CIHRT Exhibit P-2665 Page 1

From: Susan Bonnell

To: Oscar Howell; Denise Dunn; Nebojsa Denic(HCCSJ); Kara Laing;

Heather Predham; Leona Barrington;

Date: December-08-06 2:58:25 PM

Attachments: Q and A"s, ER PR Media Briefing, Dec.7.doc

We anticipate that there are some of the types of questions we will be getting next week. Clearly, we will not be able to answer many of these questions, but will need to stick closely to our key messages. Have a look at these, keeping the key messages in mind, and we will have drafted answers by Sunday for discussion.

See you at 1pm at Oscar's office.



Susan Bonnell

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ER/PR Media Technical Briefing Q & A's

- **Q1.** Why has Eastern Health taken more than a year to go public with what went wrong & release the numbers of how many women received false results? Is this acceptable in your view?
- **Q2**. Why didn't Eastern Health notify the public right away when the problem was first discovered?
- **Q3.** Did Eastern Health hold off on going public with this because of legal complications?
- **Q4.** Do you feel the organization mishandle how it informed the public? In hindsight, would you have handled things differently?
- **Q5.** Were some individuals put in danger do to the delays in retesting?
- **Q6.** Were the tests prioritized when sent to Mt. Sinai?
- **Q7.** What do you say to those women who were left for months wondering if they received the wrong care plan?
- **Q8.** How many patients have been impacted by this?
- **Q9.** What is the rate of error? How many people have had a change in treatment since this discovery?
- **Q10.** What caused the conflicting results?
- **Q11.** Are pathologists to blame for this? Did these errors occur because of the difficultly to recruit pathologists and because some haven't achieved their national examinations? Is this a competence issue?
- Q12. Were there quality checks in place when the error was discovered?
- **Q13.** What did the medical experts review reveal? What recommendations came out of that review? (Visit from the BC Cancer Institute and Chief tech. Mt. Sinai)
- Q14. Could more have been done to prevent this from happening?
- **Q15.** What's been done to prevent this from happening again?
- **Q16.** Could this happen again?

CIHRT Exhibit P-2665 Page 3

Q17. Have individuals died because of this error in testing?

Q18. Do those women who have converted now have a shorter life expectancy because of this error?

Q19. How many women were given extensive treatment (i.e. Surgery, Chemo etc.) that through this retesting you now realize they did not need to be treated so aggressively?

Q20. How many patients where given the wrong test result but could have benefited from Tamoxifen?

Q21. What is the survival rate if a patient is prescribed Tamoxifen compared to someone who is not?

Q22. What do you say to these women who have been living with mental distress because of this and who have lost faith in the health care system?

Q23. Should other cancer patients question there diagnosis?

Q24. Is there anything patients can do to inform themselves when they're having these tests done?

Q25. What are the cost implications of this discovery?