14 CHAYTOR, Q.C.:
15 Q. And is that because you were PR positive
16 originally?
17 MS. ROGERS:
18 A. Yes, perhaps, I'm not sure.
19 CHAYTOR, Q.C.:
20 Q. Did you--what did you understand from your
21 discussion with her? What did she mean by -
22 MS. ROGERS:
23 A. I understood that.
24 CHAYTOR, Q.C.:
25 Q. That's what you understood?

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1 MS. ROGERS:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. Because you were PR positive and she was
5 seeing others, a lot of other patients who
6 were originally ER negative, PR positive, who
7 were coming back as both ER and PR positive?
8 MS. ROGERS:
9 A. And it's very, very rare to be PR positive and
10 ER negative.
11 CHAYTOR, Q.C.:
12 Q. Did you know that at the time, Ms. Rogers?
13 MS. ROGERS:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. And did you know that at the time that you
17 were originally told your ER/PR status?
18 MS. ROGERS:
19 A. I didn't know if ER or PR was fit to eat when
20 I was first diagnosed.
21 CHAYTOR, Q.C.:
22 Q. But by December 2005, you have become aware of
23 that?
24 MS. ROGERS:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Okay, fair enough, and in the plan, Dr. Laing
3 indicates that she will let you know "as soon
4 as I get the ER/PR testing back?"
5 MS. ROGERS:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. If we can look then please at Exhibit C-0071?
9 THE COMMISSIONER:
10 Q. That would be the first of your book, Ms.
11 Rogers.
12 MS. ROGERS:
13 A. Thank you.
14 CHAYTOR, Q.C.:
15 Q. Ms. Rogers, this is a document we've received
16 from Eastern Health and the top, the typed
17 portion of the document, it's dated Monday,
18 February 6th, 2006, 4:43 p.m. and the subject
19 is Geri Rogers. And it says, "Hi Kara, I just
20 got off the phone with Geri Rogers. She
21 called because she has not heard a word from
22 anybody and is anxiously waiting for the
23 results of her retesting. I asked her if we
24 had called her initially to say she was being
25 retested and she said, 'No, no one called.'

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1 She found out from her doctor in December that
2 she was being retested and now she is still
3 waiting for the results. She is appalled and
4 upset about the lack of respect in the way
5 women are being treated and there is obviously
6 no organization around this whole thing. She
7 is calling the minister of health to complain.
8 Just thought you guys might like to know.
9 Bye." And this was sent to Kara E. Laing.
10 And then we have, comma, "Heather E-QI
11 Predham." And up at the top we have from
12 "Nancy J-QI Parsons." Did you ever speak with
13 Heather Predham?
14 MS. ROGERS:
15 A. No. It was Nancy Parsons, I believe I spoke
16 with.
17 CHAYTOR, Q.C.:
18 Q. Okay.
19 MS. ROGERS:
20 A. And I had already spoken to the minister of
21 health before she called me.
22 CHAYTOR, Q.C.:
23 Q. Okay. So you're confident that the order in
24 which things happened was that you spoke with
25 Minister Ottenheimer, followed by a phone call

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1 from Dr. Kara Laing from Texas and then you
2 received a phone call back from Nancy Parsons?
3 MS. ROGERS:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. And in terms of the text of what I just read
7 to you in this, it appears to be an e-mail,
8 how does that compare with the discussion that
9 you had with Nancy Parsons?
10 MS. ROGERS:
11 A. Well, I certainly was not anxiously awaiting
12 the results of my tests. I was curious as to
13 why I hadn't been notified. I wasn't fearful.
14 CHAYTOR, Q.C.:
15 Q. Okay. And if we scroll down on the same
16 exhibit, 0071, there's a handwritten note
17 which says, "Also a note in my book that Ms.
18 Rogers called January 26th," and there's an
19 "06" put in there, and "L/M", I believe that
20 means left a message, "to call her." And then
21 we have what would be two telephone numbers
22 blocked out. "No record of a conversation. I
23 can only assume I was unable to reach her."
24 Is there anything you would like to say of
25 that note?

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1 MS. ROGERS:
2 A. Pretty reachable. I have answering services
3 at all my phones.
4 CHAYTOR, Q.C.:
5 Q. And you did not receive a message on your
6 answering machines?
7 MS. ROGERS:
8 A. I don't recall that I did.
9 CHAYTOR, Q.C.:
10 Q. Okay. And this is January 26th, 2006?
11 MS. ROGERS:
12 A. Um-hm.
13 CHAYTOR, Q.C.:
14 Q. You had left a message to call her. Is that
15 consistent with your recollection around the
16 time you would have been calling Eastern
17 Health?
18 MS. ROGERS:
19 A. I believe so, yes.
20 CHAYTOR, Q.C.:
21 Q. Okay. And, Ms. Rogers, you indicated that Dr.
22 Laing told you on the phone from Texas that
23 your results had changed?
24 MS. ROGERS:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Do you know the results of your retest or were
3 you told that at the time?
4 MS. ROGERS:
5 A. I don't recall if I had the exact percentages,
6 but she told me that it had changed and I was
7 ER positive. And I was also comfortable with
8 that phone call, again because I wasn't really
9 afraid or worried and I felt very comfortable
10 in Dr. Laing's care.
11 CHAYTOR, Q.C.:
12 Q. And why is it that you weren't concerned or
13 anxious for your own health?
14 MS. ROGERS:
15 A. Well, at that--I'm well, I'm well. And when
16 there's a mess-up, when you've gone through it
17 all, you just keep going. And I knew that
18 there was a mess-up in the lab. And then you
19 deal with it one step at a time. But I'm
20 lucky, I was well and I'm still well.
21 CHAYTOR, Q.C.:
22 Q. Okay. If we could look, please, Registrar, at
23 C-0116, page 3? Ms. Rogers, this is part of
24 your pathology report. You'll see at the top
25 it's Health Care Corporation of St. John's

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1 document, your name, specimen 05:RE370,
2 received November 21st, 2005. "This specimen
3 has been retested at Mount Sinai Hospital (RS-
4 1443) for immunohistochemical studies
5 (Carbonear Hospital)" surgical number. And it
6 shows estrogen receptor protein is seen in 20
7 percent of cells using the antibody indicated
8 and the procedure indicated. Progesterone
9 receptor protein is seen in 60 percent of
10 cells using the antibody indicated and the
11 procedure indicated. And that's signed,
12 signature on file by Dr. Donald Cook, March
13 9th, 2006. Is that consistent with what you
14 were told in terms of the change in your
15 results?
16 MS. ROGERS:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. So Dr. Laing indicated that she would meet
20 with you when she was back in town. Did that
21 meeting take place?
22 MS. ROGERS:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. And what were you told then at that meeting?

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1 MS. ROGERS:
2 A. I was told the change in the pathology.
3 CHAYTOR, Q.C.:
4 Q. Okay.
5 MS. ROGERS:
6 A. And then we discussed the possibility of
7 Tamoxifen or Arimidex.
8 CHAYTOR, Q.C.:
9 Q. Okay. And do you recall when that meeting
10 took place?
11 MS. ROGERS:
12 A. It was perhaps about two weeks after she
13 returned, after I spoke with her on the phone,
14 something like that.
15 CHAYTOR, Q.C.:
16 Q. Okay. I take you to 0138. And this is
17 February 17th, 2006 progress notes, medical
18 oncology clinic. "ER negative and PR positive
19 initially, but now ER/PR positive on
20 retesting. Did not take Tamoxifen at initial
21 diagnosis. Geri returns to clinic today. She
22 has been doing fairly well. She comes to talk
23 about her ER/PR result. Her initial tumor was
24 zero percent ER and 60 to 70 percent PR. At
25 that time I offered her Tamoxifen but she did

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1 not want to take it. The retesting shows ER
2 20 percent positive and PR 60 percent
3 positive. She was presented at the panel
4 about two weeks ago. It was recommendation
5 that she be considered for Tamoxifen or an
6 Aromatase inhibitor. I have talked to her
7 about either choice. I have outlined the
8 evidence that we have for late use of hormonal
9 therapies and the evidence that we have from
10 extended adjuvant therapy from Aromatase
11 inhibitors. She has decided to take the
12 Arimidex." And you were started on that
13 prescription, you were given that prescription
14 that day and she's going to see you back in
15 three months. Is this consistent with your
16 recollection of your meeting with Dr. Laing?
17 MS. ROGERS:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. Okay. And so it took place on February 17th,
21 2006. And after discussion with her you
22 decided to take the Arimidex?
23 MS. ROGERS:
24 A. I don't recall, no, I don't recall saying that
25 I was going to take Arimidex.

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1 CHAYTOR, Q.C.:
2 Q. Did you get a prescription for Arimidex?
3 MS. ROGERS:
4 A. I don't believe I did. I may have, but I
5 don't recall getting a prescription for
6 Arimidex.
7 CHAYTOR, Q.C.:
8 Q. Did you ever start to take Arimidex?
9 MS. ROGERS:
10 A. I never did, no.
11 CHAYTOR, Q.C.:
12 Q. Okay.
13 MS. ROGERS:
14 A. We discussed the possibility of I thought it
15 was Tamoxifen or Femara or perhaps it was
16 Arimidex. But I had, I had reservations about
17 it because I was so far out from my initial
18 diagnosis and also because the chemo has put
19 me into a drug-induced early menopause and I
20 was also considering having my ovaries
21 removed. So we discussed the possibilities
22 and then I also consulted with Dr. Susan Love
23 again and then spoke with Dr. Laing and
24 decided, in fact, not to take either Tamoxifen
25 or Arimidex or Femara.

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1 CHAYTOR, Q.C.:
2 Q. And what did Dr. Susan Love advise you?
3 MS. ROGERS:
4 A. That I was this far out and that--and because
5 I was well that it didn't seem that, that the
6 benefits would outweigh the possible side
7 effects, that there wasn't a lot of research
8 to show that it was effective this far out.
9 CHAYTOR, Q.C.:
10 Q. Okay.
11 MS. ROGERS:
12 A. And that I, and that I was well.
13 CHAYTOR, Q.C.:
14 Q. Yes. Ms. Rogers, on this date, February 17th,
15 2006, when you're seen by Dr. Laing and you
16 have your discussion with her about the change
17 in your results, she indicates that your case
18 had been reviewed by a panel. She says "She
19 was presented at the panel about two weeks
20 ago." Did she explain to you who the panel
21 was?
22 MS. ROGERS:
23 A. I don't know if she explained specifically. I
24 knew that there were medical panels at the
25 cancer clinic and that people's cases were

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1 regularly discussed in these medical panels or
2 committees.
3 CHAYTOR, Q.C.:
4 Q. And it says here that "It was recommendation
5 that she be considered for Tamoxifen or an
6 Aromatase inhibitor." If I could have Exhibit
7 0142, please? And most of this document is
8 blacked out, Ms. Rogers, because it pertains
9 to other people other than yourself.
10 MS. ROGERS:
11 A. Okay.
12 CHAYTOR, Q.C.:
13 Q. This is a physician review panel meeting,
14 Thursday, January 26th, 2005. And you'll see
15 that you're No. 22 on the list, Geraldine
16 Rogers. And there's an asterisks across from
17 your name, "Nancy Parsons request." January
18 26th, 2005. And the note we saw earlier
19 indicated that Nancy Parsons had received a
20 phone message from you on January 26th. Well,
21 we assume it's Nancy Parsons. I guess we'll
22 hear from Nancy on that. The second page,
23 "Physician review panel meeting No. 9,
24 Thursday, January 26th, 2006 5 p.m." Those
25 in attendance are Dr. Kara Laing, who you know

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1 well?
2 MS. ROGERS:
3 A. Um-hm.
4 CHAYTOR, Q.C.:
5 Q. And she's the chair of the meeting. Ms.
6 Heather Predham. Do you know who Ms. Predham
7 is?
8 MS. ROGERS:
9 A. I don't.
10 CHAYTOR, Q.C.:
11 Q. Okay.
12 MS. ROGERS:
13 A. Do you?
14 CHAYTOR, Q.C.:
15 Q. We understand that she's in the quality and
16 risk management department for Eastern Health.
17 MS. ROGERS:
18 A. Okay.
19 CHAYTOR, Q.C.:
20 Q. Dr. D. Cook. Do you know who Dr. Cook is?
21 MS. ROGERS:
22 A. I'm not exactly sure what his position is.
23 CHAYTOR, Q.C.:
24 Q. Okay. He's, we understand, a pathologist with
25 Eastern Health and would have been clinical

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1 chief at this point in time for the laboratory
2 medicine program.
3 MS. ROGERS:
4 A. Right.
5 CHAYTOR, Q.C.:
6 Q. Dr. Bev Carter, do you know who she is?
7 MS. ROGERS:
8 A. Yes, she's a pathologist.
9 CHAYTOR, Q.C.:
10 Q. And Ms. D. Parsons, the recording secretary.
11 And then we had "No meeting held. There was
12 no meeting held January 19th, 2006." I assume
13 these are the minutes from January 26th, 2006.
14 Again, most of this document is blocked out
15 because it pertains to other people who would
16 have been considered at the meeting. But if
17 we scroll down to the top of page 4 in this
18 document, page 3 on our list, we have your
19 name. Your original report ER/PR negative/ 60
20 to 70 percent. Your Mount Sinai report, 20
21 percent/60 percent. Recommendation, "No
22 change in treatment plan was recommended as
23 patient had been initially prescribed
24 Tamoxifen by her oncologist but she did not
25 take it." And the follow-up physician is to

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1 be Dr. Laing with copies to Dr. Kwan and Dr.
2 Wagoner. Who is Dr. Wagoner?
3 MS. ROGERS:
4 A. It's my family position--physician.
5 CHAYTOR, Q.C.:
6 Q. Okay.
7 MS. ROGERS:
8 A. Dr. Wagoner, when the news first broke in the
9 media, I had an appointment with her for
10 something else about a week or so after and I
11 asked her if she knew anything about what was
12 going on and she said, "No," and she said, "I
13 haven't been contacted at all. None of the
14 doctors have been contacted," and she said, "I
15 have patients who are worried and afraid," and
16 she said to me, "if you hear anything, will
17 you let me know?" And I was astounded that
18 the family physicians hadn't been contacted.
19 CHAYTOR, Q.C.:
20 Q. And she as receiving inquiries from patients?
21 MS. ROGERS:
22 A. That she too had to get her information
23 through the media.
24 CHAYTOR, Q.C.:
25 Q. Okay. So the recommendation that's recorded

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1 here on this date, and if we scroll down to
2 the bottom, we see that this is signed by
3 Debbie Parsons, the secretary, and approved by
4 Dr. Laing as chair. The recommendation
5 recorded in your case is that "There is to be
6 no change in treatment plan was recommended as
7 patient had initially prescribed Tamoxifen by
8 her oncologist but she did not take it." Ms.
9 Rogers, what is your opinion on that, the fact
10 that in terms of any recommendation for change
11 being influenced by you having made a decision
12 not to take Tamoxifen when you were ER
13 negative?
14 MS. ROGERS:
15 A. Looks a little harsh on paper, doesn't it?
16 I'm not sure I've not seen this before. But
17 Dr. Laing and I did discuss, that meeting with
18 her was after this, I think, was it?
19 CHAYTOR, Q.C.:
20 Q. Yes, February -
21 MS. ROGERS:
22 A. The--February.
23 CHAYTOR, Q.C.:
24 Q. February 17th, I believe. Dr. Laing recorded
25 that the recommendation was that you would be

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1 offered Tamoxifen?
2 MS. ROGERS:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. That's what her note recorded?
6 MS. ROGERS:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. And is that your understanding, that you were
10 offered Tamoxifen in February?
11 MS. ROGERS:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. Okay. This recommendation is indicating no
15 change in treatment because you had initially
16 been prescribed Tamoxifen.
17 MS. ROGERS:
18 A. I don't know how to respond to that. I don't
19 know.
20 CHAYTOR, Q.C.:
21 Q. You indicated earlier in your evidence today
22 if you had been told initially, when you were
23 diagnosed, that you were ER positive, that you
24 would have taken Tamoxifen?
25 MS. ROGERS:

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1 A. I would have, yes. Reluctantly, but I would
2 have. It would have been what was the
3 protocol.
4 CHAYTOR, Q.C.:
5 Q. Yes, okay. And so a recommendation to not
6 have any change in treatment after your retest
7 now shows that you're ER 20 percent positive
8 and to base that on your decision you made
9 when you were ER negative, do you have any
10 response to that?
11 MS. ROGERS:
12 A. I'm not quite sure how to respond to that.
13 CHAYTOR, Q.C.:
14 Q. Okay.
15 MS. ROGERS:
16 A. It's--when I had my follow-up meeting
17 appointment with Dr. Laing, she again talked
18 about the possibility of Tamoxifen and/or
19 Arimidex.
20 CHAYTOR, Q.C.:
21 Q. Yeah, okay. If we could have 0137, please?
22 January 27th, 2006. This is a letter on
23 Eastern Health letterhead and it's written to
24 Dr. Laing and it's signed by Dr. Laing. So
25 it's clinical chief, cancer care program. And

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1 you are the subject in the subject line, "Re
2 Geraldine Rogers." Have you seen this letter
3 before, Ms. Rogers?
4 MS. ROGERS:
5 A. I did. My family doctor, Michelle Wagoner,
6 gave it to me when she received it.
7 CHAYTOR, Q.C.:
8 Q. Okay. And what do you understand or who do
9 you understand this letter to be from and the
10 significance of this letter?
11 MS. ROGERS:
12 A. It's a letter from Dr. Kara Laing to Dr. Kara
13 Laing. And I would say that this is probably,
14 I would think it's to have a paper trail of
15 what is happening or what has happened.
16 CHAYTOR, Q.C.:
17 Q. What did Dr. Wagoner tell you when she
18 presented the letter to you?
19 MS. ROGERS:
20 A. She said, "I got--I received two letters that
21 maybe you should have copies of."
22 CHAYTOR, Q.C.:
23 Q. And was she able to explain to you why this
24 letter was being written by Dr. Laing to Dr.
25 Laing and what the import of the letter might

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1 be?
2 MS. ROGERS:
3 A. No. I think we may have discussed it and we
4 may have chuckled in terms of, well, I guess
5 this is a paper trail letter.
6 CHAYTOR, Q.C.:
7 Q. Um-hm. Has Dr. Laing brought this letter to
8 your attention?
9 MS. ROGERS:
10 A. No.
11 CHAYTOR, Q.C.:
12 Q. We just have a look at this letter. "Ms.
13 Rogers was diagnosed with breast cancer in
14 June, 1999. The original report of the
15 estrogen and progesterone receptors showed
16 negative staining for estrogen and 60 to 70
17 percent staining for progesterone. A repeat
18 report from Mount Sinai Hospital has shown the
19 tumor to be estrogen receptor positive at 20
20 percent and the progesterone receptor positive
21 at 60 percent. This patient was discussed at
22 the physician review panel on January 26th,
23 2006. Review of the patient's health record
24 revealed that Ms. Rogers was initially
25 prescribed Tamoxifen by her oncologist but she

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1 did not take it. We would ask that you
2 communicate this information to your patient
3 as soon as possible. Yours sincerely, Kara
4 Laing." And it is copied to your surgeon, Dr.
5 Kwan, and your family physician, Dr. Wagoner.
6 MS. ROGERS:
7 A. And it's an odd thing, you know, because it
8 makes me sound like an uncooperative patient,
9 and that's not my understanding at all of how
10 I approached the treatment for my breast
11 cancer, nor does it seem to reflect at all
12 what I understand the patient/doctor
13 relationship I had with Dr. Laing and continue
14 to have with Dr. Laing.
15 CHAYTOR, Q.C.:
16 Q. Now, I don't see any recommendation in this
17 letter. It basically ends with saying
18 "communicate the information to your patient
19 as soon as possible," but no actual
20 recommendation from the panel, just recording
21 the fact that you initially did not take the
22 Tamoxifen.
23 MS. ROGERS:
24 A. That's correct.
25 CHAYTOR, Q.C.:

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1 Q. Ms. Rogers, this is a letter that we
2 understand went out from the physician review
3 panels on any patient that was reviewed by the
4 physician review panel of which we saw in the
5 minutes earlier that Dr. Kara Laing had
6 chaired the meeting on the day that you were
7 assessed on January 26th, 2006. And I also
8 discussed or pointed out to you the other
9 people who were in attendance at that panel
10 meeting, including two pathologists.
11 MS. ROGERS:
12 A. Um-hm.
13 CHAYTOR, Q.C.:
14 Q. And Heather Predham and Dr. Laing. So it was
15 Dr. Laing, the oncologist, Heather Predham
16 from the quality and risk management of
17 Eastern Health, Dr. Cook, Dr. Bev Carter, two
18 pathologists and Ms. Parsons, the recording
19 secretary. Do you have any opinion on the
20 appropriateness of this panel providing
21 treatment recommendations or reviewing your
22 case?
23 MS. ROGERS:
24 A. I'm somewhat curious as to the role that, for
25 instance, Heather Predham would have in a

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1 treatment recommendation for a breast, a
2 patient with breast cancer or who's--I don't
3 understand her role on that committee. I'm
4 happy that as a patient that there would be a
5 process where doctors with different degrees
6 and areas of expertise would come together to
7 consult to see how to go forward. I think
8 that that's a good thing. I as a patient
9 would like to know that that's happening and I
10 assumed that that would be happening.
11 CHAYTOR, Q.C.:
12 Q. And this was the panel that reviewed the
13 retests from Mount Sinai, okay.
14 MS. ROGERS:
15 A. It's--I don't know what to say.
16 CHAYTOR, Q.C.:
17 Q. That's fine. That's fine. If we could turn
18 then, please -
19 THE COMMISSIONER:
20 Q. A little earlier, you talked about, I believe
21 or made reference to the idea of panels?
22 MS. ROGERS:
23 A. Yes.
24 THE COMMISSIONER:
25 Q. What did you understand or who did you

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1 understand would be in those panels or how
2 they would work? What's your understanding of
3 how that works in the medical system?
4 MS. ROGERS:
5 A. In the medical system at the cancer centre, I
6 know that doctors do get together and discuss
7 different cases to see the best way to go
8 forward and what are the best treatment
9 options. And my understanding is that that
10 would be doctors, possibly nurses, if there
11 were nurses with particular areas of expertise
12 that would have to do with particular patients
13 that were being discussed, but the chemo
14 nurses, I don't know.
15 THE COMMISSIONER:
16 Q. So you see that as a) a regular process at the
17 cancer clinic.
18 MS. ROGERS:
19 A. Yes.
20 THE COMMISSIONER:
21 Q. And b) a process where medical personnel who
22 would include definitely doctors and perhaps
23 others, like nurses, would if you will combine
24 their expertise to examine the situation for a
25 particular patient who might be presented on

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1 medications, is that the kind of -
2 MS. ROGERS:
3 A. Yes, absolutely.
4 THE COMMISSIONER:
5 Q. - process you anticipate.
6 MS. ROGERS:
7 A. That's right and on a number of occasions when
8 I've gone with other patients to their
9 appointments with friends or in my own case,
10 it wouldn't be unusual for the doctor to say,
11 I consulted with Dr. So and So or Dr. So and
12 So because I wasn't sure which was the best--
13 and this is what they recommend. And I also
14 know that when I was--my case first came to
15 the cancer centre that there was a meeting
16 with the radiation oncologist, the medical
17 oncologist, so it was a team approach to your
18 care and treatment.
19 THE COMMISSIONER:
20 Q. All right, thank you.
21 CHAYTOR, Q.C.:
22 Q. Thank you, Commissioner. Ms. Rogers, so in
23 your case, your ER status changed from
24 negative to 20 percent positivity, and you
25 were offered hormonal therapy.

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1 MS. ROGERS:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. So you understood there was a change in your
5 treatment?
6 MS. ROGERS:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. We've heard a number from Eastern Health which
10 was released to the public in December of 2006
11 that there were 117 people who had a change in
12 treatment as a result of the retesting
13 process. Do you know if you're included in
14 that number of 117?
15 MS. ROGERS:
16 A. I don't know.
17 CHAYTOR, Q.C.:
18 Q. Would you expect that you would be?
19 MS. ROGERS:
20 A. I would expect that I would be because my test
21 results had changed.
22 CHAYTOR, Q.C.:
23 Q. And you were offered a change in treatment?
24 MS. ROGERS:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. And Ms. Rogers, what is your current status?
3 Are you taking any hormonal therapy?
4 MS. ROGERS:
5 A. I'm not. I've since had a double ovarectomy
6 (phonetic). I seem to be losing my "girlie
7 bits" bit by bit and I'm not on any hormonal
8 treatment at all.
9 CHAYTOR, Q.C.:
10 Q. Okay, if we could have a look at C-0139,
11 please Registrar? And this is a progress note
12 of Dr. Laing, dated May 16th, 2006 and again
13 it repeats under "Diagnosis" your initial
14 diagnosis. "ER initially said to be negative
15 and PR positive, but did not take Tamoxifen.
16 On retesting, ER 20 percent positive and PR 60
17 to 70 percent, offered Arimidex. Geri returns
18 to the clinic today. Overall she has been
19 well. She decided not to take the Arimidex.
20 She thought about it and this far out, she did
21 not wish to take any hormonal therapy." And
22 it talks about, "She also had problems with
23 hypertension" and it goes on from there.
24 Under "Plan: I am okay with her decision not
25 to take Arimidex this far out. It is a

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1 difficult situation to know what is the best
2 thing to do and if she is not comfortable in
3 taking medication, then I have told her that
4 it is fine if that is her decision." Did you
5 tell Dr. Laing about your discussions with Dr.
6 Love?
7 MS. ROGERS:
8 A. I did and where Dr. Love said that the fact
9 that I was--that I had gone into a drug
10 induced menopause with the chemotherapy, that
11 that, in effect, was a partial form of hormone
12 therapy.
13 CHAYTOR, Q.C.:
14 Q. And I take it after your discussion with Dr.
15 Laing on this date in May, May 16th, 2006, she
16 indicates she was okay with your decision?
17 MS. ROGERS:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. And that's consistent with your recollection
21 of your discussion that date?
22 MS. ROGERS:
23 A. Yes. Had she said that I absolutely believe
24 that you should take this, I would.
25 CHAYTOR, Q.C.:

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1 Q. If I could have P-0012 please? This is a--and
2 we're moving away from your medical chart and
3 this is an e-mail communication that we've
4 received through disclosure from Eastern
5 Health. It comes from Susan Bonnell, who we
6 understand is the Director of Communication at
7 Eastern Health. The date is May 16th, 2007,
8 4:25 p.m. It's sent to George Tilley, Stephen
9 Dodge, Oscar Howell and the subject is ER/PR
10 Private and Confidential. And this memo--I
11 won't take you through all of it, but there is
12 one part here where your name is mentioned, so
13 I'll just take you through that. Under a bold
14 heading "Why Should We Speak Publicly",
15 presumably the "we" being Eastern Health. The
16 first bullet, "Our credibility as an
17 organization and our ability to provide
18 quality care are being maligned." The second
19 bullet, "When you don't speak, the story
20 continues, with or without you and the media
21 look for less credible spokes people who will
22 speak to them; hence, Peter Dawe, Geri Rogers,
23 Ches Crosbie." Ms. Rogers, have you seen this
24 before?
25 MS. ROGERS:

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1 A. I did see this a few weeks ago, both you and
2 Bernie Coffey had shown this to me.
3 CHAYTOR, Q.C.:
4 Q. Ms. Rogers, were you aware of this perception
5 of you by the Director of Communications of
6 Eastern Health?
7 MS. ROGERS:
8 A. No, but I certainly feel that I'm in good
9 company with Peter Dawe and Ches Crosbie. I
10 was shocked when I saw this. I would assume
11 that Eastern Health, as an entity and God
12 knows there are fabulous people working in
13 Eastern Health and working so hard and under
14 some of the most difficult situations where
15 they have received cut back after cut back
16 after cut back, and still expected to carry
17 forth their mandate in a responsible and in a
18 caring and in an efficient and professional
19 manner, but to see something like this, I was
20 astounded and I would assume that they would
21 see the media and people like Ches Crosbie and
22 Peter Dawe and myself as irritants because
23 we've all been rather persistent about this
24 whole issue, saying that they had to speak to
25 us, they had to speak to the women involved,

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1 that they had to speak to the community. But
2 I would never have imagined--I looked at this
3 and I thought, what kind of rabbit hole have I
4 fallen into where it's all topsy turvey and
5 we're the bad guys. There were so many of us
6 who persisted in trying to say that I know
7 every time that I spoke to the media, I always
8 couched it in the terms of how important our
9 health care system is, that it's not a
10 corporation. And, you know, some of the
11 response that Eastern Health has done in this
12 is like bad corporate behaviour. But our
13 health care system is so important and it
14 belongs to all of us as taxpayers and that
15 when we look at what's been happening with
16 this ER/PR fiasco that it's not only the
17 safety of the patients, but it's the safety of
18 the doctors and the pathologists and the
19 nurses and the whole health care system. And
20 that all any of us want--this is not a
21 personal issue, on many levels it's a
22 political issue in terms of all any of us want
23 is for it to be better, for it to get better,
24 because we know that by the year 2015, the
25 Canadian Strategy for Cancer Control is

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1 telling us that one in three people at some
2 point in their life are going to get cancer.
3 And I've sat in that cancer clinic and watched
4 the people coming and going. I've seen the
5 doctors not have lunch, not have supper as
6 they work so hard to save people's lives and I
7 think thank God Ches Crosbie and Peter Dawe
8 have been persistent. They're not school yard
9 bullies as set out here in this memo and I'm
10 not a school yard bully. I'm somebody who
11 cares and everybody in this room cares and
12 everybody at Eastern Health cares, but they
13 messed up and they didn't deal with it
14 properly.
15 CHAYTOR, Q.C.:
16 Q. So, Ms. Rogers, what was your intent in
17 speaking publicly on this issue?
18 MS. ROGERS:
19 A. I'm so thankful for the work that the
20 "Independent" has done, for the work that CBC
21 Radio has done. I'm so thankful for the work
22 that CBC TV has done. Mark Quinn who won a
23 national award for the work that he has done
24 on this whole area, by the Nurses Association
25 of Canada. Vik Adhopia, they persisted and

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1 they pushed and they got more and more
2 information. I don't know where we would have
3 been had the media not pushed for this. I
4 don't know. I guess the media came to me
5 often, NTV the "Telegram", they've all done
6 excellent work and I guess they came to me
7 because of some of the work that I've done and
8 I've been somewhat of a public figure in the
9 whole area of breast cancer because of the
10 film that I've done and the advocacy I've
11 done. And I know how important it is in the
12 media to put a face to the story and almost
13 every time the media called me, after I had
14 done a few interviews, I would call other
15 women or I would call Ches Crosbie and ask him
16 if he had women who would speak, and for the
17 most part, most other women wouldn't speak,
18 they were afraid. And now the wonderful work
19 that Beverly Green has done and the women who
20 are stepping forward, it's so damn hard to put
21 your life out there. And this one has been
22 really tough, it's been tough to do the media
23 work because the whole issue of the ER/PR
24 stuff, it's complex. I don't want to know any
25 more than I have to about how it all works,

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1 the same way I don't want to know how my
2 computer works; I trust the experts. But it's
3 been really tough to do the media work, but
4 it's been so important and it's about saying
5 to a system that belongs to all of us that
6 you're not a corporation, that we need
7 transparency and accountability, that we need
8 to be treated with respect. And I was amazed
9 at the insistence of Eastern Health to try and
10 suppress the information about Dr. Banerjee's
11 and Trish Wegrynowski's reports, when I just
12 thought let's get all the information out and
13 let's make it better for everyone and move on,
14 because there's reconciliation that has to
15 happen, there's healing that has to happen and
16 the public has to have their faith or their
17 trust and their confidence restored in the
18 health care system. And I know how hard this
19 must be for some many people on so many levels
20 and people who dedicate their lives to health
21 care and to taking care of us all.
22 CHAYTOR, Q.C.;
23 Q. Thank you. Ms. Rogers, is there anything else
24 that you wanted to say in terms of your view
25 on how the responsible authorities handled the

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1 communications of this issue and its response
2 to the situation?
3 MS. ROGERS:
4 A. I would have hoped that they could have at
5 least sent us all a letter just to explain a
6 little bit, just to make it a little less
7 scary, a little clearer. There are still a
8 lot of women out there who think that maybe
9 their tests were wrong and they didn't have
10 breast cancer in the first place. That's how
11 much confusion is still out there.
12 CHAYTOR, Q.C.:
13 Q. Did you ever receive a letter from Eastern
14 Health?
15 MS. ROGERS:
16 A. I did receive one letter from Eastern Health
17 and it's dated October 16th, 2007. And my
18 name was on the envelope but my name was not
19 on the letter, so I guess it's a generic
20 letter, but they did find me. And do you -
21 CHAYTOR, Q.C.:
22 Q. I don't think we have that in our records, but
23 that's okay if you just want to go ahead with
24 it.
25 MS. ROGERS:

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1 Q. It's a letter "To the Patients of Eastern
2 Regional Integrated Health Authority"--
3 "authority" they got to get rid of that name
4 too, "and the Patient Family Members" to tell
5 me that they've been ordered to let me know
6 that I'm part of a class action suit. It's a
7 notice to individuals whose breast cancer
8 screening test results converted, where it's
9 not correct, it wasn't our screening, it
10 wasn't breast cancer screening test results
11 that converted -
12 CHAYTOR, Q.C.:
13 Q. I'm sorry, it says?
14 MS. ROGERS:
15 A. "Eastern Health is required by a Court Order
16 to send a notice to those individuals whose
17 breast cancer screening test results converted
18 from clinically negative to clinically
19 positive and who are identifiable from Eastern
20 Health's records."
21 CHAYTOR, Q.C.:
22 Q. Okay, so that's the only communication that
23 you received from Eastern Health?
24 MS. ROGERS:
25 A. Yeah, it doesn't have my name on it.

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1 CHAYTOR, Q.C.:
2 Q. Ms. Rogers, has anyone from Eastern Health or
3 your physicians told you what may have
4 happened to cause or contribute to the
5 discrepancy in your testing?
6 MS. ROGERS:
7 A. No.
8 CHAYTOR, Q.C.:
9 Q. Has anyone from Eastern Health or your
10 physicians outlined to you a plan intended to
11 rectify the harm and prevent recurrence of
12 this problem arising in the future?
13 MS. ROGERS:
14 A. No.
15 CHAYTOR, Q.C.:
16 Q. Did anyone offer you the option of a family
17 meeting or follow-up meeting to discuss this
18 issue?
19 MS. ROGERS:
20 A. No.
21 CHAYTOR, Q.C.:
22 Q. Did anyone from Eastern Health or your
23 physicians express to you acceptance of
24 responsibility for the problem and discrepancy
25 in your testing?

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1 MS. ROGERS:
2 A. No.
3 CHAYTOR, Q.C.:
4 Q. Did anyone from Eastern Health or your
5 physicians express regret or apologize to you?
6 MS. ROGERS:
7 A. I believe with Dr. Kara Laing that she may
8 have said "I'm so sorry this has happened."
9 CHAYTOR, Q.C.:
10 Q. Has anyone other than Dr. Kara Laing, anyone
11 from Eastern Health expressed regret or
12 apologized to you?
13 MS. ROGERS:
14 A. No.
15 CHAYTOR, Q.C.:
16 Q. Ms. Rogers, unless there is anything else that
17 you wanted to add, those are all of my
18 questions.
19 MS. ROGERS:
20 A. One of the questions that has been burning in
21 my mind is the memos that were released from
22 Dr. Ejeckam in the spring of '03 where he
23 clearly identifies that there's been a problem
24 in the labs, that he talks about the potential
25 disaster that the immunohistochemical stains

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1 were totally unreliable, that he said there's
2 a possibility of litigation and I received
3 copies of these memos from Vik Adhopia, CBC
4 reporter, who has done such a wonderful job on
5 this issue. And I don't understand why
6 retesting didn't happen there and I'm not a
7 medical person, I'm a layperson and I know how
8 complex this whole issue is, but if it was so
9 clear that there were so many problems with
10 the ER/PR tests then, and if action had been
11 taken then, if retesting had been started
12 then, I don't understand how come it wasn't.
13 It's a mystery to me and I would hope that the
14 scope of the inquiry would address that
15 problem.
16 THE COMMISSIONER:
17 Q. I think you can be assured that that
18 particular memo will be part of what will be
19 placed before the Commission, whose job it is
20 to look at a wide range of things, including
21 the kind of information which you have been so
22 kind as to come and give us regarding
23 communications, but as well communication not
24 only to the families, but communications
25 between institutions of various kinds and then

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1 later in the process, as Mr. Coffey has
2 indicated, we will get to the, what I call the
3 science end of it, what's done in the labs,
4 how they operate, who does what, when and what
5 was known at various stages in this process,
6 if anything about any problems that might
7 exist in the labs. So I think you can be
8 satisfied that the mandate of the Commission
9 is certainly one that would encompass the memo
10 that you've referred to.
11 CHAYTOR, Q.C.:
12 Q. Ms. Rogers, is there anything else? If not,
13 some of my colleagues may have questions for
14 you.
15 MS. ROGERS:
16 A. The other thing is that shortly after I was
17 diagnosed in 1999 and as I went through
18 treatment, in early 2000 in a teleconference,
19 Dr. John Church, who works at the Terry Fox
20 Cancer Research Lab said that the mortality
21 rate for women with breast cancer in
22 Newfoundland and Labrador was among the
23 highest in Canada. And as a Newfoundlander
24 and as a citizen of Canada, I would think that
25 I would have the right to the same level of

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1 excellent health care and that I hope that the
2 province, that this is a wake-up call to our
3 province as well to look at the health care
4 system in our province and the way that our
5 doctors are treated, whether they're paid
6 enough, whether there's enough money put into
7 training so that we, as Newfoundlanders and
8 Labradorians, can enjoy the same level of
9 excellence in health care as any citizen
10 across the country. Thank you.
11 CHAYTOR, Q.C.:
12 Q. Those are my questions, Commissioner.
13 THE COMMISSIONER:
14 Q. Thank you. Mr. Pritchard?
15 MS. GERALDINE ROGERS, EXAMINATION BY MR. ROLF PRITCHARD
16 Q. Ms. Rogers, my name is Rolf Pritchard, we've
17 met before. I'm here today representing the
18 Province of Newfoundland and Labrador. I just
19 have one question and earlier in your
20 testimony this afternoon, you made reference
21 to call the Department of Health and Community
22 Services and I thought your evidence was that
23 essentially you were referred to another
24 number, is that correct? And was that a
25 number within the Department of Health and

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1 Community Services or external to government?
2 MS. ROGERS:
3 A. Within.
4 MR. PRITCHARD:
5 Q. Okay, and did you end up speaking to anyone in
6 the end? No. Thank you.
7 THE COMMISSIONER:
8 Q. Mr. Simmons?
9 MR. SIMMONS:
10 Q. I have no questions, thank you very much, Ms.
11 Rogers.
12 THE COMMISSIONER:
13 Q. Mr. Browne?
14 MR. BROWNE:
15 Q. Good afternoon, Ms. Rogers. I have no
16 questions and I deeply appreciate your
17 evidence this afternoon.
18 THE COMMISSIONER:
19 Q. Sorry, the faces keep changing, I'm not quite
20 sure of where I have to look for sometimes.
21 MS. O'DEA:
22 Q. Thank you, Ms. Rogers, no questions.
23 THE COMMISSIONER:
24 Q. Ms. Newbury? Thank you.
25 MS. GERALDINE ROGERS, EXAMINATION BY MS. JENNIFER NEWBURY

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1 MS. NEWBURY:
2 Q. Good afternoon, Ms. Rogers. My name is
3 Jennifer Newbury and I represent the Canadian
4 Cancer Society, Newfoundland and Labrador
5 Division. I have just a couple of questions,
6 points of clarification. After learning of
7 the issue in the media in October, 2005, and
8 before your regularly scheduled appointment
9 with Dr. Laing, had you tried to contact her
10 directly or her office to learn any
11 information?
12 MS. ROGERS:
13 A. I did try to contact her. I was contacted by
14 the media for response to the whole issue and
15 I tried to contact her a few times, asking
16 her--before I spoke to the media.
17 MS. NEWBURY:
18 Q. Okay, and she didn't get back to you at that
19 time?
20 MS. ROGERS:
21 A. No.
22 MS. NEWBURY:
23 Q. Okay. Now you indicated as well that in
24 December 2005, you learned that it was very
25 rare to be ER negative, PR positive. Where

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1 did you learn that information?
2 MS. ROGERS:
3 A. I had done research, I'm not sure.
4 MS. NEWBURY:
5 Q. It wasn't from Dr. Laing, though, was it?
6 MS. ROGERS:
7 A. No.
8 MS. NEWBURY:
9 Q. Okay, and you'd received a letter from Dr.
10 Wagoner, that was the January 27th physician
11 panel letter, 2006?
12 MS. ROGERS:
13 A. I had an appointment with Dr. Wagoner, so she
14 said you may want copies of these.
15 MS. NEWBURY:
16 Q. Okay, and was that before or after your
17 consultation with Dr. Laing in February of
18 2006?
19 MS. ROGERS:
20 A. I think it would be after. I'm not sure.
21 MS. NEWBURY:
22 Q. Okay, and with regard to the physician review
23 panel and in particular the physician review
24 panel that apparently met to discuss your case
25 in, I believe it was January of 2006, would it

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1 be your preference to be advised about that
2 panel taking place, either before or after it
3 occurs? Would you like to be informed that
4 this is taking place?
5 MS. ROGERS:
6 A. As a patient in the cancer center, you know
7 that doctors are discussing your case because
8 cancer treatment in some ways is still a bit
9 of crap shoot.
10 MS. NEWBURY:
11 Q. Right.
12 MS. ROGERS:
13 A. Although there are protocols, there's a lot of
14 guessing and some of it is Science and some of
15 it is Art and because I don't want my doctors
16 or the system to have to spend a whole lot of
17 time contacting me to letting me know that's
18 happening, I assume a physician review panel
19 is a standard part of treatment and get on
20 with it.
21 MS. NEWBURY:
22 Q. Okay, and I understood, I took from your
23 earlier evidence that you're generally
24 appreciative as a patient, that these
25 consultations do take place, but the fact that

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1 this might be a little different, it's not in
2 the regular course of treatment, it's more of
3 a special occurrence, retesting. Would you
4 see that to be any different or would you
5 still consider that to be part of the regular
6 consultation and so long as it's taking place,
7 you're happy that it occurs?
8 MS. ROGERS:
9 A. Well, you know, a letter from Eastern Health
10 saying "Dear Geri Rogers: We're retesting
11 your things, they've been sent off, this is
12 the timeframe. When they're returned, we will
13 have them reviewed." That would have worked
14 really well.
15 MS. NEWBURY:
16 Q. Okay. You've mentioned as well a couple of
17 times consultations with Dr. Susan Love, who
18 is a physician you understand to be a
19 specialist from California?
20 MS. ROGERS:
21 A. Yes.
22 MS. NEWBURY:
23 Q. When you consulted with her, did you provide
24 her with any documents or was it just verbal
25 information that you related to her?

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1 MS. ROGERS:
2 A. Just verbal information.
3 MS. NEWBURY:
4 Q. Okay, and can you recall if at any point in
5 time you had provided your ER/PR specific
6 results, percentages?
7 MS. ROGERS:
8 A. Absolutely, and then after the conversation
9 with Susan Love, then I would also then speak
10 to Dr. Kara Laing again. But absolutely, it
11 was based on the written pathology I had and
12 then the verbal information I was given about
13 my ER/PR status as well.
14 MS. NEWBURY:
15 Q. Okay, and at the initial time when you were
16 initially diagnosed or determined to be ER
17 negative, PR positive, you had relayed both of
18 those results to Dr. Love?
19 MS. ROGERS:
20 A. Yes.
21 MS. NEWBURY:
22 Q. And had she indicated anything to you about
23 whether or not that was unusual?
24 MS. ROGERS:
25 A. You know, I can't remember.

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1 MS. NEWBURY:
2 Q. Okay.
3 MS. ROGERS:
4 A. I don't remember.
5 MS. NEWBURY:
6 Q. Thank you. Those are all the questions that I
7 have.
8 THE COMMISSIONER:
9 Q. Mr. Crosbie?
10 MS. GERALDINE ROGERS, EXAMINATION BY CHESLEY CROSBIE,
11 Q.C.
12 CROSBIE, Q.C.:
13 Q. Ches Crosbie, Ms. Rogers, one of those less
14 credible people. I wonder if I could ask you
15 your understanding as a patient, is the case
16 for hormone therapy, such as Tamoxifen, weaker
17 the farther out in time you get from the date
18 of your diagnosis?
19 MS. ROGERS:
20 A. Well certainly the optimal window is right
21 after treatment and then for a five-year
22 period and that what I know to be true is that
23 it's not as effective farther down the road,
24 unless there's a recurrence and then you just
25 try whatever would help. There has been some

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1 research recently, very small amount of
2 research that looks at the possible efficacy
3 of Tamoxifen even though you're farther out,
4 that there may be some benefit.
5 CROSBIE, Q.C.:
6 Q. You were diagnosed in, I think it was June
7 1999?
8 MS. ROGERS:
9 A. That's right.
10 CROSBIE, Q.C.:
11 Q. And your case came before the Tumor Panel on
12 the 28th of January, we've seen, 2006, is that
13 right?
14 MS. ROGERS:
15 A. This is the--the Tumor Panel is the -
16 CROSBIE, Q.C.:
17 Q. The panel that Dr. Laing chaired.
18 MS. ROGERS:
19 A. Yes.
20 THE COMMISSIONER:
21 Q. A letter from Dr. Laing to Dr. Laing?
22 MS. ROGERS:
23 A. That's the Tumor Panel? Okay, yes.
24 THE COMMISSIONER:
25 Q. I believe that's the one you're referring to,

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1 Mr. Crosbie?
2 CROSBIE, Q.C.:
3 Q. It is, yes, the panel. I think it's called
4 the Tumor Panel and they refer to themselves
5 as "the panel". This is not the case in your
6 situation because we've seen, you've been
7 taken through clinical notes in which Dr.
8 Laing records that she's had what appears to
9 be an extensive discussion back and forth with
10 you about the merits of taking hormone
11 treatment at that stage out from your
12 diagnosis. And you had that conversation with
13 her, I guess, in some detail, right?
14 MS. ROGERS:
15 A. Yes.
16 CROSBIE, Q.C.:
17 Q. So I would ask you hypothetically, let's say
18 there were women who the overall opinion would
19 be that there's little to no point in offering
20 any kind of additional therapy, drug therapy,
21 hormone therapy because of the length of time
22 out from the date of diagnosis. I'm not
23 saying that was--because you had that
24 discussion and there's obviously a body of
25 opinion that may have favoured giving you that

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1 treatment option, but let's say there were a
2 group of women for whom that wasn't an option
3 and the main stream medical opinion would be
4 that it's not worthwhile offering a
5 therapeutic treatment or a drug to those
6 women, let's just take that as a for instance.
7 MS. ROGERS:
8 A. Uh-hm.
9 CROSBIE, Q.C.:
10 Q. And let's say that you were in that category
11 as a further hypothetical, would you, if
12 approached for your consent to do retesting,
13 have consented or would you have wanted to
14 think carefully about it or would you have
15 withheld your consent? In other words what
16 I'm asking is if there is no therapeutic
17 option, would you consent to the retest and
18 want to know the answer?
19 MS. ROGERS:
20 A. Absolutely I would have consented and I would
21 have wanted to know the answer.
22 CROSBIE, Q.C.:
23 Q. You would?
24 MS. ROGERS:
25 A. Yes, I would have.

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1 CROSBIE, Q.C.:
2 Q. Can you say whether some patients that you
3 know, some women that you know may have
4 declined their consent in a situation like
5 what I described?
6 MS. ROGERS:
7 A. I could imagine that some might decline, yes.
8 CROSBIE, Q.C.:
9 Q. Thanks, I just wanted to raise the question.
10 I don't think we've discussed that before,
11 have we?
12 MS. ROGERS:
13 A. Not at all, no.
14 CROSBIE, Q.C.:
15 Q. Thank you.
16 THE COMMISSIONERS:
17 Q. Mr. Rogers, do you have any questions?
18 MR. ROGERS:
19 Q. No questions, Madam Justice.
20 THE COMMISSIONER:
21 Q. It seems like Commission counsel may want to
22 put their heads together about something.
23 While they are doing that, I want to raise a
24 point with counsel, other counsel in the room
25 and that is Ms. Rogers has referred to a

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1 letter which appears to me, in any event, as
2 the letter that was sent out relating to the
3 class action. As I understand it, it's not
4 among your materials, I'm just wondering
5 whether or not you want a copy of it or is it
6 so well known to everybody in this room,
7 generic form of letter having to do with the
8 class action that you really don't want to see
9 another copy of it. Is there anyone who wants
10 a copy of it, put it that way? Going, going,
11 gone, no copies are required. Okay. Was
12 there something arising?
13 CHAYTOR, Q.C.:
14 Q. There is one question, Commissioner.
15 MS. GERALDINE ROGERS, RE-EXAMINATION BY SANDRA CHAYTOR,
16 Q.C.
17 Q. Ms. Rogers, when you spoke for the second time
18 to Dr. Love and told her that you were now ER
19 positive, was there any discussion or question
20 raised by her to the fact that you had
21 converted from ER negative, when you had your
22 first conversation with her a couple of years
23 prior, and now you're speaking to her again
24 and you have a changed result. Was that the
25 subject of discussion between you and Dr.

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1 Love?
2 MS. ROGERS:
3 A. Absolutely, and I discussed with her the
4 situation of what was happening in the
5 province.
6 CHAYTOR, Q.C.:
7 Q. And was she surprised by that?
8 MS. ROGERS:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. And had she heard -
12 MS. ROGERS:
13 A. Well the depth of it.
14 CHAYTOR, Q.C.:
15 Q. - of such a situation anywhere else?
16 MS. ROGERS:
17 A. No, not to this extent, no.
18 CHAYTOR, Q.C.:
19 Q. Had she heard of the situation to a lessor
20 degree?
21 MS. ROGERS:
22 A. No, there are some variations and margins of
23 error in the whole ER/PR testing that are
24 acceptable margins of error, but not to this
25 degree.

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1 CHAYTOR, Q.C.:
2 Q. Thank you. Those are our questions,
3 Commissioner.
4 THE COMMISSIONER:
5 Q. Thank you, Ms. Rogers. It's been a long
6 afternoon and I do appreciate you taking your
7 time to come and help us with the work of the
8 Commission. Thank you very much.
9 MS. ROGERS:
10 A. Thank you. And one more thing, for the
11 Commission, I would hope that the Commission
12 at the end with your findings, that you are
13 able to somehow set up an opportunity to have
14 a two-way communication with the Commission,
15 that there be something that's tangible,
16 whether it be a letter or a pamphlet that's
17 accessible, that's easily understandable for
18 the women and the families that have been
19 affected, but that also in some way there's a
20 chance for people to ask questions, that it's
21 a two-way communication, rather than us just
22 hearing about the findings through the media
23 and also I know that whatever information
24 comes from the Commission will be -
25 THE COMMISSIONER:

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1 Q. You're expecting a large volume?
2 MS. ROGERS:
3 A. Yeah, so maybe--but there are many ways that
4 that can be set up where, again to restore
5 confidence among the women.
6 THE COMMISSIONER:
7 Q. Thank you.
8 MS. ROGERS:
9 A. And thank you for taking this on.
10 THE COMMISSIONER:
11 Q. All right, thank you very much. Now, we're
12 long past the afternoon break, so I suggest we
13 take it now before we proceed with the next
14 witness.
15 (RECESS)
16 THE COMMISSIONER:
17 Q. Mr. Coffey.
18 COFFEY, Q.C.:
19 Q. Thank you. The next witness, Commissioner, is
20 Janet Henley-Andrews.
21 MS. JANET MARIE HENLEY-ANDREWS, (SWORN) EXAMINATION BY
22 BERNARD COFFEY, Q.C.:
23 Q. Thank you, Commissioner. Ms. Andrews, what's
24 your occupation, please, could you tell us?
25 MS. HENLEY-ANDREWS:

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1 A. By profession, I'm a lawyer, but I'm currently
2 retired due to medical reasons.
3 COFFEY, Q.C.:
4 Q. And you practised, well I happen to know you
5 practised in St. John's for quite a number of
6 years, okay.
7 MS. HENLEY-ANDREWS:
8 A. Yes. Over 25.
9 COFFEY, Q.C.:
10 Q. Don't remind me. I started a little bit
11 before you did, so don't remind me please.
12 Ms. Andrews, I understand that you've had
13 encounters with breast cancer?
14 MS. HENLEY-ANDREWS:
15 A. That's correct.
16 COFFEY, Q.C.:
17 Q. Could you tell us please, give us an overview
18 of your encounters with that disease?
19 MS. HENLEY-ANDREWS:
20 A. Yes. It started really in the spring of 1996.
21 I developed a fluid discharge from my right
22 breast. I saw my family doctor and she sent
23 me on to a surgeon, Dr. Al Felix. He felt
24 that it was probably a pathaloma, which is an
25 irritation of an inside of a milk duct, but he

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1 said there was an off chance that it was
2 something else. He moved up my mammogram. My
3 family doctor had booked a mammogram because
4 that was the year I turned 40 and at that time
5 there was a nine to 12 month wait for a
6 mammogram and so my mammogram was moved up to
7 August. And he rescheduled an appointment for
8 me to see him in September of 1996. He said
9 that if the problem had remained chronic, he
10 would recommend removal of the affected ducts.
11 It did remain chronic, I went back to see him
12 in September of 1997--1996, I'm sorry. The
13 mammogram had been clear or negative and he
14 told me that I would be put on the surgery
15 list and that the surgery would be done on a
16 day-surgery basis. Several months went by and
17 I heard nothing from St. Clare's about the
18 surgery and I went back to my family doctor
19 and discussed the fact that I hadn't heard
20 anything and asked her was it really necessary
21 for me to have the surgery at all and she
22 recommended it. So I decided to bite the
23 bullet and I called--she checked the file and
24 there was a note in the file requesting that I
25 be put--sorry, I got back in touch with Dr.

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1 Felix's office and his secretary checked the
2 file, confirmed there was a note requesting
3 that I be put on the surgery list and she
4 checked with the hospital and reported back to
5 me that I somehow was not on the list, but
6 that she had ensured that I would actually
7 have the surgery fairly quickly. I had the
8 original surgery to deal with discharge
9 problem in January of 1997 and when I went
10 back to see Dr. Felix for my recheck of the
11 stitches and everything, about ten days after,
12 he called the pathology lab because he didn't
13 have the report and discovered that in fact I
14 had ductal carcinoma in-situ, otherwise known
15 as DCIS and he told me that the DCIS extended
16 to the edge of what he had removed and that I
17 would have to have a second surgery. Some
18 people, I guess, call that a lumpectomy or a
19 re-excision, but anyway, the objective of the
20 surgery, the second surgery, was to make sure
21 that they had it all. The second surgery was
22 scheduled and took place in February of 1997.
23 Dr. Felix came to see me in the day surgery
24 ward after I had been released from--after I
25 was back there and we had a--he told me that

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1 he had removed considerably more tissue than
2 he had anticipated because there were certain
3 types of benign breast disease that looked
4 very much like DCIS to the naked eye and he
5 actually, I remember that he said to me at the
6 time, he said, "you're probably not going to
7 be too happy to hear this about your breast,
8 but it's pretty mucky in there" and we kind of
9 laughed a little bit about that. I was upset
10 because it was a bit overwhelming and he
11 arranged for me to have, to stay overnight in
12 the hospital so that I could kind of pull
13 myself together and he also came to see me the
14 following morning with some literature. And
15 he discussed, he said it was too early to
16 actually discuss what we would need to do to
17 deal with the DCIS because the pathology
18 report on the second surgery had to come back
19 first, that I might require further surgery, I
20 might require radiation and that there was a
21 very recent study out of Van Nuys, California
22 where they were trying to determine which DCIS
23 patients could forego the radiation and which
24 really needed to have it. And he arranged to
25 have a copy of that study delivered to me so

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1 that I could read it, so that when we got
2 together at my re-check and when the pathology
3 report was ready, I would have had a chance to
4 digest it. He said he knew I was capable of
5 reading it, although I admit that I actually
6 still have the handwritten notes, including
7 my, what I called my dictionary because I had
8 to look up all the medical terms and then I
9 could read the article with constant reference
10 to the medical terms to make sure that I
11 understood. And I gave it to my husband, who
12 is also a lawyer and he reviewed it and I gave
13 it to my friend, Gillian Butler, also a lawyer
14 who also reviewed it and we developed a seven-
15 page list of questions which I asked on my
16 next visit.
17 COFFEY, Q.C.:
18 Q. And if we could, Commissioner, if I could
19 please have entered as exhibits the documents
20 labelled C-0145 through to C-0154, inclusive
21 please.
22 THE COMMISSIONER:
23 Q. Yes, Exhibits C-0145 through to C-0154 are
24 entered.
25 EXHIBITS C-0145 THROUGH TO C-0154 ARE ENTERED INTO

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1 EVIDENCE
2 COFFEY, Q.C.:
3 Q. And as well, please, Exhibit P-0017.
4 THE COMMISSIONER:
5 Q. Wait now, 17 seems to be -
6 COFFEY, Q.C.:
7 Q. Now it is the label, I would point out -
8 THE COMMISSIONER:
9 Q. The label is wrong, not the actual document.
10 COFFEY, Q.C.:
11 Q. Yes, the document itself is correct, but the
12 label, at least the copy that I have, which is
13 -
14 THE COMMISSIONER:
15 Q. Yes, refers to an earlier witness, but in fact
16 the document itself is correct?
17 COFFEY, Q.C.:
18 Q. Yes, it does.
19 THE COMMISSIONER:
20 Q. All right, then we'll arrange for the label to
21 be changed and the document P-0017 will be
22 entered.
23 EXHIBIT P-0017 IS ENTERED INTO EVIDENCE
24 COFFEY, Q.C.:
25 Q. The listing of exhibits, in fact, should read

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1 for my fellow counsel, P-0017, should be, when
2 you read the third line, "database report for
3 Janet Andrews" is the appropriate reference.
4 THE COMMISSIONER:
5 Q. Yes, all right.
6 COFFEY, Q.C.:
7 Q. Thank you, Commissioner. Registrar, please,
8 Exhibit C-0145? And Ms. Andrews as I
9 indicated to you before we started this
10 afternoon, we have the paper document there in
11 front of you, if you wish to use that and as
12 well, there is--it will be on the screen as
13 well, whichever you prefer. Exhibit C-0145 is
14 a Health Care Corporation of St. John's,
15 specimen inquiry for St. Clare's Mercy
16 Hospital. It's there at the top of the screen
17 and the patient is Janet Marie Andrews.
18 Received February 3rd, 1997, the attending
19 physician is Dr. Felix and under "Tissues"
20 it's from your right breast tissue and under
21 "Micro description" it indicates "sections of
22 the breast tissue show multiple areas of in-
23 situ carcinoma." And under "Pathological
24 Interpretation" toward the bottom of the page
25 "Extensive carcinoma in-situ" and as you've

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1 noted an in-situ carcinoma extending into
2 resection margin and this is a report by Dr.
3 Miriam Griffin and on the copy I have, it
4 looks to be probably the 11th of February,
5 1997, sometime anyway early in February, '97.
6 That would be your first operation.
7 Registrar, Exhibit C-0146 and this again is
8 the same sort of form, Ms. Andrews. The
9 specimen number here is 97: SU744, which is
10 right there on the screen.
11 MS. HENLEY-ANDREWS:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Received February 17th, '97 and again, of
15 course, it's for yourself. And the tissues
16 here are noted to be biopsy right breast,
17 biopsy wider excision of previous biopsy and
18 the doctor here notes "multiple sections have
19 been examined." In the second line, "no
20 residual carcinoma is seen, and a previous
21 biopsy site is identified," and at the bottom
22 there, "pathological interpretation, re-
23 excision biopsy, right breast. No residual
24 carcinoma seen," and this is a report of a Dr.
25 Jessica Shepherd, entered or signed by her

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1 electronically February 24th, 1997. So then
2 those documents accord with your recollection
3 of what was done?
4 MS. HENLEY-ANDREWS:
5 A. Yes. After the second surgery, the re-
6 excision in February of 1997, when I met with
7 Dr. Felix, I specifically asked for copies of
8 the pathology reports, so that I could have a-
9 -so that I could be sure that I understood
10 everything that they said.
11 COFFEY, Q.C.:
12 Q. Okay.
13 MS. HENLEY-ANDREWS:
14 A. And he provided those copies to me.
15 COFFEY, Q.C.:
16 Q. Now I understand that, as you indicated, Dr.
17 Felix had provided material for you to read
18 that had a lot of medical terminology?
19 MS. HENLEY-ANDREWS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Much of which was foreign to yourself. You
23 spent some time studying the matter. I take
24 it that that was with a view to you making
25 some decision about how your treatment would

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1 proceed?
2 MS. HENLEY-ANDREWS:
3 A. Yes. The Van Nuys Prognostical Index, which
4 came out of the Van Nuys study that he had
5 given me, looked primarily at three different
6 factors in determining whether a patient might
7 be able to get away without the radiation
8 treatment, and Dr. Felix and I had a long
9 discussion about the radiation treatment and,
10 but first the Prognostical Index was the
11 primary focus of our discussion, and the way
12 it worked was that there was a scoring system
13 based on a maximum point total of nine and it
14 was weighted three points to tumor size, three
15 points to nuclear grade of the cancer cells
16 and three points to the width of the clear
17 margin on the surgery.
18 When I reviewed the reports, the
19 pathology reports, I had some concerns because
20 I couldn't see anywhere on the reports a
21 specific reference to the nuclear grade. I
22 couldn't see a specific reference to the size
23 of the tumor and although there was a mention
24 of margin width after the original surgery,
25 the January surgery, but in the Exhibit C-

1 0156, it actually doesn't indicate anything
2 about margins except it does say that there
3 was no residual carcinoma seen.
4 COFFEY, Q.C.:
5 Q. I'm sorry, C-0156, what is the date of that?
6 MS. HENLEY-ANDREWS:
7 A. C-0146.
8 COFFEY, Q.C.:
9 Q. Oh, 46, I'm sorry. You had said -
10 MS. HENLEY-ANDREWS:
11 A. I'm sorry.
12 COFFEY, Q.C.:
13 Q. - you had read it as 5, so--and that's one of
14 the two I just referred you to.
15 MS. HENLEY-ANDREWS:
16 A. That's right, so right at the very bottom of
17 that, in the pathological interpretation, it
18 says "re-excision biopsy right breast, no
19 residual carcinoma seen."
20 COFFEY, Q.C.:
21 Q. Yes.
22 MS. HENLEY-ANDREWS:
23 A. So Dr. Felix told me that he had spoken to the
24 pathologist and with respect to the first
25 surgery and understood that the cells were low

1 grade, which meant a score of one. That tumor
2 size hadn't been measured, but that it was
3 either a one or a two of three, and that the
4 margins, there having been no residual DCIS or
5 any other cancer in the re-excision tissue,
6 that it was a pretty wide margin, which would
7 mean that it would be a one out of three for
8 margin width, for a total score of three or
9 four, depending on whether you used the one or
10 the two for the tumor size.
11 With the Van Nuys Prognostical Index, a
12 score of three or four was an indication that
13 you might be able to escape radiation. Five,
14 six and seven recommended the lumpectomy with
15 the radiation, and eight and nine was usually
16 an invasive breast cancer which might require
17 other alternatives.
18 So the pathology reports figured very
19 much in the discussions at the time, and the
20 reason I can remember as much detail on the
21 scoring system is because when I looked down
22 through my questions that I asked Dr. Felix,
23 it recalled a lot of those details, because I
24 asked those questions in detail. In fact,
25 when I went to see him, he at first was on the

1 other side of the desk and after I'd asked a
2 few questions, he said he really felt more
3 like he was in a discovery than meeting with a
4 patient, and he would prefer to sit on the
5 same side of the desk as I was.
6 COFFEY, Q.C.:
7 Q. So, and you were doing this all with a view to
8 trying to make up your mind about whether you
9 should have radiation treatment?
10 MS. HENLEY-ANDREWS:
11 A. That's right. He felt I was a good candidate
12 for not having the radiation treatment, but it
13 was--he did tell me that the radiation was
14 standard, but that this was new research.
15 Because I was 40, and there were very few
16 long-term studies on the effects of radiation
17 for people who had it at that age, there was
18 always the risk of some kind of radiation
19 related problems before I would normally die,
20 and in addition to that, radiation tended to
21 change the texture of the tissue in the breast
22 so that it made future mammograms a little bit
23 more difficult to read and once you've had the
24 radiation once, you can't have it a second
25 time. So it would eliminate it as a possible

1 treatment if I had a recurrence in the future.
2 And I ultimately made the decision not to have
3 the radiation. I revisited that decision many
4 times with him, but ultimately, you know, I
5 reassured myself that I was--I thought I was
6 being a bit neurotic about it because the
7 second surgery had indicated no residual
8 carcinoma and I felt that I should have been
9 satisfied by that, but I wasn't.
10 COFFEY, Q.C.:
11 Q. I understand that after the--let's see. After
12 the surgery or the biopsy in wider excision
13 right breast biopsy in February of 1997, that
14 you had surgery again?
15 MS. HENLEY-ANDREWS:
16 A. In November, yes.
17 COFFEY, Q.C.:
18 Q. Yes, of the same year.
19 MS. HENLEY-ANDREWS:
20 A. I had a--after that surgery, the second one in
21 February, right up until the time that I was
22 diagnosed with a recurrence in 2001, I had a
23 series of lumps and suspicious bumps in that
24 breast that were investigated. I seldom--I
25 was supposed to see Dr. Felix first six months

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1 after the last time he saw me following the
2 February one, and I never seemed to make it to
3 the next scheduled appointment before I ended
4 up being referred back to him again because I
5 had some kind of a new lump or suspicious area
6 that I was worried about, and in that period,
7 you're right, I had an excisional biopsy in
8 November of 1997, although the mammogram done
9 in the fall of 1997 was clear, and that report
10 was negative for cancer, and I did have a
11 number of other ones, but I don't have copies
12 of those.
13 COFFEY, Q.C.:
14 Q. Sure. One in particular I want to--and my
15 understanding is that in terms of your health,
16 from 1997 really onward, you paid--there was a
17 lot of attention paid to it, in terms of
18 mammograms, visits to Dr. Felix, and I do
19 understand though that in July of 2001, and
20 you just referred to it a couple of moments
21 ago, you had an excisional biopsy in your
22 right breast and this is before you had a
23 double mastectomy in August?
24 MS. HENLEY-ANDREWS:
25 A. That's right. Sometime in 2000, I had a lump

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1 I was concerned about. All my mammograms up
2 until that point had been clear, but the lump
3 was up fairly high, near my armpit, whereas
4 the original cancer had been right below the
5 nipple. I had, in that period between 2000
6 when that lump first sort of showed up, I had
7 ultrasound, two ultrasounds. I had two
8 mammograms. I had a fine needle biopsy and I
9 had a core biopsy, all of which were negative
10 for cancer. The core biopsy was done in May
11 or June of 2001 and when I saw Dr. Felix in
12 June of 2001, he said to me, he said "Janet,
13 you know, we've done every test we can do and
14 everything has come back negative. I think
15 you should relax," and I said to him, I said
16 "it's kind of like this," I said "it's the
17 lump or me," and he said "well, if you feel
18 that strongly about it, then we'll remove the
19 lump."
20 COFFEY, Q.C.:
21 Q. Sure.
22 MS. HENLEY-ANDREWS:
23 A. So the biopsy that you're referring to in July
24 of 2001 is the one that I specifically
25 requested because of my nervousness.

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1 COFFEY, Q.C.:
2 Q. Exhibit C-0148, please. Now, Ms. Andrews,
3 this is, again it's Health Care Corporation of
4 St. John's report. It's for yourself, your
5 name is there, "pathological interpretation,
6 excisional biopsy right breast. Ductal
7 carcinoma in situ with cribriform and
8 micropapillary configuration," and we go down,
9 it's a report from Dr. Donald Cook, signed off
10 on July 20th, 2001, and Dr. Cook notes here
11 under microscopy, he notes "examination of
12 excisional biopsy from the breast shows
13 evidence of ductal carcinoma in situ with
14 cribriform and micropapillary configurations,"
15 and toward the end, he goes on at some length,
16 of course, describing this and he concludes by
17 saying "though the margins appear clear, there
18 are some areas where the in situ change is
19 seen close to the inked line of resection,
20 less than one millimetre. This case was
21 submitted at our quality control rounds. The
22 consensus opinion is of a ductal carcinoma in
23 situ with cribriform and micropapillary
24 patterns." And under comments, he notes it's
25 submitted to QC rounds on July 19th, 2001. So

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1 apparently Dr. Cook reached the conclusion he
2 did, but as well, before doing so and signing
3 off on it, he canvassed his fellow--certain
4 other fellow physicians about the DCIS
5 diagnosis.
6 MS. HENLEY-ANDREWS:
7 A. That's correct, and Dr. Felix called me at
8 home with the results because I had, by that
9 time, been calling his office every day for
10 about four days. I would--I could go six days
11 without calling, because I knew there wasn't a
12 hope that they would have the report within
13 six days, but by the time the sixth day came,
14 I was a total wreck and my office was fairly
15 close to St. Clare's and I have--it's
16 embarrassing to admit, but I actually used to
17 drive around the hospital several times on my
18 way to work, just some how or another, it made
19 me feel closer to it or something bizarre, but
20 I thought I was losing my mind at different
21 points. Actually, I eventually did, but the -
22 COFFEY, Q.C.:
23 Q. This is the effect this had on you, just the
24 not knowing?
25 MS. HENLEY-ANDREWS:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Is what you're--I think that you're conveying.
4 MS. HENLEY-ANDREWS:
5 A. Each time, every time I had a biopsy, that was
6 the effect that it had on me. After the first
7 one, because I didn't--after the first one in
8 '97, because I didn't expect a bad result. He
9 called me at home with the result and while
10 they're not actually supposed to give the
11 results over the phone, he had learned that
12 having--phoning me, having his secretary phone
13 me and inviting me to come in meant that I
14 already knew that there was a problem. So it
15 was just as well to phone me and talk to me
16 directly, and he told me that, you know, to
17 his surprise, and mine, there was extensive
18 DCIS in the lump that had been removed and he
19 told me that because it was a recurrence, I
20 would have to have a mastectomy with respect
21 to the right breast, and then we made an
22 appointment for me to go in and discuss other
23 treatment issues.
24 COFFEY, Q.C.:
25 Q. If we could, please, Exhibit C-0149, and this

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1 is a report on Health Care Corporation of St.
2 John's letterhead. It's for yourself. The
3 specimen number is 01SS6066, received August
4 21st, 2001 and under "pathological
5 interpretation, number one, right sentinel
6 node excisional biopsy, negative for
7 metastasis. Number two, right breast
8 mastectomy, no residual tumor identified" and
9 there were other findings. Left breast
10 mastectomy, and there are findings set out
11 there, but there was no carcinoma noted. If
12 we go to -
13 MS. HENLEY-ANDREWS:
14 A. I'd just like to point out that I opted for a
15 bilateral mastectomy. I was at the end of my
16 rope on dealing with being back and forth all
17 the time and I thought it would be really
18 weird to have just one breast, and so I
19 figured that I might as well get both of them
20 removed at the same time, and then I wouldn't
21 have to worry about it again.
22 COFFEY, Q.C.:
23 Q. And under clinical history, and this
24 particular report, when you go to page three
25 of it, was signed, the signature on file is

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1 that of Nash Denic, entered August 29th, 2001,
2 and under clinical history, he just notes
3 "right breast recurrent DCIS, left breast
4 prophylactic mastectomy."
5 You've indicated that you, of course,
6 returned to speak with Dr. Felix about
7 treatment issues and how it would proceed.
8 Could you tell us about what you recall about
9 that? In particular, Tamoxifen and matters
10 related to that.
11 MS. HENLEY-ANDREWS:
12 A. I did get a copy of the pathology reports,
13 both the one from July and the one from the
14 mastectomy. I knew when I looked at the
15 pathology reports from the mastectomy that
16 with the atypical ductal hyperplasia in the
17 right breast and focal atypia in the left that
18 I'd made the right decision, in terms of
19 having the bilateral mastectomies, because
20 both of those I understood to be indicators of
21 potential future problems. DCIS normally,
22 according to what Dr. Felix told me at the
23 time, a mastectomy--with DCIS, there was
24 really no further treatment required for other
25 than the mastectomy on the recurrence, and

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1 because I asked about--I asked about radiation
2 in particular, because we had discussed it so
3 much.
4 COFFEY, Q.C.:
5 Q. Yes.
6 MS. HENLEY-ANDREWS:
7 A. And there was no discussion of Tamoxifen.
8 COFFEY, Q.C.:
9 Q. Okay, so it did not come up?
10 MS. HENLEY-ANDREWS:
11 A. No, it didn't.
12 COFFEY, Q.C.:
13 Q. How about the--was there any discussion, you
14 know, up to and including your surgery in
15 August of 2001 and then the aftermath of that
16 surgery, any discussion about ER/PR status,
17 estrogen receptor and progesterone receptor
18 status of the tumors?
19 MS. HENLEY-ANDREWS:
20 A. No, there wasn't, and I wasn't able to do the
21 research that I had obsessed about after the
22 1997 incident. My mother-in-law went into
23 palliative care within a month of my 2001
24 mastectomies. It was a very, very difficult
25 time for our family. As I was getting--as I

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1 was recovering, which and the physical
2 recovery alone was pretty bad, she was getting
3 worse. I was also trying to get back to work
4 within a month so that--because I had a public
5 hearing starting at the end of September and
6 between trying to keep the children fed and
7 dealing with all those other things, I didn't
8 do a lot of research at that time. So I
9 didn't know anything about ER/PR testing. I'd
10 never heard of it.
11 COFFEY, Q.C.:
12 Q. Okay. Now if I could, please, I understand,
13 before we go to Exhibit C-0150, I understand
14 that then you had the double mastectomy. You
15 did not have radiation afterward for it?
16 MS. HENLEY-ANDREWS:
17 A. That's correct.
18 COFFEY, Q.C.:
19 Q. Did not, and there was no chemotherapy?
20 MS. HENLEY-ANDREWS:
21 A. That's correct.
22 COFFEY, Q.C.:
23 Q. And you didn't know anything about Tamoxifen
24 at the time. We understand that in October or
25 around October 2nd, 2005 and in the days

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1 afterward or after that, ER/PR was a public
2 issue, became well known here in St. John's.
3 MS. HENLEY-ANDREWS:
4 A. That's correct.
5 COFFEY, Q.C.:
6 Q. When you first heard about that, did that
7 cause you to make any inquiries?
8 MS. HENLEY-ANDREWS:
9 A. Well, I started making inquiries a little
10 earlier than that. My mother was diagnosed
11 with breast cancer in late 2002 or early 2003
12 and I went with her to the--Dr. Felix did her
13 surgery, but I went with her to the--went to
14 her appointments at the Cancer Clinic, and Dr.
15 Laing was her medical oncologist and she did
16 have radiation, and during one of those
17 meetings, there was a discussion of Tamoxifen
18 and ER/PR status and I asked some questions
19 about it, and I told Dr. Laing that, you know,
20 I'd also had breast cancer and that--she asked
21 me some questions and I told her it was DCIS
22 and I said that I--you know, "should I be on
23 Tamoxifen?" And she said "well, we"--she told
24 me that DCIS is not normally tested for ER/PR
25 status and that Tamoxifen was not normally

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1 given to people with DCIS.
2 COFFEY, Q.C.:
3 Q. Okay, so you learned about that because you
4 were along with a relative?
5 MS. HENLEY-ANDREWS:
6 A. That's right.
7 COFFEY, Q.C.:
8 Q. For her treatment.
9 MS. HENLEY-ANDREWS:
10 A. That's right. Now I subsequently--Dr. Laing
11 has been very good to me and she subsequently
12 took me on as a patient in 2005.
13 COFFEY, Q.C.:
14 Q. Do you recall when that was in 2005?
15 MS. HENLEY-ANDREWS:
16 A. It was early in 2005, probably January or
17 February of 2005. I had been hospitalized for
18 severe depression from--for five or six weeks
19 in the fall. No, I had been hospitalized for
20 ten weeks in the fall of 2002--2004 and one of
21 the major concerns that I still had was the
22 flukiness of having picked up the recurrence
23 in 2001 and my fear of dying.
24 COFFEY, Q.C.:
25 Q. Okay. And -

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1 MS. HENLEY-ANDREWS:
2 A. And I think my mother on one of her regular
3 visits with Dr. Laing told Dr. Laing how
4 concerned I was and Dr. Laing said she'd be
5 happy to see me on an annual basis.
6 COFFEY, Q.C.:
7 Q. Okay. And then in the fall of '05, 2005 ER/PR
8 became a public issue?
9 MS. HENLEY-ANDREWS:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Did you make any inquiries after it became
13 public?
14 MS. HENLEY-ANDREWS:
15 A. Yes, I did.
16 COFFEY, Q.C.:
17 Q. Exhibit C-0150, please? What did you do at
18 the time?
19 MS. HENLEY-ANDREWS:
20 A. When the ad was put--I was concerned about it
21 when I heard about it the news. But when the
22 ad went in the paper with the telephone number
23 that you could call for information, I decided
24 that although I knew that my tissue hadn't
25 been tested for ER/PR status, that I would ask

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1 if they would test it.
2 COFFEY, Q.C.:
3 Q. Okay.
4 MS. HENLEY-ANDREWS:
5 A. So I phoned the number that was in the paper,
6 I actually kept a copy of the page from the
7 paper, and the woman who answered at the other
8 end I told her about, you know, my history,
9 the fact that my mother had breast cancer and
10 that her ER/PR status had been positive and
11 asked if it was possible to get my tissue
12 tested. And she told me that there were
13 enough tissue samples being sent at that point
14 that she couldn't really see how one more
15 would make a big difference, but that she'd
16 have to talk to the pathologist. And she must
17 have called me back or either checked with him
18 then, I don't know, but anyway, I was clearly
19 of the understanding that my tissue had been
20 sent.
21 COFFEY, Q.C.:
22 Q. You were of the understanding?
23 MS. HENLEY-ANDREWS:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. That -
2 MS. HENLEY-ANDREWS:
3 A. At that time, yes.
4 COFFEY, Q.C.:
5 Q. Okay. Now, in terms of that, if we look at--
6 do you recall the name of the person you spoke
7 to?
8 MS. HENLEY-ANDREWS:
9 A. The only reason I know the name is because of
10 now having a copy of the report.
11 COFFEY, Q.C.:
12 Q. Okay. And in Exhibit, Commissioner, Exhibit
13 C-0150 this is what--the source is Eastern
14 Health. In fact, Nancy Parsons, top left-hand
15 side of the page, from Eastern Health. And
16 this is what I understand is called a screen
17 capture. And it's for yourself, Ms. Andrews.
18 And there's handwriting and it reads as
19 follows, "November 7th, 2005. This patient
20 had DCIS but has requested that she be
21 retested. I asked Dr. Cook. He will send her
22 sample for retesting." So that--and there is,
23 as well, some notes on the bottom there which
24 Ms. Parsons will eventually tell us what they
25 mean. But it's written "Lab communication

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1 type 3, ongoing." And there's a reason for
2 her terminology there. So the notation
3 November 7th, 2005 and the fact that you were
4 going to be retested, that's consistent with
5 your -
6 MS. HENLEY-ANDREWS:
7 A. That was what I understood.
8 COFFEY, Q.C.:
9 Q. Sure.
10 MS. HENLEY-ANDREWS:
11 A. When the results, when it became clear that
12 the people were being contacted with the
13 results or that results were available and
14 there was a lot of media attention given to it
15 and eventually, you know, Eastern Health
16 announced that everybody whose tissue had been
17 retested had been contacted and I hadn't been
18 contacted, I called the same number that I had
19 called the first time and asked for my
20 results. And I said that I had understood my
21 tissue was going to be sent to be retested.
22 And whoever answered the phone said she would
23 check and she checked and she came back and
24 she told me that my tissue had not been sent
25 for testing. And I was disappointed,

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1 obviously, but I mean, I also knew that I had
2 been asking a favour when I'd asked to have it
3 sent for testing in the first place, and so I
4 kind of thought that was the end of it.
5 COFFEY, Q.C.:
6 Q. You understood that in asking, as you put it,
7 for a favour, it was not for a retest, it was
8 for, in fact, the first test for ER/PR for
9 your tissue?
10 MS. HENLEY-ANDREWS:
11 A. Um-hm, yeah. And by that time my research
12 indicated that ER/PR testing was standard for
13 DCIS.
14 COFFEY, Q.C.:
15 Q. Okay. Ma'am, with respect to the--do you
16 recall when it was that you had this phone
17 call in which you were informed that your
18 tissue sample had not been sent, do you recall
19 when that would have been?
20 MS. HENLEY-ANDREWS:
21 A. I can--it's an educated guess.
22 COFFEY, Q.C.:
23 Q. Yes.
24 MS. HENLEY-ANDREWS:
25 A. There's a press release that was issued in May

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1 of 2007.
2 COFFEY, Q.C.:
3 Q. Yes.
4 MS. HENLEY-ANDREWS:
5 A. That indicated that, or I guess that announced
6 this inquiry.
7 COFFEY, Q.C.:
8 Q. Yes.
9 MS. HENLEY-ANDREWS:
10 A. And I looked it up on the web and it said that
11 all test results had been received by February
12 of 2006.
13 COFFEY, Q.C.:
14 Q. Okay.
15 MS. HENLEY-ANDREWS:
16 A. And so it was sometime between February of
17 2006 and May of 2007.
18 COFFEY, Q.C.:
19 Q. Okay. Certainly by the time this inquiry was
20 announced, the whole thing about this inquiry,
21 and that would have been, if I recall
22 correctly, the public announcement was May
23 22nd, 2007 or thereabouts, by that point in
24 time you knew that -
25 MS. HENLEY-ANDREWS:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Or you had already had that phone call?
4 MS. HENLEY-ANDREWS:
5 A. I had made the phone call.
6 COFFEY, Q.C.:
7 Q. Phone call.
8 MS. HENLEY-ANDREWS:
9 A. And I understood that my tissue had not been
10 sent for the ER/PR testing.
11 COFFEY, Q.C.:
12 Q. Now, I understand that you do now know that,
13 in fact, your tissue was sent for retesting?
14 MS. HENLEY-ANDREWS:
15 A. Yeah, I do.
16 COFFEY, Q.C.:
17 Q. Okay. Can you tell us, please, when you first
18 learned that your tissue sample was, in fact,
19 re--or not retested, was, in fact, tested for
20 the first time or was tested?
21 MS. HENLEY-ANDREWS:
22 A. I met with you and Ms. Chaytor and with Mr.
23 Crosbie in early February of this year, of
24 2008.
25 COFFEY, Q.C.:

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1 Q. Yes, actually February 15th, 2008.
2 MS. HENLEY-ANDREWS:
3 A. Okay, February 15th of 2008. And I seem to
4 recall that when I said that my--that the
5 testing had not been done on the ER/PR testing
6 as part of that, that Ms. Chaytor said, "But
7 you have seen this, haven't you?" and she
8 produced for me the copy of the ER/PR testing
9 report that had been done in 2005.
10 COFFEY, Q.C.:
11 Q. Okay. Exhibit C-0151. Now, Ms. Andrews, this
12 is document that's on Mount Sinai letterhead,
13 pathology and laboratory medicine. And it's,
14 let me see, the last name is handwritten
15 "Henley-Andrews, Janet," first name. The
16 referring physician is, or the physician is
17 noted to be Dr. Donald Cook. And that would
18 be consistent with the note on the screen
19 capture in Exhibit C-0150. The date of the
20 procedure is noted to be November 16th, 2005.
21 The time and date of the report, November
22 22nd, 2005 at 1623 hours. And in fact, if you
23 look toward the bottom of the page here, it's
24 noted to be printed November 22nd, 2005 at
25 1658 hours. It's page 1 of 2. The second

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1 page, it's signed by a Dr. Brendan Mullen.
2 And of course, it's a final surgical pathology
3 report. It's for, and I--the number assigned
4 to it, I anticipate by Mount Sinai, is SP-05-
5 17551. Here the clinical history is ER/PR
6 assessment, right there. A gross description
7 is noted to be "Received from Department of
8 Pathology, St. Clare's site, are paraffin
9 blocks times four labelled SU480-97 EGH and K
10 from a breast specimen type and side
11 unspecified." And "Microscopic description,"
12 Dr. Mullen has noted, "Estrogen receptor
13 protein percent positive cells 60,
14 progesterone receptor protein percent positive
15 cells 25." And there's a note then about the
16 threshold for positive ER/PR results.
17 Citation of a reference. And then on the next
18 page under "Diagnosis" he has "Breast specimen
19 type and side unspecified, block H. Ductal
20 carcinoma in-situ. Positive for estrogen
21 receptor protein, positive for progesterone
22 receptor protein." Now, as well, in relation
23 to this another matter of note potentially is
24 here there's a fax header, it appears to be
25 dated '05/11/22, which is likely as not is

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1 November 22nd, 2005, Tuesday, at 1801 hours.
2 The fax number is a 416 number. MSH pathology
3 and lab medicine, right there, it's also on
4 the first page, as well, the same fax header
5 except -
6 MS. HENLEY-ANDREWS:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. - of course, it's page 1 as opposed to page 2.
10 So I take it, Ms. Andrews, that the first time
11 that you learned that, saw this or learned of
12 its contents was in mid February of this year?
13 MS. HENLEY-ANDREWS:
14 A. Yes. And to say that I was shocked is an
15 understatement.
16 COFFEY, Q.C.:
17 Q. There's handwriting here on this, it says, the
18 first page, right-hand side, it says, "Not on
19 list. DCIS. Done after patient contacted N.
20 Parsons. No follow-up by panel, December 1,
21 2005." And there's an initial there. If we
22 could before we get to what's happened since,
23 if we could have Exhibit C-0152, please? And
24 this is a document entitled "Charts for
25 Review, Physician Review Panel, Thursday,

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1 December 1, 2005." The redacted or blacked
2 out portions don't relate to yourself. And
3 there are notes below, and I don't believe
4 that--I have no reason to believe that they
5 refer to you either. But your name is there,
6 Henley-Andrews, Janet." Handwritten "DCIS."
7 "Felix" would be Dr. Felix. "ER 60 percent,
8 PR 25 percent. And that's under the heading,
9 "MSH" which is probably Mount Sinai Hospital.
10 And if we could go then to Exhibit C-0153?
11 This again, "Charts for Review, Physician
12 Review Panel, Thursday, December 1, 2005."
13 "Janet Henley-Andrews" and "Felix" and
14 somebody's handwritten "delete."
15 MS. HENLEY-ANDREWS:
16 A. Yeah.
17 COFFEY, Q.C.:
18 Q. And finally, Exhibit--I'm sorry, page 3 of
19 Exhibit C-0153. Okay, I got it right here.
20 It's page 3. And this is entitled "Physician
21 Panel Review ER/PR Results." Date patient
22 reviewed, "December, 01/05." Your name is
23 Janet Henley-Andrews. Someone has handwritten
24 "delete" and there's no original results
25 handwritten there. "Patient has DCIS. No

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1 letter." And in relation to that just to tie
2 the documentation together, Ms. Andrews, when
3 we look at Exhibit C-0151, please, Registrar,
4 which is the Mount Sinai pathology report in
5 late November of 2005, you'll note that this
6 is labelled SU480-97?
7 MS. HENLEY-ANDREWS:
8 A. Um-hm. Which is the specimen from the first
9 surgery in 1997.
10 COFFEY, Q.C.:
11 Q. It's, in fact, if you go back to Exhibit C-
12 0145, which is the pathology report for or
13 received February 3rd, 1997 and the specimen
14 number is 97:SU480. So that's the first of
15 them, which is the first such surgery you had,
16 I take it? Is that correct?
17 MS. HENLEY-ANDREWS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Okay. So they have retested the first
21 surgical sample. Not retested, I'm sorry,
22 tested for the first time?
23 MS. HENLEY-ANDREWS:
24 A. Yeah. And the percentage positive of 60
25 percent for estrogen and 25 percent for

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1 progesterone, I mean, the 60 percent is fairly
2 high.
3 COFFEY, Q.C.:
4 Q. Yes. If we could, please, Exhibit C-0154,
5 please? Now this is a report from John
6 Hopkins Hospital lab results which you or your
7 counsel have provided to the Commission. And
8 there's a collection date I believe noted to
9 be 02/08/2008?
10 MS. HENLEY-ANDREWS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. And then there's first specimen collected on
14 02/17/1997. And this is a consult case. And
15 how did you end up dealing with John Hopkins
16 earlier this year?
17 MS. HENLEY-ANDREWS:
18 A. In May of 2005 I had been referred to the
19 genetic counselling at Eastern Health or the
20 cancer centre, whichever, and I'd received a
21 report in May of 2005 from the geneticist, Dr.
22 Bridget Fernandez, indicating that I should be
23 referred for ovarian cancer screening because
24 of the breast cancer history, annual ovarian
25 cancer screening. I was originally--I was

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1 eventually give a date of September of 2006,
2 about 16 months after that to be seen for the
3 ovarian cancer screening and the appointment
4 was cancelled and was rescheduled for
5 September of 2007, at which point it was two
6 years and five months since it had been
7 recommended that I have annual screening. I
8 was not particularly pleased by the wait. I
9 understood that you often wait around awhile,
10 but I thought that was excessive. And I
11 decided that I would have the screening done
12 out of province at a private medical clinic in
13 Toronto. So in February of 2007 I went to the
14 Medcan clinic in Toronto and had what they
15 call an executive physical and also I did have
16 the ultrasound required for the ovarian cancer
17 screening at that time, and which revealed a
18 cyst, but was otherwise fine.
19 I have had another lump in the, near my
20 armpit for the last two years and it's caused
21 me a great deal of anxiety, although it's had
22 every test done on it as you can, but they
23 have previously not proven to be particularly
24 reliable in my case. And the doctor that I
25 saw there, a Dr. Greenspan, told me that they

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1 had a, Medcan had a relationship with Johns
2 Hopkins in Baltimore and that they could do--
3 they offered one of two services, a paper
4 review of all of your charts and records,
5 including the pathology specimens or you could
6 actually go and have a visit. I said I'd
7 think about it. And as I'm sure you're well
8 aware, in the spring of 2007 you could hardly
9 turn on the television without hearing
10 something about the ER/PR testing and the
11 disastrous handling of it by Eastern Health.
12 And I was getting more and more nervous about
13 it and I started the process initially to have
14 a paper review done and that was being sent to
15 Johns Hopkins through Medcan. I paid for all
16 of this myself, I would point out. And I
17 developed a gynaecological problem in the fall
18 of 2007 and the earliest appointment that I
19 could get with a gynaecologist was six or
20 seven months down the road. And I--it wasn't
21 acceptable to me. So I decided that I would
22 go to Johns Hopkins in Baltimore and see the
23 cancer specialist there and also saw a
24 gynaecologist while I was there, although as
25 it turned out, due to--I did end up seeing--it

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1 was actually kind of fluky but I did end up
2 seeing the gynaecologist at the cancer
3 treatment centre before that, but it was
4 already booked and paid for. And so I did go
5 to Baltimore at the end of January of 2008,
6 having previously requested from Eastern
7 Health that copies of all slides relating to
8 the two 1997 surgeries that we've talked about
9 and the two 2001 surgeries be forwarded to
10 Johns Hopkins so that the pathology could be
11 reviewed because by this time--and that was
12 before I found out that I'd actually had the
13 ER/PR testing done. I had lost complete
14 faith, at that point, in the system, and
15 although not in the doctor who were--
16 individual doctors I was dealing with were
17 fantastic, but I didn't have a lot of faith in
18 Eastern Health. And the document that you
19 just referred to as C-0154 is the e-mailed
20 copy of the written pathology report from
21 Johns Hopkins on the slides that were
22 forwarded from Eastern Health.
23 COFFEY, Q.C.:
24 Q. So it's your understanding that Johns Hopkins
25 personnel looked at the slides that came from

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1 St. John's?
2 MS. HENLEY-ANDREWS:
3 A. I requested that and this report confirms that
4 that was done. And I also got a second
5 opinion on the lump that nobody else was
6 worried about. I have to tell you that Johns
7 Hopkins does send out after they get all the
8 reports, I'm supposed to get a sort of formal
9 package. They tell me it's been sent, but,
10 and it's been sent for weeks, but I don't
11 actually have the formal original documents
12 from them. But I saw Kara Laing as part of a
13 regular visit a couple of weeks ago and I had
14 originally been supposed to see her before I
15 went to Johns Hopkins and I was going to tell
16 her about the visit at that time, and that
17 appointment got rescheduled because a test
18 that I needed to have done also got
19 rescheduled. And so I told her that I had
20 been to Johns Hopkins and told her that I had
21 had the pathology review and all that kind of
22 thing. And she said, "Well, let me check the
23 system and see if we have a copy of the
24 pathology report." And so she went out, she
25 came back with a pathology report in her hand.

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1 It's not that one.
2 COFFEY, Q.C.:
3 Q. When you say "that one", you mean the -
4 MS. HENLEY-ANDREWS:
5 A. It's not C-0154.
6 COFFEY, Q.C.:
7 Q. It's not the Mount -
8 MS. HENLEY-ANDREWS:
9 A. No. It's actually on Eastern Health format.
10 COFFEY, Q.C.:
11 Q. It's not C-0151, the Mount Sinai one? Is it
12 this?
13 MS. HENLEY-ANDREWS:
14 A. No, no. We're talking now Johns Hopkins.
15 COFFEY, Q.C.:
16 Q. Oh, Johns Hopkins, I'm sorry, okay.
17 MS. HENLEY-ANDREWS:
18 A. I may have mis-spoken.
19 COFFEY, Q.C.:
20 Q. No, no.
21 MS. HENLEY-ANDREWS:
22 A. So C-0154.
23 COFFEY, Q.C.:
24 Q. Johns Hopkins, yes.
25 MS. HENLEY-ANDREWS:

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1 A. Is the Johns Hopkins, that's their actual
2 report.
3 COFFEY, Q.C.:
4 Q. Yes.
5 MS. HENLEY-ANDREWS:
6 A. But what Kara Laing gave me was a, in effect,
7 a transcript of it which had been retyped from
8 this format into an Eastern Health format.
9 COFFEY, Q.C.:
10 Q. Okay.
11 MS. HENLEY-ANDREWS:
12 A. And the first thing that--and I got it as I
13 was going out through the door. Of course, I
14 wasn't expecting anything very exciting out of
15 it. And I was partway to my car when I saw on
16 item 1 where it says, "Final diagnosis."
17 COFFEY, Q.C.:
18 Q. Yes.
19 MS. HENLEY-ANDREWS:
20 A. The date was February 2nd, 2007. And then it
21 said "Ductal carcinoma in-situ." And because
22 I had had a biopsy in January or February of
23 2007 I just about lost it.
24 COFFEY, Q.C.:
25 Q. Yes.

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1 MS. HENLEY-ANDREWS:
2 A. And I went back and went up to the desk at the
3 cancer centre and asked if I could speak to
4 Dr. Laing for a few minutes because there was
5 something in the document she'd given me. And
6 anyway, she came out and spoke to me for a
7 minute and then we realized that it was the
8 '97 SU744 was the sample, so it was actually
9 the 1997 sample that was being referred to.
10 And so that was a big relief. And I went home
11 and I started to read through it and both the
12 first conclusion, the February--the reference
13 to SU744, February 17th and it should be '97
14 ductal carcinoma in-situ nuclear grade 2 of 3.
15 And the second one from 1997, both referred to
16 ductal carcinoma in-situ.
17 COFFEY, Q.C.:
18 Q. Yes.
19 MS. HENLEY-ANDREWS:
20 A. And I thought, wait now, my second surgery
21 showed no residual ductal--no residual
22 carcinoma. And I dug out my, the copies that
23 I had of the 1997 reports and discovered that
24 in comparing the two that Johns Hopkins'
25 conclusions on my re-excision, my second

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1 surgery in February of 1997 was that there was
2 "Ductal carcinoma in-situ, nuclear grade 2 of
3 3, micropapillary and cribiform patterns,
4 focal central necrosis. Biopsy site changes
5 are noted" etcetera, etcetera. "DCIS approach
6 is within one millimetre of the black ink
7 margin. It involves nine of fourteen slides
8 and the largest focus is 1.5 centimetres on a
9 single slide." And I thought, hell, because
10 all the decisions that were made in 1997 with
11 respect to my treatment were made on the basis
12 that there was no residual carcinoma. And I
13 had been through all those tests and all those
14 scares and through the double mastectomy in
15 2001 in what I thought was a recurrence, a
16 cancer for the second time and the bottom line
17 was somebody had screwed up. And to find that
18 out now, in 2008, I'm still flabbergasted.
19 And the other thing is that up until this
20 point it doesn't appear that although they
21 retyped the report into their system, if
22 Eastern Health has looked at the results from
23 Johns Hopkins and compared them to their own
24 original results, which you would think you
25 would do when you received a second opinion,

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1 they haven't seen fit to tell me about it.
2 COFFEY, Q.C.:
3 Q. To this day do you know if Eastern Health is--
4 they're obviously aware of it now having heard
5 it this afternoon, but up until you came here
6 today, do you have any reason to believe that
7 Eastern Health was aware that you had become
8 aware that Mount Sinai had tested the tissue
9 sample in November of 2005?
10 MS. HENLEY-ANDREWS:
11 A. No, not to my knowledge.
12 COFFEY, Q.C.:
13 Q. So after the point--what I'm getting at, I
14 suppose, is after you spoke to Commission co-
15 counsel, February 15th, 2008, did you contact
16 Eastern Health?
17 MS. HENLEY-ANDREWS:
18 A. I didn't contact Eastern Health. I bumped into
19 Dr. Felix's wife in the lobby at school and
20 asked her to pass the information on to him.
21 His wife and I go back to birthday parties as
22 toddlers. And I frankly, my psychiatrist
23 knows.
24 COFFEY, Q.C.:
25 Q. But Eastern Health itself, in terms of as an

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1 organization, as an administration, you
2 haven't -
3 MS. HENLEY-ANDREWS:
4 A. Well, they're able to read just as well as I
5 am, in theory.
6 COFFEY, Q.C.:
7 Q. The -
8 MS. HENLEY-ANDREWS:
9 A. And I'm really angry about it.
10 COFFEY, Q.C.:
11 Q. Ms. Andrews, in terms of the whole ER/PR issue
12 and the way Eastern Health, from your
13 perspective, as a patient has handled, I
14 appreciate that it didn't involve retesting
15 for you, because it was an initial test, but
16 do you have any thoughts about how they've
17 handled it overall, from your perspective?
18 MS. HENLEY-ANDREWS:
19 A. From my own perspective, I don't know how
20 somebody could check and come back and tell me
21 that my samples weren't sent when they already
22 had the results in their system, and since I
23 was one of the people whose samples were sent
24 to be tested, I would have expected that they
25 would have reported back to me without my

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1 needing to go chasing after them as to what
2 the results were, and I would have done, as
3 I've done with just about everything else,
4 requested a copy of the report at that time,
5 and I would have discussed it with my family
6 doctor and I would have discussed it with Dr.
7 Laing. But I didn't have the information and,
8 you know, one of the issues that was
9 fundamental to me and that was part of the
10 reason for going to Johns Hopkins, apart from
11 the other things, was I wanted to know whether
12 I should start Tamoxifen or some, whatever
13 drug is currently in vogue, that does the same
14 thing. I still live in terror of cancer, and
15 that may not be logical, but it's how I feel,
16 and everything that happened here has really
17 sort of taken the legs out from under me in
18 terms of whether Eastern Health can be relied
19 upon to provide information when it--in a
20 timely basis and whether it really cares about
21 the patients at all.
22 COFFEY, Q.C.:
23 Q. And in terms of--I won't ask you about whether
24 they've apologized to you because presumably
25 until now, they didn't know that they hadn't

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1 told you. At least I'm presuming that. I
2 don't know that.
3 MS. HENLEY-ANDREWS:
4 A. You know, I've--when Louise Jones spoke last
5 week in answer to the question about "well,
6 you know, what does it mean for me to
7 apologize, and there'll be further evidence
8 coming." I thought a lot about that, and I
9 think it means a lot for her to apologize on
10 behalf of Eastern Health to those patients who
11 now have new information with respect to their
12 cancers that they didn't have before. When I
13 go to a wake, I always say to the people who
14 are there that I'm sorry. It doesn't mean
15 that I killed their loved one or that I
16 somehow contributed to the death of their
17 loved one. It means that I'm very sorry that
18 it has happened to them, and I think Eastern
19 Health can be very sorry that it has--that
20 these things have happened to all of these
21 women without admitting liability, and I think
22 it means a lot, and I don't accept the
23 explanation.
24 COFFEY, Q.C.:
25 Q. Thank you, Ms. Andrews. They're the questions

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1 I have, Commissioner. Thank you.
2 MS. HENLEY-ANDREWS:
3 A. I have--I kind of have been following the
4 transcripts a little bit, and I notice that
5 some patients, some of the witnesses have been
6 able to make a short sort of presentation at
7 the end.
8 THE COMMISSIONER:
9 Q. If there's something you wish to say, by all
10 means.
11 COFFEY, Q.C.:
12 Q. Yes, if there is anything you wish to add,
13 yes, go right ahead.
14 MS. HENLEY-ANDREWS:
15 A. It's not as bad as it looks because in order
16 to be able to read it, the print's big. When
17 I was diagnosed with cancer in 1997, at age
18 40, my youngest son had just turned five, his
19 brother ten, and my daughter 12. I had a
20 young family, a successful law practice and
21 was an active volunteer and advocate. There
22 are some in the medical field who sometimes
23 suggest that DCIS is not really cancer.
24 However, DCIS patients do have cancer cells
25 contained within one or more ducts in the

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1 breast, just like a grape has pulp inside its
2 skin. Peer reviewed studies have demonstrated
3 that 50 percent of DCIS patients will go on to
4 have invasive breast cancer if left untreated.
5 The treatments were DCIS are the same as for
6 other breast cancers. Until medical science
7 can determine with certainty which DCIS
8 patients will get invasive breast cancer and
9 which won't, DCIS will continue to be every
10 bit as scary as any other cancer.
11 My DCIS diagnosis in February 1997
12 profoundly affected me. My body was scarred.
13 My sense of self was damaged. I had life
14 altering decisions to make regarding treatment
15 which would affect my very life. I was
16 terrified that I would die from breast cancer
17 and I was terrified that I would make the
18 wrong treatment decisions. Those decisions
19 could only be made on the basis of pathology
20 reports which were provided to my doctor. I
21 relied on the pathology reports and I relied
22 on the people in the lab to get it right.
23 The surgeon who has treated me has been
24 exceptional. In 1997, he provided literature
25 on the options and prognoses for each option.

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1 He met with me numerous times, as I've already
2 said, even when I started second guessing
3 myself, months after the initial decisions
4 were made. Every single discussion focused on
5 the pathology results from the two 1997
6 surgeries. I worried about recurrence and I
7 worried every day that I might not live long
8 enough to raise my children. I suffered from
9 anxiety and depression, but I got through.
10 Recurrent scares will newly developed
11 lumps in my right breast, the first less than
12 six months after my lumpectomy, made my life a
13 living hell. I felt foolish for being so
14 nervous. I beat up on myself for being what I
15 thought was irrational.
16 The recurrence in 2001 was devastating.
17 Having and conquering cancer once is one
18 thing. Facing it the second time is
19 unimaginable. Moreover, the way it was found
20 was such a fluke that I was left with little
21 confidence in diagnostic tools.
22 The decision to have a bilateral
23 mastectomy when I had no choice regarding
24 mastectomy of my right breast was the easy
25 part. I was tired of the fear. But being

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1 discharged from hospital after three days when
2 I could not get out of bed without assistance
3 was inhuman. Being told at the hospital that
4 a community health nurse would visit every day
5 to check the incisions across my entire chest
6 and into my armpit and having the community
7 health nurse decide not to do it was
8 frightening and frustrating.
9 The physical recovery was hard and like
10 many breast cancer patients, I continue to
11 have lingering shoulder and other physical
12 problems to remind me every day of the ordeal
13 I have endured. The emotional toll is another
14 story. I have not been able to get over the
15 fear of another cancer recurrence, as hard as
16 I have tried. I still don't know how a fine
17 needle biopsy in early 2001 and a core biopsy
18 in June 2001 could have produced negative
19 findings when the lump from which that tissue
20 came and removed at my own insistence in July
21 showed DCIS within less than one millimetre of
22 the margin and involved six of ten slides.
23 In 2002, things started to spin out of
24 control emotionally. I was denied counselling
25 at the Cancer Treatment Centre because I

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1 wasn't registered there as a patient, a policy
2 which still stands today. Having had cancer
3 twice didn't count. I had to find counselling
4 for myself and pay for it too.
5 By 2003, my hands shook constantly, my
6 eyelids twitched all the time. I was cranky
7 and irritable and had trouble sleeping. In
8 June 2003, when I got to work each morning, I
9 had to remind myself over and over that I just
10 had to get through the day and then the next,
11 until I just couldn't do it any more. My
12 anxiety attacks increased in both duration and
13 severity, so sometimes I couldn't finish a
14 sentence. This contributed to depression so
15 severe that I was hospitalized twice, once in
16 2004 and again in 2005.
17 My Johns Hopkins excursion and pathology
18 review was supposed to finally put my fears to
19 rest, but nothing, nothing, could have
20 prepared me for the shock of discovering that
21 the February 17th 1997 pathology report was
22 totally wrong. That it's finding "no residual
23 carcinoma seen" should have been "extensive
24 DCIS on 9 of 14 slides." That I should have
25 had at least additional surgery at that time.

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1 To learn that I have been through so much
2 anguish since 1997 because of errors reading
3 nine different slides is gut wrenching. How
4 can any competent person get it wrong that
5 often? I accept that there's room for
6 differences of opinion in interpreting tissue
7 specimens, but a focus of 1.5 centimetres on
8 one slide is pretty hard to miss. Moreover,
9 having read the damning evaluation reports of
10 the Eastern Health pathology labs as of 2005,
11 with their lack of quality control procedures,
12 among other things, it makes me wonder what
13 other fundamental errors affecting patient
14 care are lurking out there.
15 I do not have words to describe the
16 impact the ER/PR debacle has had. Being told
17 I would be tested, then that I hadn't been
18 tested, and then discovering through
19 Commission counsel that I'd been tested after
20 all, was never told, and was hormone receptor
21 positive had already seriously undermined my
22 faith in both the pathology lab and the
23 administration of Eastern Health. Even now,
24 after all that has been said, the Johns
25 Hopkins report has been put in the computer

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1 record keeping system, but nobody seems to
2 have cross checked the results against the
3 original findings, or if they have, they
4 haven't felt the need to tell me or any of my
5 doctors.
6 Madame Commissioner, I have been treated
7 by some wonderful doctors and other health
8 professionals over the last 11 years, but I
9 have also observed and experienced the
10 dehumanization of health care, where doctors
11 average in-patient stay is an evaluation tool
12 and an elderly patient can be in a bed for six
13 days and not have the bed made or the sheets
14 changed once, except by family members.
15 Whether you believe that Eastern Health
16 deliberately set out to deceive patients
17 regarding the extent of problems with hormone
18 receptor retesting or whether you believe that
19 Eastern Health just didn't know what it was
20 doing, three things are clear to me.
21 One, there are and probably continue to
22 be serious problems in the pathology labs at
23 Eastern Health, which extend well beyond
24 hormone receptor testing problems.
25 Two, the Government needs to take its

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1 head out of the sand so that with respect to
2 Eastern Health and the Department of Health,
3 so that they are accountable to patients and
4 to the public, not only for their actions, but
5 for their inaction.
6 And three, since I understand that
7 Eastern Health has been having doctors sign
8 confidentiality agreements whereby they can
9 have their privileges withdrawn if they report
10 on problems to anyone outside the health care
11 system, outside of Eastern Health, I think we
12 need whistle blower legislation, enabling
13 health care professions to identify serious
14 weaknesses in their fields so that we can be
15 sure that we can safely rely on the
16 Newfoundland and Labrador health care system
17 in the future. We deserve nothing less.
18 Thank you.
19 THE COMMISSIONER:
20 Q. Thank you. It's getting late in the day, but
21 I'd like to assess the situation in terms of
22 those who wish to cross-examine the witness,
23 and then we'll decide whether we'll continue
24 in the morning or if very little time is
25 needed, we may be able to complete with this

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1 witness today. Mr. Pritchard?
2 MR. PRITCHARD:
3 Q. Commissioner, I have no questions for this
4 witness. Thank you for your evidence.
5 THE COMMISSIONER:
6 Q. Mr. Simmons.
7 MR. SIMMONS:
8 Q. I have no questions either. Thank you, Ms.
9 Henley-Andrews.
10 THE COMMISSIONER:
11 Q. Mr. Browne?
12 MR. BROWNE:
13 Q. Thank you for your evidence, Ms. Henley-
14 Andrews.
15 THE COMMISSIONER:
16 Q. Yes?
17 MS. O'DEA:
18 Q. We have no questions. Thank you.
19 THE COMMISSIONER:
20 Q. Ms. Newbury.
21 MS. NEWBURY:
22 Q. I don't have any questions. Thank you, Ms.
23 Henley-Andrews.
24 THE COMMISSIONER:
25 Q. Mr. Crosbie.

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1 CROSBIE, Q.C.:
2 Q. No questions.
3 THE COMMISSIONER:
4 Q. Since there are no questions on cross-
5 examination. It is only for me to thank you
6 for coming today and sharing your experience
7 with us and we wish you the best.
8 MS. HENLEY-ANDREWS:
9 A. Thank you. It hasn't been easy, but I felt it
10 needed to be done.
11 THE COMMISSIONER:
12 Q. Thank you. We'll adjourn then until tomorrow
13 at 9:30. I'm sorry, Ms. Chaytor, was there
14 something else you wanted to add before we
15 adjourn.
16 CHAYTOR, Q.C.:
17 Q. Yes, just quickly, I realize we're out of
18 time. But Commissioner, Ms. Henley-Andrews is
19 the last of the patients who will give
20 evidence before you. Unfortunately, time does
21 not allow us to hear from each and every
22 patient and person who has been affected by
23 the ER/PR issue. Instead, we've heard from a
24 representative sample of the patients and
25 their families and we just wanted to thank

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1 them for having the courage to come forward
2 and to be part of this process.
3 Their evidence has primarily focused on
4 the communications issue and the
5 appropriateness of the response and
6 communication by the responsible authorities
7 with respect to our issue. And, of course,
8 that's been given from the patients
9 perspective.
10 Aspects of their stories will address
11 specific issues which we hope will become
12 apparent as the process unfolds.
13 There are many other stories which Mr.
14 Coffey and I have had the honour of hearing
15 over the course of the past few weeks and
16 months. Some of the people behind these
17 stories are in the room today and they have
18 been here and faithfully sat through hearing
19 other present their story and supporting them
20 in that. Some have spoken to us during the
21 breaks and conveyed to us their stories;
22 others have come forward and given us
23 information through interviews. So, we wanted
24 to thank everyone who has shared their
25 experience with us and we also wanted to

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1 acknowledge those that we have not had the
2 privilege to meet. Whether their story has
3 been told in this room or not, everybody's
4 story is equally important.
5 Commissioner, tomorrow then we will go
6 ahead with the next grouping of witnesses
7 which is the representatives of the health
8 authorities and government and we'll commence
9 tomorrow with the evidence of Ms. Joan Dawe
10 who is the Chair of the Board for Eastern
11 Health.
12 THE COMMISSIONER:
13 Q. Okay, thank you. 9:30 in the morning.
14 Upon conclusion at 5:10 p.m.

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 25th day of March, 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 25th day of March, A.D., 2008
13 Judy Moss

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