

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">October 7, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL</p> <p>Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Chesley Crosbie, Q.C.. Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike, Q.C. NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Blair Pritchett. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBITS P-3350 THROUGH P-3352 Pg. 4</p> <p>EXHIBITS P-3363 AND P-3364 Pg. 4</p> <p>EXHIBIT P-3042 Pg. 5</p> <p>EXHIBITS P-3113 THROUGH P-3118 INCLUSIVE Pg. 284</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>MS. CAROLYN MORRIS-LARKIN - AFFIRMED</p> <p>Examination by Bernard Coffey, Q.C. Pgs. 4 - 236 Examination by Dan Simmons Pgs. 236 - 240 Examination by Jennifer Newbury Pgs. 240 - 249 Examination by Chesley Crosbie, Q.C. Pgs. 249 - 273 Examination by Peter Browne, Q.C. Pgs. 273 - 282 Re-Examination by Bernard Coffey, Q.C. Pgs. 282 - 284</p> <p>MR. TERRY GULLIVER - RESUMES THE STAND</p> <p>Examination by Sandra Chaytor, Q.C. - Cont'd . . Pgs. 284 - 375</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER: 2 Q. Please be seated. Mr. Coffey? 3 COFFEY, Q.C.: 4 Q. The next witness, Commissioner, is Dr. Carolyn 5 Morris-Larkin. 6 DR. CAROLYN MORRIS-LARKIN, AFFIRMED, EXAMINATION BY 7 BERNARD COFFEY, Q.C. 8 REGISTRAR: 9 Q. Would you please state and spell your complete 10 name for the Commission? 11 DR. MORRIS-LARKIN: 12 A. Carolyn Morris-Larkin, C-A-R-O-L-Y-N M-O-R-R- 13 I-S hyphen L-A-R-K-I-N 14 REGISTRAR: 15 Q. Thank you. 16 COFFEY, Q.C.: 17 Q. Commissioner, there are some additional 18 exhibits, please. They are exhibits P-3350, 19 3351, 3352, 3363 and 3364. 20 THE COMMISSIONER: 21 Q. Entered. 22 EXHIBITS ENTERED AND MARKED P-3350 THROUGH P-3352 23 EXHIBITS ENTERED AND MARKED P-3363 AND P-3364 24 COFFEY, Q.C.: 25 Q. Thank you, Commissioner. Exhibit, Registrar,</p>

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1 when you're ready, Exhibit P-3363?
 2 REGISTRAR:
 3 Q. Is there another one?
 4 COFFEY, Q.C.:
 5 Q. Oh yes, there is another one. Yes, thank you
 6 very much. Exhibit P-3042 was referred to a
 7 previous witness. It had not been entered,
 8 although it certainly was referred to and on
 9 the screens here, and I would ask that that be
 10 entered as well. It was referred--previously
 11 referred to while Patricia Pilgrim was
 12 testifying, Commissioner, 3042.
 13 THE COMMISSIONER:
 14 Q. The Registrar sent me a note to that effect.
 15 COFFEY, Q.C.:
 16 Q. Oh yes.
 17 THE COMMISSIONER:
 18 Q. She's keeping track.
 19 COFFEY, Q.C.:
 20 Q. Oh yes.
 21 THE COMMISSIONER:
 22 Q. Thank you.
 23 EXHIBIT ENTERED AND MARKED EXHIBIT P-3042
 24 COFFEY, Q.C.:
 25 Q. 3363, when you're ready, Commissioner,

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1 Registrar, please? Thank you. Dr. Larkin, I
 2 understand this is your curriculum vitae?
 3 DR. MORRIS-LARKIN:
 4 A. Yes, it is.
 5 COFFEY, Q.C.:
 6 Q. And Doctor, earlier this morning, you did
 7 point out that there was one typo you wanted
 8 to correct in it?
 9 DR. MORRIS-LARKIN:
 10 A. Yes, towards the end -
 11 COFFEY, Q.C.:
 12 Q. Okay, if I could, just a second, toward the
 13 end here, are we getting close there?
 14 DR. MORRIS-LARKIN:
 15 A. It's almost the last thing, I believe.
 16 COFFEY, Q.C.:
 17 Q. Okay, last thing on the page.
 18 THE COMMISSIONER:
 19 Q. You have a mouse in front of you which
 20 hopefully is working, if you want to control
 21 it yourself.
 22 COFFEY, Q.C.:
 23 Q. Yes, you go ahead.
 24 DR. MORRIS-LARKIN:
 25 A. The final entry there, acting co-chair, that's

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1 actually May 2008, not 2007.
 2 COFFEY, Q.C.:
 3 Q. Okay, acting co-chair, Pathology Quality
 4 Management Committee, Eastern Health, May
 5 2008.
 6 DR. MORRIS-LARKIN:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. To the current?
 10 DR. MORRIS-LARKIN:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. Okay, Doctor, I'm going to refer to you as Dr.
 14 Larkin, okay, if I could?
 15 DR. MORRIS-LARKIN:
 16 A. That's fine.
 17 COFFEY, Q.C.:
 18 Q. Dr. Larkin, could you give the Commissioner,
 19 please, then an overview of your educational
 20 and professional backgrounds?
 21 DR. MORRIS-LARKIN:
 22 A. I went to Memorial University and from a
 23 biochemistry background went into the medical
 24 school here. I graduated in 1984, did a
 25 rotating internship in St. John's and then

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1 went into the pathology residency training
 2 program from that. I did a year of pathology
 3 and decided to take a year to do some other--
 4 explore some other aspects of medicine. So I
 5 did some locums and then went back and
 6 finished the pathology residency training
 7 program in 1990.
 8 COFFEY, Q.C.:
 9 Q. That's here in St. John's?
 10 DR. MORRIS-LARKIN:
 11 A. In St. John's, yes. At that time then, I
 12 joined the Faculty of Medicine and the staff
 13 at what would have been the General Hospital
 14 as a faculty member and a staff pathologist,
 15 and I've been in that position ever since,
 16 with the changes of course to Health Care
 17 Corporation of St. John's and then Eastern
 18 Health.
 19 COFFEY, Q.C.:
 20 Q. And so you've worked at the General, I'll
 21 refer to it, the General Hospital site ever
 22 since?
 23 DR. MORRIS-LARKIN:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. And your positions at the General Hospital
 2 have been what?
 3 DR. MORRIS-LARKIN:
 4 A. For most of the time, it's been as a staff
 5 pathologist.
 6 COFFEY, Q.C.:
 7 Q. Yes.
 8 DR. MORRIS-LARKIN:
 9 A. In recent years, I've taken on some
 10 administrative roles for Eastern Health. I'm
 11 currently the site chief for pathology at the
 12 Health Science and I've been involved recently
 13 in the Quality Management Program for
 14 pathology for Eastern Health and in the
 15 training of the pathologist assistants.
 16 COFFEY, Q.C.:
 17 Q. Yes, and Doctor, you've been site chief at the
 18 General Hospital site, I believe since 2006?
 19 DR. MORRIS-LARKIN:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Doctor, are you also involved in training of
 23 residents?
 24 DR. MORRIS-LARKIN:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. Okay. Could you tell the Commissioner--I'm
 3 going to refer to some exhibits where it comes
 4 up from time to time, but could you tell the
 5 Commissioner about how--the nature of your
 6 involvement in training residents?
 7 DR. MORRIS-LARKIN:
 8 A. Well, in a teaching hospital setting, you
 9 always are interacting with the residents on a
 10 one-to-one basis. So I would be overseeing
 11 them as they learn how to gross specimens and
 12 then when they are learning how to diagnose
 13 the slides. So you know, just sort of an on-
 14 the-job training type of interaction. As
 15 well, there are more formal teaching sessions
 16 and there have been a variety of different
 17 formats over the years. We have what's called
 18 an academic half day for our pathology
 19 residents. So I would have regularly
 20 contributed there. As well, I would interact
 21 with them on a variety of the different rounds
 22 that we have that deal sometimes specifically
 23 with patients' cases and sometimes more
 24 academic related rounds that are something
 25 that probably they may do presentations, I may

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1 assist them with that.
 2 COFFEY, Q.C.:
 3 Q. Do you have closer involvement with teaching
 4 residents than other pathologists do?
 5 DR. MORRIS-LARKIN:
 6 A. It depends on the site we're talking about. I
 7 think certainly in St. John's, all of the
 8 pathologists have a great deal of interaction
 9 with the residents, so I don't think any more
 10 than any of my colleagues at Eastern Health,
 11 no.
 12 COFFEY, Q.C.:
 13 Q. And you're a member of the--have an
 14 appointment then with the Faculty of Medicine?
 15 DR. MORRIS-LARKIN:
 16 A. I am, yes.
 17 COFFEY, Q.C.:
 18 Q. Now if we could look, please, at Exhibit 2411
 19 please, P-2411? Doctor, you'll see it there
 20 on the screen in front of you. It's a
 21 memorandum, August 21st, 1997 from Dr. Khalifa
 22 to a number of individuals including yourself?
 23 DR. MORRIS-LARKIN:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. See your own name there. The reference is
 2 "initiating ER/PR immunostaining of in-house
 3 cases" and he writes "this is a reminder that
 4 the initiation of ER/PR immunostaining of our
 5 in-house cases remains the responsibility of
 6 the pathologist who first makes the diagnosis
 7 of invasive mammary malignancy on the
 8 respective specimen. As you already know,
 9 this is done by filling in a request form and
 10 submitting it to our laboratory. Although
 11 currently ER/PR slides come to me for
 12 reporting, the procedure has to be initiated
 13 by the primary pathologist since I have no
 14 access to the case in question at the time
 15 when the diagnosis is being made." Now,
 16 Doctor, I refer to this because I want to ask
 17 you then, in your training in the late 80s
 18 really, in effect, most of your training -
 19 DR. MORRIS-LARKIN:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. - as a resident would have been here in St.
 23 John's, how much, if any, exposure did you
 24 have to immunohistochemistry?
 25 DR. MORRIS-LARKIN:

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1 A. Very little. Most of what I learned in
 2 immunohistochemistry would have been as a
 3 working pathologist.
 4 COFFEY, Q.C.:
 5 Q. Okay, in the years afterward?
 6 DR. MORRIS-LARKIN:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. And at this point, and this is in 1997, ER and
 10 PR status, I take it you would have been just
 11 aware that there was such a thing as ER/PR and
 12 biochemists were involved in it?
 13 DR. MORRIS-LARKIN:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. That was the nature of it?
 17 DR. MORRIS-LARKIN:
 18 A. That was the nature of the test up to that
 19 time, yes.
 20 COFFEY, Q.C.:
 21 Q. And here, the Commissioner has heard evidence
 22 that by the middle of 1997, Dr. Khalifa was
 23 involved in testing for ER/PR by
 24 immunohistochemistry.
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. Paraffin blocks, and what do you recall about
 4 the introduction of that here in St. John's?
 5 And I'm going to be referring to you his memo
 6 in a moment, but by the time his memo comes
 7 along, February of '98, it's already agreed
 8 that it's going to happen.
 9 DR. MORRIS-LARKIN:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. What do you recall about it?
 13 DR. MORRIS-LARKIN:
 14 A. Well, I think this was an initiative of Dr.
 15 Khalifa's. He had come from a training centre
 16 in the United States where they had already
 17 been making the move from the biochemical
 18 testing to doing IHC staining for ER/PR. He
 19 was, as far as I understood, familiar with
 20 that in his training and had discussed it with
 21 the then clinical chief, Dr. Haegert, and I
 22 think they agreed that this was an appropriate
 23 type of move. This was the trend and we
 24 should be looking into moving in that
 25 direction.

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1 COFFEY, Q.C.:
 2 Q. And from your own perspective, as a staff
 3 pathologist at the General, now Dr. Khalifa
 4 was at the General Hospital?
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. You would have kind of seen him on a--
 9 certainly on a weekly basis around the -
 10 DR. MORRIS-LARKIN:
 11 A. On a daily basis, yes.
 12 COFFEY, Q.C.:
 13 Q. On a daily basis. At the time, Doctor--I'll
 14 ask the Registrar, please, if you could bring
 15 up, please, Exhibit P-1850? This is Dr.
 16 Khalifa's memo of February 16th, 1998 to all
 17 Newfoundland pathologists, which would, of
 18 course, included yourself. The reference is
 19 reporting of estrogen and progesterone
 20 receptor immunohistochemical results, and it
 21 says "as you all know, it has been suggested
 22 that assessment of ER/PR status in mammary
 23 invasive carcinomas be performed IHC on
 24 formalin fixed paraffin embedded tissues" and
 25 he goes on then to speak about it. The third

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1 paragraph, he says "as the technique was still
 2 in its introductory phase, phase one, I have
 3 been reporting results of the majority of
 4 cases to establish consistency and
 5 reproducible techniques" and then he refers to
 6 a more advanced stage of this pursuit, which
 7 is phase two, on the second page, "each
 8 pathologist will be asked to report results of
 9 his or her own cases as indicated by the brown
 10 staining of nuclei of the invasive neoplastic
 11 cells. That will start March 1, 1998, at
 12 which time the immunostained slides will be
 13 mailed back to you with positive controls
 14 whenever it is technically possible." And
 15 Doctor, up to this point, that's February and
 16 March of 1998, had you, in your practice, ever
 17 encountered having to look at nuclei staining,
 18 do you recall?
 19 DR. MORRIS-LARKIN:
 20 A. There -
 21 COFFEY, Q.C.:
 22 Q. How common was it to look at nuclei staining?
 23 DR. MORRIS-LARKIN:
 24 A. There are some stains that would have been
 25 available that do have some nuclear staining,

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1 but this was probably the--this was probably
 2 the most prominent at that time, that I can
 3 recall.
 4 COFFEY, Q.C.:
 5 Q. And was there any particular training that was
 6 made available for the pathologists at the
 7 General Hospital site, in relation to
 8 interpreting these stains?
 9 DR. MORRIS-LARKIN:
 10 A. There was no specific training. There were
 11 the general discussions in the run of a work
 12 day or, you know, during rounds, that kind of
 13 thing.
 14 COFFEY, Q.C.:
 15 Q. Doctor, did you have any misgivings at the
 16 time or reservations about getting involved in
 17 this?
 18 DR. MORRIS-LARKIN:
 19 A. I don't think so. I think I would have seen
 20 it as a part of the evolution of knowledge
 21 within a pathology department, something new
 22 that we had to learn about and carry on with.
 23 COFFEY, Q.C.:
 24 Q. Now here, in phase two, there's a reference to
 25 with positive controls. You'll see it in the

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1 fourth line there, "whenever it's technically
 2 possible" positive controls, and he says "I
 3 will still be responsible for reviewing the
 4 positive controls here in our lab" and we've
 5 heard evidence that that, in fact, refers to
 6 positive external controls.
 7 DR. MORRIS-LARKIN:
 8 A. It does, yes.
 9 COFFEY, Q.C.:
 10 Q. We've also heard evidence concerning internal
 11 control, internal controls, internal control
 12 tissue.
 13 DR. MORRIS-LARKIN:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. In relation to ER/PR, were you aware of the
 17 usage at this time of internal controls where
 18 ER/PR was concerned?
 19 DR. MORRIS-LARKIN:
 20 A. As well as I can recall, there--I had an
 21 awareness that breast tissue might stain and I
 22 remember having discussions about do we even
 23 need external controls when, you know, there
 24 could be some internal control staining, but I
 25 came away from those discussions with a final

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1 conclusion that I couldn't rely on the ER/PR
 2 staining of internal controls. So I would not
 3 have focused on that. I would have focused on
 4 external controls.
 5 COFFEY, Q.C.:
 6 Q. I'm sorry, you came away with -
 7 DR. MORRIS-LARKIN:
 8 A. With an understanding that you couldn't always
 9 rely on the internal control expression of
 10 ER/PR.
 11 COFFEY, Q.C.:
 12 Q. And do you recall who that discussion would
 13 have been with at the time?
 14 DR. MORRIS-LARKIN:
 15 A. I don't remember specifically who it was, no.
 16 COFFEY, Q.C.:
 17 Q. At the time, in the General Hospital kind of
 18 pathologist's milieu in early--late '97, early
 19 '98, when this was starting to be reported by
 20 individual pathologists, was there much
 21 discussion about this?
 22 DR. MORRIS-LARKIN:
 23 A. No more than discussion about other things. I
 24 mean, there are always discussions about new
 25 things or particular cases, but I don't recall

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1 this standing out as being a huge issue.
 2 COFFEY, Q.C.:
 3 Q. Were there any demonstrations or seminars that
 4 you recall at the General, kind of double-
 5 headed microscope people looking at ER/PR
 6 slides?
 7 DR. MORRIS-LARKIN:
 8 A. Not specifically, not that I recall.
 9 COFFEY, Q.C.:
 10 Q. Doctor, here as well, there is a reference to,
 11 this paragraph here you see with the cursor,
 12 "attached please find a proposal for uniform
 13 reporting of ER/PR immunohistochemical
 14 staining. This proposal was discussed with
 15 many of my colleagues who mostly agree with
 16 its content and accepted it as a policy. I
 17 encourage you to adopt the attached proposal
 18 in your reporting to maintain uniformity"--I'm
 19 sorry, "as I encourage you to adopt it to
 20 maintain uniformity, it should be clearly
 21 stated that this is only a proposal" and he
 22 refers to "there is a considerable host of
 23 publications addressing this issue" and he's
 24 prepared to share any that you might request.
 25 First of all, did you ever take Dr. Khalifa up

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1 on his offer to share this host of
 2 publications?
 3 DR. MORRIS-LARKIN:
 4 A. I don't think I did, no.
 5 COFFEY, Q.C.:
 6 Q. Okay, and here, on page three of the exhibit,
 7 there's a proposal for uniformity in reporting
 8 the ER/PR immunohistochemical assessment,
 9 February '98, and this is spelled out. Now, I
 10 haven't asked you, perhaps I should, you would
 11 have received this memo, I take it, back in
 12 1998?
 13 DR. MORRIS-LARKIN:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. Okay. This proposal for uniform reporting of
 17 ER/PR immunohistochemical assessment, did you
 18 adopt this reporting format?
 19 DR. MORRIS-LARKIN:
 20 A. Yes, I did.
 21 COFFEY, Q.C.:
 22 Q. Including the comment?
 23 DR. MORRIS-LARKIN:
 24 A. Yes, the rider.
 25 COFFEY, Q.C.:

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1 Q. The rider here, down here in example two.
 2 Doctor, in terms of your own approach to
 3 reporting ER/PR, how long then did you
 4 maintain that reporting style for ER/PR, do
 5 you recall?
 6 DR. MORRIS-LARKIN:
 7 A. I don't recall exactly when the change
 8 occurred, but at some point in--you know, in
 9 the evolution of my own knowledge, I went from
 10 having an appreciation that the oncologists
 11 would treat cases that had staining of less
 12 than 30 percent and I think at that point, I
 13 simply stopped using the rider and just left
 14 the percent without any further comment.
 15 COFFEY, Q.C.:
 16 Q. Doctor, here, just look at this exhibit, the
 17 actual kind of original memo of February of
 18 1998 is three pages long. On the fourth page
 19 of the exhibit now, there's
 20 "immunohistochemical staining of steroid
 21 receptors, correlation with biochemistry" and
 22 it's a report about experience over a nine-
 23 month period, January '97 to September '97.
 24 Do you ever recall seeing this?
 25 DR. MORRIS-LARKIN:

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1 A. I don't remember seeing it, but I was aware
 2 that Dr. Khalifa had done such a review.
 3 COFFEY, Q.C.:
 4 Q. Okay. Now Doctor, at the time, and this would
 5 be, again, early in 1998, the site chief at
 6 the General was Dr. Khalifa?
 7 DR. MORRIS-LARKIN:
 8 A. Yes, it was.
 9 COFFEY, Q.C.:
 10 Q. And what was your understanding of his degree
 11 of knowledge about immunohistochemistry?
 12 DR. MORRIS-LARKIN:
 13 A. I remember him having been involved
 14 particularly in this and I don't know that I
 15 had an appreciation of any particular
 16 expertise in immunohistochemistry, but he was
 17 very well versed in quite a number of things
 18 and he had a different training background, so
 19 I did feel comfortable with what I thought he
 20 knew.
 21 COFFEY, Q.C.:
 22 Q. And Doctor, with respect then to this matter,
 23 I take it then in 1998, you began to report
 24 your own ER/PR cases?
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. And that would be--that continued on through
 4 '99, 2000 and really up until 2005?
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Did you--I'm going to get to 2002 and 2003 in
 9 a moment, but prior to 2002, did you ever have
 10 any reason to doubt the validity of what you
 11 were seeing or any cause for concern about
 12 ER/PR?
 13 DR. MORRIS-LARKIN:
 14 A. Not specifically about ER/PR. I think that we
 15 had seen evolution of changes in our lab with,
 16 you know, general aspects of
 17 immunohistochemistry. We--and in 2002 -
 18 COFFEY, Q.C.:
 19 Q. Yes.
 20 DR. MORRIS-LARKIN:
 21 A. 2002 you're asking specifically?
 22 COFFEY, Q.C.:
 23 Q. Yes.
 24 DR. MORRIS-LARKIN:
 25 A. I don't recall there being anything specific

Page 25

1 about it, no.
 2 COFFEY, Q.C.:
 3 Q. About ER/PR. How about immunohistochemistry
 4 itself? Perhaps you could just tell the
 5 Commissioner about kind of, again, in the late
 6 '80s, there was very little of it.
 7 DR. MORRIS-LARKIN:
 8 A. Right.
 9 COFFEY, Q.C.:
 10 Q. Perhaps you can kind of bring us up through
 11 the '90s then, into the 2000's, as a
 12 pathologist here locally.
 13 DR. MORRIS-LARKIN:
 14 A. Well, it was something that was very much only
 15 developing throughout the '90s. There were
 16 new antibodies coming into our knowledge base
 17 on a regular basis and we were going,
 18 sometimes individuals going "oh, this sounds
 19 like a good antibody. We should probably get
 20 that" and the technologists would order them.
 21 So it wasn't--you know, it was quite ad hoc in
 22 the '90s as more and more information was
 23 being gathered. We had some pathologists who
 24 had more access to particular antibodies. One
 25 of our pathologists brought in some antibodies

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1 from a research lab that he had worked in and
 2 I think that when Dr. Khalifa came then in the
 3 late '90s, he kind of helped to organize what
 4 knowledge and what we had available in the lab
 5 so that he produced lists of -
 6 COFFEY, Q.C.:
 7 Q. Coming up with requisition forms.
 8 DR. MORRIS-LARKIN:
 9 A. With the requisition forms. Because before
 10 that, I think we were probably--we may not
 11 have even known all the antibodies that were
 12 potentially available to us at the time.
 13 COFFEY, Q.C.:
 14 Q. Within the lab itself?
 15 DR. MORRIS-LARKIN:
 16 A. Within the lab.
 17 COFFEY, Q.C.:
 18 Q. You might bring one in and somebody down the
 19 corridor might not realize you had and vice
 20 versa?
 21 DR. MORRIS-LARKIN:
 22 A. That's right.
 23 COFFEY, Q.C.:
 24 Q. Or even over at St. Clare's, they might have
 25 asked one to be brought in and it would be in

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1 the General Hospital IHC lab, but you wouldn't
 2 know it?
 3 DR. MORRIS-LARKIN:
 4 A. That's right.
 5 COFFEY, Q.C.:
 6 Q. Before Dr. Khalifa got involved in organizing
 7 it. Doctor, as an example of that, in the
 8 1990s, if you asked, for example, if it was
 9 yourself, for example, and you asked--you saw
 10 something in an article and you wanted a
 11 particular antibody -
 12 DR. MORRIS-LARKIN:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. - how would you go about getting it and then
 16 utilizing it?
 17 DR. MORRIS-LARKIN:
 18 A. I don't remember if I asked for any specific
 19 antibodies and actually received them. I do
 20 remember suggesting this may be a good
 21 antibody for us to have, and most of the time,
 22 it would probably be mentioned to one of the
 23 senior technologists or the then lab manager.
 24 COFFEY, Q.C.:
 25 Q. And then what would happen? That's yourself--

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1 some of your colleagues, like you've asked and
 2 somebody orders it, I take it. What happened
 3 then?
 4 DR. MORRIS-LARKIN:
 5 A. I think that--you know, I think that there
 6 were antibodies brought in. As I say, I don't
 7 remember if there was one specific antibody
 8 that I asked for that I got, but definitely
 9 antibodies were acquired based upon the
 10 requests from pathologists.
 11 COFFEY, Q.C.:
 12 Q. What was your understanding of what was
 13 happening then? I take it the antibody would
 14 come in -
 15 DR. MORRIS-LARKIN:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. - in probably a liquid form, and what was your
 19 understanding then would happen between the
 20 time it was ordered and the time, for example,
 21 you saw a slide?
 22 DR. MORRIS-LARKIN:
 23 A. I really would have very little knowledge of
 24 what would happen beyond, you know, asking we
 25 should perhaps look into getting this

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1 antibody, but what would happen in the lab
 2 itself, I really wouldn't have that knowledge.
 3 COFFEY, Q.C.:
 4 Q. And what I'm getting at is in relation to, for
 5 example, how would you know then that a
 6 stained slide that you received in relation to
 7 a new antibody was appropriately stained or
 8 not?
 9 DR. MORRIS-LARKIN:
 10 A. Again, we would be looking at controls and it
 11 would be compared to controls. So that's--
 12 that would be my benchmark really.
 13 COFFEY, Q.C.:
 14 Q. And these would be these external controls?
 15 DR. MORRIS-LARKIN:
 16 A. Both external and internal, because if you
 17 were looking at a particular type of stain and
 18 you knew that there was a tissue within--a
 19 normal tissue within your section, then you
 20 would automatically be able to see, well,
 21 that's also staining.
 22 COFFEY, Q.C.:
 23 Q. Okay. But in terms of, for example, if the
 24 concentration of the antibody had to be
 25 adjusted potentially, in terms of the way it

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1 was being utilized in the lab here in St.
 2 John's, would you ever--were you ever involved
 3 in that?
 4 DR. MORRIS-LARKIN:
 5 A. I wasn't, no.
 6 COFFEY, Q.C.:
 7 Q. In terms of dilution rates or -
 8 DR. MORRIS-LARKIN:
 9 A. No.
 10 COFFEY, Q.C.:
 11 Q. - things like that. Did you have any
 12 understanding about ER/PR, that it involved
 13 antigen retrieval, compared to--you know,
 14 compared to other IHC stains?
 15 DR. MORRIS-LARKIN:
 16 A. Again, at some point, I became aware of the
 17 technique of antigen retrieval, that it was
 18 something that was being used by the
 19 technologists. I believe they were using it
 20 for a variety of antibodies, not just those
 21 against ER and PR. But beyond that, I really
 22 wouldn't know anything much.
 23 COFFEY, Q.C.:
 24 Q. Do you recall when that would have been?
 25 DR. MORRIS-LARKIN:

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1 A. No.
 2 COFFEY, Q.C.:
 3 Q. On a topic that eventually you become much
 4 more involved in, okay, I'm going to refer you
 5 to an exhibit from years ago, Exhibit P-2539.
 6 Doctor, this is the agenda for a meeting of
 7 April 24th, 2001, at the General Hospital
 8 site. Look at the second page of the exhibit,
 9 you'll see your name listed as being present.
 10 It's the division of anatomical pathology,
 11 General Hospital site, minutes of a meeting of
 12 April 24th, 2001, and there are a number of
 13 topics discussed, but in particular of
 14 interest here now, paragraph 3.8, pathologist
 15 assistant. "There's been much discussion on
 16 this issue. However, Dr. Haegert will discuss
 17 with Dr. Williams in future. However, there
 18 is no money in the budget to fund this
 19 position. Dr. Sushil Parai will talk with
 20 Terry Gulliver, exploring the possibility of
 21 training two senior technologists for doing
 22 additional grossing." See that?
 23 DR. MORRIS-LARKIN:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Of course, you eventually end up involved
 2 years later with pathologists assistants.
 3 Doctor, the idea of utilizing pathologist
 4 assistants, when were you first introduced to
 5 that?
 6 DR. MORRIS-LARKIN:
 7 A. I think my first introduction to having
 8 someone other than a pathologist or a resident
 9 assist us at the gross bench actually came
 10 during Dr. Khalifa's time when he, in fact,
 11 trained some of the senior technologists to do
 12 very basic lab--some very basic assisting at
 13 the gross bench, so very small specimens where
 14 there was no examination, sectioning,
 15 selecting of blocks required. It was simply
 16 take the specimen from the specimen bottle,
 17 put it into the cassette and up until he had
 18 introduced that, that was a responsibility
 19 that was falling on residents and
 20 pathologists. So that would have been the
 21 first introduction to this concept, although
 22 at a very basic level, and I think that that
 23 was something that was becoming more
 24 widespread elsewhere in the province as well.
 25 COFFEY, Q.C.:

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1 Q. Elsewhere in the country?
 2 DR. MORRIS-LARKIN:
 3 A. And elsewhere in the country. I think
 4 elsewhere in the country we knew about
 5 pathologist assistants.
 6 COFFEY, Q.C.:
 7 Q. Doctor -
 8 DR. MORRIS-LARKIN:
 9 A. And certainly in the United States we were
 10 aware.
 11 COFFEY, Q.C.:
 12 Q. And what's your recollection then how the
 13 local pathologists, how did they react to the
 14 idea of utilizing pathologist assistants?
 15 DR. MORRIS-LARKIN:
 16 A. The vast majority were all in favour. I think
 17 I heard one pathologist who was only briefly
 18 here voice some concern over it, but I think
 19 the overwhelming majority would be in favour
 20 of this.
 21 COFFEY, Q.C.:
 22 Q. And if we could, Exhibit P-2540? Doctor, page
 23 2 again. These are minutes of a meeting of
 24 June 14, 2001. You'll see you're listed as
 25 present. It's the division of anatomical

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1 pathology. And in particular, paragraph 3.4,
 2 pathologist assistants. "Much"--this is a
 3 couple of months later, "Much discussion on
 4 this issue. It is unlikely that the
 5 corporation will fund for pathologist
 6 assistant. However, we have three senior
 7 technologists who will be willing to do
 8 additional grossing if their jobs were to be
 9 classified to a technologist three level. It
 10 is expected that we will know this information
 11 very soon." And they refer to some issues
 12 involving specimen labelling and handling.
 13 And, Doctor, I take it at this point in time,
 14 in the middle of 2001, you weren't involved in
 15 the pathologists assistants issue? You're
 16 attending these meetings where it's being
 17 discussed, but -
 18 DR. MORRIS-LARKIN:
 19 A. Only in this meeting kind of setting, yes.
 20 COFFEY, Q.C.:
 21 Q. Yes. And in terms of the idea of utilizing
 22 the three technologists, you know, if they
 23 were to get involved, you did not get involved
 24 at that time?
 25 DR. MORRIS-LARKIN:

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1 A. I think that was more an administrative thing
 2 as a way to try and--to try and get around the
 3 fact that we were not being given an specific
 4 funding for pathologist assistants.
 5 COFFEY, Q.C.:
 6 Q. Here under 4.4 "ASCP Check Schedule", I'm
 7 sorry, "Check Sample" and can you tell us,
 8 please, well, it goes on to say, "The
 9 corporation has prescribed 2001 ASCP check
 10 samples as follows: Surgical Pathology 8 -
 11 exercises. Surgical Pathology II - 8
 12 exercises. Cytopathology - 12 exercises.
 13 These are available in the reporting room.
 14 Check sample answer sheet has been circulated
 15 to all Pathologists and this can be completed
 16 at the end of the year for CME credit hours."
 17 Can you tell us, please, what, if any--well,
 18 first of all, what this involved, what this is
 19 speaking about?
 20 DR. MORRIS-LARKIN:
 21 A. There are several proficiency testing systems
 22 available and the one that we had subscribed
 23 to at the General Hospital was from the
 24 College of American Pathologists. The one
 25 that had been subscribed to at the Grace

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1 Hospital was the ASCP check sample. I was
 2 less familiar with this, but I think that with
 3 the merger, the closure of the Grace and then
 4 the transfer of several of the pathologists,
 5 they brought this particular set along with
 6 them, although I think it was very short
 7 lived. We probably only had this particular
 8 testing or this particular proficiency test
 9 exercise for about a year. I may be wrong on
 10 the exact number of dates. But we continued
 11 with the other one, which I'm more familiar
 12 with, which is the PIP type of proficiency
 13 testing. So this basically would involve case
 14 presentation with, I think the ASCP was always
 15 just kodachrome slides, so you'd have a case
 16 presentation, you'd have slides that were
 17 essentially photographs of, micro photographs
 18 of a case and then questions to answer on it.
 19 COFFEY, Q.C.:
 20 Q. Okay. And you otherwise yourself had been
 21 familiar with and involved in the CAP?
 22 DR. MORRIS-LARKIN:
 23 A. Yes. That's -
 24 COFFEY, Q.C.:
 25 Q. Project. Could you tell the Commissioner

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1 about when, your recollection is when you
 2 first got involved with that and how long it
 3 continued for?
 4 DR. MORRIS-LARKIN:
 5 A. I think we began subscribing to the CAP again
 6 around the time Dr. Khalifa was site chief. I
 7 believe it was '96 or '97. And we have
 8 subscribed to it ever since with perhaps one
 9 year there was a lapse in the subscription for
 10 some reason, I'm not entirely certain.
 11 COFFEY, Q.C.:
 12 Q. And what does that involve?
 13 DR. MORRIS-LARKIN:
 14 A. There are four sets per year sent out, which
 15 include usually about ten glass slides that
 16 are difficult cases and then a set of
 17 questions that go with it. And what you would
 18 do is review the slides, make your diagnosis
 19 based on the history provided and the slides-
 20 it was a multiple choice type of thing. And
 21 then there would be further multiple choice
 22 questions to allow you to deepen your
 23 knowledge. So essentially what we would do is
 24 we would all get this--or photocopies of this,
 25 the slides would be available, we would all

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1 review them and then we would get together on
 2 an assigned time and review it as a group, but
 3 by then everyone would have researched the
 4 answers, looked at the slides, kind of come
 5 together and then talk about, maybe argue back
 6 and forth over why I think it's diagnosis X
 7 and why you think it's diagnosis Y. And then
 8 we would get the answers to the questions.
 9 COFFEY, Q.C.:
 10 Q. And these would be generally complicated?
 11 DR. MORRIS-LARKIN:
 12 A. They're usually complicated cases.
 13 COFFEY, Q.C.:
 14 Q. Do you ever remember ER and PR slides being
 15 utilized in that, that you recall?
 16 DR. MORRIS-LARKIN:
 17 A. Not specifically, but it's possible there
 18 could have been because certainly with time
 19 there are more and more, more and more
 20 reference to immunohistochemistry. In that
 21 particular set we would not have received
 22 ER/PR slides, they were always H&E slides. We
 23 would have just been told what the results of
 24 the immunohistochemistry testing was in the
 25 little summary that goes with the slide.

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1 COFFEY, Q.C.:
 2 Q. In order to allow you to continue on with your
 3 analysis of the H&E slides?
 4 DR. MORRIS-LARKIN:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. Okay. And these would not, though, involve
 8 any creation of local slides locally?
 9 DR. MORRIS-LARKIN:
 10 A. Not this particular -
 11 COFFEY, Q.C.:
 12 Q. Not that type?
 13 DR. MORRIS-LARKIN:
 14 A. No.
 15 COFFEY, Q.C.:
 16 Q. In your years there up until more recent,
 17 since 2005, prior to 2005 were you ever aware
 18 of, in the General Hospital site, where there
 19 was proficiency testing going on that required
 20 the creation of slides locally?
 21 DR. MORRIS-LARKIN:
 22 A. In terms of one of these organized -
 23 COFFEY, Q.C.:
 24 Q. Yes.
 25 DR. MORRIS-LARKIN:

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1 A. CAPS?
 2 COFFEY, Q.C.:
 3 Q. Yes.
 4 DR. MORRIS-LARKIN:
 5 A. I'm not aware of it, no.
 6 COFFEY, Q.C.:
 7 Q. CAP or any other program, to your knowledge?
 8 DR. MORRIS-LARKIN:
 9 A. Or any other, no. But it may have happened
 10 without--I wouldn't have been in the knowledge
 11 loop for that.
 12 COFFEY, Q.C.:
 13 Q. And you were never asked to get involved, and
 14 that's what I'm getting at?
 15 DR. MORRIS-LARKIN:
 16 A. No.
 17 COFFEY, Q.C.:
 18 Q. Okay. If we could, finally, on this again, to
 19 put some of this in context for the
 20 Commissioner, 4.5 here, "Resident Training."
 21 It says that, this is June 14, 2001. "It is
 22 expected that one pathology resident will
 23 start as of July 1st, 2001. Dr. Robb has
 24 asked all staff to teach and train the
 25 resident in a positive way. This is a

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1 challenge for the program and therefore
 2 cooperation is highly appreciated." Now,
 3 Doctor, I take it then that residencies
 4 generally start the beginning of July?
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. So this would be one pathology resident would
 9 be starting for the then, the then coming
 10 year?
 11 DR. MORRIS-LARKIN:
 12 A. And I think, I think, again, this has to be
 13 perhaps further explained.
 14 COFFEY, Q.C.:
 15 Q. Sure.
 16 DR. MORRIS-LARKIN:
 17 A. We went through a period of about four, maybe
 18 five, but I think four years where we had no
 19 pathology residents at all.
 20 COFFEY, Q.C.:
 21 Q. Yes. I was going to ask you about that, okay,
 22 this is a way of coming to that. Could you
 23 tell us, please, then about that? Like, you
 24 were trained here in the late '80s?
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. And what your recollection is of kind of the
 4 availability of residents in training here as
 5 time progressed?
 6 DR. MORRIS-LARKIN:
 7 A. I think that a major part of our problem has
 8 been, in fact -
 9 COFFEY, Q.C.:
 10 Q. If I could, just before, because I'm going to
 11 ask you about the why.
 12 DR. MORRIS-LARKIN:
 13 A. Okay.
 14 COFFEY, Q.C.:
 15 Q. Just the actual what happened, in the late
 16 '80s, like, how many would you have trained
 17 with, approximately, how many pathology
 18 residents in the late '80s?
 19 DR. MORRIS-LARKIN:
 20 A. There were usually seven to eight of us in the
 21 program. There was some turnover and, you
 22 know, people would not finish; people would
 23 come in, decide this wasn't for them. And
 24 that probably continued to the mid '90s.
 25 COFFEY, Q.C.:

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1 Q. Okay.
 2 DR. MORRIS-LARKIN:
 3 A. We had a regular, a regular group of up to
 4 about eight residents.
 5 COFFEY, Q.C.:
 6 Q. A core group of about a half dozen and maybe a
 7 bit higher?
 8 DR. MORRIS-LARKIN:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. Okay. And then what happened then?
 12 DR. MORRIS-LARKIN:
 13 A. Many of our residents have come from
 14 international medical schools and that's
 15 common in pathology across North America.
 16 What we saw in the late '90s was a much
 17 tighter restriction on who was going to get in
 18 the residency programs based upon licensure.
 19 And I think that one of the big things that
 20 resulted here in Newfoundland was the
 21 restriction, the way the criteria were
 22 written, it very much limited the availability
 23 of the pool of people who we could draw from.
 24 In particular, the rules were such that
 25 someone who was trained as a pathologist who

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1 may not have been in any kind of clinical
 2 practice for several years because they had
 3 immigrated from their country of practice and
 4 were now working at whatever job they could to
 5 keep them sustained, were out of actual
 6 clinical practice for a longer period of time
 7 than the Newfoundland Medical Board would
 8 allow and as a result, they were not eligible
 9 for educational licence. That was a major
 10 reason why we had a significant drop in the
 11 number of residents.
 12 COFFEY, Q.C.:
 13 Q. Yes. Because -
 14 DR. MORRIS-LARKIN:
 15 A. To the point where we had none. And -
 16 COFFEY, Q.C.:
 17 Q. You were about to tell the Commissioner, I
 18 apologize, I interrupted you, you said for a
 19 period of about four or five years?
 20 DR. MORRIS-LARKIN:
 21 A. It happened for about four years. And it was,
 22 it was at the initiative of the late Dr. Robb,
 23 who invested a great deal of time with the
 24 Newfoundland Medical Board to try and define
 25 criteria that would be appropriate for

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1 pathologists who had lab exposure but yet
 2 didn't have the official clinical lab practice
 3 or the clinical kinds of practice that the
 4 Newfoundland Medical Board were looking for.
 5 COFFEY, Q.C.:
 6 Q. So I take it then in the turn of the century,
 7 2000, 2001 Dr. Robb was able to -
 8 DR. MORRIS-LARKIN:
 9 A. He had been successful in trying to, you know,
 10 refine these particular requirements so that,
 11 you know, so that it made sense. And now our
 12 residency program is, you know, fairly well
 13 full again. And again, almost entirely of
 14 international medical graduates, although we
 15 do have a few Canadian graduates in the
 16 program.
 17 COFFEY, Q.C.:
 18 Q. So then beginning in the early 2000s, in
 19 effect, the residency program for pathologists
 20 here in St. John's began to slowly be built
 21 again?
 22 DR. MORRIS-LARKIN:
 23 A. It had to rebuild, yes. So we were used to
 24 doing things without residents for a period of
 25 time.

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1 COFFEY, Q.C.:
 2 Q. And so in the late '90s, certainly, you would
 3 have been used to it because you had no
 4 residents?
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. In the late '90s itself?
 9 DR. MORRIS-LARKIN:
 10 A. That's right.
 11 COFFEY, Q.C.:
 12 Q. And then even in the early 2000s you would
 13 have had relatively few residents to assist?
 14 For example, here -
 15 DR. MORRIS-LARKIN:
 16 A. It quickly, it quickly built up again.
 17 COFFEY, Q.C.:
 18 Q. Okay, in 2001, '01, '02 year, that school
 19 year, as it were.
 20 DR. MORRIS-LARKIN:
 21 A. Right.
 22 COFFEY, Q.C.:
 23 Q. Academic year, there would have been one, I
 24 take it?
 25 DR. MORRIS-LARKIN:

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1 A. There was one starting, but--and I don't
 2 remember specifically who that was at that
 3 time, but I guess we got to a full kind of
 4 complement by 2002, 2003, because we graduated
 5 four people in 2006.
 6 COFFEY, Q.C.:
 7 Q. Okay. Doctor, I don't know how fair this
 8 question is, but do residents, being involved
 9 with pathology residents, does it increase the
 10 pathologists workload or decrease it or is it
 11 neutral in terms of your interaction with
 12 them?
 13 DR. MORRIS-LARKIN:
 14 A. It definitely increases a pathologist's
 15 workload. But there was some trade off in
 16 that there are certain things that then once
 17 you trained your resident to do, you could
 18 hand off to them. So things like the
 19 grossing, once they were trained, the
 20 autopsies, that kind of thing, so there's also
 21 a bit of a trade off, as well. It also keeps
 22 you on your toes and, you know, there's a
 23 great deal more educational aspect that has to
 24 be paid attention to so that there's probably
 25 more work in preparing rounds and

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1 presentations, you know, particularly the
 2 teaching at the academic half days, as I
 3 mentioned.
 4 COFFEY, Q.C.:
 5 Q. Exhibit C-0175, please? Actually, if I could,
 6 I apologize, C-0184, first of all. Doctor,
 7 this is a redacted pathology report. It's,
 8 you'll see here from the date, the specimen
 9 number is 02SU6969. It's indicated to be
 10 received May 16th, 2002. Go on to the second
 11 page of the exhibit, see your name there at
 12 the bottom. And then the third page here, at
 13 the very bottom of the page is addendum number
 14 one, entered July 10th, 2002. And you've
 15 written "Less than ten percent of the cells
 16 show positivity for estrogen receptors. This
 17 correlates with a negative estrogen receptor
 18 result." And "Approximately 25 percent of the
 19 cells are positive for progesterone receptors,
 20 MC." And that is actually signed
 21 electronically by yourself on July 10th, 2002.
 22 So that's July 10th, '02. Addendum number two
 23 reads, "Due to the" and this entered July 22nd
 24 and signed the same day by yourself, 2002.
 25 You wrote, "Due to the unavailability of a

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1 control the ER and PR were repeated. A
 2 difference is seen in the results as follows:
 3 Approximately 30 percent of the cells are
 4 positive for estrogen receptors, best
 5 considered a positive ER result. 50 percent
 6 are positive for PR receptors." Doctor, do
 7 you actually recall this case?
 8 DR. MORRIS-LARKIN:
 9 A. I don't recall this specific case, no.
 10 COFFEY, Q.C.:
 11 Q. Specific case. And then, Doctor, and I
 12 appreciate--again for the Commissioner's
 13 benefit, that you would report approximately
 14 how many cases a year, not just ER/PR, but how
 15 many cases a year would you report?
 16 DR. MORRIS-LARKIN:
 17 A. I would--well, I would report in all of my
 18 practice, because I don't do just surgical
 19 pathology.
 20 COFFEY, Q.C.:
 21 Q. Yes.
 22 DR. MORRIS-LARKIN:
 23 A. At that time I would have done cytology, bone
 24 marrows, peripheral bloods, approximately 2000
 25 cases per year.

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1 COFFEY, Q.C.:
 2 Q. Per year.
 3 DR. MORRIS-LARKIN:
 4 A. And less than one percent of that would be
 5 related to breast cancer.
 6 COFFEY, Q.C.:
 7 Q. And in this, in terms of that, because you'd
 8 been beginning in March of '98 would begin to
 9 report ER/PR?
 10 DR. MORRIS-LARKIN:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. In breast cancer cases. Approximately how
 14 many breast cancer cases a year would you do,
 15 report?
 16 DR. MORRIS-LARKIN:
 17 A. Again, to try and give you a number would be
 18 impossible, but probably one every few weeks,
 19 maybe. You know, no more than that.
 20 COFFEY, Q.C.:
 21 Q. One a month?
 22 DR. MORRIS-LARKIN:
 23 A. One to two a month, maximum.
 24 COFFEY, Q.C.:
 25 Q. Maximum?

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1 DR. MORRIS-LARKIN:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. In a typical year?
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. And I take it that you caught whatever breast
 9 cancer cases you did on your rotation at the
 10 General Hospital, that's, in effect?
 11 DR. MORRIS-LARKIN:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. The way it would work?
 15 DR. MORRIS-LARKIN:
 16 A. Yes. We would, you know, we would be assigned
 17 cases and whatever particular rota we were
 18 using at a given time, the cases that came
 19 out, the slides that came out, they were our
 20 cases.
 21 COFFEY, Q.C.:
 22 Q. Now, Doctor, here, looking at this, this
 23 addendum number one, addendum number two, can
 24 you tell the Commissioner what appears from,
 25 you know, looking at what's written here, what

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1 appears to have happened?
 2 DR. MORRIS-LARKIN:
 3 A. I think what would have happened is I would
 4 have signed the case based upon the H&E slides
 5 so that the bulk of the information would have
 6 been available and I would have provided that
 7 for the clinician and then would have ordered
 8 the ER and PR. Reading the addendum number
 9 one, that would have, at that time, fallen
 10 into my 30 percent cutoff that I would have
 11 been using. And I can see I've done a
 12 modification of the rider. I probably didn't
 13 have the exact thing in front of me and we
 14 didn't have it as a canned text, but the -
 15 COFFEY, Q.C.:
 16 Q. So this -
 17 DR. MORRIS-LARKIN:
 18 A. Basically I was referring to that rider less
 19 than 30 percent would correlate with a
 20 negative estrogen result on biochemistry.
 21 COFFEY, Q.C.:
 22 Q. So this -
 23 DR. MORRIS-LARKIN:
 24 A. So that's -
 25 COFFEY, Q.C.:

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1 Q. This sentence was a reference to what would
 2 otherwise have been the rider -
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. - if you had it in front of you? So you were
 7 still utilizing the rider at this point in
 8 time?
 9 DR. MORRIS-LARKIN:
 10 A. Yes, I was.
 11 COFFEY, Q.C.:
 12 Q. That mind set. And I'm sorry, go ahead,
 13 Doctor?
 14 DR. MORRIS-LARKIN:
 15 A. So addendum number two where I say "Due to
 16 unavailability of a control, the ER and PR
 17 were repeated." I would have, at that time,
 18 been looking at the controls myself. I would
 19 have wanted to see the control, and if for
 20 whatever reason it hadn't been provided to me
 21 and where that would have fallen into that
 22 interpreted as negative range from a clinical
 23 point of view, I would have wanted to see a
 24 control with it, so the only way I could deal
 25 with it was to repeat the entire thing and

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1 have the control to compare it to.
 2 COFFEY, Q.C.:
 3 Q. It's apparent then, I take it, that you did
 4 reorder the test?
 5 DR. MORRIS-LARKIN:
 6 A. And I did repeat that stain with the control
 7 and with that result and my interpretation.
 8 COFFEY, Q.C.:
 9 Q. Now, the unavailability of a control, this
 10 would be an external control?
 11 DR. MORRIS-LARKIN:
 12 A. That would have been the external control.
 13 COFFEY, Q.C.:
 14 Q. External controls.
 15 DR. MORRIS-LARKIN:
 16 A. At that time I would have been referring to,
 17 yes.
 18 COFFEY, Q.C.:
 19 Q. Doctor, why would you report addendum number
 20 one, a case like here, without having seen the
 21 external controls?
 22 DR. MORRIS-LARKIN:
 23 A. Perhaps because I did see that, you know,
 24 there was a positive stain there and I don't
 25 know what the clinicians were actually doing,

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1 even though I know we were referencing this 30
 2 percent. You know, if you were to take all
 3 the other--if the clinicians were to take all
 4 the other aspects, whether or not they would
 5 utilize it--specifically why I sent it out, I
 6 don't know. Maybe I just dictated it and
 7 said, well, you know, I really shouldn't do
 8 that, the better practice would be for me to
 9 get the control, and I'd already signed it.
 10 That's the only explanation I can give you.
 11 COFFEY, Q.C.:
 12 Q. Okay, you'd already kind of gone through the
 13 process -
 14 DR. MORRIS-LARKIN:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. And thought, in effect -
 18 DR. MORRIS-LARKIN:
 19 A. Because this would have been electronic
 20 signature and -
 21 COFFEY, Q.C.:
 22 Q. Entered it and signed it off the same day, in
 23 fact.
 24 DR. MORRIS-LARKIN:
 25 A. And said, and, you know, something in my head

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1 said, well, you know, you really should make
 2 sure you see that control, and that was the
 3 best way to do it then was to repeat it.
 4 COFFEY, Q.C.:
 5 Q. Doctor, did that cause you any concern when on
 6 the repeat it went from less than ten, the ER
 7 went from less than ten to 30?
 8 DR. MORRIS-LARKIN:
 9 A. I don't remember noting that specific case. I
 10 mean, it caused me concern enough to make sure
 11 that it was reported and that the oncologist
 12 had that kind of information. But again, we
 13 were--I was just trying to report what I had
 14 there and I didn't know exactly how they were
 15 going to utilize the percentages.
 16 COFFEY, Q.C.:
 17 Q. And you've said here, "Best considered a
 18 positive ER control." I'm sorry, "Best
 19 considered a positive ER result" here in
 20 addendum number two, the second -
 21 DR. MORRIS-LARKIN:
 22 A. Yes, and that's a reflection of the agonizing
 23 that I certainly did over is it less than 30
 24 percent or more than 30 percent. I might call
 25 something 25 percent, my colleague might call

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1 it 35 percent.
 2 COFFEY, Q.C.:
 3 Q. Yes.
 4 DR. MORRIS-LARKIN:
 5 A. And these were the kinds of things that we,
 6 you know, certainly I agonized over.
 7 COFFEY, Q.C.:
 8 Q. And "Best considered a positive ER result"
 9 would be in keeping with this comment of Dr.
 10 Khalifa had utilized -
 11 DR. MORRIS-LARKIN:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. - back in '98, you're still thinking in that
 15 mode, thinking about this?
 16 DR. MORRIS-LARKIN:
 17 A. I was still thinking in terms of the reference
 18 to the biochemical assay.
 19 COFFEY, Q.C.:
 20 Q. And if you say agonizing over it, thinking
 21 well, I'm saying 30, you would have understood
 22 that a colleague might say 20, 25, 35, 40,
 23 depending upon who the colleague was?
 24 DR. MORRIS-LARKIN:
 25 A. Yes, and, I mean, this was always an issue

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1 with this 30 percent cutoff because it sounds
 2 so quantitative when, in fact, it's not. It's
 3 really a subjective judgment call. And it's
 4 always difficult. There are other areas of
 5 pathology where you see this kind of
 6 percenting, and it's always associated with
 7 the same kind of semi-quantitative judgment
 8 call that you try your best to be as accurate
 9 on as possible.
 10 COFFEY, Q.C.:
 11 Q. Would you have brought this, at the time, to
 12 the attention of anyone else, the fact it had
 13 gone from, well, in effect, ten, less than ten
 14 to 30 ER and from 25 PR to 50 PR?
 15 DR. MORRIS-LARKIN:
 16 A. I don't think I did.
 17 COFFEY, Q.C.:
 18 Q. And at the time no particular significance to
 19 you?
 20 DR. MORRIS-LARKIN:
 21 A. Other than again there's always some degree of
 22 variation.
 23 COFFEY, Q.C.:
 24 Q. Yes.
 25 DR. MORRIS-LARKIN:

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1 A. And we always, we always have a spectrum of
 2 expectation. And I don't recall this standing
 3 out as something that I did anything about.
 4 COFFEY, Q.C.:
 5 Q. Now, Doctor, this happens to be around the
 6 time that--in terms of the timing, that Peggy
 7 Deane, July of 2002 is when Peggy Deane's
 8 initially ER/PR testing was done. It didn't
 9 involve yourself, but it was done around the
 10 same time.
 11 DR. MORRIS-LARKIN:
 12 A. Okay.
 13 COFFEY, Q.C.:
 14 Q. In the summer of 2002, and I appreciate you
 15 referred here to the unavailability of a
 16 control as being the reason why you reordered
 17 the test, were there any concerns that you
 18 were aware of amongst pathologists about the
 19 ER/PR testing?
 20 DR. MORRIS-LARKIN:
 21 A. I don't remember anything being expressed, and
 22 as far as the unavailability of a control, I
 23 may have had a note that said this is with Dr.
 24 "X" and then Dr. "X" had already looked at it
 25 and filed it, so -

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1 COFFEY, Q.C.:
 2 Q. What was the practice in relation to that in
 3 terms of the - at that time in the middle of
 4 2002 about the availability of external
 5 controls for yourself at the General Hospital?
 6 DR. MORRIS-LARKIN:
 7 A. I think at that time we were, for the most
 8 part, receiving a control with our slides, but
 9 sometimes there would be just one control
 10 within the department, and that's when you
 11 would get the note that said, you know, doctor
 12 so and so has the control.
 13 COFFEY, Q.C.:
 14 Q. Was there any communication within the
 15 department at the time at the General Hospital
 16 about, like, Dr. "X" actually having examined
 17 the control and satisfied him or herself that
 18 it was working, and then communicating that to
 19 everybody else?
 20 DR. MORRIS-LARKIN:
 21 A. I don't think that was the system that was in
 22 place. I think the system that - my
 23 appreciation of the system was I had to look
 24 at my own control.
 25 COFFEY, Q.C.:

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1 Q. And then - I take it then even preparing
 2 addendum number one, looking at the slides
 3 initially, you'd be looking for, well, where
 4 are the external controls?
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. And if they were already filed away, why
 9 wouldn't you just go get them or have somebody
 10 go get them for you?
 11 DR. MORRIS-LARKIN:
 12 A. I don't know what the exact - what the exact
 13 thing was. It may have been filed with their
 14 case, and - I don't know exactly what happened
 15 in that particular one.
 16 COFFEY, Q.C.:
 17 Q. Okay. Was it a common problem?
 18 DR. MORRIS-LARKIN:
 19 A. I don't think so.
 20 COFFEY, Q.C.:
 21 Q. Controls not being available.
 22 DR. MORRIS-LARKIN:
 23 A. No, I don't think so.
 24 COFFEY, Q.C.:
 25 Q. Exhibit P-3350. I apologize - Exhibit P-2426,

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1 page three, please. Doctor, these are - page
 2 three are minutes of site chiefs and
 3 divisional managers of April 24th, '02. Drs.
 4 Cook, Parai and there, and Barry Dyer. In
 5 paragraph 3.1, there's a reference to quality
 6 control and quality assurance program, "A
 7 draft has been circulated. Some of the items
 8 of this draft were discussed in the meeting of
 9 November, however, it was felt that this draft
 10 proposal be reviewed by the site chiefs and
 11 divisional manager and their edited opinion
 12 will be discussed in the next meeting". I
 13 take it then, Doctor - I appreciate you
 14 wouldn't have been at this meeting, but as of
 15 April, 2002, there was a recognition locally
 16 that there were concerns about quality control
 17 and quality assurance programs, whether or not
 18 they existed, and if so, whether they were
 19 sufficient?
 20 DR. MORRIS-LARKIN:
 21 A. I think that's true. There have always been
 22 some quality control activities in place as
 23 well as quality assurance activities, and this
 24 was an attempt to take it to the next level of
 25 putting it into a more organized program that

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1 could be better monitored and managed.
 2 COFFEY, Q.C.:
 3 Q. Page seven, please, Registrar. This is
 4 minutes of a meeting of February 17th '03, the
 5 same group of people, three of those
 6 individuals, but under 3.1 again, quality
 7 assurance program, "Dr. Parai informed that
 8 he's prepared another draft on quality
 9 assurance. The typing is not yet complete.
 10 He will circulate it as soon as typing is
 11 complete. There will be a second document
 12 that will be reviewed in the next meeting
 13 before final approval". So I take it then,
 14 Doctor, going into early 2003, this was still
 15 going on, efforts in this regard?
 16 DR. MORRIS-LARKIN:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. From your perspective as a practising
 20 pathologist here in St. John's at the General
 21 Hospital, in relation to organizing QA and QC,
 22 who's responsible for ensuring that such a
 23 program existed and was implemented?
 24 DR. MORRIS-LARKIN:
 25 A. I think the - I think the responsibility was

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1 the management team and I think that's what
 2 this reflects as their recognition of the need
 3 to have this in a more organized manner.
 4 COFFEY, Q.C.:
 5 Q. If I could, please, Registrar, page 10, same
 6 exhibit. Here there's a Division of
 7 Anatomical Pathology pathologists meeting at
 8 the General Hospital site, March 4, '03.
 9 You're not listed as in attendance for that
 10 particular day, but when we go to the next
 11 page, 4.2, QA Program, "The draft policy has
 12 been circulated to all the pathologists for
 13 review and revision". So I take it there was
 14 by the beginning of 2003 at least a draft
 15 policy?
 16 DR. MORRIS-LARKIN:
 17 A. There was a - there was something circulated,
 18 yes.
 19 COFFEY, Q.C.:
 20 Q. What's your memory of how far they got with
 21 that at the time?
 22 DR. MORRIS-LARKIN:
 23 A. I don't think they got much further than that
 24 at that time because again it was one of many
 25 things that the leadership team were trying to

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1 deal with, and like many things, would get a
 2 certain amount of attention, and then
 3 something else would perhaps be more pressing.
 4 COFFEY, Q.C.:
 5 Q. Here at page 14 of the same exhibit, May 1st,
 6 2003, meeting of pathologists at the General
 7 Hospital site. You're noted as being absent,
 8 but I take it you would have eventually gotten
 9 the minutes?
 10 DR. MORRIS-LARKIN:
 11 A. I would have gotten the minutes, yes.
 12 COFFEY, Q.C.:
 13 Q. Here in Paragraph 3.2, there's a QA Program,
 14 "A draft proposal of this program has been
 15 circulated previously. There's been a few
 16 comments by some staff to make some changes,
 17 which will be done. In addition, the issue of
 18 cancer diagnosis by a second pathologist was
 19 discussed in detail. It was decided that all
 20 the difficult and problematic cases like
 21 prostatic needle biopsies, lymph node,
 22 gastric, and lung biopsies, the opinion of a
 23 second pathologist would be included in the
 24 microscopic description. This will be
 25 incorporated in large specimens as well. At

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1 the present moment, there is no way to put the
 2 signature of a second pathologist in the
 3 Meditech System". I take it this was an
 4 effort at the time to move ahead with this?
 5 DR. MORRIS-LARKIN:
 6 A. Yes, there were a lot of discussions. This was
 7 something that was being done at other sites
 8 and I think Dr. Ejeckam had experience with
 9 this kind of practice, but it wasn't again in
 10 any kind of formalized way that we could put -
 11 I would look at one case and then give it to
 12 my colleague and both of us would be able to
 13 officially sign it. So as a fall back, I
 14 think, what would happen is you would - if you
 15 wanted somebody's support on a case, you would
 16 have them sign an internal consult form.
 17 COFFEY, Q.C.:
 18 Q. Here looking at page 20 of the same exhibit,
 19 to follow through on this, again there's
 20 another pathologist meeting and the minutes of
 21 September 24th, 2003, at the General Hospital
 22 site. Again you're not noted to be present,
 23 but you would have been still employed there
 24 at the time, I take it. 3.2, QA Program, "The
 25 final QA program will be completed soon after

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1 a final meeting with Dr. Cook and Barry Dyer.
 2 However, the present practice of mentioning
 3 the name of the consulting pathologist in the
 4 microscopic description will continue". So
 5 that was the way around that?
 6 DR. MORRIS-LARKIN:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. If we could, page 22, same exhibit, paragraph
 10 - this is December 18th, 2003, minutes of a
 11 meeting at the General Hospital amongst
 12 pathologists - well, this is amongst the site
 13 chiefs actually. 3.1, Quality Assurance
 14 Program, "The draft quality assurance program
 15 has been reviewed and revised". It's still in
 16 draft form trying to be finalized. What were
 17 the problems with finalizing it, do you
 18 recall?
 19 DR. MORRIS-LARKIN:
 20 A. I wouldn't have been involved with that
 21 particular aspect, no.
 22 COFFEY, Q.C.:
 23 Q. I suppose what I'm trying to ask you in terms
 24 of as a staff pathologist, do you recall any
 25 resistance from the staff pathologist's

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1 perspective?
 2 DR. MORRIS-LARKIN:
 3 A. I don't think so.
 4 COFFEY, Q.C.:
 5 Q. I'm not suggesting there was, I'm just -
 6 DR. MORRIS-LARKIN:
 7 A. No.
 8 COFFEY, Q.C.:
 9 Q. Asking about it. Doctor, in the meantime, you
 10 have mentioned Dr. Ejeckam, okay.
 11 DR. MORRIS-LARKIN:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. If we could look, please, at Exhibit P-0113.
 15 Doctor, this is a series of memos. This one
 16 is April 4th, 2003, a memo from Dr. Ejeckam to
 17 pathologists, HSC, which would be the General.
 18 The Commissioner has seen this on numerous
 19 occasions now. Did you receive a copy of
 20 this?
 21 DR. MORRIS-LARKIN:
 22 A. Yes, I did.
 23 COFFEY, Q.C.:
 24 Q. And what - first of all, did you have any
 25 inkling before receiving this that there was a

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1 problem with IHC stains?
 2 DR. MORRIS-LARKIN:
 3 A. Not specifically any particular stains, no. I
 4 think we always - we were always working
 5 towards reducing variability and getting rid
 6 of background. Those were - those were things
 7 that were part of the evolution of IHC stains
 8 in the lab.
 9 COFFEY, Q.C.:
 10 Q. Prior to this, was there a discussion amongst
 11 the group of pathologists at the General?
 12 DR. MORRIS-LARKIN:
 13 A. There may have been some discussion at some of
 14 the rounds. That still happens. You know, if
 15 we have a particular stain that we say, you
 16 know, this one is not looking at bright or as
 17 distinct as I would like, maybe it's not what
 18 I remember from a few months ago, that kind of
 19 discussion does go on at the rounds and that's
 20 the place where we kind of pick up on other
 21 people having any particular issues with
 22 something.
 23 COFFEY, Q.C.:
 24 Q. Doctor, we understand Dr. Khalifa, I believe,
 25 left in 1999, if I recall correctly, and now

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1 we understand that Dr. Ejeckam showed up in
 2 September, 2002.
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. In between those two times, in between Dr.
 7 Khalifa leaving and Dr. Ejeckam coming to the
 8 General Hospital, who, if anyone, did you
 9 associate amongst the pathologists with
 10 immunohistochemistry?
 11 DR. MORRIS-LARKIN:
 12 A. No one.
 13 COFFEY, Q.C.:
 14 Q. There was no one particular pathologist who
 15 kind of owned it, as it were, or took
 16 responsibility, or you would have thought at
 17 the time, well, if there's a problem with IHC,
 18 I'll talk to Dr. So and So?
 19 DR. MORRIS-LARKIN:
 20 A. No, if I had a problem, I went to the
 21 technologists.
 22 COFFEY, Q.C.:
 23 Q. Perhaps you can tell the Commissioner then
 24 about that, how did that work?
 25 DR. MORRIS-LARKIN:

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1 A. Again it would be part of everyday work in a
 2 pathology lab, whether you were having
 3 problems with perhaps a couple of H & E stains
 4 were not quite the usual, or if we needed to
 5 cut deeper into a tissue, those are normal
 6 things, and if there was too much background
 7 in an immunohistochemical stain, I would go to
 8 the technologists and say I'm seeing this, and
 9 to let them know about it.
 10 COFFEY, Q.C.:
 11 Q. Here having received this memo of April 4th,
 12 2003, what, if anything, was your reaction,
 13 your own reaction?
 14 DR. MORRIS-LARKIN:
 15 A. I don't remember exactly, but I think I would
 16 have seen that as, well, the variation is
 17 beyond our acceptable limits, and I thought it
 18 was a very positive thing that Dr. Ejeckam was
 19 in place and he was able to focus on the
 20 troubleshooting and we did greatly appreciate
 21 the efforts of Dr. Ejeckam working with the
 22 technologists. I think that it really worked
 23 towards quality improvement.
 24 COFFEY, Q.C.:
 25 Q. At the time you understood he was doing what

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1 in relation to these eight stains?
 2 DR. MORRIS-LARKIN:
 3 A. Specifically, I didn't know, other than -
 4 COFFEY, Q.C.:
 5 Q. Okay.
 6 DR. MORRIS-LARKIN:
 7 A. You know, other than he's saying, "I see
 8 there's a problem and I'm going to try to
 9 figure it out for you".
 10 COFFEY, Q.C.:
 11 Q. Having been told eight stains including ER and
 12 PR have remained unreliable, erratic, and,
 13 therefore, unhelpful for diagnostic purposes,
 14 at the time did that cause you to have any
 15 concerns about any ER/PR slides that you had
 16 already reported?
 17 DR. MORRIS-LARKIN:
 18 A. Not specifically.
 19 COFFEY, Q.C.:
 20 Q. Okay, do you recall any discussion at all
 21 about that amongst pathologists?
 22 DR. MORRIS-LARKIN:
 23 A. No, not specifically, no.
 24 COFFEY, Q.C.:
 25 Q. Do you recall if, in fact - do you recall any

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1 discussion you yourself had with anyone else
 2 about this?
 3 DR. MORRIS-LARKIN:
 4 A. Again it would have been in general terms
 5 about, you know, Dr. Ejeckam is looking into
 6 this and it's great that we've got him there
 7 to help sort this out for us, to have somebody
 8 focused. He had - you know, it was obvious to
 9 us that he had both an interest and a greater
 10 deal of knowledge than most of us had,
 11 certainly than I had.
 12 COFFEY, Q.C.:
 13 Q. And Exhibit C-175. If we could, please,
 14 perhaps we could go back to P-0113, I
 15 apologize. Here, Doctor, the second page of
 16 this, I take it - so you're told that ER/PR
 17 and these other six stains are shut down for
 18 now?
 19 DR. MORRIS-LARKIN:
 20 A. Right.
 21 COFFEY, Q.C.:
 22 Q. He'll get back to you. This is the May 2nd,
 23 2003, memo from Dr. Ejeckam again to yourself
 24 and others. You would have received this as
 25 well?

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1 DR. MORRIS-LARKIN:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. And it says, "I am glad to inform you we have
 5 rectified the difficulties related to the
 6 immunostaining of ER/PR. Therefore, we can
 7 now resume regular requests for these antibody
 8 stains. I will, however, like to bring the
 9 following information to you attention", and
 10 then he goes on at some length, three pages
 11 about ER and PR, and different aspects of
 12 ER/PR and immunohistochemistry. Doctor, at
 13 the time you received the May 2nd memo, 2003,
 14 was some of this news to you at the time?
 15 DR. MORRIS-LARKIN:
 16 A. I think perhaps the tissue reprocessing was
 17 not something I knew much about.
 18 COFFEY, Q.C.:
 19 Q. Yes.
 20 DR. MORRIS-LARKIN:
 21 A. Certainly - yes, certainly under fixation, I
 22 would have appreciated. Over fixation, I was
 23 not aware that that would interfere with the
 24 ER/PR. So that would have been new to me.
 25 COFFEY, Q.C.:

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1 Q. And how about delayed fixation?
 2 DR. MORRIS-LARKIN:
 3 A. Oh, definitely, I would have known that, yes.
 4 COFFEY, Q.C.:
 5 Q. And uneven fixation?
 6 DR. MORRIS-LARKIN:
 7 A. Again I would put that all into the under
 8 fixation or inadequate type of fixation
 9 category.
 10 COFFEY, Q.C.:
 11 Q. Doctor, at that time in May of 2003, from your
 12 perspective, who was responsible for ensuring
 13 fixation was appropriately carried out?
 14 DR. MORRIS-LARKIN:
 15 A. Well, I think that fixation is something that
 16 has a responsibility - the responsibility for
 17 fixation crosses a number of disciplines.
 18 Certainly we had no control over specimens
 19 before they come to us, so there is a
 20 responsibility of the people collecting the
 21 specimen to make sure that there is an
 22 appropriate amount of fixative required, and
 23 from within the lab then, it would be my
 24 responsibility as a pathologist or the
 25 pathology resident who was on to make sure

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1 that specimens were appropriately handled once
 2 they were received in the lab to ensure proper
 3 fixation, to not put the specimen blocks onto
 4 the processor before they were adequately
 5 fixed. So that would have been within our
 6 responsibility.
 7 COFFEY, Q.C.:
 8 Q. And did you ever have occasion to complain to
 9 the perioperative program about fixation
 10 issues?
 11 DR. MORRIS-LARKIN:
 12 A. I did not specifically have that kind of role.
 13 I know Dr. Khalifa had spent a great deal of
 14 time working with people in the OR at the
 15 General Hospital during his time to try and
 16 establish the best possible transport. There
 17 were often issues with, you know, who's
 18 responsible, the porters and that kind of
 19 thing, getting specimens from the OR to the
 20 lab. From my point of view, if I had a case
 21 that was under fixed or if there was some
 22 reason there had been a delay, I would include
 23 it in my report and that would be the feedback
 24 to the surgeon, and that was how I would have
 25 seen my role.

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1 COFFEY, Q.C.:

2 Q. And inadequate tissue dehydration, I take it,

3 would be the technologists?

4 DR. MORRIS-LARKIN:

5 A. That would be a processing technologist issue.

6 COFFEY, Q.C.:

7 Q. Tissue reprocessing?

8 DR. MORRIS-LARKIN:

9 A. Again it wasn't something I was exposed to.

10 COFFEY, Q.C.:

11 Q. And talking about optimal fixation time for

12 immunostains, 18 to 24 hours, 10 percent

13 neutral buffer formalin, was that news to you

14 at the time in terms of the time frames?

15 DR. MORRIS-LARKIN:

16 A. No, I don't think so.

17 COFFEY, Q.C.:

18 Q. You would have understood that?

19 DR. MORRIS-LARKIN:

20 A. I think adequate - again I would put it in the

21 adequate fixation type of category.

22 COFFEY, Q.C.:

23 Q. And were there any actual rules at the time,

24 policies, or guidelines in force within the

25 General Hospital site?

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1 DR. MORRIS-LARKIN:

2 A. There were general practises, I would have to

3 say, not written policies or procedures, but

4 there was, you know, kind of a standard of

5 practice that you did these things, you

6 attended to the specimens, you appropriately

7 opened or sliced specimens that needed to be

8 fixed, and you didn't put the blocks on before

9 they were ready. If you handled a specimen

10 after some degree of fixation, you will have

11 the option to put the blocks in a container of

12 formalin and then you would tell the

13 technologist leave this again overnight and

14 put it on tomorrow. So that was kind of

15 standards of practice.

16 COFFEY, Q.C.:

17 Q. Now, Doctor, here in paragraph two, the

18 reference to ER/PR false negative results,

19 increase in core biopsies. Therefore, where

20 possible, restrict requests for ER/PR to

21 excision biopsies. Whether that's correct or

22 not is another issue, but at the time would

23 that have been news to you?

24 DR. MORRIS-LARKIN:

25 A. At the time that would have been news to me,

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1 yes.

2 COFFEY, Q.C.:

3 Q. And, "Check normal breast acini in your

4 sections as internal controls. This is a

5 second level control. Nuclear staining in

6 normal breast tissue is heterogeneous and

7 varies with menstrual cycle". Now you've

8 referred to the fact that you, in fact, were

9 somewhat aware of this even in the early days?

10 DR. MORRIS-LARKIN:

11 A. I was, although that was not what I was using

12 as my control reference.

13 COFFEY, Q.C.:

14 Q. Did this cause you to change your practice at

15 all, being told this in 2003?

16 DR. MORRIS-LARKIN:

17 A. I don't - I think it may have heightened my

18 awareness of a specimen perhaps if I saw

19 something that was totally blank. It may

20 have, but I honestly don't remember

21 specifically.

22 COFFEY, Q.C.:

23 Q. Paragraph four, "Carcinoma of the breast, most

24 PR positive tumours are also ER positive",

25 however, he's got a 10 percent of PR positive

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1 tumours are ER negative, and I appreciate he's

2 saying this in 2003.

3 DR. MORRIS-LARKIN:

4 A. Yes.

5 COFFEY, Q.C.:

6 Q. Like, 90 percent -- only 10 percent of all

7 tumours would be PR positive, ER negative.

8 Was that news to you at the time?

9 DR. MORRIS-LARKIN:

10 A. That was. I did not have an appreciation of

11 the PR usually being ER positive because, in

12 fact, I had reported PR positive cases with ER

13 negative results.

14 COFFEY, Q.C.:

15 Q. Did this cause you to change your approach in

16 any way?

17 DR. MORRIS-LARKIN:

18 A. Again specifically affecting any case, I don't

19 remember, no.

20 COFFEY, Q.C.:

21 Q. And then, "The reporting of ER/PR, certain

22 formulae are in the literature", and he refers

23 to the formulae, including the November 1 to 3

24 consensus statement of 2000. Did this change

25 your reporting style, Doctor?

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1 DR. MORRIS-LARKIN:
 2 A. At some point, and I don't know if it was with
 3 this or with further discussions with Dr.
 4 Carter later, I dropped the comment regarding
 5 the biochemistry. I think most of the time -
 6 I think probably always, but most of the time
 7 I certainly remember reporting percents
 8 anyway, and then it was, I thought, what the
 9 oncologists would do with that was within
 10 their purview.
 11 COFFEY, Q.C.:
 12 Q. Paragraph six refers to cytoplasmic staining,
 13 all of it in ER/PR immunostains are to be
 14 considered as negative. What's contained in
 15 paragraph six, was that news to you at the
 16 time?
 17 DR. MORRIS-LARKIN:
 18 A. The variability and intensity wasn't. I think
 19 the cytoplasmic staining was something that
 20 was often a little bit confusing. It wasn't
 21 clear perhaps until this that there were other
 22 things that could be contributing to the
 23 cytoplasmic staining. I often just considered
 24 it as background.
 25 COFFEY, Q.C.:

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1 Q. Background, and he refers to certain tumours
 2 as being ER positive tumours. He lists four
 3 of them and he's told us, in fact, there
 4 should have been a fifth.
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Lobular. Were you aware of these before -
 9 DR. MORRIS-LARKIN:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. As being ER positive?
 13 DR. MORRIS-LARKIN:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. You were already aware, and lobular as well?
 17 DR. MORRIS-LARKIN:
 18 A. No, I would not have. I was not aware at that
 19 time, and I think it was in discussions again
 20 with Dr. Carter following the index case that
 21 that's when I became aware of the very high
 22 frequency I should be expecting positivity in
 23 the lobular cases.
 24 COFFEY, Q.C.:
 25 Q. And that would have been in 2005, that

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1 discussion?
 2 DR. MORRIS-LARKIN:
 3 A. That was 2005, yes.
 4 COFFEY, Q.C.:
 5 Q. You would have been aware of this before,
 6 though, at the time you received this in '03,
 7 certainly these four?
 8 DR. MORRIS-LARKIN:
 9 A. Not specifically, but again I think it was
 10 more tied into number eight where these
 11 things, certainly the papillary and the
 12 tubular are better differentiated, so within
 13 that concept of a better differentiated
 14 tumour, more likely to express ER/PR. I think
 15 I had that concept.
 16 COFFEY, Q.C.:
 17 Q. Did that ever cause you any idea that some
 18 tumours are very much more apt to be positive
 19 for ER than others? Did that ever cause you -
 20 when you would get something and look at a
 21 slide, to think, well, wait now, it's a
 22 particular type of tumour, yet I'm not seeing
 23 any ER staining?
 24 DR. MORRIS-LARKIN:
 25 A. Again with - I can't recall if I had a tubular

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1 carcinoma that was negative, so I can't really
 2 speak to that.
 3 COFFEY, Q.C.:
 4 Q. Okay. Doctor, if we could look, please, at
 5 now then - well, finally, while I'm at it,
 6 this page five of the June 19th, 2003, memo
 7 from Terry Gulliver - I'm sorry, to Terry
 8 Gulliver from Dr. Ejeckam. The Commissioner
 9 has seen this on a number of occasions. It
 10 was not copied - sent nor copied to you.
 11 DR. MORRIS-LARKIN:
 12 A. No, it wasn't.
 13 COFFEY, Q.C.:
 14 Q. Were you aware of this?
 15 DR. MORRIS-LARKIN:
 16 A. No.
 17 COFFEY, Q.C.:
 18 Q. Not only the memo - you would be aware of it
 19 now, but you weren't aware of it back in '03?
 20 DR. MORRIS-LARKIN:
 21 A. No, I was aware of some of the efforts and
 22 some of the things that are mentioned here
 23 that Dr. Ejeckam was striving for, but not
 24 specifically this memo.
 25 COFFEY, Q.C.:

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1 Q. And here in paragraph six, see this line,
 2 "Diagnosis based on inappropriate
 3 immunostaining will surely jeopardize patient
 4 care and may even expose the Health Care
 5 Corporation of St. John's to litigation.
 6 Therefore, it will be ill-advised to operate
 7 unreliable and erratic immunohistochemical
 8 procedures in our laboratory". I appreciate
 9 you didn't see this, but was that notion, were
 10 you aware of the idea that Dr. Ejeckam felt
 11 that way in 2003?
 12 DR. MORRIS-LARKIN:
 13 A. I don't think he had voiced that specifically
 14 to me. I did not have a conversation that I
 15 recall.
 16 COFFEY, Q.C.:
 17 Q. How about concerns, like, within the lab
 18 itself amongst pathologists? This expresses
 19 some fairly - at least in writing, some fairly
 20 grave concern.
 21 DR. MORRIS-LARKIN:
 22 A. Yes. I think that this - again I can't really
 23 tell you what Dr. Ejeckam was thinking, but -
 24 COFFEY, Q.C.:
 25 Q. I'm asking amongst the pathologist as a rule?

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1 DR. MORRIS-LARKIN:
 2 A. And I don't remember this, you know, this
 3 being discussed amongst the pathologists in
 4 this sort of way. We're always striving to
 5 see improvements and we were seeing Dr.
 6 Ejeckam as the lead person who was working
 7 with the technologists to do that.
 8 COFFEY, Q.C.:
 9 Q. C-175, please. Doctor, this is a pathology
 10 report. The specimen number is 03SU4821.
 11 It's received March 31, 2003, which I take it
 12 is the day that the pathology lab would have
 13 received the specimen?
 14 DR. MORRIS-LARKIN:
 15 A. That's correct.
 16 COFFEY, Q.C.:
 17 Q. And this is - you can see here is a case of
 18 yours, and at the bottom of the second page,
 19 addendum number one, entered May 6th, 2003,
 20 and you'll see the addendum is signed the same
 21 day by yourself, and you begin by saying, "The
 22 stains have been delayed due to unavailability
 23 in the lab. When compared to controls, the
 24 specimen is negative for HER2/neu, ER and PR",
 25 and then you go on to speak about the HER2/neu

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1 scoring, okay?
 2 DR. MORRIS-LARKIN:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. And then here, addendum number two, which is
 6 entered May 9th, 2003, and it's signed by
 7 yourself the same day, you've written, "The ER
 8 and PR were repeated due to quality assurance
 9 issues. The repeated stains show the
 10 following; ER positive in 80 percent of the
 11 cells, PR positive in 10 percent of the cells.
 12 This replaces the previous report. Phoned the
 13 Cancer Clinic voice mail on May 9th '03".
 14 Doctor, can you tell us then what this was
 15 about?
 16 DR. MORRIS-LARKIN:
 17 A. I don't recall the specific case. The timing
 18 of it would suggest that in the first
 19 addendum, I had requested the ER/PR stain, and
 20 that was when Dr. Ejeckam was working on the
 21 issue, so I didn't have it until some weeks
 22 later.
 23 COFFEY, Q.C.:
 24 Q. When we look back, you would have received
 25 this, just to put this in context for the

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1 Commissioner, this particular one was
 2 received, surgical specimen, March 31 '03.
 3 You got the memo of April 4th, 2003, several
 4 days later, so you would have known, okay,
 5 he's shut it down for now.
 6 DR. MORRIS-LARKIN:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. And then presumably some time after that,
 10 after May 2nd, '03 when he sent you a memo
 11 saying it's up and running again, you would
 12 have received the ER/PR slides?
 13 DR. MORRIS-LARKIN:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. So go ahead, I'm sorry.
 17 DR. MORRIS-LARKIN:
 18 A. So it looks - as I read this, it looks as
 19 though I did get a set of slides very shortly
 20 after and I reported them, as you see here,
 21 and at that time I reported them as negative.
 22 COFFEY, Q.C.:
 23 Q. Right, and then what happened?
 24 DR. MORRIS-LARKIN:
 25 A. I don't know. There are two possibilities

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1 because within a few days there is the
 2 addendum that states that it was repeated due
 3 to quality assurance issues. I don't know if
 4 that was a quality issue that I was after
 5 detecting in my own case and saying I don't
 6 feel quite right about this, maybe I better -
 7 maybe I'd better repeat it, or if it was
 8 something that was triggered by the lab
 9 itself, given the timing.
 10 COFFEY, Q.C.:
 11 Q. Here you did repeat the ER and PR. You did
 12 not repeat the HER2/neu. At least there's no
 13 indication it was repeated.
 14 DR. MORRIS-LARKIN:
 15 A. I don't have a record of it there, no.
 16 COFFEY, Q.C.:
 17 Q. There's no indication here in the records. So
 18 within three days of having reported after the
 19 resumption of testing in May of '03, then
 20 three days - you've had a requisition
 21 completed again, reordered, the test is back
 22 and you've got the slides, and you're entering
 23 it. We can see that here.
 24 DR. MORRIS-LARKIN:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. And you've taken - you've been careful to note
 3 that you actually did phone the Cancer Clinic
 4 presumably to tell them that ignore the first
 5 results, there's a new one?
 6 DR. MORRIS-LARKIN:
 7 A. Because there was a significant change.
 8 COFFEY, Q.C.:
 9 Q. Did you tell anybody else about this?
 10 DR. MORRIS-LARKIN:
 11 A. Given the timing of it, I may have spoken to
 12 Dr. Ejeckam, but I honestly don't remember if
 13 I did.
 14 COFFEY, Q.C.:
 15 Q. Do you recall - you phoned the Cancer Clinic
 16 and left a voice mail, you've noted here. You
 17 would have left that for whom?
 18 DR. MORRIS-LARKIN:
 19 A. At that time, I don't know which -
 20 COFFEY, Q.C.:
 21 Q. Would it be an oncologist you'd be looking
 22 for?
 23 DR. MORRIS-LARKIN:
 24 A. It may have been one of the oncologists. I
 25 may have known which oncologist was involved,

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1 or I may have phoned the Cancer Clinic in
 2 general because I wasn't - perhaps I had
 3 phoned the surgeon and they had said, well,
 4 they've gone to the Cancer Clinic and I didn't
 5 know which oncologist, so I may have left it
 6 to the general Cancer Clinic voice mail.
 7 COFFEY, Q.C.:
 8 Q. Do you recall -
 9 DR. MORRIS-LARKIN:
 10 A. If I said I phoned to the Cancer Clinic, most
 11 likely I left it to a general Cancer Clinic
 12 voice mail and that I didn't know which
 13 oncologist was dealing with the patient.
 14 COFFEY, Q.C.:
 15 Q. Doctor, do you recall getting any feedback
 16 from this?
 17 DR. MORRIS-LARKIN:
 18 A. I don't recall, no.
 19 COFFEY, Q.C.:
 20 Q. And you've certainly just acknowledged that
 21 going from - when compared to controls,
 22 because you've noted here in addendum one,
 23 when compared to controls, which would be
 24 external controls?
 25 DR. MORRIS-LARKIN:

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1 A. At that time I still was probably referring to
 2 external controls. It was in that time frame,
 3 I think.
 4 COFFEY, Q.C.:
 5 Q. And the specimen is negative for ER and PR.
 6 At that time, by the middle of 2003, when you
 7 referred to a specimen being negative for ER
 8 and PR, that meant what?
 9 DR. MORRIS-LARKIN:
 10 A. It's totally negative.
 11 COFFEY, Q.C.:
 12 Q. Like zeros?
 13 DR. MORRIS-LARKIN:
 14 A. Zeros, yes.
 15 COFFEY, Q.C.:
 16 Q. And then within three days, you're saying the
 17 ER is 80 percent and the PR is 10 percent.
 18 You say you may have spoken to Dr. Ejeckam
 19 about it. Do you recall letting the clinical
 20 chief know? This could potentially affect the
 21 patient's care, you'd be the first to
 22 acknowledge that.
 23 DR. MORRIS-LARKIN:
 24 A. Well, I would have thought that I was
 25 impacting the patient's care in a positive

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1 way.

2 COFFEY, Q.C.:

3 Q. Oh, yes.

4 DR. MORRIS-LARKIN:

5 A. By making sure that the treating physician had

6 this report. I don't think I would have

7 brought it to the clinical chief. If I

8 brought it to anyone, I would have brought it

9 to Dr. Ejeckam because I would have seen this

10 as something that he would have been delegated

11 by the clinical chief to deal with.

12 COFFEY, Q.C.:

13 Q. And the idea how could something go from zero

14 to 80 in three days, was that pursued, do you

15 know?

16 DR. MORRIS-LARKIN:

17 A. Again it was around the time where he was

18 looking into the issue, so I would have seen

19 it within that kind of context.

20 COFFEY, Q.C.:

21 Q. And the idea that presumably the first set of

22 slides that you used for addendum number one

23 were kind of the newly improved version in

24 terms of the process -

25 DR. MORRIS-LARKIN:

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1 A. I can't say that for certain because I don't

2 know exactly what happened there, was this -

3 did the lab release slides that they knew -

4 sorry, I should say it that way, did the lab

5 release slides that were part of this

6 investigation, and then say, well, actually we

7 have a better set for you. I honestly don't

8 remember.

9 COFFEY, Q.C.:

10 Q. In terms of how you came to reorder the test,

11 you have no recollection of that?

12 DR. MORRIS-LARKIN:

13 A. No.

14 COFFEY, Q.C.:

15 Q. Do you know if - did you discuss it with any

16 of your other colleagues, do you recall?

17 DR. MORRIS-LARKIN:

18 A. I don't think so. If I spoke with anyone, it

19 would have been Dr. Ejeckam.

20 COFFEY, Q.C.:

21 Q. At the time, did you complete an occurrence

22 report?

23 DR. MORRIS-LARKIN:

24 A. I don't think I would have, no. I would have

25 seen this within - a change within something

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1 in daily practice. I mean, we do see these

2 kinds of changes. When we're looking into

3 case, we repeat stains, we get deeper

4 sections, we get additional levels, and

5 sometimes that does - that does bring us to a

6 specific conclusion. So I would have seen it

7 within that kind of realm of practice that I

8 was doing.

9 COFFEY, Q.C.:

10 Q. If we could look, please, at exhibit - I take

11 it then that your understanding at the time

12 was this would not require an occurrence

13 report?

14 DR. MORRIS-LARKIN:

15 A. I wouldn't have thought it did, no.

16 COFFEY, Q.C.:

17 Q. How about today?

18 DR. MORRIS-LARKIN:

19 A. I would - today I would see it as what I would

20 refer to as an internal lab occurrence. I

21 think that it's something that needs to be

22 reported within the lab, and to investigate

23 and implement corrective action.

24 COFFEY, Q.C.:

25 Q. The idea, for example, because you have - this

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1 sort of circumstances involved you

2 communicating with in this context the Cancer

3 Clinic?

4 DR. MORRIS-LARKIN:

5 A. Yes.

6 COFFEY, Q.C.:

7 Q. So if this was to happen tomorrow, you

8 reported something and then three days later,

9 for whatever reason, you had had the test

10 rerun and had to contact the Cancer Clinic and

11 say ignore that, this is a completely

12 different result, and under the current

13 occurrence reporting regime, would that

14 require an occurrence report, or would it

15 remain internal to the lab?

16 DR. MORRIS-LARKIN:

17 A. I don't think that this would require, from my

18 understanding, an occurrence report, and we do

19 fill out lots of occurrence reports. Again

20 this would have been something within the -

21 working towards the best result type of

22 practice.

23 COFFEY, Q.C.:

24 Q. So why would it not - if, for example, there

25 wasn't three days between them, but, say,

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1 three weeks between the two of them, would
 2 that require an occurrence report, or three
 3 months?
 4 DR. MORRIS-LARKIN:
 5 A. In months, it would I think for sure.
 6 COFFEY, Q.C.:
 7 Q. Why is that?
 8 DR. MORRIS-LARKIN:
 9 A. Well, I think it would depend on the
 10 circumstances. Again it's a little out of
 11 context and I'm not sure what would - why we
 12 would end up doing something like that, other
 13 than what we've already been through with the
 14 ER/PR retesting. So it's - so that would be a
 15 little bit different. I think, you know,
 16 depending on how it was identified that you
 17 needed to repeat the test months later.
 18 THE COMMISSIONER:
 19 Q. Referencing the occurrence report, is it
 20 something having to do with a change in the
 21 patient's status or treatment, or - I'm not
 22 sure I'm getting why the time makes the
 23 difference between the decision to have an
 24 occurrence report.
 25 DR. MORRIS-LARKIN:

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1 A. The occurrence reporting system is corporate
 2 wide, and it involves then sending
 3 notification to the quality initiatives
 4 people, and the kinds of things that would
 5 trigger is anything that may potentially
 6 interfere with patient care. So if you have
 7 mislabelled specimens, if you have
 8 inappropriately labelled specimens, that's the
 9 kind of thing which I see a number of
 10 occurrence reports filled out, and there are a
 11 things that occur within the lab that
 12 occasionally we would send an occurrence form
 13 for. If there is a mislabelled block, that
 14 kind of thing, that has any potential impact
 15 on a patient's care, again the purpose of it
 16 being part of a quality - overall quality
 17 management and making people aware of the
 18 kinds of events that can occur and getting
 19 feedback then to try and prevent those kinds
 20 of events, and heighten the vigilance to
 21 prevent them.
 22 COFFEY, Q.C.:
 23 Q. And going from zero to 80?
 24 DR. MORRIS-LARKIN:
 25 A. Again in this setting, I would have seen it

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1 within the context of Dr. Ejeckam has been
 2 looking at the ER/PR, you know, we know he's
 3 been dealing with an issue and it's related to
 4 that, and that's how I would have interpreted
 5 that.
 6 THE COMMISSIONER:
 7 Q. So if there had been no Dr. Ejeckam memo,
 8 would it have been something that would have
 9 been reported?
 10 DR. MORRIS-LARKIN:
 11 A. Again -
 12 THE COMMISSIONER:
 13 Q. Was it because Dr. Ejeckam was already working
 14 on it and you say the problem as being
 15 identified, or that you did not see this as
 16 something that potentially might interfere
 17 with a patient's care?
 18 DR. MORRIS-LARKIN:
 19 A. Well, it was within a few days, and I - again
 20 at that time, I would have been working within
 21 trying to get the best result out, and that
 22 would have been my focus. So I would not have
 23 - I would have not seen this as something I
 24 would fill an occurrence report out on, no.
 25 COFFEY, Q.C.:

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1 Q. C-184. Doctor, this is 2002 pathology report,
 2 July of '02, a report we looked at earlier. I
 3 take it this - is this the sort of thing that
 4 back in 2002, because Dr. Ejeckam is not
 5 involved at this point, he's not even at the
 6 General, going from an ER negative result to -
 7 as you point out, this correlates a negative
 8 ER result to a 30 percent PR - ER result, I'm
 9 sorry, best considered a positive ER result.
 10 Would that be the sort of thing that would
 11 occasion an occurrence report?
 12 DR. MORRIS-LARKIN:
 13 A. Again it wasn't something that I would have
 14 thought required an occurrence report, no.
 15 COFFEY, Q.C.:
 16 Q. Although it could have ramifications at the
 17 time for patient care? In fact, as you say,
 18 that's probably the reason you redid the test.
 19 DR. MORRIS-LARKIN:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. No controls, negative.
 23 DR. MORRIS-LARKIN:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. You're uncomfortable and then you redo it and
 2 it's positive.
 3 DR. MORRIS-LARKIN:
 4 A. Because it would have made the difference in
 5 whether or not--in the choice of treatment
 6 they were going to make.
 7 COFFEY, Q.C.:
 8 Q. Yes. I take it today then, if you reported a
 9 result and then had occasion to have a retest
 10 done and the retest results, to your
 11 knowledge, might occasion a change in
 12 treatment choice, would that have -
 13 DR. MORRIS-LARKIN:
 14 A. We have had--you know, there are cases where
 15 under--particularly under quality assurance
 16 types of audits that we do, we've had changes
 17 in diagnosis and those do trigger occurrence
 18 reports.
 19 COFFEY, Q.C.:
 20 Q. Now, if we could look, please, at Exhibit P-
 21 2426? And Doctor, before I get--I'll take
 22 you--if I could go to page 29, please? We go
 23 to this, then I take it, Doctor, after Dr.
 24 Ejeckam's May 2nd, 2003 memo and that
 25 pathology report we looked at involving May

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1 6th and May 9th, we just looked at just then,
 2 after that, in terms of ER/PR, do you recall
 3 anything else coming up about ER/PR or did it
 4 just continue on, in terms of your reporting
 5 your cases in a routine fashion?
 6 DR. MORRIS-LARKIN:
 7 A. In that 2003?
 8 COFFEY, Q.C.:
 9 Q. In 2003, yes, '03/04.
 10 DR. MORRIS-LARKIN:
 11 A. Things just continued on.
 12 COFFEY, Q.C.:
 13 Q. If we could up C-0174 please? Just before I
 14 go to 2004, I want to--C-0174 please. Now
 15 Doctor, this does not involve yourself. It's
 16 a pathology report. Does not involve a
 17 patient of yours, but you'll note here, the
 18 specimen number is 02SS5231, received July 5th
 19 '02, back in July of 2002. It's a report by
 20 Dr. Elms and here, he had reported the case
 21 originally, entered it and reported it on
 22 August 29th, 2002, reporting ER as negative
 23 and PR as 15--approximately 15 percent of
 24 lesional cells, and then addendum number
 25 three, entered June 11th, 2003 and signed the

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1 same day, he says "at the request of Dr.
 2 Zaidi, IHC staining for estrogen and
 3 progesterone receptors has been repeated. ER
 4 receptors show faint positivity in
 5 approximately 10 to 15 percent of lesional
 6 cells. Progesterone receptors are
 7 unequivocally positive in approximately 75
 8 percent of lesional cells." I appreciate Dr.
 9 Elms, at the time, was at St. Clare's and you
 10 were at the General.
 11 DR. MORRIS-LARKIN:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. But again, the idea that a retest would be
 15 done in June of '03, had one done in May of
 16 '03, there was no talk generally amongst the
 17 pathologists about--well, we--you know, you
 18 had had one redone, results changed, zero to
 19 80. He had had one redone after a year, zero
 20 to 10 to 15.
 21 DR. MORRIS-LARKIN:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. Which we understand would have clinical
 25 significance. There was no talk amongst the

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1 pathologists when you got together about, you
 2 know, the fact that "Ejeckam's been here and
 3 has reinstated this and we're getting--some
 4 of us are getting changed results"?
 5 DR. MORRIS-LARKIN:
 6 A. I don't recall there being any discussion.
 7 COFFEY, Q.C.:
 8 Q. I apologize, I was at 2426. Doctor, this is--
 9 these are minutes of a QC/QA meeting at the
 10 Health Care Corporation of St. John's,
 11 November 9th '04. Again, you're not listed as
 12 being one of those present, but paragraph two,
 13 "two aspects of the QC/QA committee mandate
 14 were briefly introduced" and paragraph three,
 15 "within the department, two aspects of QA/QC
 16 will be begun by anatomical pathologists.
 17 These are the intradepartmental consultation
 18 review and frozen section review," and it goes
 19 on to talk about it from there. Doctor, if I
 20 could, please--just a moment, Commissioner.
 21 You've referred already to Dr. Carter. You
 22 know Dr. Carter certainly.
 23 DR. MORRIS-LARKIN:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Dr. Carter showed up in the early 2000s, here
 2 in St. John's, in terms of she came to St.
 3 Clare's on staff.
 4 DR. MORRIS-LARKIN:
 5 A. I think in 2003, she did some locums.
 6 COFFEY, Q.C.:
 7 Q. Yes.
 8 DR. MORRIS-LARKIN:
 9 A. At the General Hospital site, and then St.
 10 Clare's.
 11 COFFEY, Q.C.:
 12 Q. Did you have any understanding about whether
 13 she had any particular training in relation to
 14 breast cancer or breast pathology, I'm sorry?
 15 DR. MORRIS-LARKIN:
 16 A. Yes, I knew she had done the year's
 17 fellowship, I believe, in Nashville.
 18 COFFEY, Q.C.:
 19 Q. And could you tell us please then about this
 20 QA/QC initiative, that I gather Dr. Carter in
 21 particular was involved in in 2004, what you
 22 recall about that?
 23 DR. MORRIS-LARKIN:
 24 A. I don't know much about the details. I knew
 25 that there was a QA committee and that Dr.

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1 Carter and Dr. Ejeckam were both involved.
 2 COFFEY, Q.C.:
 3 Q. And do you recall when this was first raised,
 4 the idea that there--did you have any concerns
 5 or was that later?
 6 DR. MORRIS-LARKIN:
 7 A. I'm not sure what you're asking.
 8 COFFEY, Q.C.:
 9 Q. Okay, I'll come back to that. If I could,
 10 please, P-1908, page two? 1908. I'm sorry,
 11 1908, apologize. These are minutes of a
 12 meeting of March 2nd, 2004, Dr. Larkin.
 13 You're noted to be present. It's a
 14 pathologists meeting at the General Hospital.
 15 Under 3.3, specimen grossing, it says "some
 16 changes of specimen grossing will start
 17 effective March 1/04, mainly of the large
 18 specimens. This will allow overnight fixation
 19 and processing the day of grossing.
 20 Pathologists are asked to process all
 21 specimens on the same day or next morning to
 22 keep the work flow updated." Do you recall
 23 what this was about or what change is
 24 implemented?
 25 DR. MORRIS-LARKIN:

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1 A. Well, I think we were always undergoing or
 2 always looking at how best to address the work
 3 flow. We had made a number of changes in how
 4 we scheduled ourselves and residents over the
 5 years. I think this specifically is referring
 6 to the timing of getting pathology specimens,
 7 the appropriate timing for getting pathology
 8 specimens onto the processor in such a way
 9 that things were adequately fixed, but things
 10 were not overly delayed. So again, trying to
 11 find that right balance. One of the issues
 12 that often would come up is if my day to
 13 attend gross specimens was today, but I've got
 14 meetings and teaching and other things that
 15 interfere, then I may spill my work over into
 16 the next day and there's only so much
 17 available space and that last line refers to
 18 that, "to process all specimens on the same
 19 day or the next morning to keep the work flow
 20 updated," so we weren't all, you know, vying
 21 for the same limited space at the same time.
 22 COFFEY, Q.C.:
 23 Q. Okay, and if we could look at 2406, please,
 24 2406, page three? Actually, I'll go back to
 25 page one, to put it in context for you. Just

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1 leave it there, please. These are minutes of
 2 a pathologist meeting, group of pathologists
 3 meeting at the General Hospital, September
 4 1/04. You're noted to be present. Doctor,
 5 here on paragraph 3.6, "HER2/neu, ER and PR
 6 immunostaining." It notes "Dr. D. Fontaine
 7 did mention that Dr. Bev Carter would like to
 8 review all the new HER2/neu, ER and PR
 9 immunostaining before returning to the
 10 reporting pathologist. Some members of the
 11 division expressed that this is unnecessary
 12 and they will continue reporting their own
 13 cases." Now this is September of '04, Doctor.
 14 Do you recall what this was about?
 15 DR. MORRIS-LARKIN:
 16 A. I do recall this meeting and my recollection
 17 is that the main concern expressed by
 18 pathologists, including myself, was losing the
 19 experience in any aspect of pathology. We
 20 have some subspecialization and we knew what
 21 it was like when our renal pathologist or our
 22 neuropathologist went away, and we hadn't seen
 23 a case for a period of time. We also knew
 24 that with the frequent turnover of people that
 25 this was something we couldn't afford to do

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1 was to lose any broad skills that we had. So
 2 my recollection was it was more about the
 3 concern of losing skills than about Dr. Carter
 4 looking at anything specific, and in fact,
 5 certainly I frequently sent Dr. Carter cases.
 6 I knew of her expertise and I often asked her
 7 questions and she was always very happy to
 8 even take the case and say "I'll take it and
 9 sign it out."
 10 COFFEY, Q.C.:
 11 Q. Doctor, then in relation to what brings us
 12 here today in particular, the ER/PR matter,
 13 when did you first become aware of it, as an
 14 issue?
 15 DR. MORRIS-LARKIN:
 16 A. That this was a bigger issue?
 17 COFFEY, Q.C.:
 18 Q. Yes, or an issue at all, first of all.
 19 DR. MORRIS-LARKIN:
 20 A. In the summer of 2005, I believe.
 21 COFFEY, Q.C.:
 22 Q. An issue at all.
 23 DR. MORRIS-LARKIN:
 24 A. Yes, in the summer of 2005.
 25 COFFEY, Q.C.:

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1 Q. Okay. What do you recall about that?
 2 DR. MORRIS-LARKIN:
 3 A. At that time, I recall hearing some discussion
 4 about the particular case that we call the
 5 index case now. Of course, many of us were
 6 familiar with Dr. Deane, although we may not
 7 have known him personally, and so--and he was
 8 quite free in discussing it, from what I
 9 understand. So we were aware that that case
 10 had happened and that that had triggered a
 11 relook at what's going on with regards to
 12 specifically then the lobular carcinoma cases,
 13 I think, were the things that Dr. McCarthy and
 14 Dr. Carter had been most addressing, and from
 15 that then, I was aware that Dr. Carter was
 16 after doing some repeats. I didn't know the
 17 details of it, and then we had a meeting with
 18 Dr. Cook and Dr. Carter, basically summarizing
 19 what they knew to that point and giving us an
 20 outline of what was happening and where things
 21 were going.
 22 COFFEY, Q.C.:
 23 Q. Where was that meeting?
 24 DR. MORRIS-LARKIN:
 25 A. I believe that meeting was at the Health

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1 Science.
 2 COFFEY, Q.C.:
 3 Q. And you recall Dr. Cook and Carter being there
 4 and you understood that they were telling you
 5 what we found to date, as it were?
 6 DR. MORRIS-LARKIN:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. Doctor, what do you recall about what they
 10 told you?
 11 DR. MORRIS-LARKIN:
 12 A. Well, some of the things that I've just
 13 outlined really and that I believe mainly Bev,
 14 but had repeated a number of cases and looked
 15 at the stains on a number of cases and within
 16 our lab, we had seen the cases that had been
 17 previously negative, she now, on the repeats,
 18 had positive results.
 19 COFFEY, Q.C.:
 20 Q. Did she tell you anything else about
 21 observations she had made about the quality of
 22 the slides?
 23 DR. MORRIS-LARKIN:
 24 A. I think there were some general discussions.
 25 Whether they were specifically at that meeting

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1 or in the, you know, obviously numerous
 2 conversations that occurred during that time.
 3 COFFEY, Q.C.:
 4 Q. And at the time, Doctor, as a staff
 5 pathologist, did you think to go look at any
 6 of your earlier cases yourself?
 7 DR. MORRIS-LARKIN:
 8 A. Well, at that time, I don't think I would have
 9 even known how to do it, other than to do a
 10 computer search of all breast cases. It would
 11 have been very cumbersome and at that time, we
 12 also had to continue on with the everyday
 13 work. So I wouldn't have had the time to try
 14 and do that kind of search, or the computer
 15 skills really to be able to search that out.
 16 COFFEY, Q.C.:
 17 Q. Mr. Simmons, earlier this morning, you gave me
 18 an exhibit number.
 19 MR. SIMMONS:
 20 Q. I think it was 0076.
 21 COFFEY, Q.C.:
 22 Q. 0076. Thank you very much. P-0076, please.
 23 Yes, you have a good memory, Mr. Simmons.
 24 This is a memo of July 28th, 2005. It's from
 25 Doctors Cook and Carter to all pathologists

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1 and pathology residents in the St. John's
 2 Eastern Hospitals of Eastern Health. The
 3 subject is optimal assessment and reporting of
 4 hormone receptor status in infiltrating
 5 carcinoma, and it goes on, it's in effect a
 6 nine-point process to achieving optimal
 7 assessment in reporting of hormone receptor
 8 status. Doctor, did you receive a copy of
 9 this?
 10 DR. MORRIS-LARKIN:
 11 A. Yes, I did.
 12 COFFEY, Q.C.:
 13 Q. And would have been just on July 28th or
 14 shortly thereafter?
 15 DR. MORRIS-LARKIN:
 16 A. In that time frame, yes.
 17 COFFEY, Q.C.:
 18 Q. And what, if anything, did you understand
 19 about the purpose for which this was sent to
 20 you?
 21 DR. MORRIS-LARKIN:
 22 A. I think it was again to try and--to
 23 standardize things, to kind of building on
 24 what Dr. Ejeckam had sent out previously, a
 25 little bit more concise, a little bit clearer,

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1 easier to follow and just, you know, the
 2 things that we could reference when we did
 3 report ER/PR.
 4 COFFEY, Q.C.:
 5 Q. Now Doctor, I take it at the time you received
 6 this, it was still anticipated that you would
 7 be reporting cases at that point?
 8 DR. MORRIS-LARKIN:
 9 A. It was anticipated, yes.
 10 COFFEY, Q.C.:
 11 Q. Still that you would continue on?
 12 DR. MORRIS-LARKIN:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. I gather things changed just after this, but -
 16 DR. MORRIS-LARKIN:
 17 A. Very shortly after.
 18 COFFEY, Q.C.:
 19 Q. Doctor, at the time, did you have any
 20 understanding about what kind of review Dr.
 21 Carter had been involved in in the second half
 22 of July?
 23 DR. MORRIS-LARKIN:
 24 A. Not specifically, other than that she had--I
 25 think I knew that she had looked at some of

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1 the old slides and that she had repeated
 2 stains on some of these cases.
 3 COFFEY, Q.C.:
 4 Q. Did you know anything--and I appreciate the
 5 retesting, you had been told that a number of
 6 them had changed results.
 7 DR. MORRIS-LARKIN:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. How about her observations concerning the old
 11 slides or the original slides?
 12 DR. MORRIS-LARKIN:
 13 A. I know that she had--these were archival
 14 slides. I don't know how far she had gone
 15 back. I know she expressed concerns about a
 16 number of things -
 17 COFFEY, Q.C.:
 18 Q. Do you recall -
 19 DR. MORRIS-LARKIN:
 20 A. - with regards to the slides. She mentioned
 21 of the things that we've talked about with
 22 regards to internal controls, with tissue
 23 staining on the slides, you know, with holes
 24 in the slides. I think those kinds of things
 25 probably were mentioned.

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1 COFFEY, Q.C.:
 2 Q. And this would be during this meeting that her
 3 and Dr. Cook had with a group of pathologists?
 4 DR. MORRIS-LARKIN:
 5 A. I believe during that meeting and around that
 6 time. I can't zone in specifically on when,
 7 but you know, within that context.
 8 COFFEY, Q.C.:
 9 Q. And here's where I'm getting at, Doctor. As a
 10 pathologist at the time at the General
 11 Hospital, okay, and I appreciate Doctors Cook
 12 and Carter were at St. Clare's, based at St.
 13 Clare's?
 14 DR. MORRIS-LARKIN:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. But at the end of July, early August, you were
 18 aware that Dr. Carter had been conducting some
 19 kind of a review, looking at old slides,
 20 original slides, and she'd been doing some
 21 retesting?
 22 DR. MORRIS-LARKIN:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. You knew that a number of the retest results

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1 involved conversions, what we now call
 2 conversions?
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. And she had noted a number of problems with,
 7 from her perspective, the original slides.
 8 DR. MORRIS-LARKIN:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. Fixation issues, holes in tissue, internal
 12 controls not there, internal controls there
 13 and not stained.
 14 DR. MORRIS-LARKIN:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. And the significance of that potentially.
 18 DR. MORRIS-LARKIN:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. And she communicated that, with Dr. Cook's
 22 knowledge, to the pathologists at the General
 23 Hospital?
 24 DR. MORRIS-LARKIN:
 25 A. Again, I do -

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1 COFFEY, Q.C.:
 2 Q. And freely?
 3 DR. MORRIS-LARKIN:
 4 A. I do think it was at a meeting, although there
 5 was so much happened at that time that it's
 6 hard to be certain.
 7 COFFEY, Q.C.:
 8 Q. But you your -
 9 DR. MORRIS-LARKIN:
 10 A. But there was an effort made on their part to
 11 let the people at the General Hospital site
 12 know what was going on because we didn't
 13 really, the same way that people at St.
 14 Clare's probably knew, just because of the
 15 proximity.
 16 COFFEY, Q.C.:
 17 Q. Doctor, so I take it then that by the time
 18 you'd learned what Dr. Carter, at least in her
 19 view, had concluded, to whatever extent she
 20 had conducted this review, did you have an
 21 understanding then that the problem or
 22 problems were not related to a change from one
 23 piece of equipment to another?
 24 DR. MORRIS-LARKIN:
 25 A. In all honesty, at that time, I did think that

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1 the change in equipment had a role to play.
 2 COFFEY, Q.C.:
 3 Q. Did you?
 4 DR. MORRIS-LARKIN:
 5 A. We had seen, in probably the couple of years
 6 prior to that, slides that were crisper where,
 7 you know, it was easier to read. You weren't
 8 struggling with background and I had seen what
 9 I thought was quality improvement. Whether it
 10 was due to a change in the machine, whether it
 11 was due to the efforts of Dr. Ejeckam or a
 12 combination, I don't know, but I certainly did
 13 see a difference.
 14 COFFEY, Q.C.:
 15 Q. And when she told you--not you in particular,
 16 but you, as a group, that internal controls,
 17 there was a problem with internal controls in
 18 the earlier--in the years gone by -
 19 DR. MORRIS-LARKIN:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. - with fixation issues?
 23 DR. MORRIS-LARKIN:
 24 A. I don't remember if fixation was--yes, I do
 25 think she referred to fixation at the time as

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1 well, and that would have been--she would have
 2 been the one during that conversation that I
 3 first learned about over fixation in a real
 4 significant way. I know it was mentioned in
 5 Dr. Ejeckam's memo as well, but I think it was
 6 a particular issue for Dr. Carter.
 7 COFFEY, Q.C.:
 8 Q. Exhibit P-1994, 1994.
 9 THE COMMISSIONER:
 10 Q. Where you can find a spot, Mr. Coffey, we'll
 11 take the morning break.
 12 COFFEY, Q.C.:
 13 Q. Okay, Commissioner. Doctor, this is a
 14 meeting, notes of a meeting of August 5th,
 15 2005 involving Dr. Fontaine, yourself and a
 16 number of others listed here. Dr. Cook is
 17 there. It's a meeting of pathologists. Do
 18 you recall this meeting?
 19 DR. MORRIS-LARKIN:
 20 A. Yes, I do.
 21 COFFEY, Q.C.:
 22 Q. Do you know anything about who typed this up?
 23 DR. MORRIS-LARKIN:
 24 A. I'm fairly certain it was me. I couldn't find
 25 the record on my computer, but it has my style

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1 and it's the kind of thing that I--it has my
 2 style of writing and it's the kind of thing I
 3 would have done to sort of help crystallize
 4 things for Dr. Cook, because of course, he was
 5 at the General site and--sorry, at the St.
 6 Clare's site and we were talking at the
 7 General site, and it sort of reflected the
 8 kinds of communications and the level of
 9 anxiety, I think, that was going on that he
 10 may not have been seeing and we wanted to try
 11 and put it into some form for him.

12 COFFEY, Q.C.:

13 Q. So you believe that it's likely, more likely
 14 than not, you typed this for the purpose of as
 15 an agenda as it were, in the sense of setting
 16 out the nature of the concerns for Dr. Cook?

17 DR. MORRIS-LARKIN:

18 A. Well, I think I did it as trying to
 19 crystallize -

20 COFFEY, Q.C.:

21 Q. Crystallize, I -

22 DR. MORRIS-LARKIN:

23 A. - some of those, some of the things that -

24 COFFEY, Q.C.:

25 Q. Before the meeting -

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1 DR. MORRIS-LARKIN:

2 A. - had been expressed, before the meeting, or
 3 between--I think we had had two meetings. I
 4 think there had been one where we first
 5 learned about the issue and then there was a
 6 great deal of discussion and various things
 7 were being said and it was, again, a time of
 8 very high emotional activity, and so I thought
 9 it was most effective to put a few things to
 10 paper for Dr. Cook.

11 COFFEY, Q.C.:

12 Q. After the break, Commissioner, thank you.

13 THE COMMISSIONER:

14 Q. Take 15 minutes.

15 (BREAK)

16 THE COMMISSIONER:

17 Q. Mr. Coffey.

18 COFFEY, Q.C.:

19 Q. Thank you, Commissioner. Exhibit P-1994,
 20 please? 1994. Doctor, just to go down
 21 through this briefly, you begin by saying
 22 "this is a list of some concerns that have
 23 emerged during conversations about the current
 24 problem. Included are some of our suggestions
 25 about how to approach this" and then

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1 "important features of the ongoing process
 2 should include: cooperation, transparency,
 3 communication, dissemination of information as
 4 the process evolves, avoidance of
 5 fingerpointing to either individuals or a
 6 group of individuals and input into the
 7 procedure and quality control and assurance
 8 initiatives surrounding it. We should ensure
 9 that no bias is introduced into the ongoing
 10 study. If the purpose is to compare methods
 11 then the following are important features."
 12 Which ongoing study was that?

13 DR. MORRIS-LARKIN:

14 A. I think that that was referring to what Dr.
 15 Carter wanted to do with regards to looking
 16 further into the previous cases.

17 COFFEY, Q.C.:

18 Q. And referring to "if the purpose is to compare
 19 methods," compare what sorts of methods?

20 DR. MORRIS-LARKIN:

21 A. Again, at that time, I would have very much
 22 seen it as an evolving methodology issue that
 23 we had changed what we were doing and we had
 24 seen an improvement as a result.

25 COFFEY, Q.C.:

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1 Q. And changed what we are--changed when?

2 DR. MORRIS-LARKIN:

3 A. Well, again, at some point with the change in
 4 the machine.

5 COFFEY, Q.C.:

6 Q. Okay.

7 DR. MORRIS-LARKIN:

8 A. You know, to me, that did play a factor in the
 9 timing of this.

10 COFFEY, Q.C.:

11 Q. Now here too, Doctor, the fourth bullet above
 12 says "dissemination of information as the
 13 process evolves," that fourth bullet.

14 DR. MORRIS-LARKIN:

15 A. Yes.

16 COFFEY, Q.C.:

17 Q. Up to that point, and this is early August
 18 2005, how much, if any, information were staff
 19 pathologists getting concerning what was going
 20 on?

21 DR. MORRIS-LARKIN:

22 A. I don't think there was anything formal,
 23 because you know, I think that Dr. Carter and
 24 Dr. Cook were doing the best they could to
 25 deal with the issue and they were probably,

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1 you know, very, very busy with that, but you
 2 hear bits of information and then that gets
 3 distorted.
 4 COFFEY, Q.C.:
 5 Q. Yes.
 6 DR. MORRIS-LARKIN:
 7 A. So it was a matter of looking for--you know,
 8 looking to find out what was going on and know
 9 that what was being said was what was actually
 10 happening, not, you know, the rumour mill kind
 11 of thing.
 12 COFFEY, Q.C.:
 13 Q. And Doctor, now around this time, in fact, the
 14 decision was made to have the samples going
 15 back over years retested at Mount Sinai. It
 16 was around this point, okay, in fact probably
 17 actually a day or two before, but it's not
 18 referred to here.
 19 DR. MORRIS-LARKIN:
 20 A. Okay.
 21 COFFEY, Q.C.:
 22 Q. And when did you first become aware that Mount
 23 Sinai was using a DAKO machine to do the
 24 retesting?
 25 DR. MORRIS-LARKIN:

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1 A. Oh, it probably would have been sometime
 2 later, much later.
 3 COFFEY, Q.C.:
 4 Q. Much later, okay. Here, you say "if the
 5 purpose is to compare methods, then the
 6 following are important features: assume
 7 pathologist reported the original test
 8 correctly." Now why would one assume that if
 9 under the newer and better machine, as it
 10 were, which you understood, was producing a
 11 different result?
 12 DR. MORRIS-LARKIN:
 13 A. Well, I think what that's referring to is
 14 again, it's if the purpose is to compare
 15 methods, then you shouldn't be looking at the
 16 variable--the other variable of the
 17 pathologist. That was a separate issue, and
 18 if the purpose was to compare methods, then to
 19 compare how we reported on one method versus
 20 how you reported on another.
 21 COFFEY, Q.C.:
 22 Q. What was the reaction amongst pathologists
 23 then to being told about Dr. Carter's
 24 observations about fixation, poor fixation or
 25 fixation issues, you know, internal controls

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1 not having been chosen, not having been
 2 included, not having stained, which presumably
 3 are comments directed at pathologist issues
 4 themselves, what was the reaction amongst
 5 pathologists?
 6 DR. MORRIS-LARKIN:
 7 A. I think that the pathologists probably--or I
 8 think that what I heard then was concern, you
 9 know. For me, I would have said "well, my
 10 goodness, did I do things the right way?" I
 11 would have been second guessing, questioning
 12 myself and thinking "how did I do it?" and you
 13 know, what impact would it have had, and I
 14 think that that's probably fair to say that
 15 many of the other pathologists were going
 16 through that same kind of mental exercise.
 17 COFFEY, Q.C.:
 18 Q. Doctor, when did you first hear that Dr.
 19 Carter had removed herself from this review
 20 process?
 21 DR. MORRIS-LARKIN:
 22 A. The exact timing, I don't remember. I do
 23 remember her saying it to me that, you know,
 24 "I've quit."
 25 COFFEY, Q.C.:

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1 Q. Did she tell you why?
 2 DR. MORRIS-LARKIN:
 3 A. I think, and I don't want to misquote her, but
 4 I think that she felt that she couldn't get a
 5 resolution with the way some people in the
 6 group were wanting to approach this and the
 7 way she felt it should be approached. The
 8 bottom line that I come away with is she felt
 9 that the lab shouldn't investigate itself,
 10 that somebody else should do it. So that's
 11 what I think -
 12 COFFEY, Q.C.:
 13 Q. That was your understanding.
 14 DR. MORRIS-LARKIN:
 15 A. I remember her, you know, being the main issue
 16 for her.
 17 COFFEY, Q.C.:
 18 Q. Here, this is circled with--kind of over here
 19 to the side, would that be something you'd
 20 have done?
 21 DR. MORRIS-LARKIN:
 22 A. No. This has Dr. Cook's writing on it.
 23 COFFEY, Q.C.:
 24 Q. Yes.
 25 DR. MORRIS-LARKIN:

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1 A. So I think he probably would have provided
 2 that and he may have done that.
 3 COFFEY, Q.C.:
 4 Q. "Persons conducting the study do not need to
 5 know which pathologist signed the report
 6 originally." Why is that?
 7 DR. MORRIS-LARKIN:
 8 A. Well, at that time, again, we were looking at
 9 it, you know--I was looking at it, as a
 10 pathologist, looking at comparing methods.
 11 We'd seen improvements. I had certainly
 12 attributed to an improvement in method, and I
 13 didn't think that it was necessary for an
 14 individual to introduce any--for one person to
 15 introduce bias into it, and I felt that that
 16 was potentially what could happen if--I mean,
 17 people being people, you go in with preformed
 18 notions of things. So I just thought that,
 19 you know, in the interest of being unbiased,
 20 that that was the kind of thing that should be
 21 done.
 22 COFFEY, Q.C.:
 23 Q. It says "anything else is an audit of
 24 individual pathologists, and if that is the
 25 aim, this is not the proper procedure for an

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1 audit of pathologists performance." What
 2 would be the proper procedure?
 3 DR. MORRIS-LARKIN:
 4 A. Well, the proper procedure would be, you know,
 5 again in relation to the kind of quality
 6 assurance principles that we see, you don't do
 7 retrospective--at this time, we'd not seen the
 8 kind of retrospective review of archival
 9 material that we've seen in recent years. So
 10 this was totally a foreign concept. What we
 11 were familiar with, in terms of auditing
 12 pathologists, would be, first of all, the kind
 13 of auditing we do ourselves by sharing our
 14 cases at rounds, by getting external consults
 15 and, you know, comparing what we thought with
 16 an external consultant and the kind of one
 17 percent audit or two percent whatever a
 18 department chooses of random review of cases
 19 and other things that are done within a time
 20 frame that's usually within a few months of
 21 when a pathologist signs a case. So it's a
 22 different sort of--totally different sort of
 23 approach.
 24 COFFEY, Q.C.:
 25 Q. Did this have anything to do with peer review,

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1 formal peer review?
 2 DR. MORRIS-LARKIN:
 3 A. This thing specifically?
 4 COFFEY, Q.C.:
 5 Q. Yes, like the reference to proper procedure,
 6 were you thinking of peer review?
 7 DR. MORRIS-LARKIN:
 8 A. Well, any of these kind of quality assurance
 9 activities I would consider peer review, yes.
 10 COFFEY, Q.C.:
 11 Q. And there was a formalized procedure for that,
 12 you would have been aware of that?
 13 DR. MORRIS-LARKIN:
 14 A. At this time?
 15 COFFEY, Q.C.:
 16 Q. Would you have been aware that there was a
 17 formal procedure in existence at the General
 18 Hospital concerning peer review?
 19 DR. MORRIS-LARKIN:
 20 A. That, I don't think I was aware that that kind
 21 of thing existed. That's a different issue
 22 from what I'm referring to here.
 23 COFFEY, Q.C.:
 24 Q. Okay, and then you go on to talk about "we
 25 should not be working in a culture where

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1 pathologists feel they are being criticized
 2 for past performances, avoid generalized
 3 statements such as," and there are a number of
 4 them attributed here. "These statements, as
 5 well as loud discussions around the issue in
 6 corridors of high public traffic are
 7 threatening and demoralizing." Now Doctor,
 8 does this accurately reflect kind of the
 9 feeling amongst the pathologists at the
 10 General Hospital at the time?
 11 DR. MORRIS-LARKIN:
 12 A. It accurately reflects my feeling and at least
 13 several of the pathologists who I had
 14 conversations with at that time, yes.
 15 COFFEY, Q.C.:
 16 Q. Okay, and there's a final reference to a
 17 pathologists outside the Health Care
 18 Corporation, which would be outside St. John's
 19 in particular.
 20 DR. MORRIS-LARKIN:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And you assert that they need to be informed
 24 and told about it and reassured about the
 25 process that's going to happen, thinking about

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1 your colleagues outside.
 2 DR. MORRIS-LARKIN:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. What was the result of this meeting?
 6 DR. MORRIS-LARKIN:
 7 A. I think Dr. Cook was very receptive to the
 8 points, some of the points that were brought
 9 to him. He appreciated that this was, you
 10 know, a very big issue for all of us and that
 11 we were concerned and I think that he took
 12 this and did his best, you know, to
 13 incorporate some of our suggestions in the
 14 proceedings that followed.
 15 COFFEY, Q.C.:
 16 Q. Exhibit P-1953? Some minutes of a meeting of
 17 pathologists at the General Hospital site,
 18 October 4th, 2005. You'll note you're there,
 19 Doctor. Here in paragraph 3.2, update on
 20 ER/PR status, reads "as all are aware, the
 21 media has gotten a hold of this issue. We are
 22 still in the process of determining how
 23 extensive this problem is. In view of this
 24 discussion with Dr. Cook, he has appointed Dr.
 25 Bev Carter as the point person for HER2/neu

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1 testing. With this in mind, there was some
 2 sentiment from the pathologists that Dr.
 3 Carter should review all breast cases with a
 4 back up person to cover in her absence. A
 5 letter to this effect will be sent to Dr. Cook
 6 stating the opinion of the pathologists at
 7 this site," which would be the General
 8 Hospital, "and this will be discussed with Dr.
 9 Carter as well." So I take it, Doctor, here
 10 that in light of what--the circumstances that
 11 existed in October 2005, things had changed.
 12 The view of having Dr. Carter look at all
 13 cases since September of '04, the breast
 14 cases, people were content to have her look at
 15 them?
 16 DR. MORRIS-LARKIN:
 17 A. I think that this reflects the sentiment that
 18 many of us were feeling that this was, of
 19 course, a very sensitive issue and that there
 20 were areas of expertise that Dr. Carter could
 21 contribute, especially now where we were going
 22 with the retesting that was being done of
 23 Mount Sinai.
 24 COFFEY, Q.C.:
 25 Q. Here, Doctor, 3.3, update on pathology

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1 assistants. "In view of the problems outlined
 2 in 3.2, there has been a decision that there
 3 will be pathology assistants made available to
 4 standardize the gross room. The pathologists
 5 expressed concerns about the qualifications of
 6 these individuals. A letter to Dr. Cook with
 7 copies to Doctors Williams and--I'm sorry, Dr.
 8 Williams and Terry Gulliver, will be sent
 9 outlining qualifications of these individuals
 10 as well as training expectations." Doctor, I
 11 take it then that there was a linkage between
 12 finally getting pathology assistants and the
 13 problem in the middle of '05?
 14 DR. MORRIS-LARKIN:
 15 A. Absolutely.
 16 COFFEY, Q.C.:
 17 Q. Yes, and the idea that there are concerns
 18 being expressed about the qualifications of
 19 these individuals and standardizing the gross
 20 room, okay, I take it that the advantage of
 21 having pathology assistants, a limited group
 22 in terms of standardization is what?
 23 DR. MORRIS-LARKIN:
 24 A. The advantage?
 25 COFFEY, Q.C.:

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1 Q. Yes.
 2 DR. MORRIS-LARKIN:
 3 A. Again, if you have a group of people who
 4 develop a special--you know, develop expertise
 5 which we would anticipate pathologists
 6 assistants would, then you're more likely to
 7 have standard standardized approaches to
 8 everything.
 9 COFFEY, Q.C.:
 10 Q. Had there been a--bearing in--at the time when
 11 pathologists generally were doing their own
 12 grossing, each pathologist was doing his or
 13 her own and residents might be assisting -
 14 DR. MORRIS-LARKIN:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. - was there a lack of standardization in that
 18 regard?
 19 DR. MORRIS-LARKIN:
 20 A. There were no standard written procedures,
 21 other than the references that we would refer
 22 to. There was, I'm sure you've heard about
 23 the Acerman Surgical Pathology book.
 24 COFFEY, Q.C.:
 25 Q. Yes.

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1 DR. MORRIS-LARKIN:
 2 A. At this time, we had in the department a copy
 3 of the Lester Approach to Surgical Pathology,
 4 which has a great deal of detailed grossing
 5 procedures, but that had just probably come
 6 into the department around that time. So
 7 there were references, but there was no one
 8 procedure that -
 9 COFFEY, Q.C.:
 10 Q. Everybody agreed to.
 11 DR. MORRIS-LARKIN:
 12 A. - everyone specifically followed. You know,
 13 in general, most things were done the same
 14 way, I think it's fair to say.
 15 COFFEY, Q.C.:
 16 Q. And, Doctor, the reference to expressed
 17 concerns about the qualifications of these
 18 individuals who have become pathology
 19 assistants, I understand that you became very
 20 involved in that afterward?
 21 DR. MORRIS-LARKIN:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. In the early days in October of '05, was there
 25 anything really known in St. John's about how

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1 a pathology assistant would be trained?
 2 DR. MORRIS-LARKIN:
 3 A. At that time, no, and I think that's what that
 4 statement reflects.
 5 COFFEY, Q.C.:
 6 Q. Okay. Doctor, the next page, paragraph 4.2,
 7 "Resident reporting of cases. Dr. Morris-
 8 Larkin brought it to the attention of the
 9 group that residents are typing cases on their
 10 own without the use of the secretarial pool.
 11 This has created confusion as there is
 12 generally several reports included in the
 13 chart as to which the staff pathologist may
 14 have difficulty identifying which is the most
 15 recent. From this, it was agreed that the
 16 policy on resident reporting of cases should
 17 be done through the secretaries, and the
 18 autopsy should be dictated at time of autopsy.
 19 There needs to be strict enforcing of policies
 20 as well as standardization of the grossing
 21 approach to be used by residents". I take it,
 22 Doctor, that you were complaining about
 23 variability across the system?
 24 DR. MORRIS-LARKIN:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. Here -
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. And wanted it addressed?
 7 DR. MORRIS-LARKIN:
 8 A. I think there are two separate issues in
 9 there. The first was specifically with
 10 regards to autopsy files, and then the second
 11 was with regards to the grossing to be used by
 12 the residents. It was an important part of
 13 residents training that we were trying to all
 14 do things the same way as well, so that the
 15 residents would be consistently trained.
 16 COFFEY, Q.C.:
 17 Q. As opposed to being with you one day, and
 18 being trained in a particular way -
 19 DR. MORRIS-LARKIN:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. And then next week potentially being with
 23 another pathologist and being trained in
 24 respect of the same procedure to do something
 25 in a different manner? That's what you're

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1 getting at, is it?
 2 DR. MORRIS-LARKIN:
 3 A. In part, but there are always some variations
 4 on a theme that are acceptable, but then the
 5 more we tried to standardize, the better it
 6 would be for the residents training. That's
 7 what that's referring to.
 8 COFFEY, Q.C.:
 9 Q. The idea of having difficulty finding
 10 something in a particular part of a pathology
 11 report, confusion, generally several reports,
 12 staff pathologists may have difficulty
 13 identifying which is the most recent. Is that
 14 a problem?
 15 DR. MORRIS-LARKIN:
 16 A. I believe -
 17 COFFEY, Q.C.:
 18 Q. Or has it been a problem in the past?
 19 DR. MORRIS-LARKIN:
 20 A. I believe that this specifically is referring
 21 to the autopsy report and the files, and
 22 having the most current version of the autopsy
 23 report in work and draft form in the file.
 24 COFFEY, Q.C.:
 25 Q. How about within pathology reports, not

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1 autopsy, but pathology reports, for example,
 2 the ER and PR and breast cancer cases, we've
 3 seen examples of it, addendum are all over -
 4 potentially all over the place, and sometimes
 5 inserted right in the middle of other text?
 6 DR. MORRIS-LARKIN:
 7 A. And that, I think, is something that has been
 8 resolved. Whenever I see an addendum now, my
 9 expectation is an addendum should always be up
 10 front because then when a report comes out, if
 11 you just have the report up front, the
 12 clinician is going to look at it and say,
 13 well, I already saw that, they're not going to
 14 be flipping through to find any addendums
 15 whereas the way that repots are generated now,
 16 the paper is such that the most recent
 17 addendum is at the top of the page on the
 18 front page.
 19 COFFEY, Q.C.:
 20 Q. And even ones we looked at earlier this
 21 morning didn't have that?
 22 DR. MORRIS-LARKIN:
 23 A. Yes, and we don't see them like that now.
 24 COFFEY, Q.C.:
 25 Q. And that has occurred since 2005, I take it,

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1 that difference in approach?
 2 DR. MORRIS-LARKIN:
 3 A. I'm not sure when that particular change
 4 occurred. That was - it was sort of a
 5 managerial organizational thing.
 6 COFFEY, Q.C.:
 7 Q. Exhibit P-1957. Doctor, this is one of a
 8 couple of exhibits involving Dr. Banerjee's
 9 report of October 17th, 2005, external quality
 10 review of immunohistochemical service.
 11 Doctor, when did you first see a copy of this
 12 report?
 13 DR. MORRIS-LARKIN:
 14 A. When it was posted on the Commission website.
 15 COFFEY, Q.C.:
 16 Q. That would be in 2008?
 17 DR. MORRIS-LARKIN:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. 2008.
 21 DR. MORRIS-LARKIN:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. Had you ever asked for it before that?
 25 DR. MORRIS-LARKIN:

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1 A. I don't think I ever asked for it. I think I
 2 alluded to it, you know, what is this report,
 3 what is it, where is it, that kind of thing,
 4 but, no, I never asked for it.
 5 COFFEY, Q.C.:
 6 Q. What exposure, if any, had you had to it or
 7 its contents?
 8 DR. MORRIS-LARKIN:
 9 A. The only exposure I had to it was in the fall
 10 or early winter of 2007 when Dr. Denic was
 11 discussing the Eastern Health's concern about
 12 this being a peer review report, and he read
 13 one or two points from it. That's the only
 14 time - I believe it was presented to the
 15 pathologists at a period before, but I was
 16 away at that time.
 17 COFFEY, Q.C.:
 18 Q. Doctor, if we could just look at - you've had
 19 an opportunity since its gone on the website,
 20 anyway, to look at this?
 21 DR. MORRIS-LARKIN:
 22 A. Yes, I have.
 23 COFFEY, Q.C.:
 24 Q. Doctor, here under review of cases, page four
 25 of the exhibit, Dr. Banerjee talks about poor

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1 fixation, negative internal controls, and
 2 absent internal controls.
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. These are the same subject matters that, in
 7 fact, Dr. Carter had referred to -
 8 DR. MORRIS-LARKIN:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. Back in the middle of '05, hadn't she?
 12 DR. MORRIS-LARKIN:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. And here under the heading, conclusions about
 16 the reasons for test failure, "Is the DAKO
 17 System faulty", he says no. "The Ventana
 18 System too sensitive", and he says "no
 19 evidence that it produces false positive
 20 results". Was this the first time when you
 21 read this that you learned that?
 22 DR. MORRIS-LARKIN:
 23 A. No, because I think that that discussion would
 24 have been happening - you know, in particular,
 25 Dr. Carter had referred to the fact that DAKO

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1 had been used in other places and she did not
 2 feel that that was the issue.
 3 COFFEY, Q.C.:
 4 Q. And the problem with tissue fixation, and he
 5 goes on to talk about that.
 6 DR. MORRIS-LARKIN:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. But again in the context here, "Inadequate
 10 attention paid by the grossing pathologist to
 11 the thickness of tissue slices, quality and
 12 adequacy of fixation, no standardized fixation
 13 protocol everyone adheres to", was that
 14 something that Dr. Carter, in effect, was
 15 speaking about in the middle of 2005?
 16 DR. MORRIS-LARKIN:
 17 A. I do think she referred to issues of tissue
 18 fixation being reflected on the slides that
 19 she had seen, yes.
 20 COFFEY, Q.C.:
 21 Q. And where she got down to, though, that you
 22 should be doing breadloafing at 10 millimetres
 23 or whatever, in fact, she may have -
 24 DR. MORRIS-LARKIN:
 25 A. I think that was something that was so widely

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1 known for so long, that would have been the
 2 practice.
 3 COFFEY, Q.C.:
 4 Q. Okay, that was already known.
 5 DR. MORRIS-LARKIN:
 6 A. Yeah.
 7 COFFEY, Q.C.:
 8 Q. So he's just making the observation, though,
 9 that in his view, anyway, inadequate attention
 10 is being paid to actually getting it down to
 11 the required maximum size. You were aware
 12 there was no standardized fixation protocol
 13 everyone adheres to?
 14 DR. MORRIS-LARKIN:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. You were aware of that before. "Inadequate or
 18 no attention is paid by the reporting
 19 pathologist to the status of internal
 20 controls". Well, that, in fact, repeats what
 21 we --
 22 DR. MORRIS-LARKIN:
 23 A. These were things that we had already been
 24 talking about with Dr. Carter and Dr. Cook.
 25 COFFEY, Q.C.:

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1 Q. Paragraph six is the same thing.
 2 DR. MORRIS-LARKIN:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. Internal controls, and better education was
 6 required for all concerned.
 7 DR. MORRIS-LARKIN:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. In his view. That wouldn't have been news to
 11 you, I take it?
 12 DR. MORRIS-LARKIN:
 13 A. No.
 14 COFFEY, Q.C.:
 15 Q. Certainly by the time you met on August 5th,
 16 2005, that list of concerns of yours, the idea
 17 that everybody concerned should know more
 18 about this and should be better educated about
 19 it, you were all very aware of that?
 20 DR. MORRIS-LARKIN:
 21 A. Yes, yes.
 22 COFFEY, Q.C.:
 23 Q. Doctor, you would have been aware that Dr.
 24 Banerjee was here in 2005?
 25 DR. MORRIS-LARKIN:

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1 A. I did not know until he had come and gone.
 2 COFFEY, Q.C.:
 3 Q. Okay, I appreciate that.
 4 DR. MORRIS-LARKIN:
 5 A. But I was aware that he had been in, yes.
 6 COFFEY, Q.C.:
 7 Q. Doctor, now having had a chance to look at
 8 this in 2008, would it have been of some
 9 assistance to yourself to actually have seen
 10 this in 2005?
 11 DR. MORRIS-LARKIN:
 12 A. To have seen this?
 13 COFFEY, Q.C.:
 14 Q. To actually have it spelled out in this way,
 15 yes, in late 2005?
 16 DR. MORRIS-LARKIN:
 17 A. I don't think that there's anything in this
 18 that we didn't already address in numerous
 19 meetings, general discussions, one on one
 20 discussions with each other.
 21 COFFEY, Q.C.:
 22 Q. Would there have been any advantage, though,
 23 to actually having it spelled out by someone,
 24 an outsider in writing, recorder and seen, and
 25 you can sit and read it and think about it?

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1 DR. MORRIS-LARKIN:
 2 A. Again, you know, it does put things - all the
 3 things that we've talked about into one
 4 document, which makes it easier to refer to.
 5 COFFEY, Q.C.:
 6 Q. Doctor, the idea that you wouldn't be given a
 7 copy of it, why wouldn't you be given - what
 8 was your understanding about why you didn't
 9 get a copy of that report?
 10 DR. MORRIS-LARKIN:
 11 A. I was not really aware of the actual process
 12 that had gone on at all. It was my
 13 understanding when it became an issue last
 14 year that it was seen as a peer review
 15 process, and I accepted that as it was
 16 described. I think many of the
 17 recommendations had been taken and
 18 implemented.
 19 COFFEY, Q.C.:
 20 Q. Would it have made any difference in this
 21 whole process to have someone from the outside
 22 come in and give his observations, even if
 23 they just reinforced what the internal
 24 investigator had found?
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. It helps, doesn't it?
 4 DR. MORRIS-LARKIN:
 5 A. It does.
 6 COFFEY, Q.C.:
 7 Q. To have somebody from outside?
 8 DR. MORRIS-LARKIN:
 9 A. Oh, yes.
 10 COFFEY, Q.C.:
 11 Q. Exhibit P-2068. Doctor, this is minutes of a
 12 discipline laboratory medicine meeting of
 13 March 28th, 2006. You'll note you're there.
 14 It's at the General Hospital, and under new
 15 business, I'm going to take you to that in a
 16 moment, but we understand from other evidence
 17 that by January, and certainly into February
 18 of 2006, the great bulk of retest results were
 19 back from Mount Sinai?
 20 DR. MORRIS-LARKIN:
 21 A. I honestly don't know much about the timing.
 22 COFFEY, Q.C.:
 23 Q. Okay.
 24 DR. MORRIS-LARKIN:
 25 A. And the return of any of that.

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1 COFFEY, Q.C.:
 2 Q. That's what I was going to ask you about. We
 3 know because of exhibits and witnesses. When
 4 did you first become aware of when the bulk of
 5 the retesting was over, when and how?
 6 DR. MORRIS-LARKIN:
 7 A. I think I was less aware of when it was over
 8 than, you know, the fact that it was taking so
 9 long to get it done, that, you know, Dr. Cook
 10 was struggling with the issues with the Mount
 11 Sinai group and they're overworked, they're
 12 backlogged, so I was aware of that. Beyond
 13 that, I don't know when the bulk of it was
 14 finished.
 15 COFFEY, Q.C.:
 16 Q. So you weren't, as a member of the staff at
 17 the Health Sciences Centre, kind of kept
 18 apprised from time to time by the management?
 19 DR. MORRIS-LARKIN:
 20 A. No.
 21 COFFEY, Q.C.:
 22 Q. As to what the status is now?
 23 DR. MORRIS-LARKIN:
 24 A. No.
 25 COFFEY, Q.C.:

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1 Q. I take it, did that in any way contribute to
 2 rumours about what the results might be, or
 3 speculation about what the results were?
 4 DR. MORRIS-LARKIN:
 5 A. I think, you know, there were occasional
 6 questions, but we also appreciated that their
 7 hands were tied and they couldn't really give
 8 us a comprehensive picture of what was
 9 happening because they didn't have the results
 10 themselves.
 11 COFFEY, Q.C.:
 12 Q. Did you - were you ever told, have you ever
 13 been told to this day how many of your own
 14 cases were retested?
 15 DR. MORRIS-LARKIN:
 16 A. I have been told that I can inquire to
 17 whatever information Drs. Cook and Denic have,
 18 but that's beyond - I mean, we know that the
 19 database is now beyond that, but that's all
 20 they have access to, and I am able to ask them
 21 and have spoken to Dr. Denic about it.
 22 COFFEY, Q.C.:
 23 Q. When were you first told that that was
 24 available to you?
 25 DR. MORRIS-LARKIN:

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1 A. I think that very early on Dr. Cook always
 2 made it clear that if you want to find out, I
 3 will certainly make this available to you. I
 4 think he had a huge - an overwhelming
 5 management issue to try and deal with, so I
 6 don't think any of us expected him to start
 7 feeding back to us. I think the onus was on
 8 us to go to him.

9 COFFEY, Q.C.:

10 Q. On the retesting when the retests came back,
 11 they came back in spreadsheets in the main,
 12 okay, I'll tell you that.

13 DR. MORRIS-LARKIN:

14 A. Uh-hm.

15 COFFEY, Q.C.:

16 Q. The evidence indicates that Dr. Cook would
 17 then generate - at least in the early days it
 18 was Dr. Cook, and then Dr. Denic would
 19 generate in St. John's an addendum.

20 DR. MORRIS-LARKIN:

21 A. Yes.

22 COFFEY, Q.C.:

23 Q. If it was you patient, did you get a copy of
 24 the addendum?

25 DR. MORRIS-LARKIN:

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1 A. No, I didn't.

2 COFFEY, Q.C.:

3 Q. Should you have, do you think?

4 DR. MORRIS-LARKIN:

5 A. At that time, I don't think we really thought
 6 about it. I don't remember really thinking
 7 about it. I think it could have been useful,
 8 but I don't think it was something that we had
 9 an issue with, and I don't remember if it was
 10 ever discussed or a decision made to do it or
 11 not do it, and it's quite possible that it
 12 could have been discussed.

13 COFFEY, Q.C.:

14 Q. Doctor, here under quality assurance, new
 15 business, quality assurance, is a reference to
 16 this is a changeover, in effect, from Dr.
 17 Denic to Dr. Cook as clinical chief, and it
 18 goes on, "Implementation of the new quality
 19 assurance program was discussed at length.
 20 Dr. Beverley Carter will act as manager of the
 21 new quality management program for the
 22 pathology department. There will be a
 23 technical member and a clerical member on the
 24 team. Dr. Carter will act independently and
 25 answer to quality management team. This is

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1 supported by Dr. Williams, VP of Quality,
 2 Diagnostics, and Medical Services. Dr.
 3 Morris-Larkin expressed concern about being
 4 audited", and then notes, "Dr. Denic stated
 5 that random slides will be audited. Dr.
 6 Carter says the random cases will be picked by
 7 the technologists who is working with the
 8 quality management program. Dr. Morris-Larkin
 9 expressed the feeling that one pathologist
 10 should not do all of the auditing. Dr. Denic
 11 also stated that there will be policies put in
 12 place regarding the auditing. Dr. Cook stated
 13 there was no QA committee before November of
 14 '04. Dr. Mathieson said it was not a good
 15 policy to have the QA committee report to
 16 anybody but the clinical chief, who would then
 17 report to Eastern Heath. Dr. Denic informed
 18 the group that Eastern Health will have
 19 regional managers for QA who will be involved
 20 with our managers, and Dr. Morris-Larkin
 21 offered to help with the QA", and then it goes
 22 on from there. Doctor, I wanted to review
 23 that with you to ask you what your concerns
 24 were about being audited, and then before the
 25 meeting ends, you've offered to get involved.

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1 So could you tell the Commissioner about that?

2 DR. MORRIS-LARKIN:

3 A. Well, again the minutes are being taken by a
 4 secretary who's recording things, and the
 5 whole context of the discussion, I think, is
 6 around how should we do this, we want to make
 7 sure we do it in an appropriate manner, we
 8 want to - again really echoing some of the
 9 things I had written in the notes from that
 10 August 5th meeting in '05. So it was the same
 11 kind of concerns that we do this in a way that
 12 is - you know, in a culture of quality that is
 13 a blameless kind of culture, you're much more
 14 likely to have successful auditing and
 15 attention to patient related events that are
 16 significant, and that's the kind of thing that
 17 I would have been referring to there. As
 18 well, I would have had a concern that if one
 19 person does all the auditing and that person
 20 leaves, then this activity falls by the
 21 wayside again, and I think that it's very
 22 important to have a structure in place that -
 23 I think that's probably what I was referring
 24 to there, have a structure in place that was
 25 not dependent upon an individual who was doing

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1 the bulk of the work, but would be sustainable
 2 after that individual left, and as well, I
 3 didn't think that one person should be
 4 burdened with all that work.
 5 COFFEY, Q.C.:
 6 Q. Here, Doctor, on page three of the exhibit is
 7 a reference to pathology assistants. "Dr.
 8 Denic stated some people have been interviewed
 9 for the pathology assistants. One with
 10 experience is starting on Monday", and this is
 11 March 28th, the date of the meeting. "Manuals
 12 and policies will be developed for the
 13 pathology assistants. They will be trained
 14 according to the standards in the United
 15 States. Four pathology assistants will be
 16 trained at the same time". Now to help put
 17 this in context for the Commissioner, if we
 18 could look, please, at Exhibit P-2092. This
 19 is a laboratory program two year operational
 20 plan from April of '06 to March of '08, and
 21 the division is pathology. "Priority
 22 issues/focus area, integrated clinical system,
 23 regional policies and procedures", and there's
 24 a detailed activity plan. In particular,
 25 could we go, please, Registrar, to page six.

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1 The operational goal there is by March of '08,
 2 lab medicine will review present staff
 3 capacity and determine efficiencies,
 4 realignments, and appropriate skill mix and
 5 use of staff resources. You will note there
 6 under directors, operational objective number
 7 three, identify and implement staff
 8 efficiencies, and then under actions required,
 9 how resources - you see, Doctor, right there,
 10 it says, "Pathologist sub-specialty, organ
 11 site tumour leader, lab flow for technical and
 12 professional duties, pathologists assistants",
 13 and, of course, your name appears out here
 14 under "delegated to responsibility". Doctor,
 15 the pathologist assistants, I take it, ended
 16 up being yours?
 17 DR. MORRIS-LARKIN:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. April '06 to March of '08, and here in this
 21 context, which one of - pathologist sub-
 22 specialty, or the organ site tumour leader, or
 23 both of them that - and the lab flow?
 24 DR. MORRIS-LARKIN:
 25 A. I think both mine and Dr. Denic's name are

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1 there because we would be - that would be a
 2 pathologist related issue.
 3 COFFEY, Q.C.:
 4 Q. The sub-specialty.
 5 DR. MORRIS-LARKIN:
 6 A. Developing sub-specialty groups essentially.
 7 COFFEY, Q.C.:
 8 Q. And there's a reference down below to
 9 electronic test ordering. Yourself and Mr.
 10 Dyer.
 11 DR. MORRIS-LARKIN:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. Trying to develop that, and I think it that's
 15 to avoid the paper requisitions?
 16 DR. MORRIS-LARKIN:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. And transcription services, yourself, Dr.
 20 Cook, and Mr. Dyer, I take it. That had been
 21 a problem for years?
 22 DR. MORRIS-LARKIN:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. I haven't taken you through the minutes, but

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1 from time to time backlogs in transcription
 2 would have been a problem?
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. Doctor, if we go then, please, to Exhibit P-
 7 3364. I want to ask you - this is May 2nd
 8 '06, a letter appointing you - it's addressed
 9 to you, appointing you as site chief physician
 10 at the General Hospital site. It's from Dr.
 11 Denic, and as well May 11th, 2006, page three,
 12 is a letter from Dr. Williams thanking you for
 13 having agreed to accept the site chief's role.
 14 Two questions. One, why did you agree at that
 15 point in time to become the site chief?
 16 DR. MORRIS-LARKIN:
 17 A. There was a need. It had to be filled.
 18 COFFEY, Q.C.:
 19 Q. Number two, Doctor, taking on the
 20 responsibility for the pathology assistants,
 21 why did you do that?
 22 DR. MORRIS-LARKIN:
 23 A. Again, I think that within that realm of site
 24 chief being responsible for the grossing room
 25 and, you know, the overall pathology

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1 activities, I felt that that was a reasonable
 2 thing to try and, you know, take that on from
 3 a co-ordinating point of view. I also had a
 4 fair bit of experience in teaching both
 5 undergraduates and pathology residents, so I
 6 felt that it was something that I could try
 7 and approach.
 8 COFFEY, Q.C.:
 9 Q. Now, Doctor, here in this letter to yourself
 10 of May 2nd, 2006, it says, "Listed below are
 11 the duties which you should assume in your
 12 position as site chief." And then it goes on,
 13 1 through 12. Did you have any input into
 14 what was contained in numbers 1 to 12?
 15 DR. MORRIS-LARKIN:
 16 A. I did from the point of view of discussing it
 17 with Dr. Denic when he gave it to me, we sort
 18 of fleshed out one or two points in
 19 particular, because at this time the Quality
 20 Management Program was just fledgling, but was
 21 certainly up and running--off to a running
 22 start with Dr. Carter and Ms. Parnell and he
 23 mentions, you know, the quality assurance
 24 there, so we needed to kind of more clearly
 25 define what were my roles and what were her

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1 roles in this. But otherwise I think, you
 2 know, Dr. Denic had looked at what it was he
 3 saw I was doing and what was needed to be done
 4 and I pretty much agreed with what he had
 5 there.
 6 COFFEY, Q.C.:
 7 Q. Now, Doctor, you are still a staff pathologist
 8 II, in the sense you still do staff
 9 pathologist work.
 10 DR. MORRIS-LARKIN:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. How much of your time beginning in May of '06,
 14 in terms of workload, was made available to
 15 you to carry out your site chief's role
 16 compared to your staff pathologist role?
 17 DR. MORRIS-LARKIN:
 18 A. Well certainly Dr. Denic indicated to me that
 19 I should try and reduce some of my clinical
 20 workload from the point of view of receiving
 21 cases. The reality of that is that a lot of
 22 times when things get down to a crunch, it's
 23 often the site chief who actually has to take
 24 on the extra work. But he did make it clear
 25 to me that I would be expected to reduce my

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1 clinical workload and I did do that.
 2 COFFEY, Q.C.:
 3 Q. And was there any percentage talked about or
 4 proportions or -
 5 DR. MORRIS-LARKIN:
 6 A. The percentages are, you know, the percentages
 7 are nice numbers of paper, but in reality it's
 8 very hard to actually apply percentages. I
 9 also had to balance my obligations to Memorial
 10 University and, you know, it was clear from
 11 the Dean that I was expected to spend a
 12 certain amount of my time in a week at
 13 activities that related specifically to the
 14 medical school and undergraduate programs.
 15 COFFEY, Q.C.:
 16 Q. And in the undergraduate programs, because
 17 here, looking through this, I don't think the
 18 undergraduate medical program is referred to
 19 here.
 20 DR. MORRIS-LARKIN:
 21 A. No, because this would be specifically an
 22 Eastern Health issue.
 23 COFFEY, Q.C.:
 24 Q. Which is the rounds and -
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. And he says, "on site, along with"--paragraph
 4 10 here, "Responsible for maintenance of all
 5 teaching rounds and same day (phonetic)
 6 activity on site, along with the education
 7 component of medical students and residents
 8 visiting that particular site." So I take it
 9 whatever is going on site, yes, but if you had
 10 to go and give a lecture somewhere, that -
 11 DR. MORRIS-LARKIN:
 12 A. That's a separate issue.
 13 COFFEY, Q.C.:
 14 Q. - would have been a separate issue entirely.
 15 DR. MORRIS-LARKIN:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. Is there a percentage of time on paper even,
 19 allotted to the site chief role and your
 20 division of responsibility with Memorial
 21 University?
 22 DR. MORRIS-LARKIN:
 23 A. The percentages that are allotted really
 24 mostly relate to the site chief and well major
 25 administrative activities, being, I think

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1 about 20 percent of a work week, so point two
 2 of your time, roughly. In the big picture for
 3 me, what would have been expected at this
 4 time, I would have had a 80 percent commitment
 5 to Eastern Health, my time being given to them
 6 or basically I guess, you know, compensated
 7 for by them to Memorial University for my time
 8 and then I would receive appropriate
 9 compensation. So the organizational structure
 10 is that I was expected to do 80 percent of the
 11 work of a fulltime hospital pathologist in
 12 prior to taking this one. Now within that 80
 13 percent, because I was now taking on this
 14 major administrative role, I would be expected
 15 to reduce the clinical workload to 60 percent.
 16 COFFEY, Q.C.:
 17 Q. Sixty out of a hundred?
 18 DR. MORRIS-LARKIN:
 19 A. Of one hundred and then I went further because
 20 within months, there was so much work to be
 21 done, I think it was actually last summer I
 22 changed my arrangement with Eastern Health so
 23 that, because I was doing so much work for
 24 them, I actually reduced it to 60 percent, so
 25 that now my work structure is, I am supposed

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1 to do 60 percent of what a hospital
 2 pathologist does. I did that because I needed
 3 to feel I could justify reducing my clinical
 4 workload even further because of the
 5 overwhelming administrative responsibilities
 6 that I was carrying.
 7 THE COMMISSIONER:
 8 Q. So that's 20 percent site chief work, 20
 9 percent to MUN and then 60 percent to your
 10 normal duties?
 11 DR. MORRIS-LARKIN:
 12 A. No, essentially it doesn't really work--it
 13 doesn't actually add up to a hundred percent,
 14 there's always a problem, but essentially I am
 15 60 percent Eastern Health and within that 20
 16 percent supposedly is to my site chief duty.
 17 COFFEY, Q.C.:
 18 Q. Twenty of the 60.
 19 THE COMMISSIONER:
 20 Q. Is it 20 percent of 60 or 20 percent of a
 21 hundred would be the site chief?
 22 DR. MORRIS-LARKIN:
 23 A. And that's where the numbers really--they just
 24 don't jive.
 25 THE COMMISSIONER:

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1 Q. So you should be 40 percent to MUN?
 2 DR. MORRIS-LARKIN:
 3 A. In rough terms and that was what I was aiming
 4 for because I had, you know, direction from
 5 the Dean that essentially a day and a half of
 6 my work week should be devoted to Faculty of
 7 Medicine duties, so -
 8 COFFEY, Q.C.:
 9 Q. Teaching undergraduates, graduates -
 10 DR. MORRIS-LARKIN:
 11 A. Teaching undergraduates the research projects,
 12 administrative things related, I don't do as
 13 much administrative things related to
 14 undergrad now. I did that in the past and
 15 I've replaced that with the Eastern Health
 16 administrative responsibilities.
 17 COFFEY, Q.C.:
 18 Q. And, Doctor, you've been in that position now
 19 for, well it's coming on to two and a half
 20 years?
 21 DR. MORRIS-LARKIN:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. Is there enough time in a week to do it?
 25 DR. MORRIS-LARKIN:

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1 A. No.
 2 COFFEY, Q.C.:
 3 Q. There's not. Has the shortage of pathologists
 4 locally had contributed to the lack of time in
 5 a week to get it done?
 6 DR. MORRIS-LARKIN:
 7 A. It has because not only the shortage, the
 8 shortage contributes in one way, even though
 9 we have found an outlet source for some cases
 10 in that we refer them to the Dynacare lab in
 11 Ottawa, that in itself creates administrative
 12 work for me because I basically triage and I'm
 13 the stop gap (phonetic), so that, you know, I
 14 try and keep anything that's going to be more
 15 significantly sensitive, time sensitive and
 16 things like that, within house. As well, what
 17 we send to Dynacare are really the smaller,
 18 simpler cases and the proportion for all the
 19 pathologists who are here in Eastern Health,
 20 the proportion of difficult cases to simple
 21 cases has gotten off balance as a result. The
 22 other thing is with the frequent turn over,
 23 there are more people that have to be oriented
 24 and with staff coming out of residency
 25 programs and we've had more of those than we

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1 had staff that had been around for five or ten
 2 years, then they need, they need somebody they
 3 can go to because we do frequently show our
 4 cases, it's an important part of our quality
 5 practice. So then the few more senior people
 6 who are left around do a lot more of reviewing
 7 cases with the newer staff members.
 8 COFFEY, Q.C.:
 9 Q. Doctor, I ask you to think about this for a
 10 moment, if the pathology positions in St.
 11 John's were fully staffed, if they were, okay.
 12 DR. MORRIS-LARKIN:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. Would there still be enough time in a normal
 16 work week for you to get what's expected of
 17 you done, within a normal work week?
 18 DR. MORRIS-LARKIN:
 19 A. At this point, still maybe not, it two years I
 20 think it might be different because as you can
 21 well imagine, there's a great deal of more
 22 administrative issues going on at this time
 23 because of the great number of changes that
 24 have occurred at this time.
 25 COFFEY, Q.C.:

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1 Q. Including, and we're going to look at this in
 2 a moment, the whole issue around written
 3 procedures and protocols -
 4 DR. MORRIS-LARKIN:
 5 A. That's correct.
 6 COFFEY, Q.C.:
 7 Q. - which is a whole time consuming issue in
 8 itself.
 9 DR. MORRIS-LARKIN:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. And you anticipate that over the next couple
 13 of years at least that will be more or less--
 14 it won't end, but the bulk of it will be done.
 15 DR. MORRIS-LARKIN:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. That's one of the things you're getting at
 19 here?
 20 DR. MORRIS-LARKIN:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. If we could, please, Exhibit P-0022? Page 29?
 24 Doctor, these are MAC minutes of, this
 25 particular page of May 10th, 2006, do you see

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1 that?
 2 DR. MORRIS-LARKIN:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. And it's got an announcement, I take it, of
 6 the MAC that you now site chief.
 7 DR. MORRIS-LARKIN:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Dr. Denic is reporting back to them. "Dr.
 11 Makarla is taking on the role of director of
 12 immunohistochemistry and Dr. Ford Elms is
 13 appointed assistant director of
 14 immunohistochemistry and Dr. Beverley Carter
 15 has agreed to take on the leadership role for
 16 QA of the Laboratory Medicine Program." Now,
 17 just to branch out from that, you are still in
 18 your job as site chief.
 19 DR. MORRIS-LARKIN:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Dr. MaKarla has gone, has moved on?
 23 DR. MORRIS-LARKIN:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Doctor Elms has come in here and testified as
 2 his role as, well, initially assistant and
 3 then finally director of immunohistochemistry.
 4 DR. MORRIS-LARKIN:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. I'm going to ask you about that, what is the
 8 relationship between yourself as site chief at
 9 the General and Dr. Elms as the director of
 10 immunohistochemistry, how does that work?
 11 DR. MORRIS-LARKIN:
 12 A. Dr. Elms spends--Dr. Elms is based at St.
 13 Clare's but he spends a great deal of time at
 14 the Health Science. I see him almost every
 15 day. Sometimes he pops into my office;
 16 sometimes I see him because I pop into the
 17 immunohistochemistry lab. So we frequently
 18 talk about what's going on in the lab, the
 19 general changes that have occurred and the
 20 current practices within the lab. As well,
 21 when we have any particular issue, I usually
 22 bring it--if I have an issue, I would bring it
 23 both to the technologists and I would let Dr.
 24 Elms know about it. And the situation has
 25 been such that there's feedback, so there is a

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1 great deal of discussion goes back and forth.
 2 COFFEY, Q.C.:
 3 Q. In your position as site chief, does he report
 4 to you?
 5 DR. MORRIS-LARKIN:
 6 A. No, no. Dr. Elm's site chief would be based
 7 at St. Clare's.
 8 COFFEY, Q.C.:
 9 Q. No, but the site for IHC is actually in the
 10 General.
 11 DR. MORRIS-LARKIN:
 12 A. And no, he does not report to me, he would
 13 report to, I presume Dr. Denic as clinical
 14 chief.
 15 COFFEY, Q.C.:
 16 Q. Dr. Denic as clinical chief, even in relation
 17 to his capacity of director of
 18 immunohistochemistry?
 19 DR. MORRIS-LARKIN:
 20 A. I would see him, you know, I would see us as
 21 laterally related.
 22 COFFEY, Q.C.:
 23 Q. "Dr. Carter has agreed to take on the
 24 leadership role for QA of the Laboratory
 25 Medicine Program." Now Dr. Carter, of course,

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1 has testified here and she certainly--and the
 2 documents bear this out, she initially got
 3 involved in this QA matter. Who is doing that
 4 role right now from a pathologist end?
 5 DR. MORRIS-LARKIN:
 6 A. That would be me.
 7 COFFEY, Q.C.:
 8 Q. Okay, and when did you begin that?
 9 DR. MORRIS-LARKIN:
 10 A. Well Dr. Carter had taken a great deal of
 11 initiative and had set up a good foundation in
 12 the Quality Assurance Program, Quality
 13 Management Program really, and with that, she
 14 managed to get funding for a permanent person
 15 who is taken from the technical group, so that
 16 now we've got a structure in place that we
 17 have a pathology quality management co-
 18 ordinator. So the bulk of this -
 19 COFFEY, Q.C.:
 20 Q. And who is that?
 21 DR. MORRIS-LARKIN:
 22 A. Currently it's Ms. Bev Rowe.
 23 COFFEY, Q.C.:
 24 Q. And before that?
 25 DR. MORRIS-LARKIN:

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1 A. It was Catherine Parnell.
 2 COFFEY, Q.C.:
 3 Q. Okay.
 4 DR. MORRIS-LARKIN:
 5 A. So Dr. Carter got that in place and then I
 6 believe it was last summer she decided to move
 7 away from this role and what we had in place
 8 at that time was basically a Quality
 9 Management Program Committee which was
 10 comprised of a number of people, including the
 11 co-ordinator, a co-chair that would have been
 12 filled by Dr. Carter for a brief period of
 13 time and then a number of other significant
 14 stakeholders, such as the site chiefs,
 15 representation from the technical lab,
 16 representation from the pathologist assistants
 17 and then ad hoc members, such as people from
 18 immunohistochemistry. So for about maybe 8
 19 months, it functioned as a committee, but with
 20 the expected retirement of Ms. Parnell, I
 21 thought that, you know, it was necessary to
 22 have somebody who was going to be at least a
 23 resource person for her successor. So I
 24 volunteered for six months to fill that role
 25 to allow Dr. Denic some time to try and find

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1 somebody to take it on a permanent basis. He
 2 had been trying previously, but had been
 3 unsuccessful in recruiting somebody to take up
 4 that particular responsibility.
 5 COFFEY, Q.C.:
 6 Q. So when did that six months begin?
 7 DR. MORRIS-LARKIN:
 8 A. That began in May.
 9 COFFEY, Q.C.:
 10 Q. Of?
 11 DR. MORRIS-LARKIN:
 12 A. Of 2008.
 13 COFFEY, Q.C.:
 14 Q. And I take it their activities are ongoing?
 15 DR. MORRIS-LARKIN:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. That group's activities.
 19 DR. MORRIS-LARKIN:
 20 A. Yes, and Ms. Rowe has just come into it, so it
 21 has taken her a few months to get up to speed,
 22 but I think that, you know, things are
 23 progressing very well.
 24 COFFEY, Q.C.:
 25 Q. Exhibit P-3351 please? Doctor, this is a

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1 series of e-mails, it's a confirmation of a
 2 meeting and in fact, it was to occur later on
 3 in June of 2006. This first e-mail here is
 4 from Terry Gulliver to Denise Dunn, June 20th,
 5 '06. It's "RE: ER/PR retesting". Mr.
 6 Gulliver writes, "Shouldn't Doctor Lynn
 7 Morris-Larkin be there. She is the new site
 8 chief for the Health Sciences Centre."
 9 Apparently they just missed you in the send
 10 out of the e-mail below about the confirmation
 11 of the meeting of June 30th, at the lab
 12 conference room at St. Clare's. Now we
 13 understand from documentation that we have
 14 otherwise seen, that this related to the idea
 15 of discussing the potential for resuming ER/PR
 16 testing in St. John's.
 17 DR. MORRIS-LARKIN:
 18 A. Uh-hm.
 19 COFFEY, Q.C.:
 20 Q. Did you attend that June 30th meeting, do you
 21 recall?
 22 DR. MORRIS-LARKIN:
 23 A. No, I did not.
 24 COFFEY, Q.C.:
 25 Q. And do you recall why not?

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1 DR. MORRIS-LARKIN:
 2 A. In all honesty, I don't even recall the
 3 communication at all, although there's a note
 4 there that says I'm on service that day, but
 5 would try to switch. So perhaps someone had
 6 called me about it, but I don't think I heard
 7 anything subsequent to that.
 8 COFFEY, Q.C.:
 9 Q. And, Doctor, I raise this here because I
 10 wanted to ask you about this whole ER/PR
 11 matter, up to that point in time until you
 12 became site chief, I take it your involvement
 13 with ER/PR was just simply as an observer, as
 14 a staff pathologist?
 15 DR. MORRIS-LARKIN:
 16 A. That's correct.
 17 COFFEY, Q.C.:
 18 Q. Having become site chief and this would have
 19 invited you to an actual meeting when ER/PR,
 20 the nitty gritty of it, retesting, was going
 21 to be discussed, did you ever then get
 22 involved in the kind of nitty gritty of the
 23 matter?
 24 DR. MORRIS-LARKIN:
 25 A. No, by that time I think that the group had

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1 been organized, things had been going ahead.
 2 Doctor Carter and Doctor Cook, I believe, were
 3 mostly dealing with the reports that came
 4 back, so I wasn't involved at all.
 5 COFFEY, Q.C.:
 6 Q. And have you ever been, in fact, to this day?
 7 DR. MORRIS-LARKIN:
 8 A. No, no.
 9 COFFEY, Q.C.:
 10 Q. Exhibit P-1616? Now, Doctor, what I want to
 11 look at is here on the second page, it's a
 12 spreadsheet where Dr. Banerjee and Trish
 13 Wegrynowski's recommendations for IHC, updated
 14 June 30th, '06, and here, Doctor, under
 15 recommendation No. 31. "SOPS for
 16 accessioning, grossing and fixation" being
 17 recommended by Trish Wegrynowski and agree
 18 with, yes, and your name is listed amongst
 19 those--Dr. Dyer, yourself and Dr. Carter are
 20 working on, September '06 to March '08, so I
 21 take it that it had begun by then -
 22 DR. MORRIS-LARKIN:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. - the process. And 32 says, "SOPS and

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1 performance evaluation of PAS documented", see
 2 that?
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. And it's yourself and Mr. Dyer, March of '08.
 7 DR. MORRIS-LARKIN:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. I take it you had signed on in effect to be
 11 involved with the PAS?
 12 DR. MORRIS-LARKIN:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. And again, why was it you agreed--who asked
 16 you to do that and why did you agree -
 17 DR. MORRIS-LARKIN:
 18 A. Dr. Denic would have asked me as clinical
 19 chief.
 20 COFFEY, Q.C.:
 21 Q. And was this before you became site chief?
 22 DR. MORRIS-LARKIN:
 23 A. It was at the same time.
 24 COFFEY, Q.C.:
 25 Q. At the same time, obviously it was part of it.

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1 DR. MORRIS-LARKIN:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Exhibit P-2106? These are the minutes of the
 5 site chief's meeting in November 6, '06, at
 6 St. Clare's, you're present, Dr. Denic, Dr.
 7 Cook and Mr. Dyer, under the heading "New
 8 Business a) Pathologist Assistants." It
 9 reads, "Dr. Morris-Larkin circulated drafts on
 10 pathology assistant training and the role of
 11 pathologists as mentors and supervisors to the
 12 PAs. This is to be reviewed by the site
 13 chiefs who will provide comments and feedback
 14 on this document. Formal PA teaching sessions
 15 have been set up by Drs. Wadden and Morris-
 16 Larkin. Dr. Morris-Larkin will work in
 17 developing an evaluation process for PAs, once
 18 PA training is complete. A log will be signed
 19 by the various site group pathologists, this
 20 is currently under development and an ITER
 21 type process will have to be developed to
 22 monitor their training and development. The
 23 goal is to eventually formulate a gross manual
 24 for PAs based on evidenced based literature."
 25 Now, Doctor, I take it that's kind of a

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1 snapshot as of November 6th as to where you
 2 were with this, yourself?
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. How did you go about, because PAs locally, I
 7 take it, were new. How did you go about
 8 organizing it?
 9 DR. MORRIS-LARKIN:
 10 A. Well I wasn't involved in the initial hiring
 11 of the people who would eventually become our
 12 pathology assistants.
 13 COFFEY, Q.C.:
 14 Q. Who did that?
 15 DR. MORRIS-LARKIN:
 16 A. Dr. Fontaine and I think Mr. Dyer had the most
 17 input, I'm not sure if Dr. Cook had any input
 18 into it, he may have. And so by the time I
 19 had agreed to sign on, we were well into that
 20 process of having people who were going to be
 21 coming into the system. And we had two--
 22 people of two different backgrounds. We had
 23 laboratory technologists with absolutely no
 24 training in pathology assisting at all, but
 25 who had a background in pathology, so they had

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1 been at the gross bench assisting a
 2 pathologist during their work, so they were
 3 familiar with many of the things. And then
 4 the other individual who came in who was also
 5 a laboratory assistant, had worked as a
 6 laboratory technologist, had also worked as a
 7 pathologist assistant in Ontario for a period
 8 of time, so she was kind of at an intermediate
 9 level of training. And then by August, we
 10 acquired a trained pathologist assistant from
 11 Ontario. She was an individual who would be
 12 identified as the lead pathologist assistant
 13 and that was very important for us because she
 14 could be at the gross bench much more readily
 15 than a pathologist, although we would, you
 16 know, have a major role in training the
 17 pathologist assistants, she could be there to
 18 co-ordinate things, to help them through the
 19 smaller issues and to contribute to the
 20 training as well.
 21 COFFEY, Q.C.:
 22 Q. And how would you go about getting kind of a
 23 syllabus, as it were?
 24 DR. MORRIS-LARKIN:
 25 A. Well, what I did was I did some looking on the

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1 internet, essentially, looked at some websites
 2 in the United States where they have
 3 accredited pathologists assistant training
 4 programs, the kinds of things that they were
 5 doing, what they were looking for and I also
 6 spoke to some people. I happened to be on a
 7 social visit in Ontario so I went to see Dr.
 8 Khalifa and we had a chat because they had a
 9 well-developed pathologists assistant group.
 10 You know, they had some six or seven. So I
 11 spoke with him about how he had gone about or
 12 how they went about training because they
 13 have a fair amount of turnover because a
 14 number of their pathologists assistants were,
 15 in fact, previously training pathologists and
 16 some of them had come here to our residency
 17 program, so there was a connection there.
 18 COFFEY, Q.C.:
 19 Q. Previously pathologists, foreign -
 20 DR. MORRIS-LARKIN:
 21 A. Pathologists, yeah, international medical
 22 graduates who had been pathologists elsewhere
 23 and were in between finding positions as
 24 pathology residents to retrain. So, you know,
 25 I had a relationship with Dr. Khalifa and we

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1 talked about some of the issues and how to go
 2 about this and he gave me some advice.
 3 COFFEY, Q.C.:
 4 Q. Is there -
 5 DR. MORRIS-LARKIN:
 6 A. And -
 7 COFFEY, Q.C.:
 8 Q. I'm sorry, I apologize, go ahead, Doctor.
 9 DR. MORRIS-LARKIN:
 10 A. So when I came back, I started to try and
 11 write up a draft that in some ways gave me an
 12 idea of what to do, you know, to keep me on a
 13 track of how should we go about this because
 14 this was entirely a new thing. We didn't have
 15 any kind of formal accredited approved
 16 program, but we wanted to try and work towards
 17 something that was comparable to such a thing.
 18 COFFEY, Q.C.:
 19 Q. And, Doctor, what's an ITER?
 20 DR. MORRIS-LARKIN:
 21 A. An ITER is an In-Training Evaluation Report, I
 22 think. It's actually something that we have
 23 for residency programs so that when a resident
 24 rotates to one of our sites, we would complete
 25 one of these. And it has a number of, a

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1 number of items on it that reflect the
 2 residents' training and their achievement of
 3 the goals of training. And we decided that it
 4 would be appropriate to try and work towards
 5 something like that for our pathologists
 6 assistants in training, as well.
 7 COFFEY, Q.C.:
 8 Q. Doctor, I mean, do you have, as it were, a
 9 filing cabinet or part of a filing cabinet
 10 that has the records, like, related to
 11 pathology assistants?
 12 DR. MORRIS-LARKIN:
 13 A. Yes, I do.
 14 COFFEY, Q.C.:
 15 Q. You do, in terms of from the beginning, kind
 16 of how, it started and how it's evolved and
 17 where it is now?
 18 DR. MORRIS-LARKIN:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. You do. And is there a training program for
 22 pathology assistants in Canada?
 23 DR. MORRIS-LARKIN:
 24 A. There is one training program in Canada in
 25 Winnipeg. I'm not sure what their

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1 accreditation, what their accrediting body is
 2 or at what level, whether it's baccalaureate
 3 or a master's, but that is the only, you know,
 4 official training program, as such. And they
 5 do require university credit hours as well as
 6 some of the things that we are doing, you
 7 know, with the on bench training, the regular
 8 seminars, the attendance at rounds and so on.
 9 COFFEY, Q.C.:
 10 Q. And so in effect you had to set up, figure out
 11 what the program should contain, set up your
 12 own syllabus and start?
 13 DR. MORRIS-LARKIN:
 14 A. Yes. And in the beginning it was done rather
 15 ad hoc. I mean, we looked at--I looked at
 16 training pathologists assistants as doing a
 17 role that pathologists did, so I would see
 18 them as, in many ways, doing the kinds of
 19 things we would train the pathology residents
 20 to do, but recognizing that they had a
 21 different level of knowledge. They would not
 22 have had the anatomy training or the same,
 23 quite the same level of--or certainly not the
 24 clinical level of knowledge, so we wanted to
 25 try and incorporate that kind of thing into

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1 our training sessions.
 2 COFFEY, Q.C.:
 3 Q. Did you consult with any actual formal program
 4 about it? I appreciate you -
 5 DR. MORRIS-LARKIN:
 6 A. I did not.
 7 COFFEY, Q.C.:
 8 Q. You did not?
 9 DR. MORRIS-LARKIN:
 10 A. No, other than to see what was available on
 11 line.
 12 COFFEY, Q.C.:
 13 Q. Yeah, not the American programs -
 14 DR. MORRIS-LARKIN:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. - nor Winnipeg?
 18 DR. MORRIS-LARKIN:
 19 A. Not, and I've only recently learned about the
 20 Winnipeg program being formal, so I've not
 21 spoken to them formally, no.
 22 COFFEY, Q.C.:
 23 Q. And how long are the programs in Winnipeg or
 24 the United States, the formal programs?
 25 DR. MORRIS-LARKIN:

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1 A. I believe that they're between 18 and 22
 2 months, and I'm not sure which ones are which.
 3 There are only five or six in the United
 4 States and then the one in Canada.
 5 COFFEY, Q.C.:
 6 Q. Do you know how much--what the qualifications
 7 are to get into them?
 8 DR. MORRIS-LARKIN:
 9 A. In the United States it's more often a
 10 baccalaureate undergraduate degree required,
 11 and five of their six programs are actually
 12 master's levels programs. In Winnipeg -
 13 COFFEY, Q.C.:
 14 Q. You have to have a master's to get into it or
 15 you -
 16 DR. MORRIS-LARKIN:
 17 A. No, no, you have to have -
 18 COFFEY, Q.C.:
 19 Q. - do a master's degree?
 20 DR. MORRIS-LARKIN:
 21 A. You have a master's level degree when you
 22 complete it.
 23 COFFEY, Q.C.:
 24 Q. Okay.
 25 DR. MORRIS-LARKIN:

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1 A. But you would need an undergraduate degree.
 2 In Winnipeg I'm not sure exactly what their
 3 requirements are, but I did think it was a
 4 baccalaureate or equivalent sometimes comes
 5 into the qualification, and very often the
 6 equivalent would be accepted as a registered
 7 laboratory technologist, which is where the
 8 bulk of pathologists assistants who are
 9 practising in Canada have come from, that
 10 route.
 11 COFFEY, Q.C.:
 12 Q. And, Doctor, in relation to that, I take it
 13 then in the United States, anyway, the
 14 programs you've looked at or inquired about,
 15 they are based in teaching hospitals,
 16 university centres, that sort of thing, is
 17 that the kind of thing?
 18 DR. MORRIS-LARKIN:
 19 A. I think so.
 20 COFFEY, Q.C.:
 21 Q. If you're giving out master's degrees and -
 22 DR. MORRIS-LARKIN:
 23 A. Yes, I would think so, but I'm -
 24 COFFEY, Q.C.:
 25 Q. You're not certain of that?

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1 DR. MORRIS-LARKIN:
 2 A. I'm not certain.
 3 COFFEY, Q.C.:
 4 Q. Has any thought ever been given to actually
 5 training, having people from here trying to
 6 attend, you know, graduate from such programs
 7 in the United States or Winnipeg, for that
 8 matter, and come here?
 9 DR. MORRIS-LARKIN:
 10 A. I don't think, I don't think that there was-
 11 there have been formal discussions. I think
 12 it's been thrown about as one of those wish
 13 things that, you know, it would be nice if,
 14 but I don't think it's entirely practical, in
 15 all honesty. There are limited numbers of
 16 programs available; the entry would be
 17 limited. And I think that we've done what
 18 most of Canada has done, and that is take
 19 these individuals and do our best to train
 20 them to the kind of standards that we want to
 21 achieve.
 22 COFFEY, Q.C.:
 23 Q. And, Doctor, here if we could look at Exhibit
 24 P-2109? This it the minutes of a meeting of
 25 site chiefs, December 5th, '06 at the--you're

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1 there along with Doctors Cook and Denic,
 2 Pirzada and Mr. Dyer. "Pathology Assistants"
 3 paragraph 1, "The pathology assistants will be
 4 trained on grossing bowel specimens by Dr.
 5 Morris-Larkin in the month of December.
 6 Commencing in the new year the St. Clare's
 7 group will do formal training in lung,
 8 stomach, breast and ENT. Dr. Morris-Larkin
 9 will organize the schedule. Some of the group
 10 felt strongly that a quiz would be appropriate
 11 for a pathology assistants. This will
 12 tentatively be set for April and will consist
 13 of short answer questions." I take it the
 14 "some of the group" is the group of
 15 pathologists, I take it?
 16 DR. MORRIS-LARKIN:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. Here. About the quiz. And I want to--and the
 20 reference to the quiz here I wanted to ask you
 21 about: Is there any formal testing procedure
 22 that has been used to determine whether or not
 23 a particular pathology assistant is kind of
 24 finished their training, as it were, in the
 25 sense of in a formal way?

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1 DR. MORRIS-LARKIN:
 2 A. No, there isn't. We did talk about it and,
 3 you know, a number of people said it would be
 4 a good idea and we discussed it with the
 5 pathologists assistants that this may be
 6 coming. But to try and actually write
 7 appropriate formal examinations is yet another
 8 challenge on top of everything else that we
 9 were trying to do. So, in effect, the
 10 training has been really very much the
 11 evaluation of performance of the pathologists
 12 assistants. And that's done on a daily basis,
 13 you know, in terms of reviewing the reports
 14 that--basically they generate a part of our
 15 pathology report now when they do their duties
 16 of grossing.
 17 COFFEY, Q.C.:
 18 Q. If we could, Exhibit P-2115? Doctor, here
 19 this is a site chiefs meeting minutes of March
 20 27th, 2007. You're there. "Pathology
 21 Assistants" paragraph 1, "Jessica Swain
 22 reported on issues regarding the pathologists
 23 assistants. Shift assignments are in place at
 24 the Health Sciences Complex and is working
 25 well. Pathologists assistants in training

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1 have been successfully accepting increased
 2 responsibility at that site. At the St.
 3 Clare's site it is expected that two big
 4 specimens per day would be appropriate.
 5 Issues regarding one pathologists assistant
 6 were discussed and this is documented in
 7 another separate letter. Pathologists
 8 assistants are working on templates. Training
 9 education log is now in placed and they are
 10 required to have supervision and sign off on
 11 five examples of significant large specimens.
 12 Implementation of review of large specimens by
 13 the pathologist with the pathology assistants
 14 and residents on site will begin. Dr. Morris-
 15 Larkin reported an audit of the workload for
 16 the PAs at the Health Sciences Centre and St.
 17 Clare's and this is approximately equal. The
 18 fixation rule was discussed. Sign out of a
 19 policy regarding this is pending. It was
 20 agreed by the group that punch biopsies would
 21 be inked." So I take it, Doctor, this is kind
 22 of a snapshot as of March, '07 as to where the
 23 teaching of the PAs was?
 24 DR. MORRIS-LARKIN:
 25 A. That's correct.

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1 COFFEY, Q.C.:
 2 Q. This is--Doctor, is there any one in Canada
 3 that you would be able to go to, that you're
 4 aware of, you know, with the records of what
 5 is being done with the pathology assistants
 6 here in terms of their training and ask
 7 somebody to review them and say, well, you
 8 know, somebody who would know, make an
 9 informed comment, to say, well, yes, Dr.
 10 Larkin, if that is being done, if this is--
 11 they've been trained in this way and they've
 12 achieved this much that from, you know, my
 13 perspective as kind of an outsider, that this
 14 is sufficient?
 15 DR. MORRIS-LARKIN:
 16 A. Again, are you talking about like a formal
 17 accrediting body?
 18 COFFEY, Q.C.:
 19 Q. Yes, accrediting body or, you know, somebody
 20 who, for example, at some of these centres
 21 that do have a formal training process?
 22 DR. MORRIS-LARKIN:
 23 A. Well, the only centre that does have the
 24 formal training process is in Winnipeg. Ms.
 25 Swain, who is mentioned here, is our lead

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1 pathologists assistant and she does have
 2 communication with this director of the
 3 pathologists assistants in Winnipeg, so we
 4 have an avenue for communication there. There
 5 is no formal accrediting body, although there
 6 is now a section within the Canadian
 7 Association of Pathologists that is dedicated
 8 to pathologists assistants and we may see
 9 formal accreditation and certification down
 10 the road. Within the United States there is
 11 an accrediting body and certification and, in
 12 fact, Ms. Swain has passed and is certified in
 13 the American, the American Society of Clinical
 14 Pathologists in that section, so that's as far
 15 as we have right now. But again, I think with
 16 time--this is still something that's very much
 17 an evolution in all of Canada. We will have a
 18 body probably in the section of the CAP, the
 19 Canadian Association of Pathologists to go to.
 20 COFFEY, Q.C.:
 21 Q. And, Doctor, here, if I could, Exhibit P-2132?
 22 These are minutes of a site chiefs meeting of
 23 October 5th, 2007. Paragraph 2.1
 24 "Pathologists Assistants." There's a note
 25 here, "The need for formal evaluation of

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1 pathologists assistants was discussed.
 2 Currently it is done in pre-style format but
 3 there is a move to have a more formal
 4 checklist for the in training PAs with a view
 5 to using a similar checklist in yearly
 6 evaluations. Suggestions were made and Dr.
 7 Larkin will put these into a form." And "The
 8 impact of the colon tumour bank collection on
 9 the pathologists assistants' workload was
 10 discussed. There is a perceived need to
 11 define the daily workload. Both site chiefs
 12 will continue to monitor the situation with a
 13 view to further discussion. A congenial and
 14 collegial relationship between pathology
 15 assistants, residents and staff is encouraged.
 16 Note is made of the new challenge of training
 17 residents on grossing in the current era of
 18 pathologists assistants. This will be
 19 referred to the anatomic residency training
 20 committee for further discussion." What is
 21 that--I take it the first paragraph just
 22 simply deals with the idea of kind of
 23 formalizing the -
 24 DR. MORRIS-LARKIN:
 25 A. Yes. I think that's "free-style format."

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1 COFFEY, Q.C.:
 2 Q. "Free-style," yeah, "format." As opposed to
 3 using a formal checklist for the training?
 4 DR. MORRIS-LARKIN:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. And yearly evaluations. But in terms of the
 8 relationship then between pathologists,
 9 residents and pathology assistants in teaching
 10 grossing, how has that worked itself out?
 11 DR. MORRIS-LARKIN:
 12 A. It's working itself out. We still have, we
 13 still have issues that we deal with on a
 14 regular basis. One of our biggest challenges
 15 which is noted at the end of the paragraph is
 16 finding the right balance between getting the
 17 residents exposed enough to this activity and
 18 getting-while the pathologists assistants need
 19 to be exposed to develop their expertise. But
 20 that's something that we constantly address on
 21 a regular basis at just about every meeting
 22 that either pathologists assistants or
 23 residents are discussed. And I think that we
 24 do have, at this point I think--I'm not sure
 25 of the date of this, but right now there's a

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1 very good working relationship. The
 2 pathologists assistants frequently, if they're
 3 doing something that's not necessarily
 4 assigned to a resident, they will give them a
 5 call and say, you know, you should see this,
 6 this is a very interesting specimen. They
 7 work with them to divide up the work
 8 appropriately so that the residents get
 9 exposed to certain types of specimens. They
 10 ask each other questions. And then there are
 11 regular rounds; every morning we have a gross
 12 bench round, essentially, at both sites so
 13 that it's the responsibility of the
 14 pathologist on call for that day to check in
 15 with the pathologists assistant, see what the
 16 gross specimens are, review them, have any
 17 discussions. And that becomes both a
 18 practical round as well as an educational
 19 round for the pathologists assistants.
 20 COFFEY, Q.C.:
 21 Q. If we could, Exhibit 2112, 2-1-1-2? These are
 22 the minutes of a division of anatomic
 23 pathology meeting of January 10th, 2007.
 24 You're present. It's at the General Hospital
 25 site. And here under "Resident Teaching and

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1 Sign-out" there's a reference to "There seems
 2 to be some problems with resident training.
 3 With more pathologists retiring or leaving
 4 there's a shortage of staff for teaching and
 5 the interest in rounds had dwindled.
 6 Residents are upset with this and also the
 7 availability of staff for signing out cases.
 8 Also cases being sent to Dynacare seem to
 9 taking away cases of interest. All gastric
 10 biopsies and skin were being sent, but this
 11 will be tailored by Dr. Cook and Dr. Larkin.
 12 The possibility of a resident shadowing one
 13 pathologist for full week was considered as
 14 this should allow exposure to a variety of
 15 cases." So, Doctor, I take it then that--
 16 because this is not the only reference to
 17 concerns about residency training?
 18 DR. MORRIS-LARKIN:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. I take it then for a period of time because of
 22 the shortage of pathologists, the Commissioner
 23 has heard about that, that there just weren't
 24 enough staff pathologists to spend enough time
 25 with residents from the residents'

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1 perspective?

2 DR. MORRIS-LARKIN:

3 A. That is a part of it. As well, because we

4 have been sending these cases away, there are

5 a lot of common type specimens that the

6 residents weren't getting exposed to and we

7 had to try and find some way to make sure that

8 there was a balance there, that we didn't

9 overdo it by sending all of these, you know,

10 common variety cases out and then the

11 residents, our residents, what we were finding

12 were getting a great deal of exposure to the

13 complex things but were less exposed to the

14 more common variety things that you would

15 expect to see in the day-to-day practice,

16 again, because of the, you know, the issues

17 that are prevailing.

18 COFFEY, Q.C.:

19 Q. Here, Doctor, at page 5 of the same exhibit

20 there's a reference to "Dr. Morris-Larkin

21 asked that the pathologists make time for

22 pathologists assistants, particularly grossing

23 unusual specimens." So this back again, this

24 is the beginning of '07. Did you find that

25 the pathologists, because you were asking

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1 here, did they, in fact, cooperate?

2 DR. MORRIS-LARKIN:

3 A. I think that the pathologists spend a lot of

4 time with the pathologists assistants and, in

5 fact, some of the pathologists who've joined

6 us from other programs are impressed by just

7 how much teaching our residents do get. But

8 there are two sides to the coin -

9 COFFEY, Q.C.:

10 Q. That's residents. This is the pathologists

11 assistants, too, in this case.

12 DR. MORRIS-LARKIN:

13 A. Oh, I'm sorry.

14 COFFEY, Q.C.:

15 Q. Yes.

16 DR. MORRIS-LARKIN:

17 A. Oh, the pathologists assistants.

18 COFFEY, Q.C.:

19 Q. Yes.

20 DR. MORRIS-LARKIN:

21 A. Sorry. And again, I think the same kind of

22 thing does happen. It's very easy to say,

23 well, we've got these pathologist assistants

24 and so they're doing the work. And we had to

25 always be vigilant of ourselves and remember

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1 that we are training them to do the work and

2 we need to interact. So again, with regards

3 to that, I think the same thing, we do spend a

4 lot of time with the pathologists assistants

5 at the grossing, at the gross rounds, I should

6 say, and perhaps more, it would be fair to say

7 we're very much available to them and I think

8 they've learned, they've learned to avail of

9 that. I believe in the beginning they weren't

10 sure should I call somebody or I feel bad

11 calling you, and we've kind of gotten over

12 that kind of hump and that everyone knows that

13 we're working together. And, you know, we try

14 and check in on them and they try and call us

15 and don't hesitate, in fact, to call us now

16 when there's anything that they want to learn

17 about or ask a question about.

18 COFFEY, Q.C.:

19 Q. And current gross, breast specimens are being

20 grossed by whom?

21 DR. MORRIS-LARKIN:

22 A. The pathologists assistants.

23 COFFEY, Q.C.:

24 Q. And where?

25 DR. MORRIS-LARKIN:

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1 A. The majority of them are done at St. Clare's,

2 but if one comes at the Health Science, I

3 believe it's still grossed there.

4 COFFEY, Q.C.:

5 Q. And current who are the pathologists

6 responsible for breast pathology?

7 DR. MORRIS-LARKIN:

8 A. Dr. Nick Makretsov who has just joined us

9 since July.

10 COFFEY, Q.C.:

11 Q. Yes. And do any other pathologists really do

12 any amount of breast pathology?

13 DR. MORRIS-LARKIN:

14 A. None at the Health Science. There have--I'm

15 not quite sure, I really couldn't speak to how

16 they organize things at St. Clare's. But

17 certainly there have been recent times when

18 there was nobody of the former established

19 breast group to sign things out, and I think

20 it was necessary for other pathologists to

21 sign breast cases then. I'm not sure what

22 their organization is over there, but Dr.

23 Makretsov does do the bulk of it.

24 COFFEY, Q.C.:

25 Q. If we could, Exhibit P-2112, 2112? Page 3.

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1 Doctor, this meeting, minutes of a meeting of
 2 January 10th, 2007. It's kind of a group
 3 meeting at the General Hospital site. I
 4 notice here under seven, "Quality Management
 5 Program." "Quality management is in the
 6 process of creating a book of policy and
 7 procedures for pathology." And it goes on to
 8 talk at some length of various aspects of it
 9 and other things involving the quality
 10 management program. So I take it was in the
 11 beginning of '07, really, that at least the
 12 pathologists generally at the General Hospital
 13 were being told that this process is under
 14 way?
 15 DR. MORRIS-LARKIN:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. And it's, I take it it's still going on?
 19 DR. MORRIS-LARKIN:
 20 A. It is. And it is the type of process that
 21 will always go on.
 22 COFFEY, Q.C.:
 23 Q. But in terms of kind of the bulk, because I
 24 take it there was initially you had to restart
 25 from scratch?

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1 DR. MORRIS-LARKIN:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Including formatting and sign off authorities
 5 and so on?
 6 DR. MORRIS-LARKIN:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. The intention right now is to create such
 10 policies and procedures for what, for what
 11 group, for the entire clinical laboratory, for
 12 the pathology end of the laboratory, what?
 13 DR. MORRIS-LARKIN:
 14 A. The intention, and Ms. Lynn Wade could speak
 15 better to this as the person responsible for
 16 quality in the lab is to have policy manuals
 17 for each of the different clinical labs. And
 18 there are -
 19 COFFEY, Q.C.:
 20 Q. Microbiology, for example?
 21 DR. MORRIS-LARKIN:
 22 A. Right. So that would not come under our
 23 umbrella here. The quality management program
 24 referred to here is specifically the one for
 25 pathology and the policy and procedures that

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1 we have focused on are specifically for
 2 pathology. Occasionally there may be a
 3 procedure that relates to sending a specimen
 4 to one of the other labs, but not overseeing
 5 those labs.
 6 COFFEY, Q.C.:
 7 Q. And how far as you along in that process in
 8 terms of policies and procedures for
 9 pathology?
 10 DR. MORRIS-LARKIN:
 11 A. I think that we're after making a great deal
 12 of progress. There are still, you know, every
 13 now and then I think, well, we should have a
 14 policy on this or somebody says we need a
 15 procedure on that. There are definitely,
 16 there are definitely a number of gaps to be
 17 filled, but there's a great deal, great deal
 18 of work already accomplished.
 19 COFFEY, Q.C.:
 20 Q. Okay.
 21 COMMISSIONER:
 22 Q. Mr. Coffey, it's about the time to break for
 23 lunch.
 24 COFFEY, Q.C.:
 25 Q. Commissioner, perhaps we could break and I'll

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1 come back and finish up in about ten minutes
 2 or so.
 3 COMMISSIONER:
 4 Q. All right. We'll meet at 2:15.
 5 (LUNCH BREAK)
 6 THE COMMISSIONER:
 7 Q. Please be seated. Mr. Coffey.
 8 COFFEY, Q.C.:
 9 Q. Thank you, Commissioner. Exhibit P-2674,
 10 2674? Doctor, this is a site chief meeting,
 11 May 15th, 2007. The attendees are there,
 12 including yourself and paragraph 2.0 says
 13 "delivery of service during summer 2007. Dr.
 14 Morris-Larkin reported that due to severe
 15 reduction in pathology manpower levels, it
 16 will be extremely difficult to provide an
 17 adequate service during the months of July,
 18 August and early September 2007" and you go on
 19 to talk--it goes on then to talk about the
 20 details of it, and it ends that paragraph by
 21 saying "it is also noted that due to the
 22 anticipated shortage of pathology assistants
 23 during the summer months, the pathologists may
 24 be expected to take up grossings which will
 25 certainly worsen an already critical

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1 situation." I appreciate this is a summer
 2 ago.
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. Just over a year ago, but Doctor, what I
 7 wanted to ask you about is this, I take it
 8 that this severe reduction in pathology
 9 manpower that's referred to here, did that
 10 really become acute then in the summer of '07?
 11 DR. MORRIS-LARKIN:
 12 A. I can't remember specifically the summer, but
 13 there certainly--I mean, it's been an acute
 14 problem for quite some time and that has been
 15 exacerbated during periods of time when
 16 particularly people go on vacation.
 17 COFFEY, Q.C.:
 18 Q. What's the situation right now, Doctor?
 19 DR. MORRIS-LARKIN:
 20 A. At the Health Science right now, we have, I
 21 believe, four vacancies available or four
 22 vacancies, and at St. Clare's, there's one.
 23 COFFEY, Q.C.:
 24 Q. So four in how many positions?
 25 DR. MORRIS-LARKIN:

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1 A. For the Health Science, and I'm including the
 2 person who is now leaving in November, not
 3 counting any vacation, there should be 11 and
 4 of that, we cover the cytology lab and
 5 coverage for flow cytometry and some
 6 hematology lab coverage for bone marrows.
 7 COFFEY, Q.C.:
 8 Q. So there are 11 positions?
 9 DR. MORRIS-LARKIN:
 10 A. 11 positions.
 11 COFFEY, Q.C.:
 12 Q. For staff pathologists. Does that include
 13 yourself?
 14 DR. MORRIS-LARKIN:
 15 A. Historically.
 16 COFFEY, Q.C.:
 17 Q. Does that include yourself?
 18 DR. MORRIS-LARKIN:
 19 A. Yes, historically have there been 11
 20 positions.
 21 COFFEY, Q.C.:
 22 Q. And as you sit here right now, there are four
 23 vacant positions or three and soon to be one -
 24 DR. MORRIS-LARKIN:
 25 A. Three and soon to be four.

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1 COFFEY, Q.C.:
 2 Q. A fourth person is leaving in November?
 3 DR. MORRIS-LARKIN:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. And in terms of recruitment, I take it that's
 7 Dr. Denic's primary responsibility?
 8 DR. MORRIS-LARKIN:
 9 A. It is, but we have essentially a perpetual
 10 recruitment committee. I've been on a
 11 committee for recruiting pathologists since
 12 before Dr. Ejeckam came, probably in 1998/99,
 13 and we just reform on a regular basis.
 14 COFFEY, Q.C.:
 15 Q. Okay. Doctor, as of right now, again because
 16 I expect you'll be the last pathologist
 17 possibly that will testify here, at least from
 18 Eastern Health, what's the current expectation
 19 in terms of being able to fill the positions?
 20 DR. MORRIS-LARKIN:
 21 A. I think that Dr. Denic probably referred to
 22 this. I know that we have one person who is--
 23 we've been trying to schedule for an
 24 interview. I know that he has a number of
 25 applications that we've not yet met to review

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1 because there have been a number of other
 2 activities obviously going on.
 3 COFFEY, Q.C.:
 4 Q. So in terms of having a full roster, as it
 5 were, as of right now, there's no kind of
 6 actual time that you could point to in an
 7 objective way and say "we'll have -
 8 DR. MORRIS-LARKIN:
 9 A. I don't see it any time soon, no.
 10 COFFEY, Q.C.:
 11 Q. And in the meantime, I take it that other than
 12 extra work being done by the pathologists who
 13 are there, some work is being sent out to like
 14 organizations such as Dynacare?
 15 DR. MORRIS-LARKIN:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. Here, Doctor, and again, bearing in mind this
 19 is May of '07, a year ago, pathology
 20 assistants, paragraph six, there's a reference
 21 here to "training has started on our new
 22 pathology assistant. However, this means that
 23 time is currently taken away from service in
 24 order to help with the new pathology
 25 assistant." This is singular, one person

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1 training?
 2 DR. MORRIS-LARKIN:
 3 A. Yes, because we had one person come in to
 4 training much later than the others.
 5 COFFEY, Q.C.:
 6 Q. And it goes on "there is also a concern that
 7 pathology assistants are getting different
 8 directions from different pathologists leading
 9 to confusion and poor communication. Daily
 10 conferences are being held between the
 11 pathologists and pathology assistants." I
 12 take it this was one of those glitches, as it
 13 were, you had to overcome?
 14 DR. MORRIS-LARKIN:
 15 A. That's right. It's, you know, I like it a
 16 little bit differently than you like it, but
 17 both are acceptable ways and what we were
 18 striving for was to have one way so that the
 19 pathologist assistant didn't have to do it--
 20 you know, didn't have to figure out who's
 21 going to get this specimen, so I can do it to
 22 make them happy.
 23 COFFEY, Q.C.:
 24 Q. Here, at paragraph eight, is dealing with
 25 residents. "Dr. Larkin has expressed strong

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1 concerns over the level of residents training.
 2 It is felt the program may not be able to
 3 sustain residency training. There are issues
 4 over cases currently going to Dynacare that
 5 residents are not seeing," and that's the sort
 6 of--you've alluded to that earlier.
 7 DR. MORRIS-LARKIN:
 8 A. We've heard that before.
 9 COFFEY, Q.C.:
 10 Q. How has that turned out so far, Doctor, in
 11 terms of your concerns at the time, in the
 12 level of training of residents?
 13 DR. MORRIS-LARKIN:
 14 A. I think with regards to the Dynacare issue,
 15 basically that mostly falls to me to try and
 16 pull back specimens that we triage to make
 17 sure that the residents get a good cross-
 18 section and otherwise, we still have a
 19 burdened group of staff pathologists who are
 20 doing their best to maintain residency
 21 teaching and are doing quite a bit, but it is
 22 taking a toll.
 23 COFFEY, Q.C.:
 24 Q. Exhibit P-2121? And Doctor, I'm going to show
 25 you a short series of exhibits dealing with

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1 policies and procedures. This is June 6th,
 2 2007. These are the minutes of a Pathology
 3 Quality Management Committee, of which you're
 4 a member.
 5 DR. MORRIS-LARKIN:
 6 A. I think that would have been the first meeting
 7 I attended.
 8 COFFEY, Q.C.:
 9 Q. Yes, and introduction, Dr. Carter opens with
 10 an introduction to QMP department as we get
 11 some new committee members. It was discussed
 12 that Terry Gulliver become a consultant or ad
 13 hoc member as opposed to a full-time committee
 14 member. There was intense dialogue regarding
 15 the roles of individual members and the focus
 16 and direction of the committee. I take it
 17 this is the beginnings of the committee,
 18 certainly from your perspective?
 19 DR. MORRIS-LARKIN:
 20 A. From my perspective. I think that there was a
 21 smaller committee that had been meeting, but
 22 they had decided to expand the group in terms
 23 of the resources and input.
 24 COFFEY, Q.C.:
 25 Q. And here, under policy and procedure

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1 implementation development, "the following
 2 policies and procedures will need to be
 3 distributed for the appropriate people to
 4 review and comment. The committee will await
 5 feedback before passing any policy procedure,"
 6 and there are four listed here, and well
 7 actually four, but there's a number on the
 8 next page too. So there were a number that
 9 existed, but they had to be vetted, as it
 10 were, throughout the organization?
 11 DR. MORRIS-LARKIN:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. In looking for--vetted in the sense of -
 15 DR. MORRIS-LARKIN:
 16 A. Looking for input. Again, things are much
 17 more effective if the people who are doing the
 18 work have some input into the development of
 19 these procedures and that was what that kind
 20 of thing was trying to address.
 21 COFFEY, Q.C.:
 22 Q. 2128, please, 2128? These are the minutes of
 23 a pathology quality management committee
 24 meeting of July 18th, 2007, about a month
 25 later. Again, you're present, and again, to

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1 give the Commissioner some sense of this,
 2 "business arising, policy and procedure
 3 implementation development. Dr. Larkin
 4 presented three procedures that have been
 5 'peer reviewed' and returned to her for
 6 committee approval," and there are three
 7 listed.
 8 DR. MORRIS-LARKIN:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. "It was decided that upon signing, the
 12 originals stay in QMP office in a binder
 13 appropriately labelled. Eventually they will
 14 be accessible online. Once approved and in
 15 place, and in-service should be planned for
 16 educational and clarification purposes" and it
 17 goes on to say "after creation and peer review
 18 of a procedure, all comments will then be
 19 forwarded for further debate at the site
 20 chiefs meeting. Questions arose regarding
 21 authorizing signatures and policy levels. It
 22 was discussed and agreed that four policies
 23 would be signed by the site chief," which
 24 would be yourself, "and division manager,
 25 Doctors Larkin, Cook and Mr. Dyer. Level

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1 three policies will be signed by the clinical
 2 chief and program director." That's Dr. Denic
 3 and Mr. Gulliver. Now Doctor, I wanted to ask
 4 you about what happens then once a policy or
 5 procedure is actually finally signed off,
 6 issued, completely put in place. What then
 7 happens?
 8 DR. MORRIS-LARKIN:
 9 A. At that point, right now, our policy and
 10 procedure manual is being managed by the
 11 quality management program coordinator and so
 12 she would, once something is approved, she
 13 would make sure that the binders that have
 14 been distributed--because I think the
 15 Commission has a binder which is in a number
 16 of places within the organization now, so that
 17 once its been approved, then it would be
 18 distributed and put into that binder as an
 19 accepted policy. What we're still trying to
 20 develop is a way in which we can make sure
 21 that everybody to whom they're relevant can be
 22 made aware that these things are in existence,
 23 that we now have a new policy or a new
 24 procedure and that they will sign off that
 25 they have in fact read them. So that's

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1 something that's still under development. The
 2 other thing that's happening is the Eastern
 3 Health site or Eastern Health has an intranet
 4 website and Ms. Wade has been instrumental in
 5 getting things organized there so that all of
 6 our approved policies, not our procedures, but
 7 our policies are uploaded to this site and
 8 we're working on getting that available to as
 9 many people as possible. There are some
 10 limits with information technology and so on,
 11 but the goal would be I could go into my
 12 office and--right now, I can, as of last week,
 13 click on the icon, go to the website, find all
 14 the policies, not only for me but for
 15 elsewhere in the organization. So that's
 16 something that's become online, I guess, now.
 17 COFFEY, Q.C.:
 18 Q. In terms of--and the procedures though are not
 19 yet online?
 20 DR. MORRIS-LARKIN:
 21 A. No, procedures are not on that website and I
 22 don't know if they will be, although we've had
 23 discussions about how to deal with procedures.
 24 I'm not quite sure where we are with that at
 25 the moment.

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1 COFFEY, Q.C.:
 2 Q. Doctor, in terms of yourself as the site
 3 chief, I take it you're site chief for the
 4 pathologists?
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. How about the pathology assistants?
 9 DR. MORRIS-LARKIN:
 10 A. And--well, the pathology assistants have--they
 11 kind of straddle a line. For various
 12 administrative managerial issues, they would
 13 go to the laboratory manager. For anything
 14 related to the medical function of their work,
 15 they would go--first, the pathologists
 16 assistants would go to the lead pathologist
 17 assistant, who would come to me, and all of
 18 them essentially know that they can come to me
 19 about issues.
 20 COFFEY, Q.C.:
 21 Q. Doctor, in terms of these policies and
 22 procedures, and you refer to signing off, the
 23 process of kind of implementing a sign off
 24 approach?
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. How far has that advanced?
 4 DR. MORRIS-LARKIN:
 5 A. I believe within the organization of the
 6 pathologists, we've not gotten very far with
 7 that yet. The pathologists are all aware,
 8 they know where the binder is, they've been
 9 notified and encouraged to go and read it, and
 10 they've been notified that it's available on
 11 the internet, but they don't yet have those -
 12 the sites available. The pathologists
 13 assistants have also been informed of the same
 14 things, but we've not got the sign up, but
 15 most certainly I think most of the things the
 16 pathology assistants have read. I don't know
 17 where we are with the pathologists reading
 18 them yet.
 19 COFFEY, Q.C.:
 20 Q. That's what I was going to ask you, as of yet
 21 you haven't kind of gone around and said,
 22 well, look, in two months time or a months
 23 time, I want your certification on each sheet
 24 that you've read all the ones that we are
 25 going to review.

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1 DR. MORRIS-LARKIN:
 2 A. We are going there, but we're not there yet,
 3 and many of these things that would have been
 4 vetted through have - people are aware of them
 5 because they would have seen them in draft
 6 form of some sort. They just don't - they may
 7 not have looked at the final draft yet.
 8 COFFEY, Q.C.:
 9 Q. Exhibit P-2131, please. This is again a
 10 pathology quality management committee meeting
 11 minutes of September 19th, 2007. You're
 12 present and here under business arising,
 13 "Discussion began regarding review of the
 14 following; fixation, pathology tissue
 15 handling", and it goes on, "tissues for gross
 16 examination only", and there's another one
 17 there as well. "It is recommended a policy or
 18 procedure sent for peer review not have
 19 changes made until the committee approves
 20 them. Sheets with comments and signatures
 21 with each policy/procedure should be brought
 22 to the meetings and discussed". Doctor, I
 23 take it then that it was only in September of
 24 2007 that the actual document dealing with
 25 fixation and pathology tissue handling, and

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1 tissues for gross examination only was being
 2 dealt with?
 3 DR. MORRIS-LARKIN:
 4 A. It had been circulating for some time. I
 5 think that preceded this, but I can't tell you
 6 exactly when.
 7 COFFEY, Q.C.:
 8 Q. And there was one that had been distributed on
 9 May 31st, 2007, by Dr. Denic to all
 10 pathologists in Newfoundland. One of the
 11 policies dealt with fixation?
 12 DR. MORRIS-LARKIN:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. And you would have received that?
 16 DR. MORRIS-LARKIN:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. So that's the - at least "a" one that had been
 20 out there?
 21 DR. MORRIS-LARKIN:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. From the middle of 2007.
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. Here, Doctor, if we could, Exhibit P-3352.
 4 These are minutes of a site chiefs meeting on
 5 November 7th, 2007. You're present, as well
 6 as Drs. Denic and Cook. Fixation policy,
 7 paragraph one, "It is agreed that the OR will
 8 need to document the time when tissue was
 9 initially submitted in formalin. This will be
 10 incorporated into the fixation policy. The
 11 PAs will need to document the day of
 12 processing as well. Dr. Denic will also
 13 liaison with Dr. Howell regarding this. A
 14 copy of the fixation policy will be forwarded
 15 by Dr. Denic to the clinics and the OR once
 16 the policy is finalized". Now, Doctor, here
 17 in relation to dealing with the perioperative
 18 program, are you involved in particularly in
 19 dealing with that in terms of fixation policy
 20 or is that Dr. Denic, as the Clinical Chief,
 21 or Dr. Howell, as the VP Medical?
 22 DR. MORRIS-LARKIN:
 23 A. At this time it would have been both, I think,
 24 Dr. Denic and Dr. Howell. I wasn't involved
 25 at that time. I am involved now in a

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1 committee that deals with perioperative issues
 2 in relation to the lab specifically, so I
 3 would be involved with any issues that arose
 4 now.
 5 COFFEY, Q.C.:
 6 Q. And when did that start, Doctor?
 7 DR. MORRIS-LARKIN:
 8 A. The first meeting was last week.
 9 COFFEY, Q.C.:
 10 Q. Last?
 11 DR. MORRIS-LARKIN:
 12 A. Last week.
 13 COFFEY, Q.C.:
 14 Q. Last week, and who's on that group - in that
 15 group?
 16 DR. MORRIS-LARKIN:
 17 A. Ms. Tracey, Maria Tracey, I believe, chairs
 18 it, and I'm not sure how it came about, it
 19 probably actually - I should say the first
 20 meeting I attended was last week. I think
 21 there was a meeting before that and I was
 22 invited to join afterwards. We have our
 23 quality management coordinator, Ms. Bev Rowe.
 24 There are several - I believe there are
 25 clinical educators from the perioperative

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1 program, and I'm not sure if we're at an ad
 2 hoc or a definite involvement of other lab
 3 representatives, but there is an awareness
 4 that there are other labs, like the cytology
 5 lab, the microbiology lab, with whom the
 6 perioperative program want to have
 7 communication, so that's - those terms of
 8 reference and the exact membership, I think,
 9 is still being developed.
 10 COFFEY, Q.C.:
 11 Q. Exhibit P-2132, please, 2132. Thank you. These
 12 are the minutes of a site chiefs meeting of
 13 October 5th, 2007. Again, Doctor, you're
 14 present, along with your compatriots, and
 15 we've looked at that paragraph 2.1, pathology
 16 assistants already, but down below here,
 17 there's a reference to 2.2, accreditation,
 18 "Dr. Denic informed the group that the review
 19 by the accreditors was generally positive,
 20 with small negative, such as the need for
 21 emergency showers in lab locations. The
 22 reviewer's assessment of the ER/PR handling
 23 was also positive". There's a reference to
 24 2.3, "OLA laboratory accreditation. Mr.
 25 Greg", and that would be Flynn, Dr. Greg

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1 Flynn, actually -
 2 DR. MORRIS-LARKIN:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. "Will be promoting the OLA laboratory
 6 accreditation service at a meeting on
 7 Wednesday, October 10th. The group will
 8 compare this to that of the CCHSA". Now,
 9 Doctor, as the site chief for the General
 10 Hospital, what is your understanding about the
 11 difference between a CCHSA involvement in its
 12 accreditation process in September of 2007
 13 with respect to the lab versus or in
 14 comparison to that of the QMPLS in December of
 15 '07?
 16 DR. MORRIS-LARKIN:
 17 A. I think at that time this was one of the
 18 objectives was to see how they actually
 19 compared. My understanding - I was fairly
 20 peripherally involved in this activity, but my
 21 understanding was that the CCHSA was a more
 22 general overview of the lab, and the QMPLS, as
 23 part of the OLA laboratory accreditation
 24 program, was much more detailed. So it looked
 25 into much finer detail, and it was the one

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1 that we actually found the most productive
 2 because you're asked for the various
 3 procedures or you're asked for documentation
 4 of various sorts, and we found that that was
 5 really what we wanted because you - it's both
 6 a learning activity as well as an accrediting
 7 activity.
 8 COFFEY, Q.C.:
 9 Q. Exhibit P-2390. Doctor, this is a letter
 10 written to Terry Gulliver, program director,
 11 laboratory medicine. It's from - it's
 12 actually three pages long. It's from
 13 yourself, copied to quite a number of people.
 14 I take it these are - well, Dr. Denic is
 15 readily apparent, and Mr. Dyer. The other
 16 individuals listed here.
 17 DR. MORRIS-LARKIN:
 18 A. Mr. Gerry McLean was in a managerial or an
 19 acting managerial role, I think probably at
 20 the time this was written, so I would have
 21 included him in the information. Ms. Swain,
 22 pathologist assistant. At this time, Ms.
 23 Searle and Ms. Milley would have completed, I
 24 think, the 18 months. That was what they were
 25 initially told would be their probation

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1 period, and Ms. Bouzanne was under that 18
 2 month time period. So this was written as a
 3 summary and an outline of where we had gone
 4 with the pathologist assistants, and I believe
 5 one of the main reasons, aside from providing
 6 a letter for the people who had completed
 7 their 18 months, was to give support to their
 8 reclassification. They're still being
 9 classified as laboratory technologists, and we
 10 really wanted to have a recognition of their
 11 role as being unique from laboratory
 12 technologists.
 13 COFFEY, Q.C.:
 14 Q. And it's written to Mr. Gulliver because
 15 that's an administrative aspect?
 16 DR. MORRIS-LARKIN:
 17 A. I would have written it to him as the program
 18 director.
 19 COFFEY, Q.C.:
 20 Q. Now, Doctor, in terms of the training of
 21 pathology assistants, there are currently how
 22 many pathology assistants in St. John's?
 23 DR. MORRIS-LARKIN:
 24 A. There are currently four.
 25 COFFEY, Q.C.:

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1 Q. And they are located where?
 2 DR. MORRIS-LARKIN:
 3 A. They rotate through both sites, and it's one
 4 of the jobs of the lead pathologist assistant
 5 is to ensure that there is coverage at both
 6 sites. So she does scheduling.
 7 COFFEY, Q.C.:
 8 Q. That's spelled out in your letter, the
 9 scheduling and all that is, yes.
 10 DR. MORRIS-LARKIN:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. So there are three at the General and one at
 14 St. Clare's?
 15 DR. MORRIS-LARKIN:
 16 A. When we're full - when they're all there and
 17 not away on leave or whatever, what usually
 18 happens is there's one and a half at St.
 19 Clare's. By that, I mean there's one person
 20 posted there for probably weeks to months at a
 21 time, and then one of the other people rotates
 22 back and forth between the two sites. So
 23 she'll spend three days - usually it's Ms.
 24 Swain, will spend three days at the Health
 25 Science site and two days at St. Clare's.

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1 COFFEY, Q.C.:
 2 Q. And keeps her kind of --
 3 DR. MORRIS-LARKIN:
 4 A. Trying to keep a balance in the workload
 5 because there's too much for one pathologist
 6 assistant to do at St. Clare's.
 7 COFFEY, Q.C.:
 8 Q. And here, Doctor, just looking at the third
 9 page of the exhibit, you've written, "The
 10 pathology assistant position is not a natural
 11 progression from a laboratory technologist.
 12 In both Canada and the United States, there is
 13 a requirement for additional training usually
 14 in the range of 18 to 24 months beyond a
 15 primary diploma. Many pathology assistants
 16 have not come from a technologist background,
 17 but have a Bachelor of Science. In the United
 18 States, pathology assistants training programs
 19 are considered master level programs", and I
 20 point out you've told the Commissioner that.
 21 DR. MORRIS-LARKIN:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. "Pathology assistants have a unique knowledge
 25 and skillset with significant and direct

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1 responsibility in patient care. For these
 2 reasons, we need to see that the
 3 classification of pathology assistants with
 4 certification for the different levels of
 5 responsibility within the classification
 6 separate from that of laboratory
 7 technologists". Now, Doctor, where has this
 8 gone? Have you gotten any response to this
 9 and what's the status?
 10 DR. MORRIS-LARKIN:
 11 A. I don't expect any response. It was written,
 12 from my point of view, for information
 13 purposes. From Mr. Gulliver, I believe it
 14 would have went to whatever - and I honestly
 15 don't know what the route is, whatever route
 16 they would have had to take to look at this
 17 issue of reclassifying and creating - within
 18 the lab union section that they're in,
 19 creating this new group to be recognized,
 20 pathology assistants, and that would
 21 involvement government and union people.
 22 Beyond that, I couldn't tell you.
 23 COFFEY, Q.C.:
 24 Q. And so you haven't heard anything further back
 25 about it?

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1 DR. MORRIS-LARKIN:
 2 A. I have heard that - you know, just by word of
 3 mouth from one of the pathologist assistants
 4 that their application has been rejected.
 5 COFFEY, Q.C.:
 6 Q. So they are currently classified and paid as
 7 what?
 8 DR. MORRIS-LARKIN:
 9 A. As laboratory technologists.
 10 COFFEY, Q.C.:
 11 Q. And whatever level -
 12 DR. MORRIS-LARKIN:
 13 A. At whatever level - I believe, and I could be
 14 corrected on this, I believe that the
 15 pathologist assistants are considered - they
 16 start at Laboratory Tech II and Tech III,
 17 maybe Tech IV. I honestly - I'm not sure of
 18 the -- you would need to ask somebody else.
 19 COFFEY, Q.C.:
 20 Q. Okay, Mr. Gulliver would know.
 21 DR. MORRIS-LARKIN:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. Mr. Gulliver would know about that?
 25 DR. MORRIS-LARKIN:

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1 A. I would think so, yes.
 2 COFFEY, Q.C.:
 3 Q. Now on this point, you're writing this letter
 4 as of the end of - May 23rd, 2008. I'm not
 5 going to take you through it, but you have set
 6 out here - you said, "Within the lab, this is
 7 a unique group with specific duties which were
 8 formerly the responsibility of pathologists.
 9 This includes", and you list them all off.
 10 DR. MORRIS-LARKIN:
 11 A. Uh-hm.
 12 COFFEY, Q.C.:
 13 Q. Headings and descriptions. At the time, the
 14 descriptions here, did they accurately
 15 encompass what you understood pathology
 16 assistants were doing at the time?
 17 DR. MORRIS-LARKIN:
 18 A. Yes, yes.
 19 COFFEY, Q.C.:
 20 Q. I take it this was an attempt to be relatively
 21 comprehensive?
 22 DR. MORRIS-LARKIN:
 23 A. This was, yes.
 24 COFFEY, Q.C.:
 25 Q. Has anything changed since? Is there anything

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1 that you would now delete or add?
 2 DR. MORRIS-LARKIN:
 3 A. As new duties?
 4 COFFEY, Q.C.:
 5 Q. Yes.
 6 DR. MORRIS-LARKIN:
 7 A. I think that, you know, they are still--as
 8 many people in medical fields are learning new
 9 things all the time, so the big thing that
 10 would stand out is their role in the autopsy
 11 performance. We've had limited opportunity to
 12 training them to do the autopsies the way a
 13 pathology--a pathologist would do, for
 14 example, but that is where we're going and
 15 with time, we will get there. So this is
 16 something we have started, but we've only--
 17 we're only in the very preliminary stages of
 18 it.
 19 THE COMMISSIONER:
 20 Q. Any questions?
 21 COFFEY, Q.C.:
 22 Q. Thank you, Commissioner, thank you, Doctor.
 23 There may be--I understand there are some more
 24 questions from others.
 25 MR. PRITCHARD:

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1 Q. Thank you, Commissioner. I don't have any
 2 questions for this witness, thank you.
 3 THE COMMISSIONER:
 4 Q. Mr. Simmons?
 5 MR. SIMMONS:
 6 DR. CAROLYN MORRIS-LARKIN, EXAMINATION BY MR. DAN SIMMONS
 7 MR. SIMMONS:
 8 Q. Good afternoon, Dr. Morris-Larkin. I have
 9 only one thing to ask you about. You gave
 10 some evidence this morning when you were
 11 looking at some of the pathology reports from
 12 back in 2002 and 2003 where there were some
 13 changed results, and you were asked about
 14 whether occurrence reports were something that
 15 would be filed there. And I understood you to
 16 say that today that sort of thing would be
 17 reviewed as an internal lab occurrence?
 18 DR. MORRIS-LARKIN:
 19 A. I think it would depend--each one of these
 20 would be individual case dependent in
 21 determining what really is an adverse event
 22 and I think that's probably where it may have
 23 gotten a little confused this morning.
 24 Depending on what the issue is, if there's a
 25 significant change in a report, so if I had

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1 for some reason an opportunity to review a
 2 previous one of my reports or someone else's
 3 or I gained new information and there was a
 4 significant discrepancy in what I had said
 5 before, then that would be something that
 6 could potentially be filed as an occurrence
 7 report and we have seen that happen within the
 8 lab. So one example that stands out is during
 9 our quality assurance activity, you would
 10 identify something that perhaps someone hadn't
 11 seen and it would be appropriate then to file
 12 an occurrence report on that. The other
 13 issue, I think, was related specifically to
 14 something that might change within the context
 15 of me trying to do the best I could with a
 16 pathology report. The example, of course,
 17 which is given it was ER/PR and I don't deal
 18 with ER/PR anymore. But I think in that
 19 particular example, that's the kind of thing
 20 that we hope with the Quality Management
 21 Program we will see more identified as an
 22 internal occurrence because it would be much
 23 more relevant to us to be able to track that
 24 kind of thing. So for instance, if there's
 25 some significant discrepancy in one of the

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1 stains when you order a repeat test, you would
 2 bring that to the immunohistochemistry lab,
 3 they have corrective action logs and things
 4 like that. So that's the kind of thing I
 5 would think would be much more relevant within
 6 the lab itself, because when we talk about
 7 occurrence reports, as you are referring to,
 8 we're talking about corporate wide and things
 9 go way up the level, and in terms of, you
 10 know, going to quality risk and initiatives
 11 management, it's something that they may not
 12 be as effective in dealing with as we would be
 13 in the lab, so it's like there are two
 14 different levels of occurrence reporting.
 15 MR. SIMMONS:
 16 Q. Right. In the current Quality Management
 17 Program, is there a particular--are you aware
 18 of a particular policy or procedure now in
 19 place for dealing with corrective action logs
 20 and these internal measures you're talking
 21 about?
 22 DR. MORRIS-LARKIN:
 23 A. There are--it depends on which level you're
 24 speaking of again, there is one for the
 25 corporate wide for the quality initiatives and

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1 the occurrence reports, the ones that go to
 2 them. There is also a general lab policy on
 3 occurrence reporting. We have not gotten one,
 4 I don't think--I could be corrected.
 5 MR. SIMMONS:
 6 Q. Well, I'll show you one.
 7 DR. MORRIS-LARKIN:
 8 A. In the pathology specifically about how we do
 9 that.
 10 MR. SIMMONS:
 11 Q. I'll just show you one, Exhibit P-2157 please?
 12 And if you could go to page 177, it's a big
 13 file, so it takes a little while to open. Is
 14 it going to open? The particular policy I am
 15 going to refer you to, when we get to see it,
 16 is one entitled "Correction actions for IHC
 17 Occurrences".
 18 DR. MORRIS-LARKIN:
 19 A. Yes, I'm aware of that.
 20 MR. SIMMONS:
 21 Q. That's one that you are aware of, is it?
 22 DR. MORRIS-LARKIN:
 23 A. Yes.
 24 MR. SIMMONS:
 25 Q. Is that the sort of policy that you would be

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1 referring to when you were talking about the
 2 internal occurrence reporting within the lab?
 3 DR. MORRIS-LARKIN:
 4 A. That kind of level of reporting, yes. It's a
 5 direct feedback and it addresses the issues
 6 much more timely and more directly.
 7 MR. SIMMONS:
 8 Q. Good. Thank you very much, that's all I have
 9 for you.
 10 THE COMMISSIONER:
 11 Q. Is this the one you're referring to, Mr.
 12 Simmons?
 13 MR. SIMMONS:
 14 Q. Yes, it is, it's on the screen there now.
 15 THE COMMISSIONER:
 16 Q. All right, thank you. Mr. Pritchett?
 17 MR. PRITCHETT:
 18 Q. No questions.
 19 THE COMMISSIONER:
 20 Q. Ms. Newbury?
 21 DR. CAROLYN MORRIS-LARKIN, EXAMINATION BY MS. JENNIFER
 22 NEWBURY
 23 MS. NEWBURY:
 24 Q. Good afternoon, Dr. Larkin. My name is
 25 Jennifer Newbury and I represent the

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1 Newfoundland and Labrador division of the
 2 Canadian Cancer Society. And I want to pick
 3 up where Mr. Simmons left off and I was just
 4 wondering if you are familiar with the concept
 5 of a near miss, in terms of policies and
 6 procedures at Eastern Health?
 7 DR. MORRIS-LARKIN:
 8 A. I am familiar with the concept, yes.
 9 MS. NEWBURY:
 10 Q. And just in terms of the application of that
 11 concept and perhaps what we can do is bring up
 12 Exhibit P-0057 please, because this
 13 specifically refers to the near miss. And as
 14 I understand it, these are the procedures,
 15 policies that are currently in place for 2007.
 16 DR. MORRIS-LARKIN:
 17 A. This is the quality and risk management which
 18 is a level above.
 19 MS. NEWBURY:
 20 Q. Right.
 21 DR. MORRIS-LARKIN:
 22 A. This is for Eastern Health.
 23 MS. NEWBURY:
 24 Q. So that's the corporate why, as opposed to
 25 something particular to Eastern or to the

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1 pathology lab in particular.
 2 DR. MORRIS-LARKIN:
 3 A. That's correct.
 4 MS. NEWBURY:
 5 Q. And on page 5 of the exhibit, there are
 6 several references in this policy which
 7 relates to occurrence reporting to near miss,
 8 is that the concept that you're familiar with?
 9 DR. MORRIS-LARKIN:
 10 A. I would probably have to read it again.
 11 MS. NEWBURY:
 12 Q. Okay, well what I can do, I'll read down to
 13 the overview, which is on page 1 of the policy
 14 and just looking up above, it's, the original
 15 approval date was August 28th, 2007. And
 16 under the second paragraph of the heading,
 17 "Overview", it indicates that "the occurrence
 18 reporting system facilitates the
 19 identification, monitoring and analysis of
 20 adverse events, sentinel events, hazards,
 21 incidents and near misses. Occurrence
 22 reporting is not designed to place blame on
 23 individuals." And near miss is referenced
 24 several times there, but there is a definition
 25 on page 10 of the document. And in the first

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1 row there, near miss is defined as "an event
 2 or circumstance which has the potential to
 3 cause serious physical or psychological
 4 injury, unexpected death or significant
 5 property damage, but did not actualize due to
 6 chance, corrective action and/or timely
 7 intervention." And I'm just wondering whether
 8 there would be any role for this type of a
 9 policy, even though it's a corporate wide
 10 policy to apply to the two situations, if they
 11 were to happen again, relating to the
 12 pathology reports that were shown at Exhibit
 13 C-0184 and C-0175 and I can bring those up, if
 14 you want.
 15 DR. MORRIS-LARKIN:
 16 A. I can certainly see where that could play a
 17 role and this is something, you know, in terms
 18 of defining a near miss, this is something
 19 that I think that within the Quality
 20 Management Program is on our radar to try and
 21 address, would the specific report that you
 22 referred to this morning, where it was
 23 negative and it changed to positive, within,
 24 again at that time would have been within my
 25 concept of working of that case. In today's

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1 event, for Dr. Makretsov in particular who
 2 would be reporting them, I wouldn't be
 3 reporting them, would such an event qualify as
 4 a near miss? And I think that within the
 5 Quality Management Program, these are the
 6 kinds of things that we would be looking at in
 7 terms of addressing so that we're clear on
 8 what does actually qualify, you know, as these
 9 particular types of events.
 10 MS. NEWBURY:
 11 Q. Right.
 12 DR. MORRIS-LARKIN:
 13 A. For a pathologist in another type of stain
 14 where it may also impact upon my final
 15 decision on what this, what this was
 16 diagnostically but has different implications
 17 because it doesn't necessarily relate to the
 18 very specific treatment that you see with the
 19 ER/PR, then we would need to define it for
 20 that as well.
 21 MS. NEWBURY:
 22 Q. Right.
 23 DR. MORRIS-LARKIN:
 24 A. So there's a broad number of things that go on
 25 in the lab that we would need to, you know,

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1 address and say, well does this qualify as a
 2 near miss and I can certainly see that the
 3 case you're suggesting might fit into that
 4 category.
 5 MS. NEWBURY:
 6 Q. Right, okay, so you're talking then the fact
 7 that some types of stains may not be used for-
 8 -specifically for decisions that might relate
 9 to patient care, so you might have to draw the
 10 line between those two?
 11 DR. MORRIS-LARKIN:
 12 A. No, it's not that, it's how you utilize the
 13 stains. For the ER and PR, it's very
 14 specifically treatment directed and there are
 15 more and more of those coming on, so if you're
 16 ER positive, then you would be a candidate for
 17 Tamoxifen. For most of the stains that we
 18 use, it's one of several stains in a panel
 19 that may sway my diagnosis in one way or
 20 another, so they could have an impact on what
 21 my diagnosis would be and then what the
 22 patient's treatment would be. But it's a bit
 23 more layered and more complex. The ER is a
 24 little bit more straightforward there.
 25 MS. NEWBURY:

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1 Q. Yes, and we have heard other evidence on that
 2 point, that other types of stains are not
 3 quite the same as ER/PR in terms of the
 4 reliance placed on that to make decisions
 5 pertaining to patient care. Just, I think you
 6 mentioned earlier this morning you were
 7 comparing a situation where you might have a
 8 mislabelled specimen and say you came across a
 9 situation where there were a mislabelled
 10 specimen and again, just to make an analogy
 11 here, if the problem had been detected in
 12 time, that it didn't interfere with patient
 13 care, however it was, you know, if it hadn't
 14 been caught, it would have been a significant
 15 issue for that particular patient. In that
 16 situation would this type of a report be used?
 17 DR. MORRIS-LARKIN:
 18 A. Oh yes, that would be a near miss, that would
 19 be a very clearly a near miss to me then, that
 20 would have an occurrence report done.
 21 MS. NEWBURY:
 22 Q. And are there any immediate plans to try to
 23 develop more concrete guidelines as to how to
 24 deal with the types of situations that, you
 25 know, arose with the two exhibits, C-0184 and

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1 C-0175 for the benefit of pathologists?
 2 DR. MORRIS-LARKIN:
 3 A. There are discussions at the Quality
 4 Management Program level of closing the
 5 various loops on corrective actions, yes.
 6 MS. NEWBURY:
 7 Q. Okay. Dr. Larkin, in your role now with the
 8 quality assurance of the Laboratory Medicine
 9 Program that you recently took over from Dr.
 10 Carter, which I believe is a temporary, you've
 11 taken it over for a temporary period of time.
 12 Is there any monitoring of, for example,
 13 positivity rates or the ER/PR rates and as
 14 compared with what might be expected based
 15 upon literature?
 16 DR. MORRIS-LARKIN:
 17 A. From the Quality Management Program view
 18 itself, we have not any data on that yet. I
 19 do think that there is, within house of that
 20 specific laboratory, that there is--and
 21 attention being paid to that, but in terms of
 22 tracking trends which is something we know we
 23 want to get to, we have not gotten there yet.
 24 But specifically within the lab itself, their
 25 awareness, I think you would probably need to

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1 address somebody, you know, who works with
 2 that on a daily basis.
 3 MS. NEWBURY:
 4 Q. Okay.
 5 DR. MORRIS-LARKIN:
 6 A. Because I think they've done a tremendous
 7 amount with regards to those kinds of issue
 8 and I'm not sure yet what is available there.
 9 MS. NEWBURY:
 10 Q. Okay, and from your role as a pathologist and
 11 particularly with your involvement in that, is
 12 that something that you planned to delve into
 13 in the future, looking at positivity rates and
 14 to develop guidelines as to what might be done
 15 if there's any deviation from those expected
 16 rates.
 17 DR. MORRIS-LARKIN:
 18 A. Again, I think that that's within the overview
 19 of the Quality Management Program as something
 20 that will need to be done.
 21 MS. NEWBURY:
 22 Q. Okay. Thank you, those are all the questions
 23 I have, Dr. Larkin.
 24 THE COMMISSIONER:
 25 Q. Mr. Crosbie?

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1 CROSBIE, Q.C.:

2 Q. Thank you.

3 DR. CAROLYN MORRIS-LARKIN, EXAMINATION BY CHESLEY

4 CROSBIE, Q.C.

5 CROSBIE, Q.C.:

6 Q. Thank you. Good afternoon. Ches Crosbie, we

7 met at break time.

8 DR. MORRIS-LARKIN:

9 A. Yes.

10 CROSBIE, Q.C.:

11 Q. Perhaps we could start by bringing back the

12 Ejeckam memorandum document, 113 please? We

13 looked at this a little bit earlier.

14 DR. MORRIS-LARKIN:

15 A. Yes.

16 CROSBIE, Q.C.:

17 Q. And we see there in that first paragraph, it's

18 a short memo and it starts out, "Kindly note

19 that the immunohistochemical stains with the

20 following antibodies"--and it lists off a

21 bunch there. There are six antibodies before

22 he gets to ER and PR, correct?

23 DR. MORRIS-LARKIN:

24 A. Yes.

25 CROSBIE, Q.C.:

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1 Q. And those would be looked upon by you and I

2 think you touched by pathologists, so I think

3 you've touched on it just a moment ago with

4 Ms. Newbury as diagnostic stains for the

5 pathologist's purposes, is that right?

6 DR. MORRIS-LARKIN:

7 A. I would look upon those as stains which

8 contributed to a diagnosis, so that in any of

9 these stains of the six that you referred to,

10 they would be perhaps one of a half a dozen or

11 a dozen stains that I would use and then from

12 looking at what we call a panel of stains in

13 addition to your opinion on the H&E, they

14 would contribute to a final diagnosis.

15 CROSBIE, Q.C.:

16 Q. The ones under ER/PR are not directly relevant

17 to prognosis, are they?

18 DR. MORRIS-LARKIN:

19 A. Only relevant in terms of helping you make the

20 diagnosis, so again, it's within that setting

21 of using the information you get from the

22 stain to determine what your diagnosis is.

23 There are other immunohistochemical stains not

24 mentioned here that we do in other settings

25 that may have prognostic implications.

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1 CROSBIE, Q.C.:

2 Q. These ones we're looking at here, though, are

3 primarily for the pathologist to refine the

4 diagnosis, that's the logical diagnosis?

5 DR. MORRIS-LARKIN:

6 A. That's correct.

7 CROSBIE, Q.C.:

8 Q. ER/PR, however, is different from that because

9 it has a prognostic application, obviously,

10 doesn't it?

11 DR. MORRIS-LARKIN:

12 A. Yes.

13 CROSBIE, Q.C.:

14 Q. And a therapeutic application?

15 DR. MORRIS-LARKIN:

16 A. Yes.

17 CROSBIE, Q.C.:

18 Q. So to that extent ER/PR is a unique stain

19 compared to those others mentioned by Dr.

20 Ejeckam?

21 DR. MORRIS-LARKIN:

22 A. Yes.

23 CROSBIE, Q.C.:

24 Q. Uniquely important, in fact.

25 DR. MORRIS-LARKIN:

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1 A. Unique--they're all important.

2 CROSBIE, Q.C.:

3 Q. In the case that Mr. Coffey looked at with you

4 from July 2000, I believe it was document

5 number 184, we need not refer to it now,

6 unless you wish to, you mentioned that there

7 is no control available, but it seems like you

8 read the slide originally without the control,

9 is that right?

10 DR. MORRIS-LARKIN:

11 A. If that's the way I reported it, what I would

12 have done is I looked at it and I didn't see

13 the control and for that reason went and

14 repeated everything with the control.

15 CROSBIE, Q.C.:

16 Q. Yes, well you added an addendum and there is

17 number one and number two, so you must have

18 dictated the initial -

19 DR. MORRIS-LARKIN:

20 A. I would have dictated it without the control

21 and for some reason, and I don't know why that

22 was, but recognized that I do need to have the

23 control and then went through the further

24 exercise.

25 CROSBIE, Q.C.:

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1 Q. But at the point of dictation you dictated it
 2 and left the matter as a finished case?
 3 DR. MORRIS-LARKIN:
 4 A. I dictated it, other than that, I can't tell
 5 you anything more. I don't remember the
 6 specific case and I don't know the sequence, I
 7 don't recall the sequence of events that
 8 triggered me to go further there.
 9 CROSBIE, Q.C.:
 10 Q. But it presents itself as an addendum No. 1 or
 11 it ended up being addendum 1 I think it's
 12 called, as a finished case at that point,
 13 right?
 14 DR. MORRIS-LARKIN:
 15 A. It presents it as finished to that point in
 16 time.
 17 CROSBIE, Q.C.:
 18 Q. And you had either second thoughts or
 19 something happened to make you go back to it
 20 and you did, you did go back.
 21 DR. MORRIS-LARKIN:
 22 A. Yes, I did.
 23 CROSBIE, Q.C.:
 24 Q. Are you familiar with the substance of Dr.
 25 Dabbs' testimony that we heard here two or

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1 three weeks ago?
 2 DR. MORRIS-LARKIN:
 3 A. Not the details, no, I've seen maybe a small
 4 amount of what he had stated, but I didn't
 5 read the transcriptions in detail and I wasn't
 6 here at the time.
 7 CROSBIE, Q.C.:
 8 Q. I see. I know you're busy and we've heard how
 9 busy you are, but it may--many of us would
 10 commend that as worthwhile reading, I suspect.
 11 In any event, amongst the many things he said
 12 was that positive and negative and internal
 13 controls are all mandatory and you understand
 14 that to be best practice at this point in
 15 time?
 16 DR. MORRIS-LARKIN:
 17 A. Yes, I do.
 18 CROSBIE, Q.C.:
 19 Q. In fact, in the case that we're now referring
 20 to, the July, 2002 case that you went back to
 21 with the control, it seems that the control
 22 did have a dramatic impact on case
 23 interpretation?
 24 DR. MORRIS-LARKIN:
 25 A. It did.

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1 CROSBIE, Q.C.:
 2 Q. Which I guess is an illustration of why people
 3 like Dabbs say that the presence of controls
 4 are mandatory.
 5 DR. MORRIS-LARKIN:
 6 A. And in essence, that's what I followed. By
 7 the time I completed the case with the
 8 addendums, that was where I was going with
 9 that.
 10 CROSBIE, Q.C.:
 11 Q. Were there any other occasions, Doctor, on
 12 which you reported without the control?
 13 DR. MORRIS-LARKIN:
 14 A. No, it was not my practice and that's why you
 15 would have seen that addendum. It was my
 16 practice to look for the controls--unless they
 17 were being reported by somebody else because
 18 we know for a time period it was.
 19 CROSBIE, Q.C.:
 20 Q. So initially when this program was set up,
 21 we've heard that Dr. Khalifa was the resource
 22 person to whom you and other pathologists
 23 looked.
 24 DR. MORRIS-LARKIN:
 25 A. Yes, that's true.

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1 CROSBIE, Q.C.:
 2 Q. He seemed to have the most experience, round
 3 experience with labs elsewhere, I think in the
 4 United States, he mentioned.
 5 DR. MORRIS-LARKIN:
 6 A. Yes.
 7 CROSBIE, Q.C.:
 8 Q. More experience than anyone else in 1997 or
 9 1998 or in fact until Dr. Ejeckam came later.
 10 DR. MORRIS-LARKIN:
 11 A. I think that's probably correct to assume. He
 12 certainly had more experience than I did and I
 13 looked--I looked to him as a resource person.
 14 CROSBIE, Q.C.:
 15 Q. You, yourself, had no formal training in
 16 reading this kind of stain, the ER/PR nuclear
 17 stain?
 18 DR. MORRIS-LARKIN:
 19 A. No, my training was at a time when this was
 20 just something that was coming on board, so
 21 most of what I would have learned, I would
 22 have learned as a practising pathologist.
 23 CROSBIE, Q.C.:
 24 Q. Would that be a true statement of the other
 25 people practising in your group here in St.

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1 John's, say, at the time in '97, '98?
 2 DR. MORRIS-LARKIN:
 3 A. It would depend upon the timing and it would
 4 depend upon the place in which they practised.
 5 For example, Dr. Khalifa had trained in a
 6 place where there was more availability to
 7 learn this information and when he came here,
 8 I learned from him.
 9 CROSBIE, Q.C.:
 10 Q. We've seen a good deal of documentation,
 11 including the sort of foundational document on
 12 which Dr. Khalifa established the
 13 immunohistochemical program for ER/PR,
 14 including a reference to literature. And I
 15 think that was looked at a little earlier
 16 today as well. And we've also seen documents
 17 from, for example, the summer of 2005, it's
 18 only a short document, but it's one in which
 19 Dr. Carter and Dr. Cook, for example, set out
 20 in list form, very shortly, here are the
 21 things that it is mandatory to be looking for
 22 when you're reading these slides and giving an
 23 opinion.
 24 DR. MORRIS-LARKIN:
 25 A. Yes.

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1 CROSBIE, Q.C.:
 2 Q. You remember that one from, I think, August
 3 2005?
 4 DR. MORRIS-LARKIN:
 5 A. Oh yes, yes.
 6 CROSBIE, Q.C.:
 7 Q. And it talked about, you've got to have this
 8 control, you got to have that control and so
 9 on. There's no document like that made
 10 available to the practising pathologists back
 11 in '97 or '98, was there?
 12 DR. MORRIS-LARKIN:
 13 A. No, the document that I would have referred to
 14 in '97 was that memo from Dr. Khalifa with
 15 recommendations on the way to report.
 16 CROSBIE, Q.C.:
 17 Q. The way to report, but in fact he didn't spell
 18 out the kind of controls that were mandatory,
 19 did he?
 20 DR. MORRIS-LARKIN:
 21 A. The controls that he refers to here are the
 22 external controls. And he does state that
 23 they are there and he was looking at them and
 24 eventually, they would be issued to us. I
 25 believe that's how the document was drawn up.

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1 CROSBIE, Q.C.:
 2 Q. Anything mentioned about external negative
 3 controls?
 4 DR. MORRIS-LARKIN:
 5 A. I don't believe in that document.
 6 CROSBIE, Q.C.:
 7 Q. Well internal controls?
 8 DR. MORRIS-LARKIN:
 9 A. I don't believe it's in that document.
 10 CROSBIE, Q.C.:
 11 Q. One of the reasons you gave the Commission for
 12 why the decision was taken not to concentrate
 13 the reading of this test in the hands of the
 14 limited number of people, is that we,
 15 pathologists generally, didn't want to lose
 16 our skills, is that correct?
 17 DR. MORRIS-LARKIN:
 18 A. I think that in the context of that particular
 19 meeting, what we were seeing, what was being
 20 discussed was, you know, this was one of the
 21 things that we do and if you just take it and
 22 one person does it, then who will do it in
 23 their absence, so it was in that context at
 24 that time, the same kind of thing that we see
 25 in other areas of subspecialty practice and we

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1 had experience with what happens when you have
 2 subspecialty practice; it's a double-edge
 3 sword. It definitely is a very good thing,
 4 but it also, in a place like this where
 5 there's a high turn over, it also has very
 6 negative impact because suddenly there's
 7 nobody left with the skills to look at a
 8 particular area and you have a void, and that
 9 was the context in which that conversation in
 10 that meeting would have taken place, I think.
 11 CROSBIE, Q.C.:
 12 Q. So I understand two things are going on: one
 13 is the concern that if you lose somebody with
 14 a subspecialty skill or a specialized skill,
 15 whether it's by reason of someone going on
 16 vacation or perhaps more of a concern, leaving
 17 altogether, then you got a void and there's no
 18 one there to do that job, that's one concern.
 19 DR. MORRIS-LARKIN:
 20 A. That's one concern.
 21 CROSBIE, Q.C.:
 22 Q. But the other one I understood separately,
 23 perhaps, is that--or perhaps it's not
 24 separate, but people wanted to maintain their
 25 skills in an overall sense, including in that

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1 area.

2 DR. MORRIS-LARKIN:

3 A. And you're right, it's not separate, it's all

4 part of the same kind of concept that we would

5 have.

6 CROSBIE, Q.C.:

7 Q. Well, there was a third alternative, wasn't

8 there, to sub-specialization here, to

9 everybody reading it here, it could have been

10 referred out?

11 DR. MORRIS-LARKIN:

12 A. And eventually that is what had to happen when

13 we were left the spring with nobody to read ER

14 and PR.

15 CROSBIE, Q.C.:

16 Q. So with no formal training, learning on the

17 job, as you did without - with, can we agree,

18 limited guidance on how to do it from Dr.

19 Khalifa?

20 DR. MORRIS-LARKIN:

21 A. Limited guidance, but some guidance.

22 CROSBIE, Q.C.:

23 Q. Did you feel confident you had the skills to

24 do this properly?

25 DR. MORRIS-LARKIN:

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1 A. I would have seen this within the context of

2 everything that I do and everything that I've

3 learned on the job. I learn all the time in

4 my practice. It's the nature of our practice,

5 so we're always faced with new things. There

6 are - not only are new things from a new

7 technology or a new available technology point

8 of view, but things that are rare or uncommon

9 that we've not encountered before. So I think

10 I would have seen it within that context, this

11 is something that's being done across North

12 America, it's being introduced here as

13 something that our lab should be doing, and I

14 would have felt that it was something I was

15 supposed to be doing.

16 CROSBIE, Q.C.:

17 Q. I guess we can all understand that. Maybe I

18 can ask you, looking back on it now in

19 retrospect knowing, in fact, what you know now

20 about the sensitivity of this procedure, do

21 you think that you were over confident?

22 DR. MORRIS-LARKIN:

23 A. I don't think I was over confident. I think I

24 had the same level of confidence that any one

25 of us had. It was something new, it was

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1 something that we were learning, and there is

2 always - there is always a learning curve

3 where you start out being uncertain, and then

4 you gain knowledge. We practice that way all

5 the time. It's the nature of medicine. It's

6 the hard part of the nature of medicine.

7 CROSBIE, Q.C.:

8 Q. So you'd do this again the same way?

9 DR. MORRIS-LARKIN:

10 A. If I'm introduced to something new. I deal

11 with this all the time. I have to learn new

12 things. I have to learn and practice new

13 things.

14 CROSBIE, Q.C.:

15 Q. But you - even knowing all you know today, you

16 put this IHC testing and the reading of these

17 slides in a category of something new, I can

18 handle it, we can all handle it, I'd do it the

19 same way?

20 DR. MORRIS-LARKIN:

21 A. I'm not sure what you're asking me beyond what

22 I've said, that I need to learn things all the

23 time.

24 CROSBIE, Q.C.:

25 Q. You made mention of a learning curve. I

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1 suppose that curve started in 1997, is that

2 the start point?

3 DR. MORRIS-LARKIN:

4 A. For the ER/PR?

5 CROSBIE, Q.C.:

6 Q. Yeah.

7 DR. MORRIS-LARKIN:

8 A. I think that's fair to say.

9 CROSBIE, Q.C.:

10 Q. For the lab here, in general, is that fair to

11 say, as well as the pathologists?

12 DR. MORRIS-LARKIN:

13 A. I can't really speak for the lab.

14 CROSBIE, Q.C.:

15 Q. When did the end of the learning curve arrive?

16 DR. MORRIS-LARKIN:

17 A. I don't think you ever at the end of a

18 learning curve.

19 CROSBIE, Q.C.:

20 Q. So you're still working on that?

21 DR. MORRIS-LARKIN:

22 A. Always. Always will be.

23 CROSBIE, Q.C.:

24 Q. So what I can get out of - what I thought

25 you'd tell me, I must say to you, is that you

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1 went into this in '97 and '98, in that time
 2 period, without knowing adequately the
 3 sensitivity of the procedure, and remember,
 4 for example, the necessity of closing down the
 5 lab for a period in 2003, there are a lot of
 6 things the pathologists here didn't understand
 7 about it, but you wouldn't agree that - you
 8 wouldn't agree with me that if you had your
 9 time back, you probably would have done it
 10 differently?
 11 DR. MORRIS-LARKIN:
 12 A. You're asking me about something that we see
 13 with hindsight now.
 14 CROSBIE, Q.C.:
 15 Q. Exactly.
 16 DR. MORRIS-LARKIN:
 17 A. And we always -
 18 CROSBIE, Q.C.:
 19 Q. I did ask you about hindsight.
 20 DR. MORRIS-LARKIN:
 21 A. And we always do look back on anything with
 22 hindsight as there are things that if we knew,
 23 would contribute or would make a change. I
 24 mean, there's no denying that kind of thing.
 25 That's - again that's the way we learn, that's

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1 the way we practice, that's the way we live.
 2 CROSBIE, Q.C.:
 3 Q. Can you tell the Commissioner is there
 4 anything important missing from the way the
 5 program was established in '97, '98 time
 6 period that wasn't done and that should have
 7 been done?
 8 DR. MORRIS-LARKIN:
 9 A. I can't speak to the technical aspect. I
 10 think that probably a more formal in-service,
 11 if such a thing were to be introduced today, I
 12 can tell you that we have a pathology update
 13 meeting that covers technical issues, that
 14 covers pathologist issues, and it's the kind
 15 of thing that this would have been presented,
 16 it's the kind of forum where this kind of
 17 thing could have been presented in a more
 18 formal teaching sort of way. I think we would
 19 have benefited from something like that, yes.
 20 CROSBIE, Q.C.:
 21 Q. Well, what about a document that you could
 22 call a feasibility analysis, I suppose, that
 23 sets out the human and financial resources
 24 that were going to be needed by the
 25 institution in order to do the service up to

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1 the standard to which it deserved to be done?
 2 We don't see anything like that in front of us
 3 hailing from '97 or '98, do we?
 4 DR. MORRIS-LARKIN:
 5 A. And that's not something I would have known
 6 anything about. As a practising staff
 7 pathologist and a faculty member, that's not
 8 where my focus or my - any kind of knowledge
 9 of expertise would be.
 10 CROSBIE, Q.C.:
 11 Q. It's more a management function?
 12 DR. MORRIS-LARKIN:
 13 A. It would be, yes.
 14 CROSBIE, Q.C.:
 15 Q. In your notes of perhaps 1994, the Exhibit
 16 1994, these are notes of August 5th, 2005,
 17 that you typed yourself?
 18 DR. MORRIS-LARKIN:
 19 A. I believe I'm the one who typed this, yes.
 20 CROSBIE, Q.C.:
 21 Q. The impulse behind this, I gather, is what you
 22 described, I think you mentioned to an earlier
 23 question here today, as the idea of the
 24 blameless culture?
 25 DR. MORRIS-LARKIN:

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1 A. Yes.
 2 CROSBIE, Q.C.:
 3 Q. Does this discuss the concept of
 4 accountability anywhere, this document you
 5 typed?
 6 DR. MORRIS-LARKIN:
 7 A. This wasn't meant to be a comprehensive
 8 document. This was probably done a half hour
 9 before we went in to meet with Dr. Cook. It's
 10 something that again I did more for his
 11 benefit, and for the pathologists who had been
 12 dealing with the emotional fallout of knowing
 13 that a major event had happened in the lab,
 14 and it was something that we had to address.
 15 So it's not meant to be a comprehensive
 16 document. So if anything is missing, it's not
 17 by - you know, it's not because it should have
 18 been there, it was just basically me putting
 19 down the thoughts and the thoughts of other
 20 people around me.
 21 CROSBIE, Q.C.:
 22 Q. You mentioned earlier that the document we now
 23 know as the Banerjee report -
 24 DR. MORRIS-LARKIN:
 25 A. Yes.

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1 CROSBIE, Q.C.:

2 Q. You just assumed that that was a peer review

3 report, and pretty much thought nothing more

4 about it, didn't ask to see it for that

5 reason?

6 DR. MORRIS-LARKIN:

7 A. I think, you know, in terms of what I knew

8 about the Banerjee report, again that's

9 something that occurred over time. I think

10 what we've - you know, what I knew was that

11 Dr. Banerjee had been in and had done a

12 report. I happened to be away at the time

13 that the report was read, so I was not even -

14 I don't think I was even aware that it was

15 read until much, much later. I knew that it

16 was referred to. I knew that Dr. Cook had

17 been trying to implement recommendations made

18 from it, and I saw that within the purview of

19 the leadership team and I was - I was not gone

20 - I did not go beyond that, no.

21 CROSBIE, Q.C.:

22 Q. So if there were a peer review report, you

23 wouldn't expect to be brought into the loop

24 and shown a copy?

25 DR. MORRIS-LARKIN:

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1 A. You know, in all honestly, I never even heard

2 about the issue of peer review until it became

3 an issue for this Commission.

4 CROSBIE, Q.C.:

5 Q. You knew there was a report?

6 DR. MORRIS-LARKIN:

7 A. I think I knew Dr. Banerjee had written a

8 report, I knew it had gone to Dr. Cook, and

9 this whole focus on this being a peer review

10 report was not something that I really had

11 much thought on. It wasn't -

12 CROSBIE, Q.C.:

13 Q. Because I thought earlier your explanation for

14 not making inquiries about the document was

15 that it was a peer review and, therefore, not

16 properly something you should be informed

17 about?

18 DR. MORRIS-LARKIN:

19 A. No, that wasn't - I apologize if I misled you

20 there because that wasn't even on my radar of

21 - the peer review report.

22 CROSBIE, Q.C.:

23 Q. Because I was going to ask you, which of your

24 peers did you think the report was about.

25 DR. MORRIS-LARKIN:

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1 A. Yeah, it was only when it became an issue for

2 this Commission that I even really became

3 aware of the whole issue of, this is peer

4 review, and how people were trying to deal

5 with it. I knew that Dr. Banerjee had

6 reported his findings to Dr. Cook, and Dr.

7 Cook was doing his best to implement it.

8 CROSBIE, Q.C.:

9 Q. However, you were a member of the team and you

10 were aware, I'm sure, that there was a

11 significant failure in this testing that had

12 extended over a period of years?

13 DR. MORRIS-LARKIN:

14 A. I knew that there was something that had

15 happened and that there had been changed

16 results and we were trying to address it in a

17 number of ways, both in terms of trying to

18 find whose results had changed so that - in

19 particular, what I understood was that the

20 focus was to provide treatment options for any

21 women to whom it may still benefit. That was

22 far and away the main focus of everything that

23 was going on in the lab. I also was aware

24 that Dr. Cook had taken the initiative to say,

25 well, you know, why is this happening let's

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1 look to outside sources to give us some

2 advice, and that's how I saw it.

3 CROSBIE, Q.C.:

4 Q. No doubt there may be some people who think

5 it's rather extraordinary that as a staff

6 pathologist in that lab faced with an error of

7 some magnitude extending over a period of

8 years that you did not exert yourself to be

9 better informed about the causes as to how

10 that had happened?

11 DR. MORRIS-LARKIN:

12 A. But I think we were learning about the causes

13 as to how that had happened because Dr. Cook

14 was sharing information, Dr. Carter was

15 sharing information, and we were seeing

16 changes happen as a result of recommendations

17 from this report.

18 CROSBIE, Q.C.:

19 Q. Except they certainly didn't share the report?

20 DR. MORRIS-LARKIN:

21 A. No.

22 CROSBIE, Q.C.:

23 Q. My final question is who, if anyone, do you

24 understand has publicly taken responsibility

25 for these testing failures in the lab?

1 DR. MORRIS-LARKIN:
 2 A. I think that all of us take responsibility. I
 3 don't know that there's any public - I've not
 4 heard of anything publicly, but I think that
 5 every one of us, and I should only speak for
 6 myself, I certainly think that we all - I take
 7 responsibility for any cases that I would have
 8 been involved in. I think that's something
 9 that is a general accepted thing. You know,
 10 we're all working toward the best result we
 11 can get, and if somehow we didn't get the best
 12 result, then we all have to take a role in
 13 taking the responsibility.
 14 CROSBIE, Q.C.:
 15 Q. Thank you.
 16 THE COMMISSIONER:
 17 Q. Mr. Pike.
 18 PIKE, Q.C.:
 19 Q. No questions. Thank you very much.
 20 THE COMMISSIONER:
 21 Q. Mr. Browne.
 22 DR. CAROLYN MORRIS-LARKIN, EXAMINATION BY PETER BROWNE,
 23 Q.C.
 24 BROWNE, Q.C.:
 25 Q. Good afternoon, Dr. Morris-Larkin. I just

1 fixation, internal controls, the absence of
 2 internal controls, all that information. That
 3 information was translated to you through Dr.
 4 Carter and through Dr. Cook fairly early on in
 5 this whole process? Is that fair?
 6 DR. MORRIS-LARKIN:
 7 A. Yes, that's true.
 8 BROWNE, Q.C.:
 9 Q. And you saw the changes--putting aside whether
 10 or not you saw that report or read that
 11 report, you saw those changes happening over
 12 the course of time as a result of those
 13 observations, both--and just so we're clear,
 14 the observations in Dr. Banerjee's report are
 15 consistent with what you were told by Dr. Cook
 16 and Dr. Carter?
 17 DR. MORRIS-LARKIN:
 18 A. Yes, they are.
 19 BROWNE, Q.C.:
 20 Q. And then the recommendations that he's made,
 21 you saw happening over the course of time?
 22 DR. MORRIS-LARKIN:
 23 A. Yes.
 24 BROWNE, Q.C.:
 25 Q. Okay. Now the last area which you were asked

1 have a couple of areas I want to cover off
 2 with you. The first one is a short area. Mr.
 3 Coffey was asking you about the current
 4 situation in terms of pathologist ratio and I
 5 think in the course of that exchange, you had
 6 mentioned about 4 out of 11 at the Health
 7 Sciences, and you were about to say there was
 8 one in relation to St. Clare's, but I don't
 9 think you completed that answer. Is there a -
 10 DR. MORRIS-LARKIN:
 11 A. There is a vacancy at St. Clare's.
 12 BROWNE, Q.C.:
 13 Q. Vacancy, so in fact, there are now five
 14 vacancies?
 15 DR. MORRIS-LARKIN:
 16 A. There are five within the City.
 17 BROWNE, Q.C.:
 18 Q. Now I want to go back and just sort of just
 19 cover off another short area and that is this
 20 questioning about the peer review report and
 21 what Mr. Coffey just asked you a moment ago.
 22 Do I understand your evidence in summary is
 23 that the information--you've now read the
 24 reports, the contents of the reports, the
 25 focus of Dr. Banerjee's points with regard to

1 about by Mr. Coffey and Mr. Simmons and Ms.
 2 Newbury is the quality assurance and how that,
 3 I guess, developed over the course of time
 4 within the pathology side of the lab. We've
 5 seen a number of documents, number of minutes,
 6 site chief minutes and so on, where there are
 7 initiatives going back as far as 2001 within
 8 the pathology department, various areas where
 9 QA was identified and there was some
 10 development to move towards developing a
 11 handbook and so on. Was there--we've heard
 12 evidence as well about cutbacks. Did cutbacks
 13 ever affect how--because I think you mentioned
 14 in your evidence about we had not gotten to
 15 that level where you are now with the quality
 16 management program, and that's where you were
 17 intending on going, I take it? Is that where
 18 all this initiative was going?
 19 DR. MORRIS-LARKIN:
 20 A. I wasn't involved in the initiative in 2001.
 21 BROWNE, Q.C.:
 22 Q. Right.
 23 DR. MORRIS-LARKIN:
 24 A. But I think that is--I think that reflects
 25 where it was going. There's quality control

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1 which is one level. There's quality assurance
 2 which is another and then there's the quality
 3 management which is a higher level that starts
 4 to loop it all together, because if--you know,
 5 that's where you get the things that have been
 6 referred to, like the trends. That's where
 7 you pick up the more repetitive errors that
 8 may be occurring. So the quality management
 9 program, we weren't anywhere near that, but I
 10 think that's where they wanted to go and one
 11 of the things that Dr. Carter managed to do
 12 was impress upon senior executive that that
 13 needs resourcing.
 14 BROWNE, Q.C.:
 15 Q. Okay, and in the early days, was resourcing
 16 available and were there cutbacks in any of
 17 these sort of quality areas as a result of
 18 lack of resources?
 19 DR. MORRIS-LARKIN:
 20 A. There were definitely things lost during the
 21 cutbacks. There were a large number of
 22 journals that circulated through the
 23 Department, pretty much all of which were cut
 24 with budget cuts. There were teleconferences
 25 from the American Society of Clinical

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1 Pathologists which happened on a regular
 2 basis. Those were cut. We were discouraged
 3 from sending things for external consult
 4 because we have to pay quite a lot of money
 5 for these external consults and although it
 6 was acceptable to send things, it had to be
 7 vetted within the department before it was
 8 sent out and you kind of had to justify it.
 9 BROWNE, Q.C.:
 10 Q. And then Mr. Simmons and Ms. Newbury showed
 11 you, I guess, the lab policy and the corporate
 12 policy, and you talked about that. Do you see
 13 the--and perhaps you could speak to this, the
 14 role of the current quality management program
 15 looping into the overall corporate policy for
 16 quality assurance and adverse events and I
 17 just want to sort of ask you about the
 18 importance of having data in order to do that
 19 and tracking trends as you mentioned a minute
 20 ago.
 21 DR. MORRIS-LARKIN:
 22 A. Yeah. I think that that's a huge part of what
 23 the quality management program will want to
 24 do. Again, the resources are limited and
 25 we've been working or, you know, before my

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1 involvement, they have been working on a large
 2 number of things and have made a great deal of
 3 progress. Those are, I think, within the
 4 scope of future plans.
 5 BROWNE, Q.C.:
 6 Q. Okay. So you see the quality management
 7 program looping into the corporate wide, and
 8 what sort of things do you view in terms of -
 9 THE COMMISSIONER:
 10 Q. I don't want to interrupt, but you're going to
 11 have to explain looping.
 12 BROWNE, Q.C.:
 13 Q. Oh, I'm sorry, connecting information and what
 14 sort of information do you--you talked, I
 15 think, Dr. Morris-Larkin talked, you talked
 16 about sort of the information within the lab
 17 itself. How do you--is there any information
 18 you would see going to sort of the corporate
 19 higher up?
 20 DR. MORRIS-LARKIN:
 21 A. Well, I think if the quality management
 22 program were to detect things like a major
 23 trend that might have a negative impact, then
 24 that's something that would definitely be
 25 communicated to the quality risk management

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1 group. I think that's the kind of--is that
 2 the kind of thing you're referring to perhaps?
 3 BROWNE, Q.C.:
 4 Q. Well, I'm just sort of thinking that would be--
 5 --would that be an issue you would see?
 6 DR. MORRIS-LARKIN:
 7 A. Oh, I think that that would--you know, again,
 8 you try and connect all the dots and close the
 9 circuit so that things are not just hanging
 10 out there meaning nothing. It's only when you
 11 connect it all together that these things
 12 really mean something.
 13 BROWNE, Q.C.:
 14 Q. And obviously in terms of we've heard several
 15 witnesses talk about metrics. Dr. Dabbs
 16 talked about tracking metrics and looking for
 17 trends and so on. Obviously in order to do
 18 all this, you would have to have a good data
 19 collection system in place?
 20 DR. MORRIS-LARKIN:
 21 A. That's right.
 22 BROWNE, Q.C.:
 23 Q. Now Doctor, I understand you have a statement
 24 that you would like to make this afternoon.
 25 That's all the questions I have for you.

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1 DR. MORRIS-LARKIN:
 2 A. I thank the Commission for the opportunity to
 3 speak here today. As a result of the Inquiry
 4 into Hormone Receptor Testing, I have seen a
 5 significant commitment to resourcing the
 6 laboratories which has led to a number of long
 7 overdue changes resulting in quality
 8 improvement. This includes a team of
 9 pathologists assistants who ensure the
 10 standardized handling of specimens and allow
 11 the pathologists time to focus on the
 12 microscopic aspect of diagnosis. As well, the
 13 permanent assignment of lab technologists to
 14 the immunohistochemistry lab along with the
 15 acquisition of a PhD scientist in this lab has
 16 resulted in a developing expertise that allows
 17 for troubleshooting and will allow for future
 18 development initiatives. As well, there is
 19 now funding for a structured quality
 20 management program which is essential in the
 21 delivery of a quality lab service. Thank you.
 22 BROWNE, Q.C.:
 23 Q. Dr. Morris-Larkin, I think Mr. Coffey does
 24 have one question or one area to cover with
 25 you. Thank you. Thank you, Commissioner.

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1 THE COMMISSIONER:
 2 Q. Mr. Coffey.
 3 DR. CAROLYN MORRIS-LARKIN, RE-EXAMINATION BY BERNARD
 4 COFFEY, Q.C.
 5 COFFEY, Q.C.:
 6 Q. Thank you, Commissioner. Mr. Browne just
 7 asked you, Doctor, about metrics and tracking
 8 and you need computer programs and systems to
 9 do that. I appreciate that up until--well,
 10 since May of this year that ER/PR has not been
 11 done at the General Hospital site.
 12 DR. MORRIS-LARKIN:
 13 A. I may be wrong, I think it was briefly done,
 14 but had to be suspended again because there
 15 was nobody to report it.
 16 COFFEY, Q.C.:
 17 Q. I appreciate that, beginning--we've heard
 18 evidence that up until--it was being done up
 19 until May?
 20 DR. MORRIS-LARKIN:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. From really February of '07 to -
 24 DR. MORRIS-LARKIN:
 25 A. And I don't believe it has restarted.

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1 COFFEY, Q.C.:
 2 Q. Okay. Doctor, do you know if anyone--you're
 3 the site chief there involved in this quality
 4 management groups. Do you know if anyone was
 5 actually keeping track of the ER/PR stats
 6 trends during the period that it was
 7 reinstated in St. John's?
 8 DR. MORRIS-LARKIN:
 9 A. That's not something I could speak to. I
 10 don't know anything about it.
 11 COFFEY, Q.C.:
 12 Q. Who would be -
 13 DR. MORRIS-LARKIN:
 14 A. Either Dr. Cook, Dr. Carter or possibly Dr.
 15 Elms.
 16 COFFEY, Q.C.:
 17 Q. Thank you. Thank you, Commissioner.
 18 THE COMMISSIONER:
 19 Q. Thank you. Thank you very much, Dr. Morris-
 20 Larkin for adding your perspective to this
 21 rather large issue. I do appreciate you
 22 coming.
 23 DR. MORRIS-LARKIN:
 24 A. Thank you.
 25 THE COMMISSIONER:

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1 Q. Mr. Coffey, I suggest we take the afternoon
 2 break -
 3 COFFEY, Q.C.:
 4 Q. Ms. Chaytor.
 5 THE COMMISSIONER:
 6 Q. I'm sorry, Ms. Chaytor, might I suggest we
 7 take the afternoon break so that we're not
 8 going to interrupt the witness five or ten
 9 minutes into this presentation.
 10 (BREAK)
 11 THE COMMISSIONER:
 12 Q. Please be seated. Ms. Chaytor.
 13 MR. TERRY GULLIVER, EXAMINATION BY SANDRA CHAYTOR, Q.C.
 14 (CONT'D)
 15 CHAYTOR, Q.C.:
 16 Q. Thank you, Commissioner. We're continuing
 17 with the evidence of Mr. Gulliver, and there
 18 are a few new exhibits that I'd ask please to
 19 have entered. P-3113 to P-3118 inclusive.
 20 THE COMMISSIONER:
 21 Q. Entered.
 22 EXHIBITS ENTERED AND MARKED P-3113 THROUGH P-3118
 23 INCLUSIVE
 24 CHAYTOR, Q.C.:
 25 Q. Thank you, and if I could have, please,

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1 Registrar, P-0901. I believe we were on page
 2 six of this document when we broke last day,
 3 Mr. Gulliver, and if we come down to the
 4 bottom of page six, you're referring to a
 5 recommendation again from the Hay report, and
 6 you write "this recommendation appears to be a
 7 trade off for three technologist FTEs to be
 8 replaced with three pathology assistants.
 9 While having three pathology assistants will
 10 be beneficial in reducing pathologists
 11 workload, it would have an increased financial
 12 implication on the division as pathology
 13 assistants are paid much more in Canada than
 14 technologists. What we have already
 15 implemented in pathology at the General site
 16 is that we have trained technologists to do
 17 more than 50 percent of grossing of surgical
 18 specimen which is part of the work of the
 19 pathology assistant. It is important to note
 20 that this additional work assigned to our
 21 technologist twos also reduces their unit
 22 producing time. Also at the General site are
 23 two autopsy technicians, go far beyond their
 24 scope of duties in performing post mortems to
 25 the point that by and large the pathologists

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1 have to spend less time performing this
 2 function. Please see my plan for reductions
 3 of FTEs in anatomical pathology as outlined
 4 earlier in the report."
 5 So Mr. Gulliver, I take it the Hay report
 6 had recommended pathology assistants? Is that
 7 correct?
 8 MR. GULLIVER:
 9 A. It was a part of, like I said, Dr. Manley's, I
 10 think his recommendations.
 11 CHAYTOR, Q.C.:
 12 Q. And what was your response in terms of that?
 13 Were you suggesting that it not be pathology
 14 assistants because of the additional cost of
 15 pathology assistants?
 16 MR. GULLIVER:
 17 A. Oh no, certainly not. Realize the Hay report,
 18 as I mentioned in my testimony Friday, was
 19 really a cost cutting measure within the
 20 laboratory and other parts of the health care
 21 system. I'm indicating there that, I guess,
 22 to sum up the Hay recommendation about this
 23 piece, Ms. Chaytor, on one side they were
 24 saying we should reduce staff in one part of
 25 our lab and use that money, I guess, to create

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1 three new positions for PAs. The position at
 2 the time within the divisions who would lose
 3 those staffing was that we need new money for
 4 three PAs and still keep the three positions
 5 in the other parts of the lab that they were
 6 recommending to cut. I'm indicating here then
 7 to Dr. Williams that pathology assistants are
 8 generally paid higher than general
 9 technologists, so it would also be an increase
 10 in our cost that they're higher salaried.
 11 CHAYTOR, Q.C.:
 12 Q. And overall then, your comments "at the end of
 13 the day, the total impact of staff reductions
 14 over the next year or so on the Laboratory
 15 Medicine Program is as follows:" and under the
 16 division of pathology, it's one full-time
 17 equivalent position, and ultimately I believe
 18 you told us last day that is what happened.
 19 Basically, the equivalent of -
 20 MR. GULLIVER:
 21 A. There was the two half times made into one and
 22 reducing the worked overtime hours.
 23 CHAYTOR, Q.C.:
 24 Q. Mr. Gulliver, last day too, you indicated that
 25 there had been a written protocol for IHC

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1 testing, and I believe you thought that
 2 document was something in 1985-1986 time
 3 frame?
 4 MR. GULLIVER:
 5 A. Around that time frame, yes.
 6 CHAYTOR, Q.C.:
 7 Q. And if we could just bring up, please, P-2156?
 8 I just want to clarify -
 9 THE COMMISSIONER:
 10 Q. Just before you go to that, on this same
 11 point, do I take it from the evidence that
 12 I've just heard from the last witness that, in
 13 fact, the PAs are still being paid as
 14 technologists?
 15 MR. GULLIVER:
 16 A. That's not 100 percent factual.
 17 THE COMMISSIONER:
 18 Q. Okay. So you might as well tell me what the--
 19 since you're nearer to them, why don't you
 20 tell me what their--what's happened?
 21 MR. GULLIVER:
 22 A. What happened, once the PA positions were
 23 created internally in Eastern Health, we
 24 assigned a salary scale, an expected salary
 25 scale to those new positions, and then we had

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1 to go through a formal classification process
 2 within Eastern Health and it goes to Treasury
 3 Board. The recommendation that we made,
 4 Justice Cameron, to Treasury Board was to
 5 create a new classification within the NAPE
 6 (unintelligible) union agreement and to call
 7 them pathologists assistants, because within
 8 the NAPE (unintelligible) agreement, there is
 9 no classification as such. It's just med-lab
 10 assistant, lab technician, medical lab
 11 technologist one, two, three and four. And
 12 what came back from Treasury Board, they took-
 13 -they made our lead PA, you just seen Jessica
 14 Swain, a technologist four, which is the
 15 highest ranking salary scale in the current
 16 union agreement, and the other three PAs, they
 17 made them lab technologist threes.
 18 THE COMMISSIONER:
 19 Q. Okay.
 20 MR. GULLIVER:
 21 A. So they're really called a lab technologist
 22 three or a lab technologist four.
 23 THE COMMISSIONER:
 24 Q. So they, in effect, recognized that the work
 25 they were doing -

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1 MR. GULLIVER:
 2 A. Is of a higher classification, higher pay.
 3 THE COMMISSIONER:
 4 Q. Except they didn't create a new classification
 5 called -
 6 MR. GULLIVER:
 7 A. Right.
 8 THE COMMISSIONER:
 9 Q. - pathologist assistants?
 10 MR. GULLIVER:
 11 A. Right, and then we're appealing that decision,
 12 and what we got back from the--I don't know
 13 what his title is, that classification pay,
 14 the chief officer and I actually spoke to him
 15 on the phone, he called me, was that they
 16 don't have the authority to create a new
 17 classification in the agreement. It has to go
 18 through Government legislation, and we're
 19 waiting for an appeal answer to come back and
 20 still we're hoping to get a new classification
 21 created.
 22 THE COMMISSIONER:
 23 Q. So your point about it costing more money has
 24 in fact come through to this other process?
 25 MR. GULLIVER:

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1 A. Yes.
 2 THE COMMISSIONER:
 3 Q. All right, thank you.
 4 CHAYTOR, Q.C.:
 5 Q. Thank you. P-2156, please? And I just want
 6 to confirm Mr. Gulliver, is this the document
 7 that you were referring to last day when you
 8 said there was a written protocol for IHC?
 9 MR. GULLIVER:
 10 A. Yes. This is the procedure.
 11 CHAYTOR, Q.C.:
 12 Q. Yes.
 13 MR. GULLIVER:
 14 A. This is your step-by-step procedure to prepare
 15 the slides and stain the slides.
 16 CHAYTOR, Q.C.:
 17 Q. And Ms. Welsh was aware of that. She went
 18 through that in her evidence as well.
 19 MR. GULLIVER:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. And if we could have then, please, P-3116?
 23 And these are the number of new exhibits that
 24 we've just entered today, and I understand,
 25 Mr. Gulliver, perhaps you can tell us, this is

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1 3116, for example, and if we could also bring
 2 up 3117, please, Registrar, and then 3118 and
 3 3114. And finally, 3115. And, Mr. Gulliver,
 4 these are a number of new exhibits that we've
 5 just received. And perhaps you can tell the
 6 Commissioner where those documents were
 7 located at this time?
 8 MR. GULLIVER:
 9 A. Well, actually, I located them over the
 10 weekend, over the weekend. And to be honest
 11 with you, it was your questioning of me on
 12 Friday afternoon about a particular--I had
 13 asked you about Dr. Ejeckam's--sorry, Dr.
 14 Khalifa's letter to me in '97, did we ever
 15 receive documentation, that I received it.
 16 And you asked me the question, well, am I the
 17 type of person to sort of throw things away or
 18 do I keep things, and I general answered, and
 19 I generally don't, that I'm not the type to
 20 keep things around for a long time. And over
 21 the weekend when I was in, I was thinking
 22 that, like, Mr. Dyer, our current pathology
 23 manager for the last six, seven years, he
 24 occupies my old office when I was the
 25 pathology manager and -

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1 CHAYTOR, Q.C.:

2 Q. So back in pre 2001 days?

3 MR. GULLIVER:

4 A. Pre 2001 days.

5 CHAYTOR, Q.C.:

6 Q. Okay.

7 MR. GULLIVER:

8 A. And I just thought, I just thought, I wondered

9 if Barry ever went through any of my old files

10 and discarded everything or kept things. So I

11 went back to my old office in my original,

12 some of my filing cabinets and sure enough

13 there were still some old, you know, file

14 folders and I looked through them all and I

15 came across one where I had titled it, "Immuno

16 Lectures." Because I knew back in the mid

17 '80s to late '80s, some of this here are

18 lectures I gave to Mary and Peggy and to our

19 pathology residents, both on the theory of

20 behind immunohistochemistry testing and

21 talking about the fixation and proper fixation

22 in pathology in general.

23 CHAYTOR, Q.C.:

24 Q. Okay.

25 MR. GULLIVER:

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1 A. And that's how I came about to get them.

2 CHAYTOR, Q.C.:

3 Q. Okay. So it was found in a filing cabinet, I

4 take it, in Mr. Dyer's current office which

5 you vacated sometime around 2001?

6 MR. GULLIVER:

7 A. Yeah.

8 CHAYTOR, Q.C.:

9 Q. And that's where those documents -

10 COMMISSIONER:

11 Q. When did you say those lectures would have

12 been given?

13 MR. GULLIVER:

14 A. I used to give those, Justice Cameron, in,

15 like, the mid '80s when we first started doing

16 the testing, when Mary and Peggy would have

17 taken over the testing when I became manager.

18 And actually, at CONA, which is now CONA, the

19 training program for medical lab technologists

20 you've heard through other various witnesses

21 that this is not something that is taught in

22 the three-year training program. And back in

23 the mid to late '80s and maybe even up to the

24 early '90s I was asked to go do a lecture to

25 the third-year students and this was the

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1 lecture I gave, talking about

2 immunohistochemistry and the theory and

3 principles.

4 CHAYTOR, Q.C.:

5 Q. Okay. And if we could have, please, 3116?

6 So, for example, this document, perhaps you

7 could tell us what this document is? Would

8 this be your notes from the lectures you would

9 have given in that time frame, the mid 1980s?

10 MR. GULLIVER:

11 A. Well, this would be sort of, this is a copy

12 of--and you see up in the corner, one, two,

13 three, four, five, I mean, back in those days

14 we had, you know, overhead projectors, so this

15 would have been the typed copy that we would

16 use for overhead projection.

17 CHAYTOR, Q.C.:

18 Q. Okay. And so these are your notes of a

19 lecture you would have given around that time

20 period?

21 MR. GULLIVER:

22 A. And certainly. I mean, and most of this

23 information, Ms. Chaytor, would have been, you

24 know, that strictly is just a photocopy take

25 from our handbook.

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1 CHAYTOR, Q.C.:

2 Q. Okay.

3 MR. GULLIVER:

4 A. Talking about the theory behind some of the

5 testing. At the time there were three

6 different methods you could use, the direct

7 method, indirect and then the peroxidase

8 method for paraffin sections.

9 CHAYTOR, Q.C.:

10 Q. Okay. And if we could look at 3117, please?

11 And this one is indicated to be seminars for

12 first-year residents in pathology. So is this

13 also a seminar you would have given for the

14 residents?

15 MR. GULLIVER:

16 A. Yeah. And on multiple occasions, you know,

17 not -

18 CHAYTOR, Q.C.:

19 Q. For residents going through pathology?

20 MR. GULLIVER:

21 A. Who are now new residents in training in

22 pathology. And we used-before the residents,

23 when they first came into the pathology

24 program, you know, and pretty well I think it

25 was every Friday, they were assigned people to

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1 do lectures. And this would have been their,
 2 part of their introduction to learning on the
 3 gross bench of about fixation, the importance
 4 of fixation in grossing. And then we talked
 5 about once specimens are fixed and grossed,
 6 the technical process the specimens would go
 7 through on routine pathology, the embedding,
 8 the cutting, the staining and-to create a H&E
 9 slide.
 10 CHAYTOR, Q.C.:
 11 Q. Right. And you write here, for example, "It
 12 is essential that fixation is effective and
 13 the appropriate fixative is used." "The
 14 amount of fixative should be about 15 times
 15 the volume of tissue to be fixed and tissue
 16 should never be more than three to five
 17 millimetres in thickness."
 18 MR. GULLIVER:
 19 A. And we would emphasize that. It's also really
 20 important on the thickness of the sections
 21 they're going to submit into the block to make
 22 a paraffin block.
 23 CHAYTOR, Q.C.:
 24 Q. Yes. And, Mr. Gulliver, whose responsibility
 25 would it be then to follow up with the

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1 residents to see whether or not they are
 2 following those recommendations?
 3 MR. GULLIVER:
 4 A. It would be the pathologists.
 5 CHAYTOR, Q.C.:
 6 Q. And if we could look at, please, P-3114? And
 7 perhaps you could identify this document for
 8 us?
 9 MR. GULLIVER:
 10 A. Again, it was in that folder that I had
 11 titled, "Immuno Lecture." A lot of the basic
 12 information that I would use to put together
 13 the overhead presentation, I would use this
 14 manual here.
 15 CHAYTOR, Q.C.:
 16 Q. Yes.
 17 MR. GULLIVER:
 18 A. Along with some information from our book at
 19 the time was called Sternberger who wrote the
 20 book on IHC.
 21 CHAYTOR, Q.C.:
 22 Q. So, for example, if we look at page 10,
 23 please, Registrar, of this document, this is
 24 one of the overheads from your presentation?
 25 MR. GULLIVER:

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1 A. I probably just photocopied it from the manual
 2 just to make it easier.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And so and I believe this is dated, I'm
 5 not sure this one actually has a -
 6 MR. GULLIVER:
 7 A. I think it's '83 or '84.
 8 CHAYTOR, Q.C.:
 9 Q. 1983 or '84, yes. So it's around that time
 10 period?
 11 MR. GULLIVER:
 12 A. Yeah.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. Then if we could look at--so again,
 15 this would be used by yourself. And there's
 16 another article in there, I won't take you to
 17 it, but 3115 is the article by Mr. Kurt Davis.
 18 And that's something else, I take it, you used
 19 -
 20 MR. GULLIVER:
 21 A. That came from a different source.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. You used that, though, as a resource
 24 for putting together your lectures or notes,
 25 is that right?

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1 MR. GULLIVER:
 2 A. No. This here is talking about accreditation,
 3 standards in Canada from a professional
 4 association perspective in 1998.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, so that's something you had in the same
 7 folder, but it's for a different -
 8 MR. GULLIVER:
 9 A. No, no, no, no, different folder. This was
 10 not from my old folder. This just came in to
 11 me in the last week.
 12 CHAYTOR, Q.C.:
 13 Q. Oh, okay. This is something new?
 14 MR. GULLIVER:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, all right. I'm sorry, go ahead and
 18 explain.
 19 MR. GULLIVER:
 20 A. It's something that I knew, at this time I was
 21 sitting on the national board of directors for
 22 CSMLS.
 23 CHAYTOR, Q.C.:
 24 Q. Yes.
 25 MR. GULLIVER:

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1 A. Mr. Davis was our, at the time, assistant
 2 executive director. And from a national
 3 professional association perspective, you
 4 know, this is late '90s. After CCHSA pretty
 5 well -
 6 CHAYTOR, Q.C.:
 7 Q. 1998 and the other -
 8 MR. GULLIVER:
 9 A. Yes, pretty well when they stopped doing sort
 10 of an in depth lab accreditation, it's kind of
 11 post Krever Inquiry, and this was sort of a
 12 position paper from our national perspective
 13 for the lack of Canadian accreditation
 14 standards for labs.
 15 CHAYTOR, Q.C.:
 16 Q. And you just received this in the past -
 17 MR. GULLIVER:
 18 A. Just a few days ago I asked Mr. Davis to e-
 19 mail me that.
 20 CHAYTOR, Q.C.:
 21 Q. Okay.
 22 MR. GULLIVER:
 23 A. Because I knew this had been done like a long
 24 time ago from my professional volunteer work.
 25 CHAYTOR, Q.C.:

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1 Q. So before that you didn't have this article in
 2 your possession -
 3 MR. GULLIVER:
 4 A. No.
 5 CHAYTOR, Q.C.:
 6 Q. - and you weren't aware of its contents?
 7 MR. GULLIVER:
 8 A. No, no.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. And if we could look at, please, P-
 11 3118? And can you identify this document,
 12 please, for the Commissioner?
 13 MR. GULLIVER:
 14 A. I submitted it, Ms. Chaytor, because that was
 15 in my folder that I had just titled, like,
 16 "Immuno Lectures." And I really cannot, you
 17 know, swear to you where I got this document
 18 originally. I'm kind of leaning towards it's
 19 something that maybe Dr. Khalifa might have
 20 passed on to me when the ER/PR testing was
 21 being set up. So this is in the same folder,
 22 but the earlier lectures are probably from
 23 '85, '86, '87. This is probably '97, '98.
 24 CHAYTOR, Q.C.:
 25 Q. It's later, yes. And it has reference to

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1 estrogen receptor. For example, there's a
 2 section on that. So you're thinking this may
 3 have been around the time Dr. Khalifa was
 4 setting up -
 5 MR. GULLIVER:
 6 A. That's just my best estimate, yeah.
 7 CHAYTOR, Q.C.:
 8 Q. And do you recall whether or not you ever used
 9 any of the information in this for lectures
 10 for anybody?
 11 MR. GULLIVER:
 12 A. No, I did not. I know that much.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, thank you. And if we could look,
 15 please, at P-1879? And this is an e-mail from
 16 yourself to all staff laboratory medicine
 17 program. And it concerns the HAY report or
 18 the HAY operational review, it's referred to
 19 here. March 27th, 2002. And it's written
 20 for, it says at the top "For Mr. Donald Cook"
 21 from yourself. But then it is a memo, it
 22 appears, to go to all of the staff. So did
 23 this, in fact, go out to all of the staff, do
 24 you know?
 25 MR. GULLIVER:

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1 A. Yes, I'm sure it did, yes.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. And you write at the beginning "You
 4 have been aware for some time now that the HAY
 5 Management Group have been conducting an
 6 operational review of the Health Care
 7 Corporation of St. John's. Of course, the
 8 laboratory program has been part of the review
 9 and I met with all of our division managers
 10 today and gave them as much information as I
 11 have to date on the lab's response to this
 12 review. Tomorrow all managers are meeting
 13 with corporate team and will be given a
 14 broader briefing on the review." Let me just
 15 scroll down here a bit. "In case of number
 16 two and the really important one, we scored
 17 much lower than in 2000." And you'll see
 18 number two is "Worked hours per patient care
 19 work unit. Basically how productive we are.
 20 But upon closer analysis of the HAY charts and
 21 figures I discovered that they have made a
 22 mistake and misinterpreted some of our
 23 workload units and therefore did not include
 24 them in our patient care workload statistics."
 25 And you've spoken about that last day when we

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1 were here. "I quickly pointed this out to our
 2 VP and corporate team and, in fact, produced
 3 the corrected version of our worked hours per
 4 patient care workload unit. It has been a
 5 battle, to say the least, in getting our
 6 corrected stats included in the final HAY
 7 report as was released today. Thanks to the
 8 support of corporate team, the HAY Group has
 9 acknowledged that they may have made an error
 10 in the lab stats." So I take it from that,
 11 Mr. Gulliver, that the corporate team, the
 12 Health Care Corporation team, were supportive
 13 of your efforts in this regard. But who was
 14 then--why was it a battle, who was the battle
 15 with to try and have your revised information
 16 included?
 17 MR. GULLIVER:
 18 A. Oh, the battle was with the HAY people
 19 themselves.
 20 CHAYTOR, Q.C.:
 21 Q. And what was the resistance, what was the
 22 nature of the resistance?
 23 MR. GULLIVER:
 24 A. I don't know 100 percent sure what the
 25 resistance was. I mean, they came in, they

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1 pretty well asked for copies of, like, yearly
 2 statistics, workload units, number of
 3 patients, number of tests, the volumes for all
 4 of our divisions. They pulled statistics from
 5 our financial data on the financial side of
 6 our system. I don't think that we had within
 7 at the time Health Care Corporation--that the
 8 statistics they had gathered from our
 9 financial reporting side matched up the actual
 10 real data that was taking place on a monthly
 11 basis in the laboratory program. And I think--
 12 yeah, so the battle was with the HAY Group in
 13 trying to make them understand this is how we
 14 capture our workload and these are the true
 15 statistics. Because they were removing
 16 several million workload units from their
 17 overall data, because they were saying it
 18 wasn't patient care units, it was other
 19 things. And, you know, this is very ironic.
 20 Sunday I worked all day because we had to
 21 prepare this year's budget submission and in a
 22 part of my briefing notes, in requesting new
 23 staff for the lab program, I was given the
 24 2007 HAY national benchmarking for
 25 productivity for our lab and we score in the

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1 top five percent in the country in for
 2 productivity and efficiency.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And you go on with this memo and you
 5 say, "I would like to make it clear to all
 6 staff that even though I have made it clear to
 7 corporate team that the HAY report is not a
 8 true reflection of our program's productivity,
 9 there are, however, areas of the program that
 10 even with the corrected stats need to be
 11 addressed to improve the productivity and to
 12 meet the national benchmarking standards."
 13 What are you referring to there?
 14 MR. GULLIVER:
 15 A. Well, as you seen in my earlier, perhaps
 16 submission, that the HAY group, you know, they
 17 didn't just look at laboratory medicine, they
 18 looked at anatomical pathology, they looked at
 19 what they call the main lab or core lab, they
 20 looked at microbiology, so they broke down
 21 different parts of our program. And so that's
 22 what I'm saying there, that overall our lab
 23 medicine program was actually performing
 24 fairly well, but there were parts within the
 25 program that were not, at that time, meeting

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1 the national benchmarking for productivity by
 2 HAY.
 3 CHAYTOR, Q.C.:
 4 Q. And then on the top of the next page "Also, I
 5 would like to point out that our program will
 6 improve our operational efficiency in the
 7 coming months and into next year with new
 8 equipment and new technology in several areas
 9 of the program, along with reorganizing some
 10 of the ways that we process and test
 11 specimens." And my question for you on that:
 12 this is March of 2002, did any of that have to
 13 do with how you would be doing things in the
 14 IHC lab?
 15 MR. GULLIVER:
 16 A. No, that had nothing there. This was strictly
 17 to do with mainly our core lab services. We
 18 were bringing in front end, what we call
 19 front-end automation for the pre-analytical
 20 preparation of the thousands of blood samples
 21 we receive every day. It was going to
 22 automate that process.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. So nothing to do with any new tissue
 25 processors or -

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1 MR. GULLIVER:
 2 A. No, no.
 3 CHAYTOR, Q.C.:
 4 Q. - anything like that, okay. And you write
 5 that, "I'm confident we will meet the targets
 6 of the HAY report in those parts of the lab
 7 that need to be addressed in the coming months
 8 and into next year. It is my opinion that
 9 this can be achieved with very little direct
 10 impact on our staff. However, as we move
 11 toward new"--I'm sorry, "move forward with new
 12 equipment, changes in operational practice,
 13 etcetera, then we will need the full support
 14 of all of you to ensure that in each case it
 15 will be a smooth transition leading us to an
 16 improved quality of service and more
 17 importantly, keeping us one of the leaders in
 18 laboratory medicine in Canada." And, Mr.
 19 Gulliver, what data did you have or what
 20 reference did you have to believe that you
 21 were one of the leaders in laboratory medicine
 22 in Canada?
 23 MR. GULLIVER:
 24 A. And right here, Ms. Chaytor, I'm more
 25 referring to the technology side of our

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1 operations. For example, in the part before
 2 we talked about some of our new equipment. We
 3 were like one of the, I think number four or
 4 number five in Canada to implement pre-
 5 analytical automation in our front-end
 6 processing, say, of the thousands of blood
 7 tubes received every day. At that point we
 8 were installing new automated analyzers in
 9 biochemistry, in hematology and other--across
 10 the program. So I'm referring there that,
 11 yeah, the leaders in Canada, really, at that
 12 time, and I still believe today, that from a
 13 technology side and the equipment that we have
 14 to operate with, we pretty well are at the--
 15 you know, one of the leaders in the country.
 16 CHAYTOR, Q.C.:
 17 Q. In terms of the acquisition of the equipment?
 18 MR. GULLIVER:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. And if we could have, please -
 22 MR. GULLIVER:
 23 A. And you know, in the--I wrote this e-mail to
 24 all staff at a time where everybody in the
 25 organization, in particular in the laboratory,

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1 everyone were really worried about job cuts
 2 and job losses. There were all kinds of
 3 rumours going throughout the organization for
 4 weeks and months leading up to this. And I
 5 felt it was important to make sure all staff
 6 were well informed of, you know, what the HAY
 7 report may have impacted upon the lab program
 8 and really to kind of reassure them that
 9 whatever cuts we'd have to make, we will do it
 10 as in so as a painless manner as possible.
 11 CHAYTOR, Q.C.:
 12 Q. Yes. And before then we leave it, your
 13 assertion here that you're confident you will
 14 meet the targets of the HAY report in the
 15 parts of the lab you indicate that needed to
 16 be addressed, what happened overall looking
 17 at--were you able to meet the targets of the
 18 HAY report and, if so, what, if any, impact
 19 overall did this have on your laboratory
 20 medicine program?
 21 MR. GULLIVER:
 22 A. Well, it certainly, it all depends what the
 23 division that we're looking at.
 24 CHAYTOR, Q.C.:
 25 Q. Well, particularly at the pathology division.

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1 MR. GULLIVER:
 2 A. Actually, pathology, there was very little.
 3 CHAYTOR, Q.C.:
 4 Q. Very little impact?
 5 MR. GULLIVER:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. Was the one person that you talked about?
 9 MR. GULLIVER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. Okay.
 13 MR. GULLIVER:
 14 A. Pathology at that time, if you look at, this
 15 is strictly workload statistics, an analysis
 16 on productivity is not measuring or assessing
 17 anything to do with quality in the lab. At
 18 the time our pathology division was performing
 19 pretty close to what the recommended national
 20 benchmark was for the HAY Group.
 21 CHAYTOR, Q.C.:
 22 Q. And is it--I'm just thinking, though, when you
 23 do your budget, you do a budget overall for
 24 your whole program. And I'm just wondering if
 25 there was other impact because of what had to

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1 happen in other areas if that then left you in
 2 a situation where there may not have been
 3 funds that could have otherwise been diverted,
 4 for example, to pathology?
 5 MR. GULLIVER:
 6 A. Yes, certainly at this time--I don't know if
 7 you mean within the lab program or you mean
 8 within the health care system?
 9 CHAYTOR, Q.C.:
 10 Q. Well, I heard what your answer is, that really
 11 overall the HAY report probably didn't have a
 12 direct impact on pathology. And I'm
 13 wondering, well, indirectly did it impact
 14 because of cutbacks or other limits that were
 15 placed on you regarding your overall program?
 16 MR. GULLIVER:
 17 A. I have to say yes. You know, even though the
 18 HAY report didn't impact pathology a great
 19 deal, other parts of our program we did reduce
 20 staffing. For example, microbiology, we
 21 consolidated our microbiology lab to one lab
 22 for the City of St. John's. By doing that we
 23 reduced our staffing by four FTES. And in a
 24 normal program management the way you're
 25 supposed to operate within your program, if

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1 you can reduce or find savings in one part of
 2 one division, you really should have the
 3 flexibility to be able to take that money and
 4 move it from microbiology division and move it
 5 over to other parts within your own program.
 6 And certainly, under the environment that we
 7 were operating at this point in time that just
 8 didn't happen. Savings were made in divisions
 9 overall in the lab and you weren't allowed to
 10 reinvest it in other parts of your lab; you
 11 just lost the funding.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. And if we could have then, please, P-
 14 1867? And this is a quality initiatives
 15 report for the laboratory medicine program.
 16 And it's from April 1st, 1999 through to March
 17 31st, 2000. And it's submitted to--submitted
 18 by, sorry, Mr. Whelan and Mr., or Dr. Cook as
 19 the clinical chief. And this is before you
 20 took over as director, obviously. And I think
 21 we actually looked at this one maybe last
 22 time. If we could look at--yes, it's page 33,
 23 if we could have, please? Don't want to go
 24 back in time, want to keep going forward.
 25 Here we go. This is a similar report. This

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1 one is for April 1st, 2001 to March 31st,
 2 2002. That's better. And this one is, in
 3 fact, submitted by you. And who would you
 4 then make this quality initiatives report to?
 5 MR. GULLIVER:
 6 A. This was something that every program is
 7 required to submit on an annual basis. It
 8 would go to your VP and then the VP brought it
 9 up to our executive, I guess, and I guess it
 10 went to the Board Quality group.
 11 CHAYTOR, Q.C.:
 12 Q. Okay, and you summarized your year throughout
 13 your document and you break down the seven
 14 divisions -
 15 MR. GULLIVER:
 16 A. Well, really it's been about four or five
 17 months, I think, I've been director.
 18 CHAYTOR, Q.C.:
 19 Q. I'm sorry, is it? Yes.
 20 MR. GULLIVER:
 21 A. It begins April 1st, 2001 to March 31st '02.
 22 I became director in October '01.
 23 CHAYTOR, Q.C.:
 24 Q. Right.
 25 MR. GULLIVER:

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1 A. So this is my first four or five months on the
 2 job.
 3 CHAYTOR, Q.C.:
 4 Q. But it's a year for the whole -
 5 MR. GULLIVER:
 6 A. But you have to submit a physical year report,
 7 yeah.
 8 CHAYTOR, Q.C.:
 9 Q. Yes, okay, and you had been the director, as
 10 you say, for since October of '01?
 11 MR. GULLIVER:
 12 A. Yeah.
 13 CHAYTOR, Q.C.:
 14 Q. So for the last quarter, all right, and the
 15 approximate--you say the breakdown of the
 16 seven divisions and approximate percentage of
 17 each division is allocated and the anatomical
 18 pathology would take up ten percent of your
 19 budget.
 20 MR. GULLIVER:
 21 A. The program budget, yes.
 22 CHAYTOR, Q.C.:
 23 Q. Your program budget, yes, and the first
 24 challenge of the year was April 1st, 2001 and
 25 that was the strike of the NAPE employees.

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1 Then at the top of page 35, "after several
 2 years of planning, the Janeway Child Health
 3 Centre moved in May of 2001, and therefore all
 4 laboratory services from the former Janeway
 5 site were brought into the General site." And
 6 then we have the reference to the program
 7 leadership change in September 2001 with
 8 yourself taking over from Mr. Whelan, and "in
 9 addition, a number of management positions
 10 were made redundant. The above changes
 11 resulted in the program reducing from nine
 12 division managers to seven in each division,
 13 and each division manager now has corporate
 14 wide responsibilities." So I take it it was
 15 not only a reduction in the number of division
 16 managers, but the scope of their
 17 responsibilities increased?
 18 MR. GULLIVER:
 19 A. Became corporate wide, yes.
 20 CHAYTOR, Q.C.:
 21 Q. And then "early 2002, the director received
 22 the report from the Hay management group" and
 23 we've talked about that and the challenges
 24 that that put forward for you. And then, you
 25 write, at the bottom here, "the following

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1 outlines two of the areas of the program that
 2 have significant challenges or changes in the
 3 past year" and then you list those, and
 4 there's challenges then. You list the strike,
 5 the consolidation of services, the change in
 6 the program management, dealing with labour
 7 management issues, keeping abreast of new
 8 technology equipment, the Hay report and
 9 CCHSA. Is that accreditation?
 10 MR. GULLIVER:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. Was there accreditation in this year
 14 for the lab?
 15 MR. GULLIVER:
 16 A. I think there probably would have been. That
 17 might have been the cycle that CCHSA were
 18 probably in.
 19 CHAYTOR, Q.C.:
 20 Q. And would the lab have been part of that, part
 21 of the accreditation process for the hospital?
 22 MR. GULLIVER:
 23 A. It would have been a part of the--well, it's a
 24 part of the CCHSA process at that time that
 25 they followed. You really wouldn't be able to

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1 call it a lab accreditation process.
 2 CHAYTOR, Q.C.:
 3 Q. And why not? It was on a superficial level, I
 4 take it?
 5 MR. GULLIVER:
 6 A. Very, very superficial, yes, yeah.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, and under the achievements then, it does
 9 refer to successful accreditation, but again,
 10 you're saying that wouldn't have been anything
 11 in depth?
 12 MR. GULLIVER:
 13 A. We certainly passed what they came in to
 14 review.
 15 CHAYTOR, Q.C.:
 16 Q. And what would it entail? What exactly would
 17 they do at that point in time, in terms -
 18 MR. GULLIVER:
 19 A. At that point in time, CCHSA had moved--and
 20 again, the document I submitted there for '98,
 21 from our professional association, really
 22 that's the concern from a lab professional
 23 perspective in the country is that CCHSA moved
 24 to these new what they called AIM standards
 25 and coming to assess, you know, hospital

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1 systems, and in that new process, pretty well
 2 when the reviewers came in, you know, they
 3 spent a bit of time with the director or the
 4 director walked them around the various labs.
 5 They had kind of a look and see and they just,
 6 you know, made a statement that, you know,
 7 "your lab seems to be equivalent to others in
 8 the country." There were very, very few
 9 standards that you kind of had to assess
 10 before the reviewers came, that you had to
 11 implement afterwards. What they relied upon
 12 in this process that there were several care
 13 teams in the organization. There was a
 14 medicine care, pediatric care team, acute care
 15 team and all the other parts of the clinical
 16 side of the hospital system, and in those care
 17 teams, the reviewers would ask them "so how do
 18 you find lab services?" or "how do you find
 19 diagnostic imaging services?" and that's
 20 really how they -
 21 CHAYTOR, Q.C.:
 22 Q. And that's it?
 23 MR. GULLIVER:
 24 A. That's pretty well how they assessed the lab
 25 services.

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1 CHAYTOR, Q.C.:

2 Q. And I take it at that point in time then, if

3 there were any--there didn't appear to have

4 been any major complaints about the lab that

5 had been brought forward by the clinical

6 teams?

7 MR. GULLIVER:

8 A. No.

9 CHAYTOR, Q.C.:

10 Q. Or the people who were providing information

11 to the accreditors. Did that change in terms

12 of the way in which CCHSA did accreditations

13 then throughout--this is 2001 into '02 and -

14 MR. GULLIVER:

15 A. And they came back, I think it was 2004, you

16 know, because it's -

17 CHAYTOR, Q.C.:

18 Q. And was it the same process?

19 MR. GULLIVER:

20 A. - sort of a three-year cycle. Well, we're

21 still following the same--pretty well the same

22 process.

23 CHAYTOR, Q.C.:

24 Q. Okay.

25 MR. GULLIVER:

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1 A. It wasn't much different than the one in 2000

2 or 2001 and I think the one before that, and

3 you know, to just expand, if we go back

4 further, the CCHSA used to do what we felt

5 like was a good job in doing accreditation

6 process for medical laboratories in Canada.

7 In the early '90s when they decided to really

8 not--and it's not just lab, it was diagnostic

9 imaging is included also. When they changed

10 their focus more on the clinical team kind of

11 focus, that's really how QMPLS evolved in

12 Ontario. Because there was no Canadian

13 conjoint health accreditation any more,

14 Ontario decided, as a government, to implement

15 their own lab accreditation program for

16 Ontario.

17 CHAYTOR, Q.C.:

18 Q. Something more was needed?

19 MR. GULLIVER:

20 A. Yes, and then Alberta followed suit after

21 Ontario.

22 CHAYTOR, Q.C.:

23 Q. Okay, and so in terms of what was happening

24 here with respect to the lab services, it was

25 a little more than really window dressing in

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1 terms of what review your lab would have

2 received?

3 MR. GULLIVER:

4 A. In my opinion, yes, yeah.

5 CHAYTOR, Q.C.:

6 Q. Okay. Overall, I'm looking, this is your

7 first year, the first quarter of your year and

8 it appears that it was somewhat of a

9 challenging year. You had a strike, the Hay

10 report to deal with, changing--the Janeway

11 moved and you--well, you had to consolidate

12 those services from the Janeway and the change

13 you took on, your own position as well, in

14 that time period. So I take it it was a bit

15 of a challenging year that year for the lab

16 medicine program.

17 MR. GULLIVER:

18 A. And I would say every year since has probably--

19 you'd probably find something else to say for

20 every year. But certainly as my first year as

21 the program director was a--I mean, it was a

22 very challenging year, I mean, for major

23 issues that we had to deal with.

24 CHAYTOR, Q.C.:

25 Q. Yes, okay, and if we could look then, please,

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1 at P-0903? And this is a letter, October

2 11th, 2002 written to Dr. Cook by Dr. Williams

3 and this is Dr. Cook being appointed as the

4 clinical chief. So I take it that happened

5 about a year after you came into your

6 position?

7 MR. GULLIVER:

8 A. Dr. Haegert, who had been away on sabbatical

9 and Dr. Cook was acting clinical chief for a

10 while. I don't know the exact time frame, but

11 Dr. Haegert did come back when I was appointed

12 the new director and worked with--you know,

13 worked with him for a while, and he decided to

14 go back to McGill in Montreal.

15 CHAYTOR, Q.C.:

16 Q. Okay.

17 MR. GULLIVER:

18 A. And then Dr. Cook was appointed as the new

19 clinical chief.

20 CHAYTOR, Q.C.:

21 Q. Okay, and Dr. Williams writes to Dr. Cook in

22 the middle of page two of our exhibit, "you

23 will be required to work closely with the

24 program director, Mr. Terry Gulliver, in

25 providing overall clinical direction to the

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1 Laboratory Medicine Program and working with
 2 Mr. Gulliver in broad administrative
 3 leadership as a member of the leadership team.
 4 This will include the main elements captured
 5 on the attached generic job description of
 6 clinical chief." So I take it that would have
 7 been the same relationship that you would have
 8 had with Dr. Haegert prior to Dr. Cook?
 9 MR. GULLIVER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. And overall, Mr. Gulliver, in terms of how
 13 that worked within your laboratory medicine
 14 program, in terms of you working with the
 15 clinical chief, how did it unfold itself? Did
 16 you work well together? Did the program
 17 management structure work within the
 18 laboratory medicine program or did you
 19 encounter any challenges along the way?
 20 MR. GULLIVER:
 21 A. You mean with Dr. Haegert or Dr. Cook or both?
 22 CHAYTOR, Q.C.:
 23 Q. Well, I guess you had a very brief period of
 24 time, your first year though would have been
 25 with Dr. Haegert, and if there is a

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1 difference, by all means, if it's--you know,
 2 if there is a difference between your
 3 experience with both individuals. But I'm
 4 just wondering how it worked in terms of what
 5 was envisioned by Dr. Williams here, in terms
 6 of the clinical chief providing overall
 7 clinical direction and both of you working
 8 together in broad administrative leadership
 9 positions?
 10 MR. GULLIVER:
 11 A. I have to say, I mean, when I was the first--
 12 went to work at the Health Sciences in 1980s
 13 as a medical lab technologist, I think Dr.
 14 Cook might have been '81/82 where he became--
 15 he was in the pathology residency training
 16 program. So I mean, I've known Dr. Cook very
 17 well since 1981/82 and you know, both he and I
 18 ended up being the leadership team for Lab
 19 Medicine and I've always worked well with him
 20 and whenever I had any issue, when I was a
 21 part of the group, myself and Dr. Williams
 22 interviewed for that position. So I was a
 23 part of the group who decided or chose Dr.
 24 Cook as the successful candidate for our
 25 clinical chief. The only difference between

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1 Dr. Cook and Dr. Haegert, and it wasn't a--
 2 sorry, not a difference, Dr. Cook was at St.
 3 Clare's and you know, for years prior, the
 4 clinical chief used to be at the--was at the
 5 Health Sciences where the program director was
 6 physically located. So you had a much more
 7 closer working relationship physically. But
 8 Dr. Cook decided to remain at St. Clare's
 9 where he had been since, I think, the early--
 10 since he graduated, and I was physically at
 11 the Health Sciences. But you know, we met
 12 regularly. We met monthly with Dr. Williams.
 13 CHAYTOR, Q.C.:
 14 Q. So from your point of view, the structure with
 15 program management with the two arms, as such,
 16 worked well and there was no difficulties
 17 encountered along the way?
 18 MR. GULLIVER:
 19 A. Well, I can't say there's no difficulties. I
 20 mean, you're working together and you're in a
 21 very dynamic environment. You're working in
 22 an environment where you're undergoing
 23 significant challenges and significant
 24 changes, not just to the medical laboratories,
 25 but to the physical buildings in the city. We

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1 had just gone through, you know, the closure
 2 of the Grace Hospital, the closure of the
 3 Janeway Hospital, and even after those two
 4 facilities closed, there was still a lot of
 5 rumours, and might even exist today, that
 6 there was talks that even St. Clare's was
 7 going to close. So again, I mean, look at the
 8 environment that we worked in, I thought that
 9 we worked really well together.
 10 CHAYTOR, Q.C.:
 11 Q. And if we could have then, please, P-2945?
 12 And this is a meeting of the laboratory
 13 division managers, February 12th 2003, and
 14 you're in attendance, along with Mr. Dyer and
 15 Lynn Wade, and a number of others, and then on
 16 page two of this document, under your budget
 17 at this point in time, and again, it's now
 18 February, actually it's up to December 2002,
 19 but you're 128,000 over budget to December
 20 2002, and you had met with Sharon Lehr and
 21 outlined the unexpected expenses incurred by
 22 the Laboratory Medicine Program, and you were
 23 asking all divisions to keep tight control on
 24 their budget, and this would be the budget for
 25 2002/03, and I think when Dr. Williams was

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1 here, he said that--or made a comment to the
 2 effect that he doesn't think, after the Hay
 3 report, that you were able to balance your
 4 budget at any point after that.
 5 MR. GULLIVER:
 6 A. Still haven't.
 7 CHAYTOR, Q.C.:
 8 Q. And that's a fair statement, I take it?
 9 MR. GULLIVER:
 10 A. Yeah, you might see another 50 minutes, copies
 11 of minutes here, either at the division
 12 managers level or our -
 13 CHAYTOR, Q.C.:
 14 Q. Certainly doesn't get any better.
 15 MR. GULLIVER:
 16 A. No.
 17 CHAYTOR, Q.C.:
 18 Q. The numbers get much worse.
 19 MR. GULLIVER:
 20 A. Yeah.
 21 CHAYTOR, Q.C.:
 22 Q. Yes.
 23 MR. GULLIVER:
 24 A. And that doesn't directly reflect--you know,
 25 it's not a full picture. While our program

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1 has yet to meet our budget targets, you know,
 2 laboratory services is the most utilized
 3 service in the health care system, believe it
 4 or not. We do over ten million tests a year
 5 and we respond to what physicians require. So
 6 it's very, very hard to budget laboratory
 7 medicine because you don't know if last year
 8 we did 1,000 bone marrows and it cost \$1,000
 9 each, and that's the kind of range that a bone
 10 marrow would cost for full investigation for
 11 genetics, we don't know this year if we're
 12 going to get 2,000, 1500, or 1200. It all
 13 depends on how the service grows. So trying
 14 to budget at the beginning of the year for lab
 15 service is really difficult and trying to
 16 project your growth this year or the new tests
 17 coming online and those kinds of things.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. If we could have, please, P-1887? And
 20 Mr. Gulliver, this is a letter that was
 21 written to you by Mr. Dyer of February 17th,
 22 2003 and he writes to you regarding some
 23 concerns with interactions that he had with
 24 Dr. Cook.
 25 MR. GULLIVER:

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1 A. Um-hm.
 2 CHAYTOR, Q.C.:
 3 Q. And I won't take you through it all. I take
 4 it you're familiar with this letter or do you
 5 need -
 6 MR. GULLIVER:
 7 A. Well, I've become more familiar with it.
 8 CHAYTOR, Q.C.:
 9 Q. - do you need me to take you through it?
 10 Okay, I'll take you through it then, okay. So
 11 he writes to you saying "I'm writing this
 12 letter with apprehension and concern to
 13 discuss the treatment of one's self during two
 14 interactions with Dr. Donald Cook. Mr.
 15 Gulliver, being my supervisor and next line of
 16 communication, and it is necessary for you to
 17 be informed in writing" and he goes on to talk
 18 about what the first encounter involved and
 19 "it happened on February 12th, 2003 when I
 20 approached Mr. Cook's secretary to arrange a
 21 meeting with him to brief him on changes I
 22 planned to make to anatomical pathology. I
 23 discussed the corporate wide recall we would
 24 use to laboratory assistants from the Health
 25 Sciences Centre and one laboratory technician

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1 from St. Clare's, as well as the transfer of a
 2 technologist two from St. Clare's to the
 3 Health Science for training with an eventual
 4 lateral transfer to an upcoming vacant
 5 technologist two position" and he goes on to
 6 say that he has an encounter, they have a
 7 debate, was slightly uneasy. "One phrase I
 8 found quite unsettling was and I quote 'heads
 9 are going to roll over this, if things do not
 10 work out'" and he interpreted that as a threat
 11 to his position as manager, and he says that
 12 he verbally informed you of that.
 13 And then the second encounter occurred
 14 February 14th '03 and he describes he was
 15 "having a staff meeting with St. Clare's
 16 pathology department to inform them of the
 17 changes pertaining to the corporate wide
 18 recall and the training and eventual lateral
 19 transfer of the technologist two position when
 20 Dr. Cook came in. I was sitting at the back
 21 of the laboratory and he stopped at the front.
 22 He pointed his forefinger directly at me and
 23 said, I quote, 'you.' He then pointed at the
 24 door and, I quote, 'I want to see you right
 25 now.'" and he goes on to say how he found that

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1 to be degrading and disrespectful and asks you
 2 to investigate as per the harassment in the
 3 workplace policy, and he also requests to
 4 have--"I request to have a meeting with St.
 5 Clare's pathology staff, myself and Mr.
 6 Gulliver, to discuss the management of
 7 anatomical pathology."
 8 So Mr. Gulliver, what--do you recall this
 9 now, and what do you recall about this?
 10 MR. GULLIVER:
 11 A. I mean, I certainly recall the event when it
 12 happened and I certainly recall receiving this
 13 letter from Mr. Dyer at the time.
 14 CHAYTOR, Q.C.:
 15 Q. So you recall Mr. Dyer coming to you -
 16 MR. GULLIVER:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. - after the first encounter and speaking to
 20 you about it?
 21 MR. GULLIVER:
 22 A. Certainly.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and what did you, as a manager or as his
 25 direct superior, what did you do about this?

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1 MR. GULLIVER:
 2 A. Well, within--of all the things you just read,
 3 there are multiple issues in there. You know,
 4 it's one, it's about how Mr. Dyer felt he was
 5 being treated by our clinical chief. Number
 6 two, it's talking about specific issues within
 7 the anatomic pathology department as a whole,
 8 and it's talking about specific issues that
 9 relate to St. Clare's pathology lab. So
 10 there's--I can't answer them all in the same
 11 context.
 12 CHAYTOR, Q.C.:
 13 Q. Well, take your time and tell us what you did
 14 about it.
 15 MR. GULLIVER:
 16 A. Well, I guess maybe we'll start from, you
 17 know, Mr. Dyer's concern first. I mean, Barry
 18 came to me and informed me of these instances
 19 and I think, you know, my response to Barry
 20 was to calm him down and to tell him that, you
 21 know, I would speak to Dr. Cook about Dr.
 22 Cook's behaviour and you know, his--and at the
 23 back end of Barry's letter, he talks about
 24 there is corporate policy that talks about
 25 workplace harassment, personal harassment and

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1 it certainly applies to every employee in the
 2 Health Care Corporation. It doesn't make no
 3 difference if you're a director, if you're a
 4 doctor, a CEO or a staff person. Everyone is
 5 treated fairly. So I did speak to Barry. I
 6 did speak to Dr. Cook. I did not write Dr.
 7 Cook formally about this here. We just talked
 8 about it. I know at the time, and I guess,
 9 Dr. Cook's behaviour, while at this time was
 10 certainly unacceptable, I really think that
 11 you need to put some timing and context around
 12 the issues that were being discussed that, in
 13 my opinion, you know, led Dr. Cook to exhibit
 14 this behaviour. You will find no documents
 15 after this here of anything of this sort
 16 between Dr. Cook or Mr. Dyer or myself.
 17 CHAYTOR, Q.C.:
 18 Q. So I take it this was something unusual for
 19 you to have to deal with, in terms of
 20 behaviour by a pathologist towards a technical
 21 staff or technical manager?
 22 MR. GULLIVER:
 23 A. Rarely. I mean, it happened, yes, over my
 24 career. It's happened, you know, less than--
 25 count him on the toes and one hand. But I

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1 think, if you really put--to frame this in the
 2 time frame, this was leading up to--I've been
 3 director for a year, is leading up to for
 4 several months before March of 2003, I had
 5 been working with the division managers and
 6 division chiefs and Dr. Cook as clinical
 7 chief. We were getting ready to have a
 8 comprehensive three-year--putting together a
 9 three-year plan for lab services for the City
 10 of St. John's, partly in response to the Hay
 11 report, to look at the long term implications
 12 from Hay report and the long term objectives
 13 that we would like to achieve, and certainly
 14 in the environment that we're in a cost
 15 cutting environment. We had, just prior to
 16 this here, you know, reduced staffing and all
 17 those kinds of things, and at this time, Barry
 18 Dyer, who was the pathology manager, was--
 19 during the planning day, was going to present
 20 what he felt him and the site chiefs would be
 21 the division for pathology for the City of St.
 22 John's, and the recommendation was going to be
 23 to have one pathology lab for the City of St.
 24 John's. We had visited that exact scenario in
 25 1998 before the Grace closed and before the

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1 Janeway closed when I was pathology manager,
 2 Mr. Whelan was director, and Dr. Haegert was
 3 clinical chief, that if we're going to close
 4 the Grace and close the Janeway, the
 5 Microbiology Division had put forward that at
 6 some point they think it would be best to
 7 operate with one lab in the city of St.
 8 John's. Pathology, it didn't work out in '98,
 9 it didn't get approval, and Mr. Dyer is really
 10 resurrecting that recommendation from five
 11 years earlier that maybe this is the time now
 12 that we should be looking at pooling all of
 13 our resources, both technical, clinical, and
 14 equipment, and operating under like one roof,
 15 one umbrella. So I think this is the context
 16 of when these events happened. In preparation
 17 for the planning day, Mr. Dyer was talking to
 18 staff and getting feedback about how do you
 19 think this could work out, what kinds of
 20 things do we need to do and put plans in place
 21 before it could happen, and this is the events
 22 around where Dr. Cook is talking about heads
 23 are going to roll over this if this doesn't
 24 work out. This means about closing the lab at
 25 St. Clare's for pathology.

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1 CHAYTOR, Q.C.:
 2 Q. And the Technologist II position, that was
 3 vacant, and it was - it was contemplated
 4 somebody would be transferred from St. Clare's
 5 to the Health Science. Was that Les Simms?
 6 MR. GULLIVER:
 7 A. I think this might be Les Simms because Peggy
 8 Welsh by this time has informed us that she's
 9 going to resign, and move away to Nova Scotia,
 10 and Les was the senior technologist in
 11 pathology in the city, so he would be the one
 12 that would go into the IHC lab and begin that
 13 training. You know, again I really - you need
 14 to put yourself in our shoes back in 2003 and
 15 understand the environment that all of us were
 16 working in and the pressure that we're under,
 17 and, you know - obviously you're probably
 18 going to ask me more down the road about this
 19 whole consolidation and where it is today.
 20 You know, I was certainly, as director, in
 21 favour of having one pathology lab for the
 22 city of St. John's. I felt, you know, when
 23 you can have all your expertise under one
 24 roof, under one leadership, I think it
 25 provides for a much better service. However,

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1 you know, put yourself in Dr. Cook's shoes,
 2 he's been a practising pathologist at St.
 3 Clare's since the early 80s. We know he's an
 4 extremely dedicated laboratory physician, and
 5 that's the facility and site, that's his home,
 6 and, you know, you're talking about physically
 7 uprooting his whole home and his pathologists
 8 over there to a whole new facility. So it's
 9 not - it's a huge issue.
 10 CHAYTOR, Q.C.:
 11 Q. So he was resistant to that idea and that was
 12 the issue that -
 13 MR. GULLIVER:
 14 A. Certainly was, yes.
 15 CHAYTOR, Q.C.:
 16 Q. Underlying tension that you saw coming out of
 17 this.
 18 MR. GULLIVER:
 19 A. Yeah.
 20 CHAYTOR, Q.C.:
 21 Q. And when you went to speak to Dr. Cook about
 22 it then back in February of 2003, is that what
 23 he articulated to you?
 24 MR. GULLIVER:
 25 A. Exactly, and, obviously, Dr. Cook apologized,

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1 and, I mean, this is not his normal behaviour.
 2 I just took it as it was a one time incident
 3 and nothing ever happened again. So we just
 4 moved on from it.
 5 CHAYTOR, Q.C.:
 6 Q. And did Dr. Cook articulate to you any other
 7 reasons, apart from the comfort level of being
 8 within your own institution? Was there
 9 anything else articulate to you, as the
 10 program director, as to why he was resistant
 11 to consolidation?
 12 MR. GULLIVER:
 13 A. At this point in time, probably not. This is
 14 before our full planning day and before the
 15 full scope of what the plans are for the next
 16 three years for lab services. At some point,
 17 maybe it's a year or so later than this, you
 18 know, myself and Dr. Cook, we meet with the
 19 executive team and we talk about this
 20 pathology consolidation. I think you'll see
 21 more articulated there.
 22 CHAYTOR, Q.C.:
 23 Q. Yes.
 24 MR. GULLIVER:
 25 A. From Dr. Cook than at this point in time.

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1 CHAYTOR, Q.C.:

2 Q. Yes, so he did have other reasons apart from

3 his affinity for St. Clare's? He had other

4 reasons?

5 MR. GULLIVER:

6 A. I certainly believe so. I mean, you know, my

7 experience with Don from, I guess, 1981 or

8 1982, when he was a resident, you know, Dr.

9 Cook, he said what he felt and I operate the

10 same way. There are times over many issues

11 where you're not going to agree upon every

12 single issue, and you try to find consensus

13 and you try to implement what you think is the

14 best. I don't think Don's resistance was

15 simply because physically moving the pathology

16 lab out of St. Clare's. I really believe, and

17 again Dr. Cook testified here for several

18 days, I don't know what he said, but Ms.

19 Chaytor, I really believe it was kind of big

20 picture stuff. You know, there were still at

21 this time - the HAY group came in, the Grace

22 was closed by government, the Janeway was

23 closed, there were a lot of rumours flying

24 around that maybe they're going to close St.

25 Clare's next, and, you know, when you start

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1 pulling out services one by one, what is St.

2 Clare's going to be left with, and I really

3 think that's probably what Dr. Cook - I think

4 it's more than just laboratory issues. I

5 think it was more of a St. Clare's health care

6 issue type of thing.

7 CHAYTOR, Q.C.:

8 Q. And is there anything else then around this

9 time period or around this - I take it it was

10 resolved to everybody's satisfaction?

11 MR. GULLIVER:

12 A. I certainly feel it was, yes.

13 CHAYTOR, Q.C.:

14 Q. And didn't impact then on a go forward basis

15 the relationship between Dr. Cook or Mr. Dyer

16 or their ability to work together?

17 MR. GULLIVER:

18 A. Nothing that I ever seen.

19 CHAYTOR, Q.C.:

20 Q. And nothing else that got brought to your

21 attention as Mr. Dyer's supervisor?

22 MR. GULLIVER:

23 A. No, no.

24 CHAYTOR, Q.C.:

25 Q. And if we could have, please, P-1890, and this

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1 is another laboratory management committee

2 meeting, and this one is March 13th, 2003, and

3 Dr. Cook is in attendance, as is yourself, Ms.

4 Wade, and Mr. Dyer.

5 MR. GULLIVER:

6 A. Yeah, and this is a group that Dr. Cook set up

7 where it's a combination of the administrative

8 part of the program and the divisional chiefs

9 clinical side where it's pretty well more

10 information exchange, keep everyone up to date

11 what's going on in the program.

12 CHAYTOR, Q.C.:

13 Q. And that was an initiative of Dr. Cook?

14 MR. GULLIVER:

15 A. Yeah.

16 CHAYTOR, Q.C.:

17 Q. So you hadn't been doing that before he became

18 clinical chief?

19 MR. GULLIVER:

20 A. We used to do it, I think, Ms. Chaytor, like,

21 before when Vern Whelan and Dr. Haegert were

22 the former director and clinical chief. We

23 did have - not regular meetings, we did have

24 occasional meetings with the management side

25 and the clinical side as the full group. In

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1 the program structure that evolved from the

2 Health Care Corporation, it was pretty well

3 the leadership team of the lab, the director,

4 the clinical chief, you met monthly with your

5 VP and you kind of keep the big picture things

6 in place.

7 CHAYTOR, Q.C.:

8 Q. And the other - who would Dr. Hutchinson be?

9 MR. GULLIVER:

10 A. Jim is our microbiologist, and he's in charge

11 of infection control. Dr. Whitman would be

12 our divisional chief for hematology. I'm sure

13 Cindy's name is there.

14 CHAYTOR, Q.C.:

15 Q. And Dr. Parai is absent.

16 MR. GULLIVER:

17 A. Sushil was the site chief for pathology,

18 Health Sciences, at the time.

19 CHAYTOR, Q.C.:

20 Q. Okay, and again under budget on page two, "The

21 laboratory budget is over by 144,000 to the

22 end of February. Terry feels that we are

23 doing a reasonably good job in managing our

24 compensation budgets. Terry also pointed out

25 that much of the over expenditure is due to

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1 staff benefits, retro pay, and the increased
 2 regular pay associated with reclassifications
 3 and doctor's salaries. Terry indicated that
 4 the laboratory program budget for 2003/2004
 5 will be reduced by 135,000 if we don't meet
 6 our 2002/2003 commitment. However, the
 7 planned 100,000 reduction for 2003/2004 will
 8 not take place". What's that all about?
 9 MR. GULLIVER:
 10 A. I can't tell you specifics, you know, from - I
 11 mean, you'll see every month in all of our
 12 meetings we're talking about budget.
 13 CHAYTOR, Q.C.:
 14 Q. Yes.
 15 MR. GULLIVER:
 16 A. This is sort of our post HAY, you know, that
 17 there was a certain level of reductions that
 18 was expected for the lab medicine program, and
 19 it was pretty well if we didn't meet those
 20 targets, that our budget would be reduced
 21 further in the next fiscal year to make up for
 22 what we didn't make up for in 2002/2003.
 23 That's pretty well the theme behind it.
 24 CHAYTOR, Q.C.:
 25 Q. Okay, that's what's happening. Under new

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1 business under quality assurance, "Dr.
 2 Hutchinson discussed quality assurance for the
 3 laboratory program. He indicated that in
 4 Ontario, there is an inter-provincial working
 5 group for microbiology. Dr. Hutchinson has
 6 concerns that if our program were required to
 7 be licensed through accreditation, such as the
 8 Ontario QMPLS program, that we may not be
 9 successful. Terry indicated that to date
 10 there is no legislation requiring laboratories
 11 in Newfoundland to be accredited and/or
 12 licensed through such a program. General
 13 discussion took place in regards to an overall
 14 laboratory quality assurance program. It was
 15 suggested that this should be a goal for the
 16 next several years and the laboratory program
 17 should have a quality officer". So in this
 18 time period now, Mr. Gulliver, and the issue
 19 of quality assurance coming up, and Dr.
 20 Hutchinson indicating that he had concerns
 21 that the program wouldn't be able to meet
 22 something such as a review by QMPLS, as was
 23 taking place by this point in time in Ontario,
 24 and this being discussed, what do you remember
 25 about that?

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1 MR. GULLIVER:
 2 A. Well, first of all, Jim is talking about
 3 microbiology, in particular.
 4 CHAYTOR, Q.C.:
 5 Q. Is he, or is he talking about -
 6 MR. GULLIVER:
 7 A. No, no, 100 percent, he was talking about
 8 microbiology. Dr. Whitman, whether it was
 9 this meeting or other, you know, Cindy
 10 expressed concerns too about hematology, which
 11 includes blood banking, you know, all the post
 12 Krever Inquiry issues, and that, you know, we
 13 all knew within the lab in Newfoundland, you
 14 know, we don't have - there is no
 15 accreditation program, there is no licensing
 16 required for labs to practise in this
 17 province. I don't think it's fair to say it's
 18 a gap in our service that we recognize within
 19 the program. However, I don't know if it was
 20 recognized above us within the program.
 21 CHAYTOR, Q.C.:
 22 Q. And what's indicated here to be your
 23 contribution to the discussion, your
 24 indication that, well, there's no legislation
 25 requiring labs in Newfoundland to be

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1 accredited or licensed, were you saying that
 2 in terms of, you know, that you thought it was
 3 a good idea that that would happen?
 4 MR. GULLIVER:
 5 A. Oh, my God, yes, certainly. I mean, I
 6 submitted a document this morning from 1998.
 7 At the time, I'm on our national Board of
 8 Directors from a professional perspective, not
 9 my workplace perspective, but from the
 10 professional perspective, and I certainly was
 11 aware of the lack of standardization - you've
 12 heard lots about lack of standards in testing
 13 protocols, but there's no standard for - there
 14 is no standard where every lab in this country
 15 must achieve in order to receive a stamp of
 16 approval to say that you can now go ahead and
 17 practise laboratory medicine.
 18 CHAYTOR, Q.C.:
 19 Q. Did you have any reason to think - you said
 20 Dr. Hutchinson would have been specifically
 21 referring to microbiology, but did you have
 22 any reason to think that it would have been
 23 anything different for the pathology portion
 24 of the lab?
 25 MR. GULLIVER:

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1 A. In which way?
 2 CHAYTOR, Q.C.:
 3 Q. His concerns that if the program had to meet
 4 such standards as QMPLS would stipulate, that
 5 microbiology, you're saying, is what he's
 6 referring to?
 7 MR. GULLIVER:
 8 A. He was, yes.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. It says the program. So he's referring
 11 to microbiology. Do you have any reason to
 12 believe that it would have been any different
 13 for your pathology division?
 14 MR. GULLIVER:
 15 A. Probably no different for chemistry, cytology,
 16 or genetics either.
 17 CHAYTOR, Q.C.:
 18 Q. All of them would have had difficulty meeting?
 19 MR. GULLIVER:
 20 A. I would feel so, yes.
 21 CHAYTOR, Q.C.:
 22 Q. Meeting the standards of QMPLS?
 23 MR. GULLIVER:
 24 A. Yeah.
 25 CHAYTOR, Q.C.:

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1 Q. General discussion it says did take place in
 2 that time period about an overall laboratory
 3 quality assurance program. So it seems that
 4 the discussion did become broader in terms of
 5 looking at such a program for the overall
 6 board?
 7 MR. GULLIVER:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. Overall program, sorry, and there's indication
 11 that discussion about a quality officer comes
 12 up at that point in time?
 13 MR. GULLIVER:
 14 A. Yeah.
 15 CHAYTOR, Q.C.:
 16 Q. Whatever happened to that idea?
 17 MR. GULLIVER:
 18 A. Well, again, and we're in the time frame, Ms.
 19 Chaytor, where as a program we're actively
 20 putting together sort of a comprehensive three
 21 year plan for lab services where each division
 22 will partake in, and each division would
 23 submit objectives and goals for their
 24 division. For the program, and I think
 25 through that process, you know, we had talked

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1 about looking to see if we can get a full time
 2 manager for quality services. As you're
 3 aware, we got approval in 2007, July.
 4 CHAYTOR, Q.C.:
 5 Q. Yes, and - but was it ever in your three year
 6 plan - would we be able to see anywhere in
 7 your three year plan then on a go forward
 8 basis that you're looking for a quality
 9 officer?
 10 MR. GULLIVER:
 11 A. Again that's probably 100 pages or more. I
 12 don't remember everything that's in it.
 13 However -
 14 CHAYTOR, Q.C.:
 15 Q. Do you remember ever putting that forward?
 16 MR. GULLIVER:
 17 A. I can't remember specifically a quality
 18 manager within the three year plan because the
 19 three year plan is mostly based by division,
 20 by division, by division, by division.
 21 However - I think this is March, 2003. I know
 22 before this here that, you know - between I'm
 23 appointed director and between this time frame
 24 that we're talking about within the lab
 25 program, you know, I had already been turned

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1 down for reassigning my management money for
 2 quality person, and now we're trying to
 3 implement post HAY in cutting even more.
 4 Sometimes you reached a point where you just
 5 knew it was a waste of time to put something
 6 forward.
 7 CHAYTOR, Q.C.:
 8 Q. Mr. Gulliver, you did say in answering my
 9 questions on this that you got it - within
 10 your laboratory medicine program, you
 11 understood that you needed this, but you
 12 didn't think that people above you understood
 13 or got it. Who are you referring to?
 14 MR. GULLIVER:
 15 A. I'm not referring to one individual.
 16 CHAYTOR, Q.C.:
 17 Q. Well, who within the structure, or what
 18 positions?
 19 MR. GULLIVER:
 20 A. I know at some point later on, you know, I do
 21 express my concerns of, you know, the
 22 environment that we practice in in
 23 Newfoundland is not like Ontario or Alberta
 24 where they are very much more regulated and
 25 accredited to Dr. Williams. Dr. Williams

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1 brought my concerns to the executive team, and
 2 this may be somewhere in the beginnings of it,
 3 and again I'm going to go back to what I said
 4 my first day of testifying on Friday, that
 5 it's particular culture that within the health
 6 care system, the cultural setup and
 7 organization of the health care system, the
 8 laboratory is physically located in the bottom
 9 of the building, and the laboratory a lot of
 10 times is the last one that people think about.

11 CHAYTOR, Q.C.:

12 Q. And also you stated that you didn't think it
 13 would have been any different for any of your
 14 divisions; microbiology pathology, chemistry,
 15 wherever, in terms of being able to meet QMPLS
 16 standards?

17 MR. GULLIVER:

18 A. At this time - no, that's not accurate.

19 CHAYTOR, Q.C.:

20 Q. Okay.

21 MR. GULLIVER:

22 A. I think, yes, for most divisions, however, in
 23 blood banking, because it was most Krever
 24 Inquiry, you know, there were national
 25 standards put in place, came out federally

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1 that all provincial governments agreed to.
 2 Certainly by this time our blood banking part
 3 of the laboratory is very heavily regulated.

4 CHAYTOR, Q.C.:

5 Q. Because they've just been through an inquiry.

6 MR. GULLIVER:

7 A. Yeah.

8 CHAYTOR, Q.C.:

9 Q. Why wouldn't the rest of your - why wouldn't
 10 the rest of your divisions have been able to
 11 meet the standards of QMPLS?

12 MR. GULLIVER:

13 A. And again - well, you're using a very broad
 14 term too, the standards of QMPLS. You really
 15 have to be more specific because -

16 CHAYTOR, Q.C.:

17 Q. Well, to be able to go through -

18 MR. GULLIVER:

19 A. They're not going to come in and assess the
 20 quality of every single division. QMPLS, by
 21 and large, are coming in to view your level of
 22 documentation, are you SOPs in place, are they
 23 updated, are they audited, are they regularly
 24 maintained and monitored. Certainly within
 25 all parts of our program you will find, even

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1 at this time, that part of the daily practice
 2 of lab medicine, you incorporate quality
 3 control material, whether it's a positive side
 4 in IHC or whether it's a commercially
 5 purchased quality control sera to do I & R
 6 testing, or cholesterol, or glucose testing.
 7 I mean, that stuff takes place every day.
 8 This is more big picture stuff looking -
 9 comparing our laboratories to the rest of the
 10 country really, that, you know, are we
 11 following the same standards and are we held
 12 to the same standard as what a lab would be in
 13 Ontario or Alberta, who I know through my
 14 professional experience were under much
 15 different regulations and accreditation
 16 processes.

17 CHAYTOR, Q.C.:

18 Q. So it's because they would have already been
 19 subjected to having to go through stringent
 20 regulations and through -

21 MR. GULLIVER:

22 A. They had been by this time for about eight or
 23 nine years.

24 CHAYTOR, Q.C.:

25 Q. So at this point in time then, and this is

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1 March of 2003, would you be aware then that
 2 there weren't standard operating procedures in
 3 the pathology lab at this point in time that
 4 would be able to meet the standards of QMPLS?

5 MR. GULLIVER:

6 A. Well, certainly every lab had operating
 7 procedures and they had protocols that you had
 8 to follow. I mean, the key word there is
 9 standard and were they in a standard template
 10 or standard format, the answer would be no,
 11 and the template format would include
 12 procedures being signed off by authorities and
 13 having a regular date on them when they need
 14 to be rechecked and reviewed to update. That
 15 certainly wasn't in place.

16 CHAYTOR, Q.C.:

17 Q. And those things would have been required to
 18 be able to -

19 MR. GULLIVER:

20 A. And those things certainly would be required
 21 if we were in Ontario or Alberta.

22 CHAYTOR, Q.C.:

23 Q. And the importance of having them standardized
 24 and having them updated on a regular basis,
 25 you would have been aware of the importance of

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1 that, I take it, in 2003?

2 MR. GULLIVER:

3 A. Yes.

4 CHAYTOR, Q.C.:

5 Q. I'm going to talk a little bit now about Dr.

6 Ejeckam.

7 THE COMMISSIONER:

8 Q. Just before you leave the standards business,

9 I'm not sure what message I'm getting from

10 you, Mr. Gulliver. Are you suggesting that,

11 you said every lab had operating procedures,

12 but you acknowledge that there were things

13 lacking in your laboratories that would be

14 required, you would expect, by organizations

15 such as QMPLS who might be doing reviews of

16 laboratories in Ontario where certain

17 standards have been required for a period of

18 time. Are you suggesting that your operating

19 procedures were sufficient that you really

20 didn't need the other--what's your, I'm

21 getting a mixed message, I think, from you

22 about the necessity of this kind of review or

23 what it accomplishes. Are you in favour of,

24 for example, requiring your laboratory to come

25 up to the kinds of standards that we would

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1 anticipate that somebody like QMPLS would

2 require?

3 MR. GULLIVER:

4 A. Oh a hundred percent, yes.

5 THE COMMISSIONER:

6 Q. Okay, and are you suggesting that your

7 laboratory would have come up to those

8 standards had they come in earlier?

9 MR. GULLIVER:

10 A. No, you mean if QMPLS had to come in in 2003?

11 THE COMMISSIONER:

12 Q. Yes.

13 MR. GULLIVER:

14 A. I think what you're seeing in Ms.

15 Wegrynowski's report in 2005, you probably

16 would have found in 2003 also.

17 THE COMMISSIONER:

18 Q. Okay.

19 MR. GULLIVER:

20 A. And I guess I'm trying to--maybe I'm trying to

21 over explain, our laboratories had operating

22 procedures, so there's your method, there's

23 your procedure where the technologist or staff

24 would know, here's the procedure you follow

25 performing this particular, it could be a

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1 stain in pathology, it could be cholesterol

2 test over in chemistry.

3 THE COMMISSIONER:

4 Q. Uh-hm.

5 MR. GULLIVER:

6 A. What we were really lacking is we had no set

7 of templates for things to be written in a

8 standard format; therefore, could lead to

9 misinterpretations if it's not written in a

10 standard format. We had no authority who

11 signed and authorized that this is the

12 operating procedure or this is the policy,

13 whether it's for pathology or chemistry or the

14 Laboratory Medicine Program overall, and there

15 was no review pros. built in to say, well,

16 we've been using this procedure now for five

17 years, is it time to review and update and see

18 if something new or something has changed.

19 And that's only a part of what we say the

20 standard operating procedures, that's the

21 whole format and template and having a

22 document and process in place to update and

23 review. Standard also means that the people

24 performing the procedure are interpreting a

25 policy, are doing it in a standardized format

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1 and you have to make sure. In order to ensure

2 or minimize that risk, it's must better to

3 have things written and presented in a

4 consistent format, as opposed to this

5 procedure manual looks this way, this

6 procedure looks over this way and this

7 procedure looks over this way. You -

8 THE COMMISSIONER:

9 Q. Well it seems to me in what you are now saying

10 is that you recognize the desirability of

11 establishing proper procedures and policies

12 within your lab and ensuring that they are

13 current and regularly reviewed.

14 MR. GULLIVER:

15 A. Yes, all labs, not just pathology.

16 THE COMMISSIONER:

17 Q. Yes, no, no, I'm not suggesting that--we are

18 concentrating on pathology, but that logic

19 would not be limited to pathology.

20 MR. GULLIVER:

21 A. Yeah.

22 THE COMMISSIONER:

23 Q. Okay, thank you.

24 CHAYTOR, Q.C.:

25 Q. So you recognize the importance of it, why

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1 didn't it happen? Why wasn't it done?
 2 MR. GULLIVER:
 3 A. I knew you were going to ask that question
 4 next. Again, I'm going to go back to the
 5 timeframe. You have heard from Dr. Lynn
 6 Morris-Larkin just this morning, today, and
 7 many other witnesses of, you know, the huge
 8 advances we made in our documentation, in not
 9 just writing SOPs and policies and having them
 10 in proper formats, in nice books and they're
 11 available on the internet, on the website for
 12 staff to review. All of that has happened
 13 because we have resources and dedicated people
 14 to do it. It's pretty well impossible and I'm
 15 going to have to say impossible five years ago
 16 in this environment that we had to work under,
 17 under the pressures that we're under for cost
 18 cutting and on top of that, the demands on the
 19 physician side and the population side for
 20 increased services, increased testing, new
 21 genetics testing to be developed for the
 22 province. I mean, that's the dynamics of
 23 working in the laboratory and really the staff
 24 and physicians who work in a laboratory, it
 25 was challenging enough just to come to work

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1 and get the work done that needed to be done
 2 for patient care today and get the results
 3 out. It really--we neither had the resources
 4 to start looking at the documentation and the
 5 auditing and those pieces of a full quality
 6 management program. We ran lots of quality
 7 control, but there certainly was no full
 8 quality management program.
 9 CHAYTOR, Q.C.:
 10 Q. And in terms of the importance that you
 11 appreciated, the importance of this piece, was
 12 that articulated to your superiors, the
 13 importance of having appropriate resources and
 14 funding for those initiatives?
 15 MR. GULLIVER:
 16 A. I don't know if you'll find, you know, written
 17 submission by me, in particular, but
 18 certainly, yes, I mean, this was certainly
 19 brought up the line by myself to my VP. I
 20 don't know how much further Dr. Williams would
 21 have brought it and I think Dr. Williams was
 22 pretty well in favour of such a program for
 23 Newfoundland, you know, I had made contact
 24 with QMPLS and asked them about their programs
 25 they have in Ontario, could they send me

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1 documentation on the kinds of things that
 2 would do if they came into a laboratory to do
 3 an accreditation and a review. I know by
 4 sometime in 2004, I think after our next
 5 CCHSA, you know accreditation, you know, I
 6 expressed my concerns to Dr. Williams that
 7 really, you know, it's a piece of paper but it
 8 really doesn't mean anything.
 9 CHAYTOR, Q.C.:
 10 Q. Yes, in terms of what happened in, I think
 11 that's late, maybe November 2004 in terms of -
 12 MR. GULLIVER:
 13 A. Which is the year after this here.
 14 CHAYTOR, Q.C.:
 15 Q. The window dressing accreditation that you go
 16 through again.
 17 MR. GULLIVER:
 18 A. Yes, but this is not something that was
 19 discussed at this particular meeting and then
 20 you never heard about it anymore.
 21 CHAYTOR, Q.C.:
 22 Q. Right.
 23 MR. GULLIVER:
 24 A. You know, this was certainly something that we
 25 talked about within the program.

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1 CHAYTOR, Q.C.:
 2 Q. So it's an ongoing issue of concern within
 3 your program and it is something that you are
 4 having that discussion with Dr. Williams about
 5 the importance.
 6 MR. GULLIVER:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. And the importance in terms of how it may
 10 impact on patient care, was that clearly
 11 appreciated and articulated to Dr. Williams?
 12 MR. GULLIVER:
 13 A. I have to say no.
 14 CHAYTOR, Q.C.:
 15 Q. And why not?
 16 MR. GULLIVER:
 17 A. I don't think myself and Dr. Cook, you know,
 18 warned Dr. Williams that patient care could be
 19 affected if, you know, if we don't have a
 20 regulated laboratory in Newfoundland similar
 21 to Ontario -
 22 CHAYTOR, Q.C.:
 23 Q. Or a Quality Assurance Program.
 24 MR. GULLIVER:
 25 A. Or Quality Assurance Program where we can

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1 stand up to the standard of Ontario, I don't
 2 think we directly linked it to say, you know,
 3 patient care can be affected. And I don't
 4 think we said that, Ms. Chaytor, because, you
 5 know, I have spent my whole career in medical
 6 laboratory and that's all we do is patient
 7 care. You know, do I have to say to the vice-
 8 president and executive team that, you know,
 9 medical laboratory, every test we perform
 10 could affect patient care. It could affect
 11 the prognosis, it could affect someone's
 12 treatment, it could affect--just preventative
 13 medicine, people just having their routine
 14 cholesterol done. So, you know, that's all we
 15 do is patient care, but I can't say to you I
 16 gave or Dr. Cook gave him something to say and
 17 here's warnings about patient care if we don't
 18 have a full Quality Management Program.
 19 CHAYTOR, Q.C.:
 20 Q. Could we have, please, P-3113? I'm going to
 21 skip ahead here in time, Mr. Gulliver, this is
 22 a memo that you wrote following the
 23 accreditation of 2004 to Dr. Williams. And
 24 you say, "Following our"--and I believe this
 25 to be, I think it's maybe December 8, 2004?

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1 MR. GULLIVER:
 2 A. December, yeah.
 3 CHAYTOR, Q.C.:
 4 Q. "Following our recent meeting in regards to
 5 the accreditation process involving laboratory
 6 medicine, please find attached a copy of the
 7 survey guidelines for the accreditors and a
 8 copy of the pre-survey questionnaire for
 9 laboratory services. As I indicated at our
 10 meeting, I felt the surveyor of the Laboratory
 11 Program was very impressed with our services
 12 and facilities. The surveyor basically toured
 13 St. Clare's and the Health Science's
 14 laboratories and asked very few questions.
 15 The current accreditation standards under the
 16 AIMS system, relies on the clinical team's
 17 input to help assess laboratory services, in
 18 addition to the on-site visit. While the
 19 survey process is, in my opinion, of less
 20 detail than prior surveys in regards to
 21 laboratory services, I still feel that it was
 22 a useful exercise. For your information, the
 23 Laboratory Program also participates in
 24 accreditation for the Resident Training
 25 Program by the Royal College of Physicians and

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1 the College of the North Atlantic and Michener
 2 Institute for Medical Laboratory Technologists
 3 Clinical Training. In addition to the
 4 laboratories successfully completing all of
 5 the above formal accreditation processes, we
 6 also voluntarily participate in multiple
 7 proficiency testing programs from outside
 8 agencies that assess our accuracy and quality
 9 of testing. While there is no legislation in
 10 Newfoundland requiring medical laboratories to
 11 be licensed, we voluntarily adhere to
 12 international standards of practice, as
 13 outlined by the NCCLS and also national
 14 standards established by the CSMLS." And
 15 first of all, Mr. Gulliver, perhaps you can
 16 tell us what is the NCCLS?
 17 MR. GULLIVER:
 18 A. Oh, that's the National Conjoint Committee on
 19 Laboratory Standards.
 20 CHAYTOR, Q.C.:
 21 Q. And the CSMLS, if you can remind us what that
 22 is?
 23 MR. GULLIVER:
 24 A. Canadian Society for Medical Laboratory Signs,
 25 that's our national, professional certifying

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1 body.
 2 CHAYTOR, Q.C.:
 3 Q. And Mr. Gulliver, you think Dr. Williams,
 4 reading this, would walk away with any concern
 5 that perhaps your laboratory is lacking in any
 6 way in terms of its quality assurance
 7 measures.
 8 MR. GULLIVER:
 9 A. I don't know what he walked away with, but
 10 this was an outcome of discussion with myself
 11 and him and Dr. Cook where I'm expressing to
 12 Dr. Williams that we just finished our
 13 accreditation. I know there are accreditors
 14 that said the laboratory passed accreditation
 15 and, you know, I'm pretty well relaying to him
 16 that, but you realize the accreditation is
 17 pretty well, they come in, they talk to me for
 18 half a day, walked around the labs, they said
 19 hello to a few staff, looked around that
 20 pretty well was the accreditation process.
 21 With the exception of before they arrived,
 22 there was some basic questions we had to
 23 answer, the lab services, which is the pre-
 24 site visit. From that discussion, Dr.
 25 Williams asked, well, does the lab

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1 participate--does anybody from outside come in
 2 and review our lab for any reason? And I
 3 said, well, yes, you know, we do have a full
 4 accredited pathology training program and
 5 during their cycle, the Royal College of
 6 Physicians come in and they do review the lab,
 7 but they're not reviewing the lab in what you
 8 perceive reviewing the lab. They're reviewing
 9 what we have in place for the training program
 10 for residents. The other two is, sort of,
 11 CONA, the ongoing accreditation we do with
 12 them for training of medical lab technologists
 13 and the other one is the Michener Institute in
 14 Toronto. We send two lab technologists every
 15 year to the Michener Institute for genetics
 16 training. It's a two year program, post
 17 appellant program. And we were, during their
 18 process, they came in to assess our genetics
 19 laboratory to ensure that we can provide
 20 clinical training to students in that program
 21 CHAYTOR, Q.C.:
 22 Q. What was the purpose of this memo? Why did
 23 you write this to Dr. Williams?
 24 MR. GULLIVER:
 25 A. I think for two reasons; one to make sure he

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1 understood that the current laboratory
 2 accreditation process really is not an
 3 accreditation similar to what the rest of the
 4 country, what most provinces in the rest of
 5 the country were being held up to. And I
 6 think around this point, I may have made
 7 inquiries to QMPLS to see, with the view, at
 8 some point, if we could actually, sort of,
 9 like, get a contract with them, where we could
 10 second them to do an accreditation review
 11 process for--at the time, Health Care
 12 Corporation.
 13 THE COMMISSIONER:
 14 Q. Your purpose in writing this memo was to
 15 convey to Dr. Williams the limitations in the
 16 -
 17 MR. GULLIVER:
 18 A. Well, I have conveyed that in speaking to him
 19 in our meeting.
 20 THE COMMISSIONER:
 21 Q. Yes, and they you follow it up with this. Was
 22 that the way I understand it happened? The
 23 sequence, you had a discussion with Dr.
 24 Williams about the process and then you follow
 25 it up with this memo?

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1 MR. GULLIVER:
 2 A. Well, he asked me could I do up a memo that
 3 would include anything that the laboratory
 4 participates in, any kind of accreditation
 5 process. And this is pretty well--well, we do
 6 CCHSA, but I'm putting a bit more into this,
 7 say, well, it's useful, but it's not really
 8 the best and here's other things that we
 9 participate in. He didn't ask me to do a memo
 10 to express my direct concern about lack of
 11 accreditation for labs in Newfoundland, in
 12 particular, Health Care Corporation.
 13 THE COMMISSIONER:
 14 Q. But you're telling us that you did do that in
 15 -
 16 MR. GULLIVER:
 17 A. In our meetings.
 18 THE COMMISSIONER:
 19 Q. - your meetings.
 20 MR. GULLIVER:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. So, in your meeting, you expressed those
 24 concerns and then he asked you to do a memo
 25 outlining what, in fact, you do do in the way

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1 of -
 2 MR. GULLIVER:
 3 A. In the absence of, really, in the absence of
 4 having no real accreditation process, what
 5 does the laboratory participate in? Who comes
 6 in to review the lab?
 7 CHAYTOR, Q.C.:
 8 Q. And you weren't asked to articulate, in
 9 writing, any of your concerns about what else
 10 should be happening or any of the shortcomings
 11 in what, in fact, was happening?
 12 MR. GULLIVER:
 13 A. No, not from writing. We talked about it in
 14 our monthly meetings and regular meetings.
 15 And you know, I think I was the one who told
 16 Dr. Williams that, you know, like Ontario does
 17 have standards and they have QMPLS. And I
 18 think he asked me to make contact to
 19 investigate and give him information on what
 20 is QMPLS.
 21 CHAYTOR, Q.C.:
 22 Q. And why wouldn't that be in writing as well?
 23 MR. GULLIVER:
 24 A. At this point in time?
 25 CHAYTOR, Q.C.:

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1 Q. Yes.
 2 MR. GULLIVER:
 3 A. No, I think that comes after.
 4 CHAYTOR, Q.C.:
 5 Q. When I read this, I was left, you know,
 6 everything is good, there's nothing lacking
 7 and I mean, you end, in your last paragraph
 8 with, in addition to the laboratory
 9 successfully completing all of the above -
 10 MR. GULLIVER:
 11 A. But those accreditation--but these three
 12 accreditation processes are training programs.
 13 They're not coming into assess the quality of
 14 your work or do you have SOPs or policies
 15 written. They're saying that you have a
 16 clinical--the scope of practice is enough that
 17 you can train pathology residents, general
 18 registered technologists and genetics
 19 technologists. They're not an accreditation
 20 process to review your policy manuals or
 21 documentation.
 22 CHAYTOR, Q.C.:
 23 Q. But that was discussed with Dr. Williams in
 24 the meeting prior to you writing this memo?
 25 MR. GULLIVER:

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1 A. No, what was discussed with him was in
 2 particular the CCHSA accreditation.
 3 CHAYTOR, Q.C.:
 4 Q. But did you also discuss with him the fact
 5 that there are other things out there for
 6 other provinces, but that's nowhere near
 7 what's happening with this accreditation
 8 process that we're going through.
 9 MR. GULLIVER:
 10 A. Yes, I did.
 11 CHAYTOR, Q.C.:
 12 Q. And that you have concerns as to what, in
 13 fact, is not being reviewed externally?
 14 MR. GULLIVER:
 15 A. I guess I'd let him be aware, he's my VP that
 16 while this is the accreditation that we're
 17 undergoing with CCHSA, it really is not a full
 18 accreditation process and that our province
 19 has no legislation requiring us to do any kind
 20 of accreditation as Ontario and Alberta has
 21 legislation requiring labs to be, not just
 22 accredited, labs had to be licensed and
 23 through that process in Ontario, Alberta, you
 24 had to be licensed, every staff member and
 25 technologist and physician has got to

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1 participate in so many continuing education
 2 hours over a three year period and you've got
 3 to prove that to the licensing process. So,
 4 that's the things I was making him be aware
 5 of.
 6 THE COMMISSIONER:
 7 Q. Ms. Chaytor, it's past the -
 8 CHAYTOR, Q.C.:
 9 Q. Thank you, I'll take up with--start the part
 10 on Dr. Ejeckam tomorrow then.
 11 THE COMMISSIONER:
 12 Q. All right. A couple of administration points,
 13 I'm advised that there is a package for all
 14 counsel before you leave. I'm sure there will
 15 be somebody near to the door, if not at the
 16 door to provide that for you, and I'm advised
 17 by counsel for the Commission also that you're
 18 being very co-operative and agreeing to have
 19 an extra long session tomorrow, so that we can
 20 hopefully keep to our schedule for this week.
 21 I thank you all for your co-operation in that
 22 respect. 9:30 in the morning, 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 7th day of October, A.D., 2008 before
 6 the Honourable Justice Margaret A. Cameron,
 7 Commissioner, at the Commission of Inquiry, St.
 8 John's, Newfoundland and Labrador and was
 9 transcribed by me to the best of my ability by
 10 means of a sound apparatus.
 11 Dated at St. John's, Newfoundland and Labrador
 12 this 7th day of October, A.D., 2008
 13 Judy Moss

Inquiry on Hormone Receptor Testing

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Inquiry on Hormone Receptor Testing

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