COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

September 17, 2008

Appearances:

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

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

Peter Browne/Jane Hennebury . . . . . . Doctors Kara Laing et al

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

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

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

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1 THE COMMISSIONER:
2 Q. Ms. Chaytor.
3 DR. KARA LAING, EXAMINATION BY SANDRA CHAYTOR, Q.C.
4 (CONTINUED)
5 CHAYTOR, Q.C.:
6 Q. Good morning, Commissioner. Good morning, Dr.
7 Laing. Commissioner, we have two new exhibits
8 this morning, please, that I would ask to have
9 entered. P-2615 and 2616.
10 THE COMMISSIONER:
11 Q. Entered.
12 EXHIBIT ENTERED AND MARKED P- 2615
13 EXHIBIT ENTERED AND MARKED P- 2616
14 CHAYTOR, Q.C.:
15 Q. Thank you. And, Registrar, if you could bring
16 up, please, P-2616? Doctor, this is the NIH
17 Consensus Statement on adjuvant therapy for
18 breast cancer, November 1st to 3rd, 2000. And
19 it was referred to not yesterday but the last
20 time you were here in your evidence, so I just
21 thought we should enter it as an exhibit. And
22 my question for you today on this is when
23 would you have become aware of this Consensus
24 Statement?
25 DR. LAING:

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1 A. I would think probably sometime in late 2001,
2 2002.
3 CHAYTOR, Q.C.:
4 Q. Okay. And how would it have come to your
5 attention?
6 DR. LAING:
7 A. I would think through meetings and discussions
8 with my colleagues across this country, that
9 we would have referred to this in some of our
10 discussions about treatment of breast cancer.
11 CHAYTOR, Q.C.:
12 Q. Okay. And do you know was it--I know I said
13 that I had one question for you on it, but
14 here's three. Do you know if it was widely
15 discussed with--amongst the oncologists in St.
16 John's?
17 DR. LAING:
18 A. No.
19 CHAYTOR, Q.C.:
20 Q. So in terms of their level of knowledge with
21 respect to this, you're unable to say?
22 DR. LAING:
23 A. I'm unable to say.
24 CHAYTOR, Q.C.:
25 Q. Okay. Now, Doctor, I think when we finished

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1 last day, I had asked you about the statement
2 that Darrell Hynes had mentioned in his
3 evidence and you stated while you wouldn't
4 particularly remember your discussion with Dr.
5 Hynes (sic.) it was in keeping with what you
6 had said to others along the way that there
7 could well have been people who were impacted
8 by not having received Tamoxifen at the time
9 of original diagnosis?
10 DR. LAING:
11 A. Yes, that there were people who may not have
12 received hormonal therapy that may have been
13 impacted, certainly.
14 CHAYTOR, Q.C.:
15 Q. I'm just wondering what would be the range of
16 potential effects for the health of those
17 patients who didn't receive the anti-hormonal
18 treatment or therapy at the time, so what
19 would the potential effects be in terms of a
20 delay?
21 DR. LAING:
22 A. Right. I think there's a couple of things
23 that need to be considered when looking at
24 that, and that would really be something that
25 would have to be looked at on an individual

Page 7

1 patient basis. So the first thing that you
2 would need to determine would be what that
3 individual patient's prognosis was, and that
4 would include looking at things like, you
5 know, did they have lymph nodes involved, the
6 size of the tumour, the grade, all the things
7 that we talked about and all the things, if
8 you remember, that are prognostic factors that
9 we looked at when we looked at the adjuvant on
10 line program. So then you would look at that
11 patient and say, give an estimation, based on
12 those factors, as to what their risk of
13 recurrence from breast cancer would be and
14 what their risk of death from breast cancer
15 would be. Then you would look to see if they
16 were pre-menopausal or postmenopausal. And
17 then you would look to things like the Oxford
18 Overview, which give us a relative risk
19 reduction for the benefits of adjuvant
20 therapies, so, for example, in terms of
21 adjuvant hormonal therapy for a postmenopausal
22 patient, that overview has estimated about a
23 45 to 50 percent relative risk reduction in
24 recurrence and about a 30 percent relative
25 risk reduction in death. So perhaps if I

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1 could use an example, as I did in that
2 patient. If we were to take someone, for
3 example, who presented with breast cancer who
4 we felt had a 70 percent chance of cure
5 without any further therapy and a 30 percent
6 risk of death, if we then applied the relative
7 risk reduction of one third, then we could say
8 that potentially ten people would be saved by
9 the hormonal therapy, but 20 people would
10 still be at risk for recurrence if we were
11 thinking about 100 patients. The difficulty
12 is, so you know, the importance to understand
13 is that not all patients benefit, but
14 certainly, there are a group that do, which is
15 why we use these therapies. The -
16 CHAYTOR, Q.C.:
17 Q. And which is why it made it worthwhile to go
18 back and try -
19 DR. LAING:
20 A. Absolutely.
21 CHAYTOR, Q.C.:
22 Q. - and determine who those patients may be?
23 DR. LAING:
24 A. Absolutely. We went back, one, because we
25 knew that there were some patients that had

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1 not had a recurrence and could still benefit,
2 because we had the paper that suggested a
3 benefit to late therapy, and we had some
4 evidence of treating people in the five to ten
5 year period with hormonal therapy. So what we
6 would then assign would be sort of what the
7 absolute benefit would be. Obviously the
8 higher your risk of recurrence, the greater
9 your absolute benefit is going to be to
10 receiving any adjuvant therapy.
11 CHAYTOR, Q.C.:
12 Q. Yes.
13 DR. LAING:
14 A. The problem is is that we are not able yet,
15 we, I mean the large oncology community do not
16 have the ability, as of yet, to identify the
17 people who are going to benefit from this
18 treatment. So when you think about it, if you
19 have 70 percent of people, so if you have 100
20 patients and 70 percent of them are cured no
21 matter what you decide to do, wouldn't it be
22 great if we knew who those 70 were. Then if
23 we could identify who the people were that we
24 knew were going to benefit from hormonal
25 therapy, then we would give them that. And

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1 then the people that we knew were not going to
2 benefit from hormonal therapy, we could try
3 something else to treat them. But we're not
4 there yet, but that is an area of research.
5 There are several gene signatures now that
6 people are looking at to try and identify
7 people who need more therapy or who don't and
8 to try and identify which therapies would
9 benefit them the most.
10 CHAYTOR, Q.C.:
11 Q. And I think my question I was thinking more in
12 terms general without--and I realize what
13 you're saying to me is to make the
14 determination of potential impact with respect
15 to any given patient, these are the issues,
16 that -
17 DR. LAING:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. - would play in that. But my question was
21 meant to be more general in terms of bearing
22 in mind the--what the purpose of hormonal or
23 anti-hormonal therapy is and what the
24 literature says in terms of its potential
25 benefits. So what would the range of

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1 potential effects be in having had it delayed
2 in the onset of that therapy? And so, for
3 example, would a potential effect be that the
4 person may have experienced a decreased life
5 expectancy?
6 DR. LAING:
7 A. Okay, I see what you mean. So just general
8 categories of what might have happened to
9 people, okay.
10 CHAYTOR, Q.C.:
11 Q. Yes, so is decreased life expectancy or an
12 early death one of the potential effects?
13 DR. LAING:
14 A. Sure. So there's three possibilities. So if
15 we think about someone who's sitting down in
16 front of me in the clinic in the fall of 2005
17 who was diagnosed three or four years ago,
18 said to be ER/PR negative, doesn't receive
19 hormonal therapy, today we have a new test
20 results says that they're possible. There's
21 three possible things that could have happened
22 to that patient. One is they were in that
23 category of people that were cured anyway. So
24 starting late therapy, they're still going to
25 have a good outcome. Two is that those

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1 patients may still have had these small cells
2 left behind, this micro metastatic disease.
3 We could have started their hormonal therapy
4 late and it could have had a positive impact
5 on their outcome. So that was, you know,
6 those are the good categories. The most
7 difficult situations, of course, were the
8 patients in which we started the late therapy
9 and we know now that it hasn't been effective
10 because those patients have had a relapse and,
11 of course, patients who at that time had
12 already developed metastatic disease. And so
13 those are the patients that when you look back
14 on, you wonder again is it possible that had
15 they had received hormonal therapy two, three,
16 five, however many years ago, would it have
17 had an impact on where they were today. And
18 that's an answer to which you cannot say
19 definitely yes or definitely no.
20 CHAYTOR, Q.C.:
21 Q. Okay. So that is that they may--so a
22 potential effect would be recurrence of the
23 disease?
24 DR. LAING:
25 A. That's correct.

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1 CHAYTOR, Q.C.:
2 Q. Or metastatic disease?
3 DR. LAING:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. And so that's one potential. And what about
7 decreased life expectancy, is that a potential
8 impact?
9 DR. LAING:
10 A. The only way that their life expectancy could
11 be decreased would be if they had recurrent
12 disease and ultimately died from that, okay.
13 So if you look at adjuvant hormonal therapy,
14 there's two ways--and that's why we always
15 talk about risks and benefits. there are
16 patients who we treat with adjuvant hormonal
17 therapy who die of complications of that
18 therapy; it's extremely rare, but we've see
19 it. So how people would eventually have a
20 decreased life expectancy would be if they had
21 recurrent breast cancer, so distant metastatic
22 disease that was incurable and they would die
23 as a result of that.
24 CHAYTOR, Q.C.:
25 Q. So it is a potential effect?

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1 DR. LAING:
2 A. Absolutely.
3 CHAYTOR, Q.C.:
4 Q. In not having received the appropriate
5 treatment at the time?
6 DR. LAING:
7 A. It's a potential effect, yes.
8 CHAYTOR, Q.C.:
9 Q. Okay. Is there also another potential effect
10 that they may have received inappropriate
11 treatment at the time?
12 DR. LAING:
13 A. Right. So we talked before about, you know,
14 were there some patients who received
15 chemotherapy that had, you know, the treating
16 physician known that they were hormone
17 receptor positive, that they may have decided
18 not to give them chemotherapy, that's a
19 possibility. Although we must realize that
20 many patients get both treatments. So, for
21 example, if you saw someone with lymph nodes
22 involved, almost irrespective of whether or
23 not they're hormone receptor positive or
24 negative, they would be offered chemotherapy
25 and then they would go on hormonal therapy.

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1 But, yes, there are a group of people that
2 potentially had we known that information,
3 then we may -
4 CHAYTOR, Q.C.:
5 Q. Had more aggressive therapy than they
6 otherwise might have had?
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. Yes, okay. What about in terms of the quality
11 of life, do you think any of them had any
12 impact in terms of the quality of life? We
13 talked about the duration of their life, but
14 what about the quality of their life?
15 DR. LAING:
16 A. Absolutely. So again, you know, quality of
17 life is a, you know, defined as a sense of a
18 person's well being that's determined not only
19 by their health state but by many other
20 factors. If you look at someone, for example,
21 who had metastatic breast cancer who we gave
22 chemotherapy to and potentially if we had a
23 known that they may have been a candidate for
24 hormonal therapy, they may have had a
25 detrimental effect on their quality of life

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1 because of the side effects of that
2 chemotherapy. Again, it comes back to the
3 issue of not all patients who have metastatic
4 disease who are hormone receptor positive are
5 going to respond to the hormonal therapy and,
6 you know, the hormonal therapy itself can have
7 negative impacts on patients' quality of life.
8 So certainly, yes, this would have had an
9 effect on people's quality of life. I think
10 you could take that even back a step before
11 that and say that this had an impact on the
12 quality of life of patients who didn't have a
13 change in their test results. You know, there
14 were people that we refer to as the confirmed
15 negatives but clearly having had something
16 like this happen to them did have an effect on
17 their quality of life.
18 CHAYTOR, Q.C.:
19 Q. Meaning the actual knowledge that -
20 DR. LAING:
21 A. Process.
22 CHAYTOR, Q.C.:
23 Q. The process. And knowledge of knowing that
24 they -
25 DR. LAING:

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1 A. That there was a change in one of their tests.
2 CHAYTOR, Q.C.:
3 Q. That there was potential of the change. So
4 then in terms of the quality of life, the idea
5 that without having received the appropriate
6 treatment there may have been an exacerbation
7 of your disease symptoms -
8 DR. LAING:
9 A. Well, people who are treated adjuvantly
10 wouldn't have disease symptoms, okay, because
11 they've had their surgery, their breast
12 primary has been removed and they are, for the
13 most part, completely asymptomatic. So in
14 terms of those patients, then, you know, their
15 quality of life from a symptom point of view--
16 if you look at patients with metastatic
17 disease, then, you know, you're sort of
18 saying, okay, well, perhaps that patient could
19 have gotten hormonal therapy and that may--
20 they may have responded and if they responded
21 and it improved their symptoms, then that may
22 have benefitted their quality of life.
23 Chemotherapy for metastatic breast cancer,
24 there are several, you know, there's probably
25 a list of about 20 different medications that

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1 we have available to use. Some of them have
2 very little in the way of toxicities and many
3 patients tolerate chemotherapy for metastatic
4 disease very well. And of course, the caveat
5 in all of this is that, you know, as people
6 respond to treatments, they feel better.
7 There are people that take hormonal therapy
8 that have to come off in it both--more so in
9 the adjuvant setting because of side effects
10 and because that in itself has a detrimental
11 effect on their quality of life, be it hot
12 flashes or vaginal dryness or some sort of
13 symptom that we often see that impacts their
14 quality of life.
15 CHAYTOR, Q.C.:
16 Q. Okay. So the potential effects are that there
17 would be no effect. Those that would have had
18 an effect, there is the potential that they
19 died earlier than they otherwise may have?
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. There's secondly those who received
24 inappropriate treatment and suffered whatever
25 side effects from that treatment. Thirdly,

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1 those whose disease recurred that may not have
2 recurred?
3 DR. LAING:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. Or recurred, fourthly, I guess, those that
7 recurred earlier than what they normally would
8 have?
9 DR. LAING:
10 A. Um-hm.
11 CHAYTOR, Q.C.:
12 Q. Which meant that their disease-free survival
13 time -
14 DR. LAING:
15 A. Was less.
16 CHAYTOR, Q.C.:
17 Q. - has been--is lessened. And then there's
18 those and perhaps all of them whose quality of
19 life has been impacted?
20 DR. LAING:
21 A. In some way.
22 CHAYTOR, Q.C.:
23 Q. In some way. Does it matter in terms of the
24 effects whether the delay was one year, two
25 years, three years, four years, seven years,

Page 20

1 does it matter?
2 DR. LAING:
3 A. We don't know. You know, if you look at--and
4 I don't know if you can recall back to my
5 initial presentation. We know that in terms
6 of breast cancer recurrence, it's something
7 that can happen for many, many years after the
8 diagnosis. The peak, there's a peak at two to
9 three years, there's a second small peak at
10 five years. But, you know, in the clinic
11 we'll see people that recur five, ten, 15, 20
12 years later. And how those cells lay
13 quiescent for all that time and why they all
14 of a sudden decide to grow is something that
15 if we knew more about, I think we'd do a
16 better job of eradicating them in the
17 beginning. But, you know, it's very difficult
18 to say, because all of the studies, save the
19 one that we looked at, of adjuvant therapy, so
20 again, treatments that are given after
21 potentially curative surgery to improve
22 disease-free survival and overall survival are
23 done so within a few months of that definitive
24 surgery. So chemotherapy, we start within 12
25 weeks of the definitive surgery and hormonal

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1 therapy would come after the chemotherapy. So
2 we don't have a lot of knowledge about late
3 hormonal therapy except for the paper that I
4 alluded to and that we used and also this
5 whole idea of treating people in the five to
6 ten year period that came from our trial of
7 extended adjuvant therapy and a benefit to
8 those patients for late treatment.
9 CHAYTOR, Q.C.:
10 Q. Thank you. And, Doctor, I'd like to turn to
11 the issue of the Physician Review Panel, which
12 I think we'll call the Panel.
13 DR. LAING:
14 A. Okay.
15 CHAYTOR, Q.C.:
16 Q. And if I could have, please, Registrar, P-
17 0350? This is the letter of Dr. Williams
18 written to a number of individuals, including
19 yourself, October 12th, 2005, in which he
20 confirms the setting up of the Panel.
21 DR. LAING:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. And he states here that, "I'm writing with
25 respect to a suggestion that was made to this

Page 22

1 organization with respect to making decisions
2 on patients whose ER and PR results changed as
3 testing is received back from Mount Sinai
4 Hospital." Doctor, did you understand then
5 that the Panel was only being instituted to
6 deal with the patients whose results, in fact,
7 changed?
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. Did the Panel deal with the patients whose
12 results were confirmed negative?
13 DR. LAING:
14 A. We would have acknowledged that, we would have
15 said, oh, this is a confirmed negative and
16 then the people in the quality office would
17 have contacted those patients to let them
18 know.
19 CHAYTOR, Q.C.:
20 Q. Okay. So the Panel would have--would the
21 Panel have reviewed any documentation with
22 respect to the confirmed negatives?
23 DR. LAING:
24 A. We would have looked at their original
25 results, which would have been on the

Page 23

1 spreadsheet, and we would have--the
2 pathologists who were at the Panel would have
3 confirmed that the Mount Sinai result was
4 still negative.
5 CHAYTOR, Q.C.:
6 Q. Okay. So in terms of looking through their
7 charts or any documentation regarding those
8 patients, that didn't happen?
9 DR. LAING:
10 A. Not unless there was some reason that we felt
11 that we needed to, but, no. I mean, these
12 were people that were said to be negative in
13 the beginning and the repeat testing from
14 Mount Sinai confirmed that they were negative.
15 THE COMMISSIONER:
16 Q. I'm sorry, I just want to make sure I
17 understand. Because up until now I was
18 thinking that somewhere before the stage of
19 the Panel somebody diverted negatives off into
20 one field and those whose results changed off
21 into another stream, as it were, with the
22 Panel being at the end of that stream. That's
23 not right, is it?
24 DR. LAING:
25 A. I don't believe that all of the confirmed

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1 negatives came, but I know certainly some of
2 them that we looked at were people that were
3 confirmed negatives. Because what we would
4 have is we would have their Cancer Centre
5 chart and we would have their Meditech, if
6 they were St. John's area people, and that
7 would be up on the screen and we could see
8 what their initial results were. And if the
9 Mount Sinai report was negative, then we would
10 just sort of say, okay, that's a confirmed
11 negative. We wouldn't send a Panel letter,
12 but there certainly, you know, they would have
13 been--many of those patients were on the list
14 and we looked at them, yeah.
15 CHAYTOR, Q.C.:
16 Q. So in terms -
17 THE COMMISSIONER:
18 Q. Do you have any reason to believe you saw them
19 all, though? That would have been thousands.
20 DR. LAING:
21 A. I don't believe we would have seen them all,
22 but I can't tell you which percentage of them
23 that we saw, but I can tell you that there
24 were, you know, on the list there were people
25 that were the confirmed negatives, and so we

Page 25

1 would not send a letter on those. And, you
2 know, and that's why sometimes it took us a
3 long time to do a whole list of patients and
4 other times it didn't take us as long if they
5 were either confirmed negatives or if they
6 were people that when we reviewed their chart,
7 we could see that they were already treated.
8 Those were the people that didn't take us long
9 to go through.
10 CHAYTOR, Q.C.:
11 Q. And the confirmed negatives then, your
12 understanding is that some came to you, you
13 don't know if it were all of them, but
14 certainly you did see some confirmed
15 negatives?
16 DR. LAING:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. And whether or not you were supposed to see
20 them all, you don't know?
21 DR. LAING:
22 A. No.
23 CHAYTOR, Q.C.:
24 Q. Okay. And those, no letter went with respect
25 to those people?

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1 DR. LAING:
2 A. Right.
3 CHAYTOR, Q.C.:
4 Q. And how did you understand they were to be
5 communicated with?
6 DR. LAING:
7 A. That they would be called by the people in the
8 quality office.
9 CHAYTOR, Q.C.:
10 Q. Okay. And -
11 DR. LAING:
12 A. QI office.
13 CHAYTOR, Q.C.:
14 Q. And why wouldn't they get a letter, why
15 wouldn't letters go to those patients?
16 DR. LAING:
17 A. I'm not sure. We didn't send Panel letters to
18 the patients, we sent the Panel letters to -
19 CHAYTOR, Q.C.:
20 Q. To their treating physicians, yes.
21 DR. LAING:
22 A. To the treating physicians, yes.
23 CHAYTOR, Q.C.:
24 Q. Yes. And why wouldn't Panel letters go to the
25 treating physicians for the confirmed

Page 27

1 negatives?
2 DR. LAING:
3 A. I'm not sure why we decided not to do that at
4 the time.
5 CHAYTOR, Q.C.:
6 Q. Okay. And in terms of the confirmed
7 negatives, you're saying there would be a
8 spreadsheet that would have the numbers on it?
9 DR. LAING:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. And do you know who compiled, what spreadsheet
13 were you looking at?
14 DR. LAING:
15 A. Well, the people from the quality office would
16 have had a list and Dr. Cook or whatever
17 pathologist was there would have had a list,
18 as well, and that's the one that I'm referring
19 to.
20 CHAYTOR, Q.C.:
21 Q. Okay. And -
22 DR. LAING:
23 A. And so on that there would be the patient's
24 name and MCP number and what their initial
25 results were and what the Mount Sinai results

Page 28

1 were.
2 CHAYTOR, Q.C.:
3 Q. Okay. And what did the Panel do to assure
4 itself that the negatives were, in fact,
5 negative, did you just look at the spreadsheet
6 or were the actual pathology reports pulled?
7 DR. LAING:
8 A. The pathologists had the reports there.
9 CHAYTOR, Q.C.:
10 Q. Okay. And so Mount Sinai's pathology report
11 would be referred to and the original
12 pathology report would be referred to?
13 DR. LAING:
14 A. That's correct.
15 CHAYTOR, Q.C.:
16 Q. Okay. And then would somebody have to sign
17 off on that?
18 DR. LAING:
19 A. You mean to initial it or -
20 CHAYTOR, Q.C.:
21 Q. Yes, like for the others letters went where
22 clearly yourself or somebody else signed the
23 letter saying what had been decided.
24 DR. LAING:
25 A. Not that I know of.

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1 CHAYTOR, Q.C.:
2 Q. So if we go back to 350, it goes on to say,
3 "The suggestion was that we get together a
4 panel of physicians to review all patients in
5 this category so that a plan can be
6 recommended to the physician who is following
7 up on each of these patients. This suggestion
8 is an excellent one, and I want to thank you
9 for agreeing to serve on this panel. On
10 contacting individuals, the best time
11 currently suggested", and then it's just the
12 logistics of setting it up.
13 DR. LAING:
14 A. Uh-hm.
15 CHAYTOR, Q.C.:
16 Q. "I want to thank all of you agreeing to serve
17 on the panel, and especially to Dr. Laing, who
18 has agreed to chair the group, and Dr. Don
19 Cook will sit on the panel ex officio to
20 ensure that all the information from the
21 laboratory medicine program is available to
22 the panel". So as we see up here, at this
23 point in time the group is going to be
24 yourself, Dr. Zulfiqar, who we understand is
25 also a medical oncologist.

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1 DR. LAING:
2 A. He is indeed.
3 CHAYTOR, Q.C.:
4 Q. And Dr. Kwan, who is a surgeon; Dr. Ganguly,
5 who is a radiation oncologist.
6 DR. LAING:
7 A. Yeah.
8 CHAYTOR, Q.C.:
9 Q. And Dr. Felix, who is a surgeon; Dr. Cook, who
10 is a pathologist, and he's there to be ex
11 officio. What did you understand that meant,
12 what was his role to be?
13 DR. LAING:
14 A. So he was there to ensure that we had the
15 correct initial and Mount Sinai pathology test
16 results, and if there were any concerns about
17 the pathology, if there was any questions that
18 were raised on reviewing the pathology, that
19 he could take those then and have them
20 addressed.
21 CHAYTOR, Q.C.:
22 Q. So he was there as a resource to the rest of
23 you to ensure that the documentation was in
24 place?
25 DR. LAING:

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1 A. So he wouldn't have been someone who was
2 making a decision about whether or not we
3 would offer hormonal therapy to a patient.
4 CHAYTOR, Q.C.:
5 Q. That wouldn't be within his area of expertise?
6 DR. LAING:
7 A. Yeah.
8 CHAYTOR, Q.C.:
9 Q. And Dr. Joy McCarthy, who is a medical
10 oncologist.
11 DR. LAING:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. And then Dr.--sorry, Ms. Heather Predham. So
15 who amongst that group would be in a position
16 to give any advice as to the course of
17 treatment and whether or not any
18 recommendations should go forward in terms of
19 treatment?
20 DR. LAING:
21 A. So the medical oncologists, the surgeons, and
22 the radiation oncologist.
23 CHAYTOR, Q.C.:
24 Q. So all of them would have appropriate training
25 to be able to give recommendations on any

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1 potential change in treatment?
2 DR. LAING:
3 A. We have to realize that prior to the late
4 1990s, there was no medical oncologist in this
5 province, so, in fact, many of the treatment
6 decisions regarding particularly hormonal
7 therapy were made by radiation oncologists and
8 surgical oncologists involved in the care of
9 breast cancer patients.
10 CHAYTOR, Q.C.:
11 Q. And in terms of the surgeons who were chosen
12 to be on the panel, Dr. Kwan and Felix, did
13 they have particular expertise in breast
14 cancer?
15 DR. LAING:
16 A. Yes, they did.
17 CHAYTOR, Q.C.:
18 Q. So in terms of the surgeons who would have
19 been doing that kind of work --
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. Back in the time frame you've indicated, they
24 would have had an active practice?
25 DR. LAING:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. And the same with radiation oncologist, Dr.
4 Ganguly, I take it?
5 DR. LAING:
6 A. That's correct.
7 CHAYTOR, Q.C.:
8 Q. So to your knowledge, were they chosen for
9 that reason as opposed to any other radiation
10 oncologist or surgical oncologist--surgeon,
11 sorry?
12 DR. LAING:
13 A. That would be my understanding, but it was Dr.
14 Williams who contacted the individuals and
15 asked them to become part of this group.
16 CHAYTOR, Q.C.:
17 Q. And what was your understanding of the role on
18 the panel of Ms. Heather Predham?
19 DR. LAING:
20 A. Ms. Predham was part of the panel, and she
21 came to the meetings, and she was there from
22 the QI office. Her role was there to help to
23 identify the patients and to identify the
24 patients who were the confirmed negatives to
25 be contacted that way, and really, you know,

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1 her involvement in the panel was to be a link,
2 if you will, back to that group.
3 CHAYTOR, Q.C.:
4 Q. I'm sorry, back to the group --
5 DR. LAING:
6 A. Quality initiatives group that was looking at
7 this issue as well.
8 CHAYTOR, Q.C.:
9 Q. And what did you understand they were doing,
10 why would the panel need a link back to them?
11 DR. LAING:
12 A. Because they were involved with contacting the
13 patients. They were coordinating with Nancy
14 Parsons who was taking phone calls from
15 patients and they were very much involved in
16 dealing with this issue and speaking to
17 patients.
18 CHAYTOR, Q.C.:
19 Q. And why would--the panel that's being set up
20 to make decisions regarding any changes
21 required in treatment, why would you need that
22 link to the people who are taking phone calls
23 from patients?
24 DR. LAING:
25 A. So that they are aware of what we are doing,

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1 so that through this process patients are
2 being identified, patients are being, if you
3 will, contacted by two different means, so you
4 know they weren't--the quality office and Ms.
5 Predham worked very closely with us during
6 this review process, and certainly she again
7 wasn't there to make recommendations on what
8 should happen, but was certainly there and
9 knew which patients were being panelled and
10 where things were.
11 CHAYTOR, Q.C.:
12 Q. So Dr. Cook nor Ms. Predham would weigh in on
13 any discussion in terms of what should happen
14 with respect to any given patient?
15 DR. LAING:
16 A. Correct.
17 CHAYTOR, Q.C.:
18 Q. Did you know that Ms. Predham was also the
19 liaison for the lawyers of the insurance
20 company and for HIROC?
21 DR. LAING:
22 A. No.
23 CHAYTOR, Q.C.:
24 Q. With respect to this issue?
25 DR. LAING:

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1 A. No.
2 CHAYTOR, Q.C.:
3 Q. So at the time that she's sitting on the
4 panel, you're not aware that's part of her job
5 and part of her job duties at Eastern Health?
6 DR. LAING:
7 A. No.
8 CHAYTOR, Q.C.:
9 Q. And had you been aware of that, Doctor, would
10 that have caused you any concern?
11 DR. LAING:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. Why not?
15 DR. LAING:
16 A. Because we were there to make decisions based
17 on the review of the patient's chart and based
18 on our knowledge of late hormonal therapy.
19 CHAYTOR, Q.C.:
20 Q. If we could have, please, P-2457. This is
21 your first meeting of the panel, October 13th,
22 2005, and you were there as chair, as are all
23 the other individuals previously mentioned, as
24 well as Dr. Robert Williams. Your recording
25 secretary is to be Ms. Parsons, and we also

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1 have added to the group Dr. Bev Carter, and
2 how did Dr. Carter come to sit on the group?
3 DR. LAING:
4 A. I believe Dr. Cook asked if she would join so
5 that there would be a second pathologist
6 available.
7 CHAYTOR, Q.C.:
8 Q. And what would her role be?
9 DR. LAING:
10 A. She aided him in reviewing the pathology and
11 ensuring that we had the ability to look at
12 the original report and the Mount Sinai report
13 and making our decisions.
14 CHAYTOR, Q.C.:
15 Q. And this says, "Dr. Williams began the
16 meeting". By the way, what time would your
17 meetings normally take place?
18 DR. LAING:
19 A. At five o'clock.
20 CHAYTOR, Q.C.:
21 Q. So they were set for five o'clock?
22 DR. LAING:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. And you would meet how often usually?

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1 DR. LAING:
2 A. Usually once a week, as long as we had work to
3 do and patients to panel. Yeah, once a week
4 on Thursdays at five, and subsequently to this
5 meeting, we moved over to the level two
6 conference room at the Cancer Centre because
7 we had ability at that site--first of all, our
8 Cancer Centre charts were on site, so we
9 didn't have to take them off site. Second of
10 all, we had access to Meditech and to the
11 Cancer Centre chart, so we could readily pull
12 up information that could be shared and seen
13 by all people in the room. So we felt that
14 was a better location.
15 CHAYTOR, Q.C.:
16 Q. Okay, and the person who's missing from the
17 list of--no, I'm sorry, he's there, Dr.
18 Ganguly. He's missing after this, I believe,
19 Dr. Ganguly doesn't show up afterwards. Do
20 you know why that is, why does Dr. Ganguly
21 leave the panel?
22 DR. LAING:
23 A. I don't know.
24 CHAYTOR, Q.C.:
25 Q. Did you ever have reason to ask him?

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1 DR. LAING:
2 A. No, because we--what we had decided was that
3 we really needed to have at least two medical
4 oncologists present so that we could have a
5 good discussion about what the appropriate
6 treatment would be, and certainly if I felt,
7 as the chair, that I required him, I would
8 have called him and said could you please
9 come, but between Dr. McCarthy, I, Dr.
10 Zulfiqar, and on occasion Dr. Ahmad, we always
11 had at least two of us present for the
12 discussions.
13 CHAYTOR, Q.C.:
14 Q. So Dr. Ganguly shows up on October 13th, and
15 then October 20th comes around, he's not
16 there, and from there on after he's not there,
17 and you never say to him, Dr. Ganguly, we're
18 having our panel meetings, where are you?
19 DR. LAING:
20 A. No, because, I guess, I didn't feel that I
21 needed to have him there once we got going and
22 had the medical oncologist there to address
23 the drug therapy for these patients.
24 CHAYTOR, Q.C.:
25 Q. But it didn't dawn on you to even ask him why

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1 he's not there, "are you getting the notices
2 of the meetings, is there a problem"?
3 DR. LAING:
4 A. No, I guess it never--it wasn't something that
5 came up after that.
6 CHAYTOR, Q.C.:
7 Q. Okay. So he made a conscious decision to
8 resign from the panel. He didn't articulate
9 to you his reasons for that?
10 DR. LAING:
11 A. Never verbally or in writing, no.
12 CHAYTOR, Q.C.:
13 Q. I'll just continue on with this for a moment
14 them, "Dr. Williams began by thanking everyone
15 for coming. He also thanked Drs. Kwan and
16 Laing for suggesting the idea of a panel, and
17 thanked Dr. Laing for agreeing to be chair".
18 So, Doctor, was the idea of a panel, in part,
19 your idea?
20 DR. LAING:
21 A. It originated with Dr. Kwan and one day when
22 he and Dr. Williams were discussing the issue
23 of how we would deal with this information as
24 it was coming back from Mount Sinai,
25 recognizing that some of these patients would

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1 have still be followed by their surgeons, such
2 as Dr. Kwan, or within the Cancer Centre, but
3 some would be followed by family physicians,
4 that it--he suggested to Dr. Williams that it
5 may be a good idea if we did with the these
6 patients the same as what we do with all
7 patients that we see in that, you know, if
8 we're not certain, if there's a question about
9 somebody's treatment or we want to get an
10 opinion, then we present patients at tumour
11 board rounds. So this was really the same
12 philosophy and idea of a tumour board round.
13 We simply knew that our Wednesday morning
14 weekly tumour board rounds often had a full
15 slate of patients to be discussed, so we felt
16 that this would be something better done as an
17 outside event; number one, so that we would be
18 able to hopefully get through patients in a
19 more timely manner; number two, so that we
20 could ensure that there were people there who
21 would be able to review the pathology, the
22 pathologists, and people who could speak to
23 the treatment. So that's why we did it this
24 way.
25 CHAYTOR, Q.C.:

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1 Q. And why would a radiation oncologist have been
2 invited to the panel in the first place?
3 DR. LAING:
4 A. Oh, the first place? Because as I explained,
5 Dr. Ganguly for many years would have seen
6 patients and started them on hormonal therapy
7 without any interaction or discussion with a
8 medical oncologist, and, in fact, for many
9 years gave chemotherapy, and so, you know, he
10 would have had knowledge in this area.
11 CHAYTOR, Q.C.:
12 Q. I understand that radiation oncologists
13 regularly meet with cancer patients?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. Was there any thought given to having another
18 radiation oncologist attend the panel?
19 DR. LAING:
20 A. No.
21 CHAYTOR, Q.C.:
22 Q. And why not? I guess I'm trying to figure out
23 why it is that you think that it wouldn't be
24 necessary to have a radiation oncologist
25 present on a go forward basis. Somebody

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1 thought it was in the first place important to
2 have someone there, and the surgeons continue
3 there.
4 DR. LAING:
5 A. Yeah.
6 CHAYTOR, Q.C.:
7 Q. And the pathologists, and your normal tumour
8 board rounds, as you've said, are comparable,
9 I understand they attend those.
10 DR. LAING:
11 A. Right, and they mostly speak to whether or not
12 a patient requires radiation therapy. So
13 that's their areas of expertise, so they give
14 radiation treatments to patients with cancer.
15 Very, very often patients who are receiving
16 cancer treatments, in fact, need both
17 modalities of therapy, so we work very closely
18 together. There was never an issue in this
19 retesting as to whether this affected
20 patient's treatment in terms of radiation,
21 either in the adjuvant setting or for
22 metastatic disease. It doesn't have anything
23 to do with hormonal therapy. You have to
24 recall that Dr. Ganguly at this point was
25 Director of Radiation Oncology, he was a

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1 senior physician, and as I said, he would have
2 over the years seen and started patients on
3 hormonal therapy. So I suspect that's why Dr.
4 Williams asked him to join. You know, he came
5 to the first meeting, we sort of got down to
6 business, and as time went on, he didn't come,
7 but it wasn't something that I can honestly
8 tell you we sat down and thought about at the
9 time because the people that we felt needed to
10 be there, were there, and we carried on doing
11 the work that we were doing.
12 CHAYTOR, Q.C.:
13 Q. So radiation oncologists aren't the primary
14 treating physician for any of the breast
15 cancer patients involved in this?
16 DR. LAING:
17 A. It depends on what your definition of the
18 primary treating physician is.
19 CHAYTOR, Q.C.:
20 Q. The people who the letters went out to as
21 being recognized by the panel as being the
22 primary treating physicians.
23 DR. LAING:
24 A. So there are people who would have been
25 diagnosed with breast cancer who are followed

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1 now by their radiation oncologist and not
2 followed by a medical oncologist, for whatever
3 reason. There are people that have shared
4 follow-up. So some of them are seen by a
5 medical oncologist one visit, by a radiation
6 oncologist at another visit. There are still
7 rare instances where radiation oncologists may
8 still decide to treat somebody with hormonal
9 therapy on their own, but I would say in the
10 last few years for sure that the majority of
11 the time if a radiation oncologist wishes to
12 change somebody's hormonal therapy, that they
13 will send an official consult to us if the
14 person--if the patient in question is not
15 currently being followed by a medical
16 oncologist. For example, when we got to the
17 issue of extended adjuvant therapy, so that
18 was giving people Letrozole after five years
19 of Tamoxifen, some of the radiation
20 oncologists may have decided to do that on
21 their own, but the majority of them at that
22 point, because there was a full group or, you
23 know, a much larger group of medical
24 oncologists available at that time in 2003,
25 into 2004, would have come and said--you know,

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1 either asked us simply as, you know, in the
2 hallway, do you think I should start this lady
3 on hormonal therapy or may have actually asked
4 us to see this person. There are still some
5 cancer centres where, for example, patients
6 with ductal carcinoma in-situ, the radiation
7 oncologist is the one who decides whether to
8 place that person on Tamoxifen or not. Our
9 practice is that those patients are seen by a
10 medical oncologist. So it kind of depends on
11 which cancer centre that you work in.
12 THE COMMISSIONER:
13 Q. Dr. Laing, can we go back for a moment to the
14 role of the surgeons in this group. When Ms.
15 Chaytor asked you about it, you referred
16 effectively to the historical relationship
17 between the surgeons post-surgery --
18 DR. LAING:
19 A. Yes.
20 THE COMMISSIONER:
21 Q. And cancer patients. What about the current
22 practice, would you expect, for example, a
23 surgeon like Dr. Kwan or Dr. Felix to in this
24 day and age be making decisions related to
25 post-surgery treatment for cancer patients?

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1 DR. LAING:
2 A. I would say currently that would be something
3 that would be very, very rare to happen. Most
4 patients now are referred to us at the Cancer
5 Centre, and the majority of patients, be it
6 somebody who had pre-invasive disease or even
7 early invasive disease, the surgeons now for
8 the majority of time will send those patients
9 along to us. Prior to when there was a full
10 or, you know, a larger complement of medical
11 oncologists, many of the surgeons,
12 particularly if it was a question of hormonal
13 therapy, would have made a decision to start
14 patients on Tamoxifen or hormonal therapy on
15 their own. In fact, when I first started
16 practice here, I would sometimes see patients
17 from the surgeons who would send them along,
18 but had already started them on hormonal
19 therapy, but as time has gone on and as the
20 complexities regarding the choice of hormonal
21 therapy, the duration, and the switching, the
22 majority of people would be referred to
23 directly to us. However, when I think about
24 the role that--because in the beginning when
25 Dr. Felix came, he came to the first few, and

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1 then over time didn't come as often. Dr. Kwan
2 came fairly regularly through the whole course
3 of things. One of the things that was
4 important in determining the late treatment
5 was we looked at the prognosis of the patient
6 as well. So it was almost like doing the same
7 thing you would have done on day one, only
8 we're doing it two, three, five, however many
9 years later. So their knowledge and their
10 sort of clinical experience over the years and
11 their expertise in assigning prognosis was
12 very valuable to us in looking at patients.
13 So, for example, of somebody was there who had
14 been treated five years ago, we would first
15 have to say, okay, what do we think this
16 person's risk of recurrence is at this point.
17 Obviously, it would be different than it was
18 if they had been right there at the time of
19 their initial diagnosis, and--so I certainly
20 found the input from the surgeons very
21 valuable from that point of view.
22 CHAYTOR, Q.C.:
23 Q. Doctor, if we just continue on then with the
24 minutes here, and just on Dr. Bev Carter being
25 added, was she also--it says here Dr. Cook was

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1 asked to be there on an ex-officio basis. Do
2 you know was Dr. Carter also there on an ex-
3 officio basis?
4 DR. LAING:
5 A. I'm not - I didn't sort of think of them in
6 that sort of capacity. They were there as
7 pathologists to provide us with information,
8 and, you know, sometimes through this process,
9 as you can imagine, there may have been people
10 that were diagnosed in '98, '99, and there may
11 have been something about that patient's
12 particular pathology that wasn't clear to us,
13 so there were instances when perhaps we would
14 have asked for them to do a review of some
15 other aspect of the pathology, for example, to
16 look at prognosis, and the pathologists were
17 able to bring up with their Meditech access
18 all pathology records, even the old ones from
19 the Grace Hospital and that sort of thing. So,
20 you know, they were there to make sure that we
21 had in our hands all the information we needed
22 from the pathology point of view.
23 CHAYTOR, Q.C.:
24 Q. If we can look at just for a second, P-0021.
25 Registrar, I will come back to this document.

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1 This is a Medical Advisory Committee meeting,
2 January 12th, 2005. Actually, I got the wrong
3 page number. Just scoot ahead here to the
4 October meeting. I take it, Doctor, once you
5 became Clinical Chief, you were a regular
6 attendee at those meetings, the Medical
7 Advisory Committee?
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. And would you then regularly report on this
12 issue to MAC?
13 DR. LAING:
14 A. We would do a report from the program at every
15 --written report from our program at every
16 second meeting of the MAC and of the clinical
17 chiefs and program directors.
18 CHAYTOR, Q.C.:
19 Q. Okay, and on page 48 of the document, it's an
20 excerpt from the October 12th meeting of MAC,
21 and it says, "A panel has been established to
22 review patients whose ER/PR receptor results
23 have changed", and that's the panel, "will
24 make recommendations to the attending
25 physicians on future therapy and membership on

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1 the panel will consist of the following", and
2 you'll see that Dr. Carter is included up to
3 this point in time, and it indicates Ms.
4 Heather Predham and Dr. Don Cook are ex-
5 officio. Were you aware--was that ever
6 discussed at the panel that Ms. Heather
7 Predham would also be an ex-officio member of
8 the panel?
9 DR. LAING:
10 A. No.
11 CHAYTOR, Q.C.:
12 Q. And any distinction in terms of the role
13 between Dr. Cook and Dr. Carter, one being ex-
14 officio and one presumably being a full member
15 of the panel with input on decision making,
16 was--any discussion like that taken place?
17 DR. LAING:
18 A. No.
19 CHAYTOR, Q.C.:
20 Q. If we could go back then, please, to P-2457,
21 the mandate of the panel, "Dr. Laing stated
22 that the mandate of this panel was to review
23 each patient individually and make a
24 recommendation as a panel on the most
25 appropriate treatment and follow up for each

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1 patient. Dr. Laing asked the group if they
2 agreed. Dr. Laing also asked discussion of the
3 group will be officially minuted, and will
4 stay as a record. All in attendance agreed".
5 Did all in attendance agree as to the mandate
6 of the panel?
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. Was there any discussion from Dr. Ganguly with
11 respect to the mandate of the panel?
12 DR. LAING:
13 A. No.
14 CHAYTOR, Q.C.:
15 Q. Was it ever brought to your attention as to
16 whether or not he may have had an issue or a
17 misunderstanding as to what the group was to
18 do?
19 DR. LAING:
20 A. No.
21 CHAYTOR, Q.C.:
22 Q. Was the panel ever involved in determining the
23 reasons for an conversions or changes in the
24 test results for any given patients?
25 DR. LAING:

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1 A. No.
2 CHAYTOR, Q.C.:
3 Q. So was it ever part of the mandate of the
4 panel to explore the reasons why the test
5 results differed or converted on retesting?
6 DR. LAING:
7 A. No.
8 CHAYTOR, Q.C.:
9 Q. If we could go to, please, 2543. This is an
10 affidavit filed by Ms. Predham in February
11 '07, and I take it you've heard about this
12 affidavit at least?
13 DR. LAING:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. In Paragraph 26 she says, "Based upon my
17 involvement as a member of the tumour board,
18 there was no one reason to explain why the
19 respective test results converted on
20 retesting, and in many instances the cause of
21 the conversions is unknown, and any number of
22 the following factors may have contributed to
23 the conversions", and then there's a list, and
24 she says that's based upon her involvement as
25 a member of the tumour board panel she's able

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1 to state that. Was there any information from
2 the tumour board panel which would allow any
3 explanation as to why the respective test
4 results resulted in conversions?
5 DR. LAING:
6 A. No. I mean, we looked at the clinical chart
7 of the patients, we didn't review the patient
8 from the point of view--you know, the
9 pathologists weren't there looking at the
10 slides, they weren't making comments on any of
11 these particular things here, and as I said,
12 that wasn't the mandate of the panel and
13 that's not something that we discussed as a
14 group.
15 CHAYTOR, Q.C.:
16 Q. If we could go back, please, to 2457. The
17 decision was made at your first meeting to
18 officially minute what happens in your group.
19 DR. LAING:
20 A. Uh-hm.
21 CHAYTOR, Q.C.:
22 Q. And this, of course, this exhibit is the
23 result of those minutes. I understand this is
24 your minutes of your first meeting?
25 DR. LAING:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. And it will stay as a record. Now who was to
4 be responsible for officially minuting what
5 happened at your panel meetings?
6 DR. LAING:
7 A. We had a recording secretary who would have
8 taken minutes.
9 CHAYTOR, Q.C.:
10 Q. And then who would be responsible at the end
11 of the day for checking the minutes to ensure
12 accuracy and sign off on the minutes?
13 DR. LAING:
14 A. I would have looked at the minutes.
15 CHAYTOR, Q.C.:
16 Q. And would that depend whether or not you, in
17 fact, sat as chair for that session?
18 DR. LAING:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. So whoever was the acting chair or the chair
22 would be the person to ensure the accuracy of
23 the minutes?
24 DR. LAING:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. And why would it be that the decision was made
3 to have these minutes "and will stay as a
4 record". A record for whom and for what
5 purpose?
6 DR. LAING:
7 A. There would have been--you know, the ultimate
8 information would have gone out in the
9 individual letters pertaining to the patients,
10 but we wanted to have, I guess, a reference
11 back to what was decided. So really the
12 minutes were a summary, if you will, of each
13 of the individual patients. They would have
14 been listed out individually and the
15 recommendation that would have ben there would
16 have been summarized, and then a letter would
17 have been generated.
18 CHAYTOR, Q.C.:
19 Q. And so was it your understanding that it was
20 Ms. Parsons who drafted the minutes?
21 DR. LAING:
22 A. Yes, and so what we did over time was, to make
23 it easier for her, we came up with a form and
24 she would fill in the information as we were
25 discussing the individual patients. So we

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1 would say, you know, at the beginning of the
2 meeting, the initial ER/PR results. We would
3 check those, the chart on the system. They
4 would be recorded. We would look at the Mount
5 Sinai reports, check them against the actual
6 report. That would be recorded. We'd look at
7 the date of diagnosis of the patient in the
8 chart to ensure that that was correct, and
9 then there would be a recommendation made and
10 she would write that down on the body of this
11 form, and then we would decide which physician
12 to send the letter to.
13 CHAYTOR, Q.C.:
14 Q. So we have a number of those forms. So the
15 handwriting on those forms is the handwriting
16 of Ms. Parsons?
17 DR. LAING:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. Who does Ms. Parsons work for?
21 DR. LAING:
22 A. At that time, she was working in the Quality
23 Initiatives office.
24 CHAYTOR, Q.C.:
25 Q. And who did she report to?

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1 DR. LAING:
2 A. I can't remember the name of the lady.
3 CHAYTOR, Q.C.:
4 Q. Okay. So she would be working with--in the
5 same department as Heather Predham?
6 DR. LAING:
7 A. The same department as Heather Predham. It'll
8 come to me in a second, but sorry.
9 CHAYTOR, Q.C.:
10 Q. And as time went on, Dr. Laing, and we do have
11 a number of those, I think, up to perhaps your
12 tenth meeting, into February of 2006, we would
13 have minutes. But it appears in February then
14 of 2006, there aren't this official minutes
15 kept in this format, and why is that? What
16 changed in that time period?
17 DR. LAING:
18 A. At that point, we realized that the minutes
19 were just exactly what was in the letter, and
20 it was felt that we would just produce the
21 letters and that we wouldn't keep those sorts
22 of minutes any more, because it was--when Ms.
23 Parsons was putting together the information
24 between meetings, she was spending a lot of
25 time making these and we felt that the

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1 priority really was to get the letters done so
2 that they could get sent out. So as time went
3 on, we didn't keep those summaries of each of
4 the individual letters as official minutes.
5 CHAYTOR, Q.C.:
6 Q. So whatever reason that it was thought to be a
7 good idea to have this as an official record,
8 by February of 2006, it wasn't deemed to be
9 necessary?
10 DR. LAING:
11 A. No, because what was in those was exactly what
12 was captured in the actual letters.
13 CHAYTOR, Q.C.:
14 Q. Except it doesn't capture--the letter doesn't
15 capture who was in attendance at the time of
16 the decision that's made with respect to the
17 patients. The letters wouldn't capture that,
18 who actually comprised the panel at any given
19 meeting in which a decision was made with
20 respect to that patient.
21 DR. LAING:
22 A. No, that was never in any of the letters, even
23 from the very beginning.
24 CHAYTOR, Q.C.:
25 Q. Right, so there would be then no record of who

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1 attended. Without having your minutes, would
2 there be a record of who actually made the
3 decisions with respect to any given patient
4 after February 2006?
5 DR. LAING:
6 A. I would think that there would be some record.
7 We would certainly, as physicians, know--you
8 know, I can tell you which ones I attended,
9 but as to whether there was anything written
10 down.
11 CHAYTOR, Q.C.:
12 Q. But who else may have been there on March 6th,
13 2006?
14 DR. LAING:
15 A. Not certain.
16 CHAYTOR, Q.C.:
17 Q. You wouldn't be able to tell me?
18 DR. LAING:
19 A. No.
20 CHAYTOR, Q.C.:
21 Q. And we can certainly see that there is other
22 information in some of the minutes of other
23 discussion that takes place regarding
24 different issues. There's certainly the
25 minutes captured that discussion. So would

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1 there be any other--once the minutes stopped
2 being taken, would there be any other record
3 of any other issues that were discussed by the
4 panel from that point on?
5 DR. LAING:
6 A. No.
7 CHAYTOR, Q.C.:
8 Q. And whose decision was it to stop taking
9 minutes?
10 DR. LAING:
11 A. I do recall at one point that Ms. Parsons said
12 to me, you know, that really all the minutes
13 were, were a summary of the letters and, you
14 know, would we continue to do that, and we
15 decided that we wouldn't.
16 CHAYTOR, Q.C.:
17 Q. And so was that brought to the panel for
18 decision or who's the we? Who decided that?
19 DR. LAING:
20 A. I can't recall.
21 CHAYTOR, Q.C.:
22 Q. So you decided it, but you don't know who else
23 along with you?
24 DR. LAING:
25 A. I decided it and I can only assume that I

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1 would have told it to the panel members, but
2 you know, I don't think at that point people
3 were thinking that the minutes were something
4 that we needed to do any more. Most of the
5 discussion and most of the logistics of how
6 this was going to work and what the letters
7 were going to look like and making of the form
8 and all those sorts of things happened within
9 the first couple of meetings, and then really
10 we were into the process of doing it and you
11 know, really the output of the meetings that
12 we felt were important were the letters.
13 CHAYTOR, Q.C.:
14 Q. And by December 10th, 2007, minutes show up
15 again. So December '07, anybody who was
16 panelled into January, June and I believe into
17 July of 2008, minutes are being taken again at
18 that point in time. Why is that?
19 DR. LAING:
20 A. Sorry, I missed when you said that we started
21 to do minutes again.
22 CHAYTOR, Q.C.:
23 Q. Okay. December 10th, 2007.
24 DR. LAING:
25 A. Oh, 2007.

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1 CHAYTOR, Q.C.:
2 Q. We've recently been given copies, just in the
3 last day or so, of minutes that were created
4 for those meetings.
5 DR. LAING:
6 A. Yeah.
7 CHAYTOR, Q.C.:
8 Q. So why was the decision then made that we will
9 keep minutes?
10 DR. LAING:
11 A. So you're talking about the more recent or the
12 later panels.
13 CHAYTOR, Q.C.:
14 Q. I'm talking December 2007 onward.
15 DR. LAING:
16 A. Yeah, and so you know, there hadn't been
17 panels for quite some time, and then there
18 were some patients identified and we were
19 asked if we would meet and discuss them again.
20 So this was now being done more within the
21 Cancer Care Program, and I guess we just felt-
22 -I'm not sure that we, you know, sort of sat
23 down and had a big meeting about it, but there
24 were very few people discussed at the
25 subsequent panels, and again, really just to

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1 keep a record of that.
2 CHAYTOR, Q.C.:
3 Q. So was taking minutes slowing down sending out
4 patient letters?
5 DR. LAING:
6 A. I think it was felt that, you know, the
7 minutes really were exactly what was in the
8 patient letters, so that when--I recall the
9 discussions that I had with Ms. Parsons, as I
10 said, were really just to sort of say "can we
11 just concentrate on getting the letters typed
12 up and over for review, and getting those
13 signed and sent out?"
14 CHAYTOR, Q.C.:
15 Q. Okay. Then -
16 THE COMMISSIONER:
17 Q. So I take it the answer to the question is--
18 the question is whether or not, in the
19 deciding to cease taking minutes, this was
20 either presented to you or was it your
21 perception that the minutes were slowing down
22 the process of getting the patient letters
23 out?
24 DR. LAING:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. And I take it what Ms. Parsons had to rely on,
3 in terms of then drafting the letters
4 afterwards, would be the notes that she took
5 on the forms?
6 DR. LAING:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. Okay. Did you ever have any discussion with
10 Ms. Predham as to whether or not it was
11 necessary to continue to take minutes?
12 DR. LAING:
13 A. Not that I recall.
14 CHAYTOR, Q.C.:
15 Q. Your minutes for October 13th continue on to
16 say "discussion ensued as to who would be
17 notified, and whose responsibility it would be
18 to carry out the follow up of each patient."
19 And when it's saying "who would be notified,"
20 is that referring to patients? Is that
21 referring to other than patients?
22 DR. LAING:
23 A. It's referring to the physicians.
24 CHAYTOR, Q.C.:
25 Q. The physicians, so which physicians would be

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1 notified?
2 DR. LAING:
3 A. Um-hm.
4 CHAYTOR, Q.C.:
5 Q. Okay, and on that point, why was the decision
6 made to only send the letter to physicians, as
7 opposed to sending a copy to the patients?
8 DR. LAING:
9 A. I don't recall, at that time, that we had any
10 discussions about sending the letters to the
11 patients. It wasn't a conscious decision that
12 I can recall that we wouldn't. We don't--I
13 mean, when we do tumour board, you know, we
14 don't send notification to the patients. You
15 know, when test results come back, that
16 information is not sent to patients. In my
17 own practice, I certainly will often give my
18 patients a copy of a report or a test result
19 or a scan result, if they ask for it, and I
20 try to, if I do that, explain to them what
21 exactly it says. For example, if a patient
22 has had a CAT scan and they say "may I have a
23 copy of that CAT scan?" I'll say yes. I'll
24 print it off and I'll go through it with them
25 sort of in detail, because, of course,

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1 there'll be things that will be said that they
2 may or may not, you know, understand and I
3 certainly wouldn't want something to be said
4 in a CAT scan that would cause concern to a
5 patient. But, it just wasn't something that
6 we thought about at that time.
7 Subsequently, there have been patients
8 who have said to me, "Dr. Laing, may I have a
9 copy of my panel letter?" and certainly, I
10 would have given it to them with the same
11 caveat as before, you know, this is what this
12 means and this is the discussion and that sort
13 of thing.
14 CHAYTOR, Q.C.:
15 Q. Yes. But in terms of many of these patients
16 weren't patients under active treatment. They
17 weren't patients who were going to walk into
18 your clinic or another clinic next week or
19 next month or even six months time.
20 DR. LAING:
21 A. Yeah.
22 CHAYTOR, Q.C.:
23 Q. So in terms of any concerns to make sure that
24 the information is transmitted to them, would
25 it not have been a good idea that they also be

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1 copied on the letter, to make sure that it's
2 not somehow falling between the cracks on a
3 busy physician's desk?
4 DR. LAING:
5 A. At the time, as I said, it wasn't something
6 that we thought about or discussed. If you're
7 asking me in retrospect, then yes, I can see
8 some value to that. But also, with the
9 concerns as I've stated that whenever you
10 provide patients with this sort of information
11 that, you know, there needs to be that ability
12 for follow up or discussion.
13 CHAYTOR, Q.C.:
14 Q. The minutes continue to say "all agreed that
15 the referring physician should be notified and
16 that the primary cancer treating physician
17 would be responsible for follow up of the
18 recommendations from the panel." In that
19 context, what is meant by the referring
20 physician?
21 DR. LAING:
22 A. So most often when patients are referred to
23 the Cancer Centre, in the front of the chart
24 would indicate who the referring physician
25 was. Most often it's a surgeon. The family

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1 physician would be listed. Some patients have
2 more than one family physician that would be
3 indicated, so we would have tried to find out
4 who the current family physician was, and any
5 of the physicians in the Cancer Centre who are
6 involved with that patients care would be
7 listed. So if I was the medical oncologist,
8 my name would be there. If Dr. Ganguly was
9 the radiation oncologist, his name would be
10 there on the front of the chart.
11 CHAYTOR, Q.C.:
12 Q. Okay. So in saying that the referring
13 physician is the surgeon, that person probably
14 would not have had any contact with the
15 patient for quite some time, unless it's
16 someone who, you know, back in the days when
17 Dr. Kwan -
18 DR. LAING:
19 A. Oh no, the surgeons do a lot of very active
20 follow up. Many of the surgeons in this city
21 continue to follow their breast cancer
22 patients for many years.
23 CHAYTOR, Q.C.:
24 Q. Okay. So in the case -
25 DR. LAING:

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1 A. Dr. Felix, Dr. Wells.
2 CHAYTOR, Q.C.:
3 Q. But in that case, they wouldn't be just the
4 referring physician. They'd also be the
5 primary treating physician.
6 DR. LAING:
7 A. No, not within the Cancer Care program. They
8 would still be considered by us to be the
9 referring physician.
10 CHAYTOR, Q.C.:
11 Q. Okay, and so the referring physician is going
12 to be notified, but the primary cancer
13 treating physician is going to be responsible
14 for follow up of the recommendations from the
15 panel?
16 DR. LAING:
17 A. Um-hm.
18 CHAYTOR, Q.C.:
19 Q. So who is the letter going to be written to?
20 Is it the referring physician, or is it to the
21 primary cancer treating physician?
22 DR. LAING:
23 A. So if someone was still being followed and we
24 could tell that by looking at the chart, then
25 we would write the letter to whoever that

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1 physician was at the Cancer Centre. If
2 somebody was discharged from the Cancer
3 Centre, then we would write the letter to the
4 family physician.
5 CHAYTOR, Q.C.:
6 Q. Okay, and so then, the referring physician is
7 copied on the letter?
8 DR. LAING:
9 A. Yes, and there were some instances when we may
10 have sent the letter to the referring
11 physician. For example, sometimes we'd be at
12 a meeting and, you know, if one of those
13 surgeons was there, Dr. Kwan or Dr. Felix,
14 they may have said "well, send the letter to
15 me and I'll deal with it." So you know, every
16 time we panelled a patient and every time we
17 discussed them, one of the discussion points
18 was who the letter would be sent to and who it
19 should be copied to, and that was made clear
20 so that the recording secretary would have
21 that information, and we also would, in the
22 case of patients who were being followed in
23 our peripheral clinics, all copies of our
24 progress notes and letters on those patients
25 are sent to the charts in those clinics, and

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1 so we would have done the same--we would have
2 sent copies to the peripheral clinics.
3 CHAYTOR, Q.C.:
4 Q. It says "notification will be in writing, and
5 a mechanism will be put in place to confirm
6 that the follow up physician has received
7 notification." What mechanism was put in
8 place to ensure or confirm that the follow up
9 physician received the notification?
10 DR. LAING:
11 A. Well, the letters would have been written to
12 the physician and then the copies would have
13 been sent to the other physicians that were
14 identified as receiving copies. I'm not
15 certain that we really had a good mechanism to
16 ensure that those letters were received by
17 those physicians.
18 CHAYTOR, Q.C.:
19 Q. Was there any mechanism put in place to
20 confirm that the letters, in fact, had been
21 received?
22 DR. LAING:
23 A. No.
24 CHAYTOR, Q.C.:
25 Q. And whose responsibility was it, on the panel,

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1 to make sure that such a mechanism was put in
2 place?
3 DR. LAING:
4 A. I think, as I mentioned yesterday, as time
5 went on, we realized that, you know, there
6 wasn't somebody who had been identified as the
7 central keeper of a central list that ensured
8 all of these things had happened.
9 CHAYTOR, Q.C.:
10 Q. So nobody was tasked, I take it, with that
11 responsibility is the answer?
12 DR. LAING:
13 A. That's correct.
14 CHAYTOR, Q.C.:
15 Q. Was any consideration ever given to having
16 anyone with knowledge in information
17 management sit on your panel?
18 DR. LAING:
19 A. No.
20 CHAYTOR, Q.C.:
21 Q. And in hindsight?
22 DR. LAING:
23 A. Wonderful idea.
24 CHAYTOR, Q.C.:
25 Q. Okay, and I take it, Doctor, in terms of

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1 setting this up and how it would work, was
2 anybody outside Eastern Health consulted, in
3 terms of any consultation to receive advice as
4 to how might we go about this?
5 DR. LAING:
6 A. When I look back, I can say no. No, that
7 didn't happen.
8 CHAYTOR, Q.C.:
9 Q. Okay, and then it goes on to say here that
10 "this letter," so we're still talking about
11 the letter that'll go out from the panel,
12 "will include a paragraph to the effect that
13 if the primary care physician is not
14 comfortable carrying out the change in
15 treatment, they have the option of referring
16 the patient to an oncologist at the Cancer
17 Clinic" and was that paragraph always included
18 in the letters?
19 DR. LAING:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. If they weren't going, I take it--if they were
23 going to a family physician, for example?
24 DR. LAING:
25 A. That's correct, yeah, or the surgeon.

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1 CHAYTOR, Q.C.:
2 Q. Or the surgeon.
3 DR. LAING:
4 A. That's correct.
5 CHAYTOR, Q.C.:
6 Q. And then there was a paper passed out on the
7 efficacy of the -
8 DR. LAING:
9 A. Yes, that's the one we've alluded to a few
10 times, yes.
11 CHAYTOR, Q.C.:
12 Q. And I finish this here with saying "it was
13 agreed that Heather Predham ask an
14 epidemiologist to review the research." Did
15 that happen?
16 DR. LAING:
17 A. I'm not certain.
18 CHAYTOR, Q.C.:
19 Q. Did Ms. Predham come back with anything
20 further for the panel on that issue?
21 DR. LAING:
22 A. Not that I can recall, no.
23 CHAYTOR, Q.C.:
24 Q. And then it refers to "the form that will be
25 set up for next meeting," and it will have the

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1 patient's name, MCP number, family doctor,
2 surgeon, oncologist and recommended treatment
3 and follow up, and I believe there's other
4 items that get added to the form?
5 DR. LAING:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. In terms of date of pathology and some other
9 things get added.
10 DR. LAING:
11 A. Right, because you can imagine as we're
12 sitting there and reading out this information
13 and the recording secretary is trying to
14 capture it, that by having a form that was
15 easy to fill in and making sure that all those
16 elements were captured right then and there at
17 the meeting.
18 CHAYTOR, Q.C.:
19 Q. Okay, and the idea of having an epidemiologist
20 to review the research, what would the purpose
21 of that be? Why would she have been asked to
22 do that?
23 DR. LAING:
24 A. You know, I really--I can't answer that. I
25 don't know. I don't know.

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1 CHAYTOR, Q.C.:
2 Q. Do you have any recollection of any discussion
3 around that?
4 DR. LAING:
5 A. No.
6 CHAYTOR, Q.C.:
7 Q. And so whether or not there were other papers
8 out there, other than the one that's
9 referenced -
10 DR. LAING:
11 A. Yeah. No, I mean, this was what I could find.
12 I had discussed this issue with Dr. Kathy
13 Pritchard and some other medical oncologists
14 when I was at a meeting way back in the spring
15 of 2005, and this was the article that she
16 knew of, but you know, we did a--I did, and I
17 can recall doing a search and couldn't find
18 any other evidence that we could go by, and
19 then of course, we had the--as I've alluded to
20 before, we had the information about the
21 people being treated in the five to ten-year
22 period from the MA17 trial.
23 CHAYTOR, Q.C.:
24 Q. Yes. So perhaps then you can tell us about,
25 this is your first meeting then. How did the

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1 panel go about its work? What information,
2 for example, was made available to the panel?
3 How did you reach your decisions, and did you
4 have any information about the patient
5 beforehand, in advance of the meeting?
6 DR. LAING:
7 A. So how it worked would be that we would all
8 get together in a conference room and we would
9 have a list of patients that would have been
10 identified prior to the meeting, and that was
11 simply so that those patients could have their
12 medical records retrieved. So when we came to
13 the meeting, in the room we would have a copy
14 of their Cancer Clinic chart and we would also
15 have access to their medical record via
16 Meditech. But as you know, the Meditech would
17 only be for--we would only have access to the
18 St. John's region. We would also have access,
19 through Meditech, to their pathology reports,
20 again for the people in the St. John's region,
21 and we could bring up their Cancer Clinic
22 chart notes electronically so that they could
23 be displayed for everybody in the room to be
24 able to see. We have pathology reports from
25 Mount Sinai.

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1 And so how it would work is we would
2 start at the top of the list. One of the
3 physicians would take the chart and go back to
4 the very first assessment, so the first time
5 the patient came to the Cancer Centre, read
6 through what we knew about the patient at that
7 time, based on that summary, and that would
8 include a lot of information about the
9 patient. Every time a patient is seen as a
10 new patient at our Cancer Centre, we do what's
11 called a first assessment summary. So that
12 would include all of the patient's past
13 medical history, their current medications,
14 allergies, family history, really a very
15 thorough assessment, and then the initial
16 recommendation that was made by the attending
17 oncologist who would have seen the patient at
18 that time.
19 We then would have followed through the
20 progress notes from the most--from the oldest
21 to the newest and followed along to see if we
22 could rebuild what had happened to the patient
23 over time, and see if there was any new
24 information about that patient's health status
25 that might be available. We would look at

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1 their pathology, to look at the prognostic
2 indicators. Did this person have lymph nodes
3 involved? We would look at where they were,
4 you know, is this something that's two years
5 out, five years out? And I guess really the
6 longest, at that time, would have been 1997 to
7 2005. So we would have had some patients that
8 were, you know, seven, eight years out.
9 And then we would make a recommendation
10 based on what we felt the risk of recurrence
11 was at that time, and what we felt their
12 potential benefit would be to the late
13 hormonal therapy, and that was really written
14 as a recommendation, because in some
15 instances, patients may not have been seen in
16 the Cancer Centre for some time and we may not
17 necessarily have known if they had new health
18 issues or things that may have been a
19 contraindication to them taking hormonal
20 therapy. If someone either initially had a
21 very good prognosis tumour and no adjuvant
22 therapy was recommended because of that, then
23 we wouldn't change our recommendation,
24 particularly now that, you know, several years
25 had gone by. So for example, if someone had a

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1 very good prognosis tumour, two, three, five,
2 seven years ago, we wouldn't, you know, have
3 any reason to recommend late starting
4 treatment at this point, because their
5 prognosis -
6 CHAYTOR, Q.C.:
7 Q. But you would still review the entire chart to
8 make sure there hadn't been any change since
9 that initial determination was made?
10 DR. LAING:
11 A. Yeah.
12 CHAYTOR, Q.C.:
13 Q. And we've seen a number of those, a lot of
14 those charts, and of course, they tend to be
15 quite voluminous, in terms of progress notes
16 are made, for example, with--or intended to be
17 made with just about every visit.
18 DR. LAING:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. So I take it, in terms of what you're
22 reviewing at the panel, there's a fair amount
23 of documentation?
24 DR. LAING:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Okay, and you said one of the physicians would
3 actually have the chart?
4 DR. LAING:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. And that person would then read it out to the
8 rest of the group?
9 DR. LAING:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. And highlight the things that, I take it, that
13 person felt was important to be highlighted?
14 DR. LAING:
15 A. Yes, and we also could put it up on the
16 screen.
17 CHAYTOR, Q.C.:
18 Q. Was that done?
19 DR. LAING:
20 A. Yeah.
21 CHAYTOR, Q.C.:
22 Q. So everybody--like we're doing here, so
23 everybody could read along?
24 DR. LAING:
25 A. Yeah.

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1 CHAYTOR, Q.C.:
2 Q. And that was done with every case?
3 DR. LAING:
4 A. So I can tell you, as time went on, we did
5 that with every case, and certainly from the
6 very beginning, if there was something that we
7 felt that the whole group needed to look at to
8 try and interpret, then we would put it up on
9 the screen. Because -
10 CHAYTOR, Q.C.:
11 Q. You said as time went on, so I take it it
12 wasn't done in this meeting that we're about
13 to look at here, your first meeting?
14 DR. LAING:
15 A. Oh, we may have. You know, if there had been
16 something in that patient's medical record
17 that the physician looking at the chart wanted
18 the whole group to see, then yes, we would
19 have put it on.
20 CHAYTOR, Q.C.:
21 Q. So it was at the discretion of the physician
22 who's reading out whether or not you need to
23 look at any -
24 DR. LAING:
25 A. Or at the request of somebody who was

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1 listening.
2 CHAYTOR, Q.C.:
3 Q. Okay. So it's not like the whole chart is
4 there and you're reading through it
5 altogether. It's put up if someone has a
6 question or if it's thought by the physician
7 who's looking through the chart that there's
8 something he or she needs to bring to your
9 attention?
10 DR. LAING:
11 A. Yeah, and then what we would do, as time went
12 on, we would just automatically bring it up
13 and then again, if there was something that we
14 needed to go to and look at specifically,
15 because we can look at our charts like that.
16 So we can--our Cancer Centre charts are
17 separate from the rest of the Eastern Health.
18 They still remain that. They are housed in
19 the Cancer Centre, so if someone comes to the
20 emergency department or we're seeing someone
21 on the in-patient unit, we can go and bring up
22 the notes the same way and review them.
23 CHAYTOR, Q.C.:
24 Q. And who of the physicians would be given the
25 task to have the actual chart and read through

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1 portions of the chart to the group?
2 DR. LAING:
3 A. We would take turns. So there wouldn't be
4 anything that would be--unless that was that
5 particular person--unless the particular
6 physician was the attending physician. So for
7 example, if Dr. Zulfiqar was there and we came
8 to a name and he said "oh, that's my patient,"
9 then he may take us through it, just because
10 he would be most familiar with that patient's
11 case. But many of these people were--not
12 many, but some of these people were certainly
13 people that none of the physicians in the
14 group may have seen, because many of these
15 people were treated at a time when those
16 oncologists involved in their care were no
17 longer available.
18 CHAYTOR, Q.C.:
19 Q. So did you read--if it were your patients,
20 were you the person who routinely were the
21 person to read out portions of the chart?
22 DR. LAING:
23 A. Yeah.
24 CHAYTOR, Q.C.:
25 Q. And the same, I take it, for Dr. McCarthy?

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1 DR. LAING:
2 A. Yeah.
3 CHAYTOR, Q.C.:
4 Q. Did the pathologists ever read through the
5 chart? Were they ever assigned -
6 DR. LAING:
7 A. In the clinical aspects of the chart?
8 CHAYTOR, Q.C.:
9 Q. In terms of what we're talking about here, the
10 physician who would be responsible for reading
11 through and telling the others what's in the
12 chart?
13 DR. LAING:
14 A. No, no.
15 CHAYTOR, Q.C.:
16 Q. Okay. I take it they wouldn't really be
17 familiar with the patient's chart in that
18 respect?
19 DR. LAING:
20 A. So they would be looking at the pathology side
21 of things.
22 CHAYTOR, Q.C.:
23 Q. Yes.
24 DR. LAING:
25 A. And we would usually task someone to be in

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1 charge of the computer, to bring up the
2 information, be it going into Meditech and
3 that sort of thing, and sometimes that would
4 be a pathologist. Sometimes it would be one
5 of the other oncologists.
6 CHAYTOR, Q.C.:
7 Q. And the list, you said that before you go to
8 these meetings, you're provided with a list of
9 the patients names.
10 DR. LAING:
11 A. A list would be provided to the Health Records
12 staff to pull the charts.
13 CHAYTOR, Q.C.:
14 Q. Okay. Did you, as a member on the panel,
15 receive any information beforehand as to who's
16 going to be panelled?
17 DR. LAING:
18 A. I can't recall. I don't think so.
19 CHAYTOR, Q.C.:
20 Q. Okay. So you walk into the meeting, you don't
21 know who's there that day, unless it's someone
22 who had been brought up at the last meeting?
23 For the most part, you're walking in there,
24 you don't know who's on the list or what's
25 going to come up?

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1 DR. LAING:
2 A. No.
3 CHAYTOR, Q.C.:
4 Q. And so you haven't had any opportunity
5 beforehand to review anything on that person?
6 DR. LAING:
7 A. No, no. No, we wouldn't have done any review
8 beforehand, not at all, no.
9 CHAYTOR, Q.C.:
10 Q. So what happens in terms of the review of the
11 patient happens once you're in that room?
12 DR. LAING:
13 A. It's all real time, yeah.
14 CHAYTOR, Q.C.:
15 Q. Okay.
16 THE COMMISSIONER:
17 Q. I'm getting the impression that the Cancer
18 Centre charts are different than the charts
19 that one would get from the Health Science?
20 DR. LAING:
21 A. They are very different, yes.
22 THE COMMISSIONER:
23 Q. And you said in--I'm also getting the
24 impression that in respect of the Cancer
25 Centre charts, you can pull them up

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1 electronically?
2 DR. LAING:
3 A. Yes, you can.
4 THE COMMISSIONER:
5 Q. So that for the Cancer Centre charts, you
6 wouldn't even have to have the document in the
7 room. You can go to the computer?
8 DR. LAING:
9 A. What's on the computer would be the notes that
10 had been generated by the physicians within
11 the Cancer Centre. What wouldn't have been on
12 the chart, would have been--what would not
13 have been available electronically that could
14 have been in the chart would be the pathology,
15 any correspondence from outside physicians,
16 some of the notes taken by allied health
17 professionals within the Cancer Care Program.
18 Nurses' notes wouldn't have been there.
19 Summaries of the chemotherapy delivery
20 wouldn't have been there. Copies of the
21 prescriptions wouldn't be there. So we still
22 needed to have our actual chart there, but
23 what we have electronically are the first
24 assessment summaries and all the progress
25 notes that are dictated.

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1 THE COMMISSIONER:
2 Q. By physicians?
3 DR. LAING:
4 A. By physicians, and more recently, my social
5 workers. They would go into the same system
6 as well.
7 THE COMMISSIONER:
8 Q. Okay.
9 CHAYTOR, Q.C.:
10 Q. Doctor, who came up with the list, the list of
11 patients who's going to be panelled any given
12 meeting?
13 DR. LAING:
14 A. I believe that the list was based on people
15 who their test results were back.
16 CHAYTOR, Q.C.:
17 Q. Now, for example, here on the 13th of October,
18 there's, I believe, 12 patients who are
19 panelled on that day.
20 DR. LAING:
21 A. Okay.
22 CHAYTOR, Q.C.:
23 Q. And there would obviously be, at that point in
24 time, I'll suggest to you anyhow, that there
25 were more than 12 patients available to be

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1 panelled.
2 DR. LAING:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. So who determined which 12 would come forward
6 first?
7 DR. LAING:
8 A. We went in the order that they appeared on the
9 list.
10 CHAYTOR, Q.C.:
11 Q. And who determined the list?
12 DR. LAING:
13 A. If I recall correctly, it was alphabetical.
14 CHAYTOR, Q.C.:
15 Q. Okay, so they were done alphabetically?
16 DR. LAING:
17 A. Yeah.
18 CHAYTOR, Q.C.:
19 Q. Was there any attempt to determine priority on
20 the basis of whether or not the patients in
21 fact had a change in results or whether or not
22 the patients may be at higher risk?
23 DR. LAING:
24 A. No, that information would only be able to be
25 determined once we started the review. There

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1 was no way beforehand that it could be
2 determined who would have had greater priority
3 over anybody else.
4 CHAYTOR, Q.C.:
5 Q. Well, who hadn't had a change in results, I
6 take it, would have been fairly easy to
7 determine.
8 DR. LAING:
9 A. Yes, so they would have--you know, they would
10 have taken us only a few moments to do. You
11 know, we were given a list. We worked through
12 that list for as long as we could. Sometimes
13 people were delayed because we felt that we
14 didn't have all the necessary information and
15 we felt that there might be something from an
16 outside hospital. So Ms. Predham would then
17 go and try and track that information down for
18 us. For example, patient may have had, you
19 know, something done in the Clarenville
20 Hospital or in Western or Central, and we'd go
21 look for that information. So that person may
22 have been deferred because of that. If we
23 identified that someone had been deceased, we
24 would put those patients to the side.
25 CHAYTOR, Q.C.:

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1 Q. Yes, and they could show up on your list for
2 that evening?
3 DR. LAING:
4 A. They could, absolutely. So sometimes we got
5 through the list that was set in front of us,
6 and sometimes we didn't. We would work until
7 I felt that we weren't being effective any
8 more. You know, this was happening at 5:00.
9 We were fed. We got going and you know,
10 whatever time the group seemed to be fading,
11 then we'd say "okay, that's it, and we'll wait
12 until next week."
13 CHAYTOR, Q.C.:
14 Q. Who gave you the list? Who came to the
15 meeting with the list of patients?
16 DR. LAING:
17 A. When I would come to the meeting, the list
18 would be brought by the Quality office. So
19 Heather Predham and Ms. Parsons would have a
20 list. There would be a trolley of charts and
21 the list would be laid on top of that. But
22 that would be the first time we would sort of
23 sit down then and look and see who was there
24 and we would start.
25 CHAYTOR, Q.C.:

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1 Q. Okay, and so Doctor, you'd show up at 5:00.
2 You'd be fed. You'd have discussion on any of
3 those issues that needed to be discussed. For
4 example, your first meeting, I take it it took
5 a little bit of time then to talk about the
6 mandate of the panel.
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. How you're going to go about things, and then
11 you'd set down to work on the business at
12 hand, of looking through the charts.
13 DR. LAING:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. And as I said, you know, to look through the
17 charts, or as you said, there's some volume of
18 paper involved in that. So approximately how
19 much time would be spent on each patient and
20 the review of that particular person's chart?
21 DR. LAING:
22 A. Oh, it varied. It varied very widely, you
23 know, depending on the volume.
24 CHAYTOR, Q.C.:
25 Q. And so, in terms of average, how--so if it's a

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1 person with no change?
2 DR. LAING:
3 A. Ten minutes at most.
4 CHAYTOR, Q.C.:
5 Q. Okay, and if it's a person other than, it's
6 more than that?
7 DR. LAING:
8 A. Right.
9 CHAYTOR, Q.C.:
10 Q. Okay.
11 DR. LAING:
12 A. I'll give you an example. If we had someone
13 who, you know, we read through the initial
14 note and, you know, sometimes even going back
15 to the early days, 1997, 1998, 1999, they may
16 not have even had a mention of the ER/PR in
17 the first note, because maybe the results
18 weren't back. Sometimes it said it was
19 pending. So you may have had to go through a
20 few notes before you would find the first
21 reference to what the receptors were and the
22 decision about hormonal therapy. If, for
23 example, it said, you know, this patient is ER
24 ten and PR 70 and they finished their chemo
25 and now we're going to place them on hormonal

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1 therapy, we would see that the patient was
2 placed on Tamoxifen. We could look at the
3 back copy of the prescriptions and see that,
4 indeed, a prescription had been given. We
5 wouldn't stop there. We would go forward to
6 see if we could ensure that on the subsequent
7 progress notes, was there an indication that
8 that patient was still taking Tamoxifen. Did
9 they have problems? Did they have, you know,
10 develop undue toxicity or some sort of
11 contraindication? So we would follow that
12 through and see that, yes, you know, that
13 patient was still or had remained on Tamoxifen
14 or had gotten five years or whatever the case
15 may have been.
16 That whole process, depending on how many
17 progress notes there were, may have taken, you
18 know, 20 minutes or so to do. If patients had
19 a change in their test results then, you know,
20 we would have--those ones would have obviously
21 meant more time. There were patients who, in
22 the interim, had developed metastatic disease
23 and so, you know, we'd have to look and see
24 what happened with all of that. We had
25 patients that had a left breast cancer and a

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1 right breast cancer. We had all sorts of
2 people that were more complex. So for some
3 people, it took us, you know, three-quarters
4 of an hour to do, and so it really depended on
5 how many volumes and how thick the chart was
6 and what information needed to be reviewed.
7 CHAYTOR, Q.C.:
8 Q. So ten minutes if there's no change, and could
9 be up to three-quarters of an hour or more -
10 DR. LAING:
11 A. If there was a change, yes.
12 CHAYTOR, Q.C.:
13 Q. And this first meeting, Doctor, you had, like
14 I said, your preliminary business discussed.
15 You had your food, and then I think it's 12
16 patients that are panelled.
17 DR. LAING:
18 A. Um-hm.
19 CHAYTOR, Q.C.:
20 Q. And it indicates that your meeting ended at
21 6:35 p.m. So about an hour and a half, 12
22 patients. Even if you hadn't done any other
23 business at that meeting, you spend less than
24 eight minutes on each of those patients.
25 DR. LAING:

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1 A. So I'd have to see which category those
2 patients would have fallen into.
3 CHAYTOR, Q.C.:
4 Q. Doctor, I'll suggest to you that as we go
5 through, that was typical that it was an hour
6 and a half spent on most of your panel
7 meetings. Do you disagree with that?
8 DR. LAING:
9 A. Well, you would have the times, but I would
10 have thought that it was a longer time that we
11 spent there.
12 CHAYTOR, Q.C.:
13 Q. Okay.
14 THE COMMISSIONER:
15 Q. (Inaudible) on those particular patients to
16 see if there was a reason?
17 DR. LAING:
18 A. Well, it would be--it's a little difficult
19 because all I have is the recommendation, but
20 you know, we have the first one is someone
21 whose risk is very low, so we would have
22 determined that. Someone who's remained
23 negative. Someone who died very shortly after
24 their diagnosis. So you know, those patients
25 wouldn't necessarily have taken a whole long

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1 time. You know, through this process too,
2 depending on when the patients were diagnosed,
3 you know, if somebody was diagnosed within the
4 last--particularly within the last five years,
5 a decision to give hormonal therapy may have
6 been made sooner or easier because, you know,
7 they were still within that time period.
8 I can tell you that this was not done in
9 a rushed fashion. In fact, we never came into
10 that meeting and said we must do everybody on
11 this list. There was no expectation that
12 everybody had to be done. We didn't sort of
13 get halfway through a chart and say "oh, this
14 is just too complicated, you know, can't do
15 this one." This was a process through which,
16 you know, we worked through each of these
17 individual patients and, you know, made a
18 recommendation and like I said, you know, your
19 recollection of how much time you spent with
20 something, I can only tell you, based on the
21 fact that I do know that we were very thorough
22 in this process.
23 CHAYTOR, Q.C.:
24 Q. Okay. Doctor, I just want to direct your
25 attention to a couple and ask you a couple of

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1 questions about them, and I think I should
2 clarify first, when you're saying no change,
3 so those were the people who went--there was
4 no change in their numbers? They were
5 negative and remained negative? Or are you
6 saying those--because you said those would
7 take about ten minutes. Or are you saying
8 those with no change in treatment?
9 DR. LAING:
10 A. So I mean, the confirmed negative people would
11 take you, you know, two minutes to determine
12 those, yeah.
13 CHAYTOR, Q.C.:
14 Q. Right, okay. That's all -
15 DR. LAING:
16 A. No, no, the sort of -
17 CHAYTOR, Q.C.:
18 Q. Those were a matter of looking at the
19 pathologies and making sure there was no
20 mistake, that what's on your spreadsheet says
21 -
22 DR. LAING:
23 A. Yeah, so the second patient here, negative,
24 negative, less than one, zero.
25 CHAYTOR, Q.C.:

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1 Q. Right. So that one wouldn't take any more than
2 a couple of minutes to confirm the pathology -
3 DR. LAING:
4 A. That's right. The people who -
5 CHAYTOR, Q.C.:
6 Q. The information is correct?
7 DR. LAING:
8 A. Right. So the people who, you know, had been
9 negative 50 and who had gotten Tamoxifen, we
10 would just verify that by the chart. Again,
11 it would depend. I mean, if this was someone
12 who was diagnosed in 2003 and at this point
13 had had, you know, six or seven follow-up
14 visits, then, you know, you could look through
15 and see Tamoxifen, Tamoxifen, Tamoxifen or
16 whatever, then, you know, that wouldn't take
17 you very long. But there were charts that did
18 take some time to go through. And you know,
19 this patient -
20 CHAYTOR, Q.C.:
21 Q. Okay. And this one here then, the no change
22 in essence in the numbers at all?
23 DR. LAING:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. That person and as time goes on that's a
2 confirmed negative that shows up in your list.
3 DR. LAING:
4 A. Yeah.
5 CHAYTOR, Q.C.:
6 Q. But as time goes on, most of those don't even
7 make it to the minutes?
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. Yes, okay, all right. This third patient,
12 yeah, let's just speak about this person for a
13 moment. So they were negative, negative and
14 then became high estrogen expressor, 90 and
15 still under one for PR. And the
16 recommendation is is "As patient died shortly
17 after diagnosis the change in ER/PR status had
18 no impact on care and therefore no action is
19 required." So I take it, Doctor, some time
20 would have had to been spent in looking
21 through the person's chart to determine that
22 the change in the status would have had no
23 impact on care?
24 DR. LAING:
25 A. Well, I think the reason that that statement--

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1 you know, it's very difficult for me to
2 comment on these without knowing who these
3 patients are. I don't know who this
4 particular patient is, I don't know what the
5 circumstances were surrounding their death. I
6 can't tell you if they died from breast
7 cancer. I mean, this may have been someone
8 who presented with very late stage disease and
9 who died before they ever had a chance to
10 receive any therapy which, you know, which we
11 sometimes see patients who present with breast
12 cancer diagnosis who are very unwell and die
13 very shortly after their diagnosis.
14 CHAYTOR, Q.C.:
15 Q. But I take it that my point is there is enough
16 attention paid in looking through the person's
17 chart, while they're a deceased, it wasn't
18 just a matter of, oh, look, this person is
19 deceased, put their chart to one side, there
20 was enough time spent on review of their chart
21 to figure out when the person had died and to
22 be able to say, well, in that amount of time
23 it would not have had any impact on their
24 care?
25 DR. LAING:

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1 A. Yes. This was the very first meeting and this
2 was before we then decided that we were going
3 to not panel patients who were deceased.
4 CHAYTOR, Q.C.:
5 Q. Okay, and so that's before the decision was
6 made to set the deceased aside?
7 DR. LAING:
8 A. That's correct.
9 CHAYTOR, Q.C.:
10 Q. Okay, and it says that there's, "therefore no
11 action is required." What did that mean at
12 this point in time, based on at this point in
13 time your decision had been, well, we will
14 panel everyone who comes before us?
15 DR. LAING:
16 A. Yeah.
17 CHAYTOR, Q.C.:
18 Q. The decision of the Panel was with respect to
19 this patient while he or she had been
20 panelled, no action was required, what did
21 that mean?
22 DR. LAING:
23 A. That we weren't going to send a letter or do
24 anything like that.
25 CHAYTOR, Q.C.:

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1 Q. So the decision of the Panel was not going to
2 be communicated to anyone?
3 DR. LAING:
4 A. That's right.
5 CHAYTOR, Q.C.:
6 Q. Okay. And who made that decision?
7 DR. LAING:
8 A. We would have made that decision as a group.
9 CHAYTOR, Q.C.:
10 Q. So the Panel?
11 DR. LAING:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. And who on the Panel would have weighed into
15 that decision?
16 DR. LAING:
17 A. All of the clinicians.
18 CHAYTOR, Q.C.:
19 Q. And just the clinicians?
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. And if we come down to this person here, if we
24 look at negative, negative, 80, zero?
25 DR. LAING:

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1 A. Um-hm.
2 CHAYTOR, Q.C.:
3 Q. The recommendation, one of the physicians on
4 the Panel advised the Panel that this was her
5 patient. And the patient has been notified
6 and started on Tamoxifen?
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And so then the follow-up is with that
11 particular patient. But we've redacted the
12 names.
13 DR. LAING:
14 A. Sure.
15 CHAYTOR, Q.C.:
16 Q. So that would be a patient of obviously either
17 you or Dr. McCarthy, being the only -
18 DR. LAING:
19 A. I would think, because it says "she".
20 CHAYTOR, Q.C.:
21 Q. Yes, because it's a her. So, Doctor, this
22 particular patient, I take it, is one of yours
23 or her patients who had been in to see you and
24 you'd already had the results so you had
25 relayed the results and told them already?

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1 DR. LAING:
2 A. Right.
3 CHAYTOR, Q.C.:
4 Q. And so in that circumstance what would be the
5 purpose of panelling the person?
6 DR. LAING:
7 A. Well, nobody would have known that that
8 necessarily had happened, right. So that
9 person would have been on the list because
10 they had retesting done, and so the person who
11 comprised the list would not know that that
12 person had already been seen.
13 CHAYTOR, Q.C.:
14 Q. Okay, so the person would also come before the
15 Panel?
16 DR. LAING:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. And then you or the treating physician in
20 question would speak up and say, "Oh, I've
21 looked after that patient."
22 DR. LAING:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. So would that patient then just be set aside

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1 and the Panel wouldn't review?
2 DR. LAING:
3 A. No, I would have presented and said what I had
4 done and we would have had some discussion
5 around that.
6 CHAYTOR, Q.C.:
7 Q. So you still would have taken the other
8 members of the Panel through what you had
9 done?
10 DR. LAING:
11 A. Yeah.
12 CHAYTOR, Q.C.:
13 Q. And with a view to what?
14 DR. LAING:
15 A. So that they would be aware of the decision
16 that I made and just to ensure that there was
17 nobody who at this point would have disagreed
18 with that decision.
19 CHAYTOR, Q.C.:
20 Q. So in essence you're looking for a second
21 opinion or at least the opinion of your peers
22 as to whether they agree with how you've
23 treated this patient?
24 DR. LAING:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Okay. So those, I take it, even though
3 they're already on Tamoxifen and made that
4 decision by yourself or the treating
5 physician, those were still put through the
6 same process as the other patients?
7 DR. LAING:
8 A. Right. And also it's important to realize
9 that, you know, when we look back to those
10 patients in the early days, be it the ones
11 that we talked about here, that first sort of
12 five patients or be it, you know, people that
13 had been identified or was this someone whose,
14 you know, results had come back the week
15 before, you know, I can't know without knowing
16 who the patient is. That I would have had
17 some discussion, yeah, informal discussion
18 with other people so perhaps I would have
19 discussed the case with Dr. McCarthy or
20 perhaps I would have--you know, in the early
21 days I did discuss this with Dr. Kathy
22 Pritchard, which is again where we got that
23 reference and--but, you know, we felt that
24 these people should be acknowledged through
25 this review process, as well, so that I could

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1 say, Oh, yes, this was my patient. Through
2 whatever mechanism I already have the test
3 results. You know, she's three years out, had
4 lymph nodes involved, so I've placed her on
5 Tamoxifen because she didn't have any
6 contraindications" and the Panel physicians
7 would say, "Okay." And then that that would
8 be it, that would have been the discussion.
9 CHAYTOR, Q.C.:
10 Q. And, Doctor, was there any consideration given
11 to setting those patients aside and not giving
12 them priority to wait and review the decision
13 that had already been made by the treating
14 oncologist, to leave those patients to one
15 side and deal with those who had yet to be
16 dealt with?
17 DR. LAING:
18 A. No.
19 CHAYTOR, Q.C.:
20 Q. And why at the end of the day were letters
21 written to you on those patients, what was the
22 purpose of their letters?
23 DR. LAING:
24 A. Because I think at the end of the day we
25 wanted to capture, you know, all the patients

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1 that had been affected and all the patients
2 who had had a change in their treatment. And
3 so we didn't want to leave them outside the
4 whole group of people of which there would
5 have been recommendations made, albeit, you
6 know, it happened sooner because of whatever
7 reason, whether they were lobular histology
8 and we had asked for it sooner or whether for
9 whatever reason they were tested prior. And
10 this particular note doesn't indicate that
11 this patient had metastatic disease, so I'm
12 just assuming that they didn't, but--because
13 often if it was, it would say that in the
14 summary or in the letter. So, you know, we
15 did want those people to be captured and to
16 be, you know, recognized as people that were
17 dealt with and who had a treatment change.
18 CHAYTOR, Q.C.:
19 Q. Yes, and the letters that went out to those
20 people, so I just want to be clear on why
21 you're doing them. And you said it's because
22 you want to have a record of how many people
23 may have been impacted?
24 DR. LAING:
25 A. Um-hm.

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1 CHAYTOR, Q.C.:
2 Q. Okay. And a record where, are those letters
3 being kept in a central registry, how are
4 those letters the record of those who have
5 been impacted?
6 DR. LAING:
7 A. Well, we assumed that at some point, once we
8 got through all of this process, that there
9 would be--you know, that this whole experience
10 would be one that would be very valuable to
11 sit down and look at in terms of, you know,
12 how many people changed and required a
13 treatment change and even to the point of, you
14 know, did people decide to go on late therapy,
15 did they not, what happened to them down the
16 road. So, you know, that was the reason for
17 doing this. When I dictate a progress note in
18 the clinic, this note would go to the family
19 physician and the surgeon, so if I had done
20 this, then, you know, those physicians
21 involved would have been aware. But we also
22 felt, you know, if we were sending Panel
23 letters out on patients, that even the people
24 who had already had a decision made, it would
25 be worthwhile to their physicians to also get

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1 a, you know, a Panel letter, as well.
2 CHAYTOR, Q.C.:
3 Q. And those are the types of letters, and I'm
4 going to show you a few of those letters later
5 on today, but they, I believe the wording in
6 those is along the lines of "No treatment
7 change required because the patient is already
8 on Tamoxifen" or words to that effect?
9 DR. LAING:
10 A. So we would--if we were communicating it to
11 another physician, we'd say, you know, this
12 has already been done, so we don't need to do
13 anything else at this point.
14 CHAYTOR, Q.C.:
15 Q. And then in terms then of using those letters
16 as your record for keeping track or down the
17 road looking back, as you say, so in terms of
18 keeping track of the number of patients that
19 ultimately had a change in treatment, were
20 those patients included in that number?
21 DR. LAING:
22 A. I did not do the final tally of that number;
23 that wasn't something that I was involved
24 with, but they should be.
25 CHAYTOR, Q.C.:

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1 Q. You would have expected them to be included?
2 DR. LAING:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. So regardless of what the Panel letter said or
6 the Panel determined, whether or not they
7 needed a change in treatment, whether the
8 Panel came to the decision no treatment change
9 required because you had already dealt with it
10 in your office or in your clinic or some other
11 treating physician had, those patients should
12 have been included in the what was the 117
13 number at the time, December, '06 when the
14 number was disclosed?
15 DR. LAING:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. You would have expected they were patients who
19 had a change in treatment?
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. And they should have been included regardless
24 of what their Panel letter said?
25 DR. LAING:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. Yes. Just look at a couple of more patients
4 on this list. This patient was negative,
5 negative originally and then 20, 50. And the
6 recommendation, "As patient has already
7 received Tamoxifen, she will be informed of
8 the change in ER/PR status." So I take it
9 this an example, Doctor, for whatever other
10 reason, maybe it's metastatic disease, the
11 patient was found to already be on Tamoxifen?
12 DR. LAING:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. However, she is to be told that there was a
16 change in her test results?
17 DR. LAING:
18 A. We didn't have a long discussion yet about the
19 other indications for Tamoxifen. So Tamoxifen
20 is used as a preventative drug in breast
21 cancer, it's used to treat ductal carcinoma
22 in-situ in a select group of patients to
23 prevent further DCIS and further invasive
24 disease, it's been shown in several studies to
25 have a decrease in risk of contralateral

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1 breast cancer. And so I've given this
2 medication sometimes to patients with a
3 diagnosis of breast cancer because of a very
4 strong family history and so even in people
5 that may have had an ER/PR negative tumour,
6 they may have been offered Tamoxifen for those
7 other reasons. And again, without this
8 person's chart, I'm just making some
9 assumptions.
10 CHAYTOR, Q.C.:
11 Q. Yes, but for whatever reason she's on
12 Tamoxifen, so there's no need for any change
13 or she's already received it, whether she's
14 still on it?
15 DR. LAING:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. But in any event, she's going to be told that
19 there was a change in her results?
20 DR. LAING:
21 A. Yeah.
22 CHAYTOR, Q.C.:
23 Q. Even though it's not going to change her
24 treatment, she's to be told her numbers
25 changed?

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1 DR. LAING:
2 A. Right, sure. Because then you could go back
3 to that patient, for example, if this was
4 someone who was given it as a preventative
5 thing, you could say, well, you know, I've
6 offered you the Tamoxifen and you've taken it
7 as a preventative, but now that we know that
8 you were truly hormone receptor positive, then
9 it's actually had even more benefit to you.
10 CHAYTOR, Q.C.:
11 Q. Yes. And the same then for the next patient,
12 as well, it appears he or she is in the same
13 category?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. And I take it was that done also by way of a
18 Panel letter?
19 DR. LAING:
20 A. I would assume so.
21 CHAYTOR, Q.C.:
22 Q. Okay. And on the top of the next page we have
23 somebody who went from negative, negative to
24 90 and 20. And again, this patient died
25 shortly after diagnosis. "The change in ER/PR

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1 status had no impact." So I take it that
2 person is in the same category as the other
3 one?
4 DR. LAING:
5 A. As the other one, yeah.
6 CHAYTOR, Q.C.:
7 Q. Okay, and then there's reference to the last
8 patient review. "The Panel agreed to proceed
9 with Dr." and the name is taken out, but I
10 suggest to you that it is a doctor who's on
11 the Panel, "patients at the next meeting." So
12 was that something that in this case--well, do
13 you recall the circumstance by which a doctor
14 asked, "Well, can my patients go next?"
15 DR. LAING:
16 A. No, I don't recall that.
17 CHAYTOR, Q.C.:
18 Q. You don't recall that happening? The Panel
19 agreeing that a particular physician's
20 patients then would be done at the next
21 meeting?
22 DR. LAING:
23 A. No, because these were people that just were
24 brought forward when their test results were
25 available. So even if they were a group of

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1 physicians' patients, they would only be able
2 to be done if we had the test results, and we
3 wouldn't necessarily have the test results
4 back sooner or later for one physician versus
5 another.
6 CHAYTOR, Q.C.:
7 Q. Okay. I guess it's ever who--whatever
8 patients are back at that particular point in
9 time, that particular physician's patients
10 will be reviewed next at the next meeting.
11 DR. LAING:
12 A. Okay.
13 CHAYTOR, Q.C.:
14 Q. Do you recall--it's in your minutes. Do you
15 recall any discussion around that?
16 DR. LAING:
17 A. Do you know what I think this is? I think
18 that this is the first few meetings we had Dr.
19 Felix and Dr. Kwan come and they brought
20 records from their office about patients, so
21 unless it refers to Dr. Felix or Dr. Kwan's
22 patients.
23 CHAYTOR, Q.C.:
24 Q. Yes, I think it would be.
25 DR. LAING:

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1 A. Okay.
2 CHAYTOR, Q.C.:
3 Q. Dr. Felix.
4 DR. LAING:
5 A. Then that's why.
6 CHAYTOR, Q.C.:
7 Q. Okay, and so he brought the records of his
8 patients that he was aware of?
9 DR. LAING:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. And was asking that those patients be reviewed
13 at the next meeting?
14 DR. LAING:
15 A. Because these were, if I think back now, I
16 believe that these were some patients that
17 would not have been referred to the Cancer
18 Centre; these may have been patients that they
19 had made the initial decision to offer
20 hormonal therapy to or not. These may have
21 been some patients that would have been
22 treated during a time when they would not
23 necessarily have been referred to the Cancer
24 Centre.
25 CHAYTOR, Q.C.:

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1 Q. Okay. And so the Panel agreed to go ahead
2 with his patients at the next meeting and you
3 remember that?
4 DR. LAING:
5 A. It appears so, yeah.
6 CHAYTOR, Q.C.:
7 Q. And then it said that Dr. Cook requested two
8 particular patients be added for discussion at
9 the next meeting. Do you recall what that was
10 about?
11 DR. LAING:
12 A. No, I don't.
13 CHAYTOR, Q.C.:
14 Q. Okay, and why would Dr. Cook be requesting
15 certain patients?
16 DR. LAING:
17 A. I'm not certain.
18 CHAYTOR, Q.C.:
19 Q. You don't recall anything about that?
20 DR. LAING:
21 A. No. Unless they were patients that whose
22 results--I really, no, I don't know.
23 CHAYTOR, Q.C.:
24 Q. Doctor, you've told me a little bit about the
25 criteria that the panel used in looking at a

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1 patient to determine whether or not a
2 treatment recommendation would be made, and
3 you've told us about some of the factors that
4 obviously would have gone into that?
5 DR. LAING:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. Was the time between the original diagnosis
9 and how long the patient had been disease
10 free, was that a factor?
11 DR. LAING:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. And, I take it, was taken into consideration?
15 DR. LAING:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. Was there any--was there any cut off time,
19 like, in your mind, was it, well, look the
20 person has been fine for two years or seven
21 years, was there anything like that?
22 DR. LAING:
23 A. No, the--you know, at this point in 2005, we
24 had evidence that treating people in the five
25 to ten year period was of benefit, and that

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1 was something that was fairly new. That was
2 information that had come out in 2003. So,
3 you know, we had been--the medical oncologist
4 had been aware that there was a benefit to
5 treating people in the five to ten year
6 period, albeit I will stress again that in
7 this trial, this was patients who had already
8 received five years of adjuvant Tamoxifen and
9 to the point of their randomization on the
10 MA17 trial, would not have had a recurrence.
11 So it is--you know, it is somewhat of a select
12 population, but we would look at where they
13 were in terms of time from initial diagnosis
14 and try and tie that into prognosis. So if
15 you had no lymph nodes involved and you had
16 one and a half centimetre tumour and you had
17 made it out to eight years, then, you know,
18 your risk of recurrence is going to be much,
19 much lower than somebody who has five lymph
20 nodes involved and is now out to eight years.
21 So we used similar prognostic criteria to what
22 we would have used in making assessments. At
23 the beginning, we would have certainly--you
24 know, the people that were in the two year
25 period, sort of the two to five year period,

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1 which is very common and part of the treatment
2 that they would be on hormonal therapy for
3 that five year duration, then we certainly--
4 you know, looking at the data that was two
5 years and beyond, at least had more
6 information in terms of making recommendations
7 to those patients, and we could also tell from
8 the MA17 trial that the people that were
9 deriving the most benefit from the extended
10 adjuvant therapy were, in fact, as one would
11 expect, the people with the highest risk of
12 recurrence. So to date, that trial has shown
13 an improvement in overall survival in the node
14 positive cohort of those patients only. So
15 this was all things that we were considering
16 when making those decisions.
17 THE COMMISSIONER:
18 Q. Ms. Chaytor, whenever you can find a
19 convenient spot.
20 CHAYTOR, Q.C.:
21 Q. Okay. Actually, Commissioner, perhaps this
22 will be a good point because the next
23 question, I think, might take some time.
24 THE COMMISSIONER:
25 Q. All right, take fifteen.

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1 (BREAK)
2 THE COMMISSIONER:
3 Q. Ms. Chaytor.
4 CHAYTOR, Q.C.:
5 Q. Thank you, Commissioner. I've been told
6 there's three new exhibits that we would ask,
7 please, to have entered. It's P-2612, P-2613,
8 and P-2614.
9 THE COMMISSIONER:
10 Q. 12, 13, and 14?
11 CHAYTOR, Q.C.:
12 Q. That's correct.
13 THE COMMISSIONER:
14 Q. Entered.
15 EXHIBITS ENTERED AND MARKED AS P-2612 THROUGH P-2614.
16 CHAYTOR, Q.C.:
17 Q. Doctor, in the panelling process, were there
18 patients that Mount Sinai, according to its
19 definition of positivity, had found to be
20 positive, but that the panel, in fact,
21 confirmed them to be negative, and if so,
22 perhaps you could explain what that was about?
23 DR. LAING:
24 A. Okay, so there were a few patients whose
25 repeat test results from Mount Sinai may have

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1 come back with very low expression of the
2 estrogen receptor, 1 percent, 2 percent, 5
3 percent. We did look at those patients and in
4 2005, we still would have been using 10
5 percent as our cutoff in terms of offering
6 therapy. Subsequent to that, we've identified
7 and recognized this group of patients who fall
8 into the uncertain category, the 1 to 10
9 percent, and again still with those patients,
10 we would review them as part of our current
11 tumour board panel to decide a regular sort of
12 weekly panel tumour board, shouldn't call it
13 panel, tumour board, to decide if we would
14 offer hormonal therapy to those patients. So
15 for some of those patients, for example, if
16 the results came back as 1 percent ER, then we
17 would have, you know, looked at that to see if
18 there was anything about that patient that may
19 have wanted us to consider treatment, but many
20 of those patients would have still been
21 considered to be negative and would not have
22 been offered hormonal therapy.
23 CHAYTOR, Q.C.:
24 Q. Okay, I want to be clear on that then because
25 we understand that Mount Sinai was using the 1

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1 percent cutoff, and --
2 DR. LAING:
3 A. The pathologists were reporting results as
4 being positive if they were greater than 1
5 percent.
6 CHAYTOR, Q.C.:
7 Q. Right, and St. John's was still using in 2005
8 and 2006 and through the panelling period, 10
9 percent, and I understand from reviewing the
10 matter that there were close to 30 of those
11 patients that would have fallen in that area,
12 does that sound right to you?
13 DR. LAING:
14 A. I don't know.
15 CHAYTOR, Q.C.:
16 Q. So those patients at the time of panelling
17 were treated by the panel on the basis of the
18 10 percent cutoff for positivity, I take it?
19 DR. LAING:
20 A. There were instances where we would have
21 looked at those--as I told you, we did--if
22 they were brought before us, we would have
23 looked at them and, you know, decided if there
24 was any reason in that patient's history or
25 where they were with their disease now that we

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1 may consider them for hormonal therapy, but
2 most of those patients would have still been
3 considered not candidates for hormonal
4 therapy.
5 CHAYTOR, Q.C.:
6 Q. Do you know if any one of those patients was
7 offered anti-hormonal therapy?
8 DR. LAING:
9 A. I wouldn't be able to tell you off the top of
10 my head for certain if there were those
11 patients who would have been offered
12 treatment.
13 CHAYTOR, Q.C.:
14 Q. And if there were, it would be a --
15 DR. LAING:
16 A. It wouldn't be very many.
17 CHAYTOR, Q.C.:
18 Q. Very rare. For the most part, they were
19 confirmed negative?
20 DR. LAING:
21 A. Yeah.
22 THE COMMISSIONER:
23 Q. Dr. Laing, when you say you looked--earlier
24 today you talked about the circumstances under
25 which a person who might be considered

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1 negative ER might be offered hormonal therapy,
2 in any event, because of other factors.
3 DR. LAING:
4 A. Yeah.
5 THE COMMISSIONER:
6 Q. So when you are talking about how you viewed
7 them in 2005 --
8 DR. LAING:
9 A. Uh-hm.
10 THE COMMISSIONER:
11 Q. Was that the kind of analysis you were looking
12 at, you were looking at them as negative, in
13 your view, and are there factors which any
14 negative ER patient would be examined for to
15 determine whether or not there are other
16 indications that --
17 DR. LAING:
18 A. Yes, I see what you mean.
19 THE COMMISSIONER:
20 Q. Was that what it was, or was it something
21 different than that?
22 DR. LAING:
23 A. No. So if people fell into that category that
24 were determined to be negative on that primary
25 tumour, but were offered Tamoxifen for other

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1 reasons, then that decision would have been
2 one that would have been made at the time that
3 they had initially been seen at the Cancer
4 Centre, so we didn't revisit that in those
5 situations. I'm thinking of some patients who
6 the results came back at maybe 5 percent, and,
7 you know, the patient now we knew that
8 metastatic disease, they had, you know, only
9 involvement, for example, of the chest wall or
10 something that--you know, a lymph node
11 recurrence, there were instances where we may
12 have said even though there's low expression,
13 you know, to consider a trial of hormonal
14 therapy for some extenuating circumstance. I
15 do recall at this point, you know, we had the
16 Mount Sinai using the 1 percent, talking to
17 physicians who practised at Mount Sinai, and
18 many of them still, although the lab reported
19 1 percent, many of them were still using 10
20 percent in the clinic as a cutoff. I recall
21 speaking to colleagues of mine who worked down
22 the road at Sunnybrook Hospital and Sunnybrook
23 Hospital reported five percent as being
24 positive in the lab, and again most of the
25 clinicians were using 10 percent as a cutoff

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1 to initiate hormonal therapy, and the people
2 that they--you know, when I talked to my
3 colleagues across the country about this,
4 would have been the people how presented with
5 locally advanced disease, inflammatory breast
6 cancer, very, very high risk recurrent disease
7 who--even if they had a very low level of
8 expression would have given them some sort of
9 hormonal therapy because of their, you know,
10 80--80 to 90 percent risk of recurrence. So in
11 some very select cases like that, we may have,
12 but most of the times if people had very low
13 expression and were negative to begin with, we
14 considered those patients to be confirmed
15 negative and we didn't --
16 CHAYTOR, Q.C.:
17 Q. They were put in a confirmed negative?
18 DR. LAING:
19 A. Yeah.
20 CHAYTOR, Q.C.:
21 Q. Who did you speak with at Sunnybrook?
22 DR. LAING:
23 A. Which physicians?
24 CHAYTOR, Q.C.:
25 Q. Yes, who told you that they were using 5

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1 percent and treating at 10 percent?
2 DR. LAING:
3 A. There were various different physicians and--
4 that I had talked to that were medical
5 oncologists from across the country.
6 CHAYTOR, Q.C.:
7 Q. Yes, but who at Sunnybrook told you that. Dr.
8 O'Malley has told the Commissioner that
9 Sunnybrook was using 1 percent, and I'm just
10 wondering who you would have spoken with and
11 when that was, was that in 2005?
12 DR. LAING:
13 A. Yeah, that would have been in 2005.
14 CHAYTOR, Q.C.:
15 Q. And who is it that told you that at
16 Sunnybrook?
17 DR. LAING:
18 A. So when I talked to people like Dr. Pritchard,
19 and Dr. Trudeau, and those people--you know,
20 my colleagues.
21 CHAYTOR, Q.C.:
22 Q. So you checked with them to see where they
23 were in 2005 as to --
24 DR. LAING:
25 A. Sure, and a friend of mine who now practises

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1 somewhere else in Ontario, but trained in
2 Toronto, saying that, you know, for the most
3 part 10 percent was what they were using in
4 the clinic except for in extenuating
5 circumstances and that's still, I would argue,
6 still true today.
7 CHAYTOR, Q.C.:
8 Q. For Sunnybrook?
9 DR. LAING:
10 A. For everybody. You know, this 1 to 10 percent
11 is not something that's been resolved.
12 CHAYTOR, Q.C.:
13 Q. The patients who then in that category who
14 were by the panel, and it would be most if not
15 all of them, were confirmed negative because
16 they were in that period between 1 to 10
17 percent, were those patients told that there
18 had, in fact, been some change, but it was a
19 change that based on the practice currently in
20 St. John's, the panel has reviewed it, and
21 still has made the decision that it would not
22 be of benefit for you to have Tamoxifen?
23 DR. LAING:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. Okay, so were those patients sent--were there
2 panel letters sent on those patients?
3 DR. LAING:
4 A. For the most part, no.
5 CHAYTOR, Q.C.:
6 Q. So who would have communicated that to the
7 patients or the patients' treating physicians?
8 DR. LAING:
9 A. So I can only speak to the patients that I
10 would know from my experience in the clinic,
11 and, you know, even people who were said to be
12 confirmed negative, many of those patients
13 were either seen by us, either because they
14 were our own patients, or there were still
15 people who called and asked if they could come
16 back and see or speak to a medical oncologist
17 that may have been under somebody else's care
18 who had gone, or may have been one of the
19 people who were still in practice there, one
20 of their patients. We had calls from family
21 doctors to say, you know, such and such a
22 patient had breast cancer and they were
23 wondering, you know--so we certainly did
24 address this issue with some patients. The
25 thing to remember is that, you know, when

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1 you're looking at that low level of expression
2 and the uncertainty as to the benefit, it was
3 more difficult to think about making a
4 recommendation to give them late therapy when,
5 you know, that group, the benefit is not as
6 well known in that group.
7 CHAYTOR, Q.C.:
8 Q. Yes, and I'm just thinking of this issue in
9 terms of--right now, in terms of what's
10 communicated to those patients. So they were
11 put in the category of confirmed negatives?
12 DR. LAING:
13 A. Uh-hm.
14 CHAYTOR, Q.C.:
15 Q. And for the most part, those patients were
16 contacted through the Quality Initiatives
17 Department through, for the most part, Nancy
18 Parsons? Those people would have been called
19 along with the other confirmed negatives and
20 told no change in your results?
21 DR. LAING:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. If any of them were your patients, you're
25 saying that you would have given them their

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1 results, would have talked to them about it,
2 and explained to them this 1 to 10 percent
3 issue?
4 DR. LAING:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. Was that asked of all of the oncologists to
8 take the time to do that and explain to these
9 patients that you're in this category, 1 to
10 10, it's a bit of a grey zone, but the panel
11 has looked at you, and this is the
12 determination?
13 DR. LAING:
14 A. Yes, and even people that were not necessarily
15 our patients. As I said, there were people
16 that we may have been asked to speak with
17 subsequently on the issue as well.
18 CHAYTOR, Q.C.:
19 Q. On this particular issue?
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. So what direction went to the treating
24 physicians in terms of how to deal with those
25 patients and what to explain to those

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1 patients?
2 DR. LAING:
3 A. That--you know, that at the time we were still
4 using 10 percent, that many other places were
5 still using 10 percent as their cutoff, that
6 this 1 to 10 area was still an area that it
7 wasn't certain how much benefit people were
8 going to derive, and that, you know, it was
9 recommended that they not have any treatment
10 and that we would still consider those
11 patients to not likely benefit from hormonal
12 therapy.
13 CHAYTOR, Q.C.:
14 Q. And was that something that was sent out in an
15 memo or an e-mail to the other physicians?
16 DR. LAING:
17 A. Not that I recall.
18 CHAYTOR, Q.C.:
19 Q. Okay. Did I understand you to say that that
20 group has--that there's been a further review
21 of that group through your tumour board?
22 DR. LAING:
23 A. No, I'm just speaking as to what would happen
24 today.
25 CHAYTOR, Q.C.:

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1 Q. What would happen today.
2 DR. LAING:
3 A. S if someone walked in my clinic today and
4 their ER was 1 to 2 percent, and their PR was
5 negative, then those patients we present at
6 our ongoing current tumour board because
7 again, I think, really need to stress to you
8 that it's still not known what's the best way
9 to treat those patients. I use this as an
10 example when I tell my patients, and perhaps I
11 could use it as an example for you to help you
12 understand, we're currently involved in an
13 international phase 3 randomized trial that's
14 looking at this so called group of triple
15 negative breast cancer patients. There's a
16 move within breast cancer oncology really to
17 further divide people even beyond just ER/PR
18 positive and that, and you may have heard some
19 reference to luminal "A", luminal "B", and
20 triple negative or basular cancers. Well,
21 this trial is looking at the drug, Avastin or
22 Bevacizumab to treat people with--adjuvantly
23 with breast cancer, who we know are not going
24 to derive any benefit from Herceptin because
25 they're HER2 negative. We know that they're

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1 not going to derive any benefit from hormonal
2 therapy because they're ER/PR negative, and so
3 these ladies get--or gentlemen, are offered
4 the standard chemotherapy that they would be
5 given by the oncologist, and then they're
6 randomized to get this medication for a year,
7 this Bevacizumab, Avastin, or not. The entry
8 criteria for the trial to be considered triple
9 negative is that you are HER2 negative by
10 immunohistochemistry, either zero or 1 plus
11 staining, and or you're 2 plus, you need to
12 have FISH, and the criteria for being ER/PR
13 negative is to have less than 10 percent
14 staining; not less than 1 percent, but less
15 than 10 percent, and the patients who are
16 between 1 and 10 percent can still go on the
17 study and it is up to the investigator's
18 discretion as to whether or not those patients
19 will be offered hormonal therapy or not. So I
20 think that speaks very well to the fact that
21 this whole area between 1 and 10 percent is
22 not completely answered.
23 CHAYTOR, Q.C.:
24 Q. And is that --
25 DR. LAING:

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1 A. Part of the reason is because many of the
2 trials, many of the large phase 3 randomized
3 trials that looked at hormonal therapy used 10
4 percent as a cutoff. I think about the big
5 198 trial. It's a very important trial that
6 has four arms; Tamoxifen, Letrozole, which is
7 an aromatase inhibiter, and a sequence where
8 people get two to three years of Tamoxifen and
9 then the aromatase inhibiter, and the other
10 way around. So far we've only gotten data on
11 the single arm. So the Tamoxifen versus
12 Letrozole and this year in San Antonio we're
13 expecting an actual update of this trial which
14 I think is going to have--you know, really be
15 a study that's going to influence how we use
16 hormonal therapy in the clinic, and that trial
17 in terms of patients being able to go on that
18 study, use greater than 10 percent as the
19 cutoff. So again ti's not going to tell us
20 about these 1 to 10 percent patients, and it's
21 really going to only be as we go forward
22 prospectively and do trials that we really
23 look at this low expressor group, or some
24 people will argue that at some point they're
25 not going--that group is going to be

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1 classified if you will, into a different
2 category. They may pan out at the end of the
3 day considered to be luminal "B" or even
4 considered to be not deriving any benefit from
5 endocrine therapy. So I don't think that
6 anybody can say for sure that, you know, this
7 issue on treating the low expressors is at all
8 resolved.
9 CHAYTOR, Q.C.:
10 Q. Okay. Doctor, in that clinical trial, is it
11 across the board regardless of what your
12 laboratory is using as a cutoff, everyone is
13 using 10 percent?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. So it's across the board regardless of --
18 DR. LAING:
19 A. It's an eligibility criteria.
20 CHAYTOR, Q.C.:
21 Q. And where are the ER/PR tests being done for
22 your institution in that study?
23 DR. LAING:
24 A. They're being done initially at the local lab,
25 but there's a central review being done.

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1 CHAYTOR, Q.C.:
2 Q. So ER/PR tests are taking place for
3 participation in that clinical study at the
4 Eastern Health Laboratory right now?
5 DR. LAING:
6 A. No. What happens is--I'll just try and
7 explain it for you. What happens is we see a
8 patient and we have the initial results from
9 the-- well, from Mount Sinai now, that comes
10 through and we screen the patients for
11 participation in the trial from the point that
12 they're triaged by the physician. If it's
13 noted on the Mount Sinai report that this
14 person's ER/PR is less than 10 percent and
15 their HER2 is negative, then they're
16 identified as potential candidate for this
17 trial and it's discussed with them when
18 they're seen as a new patient. They are given
19 a consent form and they review it. If they
20 agree to go on the trial, then tissue is sent
21 for central review to confirm that the ER/PR
22 is, in fact, less than 10, and that the HER2
23 is negative.
24 CHAYTOR, Q.C.:
25 Q. Doctor, the issue of Mount Sinai being

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1 optimized and having done their optimization
2 on the basis of their lab, on the basis of 1
3 percent positivity, their discrepancy in the
4 tests, then the patient who comes back,
5 they're 5 percent, for example, those patients
6 --I just want to be clear, if you met with
7 them and your understanding of any oncologist
8 that met with them, that would have been
9 explained to them, look, according to Mount
10 Sinai and their lab using a 1 percent cutoff
11 and that's where the retest was done, you
12 would have been considered positive, but for
13 our purposes, we're using a 10 percent cutoff
14 in our lab on tests done here, and we have
15 looked at your case and determined that you
16 are a confirmed negative?
17 DR. LAING:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. And whether or not that was explained to
21 anyone who Nancy Parsons spoke to, you're
22 unable to say?
23 DR. LAING:
24 A. Correct.
25 CHAYTOR, Q.C.:

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1 Q. And there was no direction, I take it, from
2 the panel to differentiate between those
3 patients and the ones that were negative to
4 start with and came back zero/zero or under 1
5 percent?
6 DR. LAING:
7 A. That's right.
8 CHAYTOR, Q.C.:
9 Q. If we could look at, please, P-0125, page 20.
10 THE COMMISSIONER:
11 Q. Just while it's in my mind, there was a
12 reference in your response, Dr. Laing, to the
13 current practice.
14 DR. LAING:
15 A. Yes.
16 THE COMMISSIONER:
17 Q. And as I understood you, you seem to be
18 indicating that patients who were greater than
19 1 and less than 10, at least to some extent,
20 would go to a tumour rounds, a tumour panel,
21 or a tumour board - I've never gotten straight
22 the difference between rounds, a panel, and a
23 board exactly, but to a group of experts for
24 discussion.
25 DR. LAING:

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1 A. Yes.
2 THE COMMISSIONER:
3 Q. Now is there a sort of policy that we divert
4 them, do you divert some of your cases, is
5 there a particular place where you divert them
6 for that kind of consideration, or is sort of
7 depending on the patient and their
8 circumstances, they're more likely to turn up
9 for review by the group than other patients
10 are?
11 DR. LAING:
12 A. So patients are brought to tumour board by the
13 oncologist.
14 THE COMMISSIONER:
15 Q. Uh-hm.
16 DR. LAING:
17 A. The decision that we made as a group would be
18 that we would present the patients who are
19 between 1 and 9 percent, and that there would
20 be a discussion had at the tumour board to
21 look at the patient's prognosis and to make a
22 recommendation, and that's currently our
23 practice.
24 THE COMMISSIONER:
25 Q. So as a matter of policy, patients who is ER--

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1 is it ER or ER and PR?
2 DR. LAING:
3 A. It's both.
4 THE COMMISSIONER:
5 Q. Both.
6 DR. LAING:
7 A. It would be both, yeah.
8 THE COMMISSIONER:
9 Q. Come back between 1 and 9 inclusive, are
10 referred to the tumour board for discussion
11 and a determination as to what would be
12 recommended to the patient for treatment?
13 DR. LAING:
14 A. Yes, yes.
15 THE COMMISSIONER:
16 Q. So would it be safe to conclude then rather
17 than viewing a particular number at least
18 above 1 as a cutoff, currently patients
19 between 1 and 9 are treated differently than
20 those who would be above 9 in the sense of--
21 not treated differently if you're thinking
22 about treatment, but processed differently
23 perhaps?
24 DR. LAING:
25 A. Yes.

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1 THE COMMISSIONER:
2 Q. In that they have this review, whereas perhaps
3 a patient who would be 15 percent would not
4 necessarily?
5 DR. LAING:
6 A. That's right. So the person who is 15 percent
7 may be reviewed for a different reason, but it
8 really comes back to this notion again of the
9 uncertainty as to what to do with this group
10 of patients. I think that the decision to
11 give them--offer them hormonal therapy is
12 easier as their risk of recurrence gets
13 higher. When I think about the people that
14 we've discussed in the last, you know, couple
15 of months who have fallen into this category,
16 then the decision to treat them if they've got
17 lymph nodes involved and, you know, have
18 locally advanced disease, etc, is much easier
19 because, you know, your benefit is going to be
20 greater. The people that I think that we have
21 the discussions about and that we struggle
22 with are what to do with the people who have a
23 very good prognosis, but very low expression,
24 you know, because I think their risk benefit
25 ratio is not as great. I should also stress

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1 that this is not a large group of people. You
2 know, the results that we're getting back now,
3 and thinking back over the last three or four
4 months, you know, from Mount Sinai and prior
5 to that, what we were - the results that we've
6 been getting from our own laboratory, this is
7 not a large number of patients who are--who
8 fall into this category of low expressors.
9 The majority of patients we see are very
10 clearly zero/zero or have staining that is,
11 you know, much higher than--greater than 10
12 percent for one or both, and when we had
13 discussions, you know, coming out into '06 and
14 '07, even in this last year, about what we
15 should do with these patients, that when we
16 decided that presenting them at tumour board
17 round would be an appropriate place to have a
18 discussion as to what would be the best course
19 of action. Of course, the individual
20 oncologist involved in these patient's care
21 would be explaining things to them in the
22 clinic. I think about my own patients. I
23 say, look, you know, you need to have
24 chemotherapy if your risk is high enough for
25 recurrence, your ER is 1 to 2 percent, you

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know, this is still a grey area, it's not certain what's the best thing to do, I've presented your case at our tumour board round, we've had a discussion, you have lymph nodes involved, we think that there might be enough benefit to justify it, and then we'll have the discussion about which hormone to use, which sequence, and things like that. So this is something that we are discussing with patients as there are lots of things about people's cancer diagnosis and things that we discuss about patients as they come through the door in the clinic to try and ultimately make a decision about what to do.

THE COMMISSIONER:

Q. Currently in the Cancer Clinic, do you consider yourself as having a cutoff at all?

DR. LAING:

A. In terms of saying that --

THE COMMISSIONER:

Q. Treatment for ER--treatment as a result of ER?

DR. LAING:

A. So if the result is zero percent, or it says less than 1 percent --

THE COMMISSIONER:

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Q. Less than 1.

DR. LAING:

A. Negative.

THE COMMISSIONER:

Q. Negative.

DR. LAING:

A. Don't have a discussion about treatment in terms of that cancer.

THE COMMISSIONER:

Q. Uh-hm.

DR. LAING:

A. We still may have patients, for example, as we've talked about earlier, who we may decide to give Tamoxifen to for --

THE COMMISSIONER:

Q. For other reasons, yes.

DR. LAING:

A. If they're between 1 and 10 percent, we have a discussion about what's the best thing to do, as I've outlined, and if they're greater than 10 percent, and they meet the criteria for one requiring adjuvant therapy, and if they have no contra-indication to taking hormonal therapy, then, yes, we would go ahead and treat those people without any big discussion

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or debate.

THE COMMISSIONER:

Q. Okay, thank you.

DR. LAING:

A. You're welcome.

CHAYTOR, Q.C.:

Q. And, Doctor, the patients who were part of the retest who were late in being identified and came forward even as late as 2007 and into 2008 --

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Do you know whether or not any of them fit into this 1 to 10 percent group, and if so, how were they treated?

DR. LAING:

A. I'm not certain off the top of my head if we did have people within that category. Again if we did, then we would say to them, you know, you're in this grey zone, and certainly if these people--because some of these people who were identified in this last year or two, you know, you're getting further and further away from the initial diagnosis, so that, you

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know, for example if I had someone who was treated in 2002, it's now 2008, they're six years out, they were 1 to 2 percent, I think it's harder to make a case to say that you're going to derive benefit from late hormonal therapy. I can't recall specifically if there were those cases, but if somebody was put before me today who was several years out and who had very low expression, I probably--I mean, we would discuss it as a panel, but I would say that many of those patients, the recommendation would be not to give hormonal therapy to.

CHAYTOR, Q.C.:

Q. And I've just brought up here P-0125, at page 22, and this is a briefing note, August 18th, 2006, that went to the Cabinet Secretariat at that time and on to the Premier's Office, and there was a bunch of categories broken down for the different patients and the results of the retest, and the group that I was just referring you to, it says here, "Category, number, and comments, patient test results confirmed negative by Newfoundland panel, Newfoundland and Labrador panel, the number is

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1 indicated as of August 18th, 2006, and
2 according to these statistics, to be 28.
3 Patients whose original test results were
4 considered negative by treating physician and
5 treated appropriately, there was a slight
6 change in ER/PR status as a result of the
7 testing at Mount Sinai, but following a second
8 review by the Newfoundland panel, the negative
9 ER/PR status was confirmed". So, Doctor, I
10 take it that would be referring to the people
11 who fell in that category?
12 DR. LAING:
13 A. I didn't write this, so I didn't assign these
14 categories, so I would interpret it--
15 CHAYTOR, Q.C.:
16 Q. Who else could it be? Who else could be--
17 DR. LAING:
18 A. I can't think of anybody else who it might be.
19 CHAYTOR, Q.C.:
20 Q. A slight change, and that you confirmed
21 negative.
22 DR. LAING:
23 A. That to me--looking at that, I--
24 CHAYTOR, Q.C.:
25 Q. Looking at that.

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1 DR. LAING:
2 A. Yeah.
3 CHAYTOR, Q.C.:
4 Q. Okay. If we could have, please, P-2552?
5 These are the minutes of your second panel
6 meeting, October 20th, 2005, and you have in
7 attendance yourself, Dr. Cook, Dr. Felix, Dr.
8 Carter, Dr. McCarthy, and Ms. Predham, and Ms.
9 Parsons is the recording secretary. So Dr.
10 Ganguly and Dr. Kwan are not there from the
11 original group. It says, "Distribution of
12 minutes. Dr. Laing asked group if they wanted
13 to receive a copy of minutes. All with the
14 exception of Dr. Cook declined the minutes.
15 The signed original of the approved minutes
16 will be forwarded to Dr. Williams". So did
17 that become the practice that Dr. Williams
18 would receive a copy of the signed minutes?
19 DR. LAING:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. And then the form for taking minutes says that
23 you distributed a form that would be used by
24 the secretary to assist when taking minutes at
25 the meetings, and then the form consists of a

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1 number of items?
2 DR. LAING:
3 A. Uh-hm.
4 CHAYTOR, Q.C.:
5 Q. And then the minutes of October 13th meeting
6 for it to be revised to include the extra
7 information, and then deceased patients,
8 "Patients who are deceased will be addressed
9 following the review of all the patients who
10 are currently alive. At that time, the
11 decision will have to be made whether to
12 notify the patient's physician and family of
13 the change in results".
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. So, I take it, it says as of October 20th that
18 decision is made to set aside the results of
19 the deceased patients and concentrate on the
20 living patients?
21 DR. LAING:
22 A. Correct.
23 CHAYTOR, Q.C.:
24 Q. And that was made by the panel, as you've told
25 us. "Preparation for future meetings"--or at

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1 least those in attendance at the panel on this
2 date made that decision?
3 DR. LAING:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. "Preparation for future meetings. All
7 physicians will be sent the names and MCP
8 numbers of all patients being reviewed at the
9 next panel meeting in advance in order that
10 all information is on hand for review". So,
11 Doctor, I take it from October 20th onwards
12 the intent was that you would be given the
13 names and MCP numbers, and what would be the
14 purpose of doing that, sending the physicians
15 the names and MCP numbers, how would that
16 assist in the process?
17 DR. LAING:
18 A. Well, it says here so that all the information
19 is on hand for review. So it would be--in our
20 case for the physicians in the Cancer Care
21 program, it would simply be that we would have
22 asked for those charts to be pulled.
23 CHAYTOR, Q.C.:
24 Q. And how was that any different?
25 DR. LAING:

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1 A. I can't see that it would have been any
2 different. The only thing I'm thinking is if
3 it was Dr. Kwan or Dr. Felix, and they had
4 records from their outside offices to bring.
5 CHAYTOR, Q.C.:
6 Q. So the intent wasn't that physicians would be
7 able to check whatever information beforehand?
8 DR. LAING:
9 A. No.
10 CHAYTOR, Q.C.:
11 Q. And have some advance notice and look at the
12 issues that might need to be addressed. It
13 wasn't for that?
14 DR. LAING:
15 A. No, we simply didn't have time to go through
16 beforehand and look at the charts. We did
17 that in the panel.
18 CHAYTOR, Q.C.:
19 Q. And, Doctor, on this particular meeting, the
20 minutes then continue on and it's signed by
21 you, you're chairing, and Debbie (sic.)
22 Parsons is the recording secretary, and this
23 meeting ended at 6:25 p.m. and began at 5 p.m.
24 There's a number of patients done and I'll
25 just take you through a couple of those. The

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1 first patient was negative/negative and ended
2 up being a strong expressor 90 and 30. The
3 recommendation, "The panel did not recommend
4 further treatment due to the patient's current
5 medical condition. The patient should be
6 advised of change in results", and there's a
7 follow up physician identified. So I take it
8 there would have been information available to
9 the panel that this patient has other medical
10 issues at the time, and, therefore, they're
11 not recommending a change in treatment, but
12 nevertheless the patient would be told?
13 DR. LAING:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. Then if we come down the next patient was
17 presently on Tamoxifen, so no change, and this
18 one --
19 DR. LAING:
20 A. And I would assume, sorry, that that would be
21 one of those patients who were 60 percent, so
22 they would have been treated --
23 CHAYTOR, Q.C.:
24 Q. Treated on the basis of their PR status.
25 DR. LAING:

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1 A. Yeah, as opposed to someone who, you know, the
2 letter said, oh, this person had recently been
3 started. This sounds like someone who was
4 treated right from the beginning.
5 CHAYTOR, Q.C.:
6 Q. And the next two, I believe, is actually--or
7 this one, I think this might be the same
8 patient, actually, and --
9 DR. LAING:
10 A. I'd have no way to know.
11 CHAYTOR, Q.C.:
12 Q. And the panel is requesting that there also be
13 retesting done on the left breast, and there
14 had been no change in the right breast, and I
15 believe when I saw the unredacted version,
16 that might be the case. This patient here
17 came in under 5 for both of St. John's
18 testing, and then there's no result from Mount
19 Sinai. It says, "As the patient was deceased,
20 specimen was not sent for retesting". How did
21 this patient end up at all at the panel?
22 DR. LAING:
23 A. I don't know.
24 CHAYTOR, Q.C.:
25 Q. Then on the top of the next page, patient who

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1 was under 1 and 1 percent in St. John's, then
2 became a high expressor in estrogen.
3 Recommendation, "No treatment was recommended
4 at this time due to current health issues",
5 and was also noted by one of the doctors in
6 attendance that this lady had refused prior
7 treatment. "It was the consensus that there
8 was no need to notify the patient of the
9 change in results". Doctor, I'm just
10 wondering under what circumstances would it be
11 that there would be no need to notify the
12 patient of the change in his or her results?
13 DR. LAING:
14 A. I'm not certain what patient this was or what
15 the current health issues were, or--I know
16 that there were some patients that were
17 reviewed, for example, who may have had some
18 end stage Alzheimer's or those sorts of
19 issues, but I don't know if that was--if that
20 was someone who fell into that category or
21 not. Subsequently we did have some discussions
22 about, you know, if there was a patient who
23 fell into that category, you know, would their
24 family be notified, how that would be dealt
25 with, so I--without knowing who that patient

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1 was or what their current health issue was,
2 it's difficult for me to comment.
3 CHAYTOR, Q.C.:
4 Q. And, I guess, I didn't want you to speak to
5 the particular patient situation, but I'm just
6 wondering what would the circumstances be that
7 would warrant a patient or a patient's next of
8 kin or treating physician not to be told?
9 DR. LAING:
10 A. I don't know.
11 CHAYTOR, Q.C.:
12 Q. If we can just go back to the first patient
13 who also had a medical condition and there was
14 no recommendation due to that patient's
15 current medical condition, "In any event, that
16 patient should be advised of change in
17 results". If we could look at, please, P-
18 2585, page 9? And this is a note from your
19 meeting that day. And you'll see here, this
20 patient is negative, negative. Mount Sinai is
21 90, 30?
22 DR. LAING:
23 A. Um-hm.
24 CHAYTOR, Q.C.:
25 Q. And it was Dr. Felix written here. "Patient

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1 terminal. Advance Alzheimer's. Recurrent in
2 breast. Not well enough for treatment. Would
3 not recommend further treatment at this," and
4 I would take it means at this time. And if we
5 could just go back then. So this patient is
6 terminal and this patient has advanced
7 Alzheimer's.
8 DR. LAING:
9 A. Okay.
10 CHAYTOR, Q.C.:
11 Q. And if we go back, please, to 2552, negative,
12 negative, 90, 30. This patient is to be
13 advised of the change in results. So I'm just
14 wondering what could be the circumstances of
15 this particular patient not being told?
16 DR. LAING:
17 A. I just, I don't know.
18 CHAYTOR, Q.C.:
19 Q. Come down to this patient, doctor, the
20 recommendation, "After reviewing the patient's
21 chart, it was recommended that treatment will
22 be recommended by the doctor within two weeks
23 after staging complete. As the patient is now
24 known to have recurrent disease, she may be
25 offered a hormonal therapy now." So I take it

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1 this is a patient that has had some
2 progression in her disease?
3 DR. LAING:
4 A. So if I was--again, just looking at that
5 recommendation, then I would understand that
6 that would have been someone who has developed
7 metastatic disease, that the staging that
8 they're talking about would, I would assume,
9 would be a complete reevaluation of that
10 patient to find out where the metastatic
11 disease was and to see if it was something
12 that you would consider up front hormonal
13 therapy for or whether it was something due to
14 where the disease was or the severity of
15 symptoms as the patient would get chemotherapy
16 up front. Even today if see someone in my
17 clinic with metastatic disease, for example,
18 who presents with a nodule on their chest
19 wall, I may say, "Look, you know, you've been
20 on Femara and this has recurred. If this is
21 your only site of disease, I'll likely switch
22 you to a new hormone." But, you know, until
23 you get that CAT scan and the bone scan to
24 really look and see where everything is,
25 you're not going to make your final decision

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1 about how to treat someone. So I would assume
2 that this was someone who was recently found
3 to have metastatic disease who was undergoing
4 a work up, but with this new information
5 available that they were ER positive, then
6 certainly a hormonal therapy would be on the
7 list of options available to that clinician
8 treating that patient.
9 CHAYTOR, Q.C.:
10 Q. Okay. And, Doctor, this, I think, is the
11 first time that--the first patient DCIS with
12 microinvasion that I saw come before the
13 Panel. "This patient had DCIS with
14 microinvasion. ER/PR testing is not reliable
15 on microinvasive breast cancer. Tamoxifen was
16 discussed at initial presentation but not
17 given" I think that should be "any role." or
18 anyhow -
19 DR. LAING:
20 A. I think there should be a period there.
21 "Tamoxifen was discussed but not given."
22 period.
23 CHAYTOR, Q.C.:
24 Q. Yes.
25 DR. LAING:

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1 A. "No role to do" -
2 CHAYTOR, Q.C.:
3 Q. Yes, "No role to do" -
4 DR. LAING:
5 A. - "with ER/PR testing."
6 DR. LAING:
7 A. - "with ER/PR testing." period.
8 CHAYTOR, Q.C.:
9 Q. And there's a follow-up to the physician but
10 no letter is to be sent to the doctor. Tell
11 us then about how did the Panel deal with the
12 DCIS patients that came before it and did all
13 the DCIS patients, in fact, as time went on,
14 come before the Panel or were they culled out?
15 Did the Panel, first of all, deal with all the
16 DCIS patients as time went on and if not, why
17 not, and if the Panel did deal with them, how
18 they were handled?
19 DR. LAING:
20 A. Okay. So maybe we'll address it in a step-
21 wise fashion.
22 CHAYTOR, Q.C.:
23 Q. Sure.
24 DR. LAING:
25 A. First of all, patients who have DCIS only,

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1 with no evidence of microinvasion are offered
2 Tamoxifen in certain circumstances. Tamoxifen
3 in the treatment of ductal carcinoma in-situ,
4 and I'm only speaking about ductal carcinoma
5 in-situ, not lobular carcinoma in-situ, but
6 ductal carcinoma in-situ. Tamoxifen has been
7 shown to decease the risk of developing
8 subsequent ductal carcinoma in-situ and
9 subsequent invasive disease has been shown in
10 large clinical trials. The prognosis of
11 someone who has ductal carcinoma in-situ is
12 quite good and Tamoxifen in this setting has
13 not been shown to improve overall survival.
14 Ductal carcinoma in-situ by definition is a
15 pre-malignant change in the breast. It
16 doesn't have the ability to spread to other
17 parts of the body and so the prognosis is
18 quite good. We do know, though, that it's a
19 marker for an increased risk of breast cancer,
20 more especially in that breast that's
21 involved, so in, you know, for example, if
22 someone has DCIS in the right breast, the
23 right breast is at the greatest risk for
24 further event, although there's a small risk
25 in the opposite breast, as well. When you see

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1 someone with ductal carcinoma in-situ, you try
2 and make a decision as to whether or not
3 you're going to offer that patient Tamoxifen.
4 It depends on numerous factors. It depends on
5 whether or not they have any breast tissue
6 left to be at risk. Some patients who present
7 with ductal carcinoma in-situ, particularly
8 people who have a family history, elect to
9 have bilateral mastectomies as part of their
10 treatment. In that situation there's no role
11 for Tamoxifen because there's no tissue at
12 risk. The same as if you use Tamoxifen in the
13 preventative setting, we wouldn't use it for
14 someone who's elected to have prophylactic
15 bilateral mastectomy, for example, people that
16 are known to be gene carriers. If there are
17 some features about ductal carcinoma in-situ
18 that make it more likely to recur as either
19 further DCIS or for that patient to
20 subsequently develop an invasive breast
21 cancer. One of those is if it's high grade,
22 if it's what we call a comedo type ductal
23 carcinoma in-situ, if it's a large size. And
24 of course, its dependent, as well, on the age
25 of the patient, because this is something that

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1 you're looking at happening over the next sort
2 of five, ten and beyond years. Estrogen and
3 progesterone receptor testing is not done
4 routinely on DCIS. It was not done in our lab
5 at that time routinely. And we have
6 subsequently made a decision that we are not
7 going to start to do it routinely. And I'll
8 talk to that in a minute. So patients that
9 were--who had ductal carcinoma in-situ,
10 because ER/PR testing wasn't done, would not
11 necessarily--it wouldn't have been people that
12 had test results available for retesting.
13 When you have microinvasion, what that means
14 is that there is an area within that ductal
15 carcinoma in-situ where you can see that these
16 cells have gone beyond the basement membrane
17 and actually are invading into the surrounding
18 tissue. So we know that those people have a
19 very small risk of having recurrent disease.
20 It's called microinvasion if that area is less
21 than one millimetre. If the area is between
22 one and five millimetres, it's called a T1A
23 and so on and so on. So when you have
24 microinvasion, it means that these are very
25 small areas. There may be one area and

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1 occasionally we'll get a pathology report that
2 suggests that there's more than one area of
3 microinvasion. Again, in that patient we make
4 a decision about whether or not they may be
5 offered Tamoxifen or not, but, you know, if
6 they have microinvasion and we may decide that
7 their prognosis is good enough that they don't
8 require treatment, we may decide to treat them
9 because of the DCIS, again, dependent on their
10 age, family history and all those other
11 factors that I talked about. So in this
12 particular patient we're reviewing--referring
13 to the fact that when you have such a small
14 area of tumour, my understanding from talking
15 to my pathology colleagues is that it's very
16 difficult to do an accurate test if you have a
17 piece of tumour that's less than a millimetre,
18 a piece of invasive disease that's less than a
19 millimetre. And because we don't use the
20 ER/PR results in determining whether or not a
21 patient should be offered Tamoxifen for ductal
22 carcinoma in-situ, then you know, it wouldn't
23 be a factor that we would go back and look at
24 again. It appears that on review of this
25 patient's chart that Tamoxifen was discussed,

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1 but the patient may have decided and the
2 physician may have decided after that
3 discussion that the patient wouldn't take
4 Tamoxifen, and therefore we felt that there
5 wasn't any role to do ER/PR testing. That's
6 the first category of patients.
7 The second category of patients are the
8 ones that were thought to have invasive
9 disease and then when the specimen of the
10 tumour was sent to Mount Sinai for retesting,
11 when it was looked at by the Mount Sinai
12 physicians, it was said to be ductal carcinoma
13 in-situ. Sometimes in those instances it was
14 simply that the block picked for sending up
15 there was not representative of the tumour
16 sample and so a second block was sent. There
17 were instances that I'm sure we will discuss
18 where, in fact, upon entire review of this
19 patient's specimen it was found that they, in
20 fact, had ductal carcinoma in-situ and that
21 there wasn't an invasive component to the
22 disease, and those patients were dealt with
23 separately from this Panel. And I was
24 involved, as you know, in dealing with some of
25 those patients.

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1 CHAYTOR, Q.C.:
2 Q. Yes, and I'll ask you some questions about
3 that.
4 DR. LAING:
5 A. Yeah.
6 CHAYTOR, Q.C.:
7 Q. Okay. Doctor, this particular patient, why
8 would she end up at the Panel, in any event?
9 This is the Panel to review the retests and
10 determine, and it appears there were no--there
11 was never any ER/PR test, let alone a retest?
12 DR. LAING:
13 A. Yeah. I'm not certain. I'm not sure if--I
14 think we've determined that Dr. Felix was
15 discussing these patients. And if you
16 remember back to the other minutes, could this
17 have been somebody that Dr. Cook had brought
18 forward? I really, I don't know.
19 CHAYTOR, Q.C.:
20 Q. And if we could look at P-2585, page 4,
21 please, it may shed some light on that? This
22 is a draft set of the minutes that are being
23 put forward. And with respect to that
24 particular patient, you're being told,
25 apparently, "Dr. Laing, Heather advised that

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1 this patients should not have been part of
2 Panel review. Dr. Felix added her because she
3 was asking a lot of questions."
4 DR. LAING:
5 A. Okay.
6 CHAYTOR, Q.C.:
7 Q. So, Doctor, in terms of any discussion around
8 this particular patient, that took place at
9 the Panel for review of the retest as opposed
10 to having that issue deferred to the tumour
11 board rounds? You would have been having your
12 regular tumour board rounds, but this patient
13 was done at this review Panel as opposed to
14 saying to Dr. Felix, "Well, you know, bring it
15 up at the next tumour board panel or tumour
16 board rounds. We need to move on with the
17 retest patients." That patient was actually
18 discussed, I take it?
19 DR. LAING:
20 A. She was, yeah.
21 CHAYTOR, Q.C.:
22 Q. Okay. And if we could go back then to 2552,
23 page 4? Around page 4, I think. Here we go.
24 And the last patient had originally had a 30
25 percent PR and negative ER and then 60, 80.

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1 "Review of the patient's chart revealed she
2 was offered treatment with Tamoxifen on May
3 3rd, 2001 and refused treatment. No treatment
4 or follow-up was recommended at this time."
5 And the follow-up physician is indicated but
6 no letter will be sent. And I can tell you if
7 we want to go back to 2585, page 4, I don't
8 know why those, the redactions were done, but
9 these are people present at the meeting, so it
10 is Dr. McCarthy. And no letter is to be sent
11 to Dr. McCarthy on that. And why would that
12 be, why wouldn't a letter, if you're trying to
13 capture and record what's happened, why
14 wouldn't there be letters sent on this
15 particular patient, why wouldn't there be a
16 Panel letter for her as well with the
17 decision?
18 DR. LAING:
19 A. I'm not certain.
20 CHAYTOR, Q.C.:
21 Q. Okay. And the decision when a patient has
22 refused treatment on the basis of their prior
23 ER/PR status and the decision of the Panel
24 then to not recommend any treatment or follow-
25 up, for example, in this particular patient

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1 she had originally been negative ER and then
2 she becomes 60 and 80, and her PR back in 2001
3 or at the date of her pathology -
4 DR. LAING:
5 A. 2003. Oh, sorry, one, sorry.
6 CHAYTOR, Q.C.:
7 Q. 2000 for her pathology and it looks like she
8 refused Tamoxifen in May of '01. She was 30
9 percent, so from what we've heard that would
10 have been somewhat of a border lying case in
11 your--of the Cancer Centre at the time were
12 treated as such. Why would the fact that she
13 refused treatment back then be a factor?
14 DR. LAING:
15 A. I'm not certain because I don't know she
16 refused treatment. I'm not--I can't tell you
17 that it was because she was 30 percent PR.
18 Unless I had the patient's chart and could
19 look through it, I'm not certain as to why.
20 There certainly were people who elected not to
21 take Tamoxifen because they just simply didn't
22 want to have the side effects, even people
23 that were 95 percent positive, even people who
24 had high risk disease. There certainly are
25 people that would have decided not to take

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1 Tamoxifen. And if I was to read this comment
2 below, I would think that if there was a
3 follow-up physician assigned, that Dr.
4 McCarthy was going to follow-up with this
5 patient, but I guess the Panel felt if this
6 person refused Tamoxifen then, that perhaps we
7 knew that this person wasn't post-menopausal.
8 I just, you know, without the chart I'm not
9 really certain what the discussion was around
10 this case.
11 CHAYTOR, Q.C.:
12 Q. Well, Doctor, there were a number of those
13 patients. Do you recall where--and the Panel
14 saw fit to capture the fact that they had been
15 offered it in the past and had refused it.
16 And I'm just wondering, what was the Panel's
17 view on that, should the patients nonetheless
18 be told the change and make a decision on--
19 with respect to their new results?
20 DR. LAING:
21 A. I would think, yes. But, you know, I don't--
22 you know, by saying "No treatment or follow-up
23 recommendation at this time" I'm not certain
24 if that meant that--you know, that doesn't say
25 that the patient shouldn't be told. I guess

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1 the Panel felt, based on whatever information
2 they had in front of them about that
3 particular patient, that, you know, it was
4 unlikely that they were going to--that there
5 was another hormonal therapy option for that
6 patient. And I'm not, again, I'm not certain.
7 CHAYTOR, Q.C.:
8 Q. Okay. So the decision is made, though, that
9 no letter is to go to Dr. McCarthy on the
10 patient?
11 DR. LAING:
12 A. That's what it says there, yes.
13 CHAYTOR, Q.C.:
14 Q. And we do have one patient who perhaps we
15 could look at what happened in her case
16 because she testified here, and that's Beverly
17 Green. And if we could just look at, please,
18 C-0014? And Beverly Green's letter went to,
19 addressed to Dr. Siddiqui, May 8th, 2006. And
20 in this particular case the original report of
21 the ER and PR receptors from a mastectomy
22 specimen, February, 2001 showed zero percent
23 staining for estrogen and 85, 95 staining for
24 progesterone. "A repeat report from Mount
25 Sinai has shown the tumour to estrogen and

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1 progesterone receptor positive at 20 and 70
2 respectively. Review of Ms. Green's medical
3 chart revealed that her diagnosis was based on
4 the results of the mastectomy specimen and she
5 was offered treatment with Tamoxifen which she
6 refused. Therefore, the Panel does not have
7 any further treatment recommendations at this
8 time." And this letter you can see, Doctor,
9 is signed by you?
10 DR. LAING:
11 A. Um-hm.
12 CHAYTOR, Q.C.:
13 Q. And so the way it's worded is that "Review of
14 her chart revealed," it was based on the
15 results of her mastectomy, because, of course,
16 the first paragraph deals with her biopsy, but
17 was done on the basis of her mastectomy and
18 she was offered Tamoxifen which she refused
19 and therefore the Panel didn't have any
20 treatment recommendations for her.
21 DR. LAING:
22 A. Okay.
23 CHAYTOR, Q.C.:
24 Q. And I'm just wondering, I guess, why wouldn't
25 the Panel recommend, why wouldn't the

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1 recommendation from the Panel be that the
2 patient be given an opportunity to reassess
3 the risks and benefits of taking hormonal
4 treatment in light of her new ER status? Why
5 would that not be the recommendation?
6 DR. LAING:
7 A. I'm not certain why we would have put it in
8 that way. But, you know, it was left to be
9 communicated to this patient by Dr. Siddiqui,
10 and I'm not certain as to what final decisions
11 the patient made or Dr. Siddiqui made based on
12 that information.
13 CHAYTOR, Q.C.:
14 Q. And if we could have, please, C-008? And this
15 a progress note that I take it would have been
16 reviewed by the Panel at the time. And it's
17 November 29th, 2001. And this is the first
18 discussion that the patient had with one of
19 the physicians, and it's Dr. Farrell, Clinical
20 Associate, on the issue, it appears, of
21 Tamoxifen, according to her chart. So I take
22 it this progress note would have been
23 available for the Panel to review at the time?
24 DR. LAING:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. And it says that "She is ER negative, PR
3 positive. We offered the benefit of
4 Tamoxifen. We outlined to her the side
5 effects profile, including DVT, hot flashes
6 and endometrial cancer. Interestingly, there
7 is two people in her family who had blood
8 clots. I also outlined to her the benefits
9 and the fact that she is not ER positive,
10 therefore the benefit case is not as strong as
11 it would have been--would be if she had been
12 and she's on two minds as to whether to take
13 it." And eventually she does have a meeting
14 with Dr. Siddiqui and she does refuse
15 Tamoxifen.
16 DR. LAING:
17 A. Okay.
18 CHAYTOR, Q.C.:
19 Q. So the fact, I just want to point out that you
20 would have had available to you the fact that
21 the issue of her not being ER positive was
22 pointed out to her and pointed out to her that
23 the benefit case would not have been as strong
24 therefore as if she had been. So in light of
25 that why would the Panel not recommend that go

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1 back, tell the patient she's now ER positive
2 and does that affect her decision?
3 DR. LAING:
4 A. I'm not certain.
5 CHAYTOR, Q.C.:
6 Q. Before we leave -
7 DR. LAING:
8 A. Can I make one other comment -
9 CHAYTOR, Q.C.:
10 Q. Sure.
11 DR. LAING:
12 A. - about this ER? We discussed previously that
13 the information we have about response rates
14 in metastatic disease to hormonal therapy
15 gives this idea that if you're ER/PR positive
16 and you have metastatic disease, you have a
17 better response, if you're ER positive, PR
18 negative, you're less likely to respond, if
19 you're ER negative, PR positive, you're less
20 likely to respond, and then if you're ER/PR
21 negative, you're not going to respond. I'm
22 not certain if this is what this physician was
23 referring to at that time. But this is an
24 adjuvant case and we don't really have as much
25 information, if you will, on the benefits in

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1 the subset of people that are ER negative, PR
2 positive in terms of adjuvant therapy. This
3 is sort of information, if you will, that we
4 extrapolate over from the metastatic setting.
5 Because as we've talked about before, this
6 group of patients is not a large proportion of
7 patients. And so, I just wanted to make that
8 point.
9 CHAYTOR, Q.C.:
10 Q. Okay, so whether or not this would have been
11 relevant in her case or not to have it pointed
12 out to her about her ER positivity at the
13 time, you would question?
14 DR. LAING:
15 A. Yes. I mean, I know why people did it and I
16 know we have that--I'm not saying it's wrong,
17 I'm saying but that that view and that
18 consideration is based on -
19 CHAYTOR, Q.C.:
20 Q. Metastatic?
21 DR. LAING:
22 A. Metastatic data.
23 CHAYTOR, Q.C.:
24 Q. Right.
25 DR. LAING:

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1 A. Yeah, yeah, as opposed to adjuvant data.
2 CHAYTOR, Q.C.:
3 Q. And unfortunately she does end up in that
4 category eventually, but not at this point in
5 time. If we could look, please, at C-0014?
6 And this is her Tumour Board Panel. And
7 before I leave Ms. Green's case I just have
8 one other question on this.
9 DR. LAING:
10 A. Um-hm.
11 CHAYTOR, Q.C.:
12 Q. But we know, and you would have known from
13 review of her chart that the pathology that I
14 just referred you to in the results of her
15 mastectomy specimen, that result would have
16 been actually entered and signed off on her
17 chart, so the repeat from Mount Sinai was
18 signed off on her chart on October 20th, 2005.
19 Now, the biopsy specimen is retested at a
20 later point in time, I believe it was
21 February, '06.
22 DR. LAING:
23 A. Okay.
24 CHAYTOR, Q.C.:
25 Q. But her first results on the mastectomy, which

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1 is the sample on which she was originally the
2 decision to treat or not treat was based,
3 apparently -
4 DR. LAING:
5 A. Because it's my understanding from my
6 pathology colleagues is that it's better than-
7 -this was a needle core biopsy, so I can only
8 assume that that's why.
9 CHAYTOR, Q.C.:
10 Q. They went on to mastectomy, yes. My point is
11 that that was entered on her chart October
12 20th, 2005, and it's May 8th, 2006 before her
13 Panel letter goes. Are you able to explain
14 the delay?
15 DR. LAING:
16 A. No, no. The only thing that I can think of is
17 whether or not they were waiting for the other
18 specimen to come back. You said the other one
19 came back, I'm sorry, in?
20 CHAYTOR, Q.C.:
21 Q. I believe it was February.
22 DR. LAING:
23 A. February. No.
24 CHAYTOR, Q.C.:
25 Q. Still, you know, a delay there, as well.

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1 DR. LAING:
2 A. Yeah.
3 CHAYTOR, Q.C.:
4 Q. But this is quite a delay in terms of getting
5 the information out on this patient. So, and
6 again, of course, the specimen on which her
7 original decision was made that, I would
8 think, would be the important decision and
9 appeared to be the important decision for the
10 Panel's consideration, and that was done back
11 in October.
12 DR. LAING:
13 A. Was she put on the Panel prior to this time
14 period? I don't know.
15 CHAYTOR, Q.C.:
16 Q. Not from what we have been able to determine.
17 DR. LAING:
18 A. Yeah.
19 CHAYTOR, Q.C.:
20 Q. But if you can't explain what the delay would
21 be in getting any given results to the Panel,
22 who would you suggest might be able to give
23 the explanation as to why some of the patients
24 seemed to have been delayed in getting their
25 information before the Panel?

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1 DR. LAING:
2 A. I'm not certain.
3 CHAYTOR, Q.C.:
4 Q. Do you recall ever raising that as a concern
5 as chair of the Panel, why are we only seeing
6 this patient's results now?
7 DR. LAING:
8 A. No, because we were just--you know, we were
9 getting information that was coming to us and
10 we--there were some instances that I can
11 recall, but these would have been people who
12 had to--for example, the ones that we talked
13 about with the DCIS who may have had to have
14 another block go. So with this particular
15 case, I can't tell you why there was a delay.
16 CHAYTOR, Q.C.:
17 Q. Or with respect to any patients, you don't
18 recall raising any issue as a concern as to
19 delay in Mount Sinai results being available
20 and the patient coming before the panel for
21 assessment?
22 DR. LAING:
23 A. No, because we would have worked through the
24 patients as they were brought to our attention
25 as panel members.

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1 CHAYTOR, Q.C.:
2 Q. If I could go back, please, to P-2585?
3 Actually, I'm sorry, I think it's 2552,
4 although I will come back to this one too, but
5 I think this is the actual minutes that are
6 signed off on. So Doctor, this is your second
7 meeting and then your third one is scheduled
8 for a week later, October 27th, and at this
9 time, it appears it's about--I think you did a
10 dozen or probably 13 patients on this
11 occasion, and so after making your--taking
12 care of your original business, you did 13
13 patients and your meeting that day concluded
14 in less than an hour and a half.
15 Doctor, at this rate, in terms of--and
16 knowing the magnitude of the number of
17 patients that you had to process, were you
18 concerned that this is now getting up late
19 October, how long is this going to take?
20 DR. LAING:
21 A. At that time, no, because we were still
22 waiting for the results. The results are
23 still coming in from Mount Sinai, so we don't
24 have any idea at that time, you know, at the
25 end of the day are there going to be, you

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1 know, another 50 patients to review, is it
2 going to be a longer--or sorry, larger number
3 of patients to review, and so no, not in those
4 days.
5 CHAYTOR, Q.C.:
6 Q. Okay, and please, 2585, Registrar? And this
7 is the draft of the minutes from that same
8 meeting, Doctor. I'll just show you here the
9 front page. So this appears to be a draft
10 because you'll see that there are some
11 handwritten notes, and there's some notes
12 here. Is this your writing?
13 DR. LAING:
14 A. Yes, it is.
15 CHAYTOR, Q.C.:
16 Q. Okay, and so with respect to this particular
17 patient, it was your suggestion to add "the
18 patient now is known to have recurrent
19 disease. She may be offered a hormonal
20 therapy." And we did see that on her -
21 DR. LAING:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. - on the final version of the notes. I do
25 notice, in looking at this that the patient I

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1 referred you to, the consensus of the group
2 was for the patient and her family not to be
3 notified of the change in results, and we
4 spoke to that. Eventually, I believe though
5 that it said that the patient and follow up is
6 going to be Dr. Felix.
7 DR. LAING:
8 A. Right.
9 CHAYTOR, Q.C.:
10 Q. I could be wrong, but I think what ultimately
11 goes into the final draft of the minutes was
12 that the patient not be notified of the change
13 in results.
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. Okay. So do you recall was there a decision
18 instead then perhaps the family could be
19 notified?
20 DR. LAING:
21 A. I would expect that that's what it was, yes.
22 CHAYTOR, Q.C.:
23 Q. And this, I've already brought to your
24 attention too, on this particular patient.
25 DR. LAING:

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1 A. Yes, that was the patient that we discussed
2 with the DCIS.
3 CHAYTOR, Q.C.:
4 Q. And there's some notes about this patient with
5 DCIS. Are those your notes?
6 DR. LAING:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. Okay, and -
10 DR. LAING:
11 A. And that's ultimately what was in that.
12 CHAYTOR, Q.C.:
13 Q. That's ultimately what goes into -
14 DR. LAING:
15 A. That we read.
16 CHAYTOR, Q.C.:
17 Q. Okay, and then on--this is charts for review
18 at page five, and of course, the patients
19 names are taken out, and there are some which
20 it says "delete, not for panel, not for
21 panel." And then there's somebody who--
22 there's a bunch requested, you'll remember
23 from last time, it said that Dr. Cook had a
24 couple of patients. So it appears there were
25 names put forward by Dr. Cook, and there's

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1 somebody who was "not on Heather's list." Now
2 this, I take it, would be the list that was
3 given out to you. Would this be the list that
4 was given, "charts review October 20th, 2005"?
5 So this would be the list of patients that you
6 understood were to be panelled?
7 DR. LAING:
8 A. Oh, I'm not sure what it meant by "not on
9 Heather's list."
10 CHAYTOR, Q.C.:
11 Q. Okay. But this list would have been given to
12 you as chair or as a member of the panel.
13 This is the list of panel--would this be the
14 list that you would have been provided? Were
15 you given out--well, were you given out lists
16 of this nature? Is this what you would have -
17 DR. LAING:
18 A. Oh yes, oh yes.
19 CHAYTOR, Q.C.:
20 Q. Okay, and these notes written here, is this
21 your handwriting?
22 DR. LAING:
23 A. No, it's not.
24 CHAYTOR, Q.C.:
25 Q. Okay. So you don't know what it means when it

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1 says "not on Heather's list"?
2 DR. LAING:
3 A. Yeah.
4 CHAYTOR, Q.C.:
5 Q. And did you understand that Heather Predham
6 was keeping anything in the way of a master
7 list of everybody?
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. So if somebody were not on Heather's list,
12 would that be of concern to you?
13 DR. LAING:
14 A. Well, I don't know what list this means that
15 they were not on, so I'm not certain.
16 CHAYTOR, Q.C.:
17 Q. Well, were you aware that she had more than
18 one list?
19 DR. LAING:
20 A. No, I just don't know what this is referring
21 to.
22 CHAYTOR, Q.C.:
23 Q. Okay. If it were brought to your attention
24 that there were patients who were not showing
25 up on Ms. Predham's list, would that have been

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1 of concern to you?
2 DR. LAING:
3 A. The master list?
4 CHAYTOR, Q.C.:
5 Q. Yes, in terms of the thoroughness of
6 identification for -
7 DR. LAING:
8 A. Oh, I see.
9 CHAYTOR, Q.C.:
10 Q. - patients.
11 DR. LAING:
12 A. Okay, yes, yes.
13 CHAYTOR, Q.C.:
14 Q. And then there's apparently a patient that's
15 requested by Heather Predham to be panelled.
16 Do you recall that? Would Ms. Predham
17 sometimes put forward patients?
18 DR. LAING:
19 A. I'm not sure. This may have been somebody who
20 had called or I don't know what that would
21 have been.
22 CHAYTOR, Q.C.:
23 Q. Okay, and then Dr. Felix' patients were put
24 forward. On page eight of this exhibit, we
25 have the patient that was indicated "no letter

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1 to be sent" and I take it then this is Ms.
2 Parsons' handwriting, and these are the forms
3 on which she would take notes and from which
4 she would then be able to draft the minutes.
5 Is that correct?
6 DR. LAING:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. Okay, and if you come down and look here,
10 you'll see that "she had refused Tamoxifen.
11 Patient treatment"--I'm sorry, I think it's
12 "no treatment recommended at this time.
13 Advised to be positive, but refused Tamoxifen.
14 No letter to be sent" and then "after initial
15 diagnosis, offered Tamoxifen but refused
16 because of low risk," and it goes on, not
17 sure, "would not recommend that she be offered
18 treatment" or Tamoxifen I think it says. And
19 then there's an asterisk, you'll see "no
20 letter to be sent" and then it says "panelled
21 again, November 10th, 2005. Letter sent. No
22 letter sent on October 20th, 2005." But for
23 some reason, this patient then gets put back
24 on the list and she goes through panelling
25 again, and I'll show you that reference of

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1 November 10th '05.
2 DR. LAING:
3 A. Okay.
4 CHAYTOR, Q.C.:
5 Q. And then a letter gets sent. So do you recall
6 that? Like what circumstance in the first
7 place would have, in October, warranted no
8 letter being sent and then why would there be
9 a change in position and have the letter sent?
10 DR. LAING:
11 A. I'm not certain. The only thing that I could
12 perhaps think about is that maybe as time went
13 on, we decided that we would send letters on
14 such patients, and I think that we probably
15 identified that this patient hadn't had one
16 sent back in October and so we reviewed it
17 again and decided to send a letter.
18 CHAYTOR, Q.C.:
19 Q. So at some point in time, there may have been
20 a decision of the panel not to send letters
21 regarding patients who had initially refused
22 anti-hormonal therapy?
23 DR. LAING:
24 A. Well, the only one that we've looked at so
25 far, back in the October meeting, was this

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1 lady.
2 CHAYTOR, Q.C.:
3 Q. Yes.
4 DR. LAING:
5 A. And as you've showed the notes here, that
6 there was a decision made not to send a
7 letter, and the only thing I can think is that
8 subsequently, as we saw more patients like
9 this, that we decided that we would--as a
10 panel, we decided that we would still send
11 letters about these patients, so that A. it
12 would be known that we reviewed them and then
13 we would send it to the physicians and this
14 lady, it looks like subsequently, although she
15 refused Tamoxifen initially, because of where
16 she was and what the prognosis was, it was
17 felt that her recurrence risk at this time
18 wasn't high enough to warrant it. I could
19 only tell by looking at this down here.
20 CHAYTOR, Q.C.:
21 Q. Yes. I'm just trying to think what
22 circumstances, if any, ever presented, were
23 presented to the panel where the panel decided
24 not to send a letter or that a patient not be
25 notified or told the results.

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1 DR. LAING:
2 A. Again, I can only say that at some--after this
3 first couple of meetings, we decided that we
4 would send letters on patients, even those who
5 decided at the beginning not to take it. In
6 terms of the people that we've looked at,
7 again, the only two that we've reviewed that
8 we can see that there was a reason not to
9 notify the patient was because of some medical
10 condition that the patient had.
11 CHAYTOR, Q.C.:
12 Q. Were there--how did the patient (sic.) treat
13 elderly patients or patients that may have
14 been in homes, in long-term care homes? How
15 were they treated, in terms of notification?
16 DR. LAING:
17 A. I would think that they would be treated--
18 unless there was some concern raised by the
19 physicians present, the attending physicians
20 about the patient's cognitive ability, then
21 the patient's age or where they resided
22 wouldn't have--you know, there wouldn't have
23 been any discrimination. They wouldn't have
24 been treated any differently, unless--you
25 know, I'm just thinking back to the case that

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1 you showed me that the patient had advanced
2 alzheimers, and then the case that we sort of
3 -
4 CHAYTOR, Q.C.:
5 Q. And that patient was to be told.
6 DR. LAING:
7 A. - worked through that we figured that it was
8 probably the family that Dr. Felix, you know,
9 intended to notify. We wouldn't necessarily
10 already know that information about a patient.
11 We certainly would not necessarily have known
12 it by just looking simply at their Cancer
13 Clinic chart. If they hadn't been coming to
14 the clinic for a while, we wouldn't have had
15 an updated address on that chart.
16 CHAYTOR, Q.C.:
17 Q. And that patient that I was pointing out,
18 there was no positive assertion that while the
19 family is to be told as opposed to the
20 patient, I was just showing the discrepancy in
21 the two lots of the draft minutes versus what
22 ultimately went, and all that's stated is the
23 patient is not to be told. Whether or not the
24 intent -
25 DR. LAING:

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1 A. Right, so I can just assume that -
2 CHAYTOR, Q.C.:
3 Q. - is that the family be told for some reason,
4 I don't know.
5 DR. LAING:
6 A. I don't know either.
7 CHAYTOR, Q.C.:
8 Q. But I'm just wondering, so if there's patients
9 who are in long term care facilities, and
10 we've seen some and there's other
11 documentation and e-mails where there's some
12 debate and I showed you one yesterday, I
13 think, where Ms. Predham was wondering about
14 how, you know, decisions are going to have to
15 be made as to how we notify the patients in
16 St. Pierre, and I believe the patients in long
17 term care facilities were also referenced.
18 I'm just wondering, was that discussion had at
19 the panel level? And if you're saying to me,
20 "well no, it wasn't discussed, I just assume
21 they were treated the same as everyone else,"
22 well then that's it, I guess.
23 DR. LAING:
24 A. And the only--no, I'm saying that if it was
25 discussed at the panel, it wouldn't be because

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1 they were residents of a long term care
2 facility. It would have been because that the
3 attending physician or the physician present
4 may have raised some concerns about whether or
5 not the patient would understand what was
6 being told. So if I think of an example of a
7 patient--and I have had patients in my own
8 practice. We see patients who do come to us
9 with severe cognitive disabilities, based on
10 advanced alzheimers disease, who you--you
11 know, you can't sit down and have a
12 conversation with them about, you know, "you
13 have breast cancer. This is your diagnosis.
14 This is what I think. What do you think?" and
15 often we look to the caregiver as the person
16 who's speaking for that patient. In some
17 instances, the caregiver or the next of kin is
18 a family member, but unfortunately, there are
19 people that are residents of long term care in
20 this province who I see on a regular basis who
21 do not have any family and then we look to
22 whoever the decision maker is. Often it's
23 somebody who's in a home, I can think last
24 week I had to call a patient with this sort of
25 situation and I would speak to the person who

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1 was their primary caregiver in a home and say,
2 you know, this is what's happened, and you
3 rely on those people. It makes treating
4 patients difficult because they don't
5 understand the potential risks and benefits.
6 They don't understand the potential side
7 effects of treatment, and you know, so to go
8 back to someone who had advanced alzheimers
9 and tell them that their ER/PR result changed
10 wouldn't be something that would be possible
11 to do. So then the discussion was, you know,
12 who do we tell? Do we notify their next of
13 kin? Do we notify the people who are said to
14 be their decision makers? In that situation,
15 do we talk to the physicians who--you know,
16 most of these facilities would have a
17 physician that would be assigned to them, and
18 so that was the types of discussions that I
19 recall having. So that would be the situation
20 that I can think of in which we would say not
21 to inform the patient, because they wouldn't
22 be able to understand.
23 CHAYTOR, Q.C.:
24 Q. Yes, but the one case we saw of the advanced
25 alzheimers, the decision of the panel was to

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1 tell the patient in that case.
2 MR. SIMMONS:
3 Q. (Inaudible).
4 DR. LAING:
5 A. No.
6 CHAYTOR, Q.C.:
7 Q. I'm sorry?
8 DR. LAING:
9 A. I'm not sure that -
10 CHAYTOR, Q.C.:
11 Q. No, it was. The one with the medical
12 condition, there was a debate. The advanced
13 alzheimers, you'll remember I showed you the
14 note and that person, the decision was--we can
15 go back over it, if you wish. That is -
16 DR. LAING:
17 A. But perhaps that statement to tell -
18 CHAYTOR, Q.C.:
19 Q. - 2585, page two.
20 DR. LAING:
21 A. - I mean, that might have been meant to, you
22 know -
23 CHAYTOR, Q.C.:
24 Q. Okay, that's this patient here with the
25 medical condition, should be advised, "the

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1 patient should be advised of the change in her
2 results," and then if we look at 2585, page
3 nine, remember the number is 1930.
4 DR. LAING:
5 A. Yes, I remember that it corresponded.
6 CHAYTOR, Q.C.:
7 Q. Remember she--the decision was that she be
8 told, right?
9 DR. LAING:
10 A. Yeah.
11 CHAYTOR, Q.C.:
12 Q. 2585, page nine, 1930, "patient is terminal
13 with advanced alzheimers." So the decision in
14 her case--it was the other person with some
15 medical condition that the decision was not to
16 tell the patient, and whether or not there was
17 an affirmative decision to actually tell the
18 family, I guess is arguable.
19 DR. LAING:
20 A. I mean, in this situation, I think, you know,
21 it gets to the point that often when we
22 consider a patient, we think about the patient
23 as being part of a family unit and I could
24 only assume that, you know, if somebody sent
25 me information on a patient and asked that I

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1 communicate it to the patient, then I as the
2 physician receiving that information would
3 have to then put that in context of what, you
4 know, in a patient with alzheimers disease,
5 what I felt that patient could or could not
6 understand and certainly if I felt that the
7 patient wasn't able to understand that, I can
8 tell you that I would subsequently disclose
9 that information as well to whoever the
10 caregiver was.
11 CHAYTOR, Q.C.:
12 Q. The appropriate decision maker.
13 DR. LAING:
14 A. Absolutely, yeah.
15 CHAYTOR, Q.C.:
16 Q. So if there were patients that Nancy Parsons
17 would have to contact, patients that fit into
18 the category of long term care homes, where
19 she would have to place calls because they
20 were confirmed negatives, who would she be
21 contacting?
22 DR. LAING:
23 A. I would assume that if you--I can only again
24 speak from my experience in calling homes, you
25 don't necessarily call and ask to speak to the

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1 person directly. You get put forth to whoever
2 is responsible for their care. I have called
3 and, you know, spoke to someone who then put
4 me in line with, you know, if it's a--whoever
5 the person is who deals with the medical
6 issues of these patients. You know, patients
7 who are members of--or sorry, patients who are
8 living in long term facilities who come to see
9 us are always accompanied by somebody from
10 that facility. If there is family that's
11 involved, that family is usually present. So
12 I would assume that if she called to speak to
13 someone, she would be put forth to the person
14 who was responsible for that patient's care.
15 CHAYTOR, Q.C.:
16 Q. Okay, and the panel though didn't decide, with
17 respect to those people, that perhaps letters
18 should go out if it's--if the information is
19 going to be going out to patients who may not
20 otherwise have capacity themselves or have
21 other substitute decision makers in place,
22 that perhaps there should in fact be letters
23 go on those patients?
24 DR. LAING:
25 A. Yes, but the letters were sent to the

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1 physicians in this instance.
2 CHAYTOR, Q.C.:
3 Q. When there was a change in treatment though,
4 but there was no--for those that didn't have
5 any change in treatment -
6 DR. LAING:
7 A. Oh, I see what you mean, if--yes, we didn't
8 send letters. Yeah, okay.
9 THE COMMISSIONER:
10 Q. Ms. Chaytor, wherever you can find a
11 convenient spot, we'll break for lunch.
12 CHAYTOR, Q.C.:
13 Q. Okay. If we could look at, please, P-2553?
14 And Doctor, this is a sample letter dated
15 October 20th '05.
16 DR. LAING:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. And it's written or intended to be written to
20 a doctor, and the content, I take it, is
21 intended to be a sample of what a panel letter
22 would look like.
23 DR. LAING:
24 A. That's correct.
25 CHAYTOR, Q.C.:

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1 Q. Okay, and the information would be to identify
2 the patient through both their name and their
3 MCP number?
4 DR. LAING:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. And the date on which the patient was
8 diagnosed with breast cancer, the original
9 report of the hormone receptors and what they-
10 -the fact that they showed negative staining,
11 and then to give what that staining was.
12 DR. LAING:
13 A. Um-hm.
14 CHAYTOR, Q.C.:
15 Q. And then a repeat report and what the outcome
16 of the repeat report was.
17 DR. LAING:
18 A. Yes, so that would--that first paragraph would
19 be what we decided upon would be the standard
20 introduction. The date of diagnosis that we
21 chose would have been the date of the--the
22 same date that we would use for our registry
23 purposes, so the date of the first diagnosis
24 that suggested breast cancer.
25 CHAYTOR, Q.C.:

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1 Q. So I'm sorry, would that be the date of the
2 pathology report?
3 DR. LAING:
4 A. Yes, that would be the date from pathology.
5 And then again, you know, whatever, and then
6 the next paragraph would be the one that would
7 vary, to say that the patient was discussed
8 and then the recommendation would be whatever.
9 This one actually has a specific
10 recommendation in it, but it's--you know,
11 that's not a standard one.
12 CHAYTOR, Q.C.:
13 Q. It's just meant as a sample.
14 DR. LAING:
15 A. That's right, just a sample.
16 CHAYTOR, Q.C.:
17 Q. Yes, a sample, and then whatever that
18 recommendation is.
19 DR. LAING:
20 A. Yeah.
21 CHAYTOR, Q.C.:
22 Q. And the date on which the panel reviewed, and
23 why would that be important to say, well, it
24 was on this date that the patient was
25 reviewed?

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1 DR. LAING:
2 A. Because most correspondence that we send
3 regarding patients has the date. You know,
4 patient was seen in clinic on September 17th,
5 2008, so that would be the reason, just as -
6 CHAYTOR, Q.C.:
7 Q. In terms of though patient care as well, would
8 it be important, for example, if the doctor
9 knows, well, the patient is seen on October
10 13th, 2005, and the doctor then can look at
11 and say "oh, dear, I saw that patient in here
12 three days or four days after that, and
13 there's been a change and the panel wouldn't
14 have known that when they made the
15 recommendation, so perhaps I should get back
16 in touch with Dr. Laing or whoever, and see,
17 given this new information, has it changed."
18 So from a patient care perspective with the
19 date being -
20 DR. LAING:
21 A. Right, that's why we put dates on
22 correspondence regarding any patient
23 interaction.
24 CHAYTOR, Q.C.:
25 Q. So the doctor who's receiving this knows that

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1 while this is our recommendation as of this
2 particular date?
3 DR. LAING:
4 A. Sure.
5 CHAYTOR, Q.C.:
6 Q. Yes, and "we would ask that you communicate
7 this information to your patient as soon as
8 possible" and I take it that was intended to
9 be standard?
10 DR. LAING:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. And "if you wish, this patient may be referred
14 to then one of the medical oncologists."
15 DR. LAING:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. So that was what was intended to go in a
19 standard letter?
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. And did the panel come up with this or who
24 came up with this particular sample?
25 DR. LAING:

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1 A. We worked on it together.
2 CHAYTOR, Q.C.:
3 Q. Okay. Thank you, Commissioner. This is a
4 good time to take a break.
5 THE COMMISSIONER:
6 Q. All right. 2:15, thank you.
7 (LUNCH BREAK)
8 THE COMMISSIONER:
9 Q. Please be seated. Ms. Chaytor.
10 CHAYTOR, Q.C.:
11 Q. Thank you, Commissioner. Good afternoon,
12 Doctor.
13 DR. LAING:
14 A. Good afternoon.
15 CHAYTOR, Q.C.:
16 Q. If we could have, please, P-1384? Now Doctor,
17 I'm not going to take you through all of the
18 minutes of every panel meeting. Some of them,
19 you didn't chair either, but some of them
20 identify different issues, in terms of how the
21 panel handled different issues. So I'll just
22 highlight any issues that appear to be a
23 little bit different in any given panel
24 meeting. So this is the meeting then, your
25 third meeting, on October 27th, 2005, and you

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1 are chairing this one. Dr. McCarthy is
2 present, as are Doctors Kwan and Felix, Dr.
3 Cook, Ms. Predham and Ms. Parsons, and at the
4 beginning of this meeting, it's indicated
5 "while signing the letters going out to
6 physicians" from your last meeting, "Dr. Laing
7 learned that a particular patient had died--
8 was deceased, so no follow up letter will be
9 forwarded from the review panel at that time."
10 So Doctor, I take it that--do you recall,
11 first of all, this particular instance and how
12 it would have come to your attention that
13 somebody had been deceased, but that would not
14 have come to the attention of Ms. Predham, for
15 example, in putting together who should be
16 panelled?
17 DR. LAING:
18 A. No, I don't recall.
19 CHAYTOR, Q.C.:
20 Q. And if we could have then, please, 2554, page
21 nine I believe it is.
22 REGISTRAR:
23 Q. Please, one second.
24 CHAYTOR, Q.C.:
25 Q. Sorry?

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1 REGISTRAR:
2 Q. Wait one second.
3 THE COMMISSIONER:
4 Q. She's asking you to keep your hands off the
5 mouse.
6 CHAYTOR, Q.C.:
7 Q. Oh, I'm sorry. I'm sorry. Sorry, page nine,
8 please. My handwriting is getting as bad as
9 some of the doctors. I can't read my own
10 notes here. This is page nine, and this
11 particular person was reviewed on the October
12 27th meeting, and it's indicated that they
13 were originally negative and one percent, and
14 then Mount Sinai is 20 and two, and the note
15 says "patient of Dr. Laing's," and that's
16 crossed off. "Because first sample was poorly
17 fixed, Dr. Laing sent another sample. Mount
18 Sinai advised slide wasn't very good. We sent
19 another one. Heather will be at meeting.
20 Please communicate to patient." And Doctor,
21 do you remember anything about having to have
22 another sample sent because of there being an
23 issue of the slide being of poor quality or
24 the sample being poorly fixed?
25 DR. LAING:

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1 A. I believe if this is the patient that I'm
2 thinking of, and again, without knowing who it
3 is, this was someone who had two separate
4 samples sent to Mount Sinai and there was two
5 different results that were received. One was
6 that the ER/PR was still negative, and the
7 second one was that the ER was 20 percent, and
8 there was some discussion, I didn't have, but
9 I believe that the pathologists had had to ask
10 why it may have been that there was a
11 difference between those two samples. So I'm
12 not sure if this is something that came back
13 from pathology, but it wasn't that I had asked
14 for a second sample to go. It was that two
15 separate samples had gone on this patient. I
16 believe that this was somebody who I had
17 requested retesting to happen and she had been
18 retested within the automatic retesting
19 because of her level being less than whatever
20 cut off at that appropriate time.
21 CHAYTOR, Q.C.:
22 Q. So this was a patient that you had identified
23 for retesting?
24 DR. LAING:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Okay.
3 DR. LAING:
4 A. And the initial test result came back that--I
5 don't have it in front of me, so I don't know,
6 but it was similar, you know, like one percent
7 and zero or some very low number, and so I had
8 communicated to the patient that there was no
9 change and then when this next sample came,
10 then I had to speak with her again and
11 indicate that we had had another sample that
12 had gone with the retesting and that, in fact,
13 it had come back as 20 percent and because of
14 that reason, I started this patient on
15 hormonal therapy subsequent to this meeting.
16 CHAYTOR, Q.C.:
17 Q. And there was some discussion, you think, it
18 came from the pathologist that the issue
19 having been that there was a issue with poor
20 fixation and the slide not being in very good
21 condition?
22 DR. LAING:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. Okay, and if we could go back then please to

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1 page--sorry, P-1384, page two, and you'll
2 recall the numbers being 20 and two, and this
3 is from that same panel meeting, October 27th.
4 DR. LAING:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. So this is the patient here. Recommendation
8 was two samples were sent to Mount Sinai and
9 results were different, and I believe it was
10 your name taken out here.
11 DR. LAING:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. "Dr. Laing to communicate this information to
15 patient and asked Heather Predham to be
16 present." And Doctor, why would you ask Ms.
17 Predham to be present for that meeting?
18 DR. LAING:
19 A. She subsequently was not present. I disclosed
20 this to the patient and her family on my own.
21 Initially, if there was--I was concerned that
22 there may be some questions as to why there
23 was two samples, but once we sorted out the
24 reason, I didn't feel it was necessary for
25 anybody from Quality to be involved, and so I

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1 disclosed this myself to the patient and her
2 family, and explained the reason and explained
3 that given this information, that I would
4 recommend at this time, based on the
5 discussion at the panel, that we would offer
6 this lady hormonal therapy, and indeed she
7 subsequently was started on Tamoxifen and
8 continues on it to date, and is doing well.
9 CHAYTOR, Q.C.:
10 Q. Okay. Under what circumstances would you ask
11 somebody from quality to be involved in a
12 meeting with a patient?
13 DR. LAING:
14 A. The only circumstances that I can recall were
15 when we subsequently had the issues--we didn't
16 have someone from quality, but we had someone
17 from Eastern Health who ended up being Nancy
18 Parsons with us, and that's when we had to
19 disclose to the patients who had a different
20 diagnosis.
21 CHAYTOR, Q.C.:
22 Q. And I guess I was just trying to figure why
23 this patient, why it would have occurred to
24 you to even ask Ms. Predham what would the
25 circumstance be why you would ask Ms. Predham

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1 to be present?
2 DR. LAING:
3 A. Because of the issue of two different
4 specimens having gone and then when we
5 realized the reason why two different
6 specimens went, then you know, when we could
7 track back and see that one was one that I had
8 requested and one was one that had been
9 requested in the review, I felt comfortable
10 with explaining that and disclosing that on my
11 own to the patient and her family.
12 CHAYTOR, Q.C.:
13 Q. Okay. So you had requested a consult and this
14 person was already in the queue for retesting?
15 DR. LAING:
16 A. Exactly right. Exactly right.
17 CHAYTOR, Q.C.:
18 Q. And there was no cross checking, I guess,
19 before those went off -
20 DR. LAING:
21 A. No, and it was a very short period of time
22 before this that I had disclosed to this
23 patient that her results hadn't changed, and
24 then it was so shortly after that -
25 CHAYTOR, Q.C.:

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1 Q. And then you had to get her back in and tell
2 her otherwise?
3 DR. LAING:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. Okay. Doctor, now on this occasion, October
7 27th, I believe there's about 23 patients
8 which were panelled with a variety of
9 different outcomes. On that particular
10 patient actually, it doesn't say that the
11 panel recommended that she now have Tamoxifen,
12 but that's your recollection on her, that it
13 was recommended by the panel that she be
14 started on Tamoxifen?
15 DR. LAING:
16 A. Yes, and that's indeed what has happened.
17 CHAYTOR, Q.C.:
18 Q. Okay. So not only did the panel look at this
19 issue regarding her two different results, a
20 determination was made as to her course of
21 treatment?
22 DR. LAING:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. Doctor, do you know whether or not that

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1 particular patient would be included in the
2 117?
3 DR. LAING:
4 A. I would imagine that she was, but again, I
5 would--she would belong there. Whether she is
6 or not, I'm not certain.
7 CHAYTOR, Q.C.:
8 Q. Do you know whether or not she received a
9 panel letter?
10 DR. LAING:
11 A. I believe there was a panel letter, yes. But
12 again, I can't tell you 100 percent, but I'm
13 fairly sure that there was.
14 CHAYTOR, Q.C.:
15 Q. Okay, and Doctor, then the meeting adjourned
16 at 6:45 p.m. and you've signed off and Ms.
17 Parsons have signed off. If we could look
18 then next, please, at 2558? Your next panel
19 meeting is actually November 3rd, but I don't
20 believe you were present at that one. It was
21 chaired by Dr. McCarthy. The next one after
22 that is November 10th, 2005, and this appears
23 to be a teleconference meeting and on that
24 occasion, it's yourself, Ms. Predham, Ms.
25 Parsons, Dr. McCarthy and Doctors Carter and

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1 Cook present, and there's only three charts
2 reviewed. First of all, I'm just wondering
3 how did this work, in terms of doing this by
4 way of a teleconference? Who would actually
5 have the chart material in this circumstance?
6 DR. LAING:
7 A. One of the oncologists would have had the
8 chart material.
9 CHAYTOR, Q.C.:
10 Q. So was it that you and Dr. McCarthy--is it
11 teleconference, so all the people from the
12 Health Sciences site are sat down, or Cancer
13 Centre are sat down together and who's joining
14 by teleconference?
15 DR. LAING:
16 A. I'm not certain, because it's not indicated
17 where people were, but the ones that we did,
18 the people that would have been at the Cancer
19 site would have been together and people would
20 have called in, perhaps from their offices or
21 other places, but -
22 THE COMMISSIONER:
23 Q. It's not a long way to go.
24 DR. LAING:
25 A. Sorry?

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1 THE COMMISSIONER:
2 Q. Why would you have a teleconference with
3 people--I mean, I can see it if they're out of
4 town, but why would you have a teleconference
5 from somebody in the Health Science and the
6 Cancer Centre?
7 DR. LAING:
8 A. No, they were at St. Clare's.
9 THE COMMISSIONER:
10 Q. So the ten minutes across town is a problem?
11 Just, I'm--I just--teleconferencing, is that
12 regularly used between St. Clare's and Health
13 Science?
14 DR. LAING:
15 A. Yes, all of our tumour board rounds are done
16 by -
17 THE COMMISSIONER:
18 Q. Are done by teleconference?
19 DR. LAING:
20 A. - video conference, yeah, for the whole
21 province actually.
22 CHAYTOR, Q.C.:
23 Q. Yes, well you link in people outside the city
24 that way.
25 DR. LAING:

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1 A. And the people at St. Clare's.
2 THE COMMISSIONER:
3 Q. I understand that if you're linking people
4 from outside. I just found it interesting
5 that you would--you use it so much between St.
6 Clare's and across town.
7 DR. LAING:
8 A. Yes, yeah, and the reason is because for the
9 physicians to come across town, it--you know,
10 they have -
11 THE COMMISSIONER:
12 Q. Take ten minutes.
13 DR. LAING:
14 A. They feel that--the issue is that if somebody
15 needs to attend tumour board rounds and
16 they're the physician that's responsible that
17 day for frozen section and that sort of thing
18 at St. Clare's, they have to be on site. If
19 it's the radiologist who's responsible for
20 something within radiology, they have to be
21 within their department. So it allows the
22 people to be available for their other work
23 that they need to do, but still be able to
24 participate in the rounds. So there's--that's
25 why the St. Clare's site is often mixed in

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1 this way via video.
2 CHAYTOR, Q.C.:
3 Q. So if you're not on call or not responsible
4 for those things, then you show you, you don't
5 do it by teleconference?
6 DR. LAING:
7 A. No, the St. Clare's people most often will do
8 theirs from --
9 CHAYTOR, Q.C.:
10 Q. Regardless if they're on --
11 DR. LAING:
12 A. But they can--when we do it--this is a little
13 bit difference this teleconference meeting.
14 When we do it via video, everything that's up
15 on the screen in the room can be viewed by
16 everybody. So that if somebody is doing this
17 and they're in St. Clare's, they on the screen
18 can see--there's different things you can put
19 on the screen, you can put in the people in
20 the room in St. John's, you can put up the CT
21 scan, you can put up the progress note, so
22 they're able to see the same things in the
23 room when we do it now as somebody who's
24 actually physically in the room. The
25 technology today allows that to happen.

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1 CHAYTOR, Q.C.:
2 Q. And, Doctor, I'm sorry is --
3 THE COMMISSIONER:
4 Q. I think the original question is who would
5 have the charts?
6 DR. LAING:
7 A. We would at the Cancer Centre.
8 CHAYTOR, Q.C.:
9 Q. You would have the charts.
10 DR. LAING:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. Whoever is at the Cancer Centre. So this is
14 done, though, teleconference, this is not a
15 video conference?
16 DR. LAING:
17 A. No, this is not a video conference.
18 CHAYTOR, Q.C.:
19 Q. And the reason that it says for that is
20 because there's only three charts to review.
21 Doctor, what difference would it make how many
22 charts there are to review in terms of how you
23 go about the work of the panel?
24 DR. LAING:
25 A. All I can think that it was that we didn't

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1 feel it would be as long meetings as the other
2 ones, it allowed the people who were at their
3 respective work sites to stay there, and we,
4 you know, had a discussion that--you know,
5 looking back, I can't think was different than
6 if we had all been in the same room. If I had
7 presented the medical data and there had been
8 a question, it would have been addressed. If
9 I had asked for some pathology, I would have
10 been told that verbally.
11 CHAYTOR, Q.C.:
12 Q. Okay, and Doctor, the other question I had
13 about this particular day, it indicates here
14 that the letters--note, these letters were
15 delayed in getting signed. Letters are dated
16 December 18th, and this took place on November
17 10th, 2005. Do you remember the reason for
18 the delay in getting these letters out and the
19 delay being over a month?
20 DR. LAING:
21 A. I believe it was because I was away for some
22 time during that period.
23 CHAYTOR, Q.C.:
24 Q. And so nobody else could sign the letters in
25 your absence?

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1 DR. LAING:
2 A. I don't believe anybody else was asked to, and
3 when I got back and it came to my attention
4 that they were there to be signed, I signed
5 them.
6 THE COMMISSIONER:
7 Q. Before we leave this exhibit, Dr. Laing, I
8 noticed that present for that meeting one way
9 or another, however, you were--would be you
10 and Dr. McCarthy, Dr. Carter, Ms. Predham, Dr.
11 Cook, and then Ms. Parsons. I understood from
12 your earlier evidence that Dr. Cook would not
13 participate in the discussion regarding what
14 treatment, if any changes might be suggested?
15 DR. LAING:
16 A. Right.
17 THE COMMISSIONER:
18 Q. I presume Ms. Parsons would not?
19 DR. LAING:
20 A. That's correct.
21 THE COMMISSIONER:
22 Q. I presume Ms. Predham would not?
23 DR. LAING:
24 A. Yes.
25 THE COMMISSIONER:

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1 Q. Would Dr. Carter?
2 DR. LAING:
3 A. No, she wouldn't make treatment
4 recommendations.
5 THE COMMISSIONER:
6 Q. Okay, so in this case it's really you and Dr.
7 McCarthy who are the members of the committee
8 who are considering treatment?
9 DR. LAING:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. And then continues on, and it discusses the
13 patient that I--and I believe it to be the
14 same patient that we spoke about this morning
15 about the decision of no letter to be sent.
16 This patient was reviewed again following her
17 inquiry to the information line inquiring
18 whether or not her sample was sent for
19 retesting and if the results were received.
20 At the time of the patient's initial review by
21 the panel it was recommended that a letter not
22 be sent because this lady had refused
23 treatment with Tamoxifen when diagnosed, and
24 she had a low risk tumour.
25 DR. LAING:

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1 A. Uh-hm.
2 CHAYTOR, Q.C.:
3 Q. "The panel now agreed that a letter should go
4 to her family physician with the
5 recommendation that she not be offered
6 treatment with Tamoxifen at this time because
7 of her low risk tumour".
8 DR. LAING:
9 A. Right.
10 CHAYTOR, Q.C.:
11 Q. And Dr. so and so will also be requested to
12 communicate to the patient the results
13 received from Mount Sinai Hospital.
14 DR. LAING:
15 A. Okay.
16 CHAYTOR, Q.C.:
17 Q. So, Doctor, it appears that the reason that
18 she was reconsidered for a letter to be sent
19 was because she had made contact and made
20 inquiries as to her situation.
21 DR. LAING:
22 A. Okay.
23 CHAYTOR, Q.C.:
24 Q. Do you recall the discussion around that?
25 DR. LAING:

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1 A. No.
2 CHAYTOR, Q.C.:
3 Q. And this again indicates that the meeting was
4 November 10th '05 with the letters going
5 December 18th '05. If we could have, please,
6 C-0229, and it's page 10, please, Registrar.
7 This is one of the letters, Doctor, that went
8 out on December 18th, 2005, regarding one of
9 those three patients, and you'll see here that
10 it indicates that a physician review panel
11 recently discussed this patient, and we
12 understand--and this is a gentleman, "This
13 gentleman has been informed of the above
14 results and treated appropriately". Then if
15 we could look at--actually, I'll do that the
16 next page, another one of those letters,
17 December 18th, "A physician review panel
18 recently discussed this patient". Doctor, if
19 we just compare that to your normal form of
20 letter that I took you through before the
21 lunch break --
22 DR. LAING:
23 A. Uh-hm.
24 CHAYTOR, Q.C.:
25 Q. "The patient was discussed at the physician

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1 review panel on November 3rd, 2005", and then
2 on page eight is another sample where the date
3 of the panel, and I would suggest to you that
4 your normal form in terms of inserting the
5 date of the panel meeting was included on the
6 vast majority--if not all of your patient
7 letters, certainly the vast majority, except
8 for the December 18th letters, 2005, which
9 were delayed in being sent out, and the fact
10 that the physician review panel had meet some
11 five weeks before, the date is not recorded.
12 Is there any reason for that?
13 DR. LAING:
14 A. No. No, it wouldn't have been because we
15 didn't want to indicate when it was met. It
16 may have been because I knew they were from a
17 previous panel, and I may not have known
18 exactly what that date was, but --
19 CHAYTOR, Q.C.:
20 Q. But all three of those patients weren't from -
21 those three patients weren't from a previous
22 panel, there was the last person that I
23 referred you to.
24 DR. LAING:
25 A. But they were from a panel from the previous

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1 time in November, is that correct?
2 CHAYTOR, Q.C.:
3 Q. Yes, these were panelled on November 10th.
4 DR. LAING:
5 A. Right.
6 CHAYTOR, Q.C.:
7 Q. But the date is not indicated.
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. It's some five weeks later.
12 DR. LAING:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. And would you agree with me that it would be
16 important for the treating physicians to know
17 that your recommendation is based on
18 information that you had available to you some
19 five weeks earlier?
20 DR. LAING:
21 A. Yes, I say recently, but you're correct, the
22 date had been indicated on that, but there was
23 no particular reason at that time why the date
24 would have been left out. Certainly, you know
25 in retrospect, I would agree that we should

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1 have put what the date was, but it certainly
2 wouldn't have been something that was
3 consciously left out for any reason.
4 THE COMMISSIONER:
5 Q. Dr. Laing, I was assuming that you didn't
6 actually draft each and every one of those
7 letters, did you?
8 DR. LAING:
9 A. No, they were--they were sent over to me for
10 signature.
11 THE COMMISSIONER:
12 Q. They were a form letter that somebody would
13 have done on your behalf?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. So in this particular case, Ms. Parsons, or --
18 DR. LAING:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. Was drafting the letters, I understood?
22 DR. LAING:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. And she would have used her notes from the

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1 panel meeting?
2 DR. LAING:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. And she would, I would think, have the date
6 readily available to her?
7 DR. LAING:
8 A. Yes. I'm just trying to explain to you that I
9 don't know why it doesn't say the date. It
10 says recently, and as I said, there was no
11 conscious decision on my part to change the
12 date or to leave it out, or anything like that
13 to happen. So I--that's all I can explain to
14 you.
15 CHAYTOR, Q.C.:
16 Q. Okay. If we could have, please, P-2560. This
17 is the next meeting of November 17th, 2005,
18 and you are chairing this meeting, and there's
19 a number of those patients that appeared to
20 have--I'll just take you to the second page of
21 the exhibit. A number of these patients
22 appear to have already met with their
23 physician. For example, the first one here,
24 "No recommendation from the panel as this
25 patient has already been informed of results

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1 and treated appropriately", and again the next
2 patient, no recommendation again. The third
3 one on that page, "Because they've already
4 been informed and treated appropriately". So
5 certainly those three patients. Then on the
6 next page, "No recommendation from the panel
7 as this patient has already been informed of
8 the results and treated appropriately", and
9 again the same for the next patient, and again
10 for the patient, the fourth one down. So
11 there's a number of patients on this
12 particular day which appears have already been
13 seen by you or the treating oncologist and
14 given their results, and those patients,
15 however, were panelled and it was deemed--and
16 you've told us about the reasons why that
17 happened.
18 DR. LAING:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. If we could have, please, P-0684. This is an
22 e-mail from Ms. Predham to Dr. Williams, and
23 it's copied to Dr. Cook, Pam Elliott, and
24 Patricia Pilgrim, and she writes, "As you
25 requested, here's an update on ER/PR. There

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1 hasn't been much activity other than getting
2 two more converted results back. Dr. Kwan
3 made a suggestion at the last panel that I
4 should track those we may have potentially
5 harmed. We had agreed to classify patients as
6 being converted with or without
7 recommendations, but Dr. Kwan, and rightly so,
8 felt it didn't accurately reflect those who
9 have been impacted. For example, if the
10 person was initially diagnosed with breast
11 cancer in the left breast and was ER/PR
12 negative, and then had metastases to the right
13 breast which was ER/PR positive, the patient
14 would be then treated with Tamoxifen. So when
15 we panelled the person after their first
16 results converted, the panel would have no
17 recommendations, but there has been a
18 potential impact. At the last panel meeting,
19 of the 17 panelled, there were seven patients
20 that potentially negatively impacted. I will
21 have to review all the patients panelled, but
22 I'll try to have this complete information for
23 you next week. If you have any questions,
24 call me. Heather". Doctor, was this
25 suggestion by Dr. Kwan bought to your

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1 attention, as chair of the panel or otherwise?
2 DR. LAING:
3 A. I've never seen this particular correspondence
4 before. We certainly have had discussions
5 about how patients have been impacted, and,
6 you know, we talked this morning about all the
7 different possibilities that could arise, but
8 certainly that would be a very subjective
9 interpretation of how an individual patient
10 would be impacted or not. I don't particular
11 follow the example that's outlined in this e-
12 mail, if somebody presents with a cancer of
13 the left breast, and then subsequently
14 develops a cancer in the right breast --
15 CHAYTOR, Q.C.:
16 Q. Well this says it's a metastasis, though, to
17 the right breast as opposed to a new cancer.
18 DR. LAING:
19 A. Right. Then that would be unusual, but
20 certainly can occur.
21 CHAYTOR, Q.C.:
22 Q. And I guess could be a metastasis anywhere.
23 So do you follow the example if you just think
24 about the person has a metastasis, they're now
25 being treated for their metastasis and that's

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1 why they're on Tamoxifen or whatever other
2 anti-hormonal treatment is appropriate at that
3 stage?
4 DR. LAING:
5 A. Right, yeah. So the only way that they could
6 go from--that their metastasis could be
7 treated with Tamoxifen as if there was new
8 information about that metastatic disease that
9 told you it was ER/PR positive. So this may
10 have been somebody, for example, who was
11 initially diagnosed and considered to be
12 negative, then had a recurrence, and then had
13 that recurrence biopsied and that was shown to
14 be positive, then would have started on
15 Tamoxifen.
16 CHAYTOR, Q.C.:
17 Q. Yes.
18 DR. LAING:
19 A. And as I explained previously, that most
20 patients who recur, we don't go back and re-
21 biopsy the recurrent disease unless it's
22 somewhere that's quite accessible like a chest
23 wall or a lymph node. And the only reason I
24 raised the issue about the fact that it was to
25 the breast is that when we see people who have

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1 had cancer on one side and then they present
2 with an abnormality in the opposite breast, it
3 is difficult sometimes to know for certain if
4 that's a metastatic deposit versus a new
5 primary, but we would treat that as a new
6 primary. You know, it would depend on how it
7 presented. If it was nodules on top of the
8 breast, then that would be in keeping with a
9 metastatic picture, but if it was actually
10 someone who through follow-up of one breast
11 cancer was found to have a lump in the breast
12 and we take that out and we look at it, we
13 often look at the pathology of those two
14 cancers to try and determine if it looks like
15 metastatic disease or it looks like a new
16 primary. And if we're not certain, we always
17 give the patient the benefit of the doubt and
18 treat that as a new primary. So that's the
19 only reason I--you know, that this issue comes
20 up. But in terms of that, then, yes, I mean,
21 this would be someone who would have been
22 impacted because you'd have to wonder then was
23 the initial ER/PR test result an incorrect
24 one, was this somebody who was perhaps
25 diagnosed in 1997 and had, you know, 15, 20

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1 percent staining, which would have been
2 treated as negative and now comes back to us
3 in 2005 and we would look at that as being
4 positive in this day in age and we would treat
5 that person. So, you know, it would depend on
6 the clinical context in which this was being
7 made. I think what this was getting at, and
8 my recollections in terms of having
9 discussions with Dr. Kwan about this issue
10 would be, you know, and I've said this this
11 morning, that the people that we think about
12 being greatly impacted, of course, are those
13 patients who have developed metastatic disease
14 in the interim and always that wonder if they
15 had received the hormonal therapy initially
16 could that have been prevented.
17 CHAYTOR, Q.C.:
18 Q. Yes. And so you do recall Dr. Kwan bringing
19 this up at the Panel meeting?
20 DR. LAING:
21 A. I'm not sure if it was at the Panel meeting,
22 but -
23 CHAYTOR, Q.C.:
24 Q. Or discussing it with you in some context?
25 DR. LAING:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. And Ms. Predham writes this only a few days
4 after the Panel meeting and she's suggesting
5 that it, in fact, came up at the Panel
6 meeting. So, and the idea of tracking those
7 who could be impacted, when he discussed that
8 with you, what did you think about the idea?
9 DR. LAING:
10 A. We felt that, you know, there are several
11 categories of patients that have been
12 impacted. And you know, you could put
13 somebody in a category of having gone on to
14 develop metastatic disease; you could put
15 someone into a category of having delayed
16 adjuvant therapy but not recurred yet; you
17 could put people into the category of low-risk
18 disease and even though the results changed,
19 it didn't change their treatment. So there's
20 all sorts of different categories in which you
21 could place patients. So, you know, I agree
22 that there were people who, if you look at it
23 from the clinical point of view, you could
24 categorize as to be affected from one way or
25 the other. But I do that with caution because

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1 I don't want to make it sound as if, you know,
2 even the person that was retested whose
3 results didn't change, that this didn't mean
4 anything. It certainly would have had an
5 impact on all those people involved.
6 CHAYTOR, Q.C.:
7 Q. Yes. These are, and it's worded as being a
8 potential impact, obviously.
9 DR. LAING:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. And the example that's given, it's in terms of
13 there having been some change or progression
14 in the person's disease. So at the end of the
15 day I just--did you agree that this would be a
16 worthwhile exercise or not and do you know
17 whether or not, in fact, it was carried out,
18 that Dr. Kwan's suggestion to try and track
19 those people, do you know whether or not that
20 actually happened?
21 DR. LAING:
22 A. I don't know.
23 CHAYTOR, Q.C.:
24 Q. Was it done by the Panel?
25 DR. LAING:

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1 A. No.
2 CHAYTOR, Q.C.:
3 Q. The Panel didn't do it?
4 DR. LAING:
5 A. No, no.
6 CHAYTOR, Q.C.:
7 Q. And you don't know whether or not anyone else
8 in Eastern Health then decided to track those
9 who could have been potentially impacted in
10 terms of either metastatic disease,
11 progression of their disease?
12 DR. LAING:
13 A. The only, I mean, the next time we had
14 discussions around this issue was when we were
15 looking at trying to come up with a number of
16 patients who had been affected, and that was
17 into the fall of 2006.
18 CHAYTOR, Q.C.:
19 Q. Okay. And so you were involved at that point
20 in time in trying to determine that?
21 DR. LAING:
22 A. I didn't sit down and tally up the numbers,
23 but, yes, I was very much involved in the
24 discussion of how we would identify those
25 people who had been impacted. And we wanted

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1 to include not just this cohort of people, ie,
2 the people who had developed metastatic
3 disease in the interim, but also the people
4 who the Panel felt that should be offered
5 hormonal treatment whether it was delayed in
6 the adjuvant setting or whether it was for
7 metastatic disease or for whatever reason.
8 CHAYTOR, Q.C.:
9 Q. So that was in the fall of '06 when you're
10 coming up with the number to be presented at
11 the--number to be presented to the minister,
12 minister of health, Minister Osborne at the
13 time -
14 DR. LAING:
15 A. Right, so into November of 2006.
16 CHAYTOR, Q.C.:
17 Q. - and then ultimately to the public?
18 DR. LAING:
19 A. That's correct.
20 CHAYTOR, Q.C.:
21 Q. So that's the November, 2006?
22 DR. LAING:
23 A. Yeah.
24 CHAYTOR, Q.C.:
25 Q. So you were involved in coming up with those

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1 numbers and looking at the patients to be able
2 to determine who should go in that list?
3 DR. LAING:
4 A. I didn't look at the patients to determine who
5 should go in that list, no.
6 CHAYTOR, Q.C.:
7 Q. But you were consulted as to who should be in
8 the various categories that went forward?
9 DR. LAING:
10 A. We didn't categorize people other than whether
11 or not the Panel recommended a treatment
12 change.
13 CHAYTOR, Q.C.:
14 Q. So what was it that you were involved in in
15 the fall, then?
16 DR. LAING:
17 A. As we prepared for the media briefing one of
18 the issues that came up time and time again
19 was an issue related to a conversion rate.
20 CHAYTOR, Q.C.:
21 Q. I thought that you were involved somehow in
22 looking at who may have been impacted in
23 coming up with the numbers in the fall of '06?
24 DR. LAING:
25 A. That was related to the issue of wanting--

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1 there was a lot of, I guess, interest, if you
2 will, from the media about looking at what
3 they were calling a conversion rate.
4 CHAYTOR, Q.C.:
5 Q. Yes, and I'm going to take you through all
6 that. But, Doctor, what I'm wondering is what
7 you meant when you said you were involved in
8 looking at those -
9 DR. LAING:
10 A. That's what I meant.
11 CHAYTOR, Q.C.:
12 Q. - who were impacted.
13 DR. LAING:
14 A. My argument at the time was that I felt it was
15 very difficult to come up with a conversion
16 rate because you'd have to consider very
17 carefully what you would include as your
18 numerator and your denominator so that we felt
19 that the number from a clinical point of view
20 and those of us--and this was something that
21 we did discuss amongst the physicians involved
22 in this issue would be the number of patients
23 who required a change in their therapy because
24 of this, so either they were recommended to
25 have Tamoxifen or hormonal therapy for

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1 metastatic disease, whether they were meant to
2 have late start of hormonal therapy, and that
3 was how the numbers got broken down based on
4 that. So there was a certain number of people
5 who had already been on hormonal therapy,
6 there were a certain number of people who had
7 low-risk disease that although this
8 information about their actual numbers had
9 changed, they had very good prognosis and it
10 wasn't felt that they needed to have hormonal
11 therapy.
12 CHAYTOR, Q.C.:
13 Q. So those who were already on anti-hormonal
14 therapy because they had metastatic disease
15 prior to the retesting taking place -
16 DR. LAING:
17 A. Not because they had metastatic disease. The
18 people that were PR positive.
19 CHAYTOR, Q.C.:
20 Q. Okay. Those who were already on anti-hormonal
21 therapy because there had been--because
22 they're now being treated for either disease
23 progression or metastatic disease prior to the
24 retest, they weren't included because they
25 didn't have a change in treatment, there was

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1 no change in treatment required?
2 DR. LAING:
3 A. I'm not sure that I'm following you.
4 CHAYTOR, Q.C.:
5 Q. Okay. So are you saying there was no category
6 of people who were on anti-hormonal treatment
7 because of metastatic disease?
8 DR. LAING:
9 A. Prior to?
10 CHAYTOR, Q.C.:
11 Q. Prior to the retesting.
12 DR. LAING:
13 A. But if they were on hormonal therapy -
14 THE COMMISSIONER:
15 Q. The distinction, Dr. Laing, is between those
16 who may have, as I understand it as being put
17 to you, there are those patients who because
18 of a PR result early in the game might have
19 been given hormonal treatment?
20 DR. LAING:
21 A. Yes.
22 THE COMMISSIONER:
23 Q. Say in 1999?
24 DR. LAING:
25 A. Yes.

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1 THE COMMISSIONER:
2 Q. Then in 2005 you're doing retests. Well,
3 there would also be a group who, for a reason
4 such as a metastasis.
5 DR. LAING:
6 A. Right.
7 THE COMMISSIONER:
8 Q. In, say, 2000 would have been placed on
9 hormonal treatment.
10 DR. LAING:
11 A. And what I'm -
12 THE COMMISSIONER:
13 Q. The question is how were they categorized?
14 DR. LAING:
15 A. Okay. And I guess my first point is is that
16 if someone was ER/PR negative and they
17 developed metastatic disease, the only reason
18 that they would have been put on hormonal
19 therapy would be if there was new information
20 at that time that their metastatic disease was
21 diagnosed that would have necessitated them
22 going on hormonal therapy.
23 CHAYTOR, Q.C.:
24 Q. Such as a positive ER test?
25 DR. LAING:

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1 A. On a metastatic deposit.
2 CHAYTOR, Q.C.:
3 Q. Yes.
4 DR. LAING:
5 A. Yes, absolutely. I don't know how they were
6 categorized in this. I'm just trying to think
7 -
8 CHAYTOR, Q.C.:
9 Q. So you don't know whether or not those people,
10 if there were, and we've been told that there
11 were, I think the number is 13 of those
12 people, whether or not those people who were
13 on anti-hormonal therapy for their metastatic
14 disease, because they'd in the interim, in the
15 interval, developed metastatic disease and for
16 whatever reason were treated with anti-
17 hormonal therapy.
18 DR. LAING:
19 A. Okay.
20 CHAYTOR, Q.C.:
21 Q. Whether they were included in what you looked
22 at in the fall of 2006 to determine who had
23 been impacted?
24 DR. LAING:
25 A. Would these patients have been panelled?

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1 CHAYTOR, Q.C.:
2 Q. Yes. I would assume. If they originally had
3 an ER negative, wouldn't they have been
4 panelled?
5 DR. LAING:
6 A. Yes, so they would have been panelled. So
7 then there would have been something in the
8 letter that said, you know, that they had been
9 previously treated with Tamoxifen or
10 previously -
11 CHAYTOR, Q.C.:
12 Q. So no treatment change required, no
13 recommendation.
14 DR. LAING:
15 A. Then, yes. Okay, now I know where--yes, so
16 they may have been--that may have been in the
17 body of the letter. And if whoever was
18 tallying it up looked at that, you're asking
19 me do I know for sure if those people were
20 included or excluded, and my answer is, no, I
21 don't know for certain.
22 CHAYTOR, Q.C.:
23 Q. Okay. And I guess -
24 THE COMMISSIONER:
25 Q. Then do I take it then it's the same answer,

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1 really, for those who might have two weeks
2 before been put on hormonal treatment because
3 you happened to see them in your clinic?
4 DR. LAING:
5 A. Yes, because in those letters, and we've
6 looked at some of those, it would say
7 something like this person has already been
8 seen by Dr. So and So and has started on
9 Tamoxifen and the Panel doesn't recommend any
10 more--the Panel doesn't have anything else to
11 offer at this time.
12 THE COMMISSIONER:
13 Q. So not having been the person who did the
14 tallying, you don't know if any of those were-
15 -how, if any--how they would have been treated
16 in the numbers?
17 DR. LAING:
18 A. That's right, that's right, I don't know how
19 they were treated in the numbers.
20 CHAYTOR, Q.C.:
21 Q. And did you communicate to anyone, don't just
22 rely on the letters, because, remember, that's
23 how we dealt with those being, said no
24 recommendation for any change in treatment but
25 remember, there's these other people who, in

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1 fact, may have been impacted or I probably
2 dealt with them and already had them on their
3 treatment, did you communicate with anyone to
4 make sure that they were included in the
5 numbers of people who had been impacted?
6 DR. LAING:
7 A. No, because it wasn't until this last couple
8 of weeks in going back and looking through
9 this that this issue has been raised to me
10 that perhaps they weren't captured in that
11 number. But I don't if they were or if they
12 weren't.
13 CHAYTOR, Q.C.:
14 Q. So your involvement when you said that in the
15 fall of 2006 that you looked at the issue of
16 who was impacted -
17 DR. LAING:
18 A. It was for us to say that we felt that it
19 should be the people whose treatment changed
20 as a result of this new information.
21 CHAYTOR, Q.C.:
22 Q. If we can just go back to 0684, here? So I
23 take it from what you're telling me Dr. Kwan's
24 suggestion at the time, while it was raised at
25 the Panel, was not pursued by the Panel in

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1 terms of categorizing or trying to capture who
2 had been potentially impacted, that wasn't
3 pursued by the Panel, his suggestion?
4 DR. LAING:
5 A. Not in the way that it's there, no.
6 CHAYTOR, Q.C.:
7 Q. Well, in any way, was there any trying to
8 capture those who had been potentially
9 impacted, was that done by the Panel?
10 DR. LAING:
11 A. No.
12 CHAYTOR, Q.C.:
13 Q. Was it done by anyone else in Eastern Health,
14 to your knowledge?
15 DR. LAING:
16 A. No.
17 THE COMMISSIONER:
18 Q. Would you have been able to do that within
19 Eastern Health without the knowledge and
20 cooperation of those in the Cancer Centre? It
21 would seem to me the critical information
22 would have come out of the Cancer Centre.
23 DR. LAING:
24 A. It's, you know, again, Commissioner, I go back
25 to this issue of trying to categorize these

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1 patients into what degree of impact -
2 THE COMMISSIONER:
3 Q. Oh, no, no, I meant--I think you misunderstand
4 my question. As I understand it you're saying
5 I don't know if anybody did, followed up on
6 Dr. Kwan's suggestion?
7 DR. LAING:
8 A. Right.
9 THE COMMISSIONER:
10 Q. My response is if anybody had tried to follow-
11 up on Dr. Kwan's suggestion, would they not
12 have had to go to the people at the Cancer
13 Centre and probably those were are treating
14 these patients to be able to do that, in any
15 event?
16 DR. LAING:
17 A. Yes. In fact -
18 THE COMMISSIONER:
19 Q. I don't see how it could have been done
20 without them knowing it, I suppose, is what
21 I'm saying.
22 DR. LAING:
23 A. You know, when we talked recently, even just
24 this last year, in 2008, when we had some
25 discussions about the database that the

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1 Newfoundland and Labrador Centre for Health
2 Information has put together and when we
3 looked at sort of following down through with
4 that, one of the comments that the physicians
5 involved in those meetings made were, you
6 know, at the end of the day you really have to
7 go back to the patient's chart and to see what
8 eventually unfolded. So, you know, you have a
9 Panel letter that recommended a treatment
10 change which we felt was significant and then
11 it would be helpful to know if, at the end of
12 the day, did the patients go on therapy, did
13 they stay on therapy, has their cancer
14 recurred or not at this point. And I think to
15 get the full sort of end of the story, if you
16 will, then that's the kind of data collection
17 and forward collection of this information
18 that one would eventually need. So I guess
19 what I'm trying to say is that, you know, to
20 really categorize people as to who was
21 impacted or not, then I think you would have
22 needed to have clinicians to sit down and look
23 at those and say, you know, this is how this
24 person was impacted, this is how this person
25 was impacted. And it's difficult to

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1 categorize people. You know, you could put
2 someone in a broad category of develop
3 metastatic disease, didn't, that would be one
4 category. But then you could look and say,
5 well, when did they develop the metastatic
6 disease, because certainly there are people
7 who have developed metastatic disease since
8 this whole process has happened that were
9 involved here. So it depends on when you take
10 that snapshot. So if you were to take that
11 snapshot in the fall of 2006, unfortunately
12 because of the nature of this disease, there
13 are people that were involved in this
14 retesting who have subsequently developed
15 metastatic disease. So where do you put them,
16 in what category do you put those in as being
17 impacted? Did they move then from the
18 category of delayed adjuvant therapy into now
19 has developed metastatic disease? That's the
20 difficulty with looking at this.
21 CHAYTOR, Q.C.:
22 Q. Doctor, it says here that Ms. Predham was
23 going to review all the patients panelled and
24 she was going to try to have this complete for
25 Dr. Williams' information and the others that

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1 she copied it to, I presume, for next week.
2 Did you ever seen any such information or was
3 this ever raised with you?
4 DR. LAING:
5 A. No.
6 CHAYTOR, Q.C.:
7 Q. She also writes in her e-mail that "At the
8 last Panel meeting out of the 17 panelled
9 there were seven patients that were
10 potentially negatively impacted."
11 DR. LAING:
12 A. Um-hm.
13 CHAYTOR, Q.C.:
14 Q. And if we just go back, the last patient
15 meeting would have been the November 17th
16 meeting?
17 DR. LAING:
18 A. That's right.
19 CHAYTOR, Q.C.:
20 Q. Which I believe is 2560? And you chaired this
21 meeting?
22 DR. LAING:
23 A. Um-hm.
24 CHAYTOR, Q.C.:
25 Q. And by looking at those, just scroll down

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1 through, are you able to identify--first of
2 all, did you or anyone at the Panel identify
3 people as you were going, and this issue
4 apparently having come up by Dr. Kwan at the
5 meeting, was there a discussion as to, well
6 this is one that would fit into that category
7 and here's another, was there anything like
8 that done?
9 DR. LAING:
10 A. No.
11 CHAYTOR, Q.C.:
12 Q. At the Panel meeting?
13 DR. LAING:
14 A. No.
15 CHAYTOR, Q.C.:
16 Q. You don't recall any discussion along those
17 lines?
18 DR. LAING:
19 A. No.
20 CHAYTOR, Q.C.:
21 Q. Looking down through it now are you able to
22 identify which seven people Ms. Predham may be
23 referring to?
24 DR. LAING:
25 A. I'll try, but I doubt it because I don't know-

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1 -I have the mouse, is that okay?
2 CHAYTOR, Q.C.:
3 Q. You have the mouse, please go ahead.
4 DR. LAING:
5 A. All right. So the first person it says--so
6 this is just me giving you my best -
7 CHAYTOR, Q.C.:
8 Q. I'm just wondering if you are able to tell
9 just from--I realize it's only brief what's
10 recorded here.
11 DR. LAING:
12 A. Yeah. So if I was to look at this, the first
13 patient I would think that this to me would be
14 someone who has already received Tamoxifen and
15 I could only say that that would be the most
16 likely thing because her PR was 80 percent
17 positive. And then--and it says "No treatment
18 follow-up required as this patient already
19 treated with Tamoxifen." The second one, it
20 says "No recommendation of the Panel as the
21 patient has already been informed of results
22 and treated appropriately." This would be
23 someone that was already notified by their
24 attending oncologist. Whether this person has
25 metastatic disease or is a delayed adjuvant

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1 decision, I can't tell by looking at that.
2 This next person in 2002 who was PR 30 percent
3 positive, this sounds to me like someone who
4 was already on Tamoxifen.
5 CHAYTOR, Q.C.:
6 Q. So in the same category as the first patient?
7 DR. LAING:
8 A. Yeah. So this person, the second person could
9 potentially be one of those people, but only
10 if this was metastatic disease.
11 CHAYTOR, Q.C.:
12 Q. Okay.
13 DR. LAING:
14 A. If that's the criteria that they were using,
15 that's -
16 CHAYTOR, Q.C.:
17 Q. And the next one, the last one on the page.
18 DR. LAING:
19 A. "No treatment follow-up as the patient was
20 already treated with Tamoxifen." Again, I
21 wouldn't know. I don't know if this was maybe
22 somebody in one of those situations that got
23 Tamoxifen for another reason or if this was
24 someone who had already been informed.
25 Usually if the patient--it was because the

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1 patient had already been informed, it would
2 indicate that there.
3 CHAYTOR, Q.C.:
4 Q. Usually your notes show that. So that one
5 could be a potential?
6 DR. LAING:
7 A. Yeah, probably.
8 CHAYTOR, Q.C.:
9 Q. That that person was on, already on Tamoxifen
10 because of some disease progression?
11 DR. LAING:
12 A. Yeah, that something else--no -
13 CHAYTOR, Q.C.:
14 Q. Or metastatic disease?
15 DR. LAING:
16 A. Usually we would say that, though. Let me
17 just keep looking. "No recommendation." See,
18 these are the ones that I would think that
19 maybe the patients had already been informed,
20 the patient has already been informed,the
21 patient has already been--these were the ones
22 that we had a lot of those, the patients has
23 already been informed. "This person was
24 offered treatment because of their high risk
25 of recurrence." In fact, that's the person I

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1 believe we've already referred to.
2 CHAYTOR, Q.C.:
3 Q. Yes.
4 DR. LAING:
5 A. Oh, there she is. Sorry. This one that, you
6 know, you were wondering if there had been a
7 recommendation, well, there it is. DCIS,
8 deceased, already been informed, already
9 informed. Now, this person here, you see,
10 this is somebody that I would say, yes, "This
11 lady should be offered hormonal treatment for
12 here metastatic disease." So this is
13 obviously someone that sometime between here
14 and with the new test results and when we look
15 at it on the Panel, we know that she has
16 developed metastatic disease and it doesn't
17 appear that anybody has communicated that
18 information yet to that patient. Already
19 informed. So I think it would have to be
20 somebody in these already informed group that-
21 -but I can only -
22 CHAYTOR, Q.C.:
23 Q. Because again, the ones that tended to be
24 already informed by you before they got to the
25 Panel, I believe you also indicated for the

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1 most part if they were consults on your part
2 sent away, it was because there was some
3 urgency in their case, such as metastatic
4 disease?
5 DR. LAING:
6 A. That's correct, yeah.
7 CHAYTOR, Q.C.:
8 Q. So that could be amongst -
9 DR. LAING:
10 A. That could be -
11 CHAYTOR, Q.C.:
12 Q. Those could be amongst the seven that she's
13 referring to?
14 DR. LAING:
15 A. Could definitely be amongst those seven.
16 CHAYTOR, Q.C.:
17 Q. Is there anyone else?
18 DR. LAING:
19 A. No. I think someone doesn't have a Cancer
20 Clinic chart and somebody had been -
21 CHAYTOR, Q.C.:
22 Q. And then we have this page, as well.
23 DR. LAING:
24 A. Oh, I'm sorry. Okay, get to the end.
25 Somebody was already treated. I would think

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1 that that person was someone who was already
2 on Tamoxifen. The top one, somebody should be
3 offered Tamoxifen. Looks like it hadn't been
4 done already and she definitely had change,
5 she as positive for both. And the same for
6 the last one.
7 CHAYTOR, Q.C.:
8 Q. So how would Ms. Predham, if it didn't come up
9 for discussion at the meeting, how would Ms.
10 Predham be able a few days later to tell Dr.
11 Williams there were seven such patients
12 discussed out of the 17?
13 DR. LAING:
14 A. Unless she looked at--you know, she would have
15 been present during the discussion, unless she
16 recalled that some of those patients had
17 metastatic disease, I'm not certain.
18 CHAYTOR, Q.C.:
19 Q. Okay. If we could look, please, at P-0125,
20 page 22? This is a document I took you to
21 earlier, Doctor, it's the briefing note which
22 goes to Cabinet Secretariat in August of 2006.
23 And I pointed out to you before the 28
24 patients who may have been in the one to ten
25 mark. There's also, at page 24, a category of

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1 patients on the bottom of the page here,
2 "Eastern Health advised 22 women were impacted
3 by the change in status of the ER/PR receptor
4 test. These women had changes in the progress
5 of their disease from the initial confirmation
6 of the disease and the beginning of their
7 treatment to the retesting done at Mount
8 Sinai. Overall, all of the 939 patients or
9 families of those who have died whose test
10 results were reviewed could potentially become
11 applicants in a class action law suit. The
12 basis of their claims may differ, depending on
13 the criteria established." So this idea that
14 in August, August, 18th, 2006 that there were
15 22 women impacted, were you ever consulted
16 with respect to providing that information to
17 the government?
18 DR. LAING:
19 A. No.
20 CHAYTOR, Q.C.:
21 Q. And are you able to shed any light as to where
22 that information may have come from and from
23 whom--who would have assisted in putting that
24 information together?
25 DR. LAING:

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1 A. I was given copies of some correspondence
2 yesterday that has been entered here as an
3 exhibit that has a dialogue regarding a group
4 of 13 patients and a group of nine patients.
5 I've looked at that and still have a little
6 bit of trouble figuring out what exactly that
7 we're talking about.
8 CHAYTOR, Q.C.:
9 Q. Okay, good, because I'm going to ask you about
10 that. That's dialogue between myself and Mr.
11 Simmons, I believe?
12 DR. LAING:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. Yes.
16 DR. LAING:
17 A. But prior to yesterday, no.
18 CHAYTOR, Q.C.:
19 Q. So you were never consulted on that?
20 DR. LAING:
21 A. No.
22 CHAYTOR, Q.C.:
23 Q. Would you expect for Eastern Health to be able
24 to come up with any such number that you or
25 one of the treating physicians would have had

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1 to have input?
2 DR. LAING:
3 A. I would have rather that, yes.
4 CHAYTOR, Q.C.:
5 Q. Well, would you otherwise question the
6 accuracy of the number without having any
7 treating physician involved?
8 DR. LAING:
9 A. It would depend on how that number was derived
10 and if I could follow the logical of how it
11 was come up with.
12 CHAYTOR, Q.C.:
13 Q. Well, then I'll take you to P-2618, please?
14 And this is what we've been provided in terms
15 of the logic of how it was came up with.
16 DR. LAING:
17 A. Okay.
18 CHAYTOR, Q.C.:
19 Q. And this is the portion, I take it, that
20 you're referring to. We had raised questions
21 as to, well, what--how are the 22 broken down.
22 We're told there was a 13 and a nine and we
23 asked further questions about it.
24 DR. LAING:
25 A. Okay.

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1 CHAYTOR, Q.C.:
2 Q. And the response is, "Heather explains it as
3 follows: The 13 patients were patients who
4 were diagnosed with breast cancer and were
5 considered ER/PR negative. Because of that,
6 Tamoxifen was not in their treatment plan at
7 that time. Upon retesting of that original
8 specimen there was a change which would cause
9 them to be considered positive now. When the
10 Panel reviewed their charts, it was determined
11 that during the time period between the
12 original testing and the retest," and then in
13 bold, "they had been diagnosed with a
14 recurrence/metastasis which was then treated
15 with Tamoxifen, so from a categorizing point
16 of view, they would be in the group with no
17 recommendations. However, it was clear from
18 the conversation at the Panel table that
19 earlier treatment with Tamoxifen may have had
20 an impact." Okay, so first of all if you'd
21 like to speak to that?
22 DR. LAING:
23 A. Okay.
24 CHAYTOR, Q.C.:
25 Q. And any recollections you recall, any

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1 recollection you have of conversations around
2 the Panel table to this effect?
3 DR. LAING:
4 A. I'm not certain as I read this as to whether
5 these were patients who were originally ER/PR
6 negative who through the early days of the
7 retesting were found to be ER/PR positive and
8 who were the ones with metastatic disease that
9 were treated. I'm wondering if that's the 13
10 patients. I'm not--I've never known what that
11 number would be. Remember we talked about,
12 you know, way back last week about patient
13 number one, patient number two, and patient
14 number three, of the first sort of retest that
15 we could identify. There were patients
16 amongst that group who had metastatic disease,
17 and so their retesting was requested to see if
18 they may now be potentially given hormonal
19 therapy. I'm not certain if this group would
20 contain people that between when this process
21 started and when they were reviewed, they had
22 developed metastatic disease sometime between
23 the summer and the fall of 2005 and were
24 started on treatment, but these would be
25 people that we would have talked about this

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1 morning that had not been given adjuvant
2 hormonal therapy based on having a negative
3 ER/PR results and then subsequently have
4 developed metastatic disease. That's how I
5 would understand this group to be.
6 THE COMMISSIONER:
7 Q. With respect to the early people, would you
8 have panelled those?
9 DR. LAING:
10 A. Yes.
11 THE COMMISSIONER:
12 Q. All of the early people? I mean, perhaps--I
13 don't know. This says, "When the panel
14 reviewed their charts".
15 DR. LAING:
16 A. Yes, because we had looked back through that
17 and found that those early people were re-
18 panelled--were panelled, and we discussed the
19 fact that we just looked at their Mount Sinai
20 results and there would have been letters
21 written on them, but they would --
22 THE COMMISSIONER:
23 Q. All of them were panelled? That's the
24 question, all of them were panelled?
25 DR. LAING:

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1 A. My understanding is, yes, they were panelled.
2 I'm trying to wrap my head around this idea of
3 the time period between the original test and
4 the retest, they had had recurrence, which was
5 then treated with Tamoxifen. Does that mean
6 it was then treated with Tamoxifen once we got
7 the new results; that's my understanding, as
8 opposed to being something that happened in
9 between that allowed these people to be
10 treated with Tamoxifen.
11 THE COMMISSIONER:
12 Q. So - wait now, I'm confused, you're reading--
13 is it a question mark in your mind or are you
14 understanding that the thirteen patients
15 referred to here are people who would have
16 been placed on Tamoxifen subsequent to retests
17 at Mount Sinai?
18 DR. LAING:
19 A. I don't know who these 13 people are. I'm
20 trying to sort that through in my mind. So
21 one possibility is that they are people who
22 were negative to begin with, who then were
23 retested, and they had developed metastatic
24 disease at some point, and because of the new
25 test results from Mount Sinai, they were

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1 started on Tamoxifen or other hormonal
2 therapy.
3 THE COMMISSIONER:
4 Q. Okay.
5 DR. LAING:
6 A. Or these some group of people, for whatever
7 reason, were initially said to be negative,
8 then developed metastatic disease through the
9 course of their breast cancer, then were--
10 because of a re-biopsy of a metastatic deposit
11 or something or some reason was made to place
12 them on Tamoxifen, and so by the time this
13 whole retesting and things had happened, these
14 were people that had already had metastatic
15 disease and have already been treated. I
16 can't tell by looking at that which they mean
17 because it says, "which was then treated with
18 Tamoxifen". Does that mean that once we knew
19 the new test results from Mount Sinai? That
20 would be my suspicion as to what group that
21 they're talking about, but I can only assume
22 that.
23 CHAYTOR, Q.C.:
24 Q. "Then the other nine then were patients who
25 were also diagnosed with breast cancer and

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1 were considered ER/PR negative, and again
2 Tamoxifen was not in their treatment plan at
3 that time. Upon retesting of that original
4 specimen, there was a change which will cause
5 them to be considered positive now. When the
6 panel reviewed their charts, it was determined
7 that during the time period between the
8 original test and the retest, the disease had
9 progressed, not, I guess, significantly enough
10 to warrant being placed on adjuvant therapy,
11 but enough that the clinicians around the
12 table discussed that the lack of Tamoxifen may
13 have had an impact. From a categorizing point
14 of view, they would be in the group with a
15 recommendation for treatment". So, Doctor,
16 what about that, what do you recall about
17 being discussed by the clinicians around the
18 table? Do you recall discussing that the lack
19 of treatment may, in fact, have had an impact
20 on these people?
21 DR. LAING:
22 A. I don't quite understand this. This doesn't
23 make any sense to me, and that's as simple as
24 I can put it. The sentence says, and I'll
25 start half way through the paragraph if that's

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1 okay, "Their disease has progressed". If
2 their disease had progressed, then it means
3 one of two things. One is they already had
4 metastatic disease and the disease was getting
5 worse. That's one possibility. The other
6 possibility is that they were treated
7 adjuvantly and their disease has recurred. We
8 don't call that progression, we would say that
9 the patient has recurred, which we just talked
10 about in the first --
11 CHAYTOR, Q.C.:
12 Q. Both of those would have been captured by the
13 first category because it refers to recurrence
14 metastases.
15 DR. LAING:
16 A. And then the rest of the sentence goes on to
17 say, "Not, I guess, significantly enough to be
18 warrant being placed on adjuvant therapy".
19 Adjuvant therapy is treatment that's given at
20 the time of the initial diagnosis to get rid
21 of micro metastatic disease to improve disease
22 free survival and overall survival. Adjuvant
23 therapy is not a term to be applied in the
24 disease progression setting, and it's not a
25 term to be applied to the metastatic disease

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1 setting. So that's why that sentence doesn't
2 make any sense whatsoever to me. So I don't
3 quite understand that, unless the distinction
4 is that the first people are people that were
5 negative, recurred, had metastatic disease,
6 somehow that was determined to be positive,
7 they got hormonal therapy, and then down the
8 road comes the panel and they're reviewed
9 because they had a negative test initially,
10 but we say, oh, look, we already knew
11 somewhere along the way something changed with
12 these people's history, whether it be that a
13 metastatic biopsy was retested or whether it
14 be that the definitions changed and somehow
15 those people got hormonal therapy long before
16 there was ever --
17 CHAYTOR, Q.C.:
18 Q. A panel.
19 DR. LAING:
20 A. A panel or whatever, and the second group of
21 people are people who --
22 CHAYTOR, Q.C.:
23 Q. Never had that retest done to show that --
24 DR. LAING:
25 A. Who would have been retested with the review

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1 at Mount Sinai, and then we re-panelled them,
2 and then they were put on treatment. So in
3 both cases, yes, these were people that were
4 impacted.
5 CHAYTOR, Q.C.:
6 Q. And the nine would have had a recommendation
7 for treatment from the panel because they
8 would not have already started their anti-
9 hormonal therapy, but the first 13, for
10 whatever reason, it was picked up at the time
11 of the disease progression, whether metastases
12 or recurrence, and they would have been
13 treated beforehand?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. So that's the only sense you can --
18 DR. LAING:
19 A. That's the only sense I can make out of it.
20 CHAYTOR, Q.C.:
21 Q. In terms of the differentiation between the
22 two?
23 DR. LAING:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. And again you were never consulted on coming
2 up with this, these numbers? You were never
3 consulted on this?
4 DR. LAING:
5 A. No.
6 CHAYTOR, Q.C.:
7 Q. And you don't recall any discussion around the
8 table, such as said here, that the clinicians
9 around the table discussed that the lack of
10 Tamoxifen may have had an impact? You recall
11 no discussions around the table aimed at
12 identifying who may or may not have had an
13 impact because of the delay in receiving the
14 treatment?
15 DR. LAING:
16 A. Not in a way to categorize patients or do
17 anything like that, no.
18 CHAYTOR, Q.C.:
19 Q. Well, in any manner? Do you recall the
20 discussion happening so that Heather is
21 present there, that she can take a note and
22 say, well, this is a patient that's going to
23 be impacted?
24 DR. LAING:
25 A. We would have had--we would have had those

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1 sorts of discussions around the individual
2 patient cases. I think it gets back to the
3 question you asked me earlier about would I
4 have said something to Mr. Hynes along the
5 lines of, you know, that there were people
6 that may have benefited, may have prevented
7 recurrence if they had gotten adjuvant
8 therapy, then, yes, certainly if we were
9 sitting in and a chart came before us and we
10 saw that this person had been tested negative,
11 hadn't received adjuvant Tamoxifen and, you
12 know, looking back we would have felt that
13 that would have been something had we had that
14 information, or if that patient was sitting in
15 a clinic today that we would do that, and now
16 the patient has metastatic disease, then you
17 could certainly say, oh, my, I wonder if this
18 was someone who may have--you know, this could
19 have been prevented, but as I said earlier,
20 you can't say that with any degree of
21 certainty one way or the other, and that's
22 what makes it so difficult when dealing with
23 this situation.
24 CHAYTOR, Q.C.:
25 Q. And if Ms. Predham was somehow recording or

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1 making note of those patients along the way,
2 you weren't aware of it?
3 DR. LAING:
4 A. She could have very well, you know, thought
5 that, yeah, somebody who's been very much
6 impacted and that may have been her reason for
7 identifying these patients when asked to do
8 so, yes.
9 CHAYTOR, Q.C.:
10 Q. And to you knowledge, the panel had decided
11 not to pursue Dr. Kwan's suggestion to
12 formally try and capture these people and
13 record it?
14 DR. LAING:
15 A. That's right.
16 CHAYTOR, Q.C.:
17 Q. And the decision was made by the panel not to
18 go that route?
19 DR. LAING:
20 A. We didn't decide that we were going to
21 categorize people. We didn't--you know, it
22 wasn't something that we thought about any
23 more than that. I mean, we were looking at
24 these people and making recommendations with
25 the new information at hand on how they could

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1 be treated, and again I bring you back to the
2 question in terms of saying who was--you know,
3 in a clinical point of view, you can divide
4 people into categories, but, you know, how
5 people were impacted also depends very much on
6 the perception of the person and the patient
7 involved.
8 CHAYTOR, Q.C.:
9 Q. And I think you started your evidence this
10 morning saying everybody was impacted, it's
11 really a matter of degree?
12 DR. LAING:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. If we could have, please, P-0314, page 10.
16 This is a briefing that was given to the
17 Department of Health, and in particular,
18 Minister Osborne, on November 23rd, 2006, and
19 I believe you were in attendance at that,
20 Doctor?
21 DR. LAING:
22 A. That was the time that we went to--for the
23 meeting at the Department of Health.
24 CHAYTOR, Q.C.:
25 Q. Yes.

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1 DR. LAING:
2 A. At the Confederation Building. We weren't in
3 the Department of Health that day, we were --
4 CHAYTOR, Q.C.:
5 Q. And at that time this was handed out, and this
6 is a copy with handwritten notes from the
7 Minister, but--and I'll bring you back to this
8 a little later, but I just wanted to bring it
9 to you now in terms of dealing with that issue
10 of numbers. Would you have had a copy of this
11 on November 23rd, 2006?
12 DR. LAING:
13 A. Prior to that date, no.
14 CHAYTOR, Q.C.:
15 Q. Well, on that day when you're meeting with the
16 Minister, is this a document that you would
17 have had? We've heard that it certainly was a
18 document that was referenced and the Minister
19 is taking notes on the document.
20 DR. LAING:
21 A. Right.
22 CHAYTOR, Q.C.:
23 Q. So would you have had a copy of it?
24 DR. LAING:
25 A. Not that I recall.

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1 CHAYTOR, Q.C.:
2 Q. Do you recall ever having seen this document
3 prior to me showing it to you now? Not this
4 particular copy, but a copy, or any version of
5 this document?
6 DR. LAING:
7 A. Prior to showing it to me now, and prior to
8 preparation or --
9 CHAYTOR, Q.C.:
10 Q. Well, back in the time period--yeah, prior to
11 --obviously before the inquiry comes up. Do
12 you recall being shown this document? You're
13 going to meet with the Minister, and the issue
14 --and I would suggest to you the numbers on
15 this page are discussed with the Minister,
16 and, in fact, you and Mr. Hynes had some
17 discussion about the deceased number that's on
18 the page.
19 DR. LAING:
20 A. Yes, yeah.
21 CHAYTOR, Q.C.:
22 Q. So I take it you would have been at least
23 somewhat familiar--if you hadn't seen it,
24 you're familiar with the content?
25 DR. LAING:

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1 A. Familiar with the content, familiar with the
2 numbers, but don't recall having been given a
3 copy of this during that meeting.
4 CHAYTOR, Q.C.:
5 Q. And this indicates in terms of the content,
6 change in results, but does not require
7 treatment change, and there's a number of 213
8 given.
9 DR. LAING:
10 A. Uh-hm.
11 CHAYTOR, Q.C.:
12 Q. And the third bullet says with Tamoxifen or--
13 I'm sorry, "No recommendation because they
14 were previously treated with Tamoxifen or
15 another aromatase inhibiter, 148", and then in
16 brackets and italics, "This group includes a
17 group identified as being potentially
18 impacted. Those not placed on Tamoxifen for
19 their original disease, but for subsequent
20 metastatic disease", and there's the number
21 13. So, Doctor, at that point in time back in
22 November, 2006, or around that time period,
23 were you consulted at that time in terms of
24 coming up with this number, this 13?
25 DR. LAING:

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1 A. No.
2 CHAYTOR, Q.C.:
3 Q. Did it cause you any concern at that time,
4 well, where did that number come from, that's
5 never been discussed with me, who's keeping
6 track of this?
7 DR. LAING:
8 A. No, and just as I read this, it sounds to me
9 like these were people that this was an issue
10 prior to the retesting. I would read that
11 group to be that this was an issue prior to
12 retesting.
13 CHAYTOR, Q.C.:
14 Q. That they had developed metastatic disease
15 prior to the retesting and did not require a
16 change in treatment because they had already
17 been on Tamoxifen or some equivalent thereof
18 for their metastatic disease?
19 DR. LAING:
20 A. Yeah, but it doesn't--it's hard to say does
21 that mean that it was prior to retesting or
22 was it as a result of retesting.
23 CHAYTOR, Q.C.:
24 Q. Right, yes, could also be the ones that -
25 DR. LAING:

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1 A. That we surmise it may have been even before
2 all this began.
3 CHAYTOR, Q.C.:
4 Q. The two weeks before they were panelled?
5 DR. LAING:
6 A. Or long before there was ever a retesting. I
7 can't tell from looking at that.
8 CHAYTOR, Q.C.:
9 Q. So they didn't have any change in results.
10 They had a change in results, but didn't
11 require treatment change, and your
12 understanding is the treatment change was
13 determined by what the panel said?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. Is that right?
18 DR. LAING:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. Okay. So at the time this 13, this wasn't
22 brought to your attention or for whatever
23 reason, it didn't cause you any concern or
24 any--cause you to question as to where that
25 number may come from?

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1 DR. LAING:
2 A. No.
3 CHAYTOR, Q.C.:
4 Q. If we could have, please, 2561? Actually, Dr.
5 McCarthy chaired that one. So let's go to
6 2034. It's January 12th, 2006, Doctor, and
7 you're chairing this meeting, and Dr. Carter
8 is present, Ms. Predham, Dr. Felix, Cook, Kwan
9 and Ms. Parsons, and this is the eighth
10 meeting of the panel, and you indicate that
11 "there have been no meetings held December
12 8th, 15th, 22nd, 29th and January 5th, 2006 as
13 no results requiring panelling were received
14 from Mount Sinai Hospital." So it had been, I
15 guess, over a month since there had been any
16 panelling because, at that point in time,
17 there were no results. So there'd been a slow
18 down, I take it, in receiving results.
19 It goes on to say that "Dr. Laing advised
20 the group that Dr. McCarthy could not attend
21 Thursday meetings at five p.m. and asked the
22 group were there other times. As the surgeons
23 would not be able to make any meetings before
24 five p.m., Dr. Laing advised the group that
25 she would ask Dr. Zulfiqar to attend in Dr.

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1 McCarthy's absence." So this is when Dr.
2 Zulfiqar, I take it, comes in onto the panel?
3 DR. LAING:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. It's a scheduling issue amongst the
7 physicians.
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. And there's only--even though it's been a
12 month, there's only three patients on the
13 agenda on this day, and the third patient was
14 asked to be reviewed by Ms. Predham, and this
15 patient, "her original ER/PR results performed
16 on the Ventana systems in early 2000 and
17 interpreted by pathology in Carbonear were
18 positive. Retesting by Mount Sinai indicated
19 the sample was ER/PR negative. Dr. Cook
20 reported that he and Dr. Carter reviewed the
21 slides sent to Carbonear for interpretation
22 and felt these slides indicated less than one
23 percent staining instead of being positive as
24 reported. Dr. McCarthy was aware of the
25 situation and the patient was taken off

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1 Arimidex." Do you recall the discussion
2 around that patient?
3 DR. LAING:
4 A. I recall discussions around this sort of issue
5 with the few patients that were found to have
6 a false positive result and that when the
7 pathologists had reviewed the slides, they
8 felt that the original slide was, in fact,
9 negative, and so that on review, they were
10 negative and they were negative at the--when
11 the sample was done at Mount Sinai Hospital as
12 well. Now this one was one that was done, it
13 says here, on the Ventana system, but there
14 were some patients as well, as you know, that
15 were done on the system prior to Ventana, but
16 done in St. John's, who subsequently were
17 found to be negative at Mount Sinai.
18 CHAYTOR, Q.C.:
19 Q. Doctor, there's one patient here who is
20 indicated to be negative, negative and then
21 two percent and zero percent. "No
22 recommendation from the panel, as the patient
23 was confirmed to be negative by Mount Sinai."
24 And Doctor, in terms of what Mount Sinai would
25 have said about this patient, what came back

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1 from Mount Sinai, did Mount Sinai confirm this
2 patient to be negative?
3 DR. LAING:
4 A. The pathology report stated that they had two
5 percent staining for estrogen receptor and
6 zero percent staining for progesterone
7 receptor, and we would have used that
8 information in the clinical setting to decide
9 that we were not going to offer hormonal
10 therapy to that patient because they just had
11 two percent expression.
12 CHAYTOR, Q.C.:
13 Q. So this is the panel confirmed this person to
14 be negative, as opposed to Mount Sinai?
15 DR. LAING:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. And no follow up letter was recommended by the
19 panel, and I take it that's because that
20 patient then was treated as a confirmed
21 negative and instead he or she would be told
22 their results by Ms. Parsons or someone from
23 Quality Initiatives on the phone?
24 DR. LAING:
25 A. Yes.

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1 THE COMMISSIONER:
2 Q. Ms. Chaytor, wherever you can find a spot,
3 we'll break for the afternoon break.
4 CHAYTOR, Q.C.:
5 Q. If I could have, please, P-2562? And these
6 are notes of January 30th, 2006, and it's
7 written to you, and the source is indicated to
8 be Heather Predham. "Hi, Dr. Laing. I will
9 finish the minutes on Tuesday. Usually wait
10 to see if any changes in letters before I send
11 you the minutes to sign anyway." What could
12 that be referring to?
13 DR. LAING:
14 A. I believe this is correspondence to me from
15 Ms. Parsons.
16 CHAYTOR, Q.C.:
17 Q. Okay, and so what would she mean by she
18 usually waits to see if any changes in the
19 letters before she sends the minutes to you to
20 sign?
21 DR. LAING:
22 A. I would get a draft copy of the letters to
23 review, and then we would put them on Eastern
24 Health letterhead and then they would be
25 signed.

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1 CHAYTOR, Q.C.:
2 Q. Okay, and I believe this particular note to
3 you arises out of the January 26th panel
4 meeting, which I'll take you to when we come
5 back from break, but there's 13 letters
6 enclosed, 20 patients panelled at that point
7 in time, and there's one here where it says--
8 and I'll talk to you about a couple of those
9 through the minutes, but the idea that "a
10 letter was deferred. Dr. Laing was to check
11 the status by calling Grand Falls to see if
12 patient is okay before she recommends
13 Tamoxifen." Under what circumstances would
14 you have made a phone call to, I would take it
15 it must be to other treating physicians
16 outside the region, before you made your
17 recommendation?
18 DR. LAING:
19 A. I could only think that there must have been
20 something in this patient's medical record
21 that may have indicated some concern about her
22 previous health. So we would contact the
23 physicians involved to see if the patient was
24 still alive or if, you know, there had been
25 some concern about other problems that people

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1 would have had, if they had developed a
2 secondary cancer or some other comorbidity
3 that may have made us decide not to recommend
4 Tamoxifen to them.
5 CHAYTOR, Q.C.:
6 Q. Okay. Thank you, Commissioner.
7 THE COMMISSIONER:
8 Q. All right. We'll take the afternoon break.
9 (BREAK)
10 THE COMMISSIONER:
11 Q. Now Ms. Chaytor.
12 CHAYTOR, Q.C.:
13 Q. Not to make you nervous, I didn't leave. If
14 we could have, please, P-2041? Doctor, these
15 are the panel meeting minutes of January 26th,
16 2006, and on this occasion, you are the chair,
17 and Doctors Carter and Dr. Cook are present,
18 along with Ms. Predham and Ms. Parsons. So on
19 this particular day, you are the only
20 oncologist, the only treating physician
21 present, and there's two pathologists. Did
22 you have any rule in terms of what would
23 constitute a quorum for the panel?
24 DR. LAING:
25 A. No, but we made every effort, when possible,

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1 to have two oncologists, be it surgical or
2 medical oncologists present.
3 CHAYTOR, Q.C.:
4 Q. And Doctor, I believe there's 20 patients who
5 are panelled on this day, and what would be
6 the benefit to having one oncologist and two
7 pathologists constitute the panel and make
8 recommendations, as opposed to just referring
9 those patients to their treating physician,
10 and if need be, they could consult you?
11 DR. LAING:
12 A. I think from the very beginning that we felt
13 that the recommendation that came from the
14 panel would be a recommendation and that
15 certainly if any time the recommendation that
16 was received, the person who was sent the
17 letter could have asked for further
18 information or asked the panel to reconsider
19 somebody or if there was another issue that
20 came up to address that.
21 CHAYTOR, Q.C.:
22 Q. Doctor, who was able to make any
23 recommendation as to treatment out of the
24 people who were gathered on January 26th?
25 DR. LAING:

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1 A. Me.
2 CHAYTOR, Q.C.:
3 Q. Yourself. Doctor, the second patient was
4 originally negative and becomes 80 percent 30
5 percent positive, and the recommendation is
6 "patient can now be considered for hormonal
7 therapy to treat her metastatic disease," and
8 if we could look at, please, C-0229, page 15?
9 This is that patient, Doctor, 80 percent and
10 30 percent. Reviewed on January 26th. The
11 recommendation of the panel is that this lady
12 can now be considered for hormonal therapy to
13 treat her metastatic disease, and Doctor, it's
14 a letter written by yourself to yourself. The
15 recommendation of the panel in that context
16 would be your recommendation.
17 DR. LAING:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. What's the purpose of going through this and
21 having a letter written to yourself and having
22 yourself having panelled your own patient?
23 DR. LAING:
24 A. So that again we would have a record of this.
25 That this would be something that would be on

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1 the patient's file. This was a patient who
2 had metastatic disease, so the fact that she
3 now had positivity for estrogen and
4 progesterone receptors, now knowing that she
5 had hormone receptor positive disease, then
6 this would be one of the options for this
7 patient, in terms of treating her metastatic
8 disease. So this would be something that
9 would be a standard recommendation that would
10 come out of the panel when we were dealing
11 with a situation of metastatic disease, and
12 that recommendation would be that this could
13 be something that could be considered. It
14 doesn't say--we wouldn't say that this patient
15 should receive, because then again, it would
16 be left to the physician to decide, where it
17 was a metastatic disease, was it disease that
18 the patient had that was amenable to hormones
19 or was it something that needed something more
20 than that.
21 CHAYTOR, Q.C.:
22 Q. Doctor, my point is you are the physician.
23 DR. LAING:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. Is the patient ever told that "your case was
2 discussed, yes, at the Physician Review Panel,
3 but the only one present who would have been
4 able to make that determination was me. This
5 hasn't been reviewed by anyone else. It was
6 me"?
7 DR. LAING:
8 A. I'm not certain if I would have said that to
9 the patient, but most times when I see
10 patients and make decisions, it's based on me,
11 and making recommendations based on the
12 information at hand. You know, by this time,
13 we had had several panels, so we--you know, we
14 were--had in our minds, if you will, certain
15 criteria we had, and definitely, for somebody
16 with metastatic disease, there would be no
17 question that hormonal therapy would be added
18 to the list of potential treatments available
19 for that patient.
20 CHAYTOR, Q.C.:
21 Q. Yes. My point I'm trying to determine is why
22 panel this person? Why write a letter saying
23 that the person has been panelled when the
24 recommendation is coming from yourself? And
25 that's what I'm trying to -

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1 DR. LAING:
2 A. Because that's how we did things.
3 CHAYTOR, Q.C.:
4 Q. And you wanted to have a record for whose
5 benefit?
6 DR. LAING:
7 A. So that this had happened, if for some reason,
8 I wasn't around any more, if somebody else was
9 assuming the care of this patient, if--you
10 know, for all the reasons why we document our
11 interactions with patients, so that they're
12 there and that somebody subsequently involved
13 in the care of that patient can look and see
14 what decision you made on such and such day
15 based on your clinic note or -
16 CHAYTOR, Q.C.:
17 Q. Yes, they'd get that from your progress note.
18 DR. LAING:
19 A. Sure. So it wouldn't be any different than
20 why we would want this kind of information
21 recorded in a chart.
22 CHAYTOR, Q.C.:
23 Q. And I assume it would have been recorded in a
24 progress note when you met with the patient,
25 that you had made the determination that she

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1 now be placed on hormonal therapy?
2 DR. LAING:
3 A. When I subsequently would have seen this
4 patient in the clinic, I would have then made
5 the ultimate decision as to whether or not
6 that patient would have--whether or not I
7 would have given that patient hormonal therapy
8 at that time.
9 CHAYTOR, Q.C.:
10 Q. If we could go back, please, to P-2041? The
11 top of the next page, we have a patient whose
12 original report was indicated to be
13 occasionally positive, occasionally positive,
14 and then Mount Sinai report is 90, 40.
15 "Recommendation: no follow-up letter to be
16 written. Patient originally ER negative.
17 Report said occasionally positive, which was
18 incorrectly interpreted by clinician as
19 positive and the patient was treated with
20 Tamoxifen." Now Doctor, if you had received a
21 report and this person, it looks like her
22 pathology was in 1999, if you had received a
23 report which said occasionally positive, how
24 would you have interpreted that? If you had
25 received a pathology report, even utilizing

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1 that type of language, what would you have
2 done?
3 DR. LAING:
4 A. Would have asked for clarification.
5 CHAYTOR, Q.C.:
6 Q. And Doctor, this says that the recommendation
7 of the panel is that no follow-up letter is to
8 be written. How then--what was the panel
9 recommending as to how this patient should be
10 dealt with and communicated with?
11 DR. LAING:
12 A. Without knowing who the specific patient is,
13 I'm not really certain what that all means.
14 CHAYTOR, Q.C.:
15 Q. How was the panel able to determine that the
16 patient was originally ER negative?
17 DR. LAING:
18 A. I would only assume that it meant that the
19 pathologist had reviewed the original slides,
20 but I'm not certain, without something being
21 written there to say that for sure.
22 CHAYTOR, Q.C.:
23 Q. So somebody, one of the pathologists had gone
24 back and reviewed the slides?
25 DR. LAING:

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1 A. That's a possibility.
2 CHAYTOR, Q.C.:
3 Q. And the last patient out of this 20 was
4 originally, her pathology was in 2000,
5 recommendation, she had found to be moderately
6 positive, and Mount Sinai, for some reason,
7 the results there just say negative.
8 DR. LAING:
9 A. Um-hm.
10 CHAYTOR, Q.C.:
11 Q. "Review of the patient's chart revealed that
12 the patient's ER results were positive from
13 the beginning and missed by clinician and the
14 patient was not treated. Heather Predham and
15 one of the doctors to follow up." Do you
16 recall what was discussed about this case, and
17 were you, in fact, involved in the follow up
18 with this patient?
19 DR. LAING:
20 A. If it's the case that I remember, and if I was
21 the follow-up physician, then there was a
22 patient who when we went back through the
23 panelling process, and when we reviewed the
24 initial report that had been on the chart, it
25 had been indicated and filed away in this

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1 patient's Cancer Centre chart that the result
2 was positive. We could find no record in
3 going through the progress notes back to 2000
4 that this information had ever been
5 communicated to the patient, and so they had
6 not received any adjuvant hormonal therapy,
7 and now the results are said to be negative,
8 and so with this sort of person, they sort of
9 fell outside, if you will, to a certain
10 degree, what was going on in terms of the
11 tumour panel. This would be similar to, you
12 know, the patient who had been placed on
13 Arimidex but then was found to be negative, or
14 to the patient who was subsequently found to
15 have ductal carcinoma in situ, so that we
16 would have had a meeting to disclose this to
17 this patient, and this did happen on one
18 patient that was still living that I can
19 recall, and I'm just assuming that it was this
20 patient, and so I would have--she wasn't
21 initially a patient of mine, but I had been
22 asked to meet with her and disclose this
23 information and I did. It subsequently
24 happened on review of a patient who the family
25 had asked for review and the patient was

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1 deceased, that there was--the original result
2 was there and it wasn't acted upon back in the
3 1990s.
4 CHAYTOR, Q.C.:
5 Q. So I take it you met with this patient, or a
6 patient of similar circumstance?
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And it was revealed that there had been an
11 oversight in the beginning?
12 DR. LAING:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. Was it determined why the original clinician
16 had missed the ER results in the beginning?
17 DR. LAING:
18 A. No. From what we could gather, when the--just
19 simply by looking at the dates in the
20 particular case that I'm remembering, when the
21 person came for their initial assessment, the
22 clinician involved did not have that result
23 back as of yet. It was still pending, and at
24 some point, that test result did come back and
25 was placed on the chart and the clinician

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1 wasn't aware, and we couldn't see that it was
2 addressed again by looking through the
3 progress notes.
4 CHAYTOR, Q.C.:
5 Q. So how would the panel be able to determine
6 that it had been missed? Was there any
7 indication, for example, that perhaps when the
8 patient was first seen, the results weren't on
9 the chart and next time that the -
10 DR. LAING:
11 A. Yes, that was what I was saying, that -
12 CHAYTOR, Q.C.:
13 Q. - that there was an addendum?
14 DR. LAING:
15 A. - that in the initial consult note, there was
16 no reference made to the ER/PR results, and
17 I'm not certain, I'd have to go back and look
18 at the chart. It may have said something like
19 it's pending and will follow up on it later,
20 but then we could subsequently not see that it
21 had been followed up upon.
22 CHAYTOR, Q.C.:
23 Q. And in that situation, was there any concern
24 or any--was it able to be determined that the
25 addendum with the ER/PR results had not come

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1 to the attention of the clinician? Was that
2 the issue?
3 DR. LAING:
4 A. It was on the chart, but there was no way for
5 us to identify if the clinician involved had
6 seen it or not.
7 CHAYTOR, Q.C.:
8 Q. Okay. Doctor, why would--if this person was
9 moderately positive in 2000, why would this
10 person have been part of the retest set?
11 DR. LAING:
12 A. I'm not certain. I'm not certain. You have
13 to ask the pathologist. Maybe because there
14 was absolutely no number there, that they
15 decided that they would include it.
16 CHAYTOR, Q.C.:
17 Q. So that wasn't discussed at the panel, as to
18 why you're even--why this person even came -
19 DR. LAING:
20 A. Yeah, and there's only one--I'm not certain
21 because there's only one result indicated. It
22 says moderately positive, negative. I'm not
23 sure if that was for both ER/PR or not. I
24 can't tell by looking at that.
25 CHAYTOR, Q.C.:

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1 Q. Well, I assume the negative--yes, it is -
2 DR. LAING:
3 A. There's usually two results there.
4 CHAYTOR, Q.C.:
5 Q. Usually two results given, yes.
6 DR. LAING:
7 A. Yeah, so I'm not really certain.
8 CHAYTOR, Q.C.:
9 Q. And in this situation, Heather Predham was to
10 meet with, and you together. Why would Ms.
11 Predham attend this meeting with patients?
12 DR. LAING:
13 A. Well, this was a different issue. This was
14 someone who the result was there in the first
15 place and was not acted upon. So again, the
16 same as with the patients with the changed
17 diagnosis. We had thought it would be helpful
18 to have somebody from the Quality office
19 accompany us for those disclosures.
20 CHAYTOR, Q.C.:
21 Q. So was that in her role as being part of the
22 Quality, or is it in her role as risk manager?
23 DR. LAING:
24 A. I'm not certain that I would have thought of
25 those as different.

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1 MR. SIMMONS:
2 Q. Excuse me. I don't think Ms. Predham was a
3 risk manager at that time.
4 CHAYTOR, Q.C.:
5 Q. Okay, thank you.
6 THE COMMISSIONER:
7 Q. What time are you talking about, Mr. Simmons?
8 CHAYTOR, Q.C.:
9 Q. In -
10 MR. SIMMONS:
11 Q. 2000--at the time of this panel meeting.
12 CHAYTOR, Q.C.:
13 Q. 2006.
14 DR. LAING:
15 A. January 2006.
16 THE COMMISSIONER:
17 Q. 2006, okay.
18 CHAYTOR, Q.C.:
19 Q. Ms. Predham -
20 THE COMMISSIONER:
21 Q. I'm sure Ms. Predham will clarify it when she
22 comes.
23 CHAYTOR, Q.C.:
24 Q. Thank you. Did you--in terms of this patient
25 then, and having to meet with her along with

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1 somebody from Quality, did you understand that
2 she hadn't been treated appropriately in the
3 beginning or was treated appropriately?
4 Because it appears that the results were
5 positive from the beginning, missed by the
6 clinician, and the patient was not treated.
7 DR. LAING:
8 A. She had never received any hormonal therapy.
9 CHAYTOR, Q.C.:
10 Q. So was it determined that she should? I mean,
11 the category here that we have under Mount
12 Sinai says that she's negative, whether that's
13 correct or not.
14 DR. LAING:
15 A. You don't have any other--you don't have the
16 corresponding notes related to this patient,
17 do you?
18 CHAYTOR, Q.C.:
19 Q. Not readily handy. I'm sure we could dig
20 through a lot to figure it out, but if you
21 have no recollection as to--so your
22 understanding is she was supposed to be
23 treated. Mount Sinai confirms that she should
24 have been treated and that's why you're
25 meeting with her. Is that your recollection

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1 from meeting with her?
2 THE COMMISSIONER:
3 Q. (Inaudible) that's what I understood, but is
4 it the other way around?
5 DR. LAING:
6 A. No, my recollection was that she was said to
7 be positive in the beginning. It was never
8 addressed. She never got any hormonal
9 therapy, and now Mount Sinai is coming back
10 with a different test result.
11 THE COMMISSIONER:
12 Q. And saying it's negative, so she -
13 CHAYTOR, Q.C.:
14 Q. Right, and saying it's negative.
15 THE COMMISSIONER:
16 Q. - by accident, she got the non-treatment that
17 she should have not gotten.
18 DR. LAING:
19 A. Yes, that's -
20 THE COMMISSIONER:
21 Q. If you -
22 CHAYTOR, Q.C.:
23 Q. That's what I understood the first time, but
24 then I'm thinking -
25 MR. BROWNE:

1 Q. (Inaudible).
2 DR. LAING:
3 A. That's my understanding as well.
4 CHAYTOR, Q.C.:
5 Q. That's what I understood, assuming that the
6 negative is from Mount Sinai, in fact. But
7 then I'm trying to figure out, well why do you
8 have to meet with her along with someone from
9 Quality to tell them, well, there by the grace
10 of God, you got the right treatment, but it
11 was in--or didn't get the right treatment, but
12 it was inadvertent, you know.
13 DR. LAING:
14 A. Well, we would have--the same reasons why we,
15 you know, tell other people things that have
16 happened. I think we felt that this was
17 something that this patient should know about.
18 You know, she--we did not know until we sat
19 down with this lady what her understanding was
20 of the situation. We could only surmise by
21 reviewing her clinic chart. We didn't know if
22 maybe somewhere along the way someone had told
23 her that she was positive or if that
24 information was something that she knew or her
25 surgeon had told her or somebody else had told

1 her, and so--and of course, this is going on,
2 and she may have been someone who wondered if
3 she never heard about her ER/PR testing
4 results, she may have always assumed in her
5 life that she was negative. So we just felt
6 that because we identified that this person,
7 from what we could tell, hadn't been told,
8 that it was important that somebody disclose
9 this information to her and explain the
10 fortuitous unfortunate events.
11 CHAYTOR, Q.C.:
12 Q. And so in that circumstance, it was deemed
13 appropriate that someone from Quality, in
14 whatever capacity, be present to have that
15 discussion with the patient?
16 DR. LAING:
17 A. Actually, you know, the note says "Heather
18 Predham and Dr. Laing to follow," but I
19 believe that when I disclosed to this lady, I
20 was the one who was there, and it was done in
21 the clinic and I don't recall that Ms. Predham
22 was present.
23 CHAYTOR, Q.C.:
24 Q. Okay. So whatever way Heather Predham was to
25 follow up, it may not have been with the

1 patient?
2 DR. LAING:
3 A. That's right.
4 CHAYTOR, Q.C.:
5 Q. So the follow up that we normally see on those
6 notes tends to suggest that's the person going
7 to communicate -
8 DR. LAING:
9 A. The physician.
10 CHAYTOR, Q.C.:
11 Q. That's what you've said, yes, okay. So her
12 follow up may have been something different?
13 DR. LAING:
14 A. I know that if it's the same patient that I
15 think that we're talking about, that I would
16 have disclosed it to her and she would have
17 come to the clinic.
18 CHAYTOR, Q.C.:
19 Q. And Ms. Predham was not present?
20 DR. LAING:
21 A. That's correct.
22 CHAYTOR, Q.C.:
23 Q. Okay. This patient here, the second from the
24 top. She was negative and moderately positive
25 originally and then 80 to 70.

1 DR. LAING:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. And "no change in therapy required as patient
5 had already been -
6 DR. LAING:
7 A. That's right.
8 CHAYTOR, Q.C.:
9 Q. - treated with Femara for her locally advanced
10 disease."
11 DR. LAING:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. And what does "locally advanced disease" mean
15 and how is that different from when we see
16 metastatic disease?
17 DR. LAING:
18 A. Locally advanced disease means that the
19 disease involves the breast or the lymph node
20 area to the degree that it is not surgical at
21 the time of presentation when a patient
22 presents. So it means that they have bulky
23 lymph nodes in their axilla. It means that
24 they may have a supraclavicular lymph nodal
25 involvement, or it may mean that they have a

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very large tumour in a small breast or the tumour involves the skin or the chest wall. So that the primary therapy is systemic treatment, and that's, in fact, what we call neo-adjuvant treatment. So N2 and N3 disease in the new classification and T4 disease give people a designation of locally advanced.

CHAYTOR, Q.C.:

Q. Okay, and if we could look, please, at C-0229, page 16, and this is the panel letter that went out, January 27th, 2006. Again, written to yourself, signed by yourself, regarding that patient.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And it indicates that she was discussed at the Physician Review Panel. "As this patient has already been treated with Femara, there is no impact on the patient's treatment and no treatment follow up required." Doctor, what does that mean? "There is no impact on the patient's treatment and no treatment follow up required."

DR. LAING:

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A. When this lady initially came to see me with her locally advanced breast cancer, she was treated with chemotherapy initially and did have some response. She then was considered for radiation, but did not subsequently go on to receive radiation, and based on the PR positivity, I placed her on Femara. This was back in 2002. All of the remaining disease within the breast and within the regional lymph nodes resolved, went away completely, and the Femara was working very well. She had had an excellent response to it, and in fact, this lady, to this day, remains on that medication and has had no sign that her breast cancer has ever come back. So she had been--she's one of these people that had been treated based on PR and I knew that she had responded and there was--this is not the kind of person that you would take off these medications after a certain duration of time. People with this type of locally advanced disease, we would leave on hormonal therapy indefinitely.

CHAYTOR, Q.C.:

Q. And again then, Doctor, the fact is that you

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are the only oncologist present at the--and the only treating clinician present, the other two being pathologists, and this statement that "there is no impact on the patient's treatment," that's, I take it, your opinion?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Yes, and there was no one else on the panel who would be in a position to voice that opinion?

DR. LAING:

A. Correct.

CHAYTOR, Q.C.:

Q. Okay. Do you know whether or not you communicated that to your patient?

DR. LAING:

A. Yes, I would have told her that her new results had come back and that it had showed that she was now PR positive in addition to being--ER positive, in addition to being PR positive.

CHAYTOR, Q.C.:

Q. No, I mean, did you communicate that you were the only person on the panel who would have

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been in a position to make a recommendation?

DR. LAING:

A. I'm not certain.

CHAYTOR, Q.C.:

Q. If we could go back, please, to 2041? And Mr. Coffey has given me some information on this last patient that we were discussing. So just to clarify or further confuse, I'm not sure, but apparently this is in error. At least other documentation that we have indicates that the moderately positive/negative should be in the column as being the original ER/PR report. So she was moderately positive/negative. Mount Sinai's results, in our records, indicate this patient to be 60 percent ER positive, 20 percent PR positive.

DR. LAING:

A. Okay.

CHAYTOR, Q.C.:

Q. So in terms of the discussion with the patient she was originally positive, it was missed by the clinician, it appears, and continued positive. And you would have had that discussion, I take it, with her?

DR. LAING:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. Does that help in your recollection as to what
4 was told to this patient?
5 DR. LAING:
6 A. So this would have been someone then that
7 wasn't a retrocoverter or a false positive
8 patient, then. So again, there was a patient
9 who I would have been asked to disclose this
10 to who wouldn't have been one of my patients
11 initially. And I would have explained to her,
12 you know, that this was something that wasn't
13 noted and wasn't acted upon at the time and
14 that we had new information available that
15 showed that she was retested and her results
16 had changed, but when we looked back, that
17 this information was on the chart and hadn't
18 been communicated to the patients, so we would
19 have disclosed all that to her.
20 CHAYTOR, Q.C.:
21 Q. And do you recall if that meeting took place
22 in the presence of Ms. Predham?
23 DR. LAING:
24 A. No. The only meetings that I ever had that
25 had anybody else besides myself disclosing

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1 would have been the meetings that we
2 subsequently did for the patients with a
3 change in diagnosis and those meetings would
4 have been attended by Ms. Nancy Parsons and
5 Dr. Denic and I.
6 CHAYTOR, Q.C.:
7 Q. If we could look at, please, P-2045? This is
8 February the 2nd, 2006, and it's your tenth
9 meeting. And you'll see that there's a post-
10 it here which says "The minutes are not
11 completed. Letters from this meeting are
12 enclosed." So it appears at this point there
13 was an attempt to start the minutes but they
14 weren't completed.
15 DR. LAING:
16 A. Finished, okay.
17 CHAYTOR, Q.C.:
18 Q. And again, and this is February of '06,
19 February 2nd, 2006, so it looks like that Ms.
20 Parsons, in fact, did commence them. And do
21 you have any idea as to why she wouldn't have
22 at least finished the minutes for this
23 particular meeting?
24 DR. LAING:
25 A. No, unless this was the time, as we discussed

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1 this morning, when a decision was made that we
2 would just keep the Panel letters as the
3 record and not have these sorts of minutes.
4 CHAYTOR, Q.C.:
5 Q. Doctor, now we have received some more minutes
6 just, like I said, in the past day or so for
7 to--quite late in the process.
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. The rest for '06 were missing, but December,
12 2007 and '08 we do have some minutes for. And
13 out of the ten that I reviewed, the ten
14 minutes or the ten sets of minutes, there were
15 four occasions when only one oncologist sat at
16 those meetings. And I'm wondering how well
17 known was that amongst your fellow medical
18 oncologists, that there aren't a panel of at
19 least two medical oncologists sitting here
20 making the decision?
21 DR. LAING:
22 A. I'm sorry, which times were they?
23 CHAYTOR, Q.C.:
24 Q. There were four occasions when -
25 DR. LAING:

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1 A. In this early process or in the later process?
2 CHAYTOR, Q.C.:
3 Q. Up until, well, the ten early, up until
4 February, 2006.
5 DR. LAING:
6 A. Okay, sorry.
7 CHAYTOR, Q.C.:
8 Q. There were four occasions when either only one
9 oncologist sat, yourself or Dr. McCarthy, for
10 the most part. So I'm just wondering how well
11 that was known amongst your fellow medical
12 oncologists that there's only one oncologist
13 sitting on the Panel on those occasions?
14 DR. LAING:
15 A. I would assume that they would know that. I'm
16 not certain as to if I had--I would think that
17 they knew it because if they weren't there
18 because it was impossible for them to attend.
19 As I said, we tried to have two people
20 present, but if for whatever reason there
21 wasn't anybody there, then we would have
22 proceeded with the meeting to try and have the
23 patients seen and dealt with. I can tell you
24 that if I was the person who was chairing that
25 meeting and if there was something that came

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1 up that I wasn't certain as to what the
2 recommendation should be or if I had any
3 concern in making that recommendation, then
4 that patient would have been deferred.
5 CHAYTOR, Q.C.:
6 Q. Doctor, there's one set of letters that come
7 out of a meeting, and it's not a Panel meeting
8 that, I don't believe, anyhow, we have the
9 minutes for. But there's certainly a set of
10 letters that we came across, Panel letters,
11 which were signed by Dr. Carter. Are you
12 aware of that? And I believe it may have been
13 the meeting after this, February 9th, 2006.
14 DR. LAING:
15 A. Did she chair the meeting?
16 CHAYTOR, Q.C.:
17 Q. I don't have minutes. I don't believe I have
18 minutes, so.
19 DR. LAING:
20 A. Okay. I would assume if she signed it -
21 CHAYTOR, Q.C.:
22 Q. That would be a good question.
23 DR. LAING:
24 A. - that she probably signed it because she was
25 the chair. The chair didn't necessarily have

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1 to be a medical oncologist. It just was the
2 person who, you know, kept everybody in line
3 and kept the flow going of the meeting and--
4 but, you know, it didn't have to be a medical
5 oncologist who chaired the meeting.
6 CHAYTOR, Q.C.:
7 Q. So the idea of a pathologist chairing the
8 meeting and/or signing the Panel
9 recommendation letters doesn't cause you any
10 concern?
11 DR. LAING:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. If we could have, please, P-1102? And this is
15 an e-mail copied to you from Dr. Carter,
16 February the 13th, 2006. And she writes,
17 "Heather, as I have recently resigned my
18 position with Eastern Health and I am quite
19 busy covering call and attempting to clue
20 things up at my desk, I will not be taking
21 part in any further ER/PR Panel meetings. I
22 wish you well in this endeavour. I will be
23 happy to act in the short term on a
24 consultative manner for any specific breast
25 pathology issue that may arise from your

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1 meetings." So I take it at this point in time
2 Dr. Carter resigned from her involvement on
3 the Panel?
4 DR. LAING:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. And were you involved in trying to determine
8 whether another pathologist should come on to
9 the Panel?
10 DR. LAING:
11 A. I don't recall what discussions Dr. Cook and I
12 would have had at the time. I know that at
13 some point that Dr. Denic starts to attend the
14 Panels, but I'm not certain as to when exactly
15 that was.
16 CHAYTOR, Q.C.:
17 Q. The next set of minutes that we have is P-
18 2631. I'm just going to shoot ahead in time
19 here, but I want to finish with the Panel
20 meetings.
21 DR. LAING:
22 A. Okay.
23 CHAYTOR, Q.C.:
24 Q. And this is the set of December 10th, 2007.
25 And you are chairing and Dr. McCarthy is

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1 present and we have a few new bodies, Dr. Kwan
2 is still there, Dr. Denic is now present and
3 Ms. Sharon Smith and Ms. M. Gregory becomes
4 the recording secretary.
5 DR. LAING:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. And Dr. Denic, I take it, has replaced Dr.
9 Cook -
10 DR. LAING:
11 A. That's correct.
12 CHAYTOR, Q.C.:
13 Q. - and that's the reason he's there. Ms.
14 Sharon Smith, what capacity is she there, why
15 is she there?
16 DR. LAING:
17 A. She, by this point, is the program director
18 for the Cancer Care Program and as part of her
19 role has been asked to become involved and has
20 been involved over the last little while with
21 the ER/PR issue.
22 CHAYTOR, Q.C.:
23 Q. And Ms. Predham is no longer present. And why
24 is that?
25 DR. LAING:

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1 A. Because this role has now been given over to
2 Ms. Smith.
3 CHAYTOR, Q.C.:
4 Q. I'm sorry, which role is that?
5 DR. LAING:
6 A. The person who is involved with contacting a
7 lot of the patients and that sort of thing was
8 now Ms. Smith was doing that, so she would
9 come to these meetings with us.
10 CHAYTOR, Q.C.:
11 Q. So she took that over from Ms. Predham. And
12 when did that happen?
13 DR. LAING:
14 A. I'm not sure that I can give an exact time.
15 You know, once we had finished the bulk of the
16 work of the Panel, the reason to have this
17 Panel later was because there were people that
18 were being identified as not having been
19 addressed back in 2006. I became clinical
20 chief in January of 2006. Ms. Smith would
21 have started in her role at the end of 2005.
22 You know, as I said, most of the panelling
23 work would have been finished by the spring of
24 2006. And this was really a request if we
25 could look at these patients who had not been

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1 re-panelled or somehow had been missed in the
2 process, and so we said, yes, we would
3 certainly continue to do the work that we had
4 started back in 2005. As you see, there was
5 some of the bodies the same. But this was now
6 something that was being asked to be done
7 within our Cancer Care Program. We are now
8 official part of Eastern Health. You know,
9 when we first started this in 2005, it was
10 still in the transition period, so we were
11 asked to do this and we were asked to find the
12 resources within the Cancer Care Program to do
13 that, which is why Ms. Smith was in attendance
14 and why Ms. Gregory was the recording
15 secretary, as she is one of our administrative
16 assistants.
17 CHAYTOR, Q.C.:
18 Q. And do you know why the decision was made for
19 Ms. Predham not to be involved in that
20 capacity any more?
21 DR. LAING:
22 A. No.
23 CHAYTOR, Q.C.:
24 Q. The second patient here is indicated to be
25 pathology, date of pathology is July 13th,

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1 2001. And the original report indicated the
2 patient was 30 percent positive for estrogen
3 and five percent. On retesting at Mount
4 Sinai, 75 percent, 15 percent. And the
5 recommendation coming from the Panel is that
6 the patient be offered hormonal therapy, if
7 appropriate, with Tamoxifen. Why--so this
8 patient in 2001 with a 30 percent ER, I take
9 it, was not offered Tamoxifen at that point in
10 time?
11 DR. LAING:
12 A. I'm not certain. By reading the
13 recommendation I would interpret it was you
14 did, that it doesn't sound like that she was.
15 CHAYTOR, Q.C.:
16 Q. The last patient indicates to be original
17 ER/PR ten, zero, Mount Sinai, 90 percent, two
18 percent. Recommendation, the full chart was
19 not received.
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. Okay. And, Doctor, I believe this patient
24 comes up again, this being January--or, sorry,
25 December 10th, 2007. This patient is panelled

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1 June 5th, 2008. Do you know why the chart was
2 not available on that patient and why it took
3 so long for her ultimately to be panelled?
4 DR. LAING:
5 A. My understanding is that this is a patient who
6 came from a different region, that the chart
7 was requested on several occasions. And in
8 fact, at the end of the day there were a
9 couple of patients who we never were sent any
10 medical information so we simply wrote the
11 information to the physicians because there
12 was nothing that we could make a
13 recommendation about. We simply had no
14 information on these patients other than their
15 name and their MCP number and their results.
16 We had no clinical chart, we had no way to
17 know what stage of breast cancer they had,
18 anything else about these patients.
19 CHAYTOR, Q.C.:
20 Q. Doctor, which region was that?
21 DR. LAING:
22 A. I'm not 100 percent sure. I know that there
23 were some patients from the Carbonear area
24 that we didn't have any information on, some -
25 CHAYTOR, Q.C.:

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1 Q. That would be Eastern Health.
2 DR. LAING:
3 A. - people from Central, Western. I really, I
4 can't be certain to tell you that.
5 CHAYTOR, Q.C.:
6 Q. Okay. I'm sure we could figure it out. If we
7 could have -
8 DR. LAING:
9 A. It was Eastern Health at that point, but I
10 think it's important to realize that even
11 within Eastern Health we do not have access to
12 medical records, nor the Meditech system for
13 people outside the St. John's region.
14 CHAYTOR, Q.C.:
15 Q. Yes, we've heard. 2632, please? And the
16 first patient here--again we have Dr. Cook
17 back on this occasion, on January 28th, 2008
18 and yourself and Dr. Zulfiqar, Dr. Kwan, Ms.
19 Smith and Ms. Gregory. The first patient her
20 pathology was 1999, ten percent, ten to 15
21 percent and becomes a strong estrogen positive
22 at 95 percent PR at five percent on retesting?
23 DR. LAING:
24 A. Um-hm.
25 CHAYTOR, Q.C.:

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1 Q. "The patient was treated initially with
2 Tamoxifen and is now being treated with
3 Tamoxifen again, so there is no recommendation
4 for change of treatment." And so, Doctor,
5 when you reviewed this patient's chart back in
6 1999 with a ten percent ER positivity, ten to
7 15 percent PR, this person, I take it, had
8 been offered anti-hormonal treatment back
9 then?
10 DR. LAING:
11 A. That's what it indicates in the
12 recommendation. And again, this may have been
13 someone who was given it for another reason.
14 I can't say without having the chart there.
15 I'm not really sure that means to say that she
16 was treated and now is being treated again.
17 It sounds like there may have been some sort
18 of a gap, and why that was, I'm not certain.
19 CHAYTOR, Q.C.:
20 Q. It does say "treated initially." So I take it
21 -
22 DR. LAING:
23 A. And then it says "treated again."
24 CHAYTOR, Q.C.:
25 Q. Yes. But the treated initially, I take it,

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1 means at the time of original diagnosis.
2 DR. LAING:
3 A. I would take it to mean the same, yes.
4 CHAYTOR, Q.C.:
5 Q. Yeah. Were there patients who were originally
6 ER negative and PR negative?
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. Who had been treated originally with Tamoxifen
11 or anti-hormonal therapy even though they were
12 ER and PR negative?
13 DR. LAING:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. Okay. And what was the reason for that?
17 DR. LAING:
18 A. For risk reduction for developing a new breast
19 cancer.
20 THE COMMISSIONER:
21 Q. The reasons you referred to earlier?
22 DR. LAING:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. So that's that same group?

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1 DR. LAING:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. Okay. And so if this person was considered
5 negative at the time, perhaps depending on her
6 risk, she might fall into that category?
7 DR. LAING:
8 A. Right, yes.
9 CHAYTOR, Q.C.:
10 Q. Okay, and this patient was originally zero
11 percent?
12 DR. LAING:
13 A. Minus five.
14 CHAYTOR, Q.C.:
15 Q. And I'm -
16 DR. LAING:
17 A. That's a new one.
18 CHAYTOR, Q.C.:
19 Q. - assuming that's a mistake, is it? I had a
20 big question mark by that one.
21 DR. LAING:
22 A. I've never seen--I suspect that that may be,
23 yes, I would say that's a mistake.
24 CHAYTOR, Q.C.:
25 Q. I figured we would be here a few more months

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1 if we had to look at that. Good. Okay, so
2 that's a mistake, no such thing as a negative
3 five?
4 DR. LAING:
5 A. Yeah.
6 CHAYTOR, Q.C.:
7 Q. Okay, and this patient had received hormonal
8 therapy with Tamoxifen so there's no
9 recommendation for change in treatment. So
10 whether or not that happened at some later
11 period, it's really not clear. This
12 particular patient then at the bottom is zero
13 and five to ten percent and ends up being 40
14 to 50 percent.
15 DR. LAING:
16 A. Yeah.
17 CHAYTOR, Q.C.:
18 Q. Recommendation, "There was no hormonal
19 treatment with Tamoxifen offered at initial
20 diagnosis. She's now ten years from initial
21 diagnosis having been in 1998."
22 DR. LAING:
23 A. Um-hm.
24 CHAYTOR, Q.C.:
25 Q. Patient, "And the Panel felt there would be no

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1 benefit from hormonal therapy at this point."
2 Doctor, if that particular patient had been
3 identified back in 2005, might your--and
4 assuming everything else being equal, might
5 she have been recommended for Tamoxifen back
6 in 2005, 2006?
7 DR. LAING:
8 A. It would depend on what we felt her risk of
9 recurrence was at that point. We may have
10 said it at this point because we felt that her
11 prognosis or her risk of recurrence this late
12 out wouldn't warrant it. It may have been the
13 same thing we would have said in 2005 because
14 at that point she would have been seven years
15 out.
16 CHAYTOR, Q.C.:
17 Q. Yes.
18 DR. LAING:
19 A. And, you know, we don't have--this would be, I
20 would think, one of the longest durations that
21 we have--that we would have had because this
22 is a 2008 and this was in 1998. So, you know,
23 unless it was someone we were looking at from
24 1997 and it was 2007, 2008. So this was quite
25 some time from the initial diagnosis and -

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1 CHAYTOR, Q.C.:
2 Q. Was anyone offered treatment beyond seven
3 years?
4 DR. LAING:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. If we could--I'm sorry, I'll just take you to
8 the last page of these minutes. We weren't
9 provided with signed copies of the minutes,
10 Dr. Laing. Do you know, have you signed those
11 minutes? These are from January, January
12 28th, 2008.
13 DR. LAING:
14 A. I would think so.
15 CHAYTOR, Q.C.:
16 Q. Okay. I take it you've seen them before me
17 showing them to you?
18 DR. LAING:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. Okay. And this patient here then, originally
22 zero, zero, ends up 100, 100 percent ER, 20
23 percent PR. And the recommendation, "The
24 Panel did not recommend hormonal therapy at
25 this point due to her low risk of recurrence,

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1 therefore there is no recommendation for a
2 change in treatment."
3 DR. LAING:
4 A. Right.
5 CHAYTOR, Q.C.:
6 Q. So even though the patient--and she was a 2002
7 case?
8 DR. LAING:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. Even though she's very strongly ER positive,
12 she, because of her low risk of recurrence,
13 she was not a candidate?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. And the people on the Panel on this day who
18 would have been able to make that
19 determination would be yourself, Dr. Zulfiqar
20 and Dr. Kwan?
21 DR. LAING:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. If we could have 2633? And on this date it's
25 yourself, Dr. Carter, Ms. Smith, Dr. Denic and

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1 Ms. Gregory. And the first patient is
2 indicated to be on retest a 1998 patient, ten
3 to 20 percent and 30 percent. "The Panel
4 reviewed the chart. This was also reviewed
5 with Dr. Denic and the consensus is that this
6 tumour is estrogen and progesterone receptor
7 positive. Due to her low risk of recurrence at
8 this point no hormonal therapy was
9 recommended." Why would there have to be a
10 discussion as to whether her tumour was
11 estrogen and progesterone receptor positive
12 with those numbers?
13 DR. LAING:
14 A. I wonder if this might have been someone who
15 had had two samples sent or if there was--you
16 recall that I mentioned that there were some
17 patients who the initial block sent said DCIS
18 but subsequent ones--I'm not sure what the
19 issue is, I can't recall, but I'm thinking
20 that it's Dr. -
21 CHAYTOR, Q.C.:
22 Q. There's certainly no indication there's
23 another sample from these notes, anyhow.
24 DR. LAING:
25 A. No, no. I'm sure if we had asked Dr. Denic,

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1 that there was something that we had to
2 clarify in the pathology. But those numbers
3 are definitely positive, so I can only imagine
4 that if we wanted to clarify something with
5 Dr. Denic, that there may have been another
6 sample or something or else that made us say
7 that.
8 CHAYTOR, Q.C.:
9 Q. And at the top of page 2, "This patient is a
10 1997 date of pathology and had been five
11 percent and zero percent at that time, on
12 retest is 90 percent, 80 percent. The Panel
13 noted upon review of the patient's chart it
14 was noted that no hormonal treatment with
15 Tamoxifen was offered as her risk of
16 recurrence was low. Therefore, there is no
17 recommendation for change in treatment at this
18 time." And -
19 DR. LAING:
20 A. That would have been someone who right from
21 the very beginning had a very good prognosis.
22 CHAYTOR, Q.C.:
23 Q. At the time, though, would her risk of
24 recurrence at all be influenced by her hormone
25 receptor status? It's noted in her chart, I

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1 take it, that she was at low risk for
2 recurrence?
3 DR. LAING:
4 A. Right.
5 CHAYTOR, Q.C.:
6 Q. Would that have been influenced, that kind of
7 comment by the treating physician, influence
8 by her hormone receptor status?
9 DR. LAING:
10 A. In this situation--so estrogen and
11 progesterone receptors are a weak prognostic
12 factor. So, if anything, knowing now that
13 this person was ER/PR positive, it puts her in
14 a slightly better prognosis. Often these
15 patients when we reviewed them were people
16 with stage one disease, so tumours that were
17 less than--so by virtue of stage one, it's a
18 T1, and that's tumours that are up to and
19 include two centimetres, but within that, are
20 patients who have very, very small tumours. So
21 these T1A's are one to five millimetres, and
22 T1B's five to ten millimetres. So often--
23 even today, we don't offer those patients
24 treatment because they have such a good
25 prognosis. So my recollection, and the way

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1 this is written here, I would think this is
2 someone who had a very small tumour initially
3 and--so even if somebody is--I think maybe
4 your questioning might be related to even if
5 someone is 100 percent positive, if they have
6 a tiny, tiny tumour, then we still wouldn't
7 recommend treatment based on the fact that
8 they were 100 percent positive.
9 CHAYTOR, Q.C.:
10 Q. Similar to the other patient I brought to your
11 attention?
12 DR. LAING:
13 A. That's right.
14 CHAYTOR, Q.C.:
15 Q. Okay, the next patient appears to be DCIS.
16 DR. LAING:
17 A. Yes, and she was treated based on DCIS.
18 CHAYTOR, Q.C.:
19 Q. Okay, and she was obviously retested.
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. So I take it would there have been a request
24 to have her retested? Why would she otherwise
25 be retested?

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1 DR. LAING:
2 A. I would think so, yes.
3 CHAYTOR, Q.C.:
4 Q. And she had received five years of Tamoxifen
5 and it's indicated that was appropriate
6 treatment for her DCIS at that time?
7 DR. LAING:
8 A. That's right, and again we don't look at ER--
9 we don't ask for ER/PR testing routinely on
10 ductal carcinoma in-situ, and we don't rely on
11 that result if it is available to help us
12 determine whether or not to offer that patient
13 Tamoxifen because there still isn't enough
14 data to use it routinely in making decisions
15 about treatment for DCIS.
16 CHAYTOR, Q.C.:
17 Q. Okay, and the last patient on that date, June
18 5th of this year, is a patient, the
19 recommendation--the letter was sent to
20 Patricia Pilgrim regarding this patient. The
21 panel noted that they did not have any medical
22 information on these patients.
23 DR. LAING:
24 A. That's the ones I was referring to, yeah.
25 CHAYTOR, Q.C.:

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1 Q. "And the only information we had was their
2 ER/PR results, and no chart was available, and
3 if further medical information is found, the
4 panel will review them again". Do you know
5 whether or not these patients have come up for
6 further consideration, has the information now
7 been received on these patients and have they
8 been panelled?
9 DR. LAING:
10 A. No, we never--we never did receive the charts
11 on these patients, so a decision was made that
12 Ms. Pilgrim would contact the physicians and
13 forward the results, and if that physician had
14 information on these patients, that we would
15 address them, but really felt that we couldn't
16 do that with absolutely no clinical
17 information on these patients.
18 CHAYTOR, Q.C.:
19 Q. And the limited information that you had being
20 the retest results, they looked like they --
21 DR. LAING:
22 A. They changed.
23 CHAYTOR, Q.C.:
24 Q. They changed, they've become 90 percent, each
25 of them in terms of their estrogen receptor,

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1 and it indicates that you would be available,
2 or they can contact Dr. Laing, the physicians,
3 if they have any questions related to the --
4 DR. LAING:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. Have you ever been contacted?
8 DR. LAING:
9 A. To date, no.
10 CHAYTOR, Q.C.:
11 Q. If we could have, please, 2634. This is a
12 panel meeting and there's two patients
13 panelled on this date, July 18th, 2008, and in
14 this date, yourself and Dr. McCarthy present,
15 Sharon Smith, Ms. Gregory, and Dr. Ford Elms,
16 and why would Dr. Elms be at the panel
17 meeting?
18 DR. LAING:
19 A. He was there as the representative
20 pathologist.
21 CHAYTOR, Q.C.:
22 Q. There were two patients discussed, both who
23 went from being negative to being strongly
24 positive?
25 DR. LAING:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. And the second one, the recommendation, "The
4 panel reviewed the chart. There was a new
5 cancer diagnosis in 2006 in the other breast
6 which was ER/PR positive".
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. "She's currently on Tamoxifen. There were a
11 number of questions regarding the 2003 tumour
12 that will require discussion with a particular
13 doctor, and once that happens, we will be able
14 to give the information she is looking for".
15 Doctor, this is now July 18th, 2008, that this
16 person is being panelled. Her original
17 pathology was 2003, she was ER/PR negative.
18 She was obviously back, treated, diagnosed
19 with a new cancer in the other breast 2006.
20 Why wasn't the fact that her ER/PR should have
21 been retested picked up if not through the
22 original identification of patients, while
23 she's back in in 2006?
24 DR. LAING:
25 A. I don't know. I'm not certain.

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1 CHAYTOR, Q.C.:
2 Q. Do you recall any discussion--now again this
3 is only July of this year, so it's only a
4 couple of months ago. Do you recall any
5 discussion around this patient and how she
6 could have been missed on what appears to be
7 at first blush, and this is all the
8 information that we have, appears that she was
9 perhaps overlooked on two occasions?
10 DR. LAING:
11 A. I'd have to go back and look at who she was to
12 be able to tell you.
13 CHAYTOR, Q.C.:
14 Q. So this--even though it's only two months ago,
15 you have no recollection about the discussion
16 about this patient?
17 DR. LAING:
18 A. I know that there was someone and it was
19 something to do with--that it was a lymph
20 node. I'm not sure if this is the lady who
21 that's pertaining to, that it was initially
22 done on her lymph node from 2003, and that
23 there needed to be some further clarification
24 of that, but --
25 CHAYTOR, Q.C.:

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1 Q. So are you saying there was a patient who had
2 a retest done, but it was done on her lymph
3 node and that didn't get picked up until
4 you're now dealing with again in terms of
5 panelling the patient in July of 2008?
6 DR. LAING:
7 A. I know that there was a patient who the ER/PR
8 testing was done on the lymph node.
9 CHAYTOR, Q.C.:
10 Q. Okay.
11 THE COMMISSIONER:
12 Q. Dr. Laing, the record says it will be
13 discussed with --
14 DR. LAING:
15 A. Uh-hm.
16 CHAYTOR, Q.C.:
17 Q. "There were a number of questions which will
18 require further discussion with, once that
19 happens".
20 DR. LAING:
21 A. Yes.
22 THE COMMISSIONER:
23 Q. Who would be tasked with the job of doing that
24 further discussion?
25 DR. LAING:

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1 A. The attending oncologist.
2 THE COMMISSIONER:
3 Q. Who presumably would be in the Cancer Centre?
4 DR. LAING:
5 A. Yes, I think. It's hard because the name is
6 blocked out, but I'm not sure if it was Dr.
7 Denic that was going to look into this issue
8 further. This particular patient was not my
9 patient, so I--I would have been there for the
10 discussion, but certainly there was a patient
11 that the ER/PR testing was done on the lymph
12 node, but I don't have all the details in
13 front of me about what that was, and that may
14 have been someone who had a--that's where the
15 cancer was detected was in the lymph nodes,
16 but I'm not certain.
17 CHAYTOR, Q.C.:
18 Q. Doctor, there's no follow-up physician noted.
19 Why would that be? I guess it's going to have
20 to wait until --
21 DR. LAING:
22 A. It's all sorted out.
23 CHAYTOR, Q.C.:
24 Q. It's all sorted out. Doctor, on this
25 occasion, as I said, Dr. Elms is present.

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1 DR. LAING:
2 A. Uh-hm.
3 CHAYTOR, Q.C.:
4 Q. So we've seen times when Dr. Cook, Dr. Carter,
5 Dr. Denic and Dr. Elms, and certainly Dr.
6 Cook, Dr. Denic, and Dr. Elms throughout the
7 period was reviewed, would have been the
8 original pathologist on a number of those
9 patients that came before the panel. When
10 that happened, were they excused from the
11 panel--when any patients that they had been
12 the original pathologist reporting on those
13 patients came before the panel, did they
14 excuse themselves from the room or were they
15 asked to be excused?
16 DR. LAING:
17 A. No.
18 CHAYTOR, Q.C.:
19 Q. Did that cause you any concern?
20 DR. LAING:
21 A. No.
22 CHAYTOR, Q.C.:
23 Q. And, Doctor, by the time this is happening,
24 you were aware of the concerns expressed by
25 Dr. Banerjee in terms of any involvement of

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1 the pathologists in this matter, and with that
2 in mind, you had no hesitation with having
3 some of the original reporting pathologists
4 participate in the process involving patients
5 that they had originally reported on?
6 DR. LAING:
7 A. Which issues raised by Dr. Banerjee are you
8 referring to?
9 CHAYTOR, Q.C.:
10 Q. Any issues, for example, no internal controls,
11 lack of internal controls --
12 DR. LAING:
13 A. Okay.
14 CHAYTOR, Q.C.:
15 Q. Inadequate attention being paid to internal
16 controls, for example.
17 DR. LAING:
18 A. No, because really what we were doing was we
19 wanted to have the original report that was
20 available to us, and we wanted to ensure that
21 we had the correct Mount Sinai report, and we
22 wanted to have a pathologist there to refer to
23 if we needed clarification on some of the
24 other variables, and that in the cases where
25 there was concern, and the two that I can

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1 think of would have been the issue of the
2 patients having subsequently been switched to
3 be called ductal carcinoma in-situ, they were
4 reviewed by a panel of physicians within
5 Eastern Health that included Dr. Cook, Dr.
6 Denic, Dr. Carter, and that in the issue of
7 the patients that were initially said to have
8 some positive staining, again those were
9 reviewed by a panel that included those three
10 physicians.
11 CHAYTOR, Q.C.:
12 Q. Doctor, there were times when we looked at
13 where you were the only oncologist in
14 attendance at panel meetings when your own
15 patients were being panelled, and, in fact,
16 the majority of the letters that were written
17 to you were, in fact, written by yourself, as
18 chair of the panel?
19 DR. LAING:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. If we could look at, please, P-2557, and this
23 is from Ms. Parsons to Delores Rice. Who is
24 Delores Rice?
25 DR. LAING:

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1 A. She's my assistant.
2 CHAYTOR, Q.C.:
3 Q. October 28th, 2005, enclose letter for Dr.
4 Laing's review, "Hi Delores, can you mention
5 to Dr. Laing", and I think there's a typo
6 here, "if she feels someone else should
7 letters addressed to her, in light that the
8 letter is also going to GP and surgeon. If
9 she is fine with this, let me know, and if
10 she's not, who should sign them? Probably Dr.
11 McCarthy". So I take it that Ms. Parsons was
12 inquiring as to whether or not you were
13 comfortable with signing the letters addressed
14 to yourself?
15 DR. LAING:
16 A. Correct.
17 CHAYTOR, Q.C.:
18 Q. And the fact that you did, I take it you had
19 no difficulty with that?
20 DR. LAING:
21 A. No.
22 CHAYTOR, Q.C.:
23 Q. And why not?
24 DR. LAING:
25 A. Because I considered this process to be the

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1 same as our usual tumour rounds or tumour
2 board, as we refer to them. In that instance,
3 it would be the attending oncologist. If it
4 was my patient, me, that if I had a question
5 or something to review in pathology,
6 radiology, or a question to another physician,
7 should this patient have radiation now, should
8 this patient have more surgery, that I would
9 present that case at that tumour board round.
10 I would document in the chart the discussion,
11 and I would communicate that information back
12 to the patient. So this was the usual manner
13 in which we did things. When we do our usual
14 tumour board rounds, there are minutes kept.
15 The recording person for that who's usually
16 Dr. McCarthy or Dr. Thompkins, one of our
17 radiation oncologists, will, in fact, keep a
18 record of what was discussed, but the actual
19 dictating of a note to go on the patient's
20 chart is done by the physician who presented
21 that patient. So that would be usually how we
22 did things.
23 CHAYTOR, Q.C.:
24 Q. Doctor, were the people who sat on the panel
25 paid for their services?

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1 DR. LAING:
2 A. On one occasion, we were.
3 CHAYTOR, Q.C.:
4 Q. If we could look at, please, P-1111. This is
5 a letter March 8th, 2006, to Dr. Williams from
6 yourself.
7 DR. LAING:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. "Re; ER/PR meetings. The ER/PR panel has met
11 on Saturday, February 18th, 2006, and
12 Saturday, March 4th, 2006. As previously
13 discussed and agreed upon, the physicians
14 attending this panel will receive $2500.00 per
15 day in the form of payment or for attendance
16 at a continuing medical education event". The
17 physicians on February 18th included yourself,
18 Dr. Cook, Dr. Zulfiqar, and Dr. Kwan. The
19 attendance on March 6th was yourself, Dr.
20 Cook, Dr. McCarthy.
21 DR. LAING:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. "I have contacted each of the physicians and
25 they would like to receive payment of $2500.00

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1 per day".
2 DR. LAING:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. And if we could have, please, P-2564, and this
6 is the response on March 16th, 2006, from Dr.
7 Williams to yourself, indicating that payments
8 are processed on a timely basis, and it's
9 $5000.00 for yourself and Dr. Cook, who
10 attending both days, and $2500.00 for the
11 other three. So I take it, Doctor, you were
12 paid for those two sessions, those two days?
13 DR. LAING:
14 A. That's correct. We had been asked if we would
15 consider to do panels on Saturdays, which
16 would have been outside our usual work week,
17 and although we did the other panelling after
18 hours, we had never requested payment for that
19 activity. We felt that if we were going to
20 ask physicians to work on weekends, many of us
21 end up working for various other reasons on
22 weekends, being on call, with my university
23 work, we often do examinations for the
24 students on weekends because it's just a more
25 convenient time to do that sort of thing

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1 within the hospital setting, so we felt that
2 we would ask for a payment. That would be the
3 same as the type of honorarium that we would
4 receive if were to work on the weekend for
5 another reason, such as attending a CME event
6 and giving input at that type of venue, which
7 is why the amount of $2500.00 was decided and
8 agreed upon.
9 CHAYTOR, Q.C.:
10 Q. If we could have, please, P-0383. Doctor,
11 this is an e-mail, October 25th, 2005, which
12 is sent to yourself, along with Drs. Cook and
13 Mr. Tilley and Mr. Gulliver, from Denise Dunn,
14 so I assume it's actually coming from Dr.
15 Robert Williams, and he writes, "Don, should
16 we retest all negative specimens in the future
17 as part of our normal operating procedures",
18 signed by Bob. Apparently this comes from an
19 e-mail originated by Ms. Predham in which she
20 sent along an article. Do you recall did you
21 respond at all or did you have any position on
22 whether or not all negative specimens in the
23 future should be retested as part of--I take
24 it, he's taking this as a quality assurance
25 measure. Did you have any position on that?

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1 DR. LAING:
2 A. No.
3 CHAYTOR, Q.C.:
4 Q. And do you know whether or not anyone else
5 did? Did you receive any e-mail in response
6 to this?
7 DR. LAING:
8 A. Not that I recall.
9 CHAYTOR, Q.C.:
10 Q. If we could have, please, C-229, page 17.
11 This exhibit is a number of panel letters
12 which were written to you, and several I have
13 referred to as we've gone along, Dr. Laing.
14 This one is February 8th, 2006, and this
15 particular patient, it says, "The
16 recommendation of the panel is that there be
17 no change in therapy in view of the patient's
18 current metastatic colon carcinoma".
19 DR. LAING:
20 A. Uh-hm.
21 CHAYTOR, Q.C.:
22 Q. And I take it even though this patient had no
23 change in therapy recommended given their
24 current metastatic disease, this could be a
25 patient that potentially may have been

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1 impacted by any delay in treatment?
2 DR. LAING:
3 A. I'm not certain as to who this patient is. I
4 have one patient who is in my practice that I
5 can think of who has a diagnosis of both
6 breast and colon cancer, and--but that patient
7 was treated with an aromatase inhibitor, so
8 I'm not certain. I do know of another case, I
9 don't think it's this particular patient, who
10 had another cancer as well who had metastatic
11 disease from another primary cancer, and was
12 undergoing therapy for that, and it would have
13 had a--because that person was being treated
14 for another cancer, and because that person's
15 life expectancy was based on their metastatic
16 colon cancer, that the issue of their adjuvant
17 breast cancer would not have--would have not
18 have arisen. Interestingly, we do see many
19 patients who have several primaries. This
20 province has quite a lot of genetic cancer,
21 and we have several patients in our practice
22 who have more than one cancer. Sometimes more
23 than one cancer is diagnosed all at the one
24 time, and then you have to sort of weigh the
25 risks and benefits of which one you treat

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1 versus the prognosis, and sometimes we have to
2 be inventive in how we figure out how to do
3 treatments for two separate cancers at one
4 time, and I have had patients with breast
5 cancer who have subsequently developed other
6 malignancies and died as a result of those,
7 and some people who have elected to stop their
8 adjuvant therapy once they're diagnosed with
9 another cancer because they feel that if their
10 life expectancy is short in duration because
11 of another metastatic cancer, that they don't
12 wish to take those treatments any more.
13 CHAYTOR, Q.C.:
14 Q. Page 21 of the same exhibit is another letter,
15 and, Doctor, this letter which is written to
16 yourself and signed by yourself had two
17 different patient names in it. So we have a
18 patient and we've identified the person as
19 patient B1, and there was actually in the body
20 of your letter, patient B2. So I take it that
21 didn't come to your attention when you signed
22 off on the letter?
23 DR. LAING:
24 A. No.
25 CHAYTOR, Q.C.:

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1 Q. And would you have done anything or checked
2 anything then, I take it, in terms of on
3 receipt of the letter, to check and make sure
4 that, in fact, there hadn't been any mix up in
5 the results and that it was, in fact, patient
6 B1's results that are being referred to here?
7 DR. LAING:
8 A. Each panel letter that I would have received,
9 I would have gone back and checked the
10 information against the chart, irrespective of
11 whether I noticed that there was a different
12 name at the top versus what was in the body of
13 the letter. In other words, I would have
14 looked back into the chart to see what the
15 initial ER/PR was and then to look the Mount
16 Sinai result which we ultimately would have
17 gotten and placed on that chart.
18 CHAYTOR, Q.C.
19 Q. And would you do that on the basis of who is
20 indicated to be in the subject line?
21 DR. LAING:
22 A. No, we would have done it based on who was in
23 the re: and with the appropriate MCP.
24 CHAYTOR, Q.C.
25 Q. Yes, that's what--the re: is what I refer to

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1 as the subject line, yes.
2 DR. LAING:
3 A. Oh, sorry, okay.
4 CHAYTOR, Q.C.
5 Q. Page 24 of the same exhibit and it says
6 "please replace initial letter dated February
7 20th, 2006 with the revised letter, the MCP
8 number was incorrect in this case on initial
9 letter. All other information on initial
10 letter was correct". And this letter had gone
11 and was signed by you, to you. So, at the
12 time you signed the letter, I take it, it
13 wasn't picked up.
14 DR. LAING:
15 A. Right.
16 CHAYTOR, Q.C.
17 Q. And how was it ultimately--this error picked
18 up?
19 DR. LAING:
20 A. I would think that when I saw the patient and
21 looked at it. We try and use the MCP number
22 as much as we can to be the unique identifier
23 for a patient. That used to be simpler before
24 MCP issued new MCP numbers, but I could only
25 think it was when I looked at that patient

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1 when they came. Somebody along the way picked
2 up on it and we corrected it.
3 CHAYTOR, Q.C.
4 Q. And, Doctor, this is a patient who was
5 diagnosed in 1998 and the recommendation is
6 coming out in May of 2006 and there is a
7 recommendation for change in treatment. So,
8 this an example of a patient who is more than
9 seven years out from diagnosis who, in fact, -
10 DR. LAING:
11 A. Would have been offered treatment.
12 CHAYTOR, Q.C.
13 Q. - was offered treatment.
14 DR. LAING:
15 A. Yes and again, it would have been dependent
16 very much so on the prognosis of that patient.
17 CHAYTOR, Q.C.
18 Q. And on page 25 of the exhibit, in this letter,
19 it's written that the "patient was originally
20 diagnosed in 1998, the original report of the
21 estrogen and progesterone receptors show
22 negative staining for estrogen and 50 - 60
23 percent staining for progesterone. And repeat
24 report from Mount Sinai Hospital has shown the
25 levels of estrogen and progesterone to be zero

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1 and two respectively. This patient was
2 discussed at the physician review panel on
3 June 8, 2006. Review of the patient's health
4 record revealed that she was not initially
5 treated with adjuvant Tamoxifen as it was not
6 the standard of care at the time. Now that
7 she is ER/PR negative, she should not be
8 treated with hormonal therapy for breast
9 cancer". Doctor, "Review of the patient's
10 health record revealed that she was not
11 initially treated with adjuvant Tamoxifen as
12 it was not the standard of care at the time",
13 why is that written there, what the standard
14 of care would have been at the time?
15 DR. LAING:
16 A. I suspect it was because she was a pre-
17 menopausal patient at the time of her initial
18 diagnosis.
19 CHAYTOR, Q.C.
20 Q. And do you recall this patient in particular?
21 DR. LAING:
22 A. No.
23 CHAYTOR, Q.C.
24 Q. I'm sorry, she was not a pre-menopausal -
25 DR. LAING:

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1 A. She was pre-menopausal, but that's what I'm
2 just assuming because that would be the only
3 reference I could make to it not being
4 standard of care at the time would have been
5 that she was pre-menopausal.
6 CHAYTOR, Q.C.
7 Q. Okay. And people who were ER or PR positive,
8 we've seen a number who were, in fact, treated
9 with Tamoxifen at the time, based on their PR
10 status.
11 DR. LAING:
12 A. Yes.
13 CHAYTOR, Q.C.
14 Q. So, that would depend whether or not the
15 person was pre-menopausal or not.
16 DR. LAING:
17 A. It was about 1999 that patients would have
18 started to be offered--1999 into 2000 that
19 patients who were pre-menopausal would be
20 started to be offered adjuvant Tamoxifen. You
21 recall some time in the last few days during
22 my testimony I referred you to a clinical
23 trial, the NCIC MA 12 trial which was actually
24 a trial that I participated in as a resident
25 and a fellow in the BC cancer agency which was

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1 a Canadian led trial that looked at patients
2 who were pre-menopausal who finished
3 chemotherapy and they were randomized with
4 Tamoxifen or not. So, this was still, you
5 know, in the late 1990s an area of research.
6 CHAYTOR, Q.C.
7 Q. Doctor, do you know whether or not the results
8 of the panel were provided to anyone external
9 to Eastern Health?
10 DR. LAING:
11 A. In what capacity, I'm sorry.
12 CHAYTOR, Q.C.
13 Q. In terms of your numbers and the numbers who
14 required treatment changes, for example, that
15 type of data.
16 DR. LAING:
17 A. At what point?
18 CHAYTOR, Q.C.
19 Q. At any point.
20 DR. LAING:
21 A. Well, the -
22 MR. BROWNE:
23 Q. Ms. Chaytor, are you referring to statistical
24 analysis or medical analysis.
25 CHAYTOR, Q.C.

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1 Q. I'm talking about any of the information that
2 came out of the panel. Has there been a
3 statistical analysis?
4 MR. BROWNE:
5 Q. I'm trying to clarify the question for the
6 witness, are you referring the witness to the
7 statistical analysis or medical analysis or
8 both.
9 DR. LAING:
10 A. Because I guess the only people that I can
11 think of are the -
12 CHAYTOR, Q.C.
13 Q. Any information that came out of the panel.
14 DR. LAING:
15 A. - Newfoundland and Labrador Centre for Health
16 Information.
17 CHAYTOR, Q.C.
18 Q. Yes, we are aware of that, of course. So,
19 other than NLCHI, you're not aware of whether
20 or not the information, other than obviously
21 lawyers who may be involved in the litigation,
22 you're not aware of whether or not the
23 information was just used for your purposes
24 for panelling and to be distributed to the
25 patients' charts. That's your understanding

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1 of what the information was used for.
2 DR. LAING:
3 A. Yes.
4 THE COMMISSIONER:
5 Q. Ms. Chaytor, wherever you can find a
6 convenient spot, we'll break for the day.
7 CHAYTOR, Q.C.
8 Q. Okay. If we could just look at, please, P-
9 2055 and this is a Corporate Quality
10 Initiatives Committee meeting, February 23rd,
11 2006 and page 4, under Quality and Risk
12 Management update, members were presented with
13 a copy of the November/December 2005 and
14 January 6, Quality and Risk Division Monthly
15 report. Ms. Predham reviewed verbally and
16 highlighted the following items, legal, "a lot
17 of work ongoing regarding the laboratory and
18 ER and PR testing. Verbal review of number of
19 patients tested and panelled was provided.
20 Insurance company, HIROC is reviewing first
21 Statement of Claim received focuses on getting
22 all results communicated to the expert panel
23 for their recommendation to the patient and
24 the patient's physician". And, Doctor, were
25 you aware whether or not or are you aware

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1 whether or not the number of patients tested
2 and panelled and information of that nature,
3 whether or not that was provided to HIROC?
4 DR. LAING:
5 A. No.
6 CHAYTOR, Q.C.
7 Q. And just one more, if we can, P-2036. This is
8 an e-mail, it originate January 13th, 2006,
9 Dr. Cook to Dr. Banerjee and it refers to "Dr.
10 Kara Laing, our Clinical Chief of Oncology
11 received a phone call from an oncologist in
12 Fredericton, New Brunswick stating that
13 problems with ERs and PRs have been identified
14 for a particular year from the Fredericton lab
15 and was looking for information on what
16 happened here and how we handled the issue.
17 Dr. Laing advised the oncologist that a more
18 thorough review, other than the year in
19 question is needed. As for an explanation as
20 to what is happening, the Fredericton lab
21 reports that they have a pH issue, according
22 to Dr. Laing. I anticipate that this may
23 spread to other regions in Canada as the
24 problem becomes more widely known. From a
25 Canadian Association of Pathology perspective,

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1 I think we need to stay on top of this issue
2 and liaise very closely with Canadian
3 Association of Oncologists and be ready for
4 possible media interviews. I will keep you
5 posted. Regards, Don Cook."
6 Doctor, could you tell us please about
7 your discussion with the oncologist in
8 Fredericton?
9 DR. LAING:
10 A. Certainly. I know many of the other medical
11 oncologists in Canada, but most especially the
12 oncologists in the Atlantic region. We meet
13 at least once a year. We have a set meeting
14 at our Atlantic Canada Oncology group where we
15 discuss breast cancer issues. So this is how
16 I would know this gentleman, and he did call
17 me to say that they had some concerns raised
18 by their lab for a problem with the results
19 that came during a particular period of time
20 and that he had indicated that it was, you
21 know, a problem within the lab with the
22 testing and knew, of course, what had been
23 going on in Newfoundland and asked, sort of,
24 if I could give him a synopsis of what we had
25 dealt with, and I basically would have said to

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1 him that, you know, certainly yes, we did have
2 this issue. I would have explained how it
3 would have started with the index case, and
4 that through the review, we found that there
5 were changes throughout the entire review.
6 That it wasn't just simply linked to when the
7 index case had been identified, which was
8 2002, which is why I had recommended that they
9 consider if they knew about an issue for a
10 certain period of time that they perhaps would
11 want to look at, or he, as the oncologist,
12 would suggest that they look at a wider range,
13 and that I, in fact, suggested that their
14 pathologist may want to contact our
15 pathologist, which is why I would have then
16 had contact with Dr. Cook to say that you may
17 be receiving a call from somebody from the
18 region in New Brunswick, because I had
19 received this phone call.
20 There was also, subsequently, I'm not
21 sure how this all panned out except for that I
22 know that when I spoke to this gentleman
23 subsequently, that there was some
24 consideration being given in New Brunswick to
25 doing the ER/PR testing not in all of the

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1 health regions, but for more centralized
2 testing. New Brunswick is interesting because
3 even though it's a small province, it has
4 several different health regions, and it's
5 only recently that it actually has had a
6 provincial cancer organization, probably the
7 last province in this country to have such a
8 thing. So that's my recollection of this
9 reference.
10 CHAYTOR, Q.C.:
11 Q. Okay. What did you understand it to mean that
12 they had a pH issue?
13 DR. LAING:
14 A. He says that it was a pH issue according to
15 me. It must have been what the oncologist
16 there had told me, that it was--that when
17 doing these tests there has to be a certain--I
18 mean, I know more about this test now than
19 ever thought that I would, but something to
20 do, I guess, with the buffering or the
21 reagents or something or other, that the lab
22 had come and said that, you know, we've
23 identified that there's a problem in the lab
24 and there was some discussion about what to do
25 about it. I don't--I'm sorry, I don't have

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1 any of the great details about beyond that,
2 and that really the advice that I could offer
3 him was, you know, from being an oncologist
4 involved was, you know, ask what years, you
5 know. Make sure that they're looking at more
6 than just one period of time, and certainly I
7 said to him, "look, if you need to contact me
8 any further on this issue, if you want to know
9 what we did, in terms of the panel and all
10 those sorts of things, to let me know" and
11 I've not had any further communication.
12 CHAYTOR, Q.C.:
13 Q. So you haven't heard anything further how they
14 made out with this?
15 DR. LAING:
16 A. No.
17 CHAYTOR, Q.C.:
18 Q. And were you--did you understand the problems
19 to be that they were having any changed
20 results? It says that there were problems
21 identified for a particular -
22 DR. LAING:
23 A. No, I don't know what--I don't know if they
24 went back and retested or what else might have
25 happened.

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1 CHAYTOR, Q.C.:
2 Q. And so how they had identified that they had a
3 particular problem, are you aware of how it
4 came to their attention -
5 DR. LAING:
6 A. No.
7 CHAYTOR, Q.C.:
8 Q. - that they had a particular problem?
9 DR. LAING:
10 A. No.
11 CHAYTOR, Q.C.:
12 Q. Okay, and just because it's on that issue, if
13 we could have P-1972? I'm sorry, that's the
14 same exhibit. Try P-1078. It's just another
15 copy of the same issue. 1078, and that's the
16 same one too. No, it is, I think, the 1972.
17 I'm sorry, Registrar. It's late in the day.
18 The 1972, and it's written here, this is Dr.
19 Cook's writing. Is it Dr. Hussen?
20 DR. LAING:
21 A. He's the oncologist.
22 CHAYTOR, Q.C.:
23 Q. He's the oncologist from New Brunswick, okay,
24 and "Dr. Laing advised the tumour board of
25 this issue on January 12th, 2006."

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1 DR. LAING:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. Okay, so you discussed this with your own
5 tumour board rounds.
6 DR. LAING:
7 A. Sure. I said, "guess what? I got a call from
8 my colleague in New Brunswick raising this
9 issue there, or a similar issue."
10 CHAYTOR, Q.C.:
11 Q. Thank you, Commissioner. Thank you. Thank
12 you, Doctor.
13 DR. LAING:
14 A. Okay, thanks.
15 THE COMMISSIONER:
16 Q. 9:30, thank you.

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

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