

<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;">June 3, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Stephen Mills Her Majesty in Right of NL</p> <p>Jane Hennebury Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Pamela Taylor Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Stacey O’Dea. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBIT P-1565 Pg. 127</p> <p>EXHIBITS P-1570 THROUGH TO P-1603 INCLUSIVE Pg. 131</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>MS. SUSAN BONNELL - RESUMES THE STAND</p> <p>Examination by Jennifer Newbury - Cont’d Pgs. 4 - 60 Examination by Mark Pike Pgs. 60 - 64 Examination by Daniel Simmons Pgs. 64 - 113 Re-examination by Bernard Coffey, Q.C. Pgs. 113 - 129</p> <p>DR. GERSHON EJECKAM - SWORN</p> <p>Examination by Bernard Coffey, Q.C. Pgs. 129 - 296</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER: 2 Q. Please be seated. Ms. Newbury. 3 MS. SUSAN BONNELL, EXAMINATION BY MS. JENNIFER NEWBURY 4 (CONTINUED) 5 MS. NEWBURY: 6 Q. Thank you. Can we go to P-0616 please? This 7 is the letter that you had drafted. I 8 understand the intention was that this could 9 be used for the NLMA website as a letter for 10 physicians. And we looked at that yesterday. 11 Paragraph 6 of the letter states that "Only a 12 small percentage of breast cancer patients may 13 be affected by this retesting. Approximately 14 75 percent of all breast cancer patients 15 already tested positive for ER and PR 16 receptors. From the results that we have 17 retested thus far we are anticipating that 18 less than 10 percent of all breast cancer 19 patients will convert from a negative to a 20 positive and may experience a change or 21 addition to their cancer therapy. Patients 22 with positive ER and PR results or those who 23 previously received hormone therapy for their 24 cancer are not impacted." When you drafted 25 that letter there, was this a concept that you</p>

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1 came up with yourself or is that information
 2 that had been provided to you by Dr. Williams
 3 or someone else?
 4 MS. BONNELL:
 5 A. This was the information at--what is the date
 6 on this letter, Ms. Newbury?
 7 MS. NEWBURY:
 8 Q. That date, the e-mail, I believe, is October
 9 the 4th.
 10 MS. BONNELL:
 11 A. October 4th, yeah. At that point in time I
 12 guess that's what we believed might be the
 13 case, although I don't--I think I indicated to
 14 Mr. Coffey that I don't believe this letter
 15 was ever sent.
 16 MS. NEWBURY:
 17 Q. Right. Yes, I understand that. But at the
 18 time you were drafting it, it would
 19 potentially be placed on the website?
 20 MS. BONNELL:
 21 A. Yes.
 22 MS. NEWBURY:
 23 Q. Okay. And this was shortly before the various
 24 media reports dated October 5th up through to
 25 October 14th where Dr. Williams made similar

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1 comments about the 10 percent -
 2 MS. BONNELL:
 3 A. Yes.
 4 MS. NEWBURY:
 5 Q. - are expected to convert. And you'd
 6 indicated that you later suggested to Dr.
 7 Williams that he should stay away from using
 8 that percentage figure as it might cause -
 9 MS. BONNELL:
 10 A. Yes.
 11 MS. NEWBURY:
 12 Q. - some confusion. You didn't think about that
 13 at the time you were preparing this letter,
 14 were you?
 15 MS. BONNELL:
 16 A. No, I think that's where, that's where--you
 17 know, what I indicated to Dr. Williams was
 18 that the 10 percent was being misinterpreted.
 19 MS. NEWBURY:
 20 Q. Okay.
 21 MS. BONNELL:
 22 A. And that it was best just to avoid numbers as
 23 we were trying to predict, anyway, and had no
 24 way of knowing. The test results may have all
 25 come back with no change. I mean, we had no

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1 way of knowing. They may have all come back
 2 all changed. At that point it would all be
 3 supposition.
 4 MS. NEWBURY:
 5 Q. Sure.
 6 MS. BONNELL:
 7 A. And in the meantime this letter was not set,
 8 to my knowledge.
 9 MS. NEWBURY:
 10 Q. Right, okay. But you hadn't tuned into the
 11 fact that this could possibly be
 12 misinterpreted when you prepared this draft?
 13 MS. BONNELL:
 14 A. The letter wasn't sent, Ms. Newbury.
 15 MS. NEWBURY:
 16 Q. No.
 17 MS. BONNELL:
 18 A. So, you know, in the end it's not part of what
 19 happened, anyway. But I don't recall where my
 20 head was when that particular memo was written
 21 or letter was written, drafted.
 22 MS. NEWBURY:
 23 Q. With regard to management of the ER/PR
 24 problem, generally speaking, you'd mentioned
 25 that in your view it was Dr. Williams who

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1 handled that until his retirement?
 2 MS. BONNELL:
 3 A. Yes.
 4 MS. NEWBURY:
 5 Q. And subsequent to his retirement, who took
 6 over management of the ER/PR issues?
 7 MS. BONNELL:
 8 A. After he retired?
 9 MS. NEWBURY:
 10 Q. Yes.
 11 MS. BONNELL:
 12 A. It would have been Dr. Howell.
 13 MS. NEWBURY:
 14 Q. Okay. Did he take over all aspects, all of
 15 the same aspects of the ER/PR issues that Dr.
 16 Williams had previously been handling?
 17 MS. BONNELL:
 18 A. He took over Dr. Williams portfolio, so it
 19 would be my understanding that he did.
 20 MS. NEWBURY:
 21 Q. Okay. You're not aware that any part of the
 22 ER/PR problem was -
 23 MS. BONNELL:
 24 A. I know that Ms. Pilgrim became more involved
 25 when Dr. Williams left the organization, but

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1 Dr. Williams had quality as part of his
2 portfolio and Dr. Howell did not.
3 MS. NEWBURY:
4 Q. Okay. Were there any other differences in
5 terms of what Dr. Howell had assumed in terms
6 of management of the ER/PR issues?
7 MS. BONNELL:
8 A. I can't speak to that, Ms. Newbury.
9 MS. NEWBURY:
10 Q. Now, there was some evidence given by you
11 about your communication with Carolyn Chaplin
12 in around July 22nd and 23rd. And you'd
13 indicated at that time there was some to and
14 fro, you thought that the problem was serious
15 and you had contacted Ms. Chaplin just to give
16 her the heads up that there might be some
17 press coming up in the next few days?
18 MS. BONNELL:
19 A. I think that was actually the week before
20 that.
21 MS. NEWBURY:
22 Q. Okay.
23 MS. BONNELL:
24 A. The meeting with the minister, I believe, was
25 on the 23rd. Am I correct in that?

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1 MS. NEWBURY:
2 Q. Correct.
3 MS. BONNELL:
4 A. So it would have been the week before that.
5 MS. NEWBURY:
6 Q. The week before that, July 19th, I believe was
7 the date.
8 MS. BONNELL:
9 A. Okay.
10 MS. NEWBURY:
11 Q. And then when you--I think, or maybe it was
12 July the 18th. But in the next couple of days
13 you had gone back and forth and you had
14 indicated that the problem reverted back to
15 being more serious. And I understood from
16 your evidence that you did not call Ms.
17 Chaplin back to tell her that it was now
18 considered more serious because you were not
19 planning to do a press conference?
20 MS. BONNELL:
21 A. I believe that following the meeting with the
22 minister on the 23rd, if I'm right on my date,
23 really what happened at that meeting was that
24 we made a decision that we weren't going to
25 make a decision at that point. Do you know

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1 what I mean? Like, at that meeting we said
2 that the decision on what we would do, press
3 conference, whatever option it was, was
4 delayed until we could gather more
5 information, so in the subsequent days we
6 gained new information. There was a meeting
7 on the 1st of August in the organization at
8 which point we made a decision to redo--well,
9 it was at that point or around that point that
10 the decision was made to do, in fact, what we
11 did, you know, the group that we were going to
12 do and that we weren't going to use our own
13 internal system to redo the testing, that we
14 would halt, all those sort of decisions were
15 sort of fermented at that time. And I did not
16 contact Ms. Chaplin myself, but I was aware
17 that the organization was in contact with the
18 department through Dr. Williams and Mr. Tilley
19 and others.
20 MS. NEWBURY:
21 Q. So you didn't think at the time that the
22 impression that you left with Ms. Chaplin with
23 when you last spoke with her is that this is
24 less serious, perhaps I should call her back
25 even though we don't plan to do a press

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1 conference, perhaps I should call her back
2 just to let her know that -
3 MS. BONNELL:
4 A. No, no, I -
5 MS. NEWBURY:
6 Q. - we again think this is more serious?
7 MS. BONNELL:
8 A. No.
9 MS. NEWBURY:
10 Q. Okay. Is there any reason why you would not
11 have thought it important to do that?
12 MS. BONNELL:
13 A. Because it wasn't my role do to that. If I was
14 asked to do that, I would have done that, but
15 it was my understanding that someone else was
16 making contact with the department other than
17 myself to Ms. Chaplin.
18 MS. NEWBURY:
19 Q. But you had contacted her initially. Was that
20 on your own initiative that you contacted Ms.
21 Chaplin?
22 MS. BONNELL:
23 A. No. I was asked to call Ms. Chaplin.
24 MS. NEWBURY:
25 Q. Okay. And did you know that someone would be

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1 calling her back to let her know that the
 2 problem was again more serious?
 3 MS. BONNELL:
 4 A. Ms. Chaplin is within the department, so we
 5 would assume that she would hear that through
 6 her own -
 7 MS. NEWBURY:
 8 Q. If I could have Exhibit 0361, please? This is
 9 an e-mail that you forwarded to Joan Dawe and
 10 George Tilley and copied to Dr. Williams about
 11 an interview. You've already been shown this
 12 and given some evidence about that. Do you
 13 know how the interview with Ms. Kearney came
 14 about, whether that was something arranged by
 15 Eastern Health?
 16 MS. BONNELL:
 17 A. I don't believe it was arranged by Eastern
 18 Health. If we don't have a record of the call
 19 coming in to us, it would not have been
 20 arranged by us. I don't believe it was
 21 arranged by us.
 22 MS. NEWBURY:
 23 Q. Okay. And how did you become involved in this
 24 issue?
 25 MS. BONNELL:

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1 A. There are e-mails prior to this one in which
 2 Ms. Dawe had heard about it occurring. We then
 3 had subsequent phone calls with Ms. Kearney
 4 because she was concerned about being put in a
 5 situation of having to address ER/PR, given
 6 her role within the organization. And we made
 7 some calls on her behalf and were--she called
 8 Mr. Dawe and together they made a decision
 9 that they weren't going to be talking about
 10 ER/PR, so that was my only involvement. She
 11 wanted--I remember her wanting to not do it
 12 because she was afraid of being questioned on
 13 something which she knew nothing about and my
 14 encouraging her to do it because I felt that
 15 it was something that she really wanted to do
 16 and it was a topic, I think this October might
 17 be breast cancer awareness month, is it?
 18 MS. NEWBURY:
 19 Q. Um-hm.
 20 MS. BONNELL:
 21 A. And it was a really good opportunity to get
 22 messages out about breast screening, and so
 23 everybody involved, Mr. Dawe, Ms. Kearney and
 24 Anne Budgell were all committed to talking on
 25 that topic.

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1 MS. NEWBURY:
 2 Q. Okay. Now I see there on the second line it
 3 states, "We have prepared a few messages in
 4 the event that she gets calls regarding this
 5 issue."
 6 MS. BONNELL:
 7 A. Um-hm.
 8 MS. NEWBURY:
 9 Q. And I assume that refers to the ER/PR issue?
 10 MS. BONNELL:
 11 A. Yes.
 12 MS. NEWBURY:
 13 Q. Okay. And what form were those messages
 14 provided to her?
 15 MS. BONNELL:
 16 A. I don't recall. If they're not, if they're
 17 not in an e-mail, then it might have been that
 18 we gave her a few things that she might say if
 19 she were called.
 20 MS. NEWBURY:
 21 Q. So that would have been verbally as opposed to
 22 in writing?
 23 MS. BONNELL:
 24 A. Yeah.
 25 MS. NEWBURY:

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1 Q. And do you -
 2 MS. BONNELL:
 3 A. There was probably--you know, if you have--you
 4 know, I would suspect what I would have said
 5 to her is something like, you know, I'm not a
 6 spokesperson on this issue, if you have
 7 questions, I'd suggest you call the patient
 8 relations officer, that sort of a general--
 9 that would have been the kind of thing we
 10 would have given her and others who may be
 11 questioned on ER/PR.
 12 MS. NEWBURY:
 13 Q. Okay. And were you the one that gave that
 14 message to Ms. Kearney?
 15 MS. BONNELL:
 16 A. I don't recall if it was me or Ms. Thomas. I
 17 think it was me.
 18 MS. NEWBURY:
 19 Q. Okay.
 20 MS. BONNELL:
 21 A. I'm trying to--it's two, three years ago now.
 22 MS. NEWBURY:
 23 Q. Sure.
 24 MS. BONNELL:
 25 A. I don't remember. But I do remember having a

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1 conversation with her at that time.
 2 MS. NEWBURY:
 3 Q. Okay. And do you know if anyone else within
 4 Eastern Health would have had any occasion to
 5 talk to her about this particular interview?
 6 MS. BONNELL:
 7 A. I doubt it very much.
 8 MS. NEWBURY:
 9 Q. Okay. Thank you. Now, it was your evidence,
 10 and you've spoken about this a couple of
 11 times, that a strategic plan would have been
 12 advisable and that as part of that strategic
 13 plan you would have included communication
 14 with advocacy groups such as the Canadian
 15 Cancer Society. And that would be proactive
 16 communication, I assume, as opposed to
 17 reactive communication?
 18 MS. BONNELL:
 19 A. Yes.
 20 MS. NEWBURY:
 21 Q. And would that communication be for providing
 22 information to those advocacy groups or would
 23 it also seek input or feedback from these
 24 groups?
 25 MS. BONNELL:

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1 A. It could be both.
 2 MS. NEWBURY:
 3 Q. Okay. Generally speaking, what would you do
 4 in a strategic plan, would you--would it be a
 5 two-way conversation?
 6 MS. BONNELL:
 7 A. We always encourage two-way communication. We
 8 always encourage involvement so that
 9 stakeholders feel engaged in an issue. So it
 10 would be hard to predict what I would -
 11 MS. NEWBURY:
 12 Q. So even though that you didn't have a
 13 strategic plan in place, then, you know,
 14 including dealing with the Cancer Society as
 15 an advocacy group, in 2005 Peter Dawe was seen
 16 in the media on behalf of the Canadian Cancer
 17 Society providing some of his views and
 18 concerns about the ER/PR issue. Why not, at
 19 that time, whether you have a strategic plan
 20 or not, take an initiative to involve the
 21 Cancer Society in -
 22 MS. BONNELL:
 23 A. Well, I believe he -
 24 MS. NEWBURY:
 25 Q. - to engage at that point in time?

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1 MS. BONNELL:
 2 A. - he was briefed numerous times. Maybe--well,
 3 I don't know if I should say numerous. I
 4 remember at least two, maybe three times in
 5 which I was involved in briefings. And I know
 6 that early in October Mr. Williams--Dr.
 7 Williams and Mr. Tilley informed me that they
 8 had done a briefing with him at that point.
 9 MS. NEWBURY:
 10 Q. And you were attending these meetings
 11 yourself?
 12 MS. BONNELL:
 13 A. I didn't attend that one, but I did attend
 14 others, yeah.
 15 MS. NEWBURY:
 16 Q. Okay. During those meetings did you ever
 17 initiate or seek feedback from them, you know,
 18 please tell us what the concerns are that
 19 you're hearing, or was it simply a matter of
 20 providing information that you saw fit to
 21 provide to the Cancer Society at that time
 22 just to update them on what the status was?
 23 MS. BONNELL:
 24 A. I wasn't involved in that briefing, so I don't
 25 know what was said in that briefing to Mr.

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1 Dawe.
 2 MS. NEWBURY:
 3 Q. So you have no idea what the communication
 4 was?
 5 MS. BONNELL:
 6 A. No. I think he was given information on what
 7 was happening at that point in time. Whether
 8 he was asked for feedback or not, I don't
 9 know.
 10 MS. NEWBURY:
 11 Q. And given your role in communications, do you
 12 think it would have been important to try to
 13 find out? These are the types of things I
 14 understand you would do in a strategic plan,
 15 you would have communication with the group -
 16 MS. BONNELL:
 17 A. Um-hm.
 18 MS. NEWBURY:
 19 Q. Even though that you're aware some other
 20 people in your organization might be briefing
 21 him, do you think at that point in time it
 22 might have been appropriate to take it a step
 23 further and try to open the lines of
 24 communication from the communications
 25 department perspective with the Cancer

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1 Society?
 2 MS. BONNELL:
 3 A. Well, the communications department generally
 4 doesn't have that kind of role. We're
 5 consultants and advisors. We don't generally
 6 speak on behalf of the organization. Perhaps
 7 in some organizations that's how it works, but
 8 at Eastern Health it doesn't. For example,
 9 the board of trustees holds numerous
 10 stakeholder meetings across the region and
 11 it's, that's the board's role to do that and
 12 they do that and it's not my role to interject
 13 myself into that process and be the one who's
 14 doing the communication. I may advise the
 15 board, but in the end they're the ones who are
 16 doing that and taking that feedback and using
 17 it. So, even the briefings that I have
 18 attended with Mr. Dawe, I've been there as an
 19 advisor to--I remember one we gave him late in
 20 May that I was there as an advisor to Dr.
 21 Howell, if there were questions about the
 22 media coverage or the briefing that Mr. Dawe
 23 had to answer. I wasn't there to speak on
 24 behalf of the organization.
 25 MS. NEWBURY:

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1 Q. That was late May, 2007?
 2 MS. BONNELL:
 3 A. Yes, I think so, yes.
 4 MS. NEWBURY:
 5 Q. Okay. But when you've spoken about the
 6 strategic communications plan, I was under the
 7 impression that there would be more
 8 communication directly with the advocacy
 9 groups. Perhaps you can explain what would
 10 actually be done with the strategic plan?
 11 MS. BONNELL:
 12 A. No, you're right in that a plan, but a plan
 13 directs more than the activities. In fact, a
 14 plan directs the activities of the
 15 organization and the people who work for the
 16 organization. It's not a plan to direct the
 17 actions of the communications department,
 18 specifically, although a lot of the outcomes
 19 or objectives will involve your communications
 20 people in helping to develop them. So if a
 21 strategy is to hold a town hall meeting, for
 22 example, that's a strategy that the
 23 responsibility for that falls within one of
 24 the portfolios, a director who's responsible
 25 for doing that and making that happen and

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1 being the spokesperson and conducting that
 2 meeting. The communications department's role
 3 in that is to help facilitate, it's to
 4 organize, to help prepare messaging, to make
 5 sure there's enough chairs in the room, to
 6 make sure the media are invited, that, you
 7 know, it's a facilitation role.
 8 MS. NEWBURY:
 9 Q. So the strategic plan for communications that
 10 you noted was absent in this case -
 11 MS. BONNELL:
 12 A. Would be an organizational plan.
 13 MS. NEWBURY:
 14 Q. Okay. So you would not be directly involved
 15 in the communications with the stakeholders,
 16 the stakeholder mapping that you mentioned,
 17 you would just indicate to other members or
 18 other departments of the organization this is
 19 what you should now do?
 20 MS. BONNELL:
 21 A. I think I indicated to Mr. Coffey a couple of
 22 days go that it's not my role within the
 23 organization to be a spokesperson for the
 24 organization, it's not my role to be a leader
 25 in actually conducting the communications.

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1 It's a facilitation role and a building role
 2 and a consultancy role and an advisory role.
 3 MS. NEWBURY:
 4 Q. And part of that role is to make sure that it
 5 gets done?
 6 MS. BONNELL:
 7 A. Yes, indeed.
 8 MS. NEWBURY:
 9 Q. If you see that there's a need for
 10 communication with -
 11 MS. BONNELL:
 12 A. Yes.
 13 MS. NEWBURY:
 14 Q. - stakeholders, then -
 15 MS. BONNELL:
 16 A. It's to encourage that those things get done,
 17 yes.
 18 MS. NEWBURY:
 19 Q. And as part of that strategic communications
 20 plan, do you think that there is a role for
 21 the communications department or others in the
 22 organization making sure that they understand
 23 what the issues and concerns are of the
 24 various advocacy groups?
 25 MS. BONNELL:

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1 A. Yes, I do.
 2 MS. NEWBURY:
 3 Q. And if you have a formal plan or not, I take
 4 it that you can still seek feedback and input
 5 from advocacy groups, even if you haven't had
 6 the opportunity or had overlooked getting a
 7 strategic plan in place?
 8 MS. BONNELL:
 9 A. Yes, of course.
 10 MS. NEWBURY:
 11 Q. Okay, and did you at any time after October
 12 2005, when Mr. Dawe, on behalf of the Cancer
 13 Society was reporting in the media, did you
 14 take an effort to find out yourself what
 15 exactly the issues and concerns were of the
 16 Cancer Society?
 17 MS. BONNELL:
 18 A. I was certainly informed by individuals who
 19 work more closely with Mr. Dawe, individuals
 20 from the Cancer Program, doctors in the Cancer
 21 Program, leaders in the Cancer Program who
 22 work more closely with him, what some of his
 23 concerns and issues were, yes.
 24 MS. NEWBURY:
 25 Q. Okay, but not from Mr. Dawe? He might have a

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1 different perspective as an advocate for
 2 cancer patients.
 3 MS. BONNELL:
 4 A. Well, if Mr. Dawe is speaking to Ms. Pilgrim,
 5 for example, and expressing his concerns to
 6 Ms. Pilgrim or Dr. Williams or Dr. Howell, and
 7 those concerns are expressed to me, then I
 8 have some understanding of what the concerns
 9 are. I believe I've already indicated that
 10 one of the things that we should have done
 11 following the announcement and in the period
 12 of time while the panelling was being done was
 13 do more open communications with the patients
 14 who were involved and the Cancer Society, I
 15 guess, would have some role and involvement
 16 there, but I guess our thinking, in
 17 retrospect, is that we should have had an
 18 opportunity for patients to come in and be
 19 informed of what the process was in that 2006
 20 year.
 21 MS. NEWBURY:
 22 Q. After the first briefing that you mentioned
 23 that you did not attend, and that was Mr.
 24 Tilley's briefing with Mr. Dawe?
 25 MS. BONNELL:

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1 A. Yes, I don't even know if it was a briefing,
 2 phone call, if they brought him in for a
 3 meeting, I'm not sure. I was told that they
 4 had met with Mr. Dawe.
 5 MS. NEWBURY:
 6 Q. And you didn't seek a report of what happened
 7 in that meeting?
 8 MS. BONNELL:
 9 A. From my CEO, no.
 10 MS. NEWBURY:
 11 Q. Or indirectly through someone else who might
 12 know what had happened?
 13 MS. BONNELL:
 14 A. No, I was told that Mr. Dawe was brought in
 15 and told what was going on, but I didn't ask
 16 my CEO for a report, no.
 17 MS. NEWBURY:
 18 Q. And he didn't offer one?
 19 MS. BONNELL:
 20 A. Other than that, no.
 21 MS. NEWBURY:
 22 Q. If I could have Exhibit 0304, please? This is
 23 the memo that you've seen a few times, July
 24 22nd 2005. This is page three of the exhibit,
 25 and there's a reference there at the bottom of

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1 the page, the fourth bullet, and then another
 2 indentation, the third bullet, you've
 3 indicated there "do we have the potential to
 4 ignite breast cancer advocacy groups?"
 5 If I could have Exhibit 1500, please?
 6 I'm just going to point out a couple of things
 7 and ask a couple of questions. This is an e-
 8 mail that you had forwarded to Heather Predham
 9 on August 8th, 2006, and you indicate there -
 10 MS. BONNELL:
 11 A. I think this was an e-mail from Ms. Pilgrim,
 12 wasn't it? Yes.
 13 MS. NEWBURY:
 14 Q. It's an e-mail from--yes, it starts as an e-
 15 mail from Patricia Pilgrim.
 16 MS. BONNELL:
 17 A. Yes.
 18 MS. NEWBURY:
 19 Q. To Leona Barrington, Heather Predham and to
 20 yourself and copied to Dianne Smith.
 21 MS. BONNELL:
 22 A. Yes.
 23 MS. NEWBURY:
 24 Q. And this is regarding a call that had been
 25 placed to Peter Dawe, even though he's on

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1 annual leave.
 2 MS. BONNELL:
 3 A. Right.
 4 MS. NEWBURY:
 5 Q. And then you respond to Heather, Ms.
 6 Barrington and Ms. Smith, I'm not sure if it
 7 ever got sent back to Ms. Pilgrim.
 8 MS. BONNELL:
 9 A. Dianne Smith is Pat Pilgrim's assistant.
 10 MS. NEWBURY:
 11 Q. So she would have received it, okay.
 12 MS. BONNELL:
 13 A. Yes.
 14 MS. NEWBURY:
 15 Q. And in that, you indicate "why don't you e-
 16 mail him?" and I think that refers to Mr. Dawe
 17 -
 18 MS. BONNELL:
 19 A. Um-hm.
 20 MS. NEWBURY:
 21 Q. - "and let him know there have been some new
 22 developments in the media and that if he has
 23 any questions or concerns, he can get in touch
 24 with you. Put the ball back in his court."
 25 MS. BONNELL:

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1 A. Um-hm.
 2 MS. NEWBURY:
 3 Q. The next paragraph, "perhaps you could also
 4 tell him that we are nearing completion re:
 5 the review of ER/PR tests and should be in a
 6 position to talk about causative factors as
 7 well as operational changes, solutions to
 8 address these very soon. I think the offer to
 9 keep him in the loop is as important, if not
 10 more important, than the actual information we
 11 can provide."
 12 And if I could have Exhibit 0181, please?
 13 Sure, if you wanted to go back. I think Ms.
 14 Bonnell wanted to refer back to that.
 15 MS. BONNELL:
 16 A. There's an e-mail that follows this in which
 17 Ms. Pilgrim is trying to figure out what to do
 18 and is not--her concern is that he's on annual
 19 leave.
 20 MS. NEWBURY:
 21 Q. Sure.
 22 MS. BONNELL:
 23 A. And so I guess we felt we had information that
 24 we wanted to share with him. What I'm
 25 suggesting to her at this point is e-mail him,

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1 let him know there's more information that you
 2 want to share with him, and let him make the
 3 decision if on his annual leave, he wants to
 4 call you.
 5 MS. NEWBURY:
 6 Q. Okay.
 7 MS. BONNELL:
 8 A. And we did believe in August of 2006, I
 9 certainly believed that we'd be in a position
 10 to talk about causative factors. Just before
 11 we skip off of this, in terms of the issue of
 12 keeping him in the loop, I think this speaks
 13 to what I was saying to you earlier that
 14 regardless if you have any information to
 15 share at all, it's almost better to say "look,
 16 Peter, we're trying to keep you aware of
 17 what's going on, even if there's no
 18 information to share."
 19 MS. NEWBURY:
 20 Q. But you're indicating here that it is more
 21 important than the actual information that can
 22 be provided.
 23 MS. BONNELL:
 24 A. It is as important, if not more important.
 25 I'm trying to make the point to Ms. Pilgrim

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1 that it's important to keep stakeholders in
 2 the loop even if we don't have new information
 3 to share, to at least open the door and to let
 4 Mr. Dawe feel that we can communicate with him
 5 is as important if not more important than any
 6 information that we could actually provide to
 7 him.
 8 MS. NEWBURY:
 9 Q. Okay. Exhibit 0181, please. This is an e-
 10 mail that you've already addressed and this is
 11 the e-mail that you indicate that "Mr. Dawe
 12 won't be getting the advanced goodwill
 13 presentation you had offered to him last week,
 14 and you throw someone an olive branch and they
 15 whip you to death with it. Fool me once"--and
 16 you've already offered an explanation on that.
 17 If I could have Exhibit P-0012, please?
 18 This is the e-mail that you testified about
 19 yesterday where you indicate that the media
 20 might look for less credible people,
 21 spokespeople, including Peter Dawe, and also
 22 the last bullet under the first heading, "we
 23 are allowing the Canadian Cancer Society to
 24 leave the general public with the impression
 25 that there are a new group of women. This is

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1 causing confusion and we're getting calls
 2 asking about this. There is a new level of
 3 fear and anxiety that Peter Dawe is creating
 4 and then blaming us for."
 5 Now I know that you've offered
 6 explanations on these various e-mails at the
 7 time to perhaps explain that those are
 8 isolated events in a moment of frustration or
 9 perhaps to neutralize the tone or explain the
 10 meaning behind those e-mails. I'm wondering
 11 if you had offered the explanations to those
 12 recipients of these e-mails at the time?
 13 MS. BONNELL:
 14 A. At the time that the e-mail was written?
 15 MS. NEWBURY:
 16 Q. Yes.
 17 MS. BONNELL:
 18 A. Did I offer an explanation?
 19 MS. NEWBURY:
 20 Q. To those people. I mean, did you say to Mr.
 21 Tilley, "don't mind my e-mail this morning. I
 22 was up all night. I was tired"? It might
 23 leave the impression in the mind of the person
 24 reading these e-mails that Peter Dawe and the
 25 Canadian Cancer Society is not held in

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1 particularly high regard, and you've offered
 2 explanations over the last couple of days to
 3 explain that that's not really how you felt,
 4 but I'm wondering if the recipients of these
 5 e-mails at the time had the benefit of those
 6 explanations?
 7 MS. BONNELL:
 8 A. No, they didn't get an explanation from me. I
 9 wasn't questioned on this e-mail.
 10 MS. NEWBURY:
 11 Q. Okay. But you didn't take the initiative to
 12 say, "listen, I spoke a little hastily this
 13 morning. I was frustrated. You know, I
 14 really do think Mr. Dawe and Ches Crosbie and
 15 Geri Rogers are credible, but"--you know, to
 16 explain it, just as you have done yesterday?
 17 MS. BONNELL:
 18 A. As I said yesterday, and I'll say it again,
 19 that although it would appear that that
 20 sentence indicates that I believe that Mr.
 21 Dawe is not a credible individual, Ms. Rogers,
 22 or Mr. Crosbie, I do not feel that way and the
 23 sentence doesn't say "the media will look for
 24 less credible people like Peter Dawe," it says
 25 "hence, all these people are doing stories."

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1 I think that, you know, as I've indicated
 2 already, I do not feel that these people are
 3 less credible individuals. I was making the
 4 point that they--that the individuals with the
 5 credibility, in terms of speaking from an
 6 Eastern Health's perspective, should be the
 7 individuals who work for Eastern Health.
 8 And the last bullet, I also explained at
 9 great length yesterday and did attempt to say
 10 that it's patently false and when I read it,
 11 it was never an impression of the
 12 organization. I'm not speaking on behalf of
 13 anybody else here, and this e-mail, when I see
 14 it, is extremely embarrassing to me as someone
 15 who tries to always deport themselves in a
 16 professional way, and that I was even thinking
 17 that at 4:25 on May 16th is somewhat of an
 18 embarrassment to me. But I can tell you at
 19 4:30 and 5:00, I was not thinking these
 20 things, and I've worked with Mr. Tilley for
 21 eight years, I've worked with Mr. Dodge for
 22 the same amount of time, a shorter amount of
 23 time with Dr. Howell. These individuals know
 24 me. They know what I am like and I would
 25 suspect if you were to ask them, and not me,

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1 that they would indicate to you that they did
 2 not feel that I felt this way and that I would
 3 hope, and certainly my own boss has indicated
 4 to me in private conversations about this
 5 since this has become such a big media story
 6 in the last couple of months, that he never
 7 felt that I believed that way and that they
 8 knew that I was frustrated, and they knew that
 9 I was upset and that the inaction of the
 10 organization to speak at this point, we all
 11 felt some culpability for that and that's
 12 where our heads were at that point in time.
 13 As to the issue with Ms. Mundon, I
 14 indicated to Mr. Coffey yesterday that I wrote
 15 that in a moment of frustration. I believe I
 16 discovered after that point that Mr. Dawe had
 17 actually spoken to the media prior to our
 18 informing him that he was going to--that there
 19 were going to be briefings. The issue of
 20 briefing somebody so far in advance puts an
 21 individual who is as public as Mr. Dawe is in
 22 a very awkward position, in that if we were to
 23 brief him two weeks in advance of the media
 24 briefing and for him to have that information
 25 would put him in an awkward position. We made

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1 a decision that we would not do the briefing
 2 that far in advance, and that was the decision
 3 that we made.
 4 MS. NEWBURY:
 5 Q. But the tone of your e-mail, you have to admit
 6 -
 7 MS. BONNELL:
 8 A. Oh, I totally agree, yes.
 9 MS. NEWBURY:
 10 Q. - is a bit different from that.
 11 MS. BONNELL:
 12 A. Yes.
 13 MS. NEWBURY:
 14 Q. And again, I appreciate that you've offered
 15 some explanations and indicated that this is
 16 not really how you felt, but upon reviewing
 17 the various e-mails within the communications
 18 department of Eastern Health, I guess I'm more
 19 concerned about what I'm not seeing, which is,
 20 you know, "let's see what Peter Dawe has to
 21 say on behalf of the Cancer Society. Maybe we
 22 should try to find out what are the basis of
 23 his concerns here. He's made some comments in
 24 the media. Let's try to sort out where he's
 25 getting these concerns, and is there anything

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1 we can do to perhaps ease those concerns and
 2 try to find some sort of balance here in terms
 3 of communications on these issues?" So it's
 4 not just the fact that there's some e-mails
 5 here that appear to show that the
 6 communications department didn't hold the
 7 Cancer Society in high regard.
 8 MS. BONNELL:
 9 A. But that's not -
 10 MS. NEWBURY:
 11 Q. There's also the absence -
 12 MS. BONNELL:
 13 A. That's not fair, and I have spoken to that.
 14 MS. NEWBURY:
 15 Q. That's an interpretation of that, and I
 16 appreciate that. That's an interpretation of
 17 these e-mails.
 18 MS. BONNELL:
 19 A. And I have written--you know, in providing the
 20 e-mails to the Commission, with all due
 21 respect, I've written thousands of e-mails in
 22 the eight years that I've been in the
 23 organization and I attend hundreds of
 24 meetings, and all I can say to you is that
 25 what we are looking at on the record are a

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1 series of two or three e-mails that seem to
 2 present an impression of the organization and
 3 of me in one particular light. I've indicated
 4 to you that we could have done a better job of
 5 dealing with the Canadian Cancer Society as a
 6 stakeholder, but I've also indicated to you
 7 that I do not hold Mr. Dawe or the Canadian
 8 Cancer Society in poor ill regard, and so have
 9 other people who've spoken to the Commission
 10 have indicated to you that they consider the
 11 Canadian Cancer Society to be an important
 12 stakeholder and it's unfortunate that after
 13 all this time that the impression that's being
 14 left with you and with others is that I am an
 15 unprofessional person who feels that Mr. Dawe
 16 is less credible and is responsible for this
 17 issue. I've tried, over the last three days
 18 of testimony, to indicate to you that at
 19 Eastern Health, I certainly take
 20 responsibility for my part in this and we have
 21 all looked at this and welcomed this
 22 Commission and the opportunity to go through
 23 all of this. I've tried, to the best of my
 24 ability, to do that.
 25 MS. NEWBURY:

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1 Q. Yes, I do appreciate the explanations that
 2 you've given. I guess my concern is that
 3 people reading this might have their own
 4 interpretation on it, including the recipients
 5 at the time, and again, you've offered the
 6 explanation that you think that these people
 7 know you better, but my next question is
 8 perhaps can you explain why there are not e-
 9 mails or other documentation to show that,
 10 aside from these aberrant comments that there
 11 were actually steps taken by the
 12 communications department to say "listen, we
 13 really need to find out what the Canadian
 14 Cancer Society is concerned about. What are
 15 they hearing from their patients? What is it
 16 that they need to know? Why is Mr. Dawe
 17 making these comments in the media about
 18 that?" To delve into what his concerns are.
 19 MS. BONNELL:
 20 A. No, I can't show you any e-mails to say that,
 21 other than to say to you that when briefings
 22 were conducted, I was certainly encouraging
 23 the organization to do those things, and we
 24 followed up on concerns that Mr. Dawe
 25 expressed in the media by following up with

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1 individuals within the organization. So when
 2 a concern was expressed about something, we
 3 would go follow up with that concern and say
 4 "why is Peter Dawe saying this? Is there an
 5 issue with notification? Is there an issue
 6 with this? Is there an issue with that?" So
 7 that follow up was done.
 8 MS. NEWBURY:
 9 Q. Did you follow up directly with Mr. Dawe or
 10 did you ask that someone make sure that they
 11 follow up with Mr. Dawe?
 12 MS. BONNELL:
 13 A. In the three years, I think I've probably had
 14 one or two conversations with Mr. Dawe,
 15 usually about a media issue. But as I
 16 indicated to you earlier, it wouldn't be my
 17 role to speak directly with advocates. It
 18 would be better for the Director of the Cancer
 19 Program or the Vice President responsible for
 20 the Cancer Program or the physicians in the
 21 Cancer Program to make that contact and have
 22 that phone conversation because they're more
 23 intimately involved in the program than I
 24 would be. That would not be my role.
 25 MS. NEWBURY:

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1 Q. And was it your role to make sure that it was
 2 done and that you, as the communications
 3 director, are aware of what those concerns
 4 are, as it may have some impact upon -
 5 MS. BONNELL:
 6 A. I was aware of concerns that were raised, that
 7 were brought back through that process, but
 8 Ms. Newbury, I'm not even a member of
 9 executive, so I'm in no position to go tell
 10 Kara Laing that she has to report back to me
 11 on a conversation that she has with Mr. Dawe
 12 or to ask one of my executives to report back
 13 to me on a conversation that they would have.
 14 MS. NEWBURY:
 15 Q. But you do have the ability, if you had saw
 16 fit to do so from the beginning, to implement
 17 a strategic communications plan where you
 18 would perhaps advise that this should be done.
 19 Obviously, you can't force someone to -
 20 MS. BONNELL:
 21 A. I could have written the plan and I agree and
 22 I've indicated that the plan should have been
 23 written. Whether the plan would have been
 24 followed to the letter, you know -
 25 MS. NEWBURY:

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1 Q. You can put it out there, but you can't
 2 control it. Sure.
 3 MS. BONNELL:
 4 A. I can't speak to--you can't--I can't control
 5 it.
 6 MS. NEWBURY:
 7 Q. I appreciate that.
 8 MS. BONNELL:
 9 A. I'm not the CEO, so you know, there's a limit
 10 to the amount of control that I can have
 11 within an organization. I can make advice, I
 12 can consult, but there is a limit to the
 13 amount of control that I have.
 14 MS. NEWBURY:
 15 Q. Do you think, looking back on it, that perhaps
 16 the communications department could have
 17 considered the Cancer Society's views in a
 18 more positive light?
 19 MS. BONNELL:
 20 A. That would indicate, I guess, by answering
 21 that question that we didn't consider the
 22 Cancer Society's views in a positive light,
 23 which I don't think is -
 24 MS. NEWBURY:
 25 Q. So you think you saw the Cancer Society's

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1 views in a positive light?
 2 MS. BONNELL:
 3 A. I think that we saw the Cancer Society's
 4 views, like the views of other advocates, you
 5 know, there are individuals advocating on any
 6 number of issues. They have important
 7 perspectives to bring forward and it's not a
 8 matter of viewing things in a positive or a
 9 negative light. You know, there were times
 10 during this three-year period that I was
 11 frustrated, I was frustrated by the coverage
 12 and, you know, what we're looking at are these
 13 moments in time.
 14 MS. NEWBURY:
 15 Q. If I could have exhibit P-0196 please, page 14
 16 of that exhibit. This is not an e-mail that
 17 you saw or received or had any involvement in
 18 that I'm aware of, I'm just going to show this
 19 to you, not to ask you anything about how that
 20 was generated or why, it's an e-mail from
 21 Darrell Hynes is the original message to Tansy
 22 Mundon and attached is a transcript, you can
 23 see down here at the bottom, it's a transcript
 24 of December 11th, 2006 from CBC News and in
 25 that there are some comments attributed to Mr.

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1 Dawe and Mr. Dawe at the end of that report
 2 says, "Not receiving this treatment could very
 3 well mean a life and death issue for people
 4 going through the process." And then he, in
 5 the next paragraph, "The lack of disclosure
 6 raises questions" said Dawe, "about what the
 7 problem is and how it can be fixed." And in
 8 forwarding this to Tansy Mundon, Mr. Hynes
 9 says, "I hate to say it, but Peter has a
 10 point." And Ms. Mundon says, "He does
 11 indeed." Now I haven't seen any e-mails of
 12 that sort or communication of that sort within
 13 the communications department itself or
 14 Eastern Health. Do you feel that in the
 15 communications department there was also an
 16 appreciation that Mr. Dawe had a point, as Mr.
 17 Hynes is saying here to Tansy Mundon?
 18 MS. BONNELL:
 19 A. Yes.
 20 MS. NEWBURY:
 21 Q. Okay.
 22 MS. BONNELL:
 23 A. And I indicated yesterday in talking about our
 24 preparation for the briefing that certainly
 25 from the beginning of August, an e-mail you

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1 showed me moments ago, that it was my
 2 understanding that at the briefing we would be
 3 a position to talk about causative factors and
 4 that I did want to release more information
 5 than we were able to do for that December 11th
 6 briefing.
 7 MS. NEWBURY:
 8 Q. Did you ever think of perhaps relying on the
 9 fact that you've got an advocate for cancer
 10 patients out there in the media asking
 11 questions and raising questions. Did you ever
 12 think at anywhere along that continuum from
 13 October, 2005, to recommend that listen, you
 14 know, we've got someone here who is an
 15 advocate for cancer patients calling for more
 16 information and calling for it more quickly,
 17 to use that as support for trying to get out
 18 there with as much information as possible?
 19 MS. BONNELL:
 20 A. I certainly did advocate within the
 21 organization for us to release more
 22 information in as quickly as possible, but in
 23 2005, we made a commitment that we would
 24 notify all patients first before we talked
 25 about it publicly and we stuck by that

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1 commitment in as much as we could until May of
 2 2006 when all the patients were finally
 3 notified of their changed test results. After
 4 that point, I did start advocating for and
 5 you'll see indications that we were planning
 6 for a more public announcement at that point.
 7 MS. NEWBURY:
 8 Q. That was after -
 9 MS. BONNELL:
 10 A. I don't recall ever saying, you know,
 11 mentioning Mr. Dawe or the Canadian Cancer
 12 Society by name, but, you know, there are lots
 13 of advocates, I understand that's the Canadian
 14 Cancer Society's role, but the physicians
 15 within the cancer programs are advocates for
 16 cancer patients and cancer as well, and so are
 17 others. And we certainly did feel, that is
 18 the communications department certainly did
 19 feel that we would have liked to have released
 20 information faster than we did. I've
 21 indicated that to Mr. Coffey repeatedly.
 22 MS. NEWBURY:
 23 Q. Yes, you have, but you never thought, well
 24 let's use the fact that Peter Dawe is out
 25 there speaking on behalf of -

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1 MS. BONNELL:
 2 A. I didn't have to use the fact that Peter Dawe
 3 was out there because it was part of
 4 everybody's understanding that Mr. Dawe was
 5 pushing and that others were pushing.
 6 MS. NEWBURY:
 7 Q. But some of the e-mails you would have to -
 8 MS. BONNELL:
 9 A. I guess it's implicit that if you're pressing
 10 that the pressure that the Canadian Cancer
 11 Society was applying was part of that pressure
 12 to make us, you know, to encourage us to
 13 speak.
 14 MS. NEWBURY:
 15 Q. But would you agree that perhaps some people
 16 reading, you know, some of the e-mails which
 17 didn't put a whole lot of credence into some
 18 of the things that Mr. Dawe was saying, that
 19 perhaps they don't appreciate that, this is a
 20 reason why we should get out there with more
 21 information, more quickly?
 22 MS. BONNELL:
 23 A. My communication on ER/PR and on many issues
 24 is more than what is seen in e-mail and all I
 25 can tell you is what I have said over the last

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1 couple of days in this regard, that we were
 2 applying pressure and that the organization
 3 was struggling with other issues through the
 4 summer and fall of 2006, which distracted them
 5 from being able to move more quickly on the
 6 ER/PR issue. And I don't know what more I can
 7 say to you other than the fact that everybody
 8 was aware that Mr. Dawe was anxious for there
 9 to be information presented publicly, as well
 10 as others.
 11 MS. NEWBURY:
 12 Q. But was everyone aware that there's a very
 13 good reason why Mr. Dawe is anxious for it -
 14 MS. BONNELL:
 15 A. Yes.
 16 MS. NEWBURY:
 17 Q. - and what those reasons are?
 18 MS. BONNELL:
 19 A. Yes, I believe every -
 20 MS. NEWBURY:
 21 Q. You feel that everyone was aware of that?
 22 MS. BONNELL:
 23 A. Yes.
 24 MS. NEWBURY:
 25 Q. And notwithstanding some of the, I guess the

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1 negative tones in some of your e-mails, you
 2 feel that other people would know that you
 3 agree with some of the concerns as expressed
 4 by Peter Dawe and the legitimacy of those
 5 concerns?
 6 MS. BONNELL:
 7 A. Yes.
 8 MS. NEWBURY:
 9 Q. And in terms of the issue of resources, you
 10 had indicated that it was a resource issue in
 11 2006 that prevented the organization from
 12 getting out there earlier. Was anything done
 13 to -
 14 MS. BONNELL:
 15 A. No, I didn't--if I did suggest that, I didn't
 16 mean to suggest that.
 17 MS. NEWBURY:
 18 Q. So why didn't they get out earlier in 2006?
 19 MS. BONNELL:
 20 A. Well in the summer of 2006 and into the fall,
 21 I said that the organization was distracted by
 22 other major issues that it was dealing with.
 23 It wasn't a resource issue other than the fact
 24 that there's only so much that any
 25 organization can handle at one time from a

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1 public perspective and we had to deal with the
 2 release of the Markenstein report, we had a
 3 shortage in our pharmacists, we had a crisis
 4 with our paramedics and I've forgotten what
 5 else, but there were a number of issues in
 6 August and September and July that were
 7 causing a great amount of effort to be drawn
 8 or energy to be drawn away from moving forward
 9 with this briefing.
 10 MS. NEWBURY:
 11 Q. Do you mean energy from a human resource
 12 perspective?
 13 MS. BONNELL:
 14 A. Yes, I guess so, yes.
 15 MS. NEWBURY:
 16 Q. Did you think at that time of perhaps
 17 approaching an external consultant, as you did
 18 on another occasion?
 19 MS. BONNELL:
 20 A. Well that was the same time, that was that
 21 summer of 2006.
 22 MS. NEWBURY:
 23 Q. Right, but you didn't engage that consultant.
 24 MS. BONNELL:
 25 A. No.

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1 MS. NEWBURY:
 2 Q. I was thinking about in 2007 finally Bristol
 3 was engaged, why not have engaged them in
 4 2006?
 5 MS. BONNELL:
 6 A. I should have. I should have engaged a
 7 consultant much earlier, I should have engaged
 8 a consultant in 2005, I think.
 9 MS. NEWBURY:
 10 Q. Okay, and do you think there would ever be a
 11 role for the Department of Health perhaps to
 12 lend some assistance in terms of human
 13 resources?
 14 MS. BONNELL:
 15 A. No.
 16 MS. NEWBURY:
 17 Q. Okay, so it would have to be an external
 18 consultant from your point of view?
 19 MS. BONNELL:
 20 A. Or additional resources, but hiring a crisis--
 21 when you're looking at crisis communications
 22 skills, you know, a publicly funded
 23 organization is never going to be able to
 24 afford to have a crisis communications expert
 25 on staff. That's a financial issue.

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1 MS. NEWBURY:
 2 Q. Sure, so it would be more appropriate to hire
 3 an external consultant on an as needed basis.
 4 MS. BONNELL:
 5 A. For the times of need, yes.
 6 MS. NEWBURY:
 7 Q. If I could have exhibit P-0367 please? This
 8 is an e-mail from George Tilley to Peter Dawe.
 9 You are copied on it, as was Dr. Williams and
 10 I understand you didn't get the original
 11 message because of the typo in the e-mail
 12 address.
 13 MS. BONNELL:
 14 A. Yes.
 15 MS. NEWBURY:
 16 Q. And in that particular instance, Mr. Dawe was
 17 contacting you and states, "I understand there
 18 were some concern about my call for more
 19 direct information. After speaking with Bob
 20 Williams late yesterday afternoon, I am
 21 pleased to hear that Eastern Health will be
 22 having direct contact with all the women who
 23 are being retested. Any perspectives put
 24 forward by me on this topic have been
 25 reflective of the feedback CCS is receiving

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1 from the public. I believe that is the role
 2 of this organization. And do I understand
 3 that you would have received the e-mail at the
 4 time that George Tilley replied to you as one
 5 of the recipients?
 6 MS. BONNELL:
 7 A. Yes.
 8 MS. NEWBURY:
 9 Q. Okay, so that would have been October 20th,
 10 2005?
 11 MS. BONNELL:
 12 A. Uh-hm.
 13 MS. NEWBURY:
 14 Q. So you're aware at this point in time for
 15 sure, which is fairly early on in the
 16 communications feature of this issue, that the
 17 perspectives of the Canadian Cancer Society
 18 are actually reflective of what the public is
 19 communicating to Mr. Dawe and the Canadian
 20 Cancer Society?
 21 MS. BONNELL:
 22 A. Certainly.
 23 MS. NEWBURY:
 24 Q. Okay, and did you assume that that would be
 25 consistent throughout 2005, 2006, 2007?

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1 MS. BONNELL:
 2 A. Yes.
 3 MS. NEWBURY:
 4 Q. And would you assume that the public would
 5 include cancer patients?
 6 MS. BONNELL:
 7 A. Of course.
 8 MS. NEWBURY:
 9 Q. Do you know what comments had triggered this
 10 e-mail?
 11 MS. BONNELL:
 12 A. No, I don't.
 13 MS. NEWBURY:
 14 Q. Had you expressed any concerns about Mr.
 15 Dawe's media involvement prior to this?
 16 MS. BONNELL:
 17 A. No, I don't recall what triggered this.
 18 MS. NEWBURY:
 19 Q. If I could have exhibit P-0348 please? This
 20 is an e-mail, again October 2005, October 6th,
 21 2005. This is an e-mail from you to Mr.
 22 Tilley and this has to do with the Globe and
 23 Mail article and you had indicated that on
 24 October 6th, 2005 at 9:30 a.m. there's a note
 25 there, "I thought the Globe piece was

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1 accurate. Peter is referring to his own quote
 2 which was very negative by the way. The best
 3 thing he could do at this point is let this
 4 go, but by the sounds of it, he's going to go
 5 to the media again. How informed is he?" Did
 6 you have concerns about his information
 7 relayed in that article? And perhaps we can
 8 bring up, I believe it's 803?
 9 MS. BONNELL:
 10 A. Well what I was concerned about, Ms. Newbury,
 11 was whether he had any information or not and
 12 was pleased to hear that he was getting the
 13 briefing because it didn't seem to me that he
 14 was speaking with--it didn't seem to me that
 15 he was briefed, that his comments indicated to
 16 me that he probably had no information.
 17 MS. NEWBURY:
 18 Q. This is an e-mail, you're not either the
 19 sender or the recipient of the e-mail, but it
 20 attaches an article dated October 6th, 2005 by
 21 Peter Gullage. Is this the Globe and Mail
 22 article that -
 23 MS. BONNELL:
 24 A. I believe so, yes, that's the only one I
 25 remember from that time.

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1 MS. NEWBURY:
 2 Q. And Mr Dawe's comments are down towards the
 3 end of the article. "Peter Dawe, director of
 4 the Newfoundland and Labrador chapter of the
 5 Canadian Cancer Society warns that this has
 6 the potential to be a big issue for the
 7 province's health care system and patients.
 8 It alters the treatment, you could be having
 9 an inadequate treatment based on a test
 10 result", Mr. Dawe said, "There is a group that
 11 has the test result in question and our fear
 12 is that they should have received treatment
 13 and didn't." What part of that might have
 14 lead you to believe that he wasn't informed?
 15 MS. BONNELL:
 16 A. Just very general and I just wondered if we
 17 had given him a briefing.
 18 MS. NEWBURY:
 19 Q. Okay.
 20 MS. BONNELL:
 21 A. Which in fact I discovered we had not, which
 22 he was then given.
 23 MS. NEWBURY:
 24 Q. So it's the lack of specific detail?
 25 MS. BONNELL:

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1 A. Yes.
 2 MS. NEWBURY:
 3 Q. And what about that article is negative? Very
 4 negative I think your e-mail had indicated.
 5 MS. BONNELL:
 6 A. It isn't very negative. I don't know why I
 7 said that. "Peter Dawe warns this has a
 8 potential"--I don't know what I thought was
 9 negative about it. The coverage at that time
 10 was relatively positive, it was relatively
 11 positive, so maybe in context of all the other
 12 coverage, this was a more negative comment,
 13 but it's not very negative.
 14 MS. NEWBURY:
 15 Q. And there's nothing unwarranted in what he has
 16 said here?
 17 MS. BONNELL:
 18 A. No.
 19 MS. NEWBURY:
 20 Q. Do you think that the ultimate eruption, I
 21 think you have a reference to this being like
 22 a volcano erupting, do you think that the
 23 ultimate eruption of this issue in May of 2007
 24 could have been less severe or less
 25 significant had the concerns expressed by Mr.

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1 Dawe and other spokespeople, such as Mr.
 2 Crosbie, Ms. Rogers been heeded and addressed
 3 earlier than it was?
 4 MS. BONNELL:
 5 A. I think that's part of it, yes.
 6 MS. NEWBURY:
 7 Q. Okay, and what other parts would have made it
 8 less severe, less significant an eruption?
 9 MS. NEWBURY:
 10 Q. Well what would have made it less significant
 11 was our reaction to that, as opposed to just a
 12 matter of heeding the comments, it's the way
 13 in which we communicated information.
 14 MS. NEWBURY:
 15 Q. So it was a bit of a red flag that Mr. Dawe
 16 threw out was saying this is what people want
 17 to know, they want to know causes, they want
 18 to know more information about the numbers
 19 involved.
 20 MS. BONNELL:
 21 A. Yes, I suppose so, yes. We were aware of
 22 that, though, I mean, I've indicated that we
 23 were aware that that's what people wanted to
 24 know. I knew because I was in contact with
 25 the media myself and I listened to what

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1 individuals were saying and we knew that--we
 2 knew what the public wanted and what Mr. Dawe
 3 said reflected that.
 4 MS. NEWBURY:
 5 Q. Thank you, those are all the questions I have.
 6 Thank you, Ms. Bonnell.
 7 THE COMMISSIONER:
 8 Q. Thank you, Ms. Newbury. Mr. Pike?
 9 MR. PIKE:
 10 Q. Just a few questions, Commissioner.
 11 MS. SUSAN BONNELL, EXAMINATION BY MR. MARK PIKE
 12 MR. PIKE:
 13 Q. Good morning, Ms. Bonnell. Mark Pike is my
 14 name, I'm the lawyer for the Newfoundland and
 15 Labrador Medical Association. There's just
 16 one point in reviewing your testimony last
 17 evening, during the meetings at Eastern Health
 18 about what you could or could not or should or
 19 should not disclose about this whole process,
 20 you mentioned or you brought up the concept of
 21 not commenting on an issue that's before the
 22 Court or when a matter is being subject to
 23 litigation. You described it, I believe, and
 24 correct me if I'm wrong, as a tradition in the
 25 communications business or communications

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1 profession.
 2 MS. BONNELL:
 3 A. No, what I think I--if I did say that, that's
 4 not what I intended to say.
 5 MR. PIKE:
 6 Q. Well what did you intend?
 7 MS. BONNELL:
 8 A. That within our organization that was
 9 certainly the traditionally held belief and
 10 practice that when a matter was before
 11 litigation that we wouldn't speak to it, yes.
 12 MR. PIKE:
 13 Q. So that's a tradition at Eastern Health, but
 14 not in communications in general?
 15 MS. BONNELL:
 16 A. No.
 17 MR. PIKE:
 18 Q. What's the reason for that concept of not
 19 commenting?
 20 MS. BONNELL:
 21 A. Well my understanding of it is that you would
 22 be concerned that anything that you could say
 23 might in some way prejudice the case, and I'm
 24 not a legal person, but that's sort of my
 25 understanding of why you wouldn't speak.

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1 MR. PIKE:
 2 Q. That you might influence the judge you mean
 3 deciding the case?
 4 MS. BONNELL:
 5 A. No, that you may, in some way, prejudice the
 6 case that -
 7 MR. PIKE:
 8 Q. You might do harm to your case or -
 9 MS. BONNELL:
 10 A. Things may be said that may, in some way, have
 11 an impact on what was before the courts.
 12 MR. PIKE:
 13 Q. So, it's part of the risk, managing the risk
 14 of litigation that you might give away
 15 something that would otherwise be unknown to
 16 the other party and put your client at a
 17 disadvantage.
 18 MS. BONNELL:
 19 A. Yes.
 20 MR. PIKE:
 21 Q. Nothing to do with the concept of contempt of
 22 court?
 23 MS. BONNELL:
 24 A. You'd have to explain to me what you mean in
 25 that sense.

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1 MR. PIKE:
 2 Q. Well, I'm just asking you now.
 3 MS. BONNELL:
 4 A. No, no, I just thought--you know, it's always,
 5 it's just always sort of accepted that you
 6 don't talk about things that are before the
 7 courts.
 8 MR. PIKE:
 9 Q. So, you said that sometimes this concept is
 10 observed and sometimes not, is that what you
 11 said before?
 12 MS. BONNELL:
 13 A. I think that there have to be exceptions and
 14 that perhaps ER/PR by its very nature was one
 15 of those times when an exception should have
 16 been made to some degree. And in some degree
 17 it was, I mean, we did a briefing in December
 18 of 2006 with the media which, you know, in the
 19 middle of a typical litigation on an issue, we
 20 would not do that sort of media briefing and
 21 that most times, comment is very limited or
 22 referred to the lawyer for comment on the case
 23 itself, as opposed to talking about details or
 24 specifics of a court case.
 25 MR. PIKE:

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1 Q. Well, in a given case, how would you decide
 2 when to comment and when not?
 3 MS. BONNELL:
 4 A. Well, in the case of ER/PR we had to make a
 5 decision based on the impact that it was
 6 having on the public's trust of the
 7 organization, in a sense. I mean, it was
 8 clear to us that we were doing greater damage
 9 to the organization by not speaking than would
 10 ever be caused by any litigation.
 11 MR. PIKE:
 12 Q. So, it's when the stakes are higher and the
 13 risk is greater that it overrides your concern
 14 about harming your interests.
 15 MS. BONNELL:
 16 A. Yes.
 17 MR. PIKE:
 18 Q. Thank you.
 19 THE COMMISSIONER:
 20 Q. Thank you, Mr. Pike. Mr. Simmons?
 21 MS. SUSAN BONNELL, EXAMINATION BY DANIEL SIMMONS
 22 MR. SIMMONS
 23 Q. Good morning, Ms. Bonnell.
 24 MS. BONNELL:
 25 A. Good morning.

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1 MR. SIMMONS
 2 Q. You know who I am.
 3 MS. BONNELL:
 4 A. I do.
 5 MR. SIMMONS
 6 Q. I'm going to have to go back again to July of
 7 2005 for just a few points that I want to ask
 8 you about. And you've told us before of the
 9 events as they transpired through to the
 10 meeting with the minister on the 21st of July
 11 and then in the days after that. And just to
 12 set the scene for the question that I wanted
 13 to ask you, can I show you first document P-
 14 0312, page five. You've been shown this e-
 15 mail before from Carolyn Chaplin to Mr. Cake
 16 on July 19, 2005, this is 2:37 in the
 17 afternoon. This is the one where Ms. Chaplin
 18 informs Mr. Cake that there won't be a
 19 forthcoming announcement this week regarding
 20 the ER/PR issue. And you've described to us
 21 also that this was the time when some new
 22 information had come forward within Eastern
 23 Health -
 24 MS. BONNELL:
 25 A. Yes.

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1 MR. SIMMONS
 2 Q. - that affected the evaluation of the issue at
 3 that point. You described it being a roller
 4 coaster up and down with new information
 5 coming forward frequently.
 6 MS. BONNELL:
 7 A. Yes.
 8 MR. SIMMONS
 9 Q. On the same day, if we can also go, please to
 10 Exhibit 0329, please. You were shown this
 11 before, this is Mr. Tilley's note of speaking
 12 to you on that day and it says, "Susan B.,
 13 today's meeting revealed the potential that
 14 scope of problem restricted on basis of a
 15 review of percent, positive results for 2003
 16 being 75 percent which is consistent with
 17 national benchmarks". And it says,
 18 "discussion with Carolyn re: announcement and
 19 concerns of minister".
 20 Now, you were asked about this new
 21 information concerning the percentage of
 22 positivity of results and it was presented to
 23 you that the 75 percent results for 2003 which
 24 were within national benchmarks, while that
 25 information might be useful, there were still

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1 six or seven other years where there were
 2 different results that weren't up to national
 3 benchmarks and you were asked questions along
 4 the lines of what difference would that really
 5 make to the consideration at that time
 6 MR. SIMMONS
 7 Q. Yes.
 8 MR. SIMMONS
 9 Q. Now, first of all, the source of the
 10 information about the positivity rates, where
 11 did that come to you from, who provided you
 12 with that?
 13 MS. BONNELL:
 14 A. It would have been somebody involved in doing
 15 that work. So, either Mr. Gulliver or
 16 potentially Ms. Predham.
 17 MR. SIMMONS
 18 Q. Okay. Can I have Exhibit P-0514, please.
 19 This is a message from Mr. Gulliver dated July
 20 20. It is dated the following day after the
 21 19th. I believe you've seen this before, have
 22 you?
 23 MS. BONNELL:
 24 A. Yes.
 25 MR. SIMMONS

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1 Q. And I think you were shown it during the
 2 course of your examination a couple of days
 3 ago. And it says, it's a review of ER/PR
 4 stats from 2000 to 2004/5 and there are five
 5 columns there for different years with
 6 statistics under those columns leading down to
 7 the second last row which is a total
 8 positivity number.
 9 MS. BONNELL:
 10 A. Um-hm.
 11 MR. SIMMONS
 12 Q. Actually, I'll go up to the middle, if you go
 13 to the middle, it says, number positive and
 14 then it says percentage positive and if you
 15 follow across that row for 2003, 75 percent is
 16 there.
 17 MS. BONNELL:
 18 A. Right.
 19 MR. SIMMONS
 20 Q. Do you see that?
 21 MS. BONNELL:
 22 A. Um-hm.
 23 MR. SIMMONS
 24 Q. And if you look back at the other rows, there
 25 are lower numbers there. The retesting is

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1 going to be for 1997 all the way to 2004 at
 2 this point. Were the positivity figures for
 3 1997, 1998, and 1999 known on the 19th and
 4 20th?
 5 MS. BONNELL:
 6 A. I don't believe they were. I believe that
 7 this was all the information that we had at
 8 that point in time.
 9 MR. SIMMONS
 10 Q. Right.
 11 MS. BONNELL:
 12 A. But the better person to ask that would be Mr.
 13 Gulliver.
 14 MR. SIMMONS
 15 Q. Right, okay. So, at the point on the 19th
 16 when there was a perception that maybe the
 17 extent of the problem won't be so bad as we
 18 were thinking the day before, was were all the
 19 positivity numbers for the entire period known
 20 then or where there still numbers to come?
 21 MS. BONNELL:
 22 A. I would say there were still numbers to come
 23 as this clearly indicates 2000 to 2004/5.
 24 MR. SIMMONS
 25 Q. Right, okay. So, at that point then on the

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1 19th and the 20th, was the thinking then that
 2 we know the problem isn't as big as we thought
 3 it was a couple of days ago or was the
 4 thinking that it may not be as big and we need
 5 to do more work in order to find that out?
 6 MS. BONNELL:
 7 A. I would say more the latter in that we really
 8 didn't know what we were dealing with now.
 9 There was some information that was pointing
 10 in a different direction.
 11 MR. SIMMONS
 12 Q. Okay.
 13 THE COMMISSIONER:
 14 Q. Pointing in a different direction from what?
 15 MS. BONNELL:
 16 A. Just that -
 17 THE COMMISSIONER:
 18 Q. Did you know this information before that
 19 date?
 20 MS. BONNELL:
 21 A. No, ma'am, I don't believe I did, no.
 22 THE COMMISSIONER:
 23 Q. So, before that date you were working on the
 24 information which was essentially about what
 25 happened in 2002.

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1 MS. BONNELL:
 2 A. That's right, yes.
 3 THE COMMISSIONER:
 4 Q. Okay, thank you.
 5 MR. SIMMONS
 6 Q. Now, a couple of days ago when you were
 7 talking about the results of the meeting with
 8 the minister on the 21st of July.
 9 MS. BONNELL:
 10 A. Yes.
 11 MR. SIMMONS
 12 Q. You had some discussions with the Commissioner
 13 about what was placed on hold -
 14 MS. BONNELL:
 15 A. Yes.
 16 MR. SIMMONS
 17 Q. - as a result of that meeting. Now, at that
 18 point, was a decision made that a public
 19 announcement would be placed on hold in the
 20 sense that it was decided on the 21st that
 21 there would be no public announcement or was
 22 what happened on the 21st that the decision
 23 about what to do was placed on hold
 24 temporarily until more information was
 25 obtained?

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1 MS. BONNELL:
 2 A. It was that there was no--it was that the
 3 decision was not made. It was that we went
 4 away from the meeting on the 21st seeking more
 5 information with which to make a decision.
 6 MR. SIMMONS
 7 Q. Okay. And that, by mid August though, that
 8 decision was made.
 9 MS. BONNELL:
 10 A. Yes, that's correct.
 11 MR. SIMMONS
 12 Q. And between the meeting with the minister on
 13 the 21st and mid August when the decision was
 14 made, do I take it from your evidence that a
 15 new factor that came to bear was the opinions
 16 of the oncologists regarding contact with the
 17 patients and the effect of contacting patients
 18 before their individual test results were
 19 known.
 20 MS. BONNELL:
 21 A. Yes, that is one of the factors that came to
 22 bear in that period of time, yes.
 23 MR. SIMMONS
 24 Q. Can I show you exhibit P-0566, please. These
 25 were some notes you kept of a meeting of

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1 August 20 which you've been referred to
 2 earlier, just in that time period we just
 3 spoke of. And on the bottom there's an arrow
 4 there and a note written diagonally across the
 5 bottom of the page. That's your note, is it?
 6 MS. BONNELL:
 7 A. It is.
 8 MR. SIMMONS
 9 Q. Okay. And I believe it says "striking balance
 10 between waiting and giving patients good info.
 11 or speaking publicly to soon and creating undo
 12 anxiety".
 13 MS. BONNELL:
 14 A. This is-
 15 MR. SIMMONS
 16 Q. Why did you make that note there at that time
 17 on the 10th of August?
 18 MS. BONNELL:
 19 A. Because I guess that sort of captured for me
 20 what it was that we were trying to do which
 21 was find the appropriate place to be in which
 22 we're giving patients the right information
 23 about their own health and having that dealt
 24 with in an appropriate manner which is in the
 25 setting between physician and patient. And

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1 going out so soon that we create people who
 2 don't need to be anxious about this, create a
 3 level of anxiety--that to us was the balance.
 4 MR. SIMMONS
 5 Q. Was this just your personal view that you -
 6 MS. BONNELL:
 7 A. No.
 8 MR. SIMMONS
 9 Q. - or was this a view and an issue that was
 10 openly discussed in this way among the group?
 11 MS. BONNELL:
 12 A. It was openly discussed. This is me trying to
 13 put words around the opinions that were being
 14 expressed by the group.
 15 MR. SIMMONS
 16 Q. Okay. Was it clear to anyone in the group
 17 that it was obvious which way to go on this
 18 issue?
 19 MS. BONNELL:
 20 A. Yes, in that we knew that there was a risk
 21 inherent with not speaking publicly, but that
 22 we felt that the weight of the balance came
 23 down on the obligation that we had to the
 24 patients. And the opinions expressed by the
 25 experts were that if we were doing a

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1 disclosure with one person who had an adverse
 2 event that that person would be afforded
 3 certain privacy and, you know, they'd be
 4 handled in a certain way is what I'm trying to
 5 say. And that we felt that regardless of the
 6 fact that there were hundreds, potentially,
 7 that they deserved the same opportunity.
 8 MR. SIMMONS
 9 Q. Now, you've told us -
 10 MS. BONNELL:
 11 A. But I think we knew, Mr. Simmons, that there
 12 was inherent risk in that because of the size
 13 of the numbers.
 14 MR. SIMMONS
 15 Q. Yes. You've told us that your role as a
 16 communications professional within the
 17 organization was to look out--part of what you
 18 had to do was look out for the overall
 19 interests of the organization, the way that it
 20 was perceived in the public and communication
 21 of issues related to the organization to the
 22 public.
 23 MS. BONNELL:
 24 A. Yes.
 25 MR. SIMMONS

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1 Q. And that was part of your job?
 2 MS. BONNELL:
 3 A. Yes.
 4 MR. SIMMONS
 5 Q. And would you agree with me that that is a bit
 6 of a different role from that fulfilled by
 7 most other people within a health care
 8 organization like Eastern Health?
 9 MS. BONNELL:
 10 A. Yes.
 11 MR. SIMMONS
 12 Q. And the other participants in these
 13 discussions in July of 2005 included
 14 physicians.
 15 MS. BONNELL:
 16 A. Um-hm.
 17 MR. SIMMONS
 18 Q. Correct? Administration people?
 19 MS. BONNELL:
 20 A. Yes.
 21 MR. SIMMONS
 22 Q. Technical people, quality assurance?
 23 MS. BONNELL:
 24 A. Yes, and nurses.
 25 MR. SIMMONS:

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1 Q. And nurses. From your familiarity with
 2 working with those peoples in their positions,
 3 do you have any observation about what their
 4 perspective would be on the issue of
 5 priorities of patient interests versus public
 6 interests?
 7 MS. BONNELL:
 8 A. It would be patient interest above all else.
 9 MR. SIMMONS
 10 Q. Um-hm.
 11 MS. BONNELL:
 12 A. It would be patient interest above all else
 13 and their concern would be in doing what they
 14 felt was right from a patient perspective.
 15 MR. SIMMONS
 16 Q. Yes. During these discussions in July and
 17 into August of '05, did you see anything
 18 different from them in their contributions to
 19 those discussions?
 20 THE COMMISSIONER:
 21 Q. Are you asking the witness if she saw that any
 22 differently over time?
 23 MR. SIMMONS
 24 Q. Yes, any differently during that time.
 25 MS. BONNELL:

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1 A. No. You know, when you're dealing with an
 2 issue like this, you have moments where you
 3 have heated discussions, you have moments of
 4 concern being expressed about, you know,
 5 personal, professional, organizational
 6 reputation. But these are moments and at the
 7 end of the day it's always put aside in favour
 8 of what's right for the patient.
 9 MR. SIMMONS
 10 Q. Okay. Exhibit 0304 again, please, sorry to
 11 have to bring you back to this one, but I do
 12 have a question for you about it and we'll go
 13 to page four please. This your memo of July
 14 22nd written to Mr. Tilley and copied to Dr.
 15 Williams. And it followed the previous day,
 16 that meeting with the minister where you've
 17 told us there was really no decision made
 18 about whether there was going to be or when
 19 there was going to be a public announcement.
 20 The thing was just on hold as the
 21 investigation continued.
 22 MS. BONNELL:
 23 A. Yes.
 24 MR. SIMMONS
 25 Q. And at the end of this memo, at the very

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1 bottom, in the last paragraph, second last
 2 paragraph, you make some recommendations about
 3 how to proceed.
 4 MS. BONNELL:
 5 A. Yes.
 6 MR. SIMMONS
 7 Q. And the first one says, "we notify patients of
 8 the retesting either through formal letter or
 9 by some other means deemed appropriate by the
 10 oncologists".
 11 MS. BONNELL:
 12 A. Yes.
 13 MR. SIMMONS
 14 Q. Were you, at that point, recommending
 15 contacting patients to inform them that their
 16 samples would be retested or was this a
 17 recommendation to contact them once the
 18 results of their retesting were known?
 19 MS. BONNELL:
 20 A. No, I was of the belief that we should have
 21 notified them of the retesting itself.
 22 MR. SIMMONS
 23 Q. And this, of course, is the 22nd of July which
 24 is before the oncologists involved, what we
 25 spoke of earlier-

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1 MS. BONNELL:
 2 A. That's correct.
 3 MR. SIMMONS
 4 Q. - which influenced a change in the decision.
 5 MS. BONNELL:
 6 A. That's right.
 7 MR. SIMMONS
 8 Q. So, at this point, despite whatever else is
 9 said in this memo, your recommendation is by
 10 one means or another notify the people that
 11 their samples are going to be retested?
 12 MS. BONNELL:
 13 A. That's how I felt, yes.
 14 MR. SIMMONS
 15 Q. Okay. Then you say in two, "we move fast to
 16 identify and retest the individuals". Three,
 17 "contact oncologists and surgeons immediately
 18 with new test results". And then it goes on
 19 to four and five to make sure that measures
 20 are taken to make sure that patients are made
 21 aware of the test results.
 22 Now, the paragraph above that is the one
 23 you've been questioned on to some extent,
 24 which says, "a full public disclosure with a
 25 press conference, information line, letters to

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1 all impacted patients in support of
 2 ministerial comment is not recommended".
 3 MS. BONNELL:
 4 A. Today.
 5 MR. SIMMONS
 6 Q. Because you could read those and say it's a
 7 contra diction.
 8 MS. BONNELL:
 9 A. Yes.
 10 MR. SIMMONS
 11 Q. Because in point one below you say "notify the
 12 patients either through a formal letter or by
 13 some other means".
 14 MS. BONNELL:
 15 A. Um-hm.
 16 MR. SIMMONS
 17 Q. But in the paragraph above you can read it as
 18 saying, "letters to impact the patients are
 19 not recommended".
 20 MS. BONNELL:
 21 A. Yes.
 22 MR. SIMMONS
 23 Q. And your explanation is that in the paragraph
 24 above, if I understand it, you've said your
 25 recommendation was not to make that kind of

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1 public announcement today.
 2 MS. BONNELL:
 3 A. That's correct.
 4 MR. SIMMONS
 5 Q. And to proceed as outlined below.
 6 MS. BONNELL:
 7 A. That's correct because as you would recall, we
 8 were in discussions with the minister at that
 9 point in time, had just come from a meeting
 10 with the minister, had certainly indicated a
 11 week before that we were going to do a press
 12 conference. So, I was just making the point
 13 that doing that right now is not what I would
 14 recommend.
 15 MR. SIMMONS
 16 Q. Right, okay.
 17 MS. BONNELL:
 18 A. Mr. Simmons, if I may also -
 19 MR. SIMMONS
 20 Q. Yes, go ahead.
 21 MS. BONNELL:
 22 A. - the amount of weight that has been put on
 23 this memo is unbelievable. It's just one
 24 memo. It's just not that important.
 25 MR. SIMMONS

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1 Q. Did it surface again in the discussions that
 2 followed during the course of that summer and
 3 into the fall?
 4 MS. BONNELL:
 5 A. No.
 6 MR. SIMMONS
 7 Q. Did anyone ever put it on the table at any
 8 meeting and sit down and discuss it?
 9 MS. BONNELL:
 10 A. No, never.
 11 MR. SIMMONS
 12 Q. Did Mr. Tilley even get back to you afterwards
 13 -
 14 MS. BONNELL:
 15 A. No.
 16 MR. SIMMONS
 17 Q. - to discuss any of this with you -
 18 MS. BONNELL:
 19 A. Never.
 20 MR. SIMMONS
 21 Q. Okay. You were asked a number of questions
 22 regarding your understanding of whether a
 23 change in technology was understood to be part
 24 of the background reasons, I guess, for the
 25 changes in test results that ultimately

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1 occurred. And I've understood you to say that
 2 you learned through the course of this or
 3 understood through the course of this that it
 4 wasn't simply the change from one set of
 5 machinery to another -
 6 MS. BONNELL:
 7 A. No.
 8 MR. SIMMONS
 9 Q. - that could be attributed to--and you've told
 10 us about that quite a bit. But my question
 11 is, did that change from the DAKO system to
 12 the Ventana system, nevertheless play a part
 13 in the story that had to be told about how
 14 these retests came to be done?
 15 MS. BONNELL:
 16 A. Yes, because it was--certainly, it was because
 17 of the change from one technology to another
 18 that the original changes were identified.
 19 MR. SIMMONS
 20 Q. Um-hm. So, in commenting on this in -
 21 THE COMMISSIONER:
 22 Q. I'm sorry, I thought you had said earlier that
 23 that was not the reason that the original
 24 changes had been identified? If you go back
 25 to the index case, for example, -

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1 MS. BONNELL:
 2 A. The index -
 3 THE COMMISSIONER:
 4 Q. - did that have anything to do -
 5 MS. BONNELL:
 6 A. Well, the index case was identified to be
 7 changed from a second opinion. That was a
 8 consultation. But in the original 525 or 30,
 9 however many it was that we did in the
 10 original group, those changes were--that was
 11 identified using the Ventana. It was the
 12 Ventana that was involved in retesting, if I'm
 13 correct.
 14 MR. SIMMONS
 15 Q. So, regardless -
 16 THE COMMISSIONER:
 17 Q. Okay. Perhaps I'm confusing what instrument
 18 was used in a particular test with a question
 19 which I thought Mr. Simmons was asking and
 20 perhaps he wasn't. Because I thought you were
 21 saying that somehow you thought the reason for
 22 the change was connected to the Ventana as
 23 opposed to the fact that the Ventana was a
 24 method or an instrument which was going to be
 25 used in identifying changes, if any had

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1 occurred.
 2 MS. BONNELL:
 3 A. There was a point in time when we weren't sure
 4 if, in fact, -
 5 THE COMMISSIONER:
 6 Q. The Ventana was overcalling?
 7 MS. BONNELL:
 8 A. No, that the Ventana was picking up things
 9 that--there was a point in time where we
 10 wondered, where I certainly wondered if the
 11 Ventana, being a more sensitive system was
 12 doing a better job than the DAKO. There was a
 13 point in time where we did wonder if that was
 14 the case.
 15 THE COMMISSIONER:
 16 Q. Yes, I'd understood that. Okay, perhaps I
 17 didn't understand your question, Mr. Simmons.
 18 Why don't you try it again and it may be
 19 clearer.
 20 MS. BONNELL:
 21 A. That would have been prior to us making the
 22 decision to retest the Ventana as well.
 23 MR. SIMMONS
 24 Q. Even after that point, in order to tell the
 25 story about what had led to retesting, story

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1 of the index case and so on.
 2 MS. BONNELL:
 3 A. Um-hm.
 4 MS. BONNELL:
 5 A. Was the switch from DAKO to Ventana still part
 6 of the story?
 7 MS. BONNELL:
 8 A. It's part of the story, yes, that there was a
 9 change in the lab, yes.
 10 MR. SIMMONS:
 11 Q. And even though it was your understanding that
 12 there wasn't anything inherent in the
 13 machinery which made the Ventana a better
 14 system than the DAKO for identifying the
 15 results, I understand that, nevertheless, I
 16 think you'd also said that you'd understood
 17 that the Ventana system was more automated and
 18 -
 19 MS. BONNELL:
 20 A. Yes.
 21 MR. SIMMONS:
 22 Q. - removed some opportunities for -
 23 MS. BONNELL:
 24 A. That's right.
 25 MR. SIMMONS:

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1 Q. - human error, I'll say?
 2 MS. BONNELL:
 3 A. That's right.
 4 MR. SIMMONS:
 5 Q. Yeah, okay. So in the fall of '05, then, in
 6 having Dr. Williams speak to the media about
 7 this story, would you have expected him to
 8 leave those parts of it out of the story
 9 altogether or the fact that there had been a
 10 DAKO machine and a Ventana machine still have
 11 played part in what he -
 12 MS. BONNELL:
 13 A. That's part of the story, yes.
 14 MR. SIMMONS:
 15 Q. Yes.
 16 COMMISSIONER:
 17 Q. But was it a part of the story for the purpose
 18 of saying if you're worried about what's
 19 happening now, we have this new machine, or
 20 was it the part of the story for another
 21 reason?
 22 MS. BONNELL:
 23 A. Well at that point -
 24 COMMISSIONER:
 25 Q. In the sense of is--did you view the Ventana

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1 as part of reassuring the public in terms of
 2 the--and during the time frame now, of course,
 3 when you were actually going to do it
 4 internally before you made the decision to
 5 send everything out?
 6 MS. BONNELL:
 7 A. Yes.
 8 COMMISSIONER:
 9 Q. Were the references to the Ventana part of
 10 your, what you would perceive as assuring the
 11 public about the current testing or was it for
 12 another reason?
 13 MS. BONNELL:
 14 A. Prior to the story becoming public, prior to
 15 our decision to retest the samples that had
 16 been done using the Ventana, as well.
 17 COMMISSIONER:
 18 Q. Um-hm.
 19 MS. BONNELL:
 20 A. Because originally we were going to use the
 21 Ventana to do the retest of the other numbers.
 22 COMMISSIONER:
 23 Q. Yes, that's what I understood.
 24 MS. BONNELL:
 25 A. So prior to that decision being made we'll

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1 certainly see drafts of press releases and
 2 things in that nature where we sort of say,
 3 you know, due to new improved technology,
 4 because that's what we were thinking we could
 5 be able to say at that point in time, whereas
 6 following the decision to retest even those
 7 samples that had been done on the Ventana, the
 8 issue of reassuring individuals that we had
 9 new technology didn't really, it wasn't really
 10 the issue in that we weren't doing any testing
 11 in the laboratory at that particular time
 12 anyway. All testing had been halted while
 13 tests were being sent to Mount Sinai. Even
 14 new ones that were coming in were being sent
 15 to Mount Sinai at that point. We weren't
 16 using our technology in the laboratory at that
 17 point in time, and that was certainly
 18 indicated by Dr. Williams. But all along, I
 19 think, the feeling was that the implementation
 20 or the purchase of the Ventana was a positive
 21 move for the organization.
 22 MR. SIMMONS:
 23 Q. Um-hm.
 24 MS. BONNELL:
 25 A. That is was being presented as a piece of

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1 technology that ensured more consistency in
 2 results because of the lack of manipulation of
 3 the--I'm outside my league.
 4 MR. SIMMONS:
 5 Q. Yes.
 6 MS. BONNELL:
 7 A. Because of the lack of manipulation of the
 8 test that it was one of these things that was
 9 being touted as something that would be--that
 10 we were sort of leading the edge in
 11 Newfoundland because we had implemented this
 12 new piece of technology.
 13 MR. SIMMONS:
 14 Q. Okay. I'm going to go on now to end of
 15 September, beginning of October, '05. And
 16 you've told us that when the call came, or
 17 when you were told of the call from The
 18 Independent, you were actually meeting with
 19 Ms. Predham reviewing form of a letter?
 20 MS. BONNELL:
 21 A. Yes.
 22 MR. SIMMONS:
 23 Q. At that time. Now, we know that by mid August
 24 the decision had been made to obtain test
 25 results and inform patients before making any

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1 kind of a public announcement and before
 2 making any kind of general communication to
 3 people to say, you are going to be retested?
 4 MS. BONNELL:
 5 A. Yes.
 6 MR. SIMMONS:
 7 Q. That that had been changed. What had changed
 8 by the 30th of September for you and Ms.
 9 Predham to be sitting down essentially
 10 revisiting that decision about a letter to all
 11 the patients?
 12 MS. BONNELL:
 13 A. The fact that we were getting very close to
 14 the promised deadline for getting the test
 15 results back and we weren't seeing them coming
 16 in the fashion that we had hoped.
 17 MR. SIMMONS:
 18 Q. So how widely discussed at that point was the
 19 idea of revising the decision about whether or
 20 not to inform patients that their tests were
 21 going to be retested?
 22 MS. BONNELL:
 23 A. It wasn't widely in discussion at that, we
 24 hadn't reached the point yet of sitting down
 25 and saying this is taking too long.

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1 MR. SIMMONS:
 2 Q. Right. It was known, certainly it was under
 3 discussion certainly between yourself and Ms.
 4 Predham at that point, was it?
 5 MS. BONNELL:
 6 A. Yes, and others, as well. I think there was
 7 some general--there hadn't been a meeting
 8 where we all sat down and said we need to
 9 revisit this decision.
 10 MR. SIMMONS:
 11 Q. Yeah, and I know this is hypothetical, but if
 12 the call hadn't come from The Independent that
 13 day, do you have any idea of what the--what
 14 your thinking was at that time about where to
 15 take this concept of revisiting notice to all
 16 the patients that they were going to be
 17 retested? Because you'd started on it by
 18 talking to Ms. Predham about it?
 19 MS. BONNELL:
 20 A. Yeah. It would be extremely hypothetical.
 21 MR. SIMMONS:
 22 Q. Um-hm.
 23 MS. BONNELL:
 24 A. And you know, we made decisions based on the
 25 opinions of a number of different groups of

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1 individuals.
 2 MR. SIMMONS:
 3 Q. Um-hm.
 4 MS. BONNELL:
 5 A. And I was feeling uncomfortable, I was
 6 starting to feel like there's probably too
 7 many disclosures being done that we can't
 8 anticipate that this is going to be able to
 9 wrap itself up in the way we originally
 10 envisioned.
 11 MR. SIMMONS:
 12 Q. So -
 13 MS. BONNELL:
 14 A. But I don't think it had gone beyond that
 15 point. And where it would have gone, it would
 16 be difficult for me to suppose. I guess the
 17 next step would have been for the group to get
 18 back together and revisit it and talk about
 19 what the implications would be of changing our
 20 minds.
 21 MR. SIMMONS:
 22 Q. And I presume there would have been no point
 23 in you and Ms. Predham looking at the letter
 24 unless there'd been some thought, at least
 25 between the two of you, of suggesting that

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1 such a meeting be convened to bring the group
 2 back together?
 3 MS. BONNELL:
 4 A. Yes.
 5 MR. SIMMONS:
 6 Q. Okay. Now, as October progressed, one of the
 7 exhibits that you were shown was P-0092. This
 8 is an e-mail message from Ms. Predham to you,
 9 Dr. Williams and Ms. Pilgrim attaching a
 10 message from Mr. Boone of October 18th. And
 11 at this point, if I recall correctly, the
 12 matter having become public, what's under
 13 discussion now is the form of a letter that
 14 would go to all patients informing them of the
 15 retesting being carried out or giving them
 16 some information about it?
 17 MS. BONNELL:
 18 A. Right.
 19 MR. SIMMONS:
 20 Q. And the e-mail starts, "My initial reaction is
 21 that I do not agree with sending this letter
 22 at this time." And that part was read to you
 23 earlier. It goes on then to say, however,
 24 "There are a significant number of people
 25 whose results will not be changed. Notifying

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1 these people may be seen as raising their
 2 hopes for treatment possibilities. In most
 3 cases these expectations or hopes will not be
 4 satisfied." My question is, when you read
 5 this e-mail message, is the issue that's being
 6 addressed here whether the letter is the right
 7 form of communication or whether there should
 8 be communication at all with people for whom
 9 there's no test results back yet?
 10 MS. BONNELL:
 11 A. Well, I guess you'd have to ask Mr. Boone
 12 himself what he meant, but -
 13 MR. SIMMONS:
 14 Q. Yes, but what do you understand it when you
 15 read it?
 16 MS. BONNELL:
 17 A. - clearly when you read it, he says,
 18 "Notifying people may be seen as raising their
 19 hopes for treatment possibilities," etcetera.
 20 So in the end we made phone calls which is a
 21 notification.
 22 MR. SIMMONS:
 23 Q. Right.
 24 MS. BONNELL:
 25 A. So it's a letter or phone call, we did notify

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1 them.

2 MR. SIMMONS:

3 Q. Right.

4 MS. BONNELL:

5 A. Regardless of what he says here.

6 MR. SIMMONS:

7 Q. So if the concern was notification, whether by

8 letter or by other means, was that view then

9 followed by Eastern Health?

10 MS. BONNELL:

11 A. No.

12 MR. SIMMONS:

13 Q. No. And, in fact, within a couple of days

14 phone calls were being made to patients to

15 notify them that their samples were being

16 retested?

17 MS. BONNELL:

18 A. That's correct.

19 MR. SIMMONS:

20 Q. Exhibit P-1402, please, second page? This was

21 an e-mail message from Ms. Predham. And this

22 is October 26th, 2006. By this point there's

23 been probably six days of phone calls being

24 made and a fairly intensive effort to make

25 contact with patients by telephone. Ms.

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1 Predham is doing a report to a number of

2 people here, including you. You were referred

3 earlier to the last paragraph and you were

4 read the first sentence and the last sentence,

5 but I'm going to read the whole thing for you.

6 "This entire ER/PR review has been very

7 difficult and drawn out." This is Ms. Predham

8 speaking. "With constant hard and difficult

9 decisions being made. The only thing making

10 it bearable at all is that we were doing what

11 we had to do to make it right for our

12 patients. We were always doing the right

13 thing. Personally, this combined with the two

14 situations involving Dr. Ganguly in the past

15 two weeks has left me totally and absolutely

16 disheartened." Now, the middle sentence there

17 about the only thing making it bearable was

18 that we were doing the right thing by the

19 patients and always doing the right thing, was

20 that a sentiment that you heard expressed at

21 any other times by anyone else throughout this

22 entire process?

23 MS. BONNELL:

24 A. Yes, by everybody, Mr. Coffey (sic.), by all

25 the doctors who spent their nights panelling,

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1 by all the administrators, by all the support

2 people, by everybody in the lab, by everybody.

3 MR. SIMMONS:

4 Q. Okay. And also refer you to P-0189, please?

5 This is, on the bottom of it there's an e-mail

6 message from you to Mr. Tilley and others on

7 December 9th when you sent them the materials

8 for the media briefing on the 11th. And in

9 the middle there's a reply from Mr. Tilley on

10 Sunday, December 10th about 3:00 in the

11 afternoon. He says, "This is very

12 comprehensive. I appreciate the efforts you

13 are all putting into this. In the end we need

14 to keep reminding ourselves that we are here

15 to do the best for our patients, despite what

16 the media may choose to present. Good luck.

17 George." Is that a view that you heard Mr.

18 Tilley express on any other occasions, as

19 well?

20 MS. BONNELL:

21 A. I indicated to you or to Mr. Coffey a couple

22 of days ago now that when Mr. Tilley said in

23 August of 2005, "If we can help one patient,

24 then we need to do this retest and we need to

25 deal with everything that comes out of it," I

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1 heard Mr. Tilley say that and this many, many

2 times. And all of the people who worked on

3 this issue did so with that in their, in the

4 foremost.

5 MR. SIMMONS:

6 Q. Okay.

7 MS. BONNELL:

8 A. Part of their minds.

9 MR. SIMMONS:

10 Q. Good. Now, I have a couple of questions for

11 you about that media briefing on the 11th of

12 December, in particular in relation to the

13 discussion about trying to develop an error or

14 conversion rate for presentation to the media.

15 First of all, in all the meetings and

16 discussions that you were participating in up

17 to that time are you--did anyone ever suggest

18 or raise as an issue that there was any

19 clinical reason to have to define a rate, a

20 percentage change rate for these results, any

21 clinical reason that would affect patient care

22 that was driving, defining a rate?

23 MS. BONNELL:

24 A. No.

25 MR. SIMMONS:

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1 Q. Okay. Did you have reports from time to time
 2 from the people in quality concerning the
 3 types of things they were hearing from the
 4 patients that they spoke to, that the patients
 5 relations officer was, and others were hearing
 6 from the people they were speaking to?
 7 MS. BONNELL:
 8 A. Yes.
 9 MR. SIMMONS:
 10 Q. Was it ever reported back to you that there
 11 were requests from patients specifically for a
 12 rate or a percentage of change?
 13 MS. BONNELL:
 14 A. No.
 15 MR. SIMMONS:
 16 Q. Okay. Now, from your point of view you've
 17 told us that you anticipated that the media
 18 would have an interest in such a rate?
 19 MS. BONNELL:
 20 A. Yes.
 21 MR. SIMMONS:
 22 Q. Okay. In December of '06 would there have
 23 been any purpose calculating and settling on
 24 such a rate other than for the purpose of
 25 disclosing it to the media in response to

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1 their request so that they could then
 2 communicate it more publicly?
 3 MS. BONNELL:
 4 A. No.
 5 MR. SIMMONS:
 6 Q. Okay. You've told us something about the
 7 discussions that went into looking at the
 8 numbers that were known of the retest results
 9 and discussions about potential ways to
 10 calculate a rate?
 11 MS. BONNELL:
 12 A. Yes.
 13 MR. SIMMONS:
 14 Q. Would it be fair to say that there would be a
 15 range of rates that could be calculated
 16 depending on what tests were included and
 17 excluded from both the numerator and the
 18 denominator?
 19 MS. BONNELL:
 20 A. Absolutely, yeah, we did a lot of that, trying
 21 to figure out, yes.
 22 MR. SIMMONS:
 23 Q. Would it be fair to say that those rates would
 24 range anywhere from 10 or 11 percent up to the
 25 42 percent that was eventually reported by the

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1 media in May?
 2 MS. BONNELL:
 3 A. Yes, depending on what you exclude and
 4 include.
 5 MR. SIMMONS:
 6 Q. Okay. Was there ever any consideration given
 7 to using a rate which would be viewed as
 8 reflecting more favourably on the organization
 9 than any other rate?
 10 MS. BONNELL:
 11 A. No.
 12 MR. SIMMONS:
 13 Q. Was that part of the discussion?
 14 MS. BONNELL:
 15 A. No, absolutely not.
 16 MR. SIMMONS:
 17 Q. And at the media briefing on December 11th, I
 18 believe you've told us already that the media
 19 were informed explicitly that they were not
 20 being told the total number of changed tests?
 21 MS. BONNELL:
 22 A. Yes, and they reported it at that time.
 23 MR. SIMMONS:
 24 Q. At that time, right. Was any suggestion made
 25 to the media at all about what the rate of

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1 change for test results was?
 2 MS. BONNELL:
 3 A. No, never.
 4 MR. SIMMONS:
 5 Q. And are you aware that in May of '07 that
 6 there were media reports which said that in
 7 December of '06 Eastern Health had predicted a
 8 10 percent change?
 9 MS. BONNELL:
 10 A. Yes, yes. I was aware of those. There was a
 11 CBC story for sure I recall that being said
 12 in, and it certainly became part of the
 13 general discussion, I believe, in the House of
 14 Assembly as well, rate of error and
 15 percentages and that sort of thing.
 16 MR. SIMMONS:
 17 Q. And had Eastern Health made any such
 18 representation at the December press
 19 conference?
 20 MS. BONNELL:
 21 A. No, we did not.
 22 MR. SIMMONS:
 23 Q. Since October of '05 when Dr. Williams had
 24 said that it was possible that ten percent of
 25 all the change--all the tests done could

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1 change, had there been any public statements
 2 from Eastern Health predicting any kind of
 3 rate of change?
 4 MS. BONNELL:
 5 A. No, there had not.
 6 MR. SIMMONS:
 7 Q. Okay. I'm going to ask you some look-back
 8 questions now, and first, about the time
 9 period, the first, what I'll call the first
 10 decision making period here, which for you
 11 would start when you were first involved in
 12 early July of 2005, late June?
 13 MS. BONNELL:
 14 A. No, I was involved in late May.
 15 MR. SIMMONS:
 16 Q. In late May, and leading up to the decision in
 17 mid August, which adopted the plan which was
 18 no immediate public announcement, get test
 19 results, inform patients first -
 20 MS. BONNELL:
 21 A. Yes.
 22 MR. SIMMONS:
 23 Q. Looking back at that time period, what would
 24 you identify as being the most difficult
 25 questions or issues that were faced by the

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1 people making decisions about what information
 2 to release publicly and how to inform the
 3 patients?
 4 MS. BONNELL:
 5 A. Well, certainly the decision as to whether we
 6 should make a public announcement ahead of
 7 making contact with anybody specifically was a
 8 very difficult decision to make. What way to
 9 go about making this public information was a
 10 very difficult decision to make.
 11 MR. SIMMONS:
 12 Q. That decision at the time had to be made known
 13 on the information--had to be made based on
 14 the information known then.
 15 MS. BONNELL:
 16 A. Um-hm.
 17 MR. SIMMONS:
 18 Q. Looking back now, with the benefit of
 19 everything we learned in the meantime, do you
 20 have any comment on what sort of
 21 considerations you would now see that would be
 22 useful to bring to bear if there were such a
 23 situation to be confronted again? What would
 24 some of the competing interests be that would
 25 have to be taken into account?

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1 MS. BONNELL:
 2 A. Competing interests? Competing interests in
 3 that time, I guess, were principles of
 4 confidentiality and the principle of
 5 transparency and open accountability. I mean,
 6 there is some inherent contradictions in those
 7 two values of the organization and trying to--
 8 I'm back to the strike a balance, I guess.
 9 MR. SIMMONS:
 10 Q. Yes.
 11 MS. BONNELL:
 12 A. Trying to strike a balance between knowing
 13 that you're communicating with good
 14 information, that you're not going out and
 15 saying "we think we have an issue. We don't
 16 know what it is. We don't know how many
 17 people it impacts." It's uncomfortable from
 18 the perspective of making any kind of a public
 19 announcement. And also the other side of that
 20 being, do patients have a right to learn about
 21 their own health care and their own health in
 22 a way that we would all want to learn issues
 23 that may or may not impact our own individual
 24 treatment? Would I want to hear about this in
 25 the media? No, I would not want to hear about

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1 this in the media. And so we made a decision
 2 based on that. Unfortunately, circumstances
 3 conspired against that principle and perhaps
 4 we should have been--we should have predicted
 5 that more. We shouldn't have expected that
 6 the tests could get done in the timely fashion
 7 that we had expected they would.
 8 I think it's also, you know, the
 9 organization was formed on April 2007. Going
 10 into this, we were half Health Care
 11 Corporation, we were--and six other boards and
 12 half--Mr. Gulliver was a director of the lab
 13 in St. John's in May of 2005. He was not the
 14 director of the labs across Eastern Health.
 15 Ms. Predham didn't know what her job was, and
 16 in the midst of all this, had to apply for a
 17 job. You know, of all of them, I was the only
 18 one who knew how it was going to pan out for
 19 me. That can't be underestimated, the impact
 20 that restructuring and this having at the same
 21 time.
 22 We didn't have in place the kinds of
 23 formalized plans and strategies. Ms. Newbury
 24 asked me this morning about strategic
 25 planning, and you know, those things--a

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1 strategic plan for the organization was not in
 2 place. A plan for this wasn't developed.
 3 Those are essential--if we look at an issue
 4 now, I can't think of an issue, certainly
 5 while I was director of strategic
 6 communications, that we dealt with that didn't
 7 have a communications strategy attached to it.
 8 I think it was the timing of this, the fact
 9 that there wasn't staff in place.
 10 It's hard to look back and say with
 11 retrospect "I'd have done this differently and
 12 I'd have done that differently." But I think
 13 what we do do is we look at this and say "what
 14 can we learn from this? What did we learn
 15 from the release of the Markenstein report?"
 16 Well, the way that we learned things from that
 17 about how to effectively manage staff within
 18 an organization, there were lessons learned in
 19 that, and during the Commission of Inquiry,
 20 Eastern Health is doing a better job in that
 21 regard. I think you learn from these
 22 experiences and you move forward.
 23 MR. SIMMONS:
 24 Q. Okay. Ms. Bonnell, anything else that you
 25 feel you'd like to--you've had to say quite a

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1 bit since you've been here, but if there's
 2 anything else you feel you'd like to add,
 3 there's an opportunity now to do it.
 4 MS. BONNELL:
 5 A. No, thank you very much. I thank you all for
 6 the opportunity to speak to you.
 7 MR. SIMMONS:
 8 Q. Thank you.
 9 THE COMMISSIONER:
 10 Q. Do you have anything arising, Mr. Coffey?
 11 COFFEY, Q.C.:
 12 Q. I do, Commissioner.
 13 THE COMMISSIONER:
 14 Q. While Mr. Coffey is coming around, there's a
 15 point you raised this morning that I just
 16 wanted to be sure that I'm clear on. It's
 17 another one of those little details that I
 18 want to be clear about, because when Ms.
 19 Newbury was asking you about certain events in
 20 July of 2005, you were responding by saying
 21 that, you know, "at that point, I thought we
 22 were going to be talking about causation."
 23 MS. BONNELL:
 24 A. That was in--she brought me to an e-mail of
 25 2006, I believe.

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1 THE COMMISSIONER:
 2 Q. I thought it was a 2005 one, but I'll just
 3 double check now. Maybe you're right. P-
 4 1500. You might have been talking about that.
 5 It was in the context of looking at this
 6 document, so we'll just double check. It was
 7 2006 memo. You're right, okay. So you were
 8 saying, in the context of your discussion with
 9 Ms. Newbury at that point that you thought
 10 that you were going to be in a position to
 11 talk about causative factors, but you never
 12 were, as I understand it.
 13 MS. BONNELL:
 14 A. No.
 15 THE COMMISSIONER:
 16 Q. From the organizational point of view.
 17 MS. BONNELL:
 18 A. Yes.
 19 THE COMMISSIONER:
 20 Q. And what I wanted to clarify was at what point
 21 it came home to you that that was not going to
 22 be something that you could talk about?
 23 MS. BONNELL:
 24 A. When we started to prepare for the media
 25 briefing, which would have been in, I think,

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1 probably late in that fall, maybe in October
 2 sometime.
 3 THE COMMISSIONER:
 4 Q. So in the preparation leading up to the media
 5 briefing, somewhere around October, it came
 6 home to you that you would not be in a
 7 position to talk about causative factors?
 8 MS. BONNELL:
 9 A. That's right.
 10 THE COMMISSIONER:
 11 Q. And what was it that drove that home to you?
 12 MS. BONNELL:
 13 A. Certainly conversations with legal counsel
 14 did, and also the fact that I was under the
 15 impression that we would probably release the
 16 external reviews publicly, and was not aware
 17 that those were being protected under the
 18 Evidence Act as peer reviews.
 19 THE COMMISSIONER:
 20 Q. Okay, and was it also around that period of
 21 time that you realized that that was the
 22 position in respect of the external reviews?
 23 MS. BONNELL:
 24 A. Yes.
 25 THE COMMISSIONER:

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1 Q. All right. Mr. Coffey.
 2 MS. SUSAN BONNELL, RE-EXAMINATION BY BERNARD COFFEY, Q.C.
 3 COFFEY, Q.C.:
 4 Q. Thank you, Commissioner. Exhibit P-0104,
 5 please, page four please. Ma'am, Mr. Simmons
 6 was asking you questions about percentages and
 7 Dr. Williams' usage of ten percent back in
 8 October of '05 and then what, if any, thought
 9 was given to what percentages or figures were
 10 to be released in December of '06. This is
 11 the actual press release for December 11th,
 12 2006, and when you look at the second
 13 paragraph, the middle of the paragraph says
 14 "939 of these test results were originally
 15 negative. These test samples were sent to
 16 Mount Sinai Laboratory in Toronto for review."
 17 And it goes on to say "however, 117 patients
 18 have been identified as requiring treatment
 19 changes."
 20 So although there's not a rate there, I
 21 take it if one was to divide 117 by 939, my
 22 arithmetic gives me a figure of 12.4 percent.
 23 MS. BONNELL:
 24 A. Okay.
 25 COFFEY, Q.C.:

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1 Q. Which bears more than a passing potential
 2 relationship with ten percent, doesn't it?
 3 It's close. It's close to ten percent.
 4 MS. BONNELL:
 5 A. It's close to ten percent, yes.
 6 COFFEY, Q.C.:
 7 Q. And you were aware, I think you've told us
 8 already, and remained aware that Dr. Williams
 9 had, in October of '05, referred to ten
 10 percent.
 11 MS. BONNELL:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. Ma'am, if we could look at, please, Exhibit
 15 1402, please? Page two, please. This is an
 16 e-mail Mr. Simmons just asked you to look at,
 17 and referring to, "we were always 'doing the
 18 right thing'" okay. I gather from your
 19 evidence given in answer to questions by the
 20 other lawyers here in the room that you
 21 understood that an individual patient who
 22 suffered an adverse event should be dealt with
 23 in a particular manner. Would that be
 24 correct?
 25 MS. BONNELL:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. And to be told privately what had gone wrong?
 4 MS. BONNELL:
 5 A. Yes, or well, that it--I mean, I guess the
 6 primary thing is that it would be between the
 7 physician and the patient to have that
 8 conversation.
 9 COFFEY, Q.C.:
 10 Q. But we looked at the adverse event -
 11 MS. BONNELL:
 12 A. Policy.
 13 COFFEY, Q.C.:
 14 Q. - policy, you were shown that. And that
 15 involves the patient being notified as to what
 16 went wrong, why it went wrong, if it's known.
 17 MS. BONNELL:
 18 A. Yes, yes.
 19 COFFEY, Q.C.:
 20 Q. And what's proposed to be done about it, in
 21 terms of future treatment?
 22 MS. BONNELL:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. So here, though, I take it that the whole of

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1 the group involved always understood that none
 2 of these patients were going to be told why or
 3 had been told why or what was known about why
 4 things had gone wrong, so in doing right, I'm
 5 going to suggest to you, everyone involved in
 6 this knew full well that the patients had not
 7 been told what was known about what went
 8 wrong?
 9 MS. BONNELL:
 10 A. I don't know that I can speak to that. I
 11 agree with you that we certainly weren't
 12 talking publicly about causative factors.
 13 What was said by Eastern Health in terms of
 14 the phone calls to the individuals who
 15 remained negative would have to be addressed,
 16 I guess, by the people who made those phone
 17 calls, but I don't think that they got into
 18 causative factors. What happened in the room
 19 between an oncologist and their patient in
 20 discussing if the patient were to ask what
 21 happened, I guess the physician would have to
 22 indicate to you what level of detail they
 23 would have gotten into in that setting,
 24 because I wouldn't know that, but I agree with
 25 you absolutely, we did not talk about those

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1 things publicly.
 2 COFFEY, Q.C.:
 3 Q. And do you have any reason to believe that
 4 they were talked about privately?
 5 MS. BONNELL:
 6 A. I have no reason to believe one way or the
 7 other if they were or weren't.
 8 COFFEY, Q.C.:
 9 Q. Okay, well we'll have to hear then from the
 10 oncologists on that point, but I'm going to
 11 suggest to you that it certainly wasn't talked
 12 about openly within the group as to the
 13 reasons for test failure.
 14 MS. BONNELL:
 15 A. Not -
 16 COFFEY, Q.C.:
 17 Q. Not like Dr. Banerjee set it out.
 18 MS. BONNELL:
 19 A. No.
 20 COFFEY, Q.C.:
 21 Q. When did the group last meet before September
 22 30th, 2005, do you know? Mr. Simmons was
 23 asking you about, you know, the phone call
 24 that you received that day and what was done.
 25 You made a reference to, in the context, the

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1 group and I'm just wondering do you recall
 2 when it was that the group had last met? This
 3 was in the context of Ms. Predham and you
 4 looking at that letter again.
 5 MS. BONNELL:
 6 A. Uh-hm.
 7 COFFEY, Q.C.:
 8 Q. I'm just trying to get some sense for the
 9 Commissioner when the group last met.
 10 MS. BONNELL:
 11 A. I don't recall there being any meetings in
 12 September. I would probably have been August
 13 12th or 10th or whenever.
 14 COFFEY, Q.C.:
 15 Q. Before the August 15th meeting with the
 16 Minister? There was a meeting with the
 17 Minister on August 15th.
 18 MS. BONNELL:
 19 A. I didn't attend -
 20 COFFEY, Q.C.:
 21 Q. You didn't attend that ma'am, no, you didn't,
 22 but it was around the time that you did that
 23 August 12th pros cons list -
 24 MS. BONNELL:
 25 A. Cons thing, yes.

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1 COFFEY, Q.C.:
 2 Q. Around that time was the last time the group
 3 would have met.
 4 MS. BONNELL:
 5 A. Yes, I think so.
 6 COFFEY, Q.C.:
 7 Q. Okay. Just as a point of clarification,
 8 ma'am, because I know when I asked certain
 9 questions about it, you gave one answer and
 10 then when I showed you another e-mail, you
 11 acknowledged that that was in fact the state
 12 of affairs, and then it came up with Ms.
 13 Newbury. If I could look, please, at exhibit
 14 P-0616. This has to do with the patient
 15 letter and the NLMA in the fall of '05.
 16 MS. BONNELL:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. This is this e-mail of October 4, 2005, 2:59
 20 p.m. and this indicated an e-mail you drafted
 21 potentially for Dr. Williams' endorsement.
 22 MS. BONNELL:
 23 A. Uh-hm.
 24 COFFEY, Q.C.:
 25 Q. And I think you, in responding to Ms. Newbury,

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1 she asked you some questions about it that it
 2 had not actually been used, well if we look,
 3 please, at exhibit P-0626? Now this is an e-
 4 mail of yourself, October 6th, two days later,
 5 11:20 a.m. to Dr. Williams and others. It's
 6 forwarding the letter from Dr. Williams re:
 7 screening; in fact, even internally your
 8 organization -
 9 MS. BONNELL:
 10 A. I apologize.
 11 COFFEY, Q.C.:
 12 Q. No, no, and I appreciate that, you're not
 13 alone, by far, on that, okay.
 14 MS. BONNELL:
 15 A. I apologize, it was posted, yes.
 16 COFFEY, Q.C.:
 17 Q. It was actually posted as Lynn Barter had
 18 advised you on that same day at 11:05 a.m. and
 19 the actual letter, looking at it on page two
 20 of this letter--page two of the exhibit, the
 21 letter itself, when you look at the fourth
 22 last paragraph, it says "From the results that
 23 we have retested thus far, we are anticipating
 24 that less than 10 percent of all breast cancer
 25 patients will convert from a negative to a

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1 positive and may experience a change or
 2 addition to their cancer therapy."
 3 MS. BONNELL:
 4 A. Uh-hm.
 5 COFFEY, Q.C.:
 6 Q. And if you can look back, please, that's the
 7 one that apparently went up on the NLMA
 8 website, look back at P-0616, if you look at
 9 the corresponding part of that letter, there
 10 are a couple of words changed in the beginning
 11 of the letter, but when we look down at that
 12 same paragraph, the fourth last paragraph, "We
 13 see from the results that we have retested
 14 thus far, we are anticipating that less than
 15 10 percent of all breast cancer patients will
 16 convert from a negative to a positive and may
 17 experience a change or addition to their
 18 cancer therapy."
 19 MS. BONNELL:
 20 A. Uh-hm.
 21 COFFEY, Q.C.:
 22 Q. So that that apparently was, at least as of
 23 October 4th, the letter that you had drafted
 24 for Dr. Williams?
 25 MS. BONNELL:

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1 A. I apologize.
 2 COFFEY, Q.C.:
 3 Q. That's fine, it's just a point of
 4 clarification. You were also asked a question
 5 concerning inaccuracies in media coverage in
 6 October of '05 and you were asked whether
 7 reporters were contacted to correct such
 8 inadequacies or inaccuracies, I'm sorry. Do
 9 you recall what reporters in October of '05
 10 you or your department contacted?
 11 MS. BONNELL:
 12 A. About an inaccuracy?
 13 COFFEY, Q.C.:
 14 Q. Yes.
 15 MS. BONNELL:
 16 A. The only inaccuracy that we corrected was one
 17 that was on the CBC website in my
 18 recollection.
 19 COFFEY, Q.C.:
 20 Q. Okay, that's the one we looked at, one of the
 21 e-mails here when I was asking you about -
 22 MS. BONNELL:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. Okay.

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1 MS. BONNELL:
 2 A. And I don't know if, I think Deborah would
 3 have done that and I don't know she would have
 4 even spoken to a reporter because sometimes
 5 information is posted on the website and you
 6 can--and there is an individual, well I guess
 7 he's a reporter, but he's an individual who is
 8 responsible for posting information on the web
 9 and that contact may have been made directly
 10 with that individual, I'm not sure.
 11 COFFEY, Q.C.:
 12 Q. Okay. You, as well in a response to a
 13 question indicated that, I believe your words
 14 were to the effect "there are so many issues
 15 that one can deal with at any one point in
 16 time from an organization's perspective"?
 17 MS. BONNELL:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. I take it that's issues involving sort of bad
 21 news issues?
 22 MS. BONNELL:
 23 A. No, not necessarily.
 24 COFFEY, Q.C.:
 25 Q. In commenting on it, you did refer to, what

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1 can only be seen as negative issues, the
 2 Turner report, Markenstein's Turner report and
 3 others, that you -
 4 MS. BONNELL:
 5 A. Those happened to be big news stories. I
 6 mean, the pharmacy issue wasn't necessarily a
 7 negative one. It began of, you know, in that
 8 sort of a way, but it's about capacity, I
 9 think, and perhaps is the better word to use
 10 than--and I certainly struggled with capacity
 11 issues. I don't think in the last three years
 12 I've worked less than 50 or 60 hours a week,
 13 every week, you know. It just can't be done.
 14 COFFEY, Q.C.:
 15 Q. And if I could, Commissioner, and this is just
 16 for point of--well three different exhibits.
 17 In my examination of Ms. Bonnell, we did refer
 18 to them, but I'd like to just identify them
 19 for your own purposes and counsel's purposes.
 20 Exhibit P-1211 and I apologize, Ms. Bonnell, I
 21 should have had them brought up when you asked
 22 about them in the first place, I won't ask
 23 you--just to have you identify them. P-1211
 24 please? This is a May 7th '07 media
 25 statistics form, this would be the date, the

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1 contact date for Mark Quinn involving the
 2 court documents, I think you did refer to your
 3 conversation with Mr. Quinn and what happened
 4 as a result.
 5 MS. BONNELL:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. This is the form of that day.
 9 MS. BONNELL:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. And as well if we could, P-1212? And this is
 13 a form dated May 14th, 2007 involving Heather
 14 Barrett of The Current, CBC Radio, The
 15 Current, and this is again your record that
 16 day of your dealings with her.
 17 MS. BONNELL:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. Okay, and finally, Commissioner, there is an
 21 exhibit, it hasn't been entered, but for the
 22 sake of completeness, it's Ms. Bonnell's
 23 redacted calendar and it's exhibit P-1565.
 24 THE COMMISSIONER:
 25 Q. And that's redacted by us?

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1 COFFEY, Q.C.:
 2 Q. Well -
 3 MR. SIMMONS:
 4 Q. By agreement.
 5 THE COMMISSIONER:
 6 Q. By agreement.
 7 COFFEY, Q.C.:
 8 Q. I don't know by agreement, but who physically
 9 did the -
 10 THE COMMISSIONER:
 11 Q. But we don't want a continuing redaction
 12 problem.
 13 COFFEY, Q.C.:
 14 Q. Okay, I will check that Commissioner and we'll
 15 -
 16 THE COMMISSIONER:
 17 Q. Well why don't we just double check that
 18 before -
 19 MR. SIMMONS:
 20 Q. We marked them with opaque--with transparent
 21 markings, so if they're now opaque, it means
 22 they've been done here.
 23 THE COMMISSIONER:
 24 Q. We have done our own redaction.
 25 COFFEY, Q.C.:

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1 Q. Thank you, Registrar. If we could have the
 2 exhibit -
 3 THE COMMISSIONER:
 4 Q. So the number again is P-1565? All right,
 5 entered.
 6 EXHIBIT ENTERED AND MARKED P-1565
 7 COFFEY, Q.C.:
 8 Q. Thank you, Commissioner. Now before we break,
 9 I have no further questions for Ms. Bonnell.
 10 I have a comment, though, to the Commissioner,
 11 if I could.
 12 THE COMMISSIONER:
 13 Q. About other business?
 14 COFFEY, Q.C.:
 15 Q. Yes.
 16 THE COMMISSIONER:
 17 Q. All right. Thank you, Ms. Bonnell very much.
 18 As I've said it to other witnesses, we really
 19 do need to get the perspective of a lot of
 20 people on this issue and see how events
 21 unfolded from a number of different
 22 perspectives before I can even attempt to put
 23 it together and I very much thank you for your
 24 contribution to this process.
 25 MS. BONNELL:

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1 A. Thank you very much.
 2 THE COMMISSIONER:
 3 Q. Thank you. Now, Mr. Coffey?
 4 COFFEY, Q.C.:
 5 Q. Yes, Commissioner, I'm going to ask,
 6 Commissioner, that we adjourn until 2:00 at
 7 which point we would begin the evidence of Dr.
 8 Ejeckam. He is, of course, had travelled from
 9 outside the country. I understand that he has
 10 met with his counsel yesterday and I gather
 11 again this morning, and -
 12 THE COMMISSIONER:
 13 Q. So I presume counsel and Dr. Ejeckam agreed to
 14 this change in scheduling?
 15 COFFEY, Q.C.:
 16 Q. Yes, we have and I've advised counsel--he was
 17 anticipated to be here tomorrow at 9:30
 18 anyway. I've advised counsel in the room
 19 earlier this morning that that was going to
 20 happen.
 21 THE COMMISSIONER:
 22 Q. All right.
 23 COFFEY, Q.C.:
 24 Q. So if we could begin, and rather than start a
 25 witness now -

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1 THE COMMISSIONER:
 2 Q. And then have to interrupt.
 3 COFFEY, Q.C.:
 4 Q. Yes, that was the -
 5 THE COMMISSIONER:
 6 Q. All right then, we'll adjourn until 2:00.
 7 COFFEY, Q.C.:
 8 Q. Thank you, Commissioner.
 9 (ADJOURNED FOR LUNCH)
 10 THE COMMISSIONER:
 11 Q. Thank you. Please be seated. Mr. Coffey.
 12 COFFEY, Q.C.:
 13 Q. The next witness, Commissioner, is Gershon
 14 Ejeckam, Dr. Ejeckam.
 15 MR. GERSHON EJECKAM (SWORN) EXAMINATION BY BERNARD
 16 COFFEY, Q.C.
 17 DR. EJECKAM:
 18 A. My name is Gershon Chukwuemeka Ejeckam. G-E-
 19 R-S-H-O-N C-H-U-K-W-U-E-M-E-K-A. The last
 20 name, E-J-E-C-K-A-M.
 21 COFFEY, Q.C.:
 22 Q. Thank you, Commissioner. Good afternoon, Dr.
 23 Ejeckam. Commissioner, just at the outside I
 24 wanted to say, I wanted to thank Dr. Ejeckam
 25 for having come from Africa, as he's come

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1 quite a distance to testify. Myself and Ms.
 2 Chaytor have had the opportunity via telephone
 3 to interview him some time ago, but because of
 4 travel arrangements and his own schedule, it
 5 was convenient to have him testify at this
 6 point in time, and he, of course, is a
 7 physician and a pathologist and will be the
 8 first pathologist testifying before you.
 9 There will, of course, be subsequently a
 10 significant amount of pathology evidence which
 11 will come and laboratory evidence which will
 12 come from other witnesses, so Dr. Ejeckam
 13 will, in that sense, be somewhat testifying
 14 out of turn, as it were, but we did want to
 15 take advantage of his recollection of past
 16 events and his expertise and I gather in
 17 particular to a certain extent in terms of
 18 IHC.
 19 THE COMMISSIONER:
 20 Q. All right.
 21 COFFEY, Q.C.:
 22 Q. Doctor, I understand, Doctor--I want to thank
 23 you for providing your curriculum vitae.
 24 Registrar, please, if we could look at exhibit
 25 1601.

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1 THE COMMISSIONER:
 2 Q. So are there a number that have to be entered?
 3 COFFEY, Q.C.:
 4 Q. I apologize, yes, again, I'm ahead of myself.
 5 If I could please, Commissioner, if I could
 6 have entered the following exhibits, I
 7 understand 1570 through 1603.
 8 THE COMMISSIONER:
 9 Q. All right then, entered.
 10 EXHIBITS ENTERED AND MARKED P-1570 THROUGH TO P-1603
 11 COFFEY, Q.C.:
 12 Q. Thank you. Now, Doctor, if we could, please
 13 Registrar, bring up exhibit 1601? Thank you.
 14 Doctor, this is your curriculum vitae, Doctor,
 15 as well you do have, of course, a paper copy
 16 available to you, and as well you will see at
 17 times that the exhibits will come up on the
 18 screen in front of you. If you need to refer
 19 to it, I have it there for you, but what I am
 20 going to ask you is if you can give, perhaps,
 21 the Commissioner an overview of your
 22 educational and professional background.
 23 DR. EJECKAM:
 24 A. Thank you, Commission. I attended the
 25 elementary school in Nigeria and after I did

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1 my high school and went to University of
 2 Ibadan, that was one of the, I will say best
 3 medical schools in Africa at that time, and
 4 after my internship in 1972 to '73, then I
 5 came down to Canada, came up to Canada in
 6 Ottawa where I did my pathologic training. I
 7 did my anatomic pathology training in Ottawa
 8 and at the end of my training, I passed my
 9 exams and I had a fellow of Royal College of
 10 Physicians of Canada and I am a member of
 11 Royal College of Pathology, U.K. and diplomat
 12 of American Board of Pathology, I did do the
 13 exams and passed all those exams. Then after
 14 that, I went back to Nigeria to start work in
 15 the--teaching in the university of Nigeria
 16 there.
 17 COFFEY, Q.C.:
 18 Q. Go ahead, Doctor, from there?
 19 DR. EJECKAM:
 20 A. From there I spent about 20 months, Enugu,
 21 that's University of Nigeria Teaching Hospital
 22 and then I got invited to come to St. John's
 23 by Professor Kwan. I met Professor Kwan the
 24 first time, he was a professor at McGill
 25 University in Montreal. I spent some time

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1 doing some research with him on
 2 immunoflorescence and he invited me, I came
 3 for an interview and I was selected, so I
 4 started as an assistant professor of pathology
 5 at Memorial University. And I was doing my
 6 pathology practice at Grace Hospital, now
 7 closed. I spent roughly three years and
 8 returned to Nigeria in 1983 and went back to
 9 the university that I left, University of
 10 Nigeria, and I was there for awhile and later
 11 on, about 1989, I moved to Doha, the capital
 12 of Qatar in the middle east and I spent 13
 13 years there, working as an anatomic
 14 pathologist and held several positions within
 15 the department. And then, year 2002, I came
 16 back to St. John's and was re-hired as
 17 clinical associate professor of pathology at
 18 Memorial and then as staff pathologist at
 19 Health Sciences, General Hospital, and I
 20 remained there until I retired and went back
 21 to Nigeria in year 2006.
 22 COFFEY, Q.C.:
 23 Q. And, Doctor, what are you doing--what have you
 24 been doing since 2006?
 25 DR. EJECKAM:

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1 A. I got involved with trying to help a new
 2 medical school, University of Enugu State
 3 University of Science and Technology, Medical
 4 School, so I'm the chief pathologist and head
 5 of clinical laboratories. So I teach,
 6 basically, I teach medical students.
 7 COFFEY, Q.C.:
 8 Q. Even today, you're still teaching medical
 9 students.
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.:
 13 Q. Now, Doctor, I understand that in preparing to
 14 come here to testify that you've prepared a
 15 short slide presentation on basic
 16 immunohistochemistry. Before I have you take
 17 us through that, looking at your CV, okay, and
 18 if we could, please, Registrar, page 9.
 19 Doctor, I'm not going to take you through it
 20 in detail, but I gather, Doctor, beginning at
 21 page 9 of your resume through 10, through 11,
 22 through 12, and 13 and 14 and into page 15 of
 23 the exhibit, which is page 14 of your resume,
 24 that you have published a number of articles,
 25 authored and co-authored a number of articles.

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. And relating to pathology, pathology related
 5 matters and other aspects of medicine
 6 throughout your career?
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Okay, Doctor, in terms of immunohistochemistry
 11 or histochemistry and in particular
 12 immunohistochemistry, have you had
 13 professional experience in that regard?
 14 DR. EJECKAM:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. Could you tell the Commissioner then about how
 18 you got involved in it and what that
 19 experience is?
 20 DR. EJECKAM:
 21 A. Madam Commissioner, I got involved with
 22 immunohistochemistry quite early, I came in
 23 from my residency, then it was
 24 immunoflorescence that was being done and just
 25 simple interest. In our residency you had a

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1 choice of having an elective and I spent one
 2 month elective in immunology laboratory that
 3 was based in civic hospital in Ottawa and then
 4 from then on, when I finished my training,
 5 even during the training, I tried to at any
 6 time there was a conference who had college of
 7 American Pathology Conference, it's called
 8 CAP, then IAP, International Academy of
 9 Pathology, then ASCP, American Society of
 10 Clinical Pathology and then those were the
 11 main conferences, amongst other things that I
 12 entered from the same--I always tried to enter
 13 for anything that had to do with immunological
 14 things, so immunochemistry. I had no
 15 florescence at that time. So I developed the
 16 interest and carried on that and when I
 17 finished and went to Doha, in fact, before
 18 then, one of my papers, one of my good papers
 19 in CASA (phonetic) was the work I did with
 20 Professor Kwan that was published in CASA,
 21 that was immunoflorescence then because
 22 immunochemistry wasn't hardly in use, but it
 23 had the same principle. Then, of course, I
 24 continued with that and I wrote a number of
 25 papers, immunoflorescence, immunochemistry

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1 later on and then I continued with my
 2 interest, attending conferences in
 3 immunohistochemistry. But when I got into
 4 Doha, that's an opportunity because they had--
 5 initially had a small corner where we were
 6 doing it, but we found that it was not
 7 particularly good enough, so we created a good
 8 atmosphere, had a separate room and we had
 9 proper equipment, whereas it was DAKO part
 10 equipment and we developed a good
 11 immunohistochemistry and as head of anatomic
 12 pathology, that department was under my
 13 supervision. And so my interest in this
 14 subject grew and during that time, I was
 15 developing the subject, I sent some of my
 16 technologists to go to Florida to observe
 17 where a good immunohistochemistry laboratory
 18 is. I did that because for Dr. Nadji, whom I
 19 attended some of his conferences, was in
 20 Florida and he was a good immunohistochemist
 21 then and some of my staff went over there,
 22 spent, I think two of them went to spend one
 23 month each and that helped them to see the
 24 scope where a big laboratory and how it's
 25 done. So we developed a good laboratory and a

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1 good diagnostic (unintelligible) there and of
 2 course, when I came over -
 3 COFFEY, Q.C.:
 4 Q. So this was in Qatar.
 5 DR. EJECKAM:
 6 A. In Qatar.
 7 COFFEY, Q.C.:
 8 Q. In your area of time there.
 9 DR. EJECKAM:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. So when you went to Qatar, I take it, when you
 13 arrived there, do I understand you correctly
 14 that immunohistochemistry was not really
 15 developed within the laboratory -
 16 DR. EJECKAM:
 17 A. Yeah, it wasn't fully developed.
 18 COFFEY, Q.C.:
 19 Q. Fully developed within the lab there.
 20 DR. EJECKAM:
 21 A. Yeah, it was being done, but it wasn't, we had
 22 to--I had to take part in ensuring the overall
 23 development there, myself and Professor--Dr.
 24 Atalla (phonetic) who was the chairman of the
 25 department, but incidentally also an anatomic

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1 pathologist, but I was head of anatomic
 2 pathology division.
 3 COFFEY, Q.C.:
 4 Q. And as part of your duties in that regard, the
 5 IHC procedures were within your area of
 6 responsibility.
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. And so I understand you got a separate
 11 facility or a portion of a facility devoted to
 12 IHC, particular technologists devoted to it.
 13 DR. EJECKAM:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. And you arranged for education, for example of
 17 them in the United States, in Florida.
 18 DR. EJECKAM:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. Okay. And then over time, as the 90's went
 22 on, you developed, from your perspective what
 23 kind of quality lab did you develop?
 24 DR. EJECKAM:
 25 A. We developed a very good laboratory because

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1 having identified a structure and got
 2 equipment in, we trained our staff and in
 3 fact, we also encouraged them to go for
 4 conferences, so we worked hard on that and
 5 over a period, we developed a good laboratory
 6 and we also were registered with the CAP,
 7 College of American Pathologists for a
 8 standard of quality assurance. Later on we
 9 also hooked up with the British one, but the
 10 first was the CAP, so we had a kind of quality
 11 assurance going on and my supervisor, my
 12 technical supervisor encouraged hard to work
 13 hard and she--we developed a manual for
 14 immunohistochemistry and also a manual for the
 15 anatomic pathology generally, quality
 16 assurance manual.
 17 COFFEY, Q.C.:
 18 Q. Within your own--for your facility.
 19 DR. EJECKAM:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. And, Doctor, and you say eventually when the
 23 British or the United Kingdom, UKNEQAS program
 24 stated it, you became part of that as well?
 25 DR. EJECKAM:

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1 A. Yeah, but that was the tail end, I was about
 2 leaving by the time they hooked onto it, but I
 3 participated in encouraging them to hook up to
 4 that because seemed to have a fairly better
 5 program than the CAP one.
 6 COFFEY, Q.C.:
 7 Q. So, Doctor, if I could then, please, if we
 8 could bring up exhibit P-1603? Now this is
 9 just, of course the title page, "Basic
 10 Immunohistochemistry, IHC". If we could go
 11 to, please, to page 2, Registrar. Now I'm
 12 going to ask you then to take us through this,
 13 Doctor, and you can, of course, expand upon it
 14 as you see fit. You go ahead, sir.
 15 DR. EJECKAM:
 16 A. The first slide has three lines on it, three
 17 sentences, "IHC, Immunohistochemistry
 18 harnesses, the immunological mechanism in
 19 human beings in cold virus." What happens is
 20 we all have cold one time or the other and
 21 this is due to viruses. Now when the virus
 22 enters our body, it causes disease, but the
 23 body will recognize the virus as a foreign
 24 material. Now those whom we call immune
 25 competent, that's people whose immune system

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1 is okay, as opposed to, let's say, Aids
 2 patients whose immune system is depressed,
 3 will mount defence against that virus and the
 4 process of defending themselves, the body will
 5 not develop antibodies against those viruses.
 6 Now, the antibody is not developed against the
 7 whole virus, there are molecules within that
 8 virus will call antigens sites where the, that
 9 will excite the production of antibody. Now
 10 these antibodies would then combine with the
 11 virus at the sites, through complex processes
 12 we kill the virus and that is the way the
 13 body's defence mechanism goes, and the cells
 14 that are responsible for providing these
 15 antibodies are lymphoid cells, lymphocytes and
 16 plasma cells, but we'll call them lymphoid
 17 cells. So the antibodies are manufactured as
 18 in the last line there, they are biologically
 19 manufactured by these cells to target the
 20 foreign object that has the virus, which is
 21 the foreign object within us. So our body
 22 that way is able to defend itself. Now what
 23 has happened that the immunochemistry has now
 24 used the same principle, because what we try
 25 to do in immunochemistry that we want to find

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1 out, we want to target certain molecules
 2 within cells. Now those molecules, we can
 3 not--if you have a tumor that has some
 4 molecules in them, I may not be able to tell
 5 what it is, but if I can pick up a molecule
 6 there and develop antibody to it, then I might
 7 then be able to combine that antibody to that
 8 site and then look at it under a microscope,
 9 then I can now tell, oh, that's what is in
 10 there, and each cell has its own
 11 peculiarities. So when I pick a cell that is
 12 from the skin, there are some peculiarities
 13 there that if I use it, I will develop
 14 antibodies that will tag onto that and tell me
 15 it's from the skin. If I take some molecules
 16 from the liver, and produce antibodies, it
 17 will tag onto it and I will know that this is
 18 from--because the way you combine that
 19 antibody produced will combine with the
 20 antigen that made it to be produced. It's not
 21 going to combine with some, you have
 22 background problem, okay, so when this
 23 combination takes place, it tells you that
 24 that antigen or that foreign stuff that had
 25 been injected, has excited the production of

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1 the antibody. So this is exactly what we do
 2 in the immunochemistry--my people, the
 3 companies take cells from different parts of
 4 the body and inject it in mice or rabbits,
 5 because we have to make sure that molecules is
 6 injected in a different species of animal,
 7 which will recognize that as foreign, that's
 8 important. If you recognize that as foreign,
 9 then to mount a defence against it and that
 10 defence is producing antibodies. So when
 11 injected in rabbit or mice, antibodies are
 12 produced.
 13 COFFEY, Q.C.:
 14 Q. Go ahead, Doctor, I'll show you right here, do
 15 you see that?
 16 DR. EJECKAM:
 17 A. Okay, okay. The antibodies will be produced
 18 and these antibodies will be combining
 19 specifically with those antigens. So what
 20 we've done now is we've taken a molecule from
 21 human beings, injected it in mice, it will
 22 produce antibodies. So now immunochemistry,
 23 what we now do is we have this antibodies
 24 marketed so that if I'm looking for a tumor
 25 from the skin or liver and if I get antibody

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1 against liver cell, I can then react it to the
 2 tumor. And if I do, if it attaches onto it,
 3 then I will know that tumor is from liver.
 4 Now, the process doesn't end there because
 5 that reaction you cannot see it, visualize it
 6 at the first stage, then you have to go
 7 further to amplify that. Now, just back to
 8 what you're saying, this is valuable to do
 9 with estrogen receptors here, that in breasts,
 10 the same type of molecules in the breast
 11 cells, when we start them, we inject them in
 12 rabbit, we get antibodies against estrogen and
 13 progesterone. So when we get those antibodies
 14 in the rabbit tumor that we have in the lab,
 15 then we try to react that and see whether
 16 there is presence of estrogen or progesterone
 17 receptor on that tumor because if they are
 18 there, that antibody produced will then
 19 combine with it. Then after the combination,
 20 then you need to highlight so they can see
 21 that.
 22 Now, because you fix the tissues in
 23 formalin, normally if you get the tissue
 24 fresh, if you don't fix it, the cell membrane,
 25 because every cell had a cell membrane, once

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1 you take it from the body, the mechanism
 2 keeping that cell membrane intact while in the
 3 body would be removed, and if you don't fix
 4 it, the enzymes will elute out and destroy the
 5 cell. So we fix it in formalin. Now, this
 6 fixation in formalin sort of binds the protein
 7 and sort of marks the sites where these
 8 antigens are.
 9 So we go through the process of
 10 processing the tissue and after we finish
 11 processing tissue, we use the number dye we
 12 use for staining histology, we call it HNE
 13 hematoxylin and eosin. Hematoxylin will stain
 14 the nucleus and eosin will stain the cell
 15 cytoplasm. Now, when you then look at those
 16 slides and pick the best one, that best one
 17 will contain the tumor that you want to
 18 examine, it should also contain no more tissue
 19 as an internal control for you. Then that,
 20 when you choose it, then you ask the
 21 technologist to pick the block from which that
 22 particular slide was produced to do the
 23 immunohistochemistry. And so what they would
 24 do is to cut sections and do what you call
 25 antibody retrieval, and the reason for this is

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1 this, if you try to do the stain to show those
 2 antibodies antigen sites that early, because
 3 of formalin fixation, you may have destroyed
 4 some of those sites or it may have been masked
 5 by reaction. So when what you call antigen
 6 retrieval is to put the sections and heat it
 7 up, there are many methods, either you boil
 8 them up in pressure cooker or use microwave,
 9 different methods in different laboratories.
 10 What you are trying to do is to unmask those
 11 sites, those molecules that were used to
 12 produce antibodies. So once you unmask it,
 13 then the antibodies that you using now will
 14 combine with it.
 15 Now, after the combination you need to
 16 now visualize it. The reaction has taken
 17 place. So in this diagram here, the flat area
 18 where you have the small, small squares or
 19 triangles--squares, those are the sites of the
 20 antigen on the tissue. Now, the other figure
 21 on top of it is the antibody. The antibody
 22 has two light chains and two heavy chains, but
 23 we'll not go into that.
 24 Now, in our reaction we get an antibody,
 25 we'll call it the primary antibody and put it

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1 on the tissue so it will react with the
 2 antigen, but you will still not be able to see
 3 it. Then you go to the next stage where you
 4 now add a second antibody. Now, in the first
 5 stage you can try to see by using a dye, but
 6 because it's limited, then what you see may be
 7 also limited, so we expand it by using
 8 secondary antibody. And secondary antibody
 9 will now contain material that will help us to
 10 visualize this reaction. So that is second
 11 stage.
 12 Then you go to the next stage after the,
 13 everything has done, the reaction has been
 14 done, then you want to visualize it. This
 15 shows the antigen, antibody reaction already
 16 done there with the two antibodies there, but
 17 you cannot see it. Then all this Avidin, the
 18 one in green on top of there and the
 19 biotinylated peroxidase, the one in the red
 20 and blue, they need to combine to this
 21 antibody for us to see it. So the next stage
 22 is when this reaction goes on, you see what
 23 has happened, it has combined and is tightly
 24 attached to it. You still won't be able to
 25 see it under microscope because you need a

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1 dye. So what you, what DAB, it's called
 2 diaminobenzidine, this is a compound that when
 3 you react it with hydrogen peroxide and this
 4 complex, it will turn brown. So what's
 5 happened that at this stage, then you get the
 6 brown colour that we see in
 7 immunohistochemistry. Now, the brown colour
 8 has to be properly interpreted because this
 9 antigen we're talking about the molecule of
 10 taking (unintelligible) antibody can be in
 11 three different places. It can be on the
 12 nuclear material, so certain antibodies,
 13 certain like estrogen and progesterone, the
 14 staining will be inside the nucleus. If there
 15 is any staining in the cytoplasm, that is not
 16 a positive reaction. Now, some other tissues
 17 will be cytoplasmic, within the cytoplasm.
 18 The nucleus will be free, the cell membrane
 19 will be free and the reaction within the
 20 cytoplasm. The third point will be membranous
 21 like leukocytic common antigen which we use to
 22 identify lymphoid cells, it stains only the
 23 membrane. So if it's staining the cytoplasm
 24 when it is supposed to be staining membrane,
 25 then that's not an expected reaction. So this

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1 is basically the, what we need to, what you
 2 do.
 3 Now, what is the use of
 4 immunohistochemistry? I've listed here one,
 5 the differentiation of tumors. Why?
 6 Sometimes you get a biopsy that has small
 7 tumors in it, call it small or like cell
 8 tumors. Under a microscope you cannot tell
 9 whether it's coming from lymphoid origin or
 10 from a particular origin or from stromal
 11 origin, that's connective tissue origin.
 12 There is malignant, all right, but treatment
 13 would be different depending on what you call
 14 it. So for differentiation what they use
 15 antibodies produced against a particular
 16 molecule, lymphoid molecule, then stromal
 17 molecule because you should have a panel, it's
 18 not just doing one. Then that panel outside
 19 the staining, then you look at it and it tells
 20 you, oh, that tumor is of lymphoid origin,
 21 then leukocyte common antigen will be
 22 positive. A particular antigen like
 23 cytokeratin will be negative. The
 24 (unintelligible) for stromal will be negative.
 25 So you now have a diagnosis instead of saying

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1 undifferentiated carcinoma, you then say
 2 lymphoma.
 3 Then of course you go further to classify
 4 the lymphoma, is it a B-cell lymphoma or a T-
 5 cell lymphoma because the treatment the
 6 oncologist will use will depend on what type.
 7 And there are also molecules in these
 8 lymphomas, lymphoid cells that are being used
 9 to produce antibodies. So for B-cell
 10 lymphomas will have antibodies like CD20,
 11 CD19, these are specific for B cells. For T
 12 cells you have CD3, so, or CD5. So you use
 13 this panel again to tell the oncologist that
 14 this tumor is a lymphoma and then give to them
 15 then, depending on if it's large or small or
 16 what type, and I say B-cell lymphoma because
 17 the treatment will be different if you said a
 18 T-cell lymphoma.
 19 Then we look for original invasion of
 20 cancerous cells. Example, if someone has a
 21 tumor on his skin and I look at it and it's an
 22 a petalia (phonetic) tumor and it's not
 23 arising from the skin, then we need to find
 24 the primary. And the way it looks on the HNE,
 25 because that's the first thing you got to look

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1 at, the HNE will be the first thing you look
 2 at, the way it looks will make you now
 3 determine which panel to use. Then if it's a
 4 petalia, it could be coming from the prostate,
 5 if it's a man. If it's a woman, it could be
 6 coming from the ovary, could be coming from
 7 the endometrium, it could be coming from the
 8 cervix, it could be coming from liver, if it's
 9 either sex. So, what you do now from the way
 10 it looks on HNE, then you review the panel to
 11 see what antibody that will react with this
 12 antigen inside the cells. And when you do
 13 that, you may end up saying, oh this tumor in
 14 the skin here came from the lungs, came from
 15 the prostate. So, the oncologist will know
 16 that they're dealing with a metastatic tumor.
 17 That is not the primary tumor in the skin
 18 because if it was a primary tumor on the skin,
 19 the treatment is a lot easier, they just
 20 excise it or do a (unintelligible) whatever
 21 they wish to do. But it is metastatic, he
 22 needs to know that the tumor has left the site
 23 of origin and spread. And for it to go to the
 24 skin from the liver or prostate, it has
 25 travelled some distance.

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1 So, the immunohistochemistry is useful in
 2 this area and then, of course, down to the
 3 problem we have, the diagnostic and prognostic
 4 proteins of ER/PR. So, the antibodies
 5 reaction will help in telling the oncologists,
 6 treatment modalities. As in breast, if you
 7 have a breast tumor, we go through the same
 8 process, cut sections, process it, pick a
 9 section, go through the process I've just
 10 described and then use antibodies to estrogen
 11 and progesterone. Now, if it is positive and
 12 there's a nuclear stain, you have to know it's
 13 a nuclear stain--sorry, a cytoplasm stain, if
 14 it's positive then, you will report that this
 15 is positive. Now, the reporting system will
 16 probably go into that later, because there is
 17 not--you know, it's not completely agreed on
 18 what the cut off line is, but if it's
 19 positive--and what does it tell to the
 20 oncologist? It tells the oncologist that this
 21 tumor is estrogen positive, therefore, he
 22 could use anti-estrogen to treat the patient.
 23 If it's negative, he or she may not waste the
 24 time to give this therapy. Having say that,
 25 we know that 10 percent, about, of positive

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1 cases do not respond to anti-estrogen
 2 treatment, and 10 percent of tumors that are
 3 negatives will respond. So, it's a question
 4 of putting everything on balance. So, I think
 5 that will summarize the use a what
 6 immunohistochemistry stands for and where we
 7 use it. Thank you.
 8 COFFEY, Q.C.:
 9 Q. Now, Doctor--no, thank you, Doctor. Could you
 10 tell us, please, what you've just described
 11 here, at what stage in your training or by
 12 what stage in your training would you have
 13 come to the understanding you just gave us?
 14 DR. EJECKAM:
 15 A. Well, it came on long over a period of time.
 16 There's no particular point where you can say,
 17 here I've got it, but this was being done
 18 along the line and I was doing
 19 immunofluorescence before. And the process is
 20 the same thing. But as you do it, you then
 21 look at--I mean, with years of experience then
 22 you will be able to gather some more
 23 information. I mean, it's a question of how
 24 much time you have been with it and how much
 25 you've been doing, working on it.

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1 COFFEY, Q.C.:
 2 Q. In terms of, for example, in your period in
 3 Qatar.
 4 DR. EJECKAM:
 5 A. Yeah.
 6 COFFEY, Q.C.:
 7 Q. Which would be effectively the 1990s?
 8 DR. EJECKAM:
 9 A. Yeah.
 10 COFFEY, Q.C.:
 11 Q. Before the 1990s and just afterward, but
 12 effectively in your case throughout the 1990s,
 13 this approach to usage of IHC, was that, in
 14 effect, within your hospital at the time?
 15 DR. EJECKAM:
 16 A. I mean, the immunohistochemistry?
 17 COFFEY, Q.C.:
 18 Q. Yes, this approach.
 19 DR. EJECKAM:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Okay.
 23 DR. EJECKAM:
 24 A. That's what we used, that's what we used.
 25 COFFEY, Q.C.:

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1 Q. Now, Doctor, again, to help put this in some
 2 perspective for the Commissioner, I take it
 3 when you began, as you say, it was
 4 immunofluorescence?
 5 DR. EJECKAM:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. Was the precursor at the time to IHC?
 9 DR. EJECKAM:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. When you first got involved in IHC,
 13 approximately how many stains would there have
 14 been available when you first got involved?
 15 DR. EJECKAM:
 16 A. Oh, very few, very few, probably cytokeratin,
 17 S100 and very few of them.
 18 COFFEY, Q.C.:
 19 Q. Very few.
 20 DR. EJECKAM:
 21 A. But now probably, depending on how much money
 22 the laboratory has, some up to 150, some 200
 23 antibodies in the market now. So it depends
 24 on the practice in the laboratory.
 25 COFFEY, Q.C.:

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1 Q. So in the early days there would have been
 2 certainly less than a dozen?
 3 DR. EJECKAM:
 4 A. Yeah.
 5 COFFEY, Q.C.:
 6 Q. In the very early days?
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.
 10 Q. And now it's 150, 160 and rising, I take it?
 11 DR. EJECKAM:
 12 A. Yeah.
 13 COFFEY, Q.C.
 14 Q. Could you tell the Commissioner, please, again
 15 with your experience, during what period the
 16 number of stains that have come onto the
 17 market, has it come faster and faster as time
 18 has gone on? And if so, what period saw the
 19 greatest develop?
 20 DR. EJECKAM:
 21 A. I would say '80s, late '70s, early '80s, a lot
 22 of antibodies were being pushed into the
 23 market, some of them weren't completely
 24 useful. It's a question of when they come
 25 out, you buy it and try it in your laboratory

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1 and that's if you--depend on your practice.
 2 If you want to be identifying certain
 3 particular type of lesions, then you had to
 4 buy antibodies that will help you do that.
 5 And depending on your budget, too.
 6 COFFEY, Q.C.
 7 Q. Now, on that point, talking about budgets and
 8 money, in Qatar during the beginning of '89, I
 9 gather, when you moved there and throughout
 10 the '90s as you developed the IHC portion of
 11 the lab there, was money a concern?
 12 DR. EJECKAM:
 13 A. No.
 14 COFFEY, Q.C.:
 15 Q. At the time?
 16 DR. EJECKAM:
 17 A. We had no problem with money. It's a rich
 18 country. But it's not just being rich, I
 19 think there's the proper management of the
 20 funds.
 21 COFFEY, Q.C.:
 22 Q. And so you had, in terms of your vision for
 23 the development of IHC within your hospital
 24 there, you had a vision and your fellow staff
 25 did in management and access to a significant

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1 amount of money to do it?
 2 DR. EJECKAM:
 3 A. Yes. The process works this way, whatever you
 4 needed and you requested for it, you will be
 5 required to justify that. If you justify it
 6 that this is for patient care and of
 7 diagnostic use, most of the times the budget
 8 committee will approve that and within three
 9 months, six months, they will send out for
 10 tender to procure that for you.
 11 COFFEY, Q.C.
 12 Q. Now, Doctor, when you were here, and I gather
 13 you were here in the 19--between about 1980
 14 and '83?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.
 18 Q. In St. John's, or at St. Clare's.
 19 DR. EJECKAM:
 20 A. Grace Hospital.
 21 COFFEY, Q.C.
 22 Q. I'm sorry, the Grace. I apologize. Was there
 23 any usage of IHC here at the time, that you
 24 recall?
 25 DR. EJECKAM:

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1 A. Not for diagnosis purposes.
 2 COFFEY, Q.C.
 3 Q. Okay. And when you returned to Newfoundland
 4 in 2002, what did you find--well, first of
 5 all, where did you go to work first, in -
 6 DR. EJECKAM:
 7 A. General Hospital.
 8 COFFEY, Q.C.
 9 Q. General Hospital?
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.
 13 Q. And your position there at the time was what,
 14 exactly?
 15 DR. EJECKAM:
 16 A. Staff pathologist.
 17 COFFEY, Q.C.
 18 Q. Staff pathologist.
 19 DR. EJECKAM:
 20 A. And then a title, titled university associate
 21 clinical professor.
 22 COFFEY, Q.C.
 23 Q. Did you do any teaching?
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.
 2 Q. And what sorts of level of students did you
 3 teach?
 4 DR. EJECKAM:
 5 A. Pathology, pathology students. They do
 6 pathology one time, I think, third or fourth
 7 year student, but pathology students end with
 8 (phonetic).
 9 COFFEY, Q.C.
 10 Q. Doctor, when you--that would be on the General
 11 Hospital site. Who was the clinical chief
 12 when you arrived?
 13 DR. EJECKAM:
 14 A. Dr. Don Cook.
 15 COFFEY, Q.C.
 16 Q. And was there a discipline chair at the time,
 17 do you recall?
 18 DR. EJECKAM:
 19 A. Chairman of the -
 20 COFFEY, Q.C.
 21 Q. Yes.
 22 DR. EJECKAM:
 23 A. Doctor Robb.
 24 COFFEY, Q.C.
 25 Q. And so you arrived, how was IHC--first of all

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1 when you arrived in Newfoundland in 2002, do
 2 you recall what month of year that was?
 3 DR. EJECKAM:
 4 A. I think I came in in August and started
 5 working in September.
 6 COFFEY, Q.C.
 7 Q. Okay. When you arrived, who, if anyone on the
 8 medical staff did you already know?
 9 DR. EJECKAM:
 10 A. I know Don, I knew -
 11 COFFEY, Q.C.
 12 Q. So, you know Doctor Cook from the -
 13 DR. EJECKAM:
 14 A. Yeah, because when I was--then the agency--the
 15 residents training then and descendant with
 16 Avis, those were residents.
 17 COFFEY, Q.C.
 18 Q. Who?
 19 DR. EJECKAM:
 20 A. Doctor Avis.
 21 COFFEY, Q.C.
 22 Q. Okay. Dr. Simon Avis.
 23 DR. EJECKAM:
 24 A. Yeah, Simon, yeah. I think both of them were
 25 residents in those days, these are the ones

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1 that I knew before coming in. And then Doctor
 2 Fernandez and Dr. Chital (phonetic), those
 3 were colleagues when I was there before.
 4 COFFEY, Q.C.
 5 Q. Could you tell the Commissioner, please, as a
 6 staff pathologist at the time when you first
 7 arrived, I mean, how did your, kind of, normal
 8 routine work go, in the sense of who did
 9 report to if anybody, how was work assigned?
 10 DR. EJECKAM:
 11 A. My job then was to work as a staff pathologist
 12 and what we did was to diagnose tissues that
 13 were sent from the surgeons, whichever
 14 orthopaedic or general surgeon or
 15 dermatologist and then secondly to do
 16 autopsies if any time that a request was
 17 obtained, and there was scheduling, so I
 18 worked on the day that I was scheduled to work
 19 and I was a site chief and effectively would
 20 report to the site chief and then to the
 21 clinical chief.
 22 COFFEY, Q.C.
 23 Q. And your work, I take it would be whatever was
 24 assigned to you -
 25 DR. EJECKAM:

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1 A. Yes, whatever comes the day I'm on.
 2 COFFEY, Q.C.:
 3 Q. At the time you arrived in Newfoundland in
 4 2002, where in Newfoundland was IHC testing
 5 being done or processing being done?
 6 DR. EJECKAM:
 7 A. At the General Hospital.
 8 COFFEY, Q.C.:
 9 Q. When you first arrived and would have gone to
 10 work, I take it, in September of 2002, where
 11 was the IHC lab located?
 12 DR. EJECKAM:
 13 A. Within the laboratory, anatomical pathology
 14 laboratory, within the open laboratory.
 15 COFFEY, Q.C.:
 16 Q. And how would what you found there compare to
 17 what you had left in Qatar, the facility
 18 there?
 19 DR. EJECKAM:
 20 A. Well, what they had then was what you had
 21 initially in Qatar, before we moved to
 22 separate structure, separate room. So you
 23 know, it was--by the time I left Qatar, the
 24 institution was different.
 25 COFFEY, Q.C.:

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1 Q. Yes, I appreciate that you said when you went
 2 to Qatar in the beginning, it was all -
 3 DR. EJECKAM:
 4 A. Yeah, same situation.
 5 COFFEY, Q.C.:
 6 Q. So what you found in St. John's in 2002 was
 7 similar to what you'd found in Qatar in 1989?
 8 DR. EJECKAM:
 9 A. Yeah.
 10 COFFEY, Q.C.:
 11 Q. In the sense of the layout?
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. And the position or lack of isolation from the
 16 rest of the lab?
 17 DR. EJECKAM:
 18 A. Yeah, that was in the open laboratory.
 19 COFFEY, Q.C.:
 20 Q. What is the--why is it desirable to have IHC
 21 portion of the lab separate from the general
 22 lab facility?
 23 DR. EJECKAM:
 24 A. Well, for a number of reasons.
 25 Immunohistochemistry, I contend that it's not

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1 just ordinary special stains. It is very
 2 sensitive stain and if you do this in open
 3 laboratory where you have fumes of formalin,
 4 xylene and things like that, you may never be
 5 sure what may affect it. That's one, and two,
 6 you need a room that has--that's air-
 7 conditioned and has good humidity for the
 8 machines to work properly. If you leave them
 9 open laboratory, they may or may not be
 10 working properly. But that may not have been
 11 a problem, because, you know, it wasn't an
 12 issue. But to have an optimum place, you need
 13 to have it isolated.
 14 COFFEY, Q.C.:
 15 Q. Isolated and -
 16 DR. EJECKAM:
 17 A. From the general open laboratory and also have
 18 dedicated technologists to work there.
 19 COFFEY, Q.C.:
 20 Q. Now when you had shown up in Qatar first in
 21 1989, were the technologists who were doing
 22 IHC dedicated?
 23 DR. EJECKAM:
 24 A. No.
 25 COFFEY, Q.C.:

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1 Q. And how did that change over time?
 2 DR. EJECKAM:
 3 A. It changed when we moved to the new structure
 4 and the new laboratory and we also noted that
 5 if we didn't put people there permanently,
 6 then it would be difficult to master the
 7 technique and also to be able to do trouble
 8 shooting. We also realized that if we
 9 dedicate staff, we would be able to send them
 10 out periodically for additional training. So
 11 this was what we did and it worked out fine
 12 for us.
 13 COFFEY, Q.C.:
 14 Q. So in 2002, in September when you arrived,
 15 what did you find with respect to which staff
 16 were doing the IHC work in St. John's? Were
 17 there any dedicated staff at the time?
 18 DR. EJECKAM:
 19 A. I wouldn't say there was dedicated staff. The
 20 senior people then, Ken Green, Mary Butler.
 21 COFFEY, Q.C.:
 22 Q. Mary Butler.
 23 DR. EJECKAM:
 24 A. And I think Les were all assigned to this. I
 25 think Les came later on, because I think he

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1 was at St. Clare's. He came over later.
 2 These two guys were responsible for this and
 3 they were also responsible for other duties in
 4 the laboratory.
 5 COFFEY, Q.C.:
 6 Q. I'm sorry, they were also?
 7 DR. EJECKAM:
 8 A. They were also responsible for other duties in
 9 the laboratory.
 10 COFFEY, Q.C.:
 11 Q. Other duties?
 12 DR. EJECKAM:
 13 A. Yeah.
 14 COFFEY, Q.C.:
 15 Q. Okay, and in the fall of 2002, did you have
 16 any particular interaction with IHC portion of
 17 the lab, in the fall of 2002, any more so than
 18 other pathologists?
 19 DR. EJECKAM:
 20 A. No, not really. Well, I looked in once in a
 21 while, but not in particular.
 22 COFFEY, Q.C.:
 23 Q. Okay. Did you have any--now bearing in mind
 24 what you'd seen and done in Qatar throughout
 25 the 1990s, did you have any thoughts or

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1 feelings at the time about the desirability of
 2 what was going on in the IHC at that point, in
 3 the fall of '02?
 4 DR. EJECKAM:
 5 A. Yeah, well, I mean, in my mind, I thought that
 6 it would be nice to have the same situation as
 7 we finally achieved in Qatar.
 8 COFFEY, Q.C.:
 9 Q. Did you communicate that to anybody initially?
 10 DR. EJECKAM:
 11 A. No, because I mean, I wasn't particularly
 12 involved with this, so I didn't discuss that
 13 with anybody.
 14 COFFEY, Q.C.:
 15 Q. Doctor, if we could, again, if we could look,
 16 please, at Exhibit P-1600? And Doctor, this
 17 is--this will come on the screen in fact as
 18 well in front of you there, and now this is
 19 just a listing, Doctor. It relates to
 20 pathologists staff turnover, but it shows the--
 21 there's a list of incumbents, as it were, or
 22 list of pathologists. You'll recognize a
 23 number of names.
 24 DR. EJECKAM:
 25 A. Yeah.

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1 COFFEY, Q.C.:
 2 Q. You'll see the cursor right here?
 3 DR. EJECKAM:
 4 A. Yeah.
 5 COFFEY, Q.C.:
 6 Q. Gershon Ejeckam.
 7 DR. EJECKAM:
 8 A. Yeah.
 9 COFFEY, Q.C.:
 10 Q. And it has the start date, September 16th 2002
 11 and what they refer to as the termination
 12 date, April 30th 2006, your retirement.
 13 DR. EJECKAM:
 14 A. Yeah.
 15 COFFEY, Q.C.:
 16 Q. Okay, so that would bracket more or less the
 17 time you worked in St. John's?
 18 DR. EJECKAM:
 19 A. Yes, that reflects the time I was there.
 20 COFFEY, Q.C.:
 21 Q. At least the second time around. Just a
 22 moment, please. Just a moment, please,
 23 Commissioner. When you came to work in St.
 24 John's in 2002, is there any particular
 25 process you had to go through to apply and to

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1 get certified here, you know, to carry on as a
 2 pathologist in Newfoundland?
 3 DR. EJECKAM:
 4 A. I already have--I'm already a Fellow Royal
 5 College of Physicians of Canada.
 6 COFFEY, Q.C.:
 7 Q. Yes.
 8 DR. EJECKAM:
 9 A. I trained in Canada, so that qualifies me to
 10 work and then the sponsoring body sponsored me
 11 to the Newfoundland Medical Board for license
 12 to practice.
 13 COFFEY, Q.C.:
 14 Q. And if we could, please, Exhibit P-1570, in
 15 particular, I'm just going to go to--just a
 16 second. Actually, Doctor, just so you have
 17 some sense of this, this is a performance
 18 goals and objectives for clinical chiefs for
 19 2002-2003 for Dr. Cook, but there's a--looking
 20 at page three of the exhibit, one of the
 21 objectives for Dr. Cook is to oversee the
 22 start up of a surgical pathology review
 23 committee, and the goal as of January 1, 2003
 24 was the committee would be set up under the
 25 chairperson, yourself?

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. You chair it?
 5 DR. EJECKAM:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. And they're hoping to have their first meeting
 9 by May or June of 2003, and there's a note
 10 here that by April 1st 2003, the committee had
 11 been operationalized or started or organized
 12 by that time, and by October 1st 2003, the
 13 committee was meeting on a regular basis and
 14 issues were referred to the clinical chief and
 15 VP Medical Services to follow up. So could
 16 you tell us, please, first of all, have you
 17 confirm, you did chair that committee?
 18 DR. EJECKAM:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. Could you tell the Commissioner how the
 22 committee came about?
 23 DR. EJECKAM:
 24 A. During some of my discussions with Dr. Cook,
 25 because he would come over when I arrived and

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1 we would have general chatting about the
 2 general work process, about the need for
 3 quality assurance and the need for tissue
 4 audit, then based on that, I would suspect he
 5 set up this surgical review committee and I
 6 believe looking through my curriculum vitae, I
 7 was a chairman of tumor board and tissue
 8 committee and several in Doha. So he probably
 9 felt that I could wait and then requested me
 10 to chair the committee. So he went ahead and
 11 formed the composition of the committee and I
 12 believe he discussed it with the higher
 13 authorities and we had membership to this
 14 committee, representative from all--I think
 15 most of the clinical departments were there.
 16 So, and we had a mandate, you know, to
 17 kind of conduct basically tissue audit and
 18 quality assurance process among the
 19 laboratory, specimens sent into the laboratory
 20 and as well as the reports going out of the
 21 laboratory.
 22 COFFEY, Q.C.:
 23 Q. And you say that when Dr. Cook, I take it,
 24 would come over to the General Hospital site,
 25 because he was at St. Clare's?

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Stationed in St. Clare's. That I gather this
 5 would be what, in the fall of 2002?
 6 DR. EJECKAM:
 7 A. Well, I can't put a date to that, but you
 8 know, he would come in, you know, either for
 9 meetings or whatever.
 10 COFFEY, Q.C.:
 11 Q. And the subject of quality control, quality
 12 assurance would come up?
 13 DR. EJECKAM:
 14 A. Yeah.
 15 COFFEY, Q.C.:
 16 Q. And the need for that?
 17 DR. EJECKAM:
 18 A. Yeah.
 19 COFFEY, Q.C.:
 20 Q. Do you recall how that came about? I mean,
 21 the discussion about that.
 22 DR. EJECKAM:
 23 A. There was nothing other than, I believe, just
 24 he would come to my room chatting about the
 25 work process and I would probably have tell

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1 him--discussed my experience in Doha. There
 2 was no particular--I don't remember of any
 3 particular issue that made that happen.
 4 COFFEY, Q.C.:
 5 Q. Okay.
 6 DR. EJECKAM:
 7 A. It was based on general discussion.
 8 COFFEY, Q.C.:
 9 Q. And a general approach I take it?
 10 DR. EJECKAM:
 11 A. Yeah, yeah.
 12 COFFEY, Q.C.:
 13 Q. And in the course of talking about it, you
 14 would speak about your own experiences?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. In the '90s in particular?
 19 DR. EJECKAM:
 20 A. Yeah.
 21 COFFEY, Q.C.:
 22 Q. And it's your understanding that Dr. Cook,
 23 having listened to you talk about it, was
 24 interested in having you get involved in it?
 25 DR. EJECKAM:

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1 A. I believe so.
 2 COFFEY, Q.C.:
 3 Q. Yes. Tissue audit, because you referred to
 4 that, could you tell the Commissioner, please,
 5 what a tissue audit is?
 6 DR. EJECKAM:
 7 A. Well, it may have different meaning to
 8 different people, but my understanding is that
 9 when you do tissue audit, we'd look at the
 10 surgical material, that is biopsies or
 11 whatever has been taken out from the patient,
 12 sent into the laboratory by the surgeons.
 13 Now first of all, to see somebody may
 14 remove normal tissues, where they're so often,
 15 then of course, if there is no pathology in
 16 this, for instance, an appendix, a surgeon may
 17 be having a lot of appendixes removed and then
 18 if we keep saying no pathology in that
 19 appendix, then that may--we tend to flag it to
 20 see is he making a proper diagnosis before
 21 removing the appendix. The same things goes
 22 with people who may be doing hysterectomies.
 23 These are things that you look at.
 24 Then of course, looking at the request
 25 for the surgical material when it comes down,

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1 we would look at the forms, whether they were
 2 properly completed, whether the information
 3 required by the pathologist were there or not,
 4 and then again, you should also look at the
 5 reports by the pathologist because the
 6 clinician may be unable with a report. This
 7 committee should be able to deal with that
 8 kind of complaints.
 9 COFFEY, Q.C.:
 10 Q. And when you -
 11 THE COMMISSIONER:
 12 Q. It worked both ways?
 13 DR. EJECKAM:
 14 A. Yes.
 15 THE COMMISSIONER:
 16 Q. The things that you could--your committee
 17 could look at what came from the surgeons who
 18 would be either sending samples or requests to
 19 you to see whether or not things were going
 20 well from that end, and the surgeons, if they
 21 had a problem with the information they were
 22 getting back from the pathologists, could
 23 raise that in this context as well?
 24 DR. EJECKAM:
 25 A. Yes, Commissioner, yeah.

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1 THE COMMISSIONER:
 2 Q. Okay.
 3 COFFEY, Q.C.:
 4 Q. Now Doctor, when you arrived in St. John's in
 5 2002 and went to work, what, if any, quality
 6 assurance or quality control programs did you
 7 see or understand the pathology department was
 8 involved in, from the perspective of
 9 anatomical pathology? Were they participating
 10 in anything, and if so, what do you recall?
 11 DR. EJECKAM:
 12 A. I don't recall any particular quality
 13 assurance process, but I would suspect that
 14 the laboratory was already registered with the
 15 CAP, College of American Pathologists. I
 16 don't know if that time they registered, so
 17 they could have registered before I came in,
 18 and that's a quality assurance process.
 19 COFFEY, Q.C.:
 20 Q. And do you know, at the time again you arrived
 21 and got involved in this surgical--or after
 22 you arrived and you got involved in this
 23 surgical pathology review committee, was there
 24 at that point any tissue audit process in
 25 place?

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1 DR. EJECKAM:
 2 A. No, not that I--none that I know of.
 3 COFFEY, Q.C.:
 4 Q. Because you were about to start or embark upon
 5 it?
 6 DR. EJECKAM:
 7 A. Yes, yes.
 8 COFFEY, Q.C.:
 9 Q. You were being asked to do that. How about
 10 this issue of reports, written requests,
 11 requisitions coming in from surgeons for
 12 example, okay, and I will be referring you to
 13 some of that because there's material here on
 14 what you did about it, but did you have any
 15 concerns when you first arrived and started--
 16 you know, and got into the work here in 2002
 17 as to deficiencies in that regard?
 18 DR. EJECKAM:
 19 A. This is not peculiar. Surgeons are notorious--
 20 well, I shouldn't use the word--surgeons are
 21 known--when you--most laboratories world over,
 22 if you talk to pathologists, they will tell
 23 you that they don't receive enough clinical
 24 details with the sample. So it's nothing
 25 peculiar, but it has to be cured. I mean, you

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1 have to pursue it, but it wasn't anything
 2 peculiar to St. John's or Memorial Hospital.
 3 COFFEY, Q.C.:
 4 Q. Okay, and your concern in that regard was to
 5 do what? I take it look for better--more and
 6 better information from the surgeons or
 7 requesting physicians?
 8 DR. EJECKAM:
 9 A. Yes, because some of the diagnosis that were
 10 made would depend on the clinical information
 11 given. I maintain that when a surgeon sends
 12 sample to the laboratory, it's a consultation,
 13 and when you consult a fellow physician, you
 14 should write and they do that, write the
 15 clinical history, and so that that would be a
 16 guidance for the physician that's going to
 17 come and look after your patient.
 18 The same way, we would explain that if
 19 somebody sends a piece of bowel or uterus or
 20 keratin to the laboratory, they will also be
 21 some information because that may help in
 22 final evaluation of that tissue. In some
 23 instances, it may not matter what information
 24 he give, but in some areas, it may be very
 25 critical and every sample ought to come with

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1 that clinical information.
 2 COFFEY, Q.C.:
 3 Q. And so at least as part of the duties or
 4 activities of this surgical pathology review
 5 committee, the committee set out to remedy any
 6 deficiencies that they could?
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Okay. What about the reports going out from
 11 pathology? Because you referred--the
 12 Commissioner asked you about that. You
 13 referred to it and she asked you to confirm
 14 that was the case.
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. What were the concerns in the beginning when
 19 you got involved about that? What were the
 20 complaints, as it were, or concerns about what
 21 was coming out of the pathology department in
 22 terms of their reports?
 23 DR. EJECKAM:
 24 A. I'm not aware of any concerns about the
 25 reports, but if you have a surgical review

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1 committee, you don't review only the things
 2 that are coming in. You also set up to review
 3 what is going out. There was no concerns
 4 right then, but it was the surgeons' duty to
 5 now complaint or bring up case to the
 6 committee and there was none.
 7 COFFEY, Q.C.:
 8 Q. What, if anything, is your understanding--I
 9 mean, you have decades of experience as a
 10 pathologist, in making or filling out a
 11 pathology report, okay? Are there any basic
 12 criteria did you feel that have to be met by
 13 pathologists?
 14 DR. EJECKAM:
 15 A. It depends on the tissue. Each tissue has its
 16 own what has to be to make a complete report,
 17 and I believe that trained pathologists would
 18 do that. So if you take an efficient biopsy
 19 for tumor, besides diagonals in the tumor
 20 gradient, you also needed to talk about the
 21 margins, whether they were involved or not.
 22 So this is routine job for pathologists and
 23 there was no concern again about this.
 24 COFFEY, Q.C.:
 25 Q. Now, on this point, in particular, dealing

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1 with ER/PR and breast cancer, because you did,
 2 in your opening remarks make reference to
 3 negative or positive and as well though,
 4 percentages.
 5 DR. EJECKAM:
 6 A. Yeah.
 7 COFFEY, Q.C.:
 8 Q. And there's a lot of material we're going to
 9 see here in the future dealing with some
 10 reports have just used the words negative and
 11 positive, one or the other. Others use
 12 percentages, sometimes combined with words and
 13 sometimes not. Is there any standards in that
 14 regard in relation to ER/PR that you are aware
 15 of?
 16 DR. EJECKAM:
 17 A. Each laboratory and the oncologist usually
 18 will set their own standard. The problem in
 19 the literature a lot of, I will say confusion
 20 because people will accept 30 percent
 21 positivity of the tumors as positive at one
 22 time. It came down to 10 percent, it came
 23 down to five percent and it came down with a
 24 study saying one percent and then consensus
 25 statement said, even one set as positive,

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1 that's an indication for trial of Tamoxifen,
 2 anti-estrogen medication. So, it's a question
 3 of the oncologist and the laboratory coming
 4 together to now have a cut off or the
 5 laboratory will report what they see and then
 6 the oncologist decides what he wants to do.
 7 THE COMMISSIONER:
 8 Q. So, would it be normal for a--perhaps it is
 9 dependent, but it seems to me that on the face
 10 of it, if there is this continuing discussion
 11 about what is positive or negative or what the
 12 cutoffs are, then there's the potential for a
 13 miscommunication unless you actually say what
 14 the percentages are as well, if you're using
 15 positive and negative.
 16 DR. EJECKAM:
 17 A. Well, yes, that's a possibility, but like I
 18 said, every laboratory, there's kind of
 19 dialogue between the oncologists and the
 20 pathologists. Now, there'd be no problem
 21 about being positive or negative because
 22 that's a fact of what you found there.
 23 THE COMMISSIONER:
 24 Q. Okay.
 25 DR. EJECKAM:

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1 A. I interpret it as negative or interpret it as
 2 positive, but in terms of cut off -
 3 THE COMMISSIONER:
 4 Q. Um-hm.
 5 DR. EJECKAM:
 6 A. - then it's a question of a comment to say,
 7 we're a part of this as positive or negative
 8 and oncologists say that if it's positive,
 9 treat, or we'll say we have ten percent or
 10 twenty percent, the oncology will then
 11 determine what they want to do, or they come
 12 together, pathology and oncologists, have a
 13 merger and say, report as positive, give the
 14 percentage or ten percent or five percent, but
 15 that has to be agreed upon.
 16 THE COMMISSIONER:
 17 Q. Um-hm, okay.
 18 COFFEY, Q.C.
 19 Q. Now, in that regard, Doctor, what was the
 20 practice when you left Qatar in that regard,
 21 do you recall?
 22 DR. EJECKAM:
 23 A. We were reporting percentages.
 24 COFFEY, Q.C.
 25 Q. Percentages, whatever the percentage was -

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1 DR. EJECKAM:
 2 A. Yes, yes.
 3 COFFEY, Q.C.
 4 Q. - you would give that figure and that would be
 5 it. The surgical pathological review
 6 committee, I take it, had surgeons and
 7 pathologists on it?
 8 DR. EJECKAM:
 9 A. Yes, radiologists, clinical medicine and
 10 gynecologists.
 11 COFFEY, Q.C.
 12 Q. Okay, so, the surgical pathology review
 13 committee wasn't limited to surgeons and
 14 pathologists, there were other disciplines on
 15 it.
 16 DR. EJECKAM:
 17 A. Yes.
 18 COFFEY, Q.C.
 19 Q. I just want to clarify that because that can
 20 be misleading, you know, in a sense of you
 21 just see surgery and pathology and you assume
 22 it's--so, there were people from other
 23 disciplines.
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.
 2 Q. Medicine, oncology.
 3 DR. EJECKAM:
 4 A. Radiology.
 5 COFFEY, Q.C.
 6 Q. Radiology.
 7 DR. EJECKAM:
 8 A. Gynecology.
 9 COFFEY, Q.C.
 10 Q. And so, Doctor, when you arrived again in the
 11 fall of '02 and this would be early '03, the
 12 committee, was there any particular mandate
 13 given that committee initially.
 14 DR. EJECKAM:
 15 A. The mandate, I know, is the terms of reference
 16 that are written to me, copied to members by
 17 the clinical chief.
 18 COFFEY, Q.C.
 19 Q. Okay. And it is in there, it's not in that
 20 material there, it is in the larger material
 21 and I'll refer you to that, but leaving aside
 22 any--because some times things that are
 23 written are not necessarily descriptive of
 24 what, in fact, the people involved understand,
 25 okay. So, from your perspective at the time

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1 in terms of, look, I'm getting myself involved
 2 in this surgical pathology review committee,
 3 I'm going to chair it, who were you going to
 4 report to?
 5 DR. EJECKAM:
 6 A. The way it was set up, our reports go to vice
 7 president of clinical--Dr. Williams and then
 8 copied to each clinical chief.
 9 COFFEY, Q.C.
 10 Q. Okay. And that would be each clinical chief
 11 of each of the disciplines?
 12 DR. EJECKAM:
 13 A. No, no, our own clinical chief, Don Cook.
 14 COFFEY, Q.C.
 15 Q. And the VP medical at the time was Dr.
 16 Williams. Had you known Dr. Williams?
 17 DR. EJECKAM:
 18 A. I know him, but not very well because I must
 19 have seen him when I was there in the Grace
 20 Hospital, but we didn't have any interaction
 21 as such.
 22 COFFEY, Q.C.
 23 Q. Okay. When you arrived, in St. John's in the
 24 fall of '02, what, if any, committees or
 25 groups did you observe pathologists to be

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1 routinely involved in? Like, I'm thinking
 2 about things like tumor boards and rounds and
 3 -
 4 DR. EJECKAM:
 5 A. Yes, there was a tumor round then.
 6 Pathologists will attend with the oncologists
 7 and I think there was the lymphoma rounds too
 8 where this was within the pathology group.
 9 And apart from that, we had Tuesdays teaching
 10 and divisional conferences within the
 11 laboratory where we review slides with
 12 residents, difficult slides, interesting
 13 slides were discussed on Tuesdays. One of the
 14 days, I think, well informal groups then other
 15 days you had the tumor board that pathologists
 16 attended.
 17 COFFEY, Q.C.
 18 Q. And this was when you first arrived, this was
 19 already organized?
 20 DR. EJECKAM:
 21 A. Yeah, it was there.
 22 COFFEY, Q.C.
 23 Q. Already there. Was it the rule that it would
 24 be attended or was it occasionally or sporadic
 25 that there'd be such sessions?

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1 DR. EJECKAM:
 2 A. It was for a particular day.
 3 COFFEY, Q.C.
 4 Q. Okay.
 5 DR. EJECKAM:
 6 A. And people attended, especially if you had
 7 your case coming up for discussion.
 8 COFFEY, Q.C.
 9 Q. Who is responsible for organizing at the time?
 10 DR. EJECKAM:
 11 A. I don't know exactly who was responsible, but
 12 it was on.
 13 COFFEY, Q.C.
 14 Q. Okay. And Doctor, again, in the latter part
 15 of 2002 into early 2003 you've referred, for
 16 example, to the--within any one institution,
 17 there might be an understanding between the
 18 pathologists and the oncologists as to the
 19 reporting of positivity rates, positivity
 20 percentages, cut off percentages.
 21 DR. EJECKAM:
 22 A. Yeah.
 23 COFFEY, Q.C.
 24 Q. When you arrived in St. John's in 2002, was
 25 there any such understanding that you could

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1 see at the time?
 2 DR. EJECKAM:
 3 A. I don't think so. I don't remember of any
 4 particular meeting specifying that kind of cut
 5 off, but I suspect that people were reporting
 6 percentages.
 7 COFFEY, Q.C.
 8 Q. And if I could please, Exhibit P-0904. And,
 9 Doctor, this is the first page of this,
 10 surgical pathology review committee, Health
 11 Science Centre, April 15, 2003, 2:00 p.m. and
 12 there's an agenda called the order in
 13 business. This is the agenda, I take it, for
 14 the first meeting.
 15 DR. EJECKAM:
 16 A. Yeah.
 17 COFFEY, Q.C.
 18 Q. And the terms of references are stated to be,
 19 well, I'm going to refer to it as to "SPRC
 20 will review standardized reporting of
 21 pathology specimens. Number two, the SPRC
 22 will perform tissue audits on surgical
 23 specimens. Number three, the SPRC will serve
 24 as forum for interesting and/or difficult
 25 cases that can be reviewed on an individual

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1 basis or on a specific request. Number four,
 2 the SPRC will be chaired by a pathologist.
 3 Number five, the SPRC would meet once every
 4 two months. Number six, the SPRC would report
 5 directly to the Vice President of Medical
 6 Affairs. Number seven, the committee would
 7 make recommendations, if necessary. It's
 8 copied to Dr. R. Williams, Robert Williams and
 9 Dr. D. Cook, and then of course, the agenda
 10 sets out reference to new business and an
 11 adjournment.
 12 So do you recall who drew up the agenda
 13 and the terms of reference?
 14 DR. EJECKAM:
 15 A. The terms of reference was sent to me by the
 16 clinical chief.
 17 COFFEY, Q.C.:
 18 Q. Okay, which was Don Cook.
 19 DR. EJECKAM:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. If we could, please, look at Exhibit P-0113?
 23 Now Doctor, this is a memo dated April 4th
 24 2003. It's to pathologists, Health Sciences
 25 Centre, St. Clare's and out-of-town hospitals.

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1 It's from yourself, described as a pathologist
 2 at the Health Sciences Centre. The subject is
 3 immunohistochemical stains. It's dated April
 4 4th 2003, and it's--sorry, Doctor, just go up
 5 a bit, and it's signed--initialled by yourself
 6 and copied to Barry Dyer and all technical
 7 staff on immunohistochemistry.
 8 Doctor, when you came into St. John's in
 9 2002, who was the non-clinician person in
 10 charge of the lab, the non-doctor, who was--
 11 how was the lab organized in terms of--you
 12 referred to Mr. Green and Ms. Butler, Mary
 13 Butler. Who did they report to?
 14 DR. EJECKAM:
 15 A. When I came in, there was a laboratory manager
 16 and the laboratory manager was Barry Dyer.
 17 COFFEY, Q.C.:
 18 Q. Yes.
 19 DR. EJECKAM:
 20 A. And all the technologists reported to him, and
 21 also the clerk, the clerical staff. Then
 22 there was a program manager, Terry Gulliver.
 23 I believe Barry reported to him, okay, and
 24 then we have site chief who looks sort of if
 25 there's problem among the pathologists.

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1 COFFEY, Q.C.:
 2 Q. And the site chief at the time was?
 3 DR. EJECKAM:
 4 A. Dr. Parai.
 5 COFFEY, Q.C.:
 6 Q. Parai?
 7 DR. EJECKAM:
 8 A. Yeah, Sushil Parai, because there are two
 9 Parai's.
 10 COFFEY, Q.C.:
 11 Q. Yes, I was going to say, yes, there are two of
 12 them. So administratively then, you would
 13 have reported to the site chief, Dr. Parai,
 14 yourself?
 15 DR. EJECKAM:
 16 A. Yes, yes.
 17 COFFEY, Q.C.:
 18 Q. And he would have reported to Don Cook, the
 19 clinical chief?
 20 DR. EJECKAM:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. That kind of an arrangement or organization,
 24 how did that compare with what had existed in
 25 Qatar? How was Qatar organized?

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1 DR. EJECKAM:
 2 A. The Qatar organization, I believe, is a lot
 3 better because the situation where the
 4 laboratory manager and the program manager
 5 reported straight to the vice president of the
 6 hospital, bypassing the pathologists in the
 7 laboratory, because they never reported to the
 8 site chief or to the clinical chief, I think
 9 was flawed because you're going to have
 10 parallel thinking here. But in Doha, a
 11 pathologist was in charge. We had we call
 12 them supervisors, they call them manager here.
 13 They report to the head of the anatomy
 14 pathology who is a doctor, who is a consultant
 15 pathologist and that was me, and then I
 16 reported to chairman who is a doctor who is
 17 also a pathologist. So there was no way that
 18 anything that happens in that division, you as
 19 the clinician person, you needed to know about
 20 it and take it on further if you think it was
 21 necessary. So it's a different system that
 22 was there.
 23 COFFEY, Q.C.:
 24 Q. Yes.
 25 DR. EJECKAM:

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1 A. I wouldn't say it's bad or good. Actually it
 2 was a different system.
 3 COFFEY, Q.C.:
 4 Q. And the advantage that you saw in the
 5 situation at Qatar, the reporting situation
 6 was what, in terms of yourself in your
 7 position?
 8 DR. EJECKAM:
 9 A. It was--well, my advantage for me that was
 10 ease of operation and then it was a lot better
 11 actually from my standpoint that I knew what
 12 was going on in my laboratory because if my
 13 supervisor didn't report to me, the equipments
 14 would be bought without my knowing and -
 15 COFFEY, Q.C.:
 16 Q. I'm sorry, what?
 17 DR. EJECKAM:
 18 A. Equipments would be bought without my knowing
 19 about it.
 20 COFFEY, Q.C.:
 21 Q. Would or would not be?
 22 DR. EJECKAM:
 23 A. Would be bought.
 24 COFFEY, Q.C.:
 25 Q. Would be bought.

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1 DR. EJECKAM:
 2 A. If not reporting to me.
 3 COFFEY, Q.C.:
 4 Q. Yes.
 5 DR. EJECKAM:
 6 A. If they reported to somebody else, then the
 7 supervisor would have the freedom to do
 8 whatever he or she wanted, and you are the
 9 person in charge. In our operation, you would
 10 be held responsible. So you are being held
 11 responsible as site chief or consultant in
 12 charge and yet, you don't have any authority
 13 over what's going on.
 14 COFFEY, Q.C.:
 15 Q. That's here in St. John's you mean?
 16 DR. EJECKAM:
 17 A. Yes, St. John's, yeah. But in Qatar, it was
 18 completely different. I mean, as head of the
 19 unit, I have to agree to any equipment that
 20 needs to be bought. I have to sit down with
 21 the supervisor and decide that we need that.
 22 Then for staff too, all the staff under my
 23 department, at the end of their contract,
 24 which is every three years, the secretary of
 25 the chairman will call me and ask me if I

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1 wanted to renew anybody's contract and I will
 2 say to renew that, and if mine came up, then
 3 the medical director would ask the chairman
 4 whether he wanted to renew my contract and he
 5 would say renew. So it worked that way. So
 6 you knew that somebody was in charge of any
 7 particular section at that time.
 8 COFFEY, Q.C.:
 9 Q. Now Doctor, could you tell us, please, how it
 10 was that you came to--well, first of all,
 11 we'll get into that. You have copied this to
 12 Barry Dyer and all technical staff on
 13 immunohistochemistry. Well, Mr. Dyer, you've
 14 explained who he was. Who were the "all
 15 technical staff"?
 16 DR. EJECKAM:
 17 A. I think Mary Butler and -
 18 COFFEY, Q.C.:
 19 Q. Okay, it's the technologists that you're
 20 referring to?
 21 DR. EJECKAM:
 22 A. Technologists.
 23 COFFEY, Q.C.:
 24 Q. Okay, who are actually involved in doing IHC?
 25 DR. EJECKAM:

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1 A. Yeah, in the actual--yeah.
 2 COFFEY, Q.C.:
 3 Q. And it's addressed to pathologists, Health
 4 Sciences Centre I take it is the General
 5 Hospital and -
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. - the pathologists at St. Clare's. The out-
 10 of-town hospitals, who were you trying to
 11 communicate with there?
 12 DR. EJECKAM:
 13 A. Immunohistochemistry in Newfoundland is done
 14 only at Health Sciences. So we would receive
 15 material for immunohistochemistry from Gander,
 16 Corner Brook, Clarenville. So those--
 17 Carbonear, all those other pathologists that
 18 are not within St. John's, they send material
 19 when they wish to. So this was to inform them
 20 about this.
 21 COFFEY, Q.C.:
 22 Q. Now, Doctor, at the time this was prepared and
 23 you initialled it, who did you give this to
 24 have--how did you expect this would be
 25 distributed?

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1 DR. EJECKAM:
 2 A. This would be typed by one of the secretaries
 3 in the--we have a secretarial pool and one of
 4 them would type that and once it's initialled,
 5 they would distribute it. That is the way it
 6 worked.
 7 COFFEY, Q.C.:
 8 Q. Okay, and the idea, for example, sending a
 9 communication to all the pathologists in
 10 Newfoundland, which is really what this is?
 11 DR. EJECKAM:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. Do you know if there was any process or system
 15 in place to ensure that everybody actually got
 16 a copy of it?
 17 DR. EJECKAM:
 18 A. No, I don't know of any process. I had to
 19 rely on the secretary that it was sent out.
 20 THE COMMISSIONER:
 21 Q. Mr. Coffey, wherever you can find a convenient
 22 place, we'll break and I was just going to
 23 suggest if you're going to get into the letter
 24 before then.
 25 COFFEY, Q.C.:

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1 Q. So in terms of that, there was one thing I
 2 wanted to ask you about, Doctor. You, at the
 3 time you prepared this, and there's another
 4 one following and there may be others for all
 5 I know, okay, in terms of--if you wanted to
 6 communicate with all pathologists in
 7 Newfoundland, you would just ask--you'd
 8 prepare the memo. The secretarial, somebody
 9 in the group there would type it for you.
 10 You'd review it and be satisfied you wanted to
 11 sign it. You would sign it.

12 DR. EJECKAM:
 13 A. Yeah.

14 COFFEY, Q.C.:
 15 Q. And you would give it back to him or--well,
 16 her, I suspect.

17 DR. EJECKAM:
 18 A. Yeah, right.

19 COFFEY, Q.C.:
 20 Q. And you expected then that they somehow would
 21 have a system in place to distribute it?

22 DR. EJECKAM:
 23 A. Yes.

24 COFFEY, Q.C.:
 25 Q. And were you ever told, was it ever suggested

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1 to you that we have no means of sending this
 2 out?

3 DR. EJECKAM:
 4 A. No.

5 COFFEY, Q.C.:
 6 Q. And the secretarial staff or administrative
 7 staff you would be relying upon, who did they
 8 work for?

9 DR. EJECKAM:
 10 A. They worked for the department, but they
 11 reported directly to Barry.

12 COFFEY, Q.C.:
 13 Q. Barry?

14 DR. EJECKAM:
 15 A. Yeah.

16 COFFEY, Q.C.:
 17 Q. So it would be Barry's staff or somebody who
 18 reported to Barry that would be the one who
 19 would be responsible for actually sending this
 20 out with the right addresses and so on?

21 DR. EJECKAM:
 22 A. Yes.

23 COFFEY, Q.C.:
 24 Q. Okay. If we could take a break, Doctor.
 25 We're going to have a short break.

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1 THE COMMISSIONER:
 2 Q. Yes, okay then. We'll take 15 minutes.
 3 (BREAK)

4 THE COMMISSIONER:
 5 Q. Please be seated. Mr. Coffey.

6 COFFEY, Q.C.:
 7 Q. Thank you, Commissioner. Doctor, just looking
 8 at this April 4th 2003 memo, you've had an
 9 opportunity to read this, of course, preparing
 10 in coming here today?

11 DR. EJECKAM:
 12 A. Yes.

13 COFFEY, Q.C.:
 14 Q. Okay. Doctor, could you tell us please about
 15 how this came to be written?

16 DR. EJECKAM:
 17 A. This came into being, Commissioner, during the
 18 tail end of 2002 going to 2003, like I said,
 19 we usually have in-house conferences.
 20 Tuesdays we had slide reviews with residents
 21 and anybody who had any difficult case would
 22 bring it for review. Then Wednesdays we had
 23 lymphoma rounds, and these two conferences, we
 24 would use stains done by immunohistochemistry,
 25 especially in the Wednesday one where we were

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1 looking at lymphoma.
 2 Now if you look at the second line there,
 3 the CD 3, CD 5, CD 20, CD 79, these are what
 4 you would do for lymphoma panels, and then the
 5 other ones are--the first one is for prostate.
 6 So during these conferences, we came to the
 7 conclusion that some of the stains that we
 8 were receiving were not helping us in making a
 9 diagnosis because they were not properly--they
 10 were not interpretable. So there was a
 11 consensus among us that somebody has to do
 12 something about them and I showed interest in
 13 this and there also, my colleagues realized
 14 that I've got some measure of interest in the
 15 subject. So I took that up and then in the
 16 process of supervising that, we identified
 17 these stains as one that we needed to watch
 18 very closely to make sure they're
 19 interpretable and also used for diagnose
 20 purposes. That's why I then had to stop,
 21 because there's no point doing them and
 22 they're not using them. So I had to stop
 23 them.

24 COFFEY, Q.C.:
 25 Q. I'm sorry, there's no point in?

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1 DR. EJECKAM:
 2 A. Using--doing the stain and not using them for
 3 diagnosis. So I had to stop the process of
 4 this antibodies. Now there are still lots of
 5 other antibodies that were being done. So we
 6 didn't shut down the immunohistochemistry
 7 laboratory. What we did was to stop some of
 8 the antibody stains to make sure that they
 9 are--we are having reproducible and
 10 interpretable results.
 11 COFFEY, Q.C.:
 12 Q. Now who is the "we" in this context?
 13 DR. EJECKAM:
 14 A. The pathologist.
 15 COFFEY, Q.C.:
 16 Q. Okay. So you say on these Tuesdays and
 17 Wednesdays, you'd have meetings?
 18 DR. EJECKAM:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. Would they be at the General Hospital?
 22 DR. EJECKAM:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. Okay. Would they involve the St. Clare's

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1 pathologists?
 2 DR. EJECKAM:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. So these meetings -
 6 DR. EJECKAM:
 7 A. The St. Clare's would be in on Wednesdays.
 8 Lymphoma rounds was done at the Health
 9 Sciences and they would come in for that
 10 discussion.
 11 COFFEY, Q.C.:
 12 Q. On Wednesdays?
 13 DR. EJECKAM:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. And on Tuesdays?
 17 DR. EJECKAM:
 18 A. Tuesdays would be residents and the
 19 pathologists at Health Science. They have
 20 their own conference. All residents rotate
 21 through that too.
 22 COFFEY, Q.C.:
 23 Q. So Tuesdays, the conferences would be with the
 24 pathology residents and the local General
 25 Hospital pathologists?

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Kind of get together and look at particular
 5 cases and people would present difficult cases
 6 and so on, and discuss things?
 7 DR. EJECKAM:
 8 A. Right.
 9 COFFEY, Q.C.:
 10 Q. Okay, and on Wednesdays though, there were
 11 lymphoma rounds?
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. And that involved the pathologists from St.
 16 Clare's coming over as well?
 17 DR. EJECKAM:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. And the General Hospital pathologists?
 21 DR. EJECKAM:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. And as well then, just looking at this, which
 25 of these stains are lymphoma related stains?

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1 DR. EJECKAM:
 2 A. Pardon?
 3 COFFEY, Q.C.:
 4 Q. Which of these are lymphoma related?
 5 DR. EJECKAM:
 6 A. The CD 3, CD 5, CD 20, CD 79a.
 7 COFFEY, Q.C.:
 8 Q. They're lymphomas, or they're lymphoma related
 9 stains?
 10 DR. EJECKAM:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. And they are utilized to do what in relation
 14 to lymphoma?
 15 DR. EJECKAM:
 16 A. To classify lymphomas.
 17 COFFEY, Q.C.:
 18 Q. Okay.
 19 DR. EJECKAM:
 20 A. Whether it's a B cell lymphoma or T cell
 21 lymphoma.
 22 COFFEY, Q.C.:
 23 Q. Which you gave an example of earlier.
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. Then there's a--I believe it's--well, it's

3 CKHMW-34BE12, but I gather it's CK34 is?

4 DR. EJECKAM:

5 A. Yeah, that's (unintelligible), that's what

6 that means.

7 COFFEY, Q.C.:

8 Q. Yes.

9 DR. EJECKAM:

10 A. CK (unintelligible) attach beta 12. This was

11 used for prostate cancer.

12 COFFEY, Q.C.:

13 Q. And is that referred to in any shorthand way,

14 CK--is that called CK34 in shorthand or is

15 that--do you always spell it all the way out

16 when you're referring to that particular -

17 DR. EJECKAM:

18 A. Yeah, the way we write in the laboratory, just

19 34 Beta 12

20 COFFEY, Q.C.:

21 Q. 34 Beta 12?

22 DR. EJECKAM:

23 A. Yeah.

24 COFFEY, Q.C.:

25 Q. Okay. When in the discussions on Tuesdays and

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1 Wednesdays did the problem with that come up?

2 DR. EJECKAM:

3 A. The same process that were in Tuesdays when we

4 review cases, we will have biopsies that

5 people will bring in to get second opinion or

6 to show the residents and then this stain

7 would be helpful because what happens with

8 this stain, like I explained initially the

9 cancer cell--cancer glands in prostate are not

10 curtailed by external cells. In the normal

11 gland, you have the normal inner layer; they

12 have the outer layer. That's normal prostate

13 gland. This antibody will stain the outer

14 layer of the normal gland. So if it's

15 malignant, it's going to be absent.

16 So if you now have a few glands, normally

17 three or four glands that you see in a corner

18 and you are not 100 percent sure whether it is

19 malignant or not, that's when you request for

20 this stain. Now if it's--if it comes out okay

21 and if it's negative, then that gives you an

22 additional factor to say this is malignant.

23 If it is positive, then that will tell you no,

24 this is a benign gland. That's where we used

25 it.

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1 COFFEY, Q.C.:

2 Q. And at the time perceived to be potential

3 problems with the CK Beta--I'm sorry, 34 Beta

4 12, was that--the fact that there was such a

5 problem or potential problem existing with

6 that, was that your conclusion, your own

7 personal conclusion?

8 DR. EJECKAM:

9 A. Not my personal, this was the consensus

10 because other pathologists will do this, will

11 request the same stain, okay, and then if they

12 couldn't be sure that it was positive or

13 negative, it wasn't then helpful.

14 COFFEY, Q.C.:

15 Q. And with respect to the four lymphoma stains

16 that are listed here, was it--again, was that

17 a consensus opinion?

18 DR. EJECKAM:

19 A. Yes.

20 COFFEY, Q.C.:

21 Q. There was a problem with those stains?

22 DR. EJECKAM:

23 A. Yes.

24 COFFEY, Q.C.:

25 Q. The CEA stain is for -

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1 DR. EJECKAM:

2 A. That is carcino embryonic antigen. This is

3 also an antigen that's present in colon

4 cancers, stomach cancer. You can also find it

5 in other primary sites. So the stain has to

6 be right. So it helps us to determine the

7 presence of tumor from a particular site.

8 COFFEY, Q.C.:

9 Q. And so this again was identified, I take it,

10 in relation to probably the Tuesday meetings?

11 DR. EJECKAM:

12 A. Yes.

13 COFFEY, Q.C.:

14 Q. And again, was that a consensus view?

15 DR. EJECKAM:

16 A. Yes, that's my understanding.

17 COFFEY, Q.C.:

18 Q. And the ER and PR, both the ER and PR, which

19 are two different stains?

20 DR. EJECKAM:

21 A. Yes.

22 COFFEY, Q.C.:

23 Q. Okay. Relate to breast cancer, I take it,

24 primarily?

25 DR. EJECKAM:

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1 A. Yes, yeah.
 2 COFFEY, Q.C.:
 3 Q. How did the concern about them arise?
 4 DR. EJECKAM:
 5 A. The same process that we noticed that possibly
 6 you would have the stains done and when you
 7 want to use it to make an interpretation of
 8 being positive or negative, the stains were
 9 not crisp enough or they were not immediately
 10 interpretable. We needed to have nuclear
 11 stain to say it's positive and if the stain is
 12 done and you start finding lots of cytoplasmic
 13 stain, then you start wondering what went
 14 wrong. So it happened--and then sometimes,
 15 you know, you get a good stain today and
 16 tomorrow, the same block may not show the same
 17 thing. So we thought we needed to look at it
 18 and be sure what we're dealing with.
 19 COFFEY, Q.C.:
 20 Q. And was this a consensus view?
 21 DR. EJECKAM:
 22 A. That's my view, it was consensus. Yeah,
 23 that's my view. We didn't take any vote at
 24 the meeting.
 25 COFFEY, Q.C.:

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1 Q. Oh no, I appreciate that. I appreciate that.
 2 Doctor, the problem--and you've indicated, I
 3 believe, that this would be in late 2002,
 4 early '03, the initial recognition that this
 5 was a problem?
 6 DR. EJECKAM:
 7 A. Ongoing from the moment--I meant, from the
 8 fall. I joined in September and then from
 9 then on, when we were sort of seeing slides as
 10 we had our conferences, we went on and the
 11 reviews identified this problem over a period
 12 of time and then I said, okay, since I have
 13 been identified and have an interest in this
 14 area, best thing is to work more closely to
 15 see what you can do with it.
 16 COFFEY, Q.C.:
 17 Q. Well -
 18 DR. EJECKAM:
 19 A. But I cannot tell you that this was at a
 20 particular time that decision was taken.
 21 COFFEY, Q.C.:
 22 Q. Was there any vote, as it were, taken though
 23 in terms of your getting involved and taking
 24 kind of, you know, intervening and proceeding
 25 at this point?

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1 DR. EJECKAM:
 2 A. No, I think my colleagues appreciated that I
 3 showed interest in this, in the subject.
 4 COFFEY, Q.C.:
 5 Q. With respect to that, and based upon the
 6 meetings on these Tuesdays and Wednesdays
 7 weekly, was it your--did you have any sense as
 8 to whether or not any other pathologists at
 9 St. Clare's or the General Hospital had any
 10 particular interest in IHC, in the same way
 11 that you did?
 12 DR. EJECKAM:
 13 A. I can't say because every--they were doing the
 14 test before I arrived, so obviously somebody
 15 had interest in these things, but you know,
 16 the test was being done before I came in.
 17 COFFEY, Q.C.:
 18 Q. Oh yes.
 19 DR. EJECKAM:
 20 A. So there must be somebody who, a group of
 21 pathologists who have interest in the subject.
 22 COFFEY, Q.C.:
 23 Q. But I take it when you offered yourself up as
 24 potentially getting involved, there wasn't a
 25 lot of competition for the position, I take

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1 it?
 2 DR. EJECKAM:
 3 A. There was no position to be taking care of it.
 4 COFFEY, Q.C.:
 5 Q. Yes, okay, so you offered to get involved and
 6 you saw--you encountered no resistance to
 7 that? Everybody was there, you understood
 8 agreed?
 9 DR. EJECKAM:
 10 A. Right.
 11 COFFEY, Q.C.:
 12 Q. There was no one that voiced any objections to
 13 you -
 14 DR. EJECKAM:
 15 A. No, no.
 16 COFFEY, Q.C.:
 17 Q. - getting involved? Did your colleagues, do
 18 you think--did you ever tell them about or
 19 explain to them the fact that you had had--you
 20 did have some experience with IHC?
 21 DR. EJECKAM:
 22 A. Well, I didn't think I needed to explain that
 23 to them because it was obvious during our
 24 meetings that I showed some interest and
 25 showed some degree of knowledge of what was

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1 going on, so you know, they decided that well,
 2 if you have this interest, why don't you look
 3 at this much more closely. That's my view.
 4 That's what I thought.
 5 COFFEY, Q.C.:
 6 Q. Oh yes, and that's again what I'm asking you
 7 for, in terms of that. So you're advising
 8 everybody to whom this memo is directed that
 9 "staining with these antibodies will stop
 10 forthwith until we can solve the reliability,
 11 sensitivity and specificity problems." Can you
 12 explain to the Commissioner what reliability
 13 problem? What are you talking about there?
 14 DR. EJECKAM:
 15 A. Well, I give an example, Commissioner, like
 16 the prostate one. If I have a benign gland
 17 that I can identify--mind you,
 18 immunohistochemistry is a secondary thing.
 19 You must look at initial hematoxylin and eosin
 20 slide and make a judgment. You are looking at
 21 this to help you to get across the line. So
 22 if I have a benign gland, I know that in a
 23 benign gland, the stain should be positive and
 24 then I do the stain and I find that benign
 25 glands are not picking up the stain, then it's

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1 unreliable because it's supposed to be
 2 positive and then maybe today--and I use that
 3 benign gland as a control. Tomorrow it will
 4 stain positive, next day may not stain. So
 5 it's not showing what it's supposed to show
 6 and that's what I mean by unreliable.
 7 COFFEY, Q.C.:
 8 Q. Sensitivity problem, what are you--because you
 9 do differentiate between reliability,
 10 sensitivity and specificity.
 11 DR. EJECKAM:
 12 A. Yeah, well -
 13 COFFEY, Q.C.:
 14 Q. So sensitivity in this context means what?
 15 DR. EJECKAM:
 16 A. Then it's supposed to be, in this context, in
 17 terms of prostate, supposed to stain prostate
 18 outside cells on the gland, outer layer. Now
 19 if, in that case, you find it staining other
 20 things, a number of other things, then it
 21 becomes a problem. Mind you, if you look at
 22 the literature, this antibody may stain other
 23 things, but in the context of evaluating a
 24 prostate section, then that's where we have to
 25 consider whether it is sensitive or not.

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1 COFFEY, Q.C.:
 2 Q. Specificity problems?
 3 DR. EJECKAM:
 4 A. Well the same way that it stains only that
 5 particular antigen that raised the antibody,
 6 because if it's now staining other things,
 7 then it's not very specific because it could
 8 stain other stuff.
 9 COFFEY, Q.C.:
 10 Q. Doctor, you go on to say "efforts are under
 11 way, and hopefully a solution will be found
 12 within the next four to six weeks. You will
 13 be duly informed when such stains can resume."
 14 Now Doctor, at the time you decided to do
 15 this, would all of the pathologists who had
 16 attended these--I'll back up a bit. Who knew
 17 that you were sending out this memo?
 18 DR. EJECKAM:
 19 A. You mean before it was sent?
 20 COFFEY, Q.C.:
 21 Q. Yes. Was anybody aware that you were going to
 22 do this? "I'm actually going to write a
 23 memo."
 24 DR. EJECKAM:
 25 A. No. Well, definitely during the discussion,

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1 we sort of agreed that the best thing to stop
 2 doing them until we are able to come up with
 3 something better.
 4 COFFEY, Q.C.:
 5 Q. And whom, if anyone, did you report to to tell
 6 them that "I'm going to stop the staining on
 7 these eight stains"? Did you tell Dr.
 8 Williams, for example?
 9 DR. EJECKAM:
 10 A. Bob Williams?
 11 COFFEY, Q.C.:
 12 Q. Yes.
 13 DR. EJECKAM:
 14 A. I didn't need to tell him. I mean, this is
 15 laboratory issue. He didn't need to know
 16 about it.
 17 COFFEY, Q.C.:
 18 Q. Within the laboratory, who had to know?
 19 DR. EJECKAM:
 20 A. This was sent to all the pathologists, so
 21 including site chiefs, clinical chiefs and all
 22 my colleagues.
 23 COFFEY, Q.C.:
 24 Q. During the intervening period, during what you
 25 then anticipated to be the next four to six

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1 weeks -
 2 DR. EJECKAM:
 3 A. Yeah.
 4 COFFEY, Q.C.:
 5 Q. - what did you expect or anticipate would
 6 happen with respect to any tests that had to
 7 be done using these sorts of stains that would
 8 normally be done in the General Hospital?
 9 What did you expect would happen?
 10 DR. EJECKAM:
 11 A. That wasn't any big problem. There was no
 12 patient danger here at all, because as far as
 13 you were talking for the first one, if you
 14 found three or four glands that were
 15 suspicious for malignancy and we did the tests
 16 and it didn't show what we expected, it wasn't
 17 interpretable and has been shown around and
 18 there's a concern that it couldn't be
 19 interpreted, Commissioner, what we would do is
 20 to--and it's accepted report, to write to the
 21 urologist, "there are four slides (phonetic)
 22 of two or three suspicious looking glands,
 23 suspicious for malignancy. Please repeat
 24 biopsy at that quadrant that you cite."
 25 That's accepted standard. You could do that.

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1 So there was no question of saying somebody
 2 had cancer when he didn't have or something
 3 like that.
 4 Then for this lymphoma group who had
 5 another test, flow cytometry, which was done
 6 by one of the pathologists, so if this didn't
 7 work, flow cytometry usually will work, and
 8 then you know, again, diagnosis would be
 9 given. And of course, for the other, the rest
 10 of them, the ER/PR, if it didn't work, then we
 11 didn't report anything -
 12 COFFEY, Q.C.:
 13 Q. If the stain -
 14 DR. EJECKAM:
 15 A. If the stain didn't work out the way it's
 16 supposed to work or that, you know, you
 17 couldn't interpret it, if we didn't have--it
 18 was only four to six weeks, you send it out.
 19 So there was again, no danger to anybody, in
 20 terms of this stoppage.
 21 COFFEY, Q.C.:
 22 Q. During the four to six-week period?
 23 DR. EJECKAM:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. But in any case, there'd be no report, no
 2 slides, for example, ER/PR slides produced
 3 during that four to six-week period?
 4 DR. EJECKAM:
 5 A. We were (unintelligible) for diagnostic
 6 purposes, no.
 7 COFFEY, Q.C.:
 8 Q. No, for--and you were telling everybody in the
 9 meantime, the next four to six weeks, we will
 10 not be processing ER/PR -
 11 DR. EJECKAM:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. - new cases?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. And presumably the pathologists would make
 19 their own decisions then about whether they
 20 wanted to go to Halifax or wherever?
 21 DR. EJECKAM:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. Okay, and you understood that would happen?
 25 DR. EJECKAM:

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1 A. Yeah, and in any event, within that period, we
 2 may not have received more than one or maybe
 3 none of the breast cancers.
 4 COFFEY, Q.C.:
 5 Q. And with respect to that, Doctor, could you
 6 tell us, please, what--because you say here
 7 "efforts are under way." What was done with
 8 respect to the ER/PR stains? "Efforts are
 9 under way," I take it they're efforts to
 10 correct the problems?
 11 DR. EJECKAM:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. What was done with respect to the ER/PR, could
 15 you tell the Commissioner what happened?
 16 DR. EJECKAM:
 17 A. Commissioner, what we did was to look at the--
 18 first of all I had to source good controls.
 19 We went through the archives and found breast
 20 lesion that were positive and then after
 21 assessing that, we now looked at the
 22 methodology and then tried to titrate a time
 23 of antigen retrieval. So, that's probably
 24 where the problem might come in. You use to
 25 talk about fixation, but I think that come to

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1 origin (phonetic) by good antigen retrieval.
 2 So, what we do was to change to titration
 3 with, say, I think we use three or four
 4 different times. We heat this tissue, ten
 5 minutes, 20 minutes, 30 minutes, in this
 6 order. We are trying to see which of the time
 7 give the best reaction. And when we are
 8 satisfied that we picked a particular time,
 9 which I can't remember right now, but give the
 10 best reaction and was producible (phonetic)
 11 then we now say that this resume.
 12 COFFEY, Q.C.
 13 Q. Do you recall -
 14 DR. EJECKAM:
 15 A. And the same thing was done with the rest of
 16 the antibodies.
 17 COFFEY, Q.C.
 18 Q. Okay. Now, which antibodies did you deal with
 19 first?
 20 DR. EJECKAM:
 21 A. ER/PR.
 22 COFFEY, Q.C.
 23 Q. ER/PR was the first one.
 24 DR. EJECKAM:
 25 A. Yeah.

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1 COFFEY, Q.C.
 2 Q. And that would have been in April of '03.
 3 DR. EJECKAM:
 4 A. Pardon?
 5 COFFEY, Q.C.
 6 Q. That would have been in April of '03?
 7 DR. EJECKAM:
 8 A. Yeah.
 9 COFFEY, Q.C.
 10 Q. Okay. So, do you recall who the technologist-
 11 -was there any particular technologist
 12 involved in this?
 13 DR. EJECKAM:
 14 A. I think Mary Butler took most of it. They
 15 worked together, but I think Mary Butler did
 16 most of it, the titration.
 17 COFFEY, Q.C.
 18 Q. And do you recall whether or not DAKO was
 19 involved or DAKO's representatives were
 20 involved in any way?
 21 DR. EJECKAM:
 22 A. Not with this; I didn't involve them. If they
 23 came into the lab in my absence, I -
 24 COFFEY, Q.C.
 25 Q. Not so much came into the lab as communicated

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1 with them about the fact that the problems
 2 existed.
 3 DR. EJECKAM:
 4 A. I didn't invite them and I don't know that
 5 they came, but if they discussed with the
 6 techs, because they could call them on the
 7 phone if there's a problem. So, if they
 8 communicated with them, I have no knowledge of
 9 it.
 10 COFFEY, Q.C.
 11 Q. Okay. And there is, we're going to see a fax
 12 that, at least a fax anyway between a DAKO
 13 representative and some of the technologists
 14 and I believe Mr. Dyer. But if that happened,
 15 you weren't involved in that?
 16 DR. EJECKAM:
 17 A. No, they didn't let me know that.
 18 COFFEY, Q.C.
 19 Q. All right. So, your involvement--so, I take
 20 it you knew--and I'll just concentrate first
 21 of all on the ER and PR. To go about
 22 addressing the concerns, you first of all
 23 addressed what?
 24 DR. EJECKAM:
 25 A. I said ER/PR.

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1 COFFEY, Q.C.
 2 Q. Yes, ER/PR, no, no, but what about ER for
 3 example. I'll just use ER, was it the time,
 4 the amount of time -
 5 DR. EJECKAM:
 6 A. Yeah, time of--first, get credible controls
 7 and then we looked at the timing of antigen
 8 retrieval.
 9 COFFEY, Q.C.
 10 Q. Okay.
 11 DR. EJECKAM:
 12 A. And there was--I think we--it was to change
 13 the dilutions of the secondary or primary
 14 antibodies.
 15 COFFEY, Q.C.
 16 Q. Yes, okay. So, it was the controls first and
 17 foremost because--the purpose of that is what?
 18 What's the importance of that?
 19 DR. EJECKAM:
 20 A. Well, I mean we need to have a credible
 21 control because if we cannot say that this is
 22 the positive control, then how can we now
 23 interpret this?
 24 COFFEY, Q.C.
 25 Q. Yes.

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1 DR. EJECKAM:
 2 A. So, it was necessary to have a case that was
 3 positive as control and then, of course, we
 4 know that you can use tissue that are not
 5 breast as negative control.
 6 COFFEY, Q.C.
 7 Q. And so you would be looking to, first of all
 8 identify a good positive control tissue.
 9 DR. EJECKAM:
 10 A. Yes.
 11 COFFEY, Q.C.
 12 Q. You would also utilize non breast tissue for,
 13 suitable non breast tissue for negative
 14 control.
 15 DR. EJECKAM:
 16 A. You could do that or you can use breast, but
 17 omits (phonetic) the primary antibodies.
 18 COFFEY, Q.C.
 19 Q. Okay.
 20 DR. EJECKAM:
 21 A. Because if you don't put the primary
 22 antibodies as explained, then the secondary
 23 will have nothing to latch onto. So, nothing
 24 will show.
 25 COFFEY, Q.C.

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1 Q. Sure. And so you would address your minds to
 2 the controls first, positive and negative.
 3 You then looked at the antigen retrieval time.
 4 DR. EJECKAM:
 5 A. Yeah.
 6 COFFEY, Q.C.
 7 Q. Varying that, you experimented with that, I
 8 take it, varying amounts of time and would use
 9 a particular period of time, as an example,
 10 like eight minutes or so.
 11 DR. EJECKAM:
 12 A. Yeah, yeah.
 13 COFFEY, Q.C.
 14 Q. And see what that looked like on a slide.
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.
 18 Q. And then you perhaps, at ten minutes and see
 19 what that looked like that.
 20 DR. EJECKAM:
 21 A. Yes.
 22 COFFEY, Q.C.
 23 Q. And maybe six and got to go back and forth
 24 until you got, from your perspective, the
 25 best?

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.
 4 Q. Okay. As well, the dilution?
 5 DR. EJECKAM:
 6 A. Yeah, I think we changed that dilution so
 7 either primary or secondary antibody, but I
 8 don't remember which right now, but one of the
 9 dilutions was changed to see because sometimes
 10 if it is too diluted or over-concentrated, you
 11 may have problem with that. So, have to
 12 titrate that.
 13 COFFEY, Q.C.
 14 Q. And again, this was done in a systematic way,
 15 I take it -
 16 DR. EJECKAM:
 17 A. Yes, yes.
 18 COFFEY, Q.C.
 19 Q. - in terms of you go about it--and it was
 20 under whose direction? Was it your direction?
 21 Your -
 22 DR. EJECKAM:
 23 A. Yes, I will discuss with them and write down
 24 what dilution would try and what time would
 25 try.

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1 COFFEY, Q.C.
 2 Q. And the actual work then, in terms of
 3 utilizing, doing the heating, doing that
 4 dilution -
 5 DR. EJECKAM:
 6 A. That done by the technologists.
 7 COFFEY, Q.C.
 8 Q. The technologists would do that, they'd
 9 follow--your understand was that they would
 10 follow your instructions and -
 11 DR. EJECKAM:
 12 A. I believe they did.
 13 COFFEY, Q.C.
 14 Q. And this process then in terms of ER/PR went
 15 on for approximately how long?
 16 DR. EJECKAM:
 17 A. I can't tell you that, but it took most of the
 18 time within the first six weeks because within
 19 that period, I was happy that we had something
 20 that was credible, could go back to doing the
 21 stain.
 22 COFFEY, Q.C.
 23 Q. Now Doctor, we do have written record for the
 24 ER/PR because we'll see it subsequently, but
 25 the other six stains that are listed here in

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1 this memo, you've told the Commissioner that
 2 they also go dealt within, I take it, in due
 3 course.
 4 DR. EJECKAM:
 5 A. Yeah.
 6 COFFEY, Q.C.
 7 Q. Okay. Was the same process followed for them?
 8 DR. EJECKAM:
 9 A. Yes, but not--mainly for antigen retrieval, we
 10 didn't change the dilutions on those ones and
 11 that was also okay.
 12 COFFEY, Q.C.
 13 Q. And how were people notified that the other
 14 six stains were re-instituted, do you recall?
 15 DR. EJECKAM:
 16 A. What? Putting them back into use?
 17 COFFEY, Q.C.
 18 Q. Yes.
 19 DR. EJECKAM:
 20 A. I mean, I did mention these at the conference,
 21 I don't think I put these in the second memo,
 22 but the ER/PR, was definitely a memo to cover
 23 that because of the nature of it. But the
 24 other ones, during a conference again will
 25 show the slides, showing that everything was

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1 okay and so, you know, we resume then.
 2 COFFEY, Q.C.
 3 Q. Okay. So, these conferences, you're able to
 4 bring out, kind of, your brand new, most
 5 recently produced slides as a result of this -
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.
 9 Q. - effort you--and be able, in effect, show
 10 them off.
 11 DR. EJECKAM:
 12 A. Yeah, yeah, I would say that, yes.
 13 COFFEY, Q.C.
 14 Q. Okay. Doctor, at the time, from your
 15 perspective as a pathologist, your knowledge
 16 of IHC, how did you feel about the quality of
 17 the slides that you were producing, the lab
 18 was producing in the beginning of May of '03,
 19 after your effort?
 20 DR. EJECKAM:
 21 A. After we rectified the problem?
 22 COFFEY, Q.C.
 23 Q. Yes.
 24 DR. EJECKAM:
 25 A. I was satisfied with it. It was as good as

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1 anywhere else.
 2 COFFEY, Q.C.
 3 Q. If we could, please, I want to go to page two,
 4 Doctor of the--I'll just go ahead there. Now,
 5 this is a memo dated May 2, 2003 again, it's
 6 on Health Care Corporation of St. John's
 7 letterhead, this one to pathologists of the
 8 Health Sciences Centre, St. Clare's and out of
 9 town hospitals from yourself. That, I take
 10 it, is your initial?
 11 DR. EJECKAM:
 12 A. Yes.
 13 COFFEY, Q.C.
 14 Q. The subject is ER/PR immunohistochemical
 15 stains. It's dated May 2 of 2003 and it goes
 16 on for some three pages with your signature,
 17 initials and it's copied to the site chief of
 18 the Health Sciences Centre and St. Clare's to
 19 Barry Dyer and to all technical staff on
 20 immunohistochemistry. So, I take it this is
 21 the technologists?
 22 DR. EJECKAM:
 23 A. Yes.
 24 COFFEY, Q.C.
 25 Q. Mr. Dyer is their boss, immediate boss.

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1 DR. EJECKAM:
 2 A. Yeah.
 3 COFFEY, Q.C.
 4 Q. And the site chiefs were Doctor Parai and -
 5 DR. EJECKAM:
 6 A. Don Cook was -
 7 COFFEY, Q.C.
 8 Q. Don Cook was St. Clare's site chief as well as
 9 -
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.
 13 Q. Now, you would have had the opportunity to
 14 review this before coming here today.
 15 DR. EJECKAM:
 16 A. Yeah, I looked at it.
 17 COFFEY, Q.C.
 18 Q. Doctor, you begin by saying, "I'm glad to
 19 inform you that we have rectified the
 20 difficulties related to the immunostain or
 21 ER/PR. Therefore, we can now resume regular
 22 requests for these antibody stains. I will,
 23 however, like to bring the following
 24 information to your attention". And then you
 25 have a list beginning with paragraph one,

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1 "results of the immunostains may be affected
 2 by (a) delayed fixation, (b) over fixation,
 3 (c) under fixation, (d) uneven fixation, (e)
 4 inadequate tissue dehydration, and (f) tissue
 5 reprocessing". Now, you then go on at some
 6 length then about that, Doctor. Paragraph two
 7 though goes on to note "ER/PR false negative
 8 results increase in core biopsies therefore,
 9 where possible, restrict request to excision
 10 biopsies. Three is check normal breast
 11 acini".
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.
 15 Q. Okay, "in your sections as internal controls.
 16 This is a second level control, nuclear
 17 staining in normal breast tissue is
 18 heterogeneous and varies with menstrual
 19 cycle". And then you point out, "in carcinoma
 20 of the breast, most PR positive tumors are
 21 also ER positive", and you go on and explain
 22 that further. "Reporting of ER/PR" and you
 23 talk about different reporting criteria or cut
 24 off points, I'll refer to it as. And then you
 25 note that higher staining intensity does not

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1 reflect better results and you go on and talk
 2 about that. And then ER positive tumors, you
 3 list a number of them, four of them here and I
 4 take it as well that the fifth which would be
 5 listed here would be lobular.
 6 DR. EJECKAM:
 7 A. Yes, this an exhaustive list.
 8 COFFEY, Q.C.
 9 Q. Yes, and I appreciate that, Doctor. And
 10 number eight you finally note, "low nuclear
 11 grade tumors are usually positive for ER/PR
 12 and negative for Her2Neu, while high grade
 13 tumors tend to be positive for Her2Neu and
 14 negative for ER/PR". And you note finally,
 15 "we are working on the remaining antibodies
 16 and hopefully all normal immunostains will
 17 resume soon". Okay?
 18 DR. EJECKAM:
 19 A. Yeah.
 20 COFFEY, Q.C.
 21 Q. Now Doctor, other than the obvious which is to
 22 point out to everybody that you've resumed
 23 ER/PR testing in St. John's or processing in
 24 St. John's, why did you write this memo?
 25 Because you could have stopped it right here

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1 where I've got the cursor right now, which is
 2 after the first two sentences. So, why did
 3 you continue on?
 4 DR. EJECKAM:
 5 A. I was just simply providing information as a
 6 source person at that point, I saw nothing
 7 wrong providing information. My colleagues
 8 would have probably known this information or
 9 if they didn't know, but I think probably they
 10 knew that, but it's just information. That's
 11 all I provided.
 12 COFFEY, Q.C.
 13 Q. Did you ever write any other memo with similar
 14 detail to this to pathologists throughout
 15 Newfoundland?
 16 DR. EJECKAM:
 17 A. It wasn't necessary, I didn't do that.
 18 COFFEY, Q.C.
 19 Q. No, you didn't--for example, for the other
 20 stains, the other six stains, when you re-
 21 instituted those.
 22 DR. EJECKAM:
 23 A. No, I didn't do that because I mean, what I
 24 have here covers every other stain, not ER/PR
 25 only.

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1 COFFEY, Q.C.
 2 Q. Yes. And I appreciate it has a wider
 3 potential, some aspects of it do have a wide
 4 application than just ER/PR, don't they?
 5 DR. EJECKAM:
 6 A. Yeah.
 7 COFFEY, Q.C.
 8 Q. And I'll just deal first of all with the
 9 paragraphs one (a) through (f), particularly
 10 (a) to (d) is certainly fixation is a concur
 11 for all types of stains.
 12 DR. EJECKAM:
 13 A. Yeah.
 14 COFFEY, Q.C.
 15 Q. And "inadequate tissue dehydration", (e) and
 16 "tissue reprocessing" as well could apply to,
 17 if not all, certainly most other stains.
 18 DR. EJECKAM:
 19 A. Yeah.
 20 COFFEY, Q.C.
 21 Q. Did anyone else know that you were going to
 22 draft and send this memo, this May 2 one?
 23 DR. EJECKAM:
 24 A. Before it was sent?
 25 COFFEY, Q.C.

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1 Q. Yes.
 2 DR. EJECKAM:
 3 A. No.
 4 COFFEY, Q.C.
 5 Q. Before I omit to do so, I'll ask you this, the
 6 April 4, 2003 memo, after you wrote it and
 7 sent it, did you receive any feedback on it?
 8 DR. EJECKAM:
 9 A. Not in writing, but when we discuss cases that
 10 were reprocessed and people were quite happy
 11 doing the conferencing or were not getting
 12 good stain. There was no letter from anybody
 13 and I wasn't suspecting any letter, but during
 14 the period we are discussing that there was,
 15 again, happiness that we are getting something
 16 now that is useful.
 17 COFFEY, Q.C.
 18 Q. Now the memo at page two of the exhibit, P-
 19 0113, the May 2nd, 2003 memo, did you get any,
 20 having prepared this, initialled it and sent
 21 it, did you get any feedback on this one?
 22 DR. EJECKAM:
 23 A. No, Again, it's an information memo, so they
 24 didn't need to make any further contact.
 25 COFFEY, Q.C.

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1 Q. Now you weren't asking here for any feedback,
 2 I appreciate that in your -
 3 DR. EJECKAM:
 4 A. Yeah.
 5 COFFEY, Q.C.
 6 Q. Well, I'm just asking you, in terms of that,
 7 having taken it upon yourself to prepare it
 8 and to send it out, there is no one came back
 9 to you, one way or the other, saying great
 10 job, Gershon, what are you talking about; or
 11 anything like that? There was no feedback one
 12 way or the other on this?
 13 DR. EJECKAM:
 14 A. No, not the way you put it.
 15 COFFEY, Q.C.
 16 Q. Well, any other way on this one?
 17 DR. EJECKAM:
 18 A. No, I said that the people were happy, that
 19 during the discussion, that we now have stain
 20 that work and for me that was some kind of
 21 feedback. I wasn't expecting a letter or
 22 congratulations from anyone.
 23 COFFEY, Q.C.
 24 Q. Well, Doctor, if we could, please, just on
 25 some of this because you have to appreciate,

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1 of course, we're not physicians, I don't think
 2 there's a physician in the room, but -
 3 THE COMMISSIONER:
 4 Q. Only the one on the stand.
 5 COFFEY, Q.C.
 6 Q. The Commissioner has got a good vantage point.
 7 Other than the doctor himself, I don't think
 8 any of the rest us are physicians. So, if I
 9 could just, Doctor, several questions related
 10 to this. You've pointed out in paragraph one
 11 on page one of the memo itself, results of the
 12 immunostains may be affected by delayed, over,
 13 under and uneven fixation. How significant
 14 can the problems be for immunostains that can
 15 be caused by fixation problems?
 16 DR. EJECKAM:
 17 A. Initially, it could be a problem, but with
 18 good antigen retrieval you can override the
 19 problem of fixation. So, you know, but if you
 20 fix it right and did antigen retrieval right,
 21 then you get optimal result. But if you had
 22 problem with the fixation and by any reason
 23 your retrieval time is not optimal, you may
 24 have problem. So, in as much as you can
 25 override this fixation--mind you, these memos,

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1 these--what you have here, in the text book
 2 and there are research going on trying to
 3 modify what might affect that. So, at a time
 4 these things are in the text book, fixation
 5 was a big problem and we can testify to that
 6 because with delayed fixation, then the
 7 tissue, the cell membrane will kind of lose
 8 its integrity and enzymes will diffuse out,
 9 those antigen will diffuse out and that will
 10 cause background staining. So you then have
 11 what you have (unintelligible) original
 12 background staining and maybe create a problem
 13 for interpretation. So but now with antigen
 14 retrieval, if you do it with proper timing and
 15 then you could override those fixation
 16 problem.
 17 COFFEY, Q.C.:
 18 Q. The reference to inadequate tissue
 19 dehydration, what is that referring to?
 20 DR. EJECKAM:
 21 A. Now when you process tissue in the tissue
 22 processor, it goes through gradient alcohol
 23 and trying to extract water. If the water is
 24 in there by the time it gets into the xylene,
 25 the next solution, and try to impregnate with

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1 wax before you cut it, you can imperforate,
 2 you cannot get a good impregnation and that is
 3 going to affect the stain. But this is
 4 chemical reaction and if it's not properly
 5 processed, then that area will be soft and
 6 well, I'll put it--well, not necrose, but it's
 7 going to be soggy in a way, you know,
 8 (unintelligible) and going to be soggy, and
 9 when it's soggy, you can't--the stain will not
 10 have paculation of stain and that area may be
 11 darker than the stain than what you expect,
 12 and then they were thinking it's real, but
 13 it's not real because of this problem.
 14 COFFEY, Q.C.:
 15 Q. Okay, and the problem with inadequate tissue
 16 dehydration, if that was to--if that is to be
 17 addressed, that is addressed where physically?
 18 Who has to do that? Is that within the
 19 laboratory itself?
 20 DR. EJECKAM:
 21 A. Yeah, laboratory, that would be a thing that
 22 any technologist will have to deal with in the
 23 tissue processor. So that means that we
 24 should be changing the solution in the tissue
 25 processor fairly regularly, depending on the

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1 volume that you put through it. Again, this
 2 is something that it will depend on the volume
 3 of the tissue that go through it.
 4 COFFEY, Q.C.:
 5 Q. Now the problem, the reference to delayed,
 6 over, under and uneven fixation, who or what
 7 sort of individual or professional would be
 8 expected to deal with those problems?
 9 DR. EJECKAM:
 10 A. Now the delayed fixation will come from the
 11 OR.
 12 COFFEY, Q.C.:
 13 Q. OR.
 14 DR. EJECKAM:
 15 A. When they take it and they don't put it in
 16 formalin quickly, that may be delayed
 17 fixation. Then over fixation, of course, if
 18 it is already in formalin and left in the
 19 laboratory for a long time. Now like I said,
 20 the optimal period we said 18 to 24 hours.
 21 Now there are information in the literature
 22 saying that you can fix for six hours, seven
 23 hours and still get a good result. So it's a
 24 question of the experimentation is going on
 25 and to shorten this time, so it depends on how

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1 much effort you put in it and which laboratory
 2 you are in. But generally speaking, most
 3 people will tell you that optimal period of
 4 fixation will be 18 to 24 hours.
 5 COFFEY, Q.C.:
 6 Q. And so that's over and under. Uneven fixation
 7 is a problem, who would have to attend to
 8 that?
 9 DR. EJECKAM:
 10 A. If you put in an big tissue in formalin in a
 11 container, some areas will fix, some areas
 12 will not fix, so that's why he needs to cut
 13 clean section and then immerse the tissue
 14 completely in formalin.
 15 COFFEY, Q.C.:
 16 Q. You do go on to point out "The optimum
 17 fixation time for immunostains is 18 to 24
 18 hours."
 19 DR. EJECKAM:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Now, you knew that at the time, why, where
 23 would get that figure?
 24 DR. EJECKAM:
 25 A. In the literature.

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1 COFFEY, Q.C.:
 2 Q. And was that literature readily available to
 3 pathologists?
 4 DR. EJECKAM:
 5 A. I believe so.
 6 COFFEY, Q.C.:
 7 Q. Now, you've underlined "In 10 percent neutral
 8 buffered formalin." Why is that?
 9 DR. EJECKAM:
 10 A. Well, that is the usual--you see 10 percent
 11 formalin is what we use for fixation. Some
 12 people may use alcohol and alcohol fixation
 13 will destroy the antigen. And there are other
 14 fixatives, so I just wanted to highlight the
 15 fixative of first choice.
 16 COFFEY, Q.C.:
 17 Q. You say, "It is advisable to maintain a
 18 regular check on the pH of the buffered
 19 formalin even if it is procured commercially.
 20 Regular check and change of grades of alcohol
 21 in the tissue processor will eliminate
 22 inadequate tissue dehydration." You spoke to
 23 us about that. Why did you feel it necessary
 24 to refer to a regular check of the pH of
 25 buffered formalin, even commercial?

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1 Commercially procured should be checked. Why
 2 would you have to point that out?
 3 DR. EJECKAM:
 4 A. Well, it is again offering information that
 5 may be of practical use, of practical
 6 importance. If you buy a gallon of radiant
 7 and leave it on the desk where it's supposed
 8 to be in the open lab and if it has not been
 9 used up, there's a possibility if it's been
 10 there for quite awhile that the pH may change,
 11 so it's necessary to monitor those.
 12 COFFEY, Q.C.:
 13 Q. And what can be the possible effect of that
 14 be, if the pH is not being monitored and
 15 maintained properly, what's the down side?
 16 DR. EJECKAM:
 17 A. Yeah, fixation capability of the formalin.
 18 COFFEY, Q.C.:
 19 Q. It'll lessen, I take it?
 20 DR. EJECKAM:
 21 A. Yeah, it would lessen, yeah.
 22 COFFEY, Q.C.:
 23 Q. Now, there's a reference there to tissue
 24 reprocessing, what is that?
 25 DR. EJECKAM:

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1 A. Yeah, we do that to--now, if you process
 2 tissue and it's cut and you find that maybe
 3 the time it was being embedded, it was not
 4 embedded properly. Embedded, I mean when they
 5 take the tissue and put it in the cassette
 6 corridor (phonetic) and then pour the molten
 7 wax on it, if the tissue hasn't been properly
 8 arraigned (phonetic) then you may not see all
 9 the layers of the tissue when they cut it, and
 10 when you get your slide, I find that this has
 11 happened, you have to reprocess that tissue or
 12 you have to re-embed it, sorry. Now,
 13 reprocessing comes when like we said, if you
 14 had dehydration problem and there's a lot of
 15 water in it, that's where it wasn't properly
 16 dehydrated. You cannot remove that water in
 17 that block. The only way you can do is to
 18 reprocess the tissue, go to the--start afresh.
 19 And of course, when you do this, these
 20 chemicals are harsh to the antigen inside. We
 21 are able to retrieve them, but if you have to
 22 do it over and over again, definitely you're
 23 going to lose some antigen, I mean, molecule
 24 site that antibodies are supposed to attach
 25 to.

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1 COFFEY, Q.C.:
 2 Q. So tissue reprocessing in terms of
 3 immunostains -
 4 DR. EJECKAM:
 5 A. But in immuno, you're going to create problem
 6 -
 7 COFFEY, Q.C.:
 8 Q. Immuno, yes.
 9 DR. EJECKAM:
 10 A. But generally speaking, it causes
 11 interpretative problem when you do that.
 12 COFFEY, Q.C.:
 13 Q. It's something, if possible, to be avoided?
 14 DR. EJECKAM:
 15 A. Yes. It's not done very commonly, actually.
 16 This again is information from literature, but
 17 in most laboratories they don't do any more
 18 reprocessing because poor (unintelligible) if
 19 you have good solution and everything, you
 20 don't have to run into that kind of trouble.
 21 COFFEY, Q.C.:
 22 Q. Now, how much tissue reprocessing did you
 23 observe as going on at the General Hospital?
 24 DR. EJECKAM:
 25 A. None. None?

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1 COFFEY, Q.C.:
 2 Q. Oh, one word, none, okay. Do you know if
 3 there was any going on elsewhere, like, for
 4 example, at St. Clare's?
 5 DR. EJECKAM:
 6 A. No, I have no information to that, but I don't
 7 believe they were doing it.
 8 COFFEY, Q.C.:
 9 Q. Sir, in terms of the slides, because I take it
 10 having made this fairly lengthy reference to
 11 fixation and related matters here on this
 12 first page, was there anything that you'd seen
 13 that caused you to believe that fixation was a
 14 problem at the time, in 2003?
 15 DR. EJECKAM:
 16 A. No. This memo was simply to provide
 17 information to my colleagues. It wasn't based
 18 on any findings of any stains.
 19 COFFEY, Q.C.:
 20 Q. Now, up to this point in time, which would be,
 21 well, April and May of '03, in terms of ER and
 22 PR slides, okay, you would have had occasion
 23 to read whose ER and PR slides, what sorts of
 24 patients? Would you just read your own
 25 patients' slides?

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1 DR. EJECKAM:
 2 A. I would look at my own.
 3 COFFEY, Q.C.:
 4 Q. Yes.
 5 DR. EJECKAM:
 6 A. And then I would look at the--during the time
 7 we were trying to optimize the stain, I would
 8 look at it with a technologist before they
 9 pass them on, especially those that came in
 10 from outside of St. John's. But you have to
 11 send the slides back to the pathologist, so I
 12 would look at it with them to satisfy that it
 13 is a good stain before they send them out.
 14 COFFEY, Q.C.:
 15 Q. And when was that occurring?
 16 DR. EJECKAM:
 17 A. Within the--it wasn't a particular period, but
 18 during--it was a process that was going on.
 19 COFFEY, Q.C.:
 20 Q. This is during April and May, I take it?
 21 DR. EJECKAM:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. For ER/PR?
 25 DR. EJECKAM:

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1 A. Yeah.
 2 COFFEY, Q.C.:
 3 Q. Okay. So after that did you have occasion to
 4 review ER and PR slides for pathologists from
 5 outside St. John's?
 6 DR. EJECKAM:
 7 A. The word "review", I mean, I didn't have to.
 8 Just if--after the staining, I would look at
 9 it with the technologist to satisfy that it's
 10 okay. I wasn't reviewing to make any report.
 11 COFFEY, Q.C.:
 12 Q. Yeah, and it's -
 13 DR. EJECKAM:
 14 A. If it was technically okay, then I would ask
 15 them to send it on.
 16 COFFEY, Q.C.:
 17 Q. How long did that continue for in terms of ER
 18 and PR slides that you would -
 19 DR. EJECKAM:
 20 A. It continued, that continued until we stopped
 21 doing it. It was--a (unintelligible) would
 22 come into my room with it, I would look at it.
 23 It wasn't a formal type of thing, they will
 24 bring sections of stain to my room to look at
 25 and I would look at it and say that's fine,

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1 then they will go ahead and send them out.
 2 COFFEY, Q.C.:
 3 Q. Was there any procedure in place that they--
 4 requiring them to come, requiring them to come
 5 to you with all ER and PR slides?
 6 DR. EJECKAM:
 7 A. I don't remember it was mandatory for them to
 8 do, but they knew that they needed to show
 9 them to me before they go out. The in-house
 10 pathologists would look at theirs and it's not
 11 a problem there, they needed to consult me,
 12 they would come to me, but there was probably
 13 no need for it. But since we were sending the
 14 slides out to people outside St. John's and
 15 they are not here physically, I thought that
 16 was necessary to look at the section before
 17 they go.
 18 COFFEY, Q.C.:
 19 Q. So what would you be looking for in relation
 20 to the ER and PR slides?
 21 DR. EJECKAM:
 22 A. The controls.
 23 COFFEY, Q.C.:
 24 Q. So what type of controls?
 25 DR. EJECKAM:

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1 A. If I'm doing internal controls and external
 2 controls, internal controls that mean when I
 3 say look at asini, the asini in normal breasts
 4 will stain positively and if the stain was
 5 done and it's negative, then it has to be
 6 repeated before we send it out. It has to be
 7 positive.
 8 COFFEY, Q.C.:
 9 Q. So and would you look at the external controls
 10 too?
 11 DR. EJECKAM:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. Okay. To make sure that they were staining
 15 positive, external positive controls -
 16 DR. EJECKAM:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. - were staining positive? Was the fact that
 20 you had looked at those, was that recorded in
 21 any way?
 22 DR. EJECKAM:
 23 A. No, we didn't keep logbook about any of those.
 24 COFFEY, Q.C.:
 25 Q. And in terms of the ER and PR slides for the

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1 local pathologists, say at the St. Clare's and
 2 the General Hospital pathologists, ER/PR and
 3 slides, would you be asked by the
 4 technologists to review them?
 5 DR. EJECKAM:
 6 A. Not really. You know, it was mainly the ones
 7 going out.
 8 COFFEY, Q.C.:
 9 Q. Out. Anything that was going out of town?
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.:
 13 Q. You'd have a look at. And that would involve
 14 Mary Butler and Ken Green?
 15 DR. EJECKAM:
 16 A. And when Les joined -
 17 COFFEY, Q.C.:
 18 Q. And when Les joined?
 19 DR. EJECKAM:
 20 A. Yeah.
 21 COFFEY, Q.C.:
 22 Q. Les would, as well. If we could, please, the
 23 ER/PR false negative results at paragraph 2,
 24 "Increase in core biopsies, therefore, were
 25 possible, restricting ER/PR requests to

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1 excision biopsies." Could you explain that to
 2 the Commissioner generally what that was
 3 about?
 4 DR. EJECKAM:
 5 A. Commissioner, the core biopsy is obtained by
 6 needle approach. And sometimes the needle
 7 goes through the tumor and obtains good volume
 8 of tumor. Sometimes it may glance through a
 9 fibrous tissue and then it doesn't obtain
 10 enough cells and they may obtain only fibrous
 11 tissue or necrotic tissue. Or they may obtain
 12 some tumor cells that may biologically be
 13 negative. So if you did the stain and find
 14 that you don't have so much of tumor volume
 15 and those tumor cells that you've done show
 16 negative, then you report it as negative, in
 17 actual fact the bulk of the tumor, if you
 18 excised it, may show positivity. So unless it
 19 is imperative--have, I've seen publications
 20 now where people are saying core biopsy no
 21 problem, (unintelligible) no problem, but at
 22 this time we know this can happen, you know,
 23 the person who is taking it and how much
 24 volume of the tumor that was obtained and this
 25 tumor may have estrogen 80 when it comes out.

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1 So it may just look negative and then the
 2 positive ones are back in the patient.
 3 COFFEY, Q.C.:
 4 Q. So I take it the overall idea then was the
 5 more tumor tissue, the better?
 6 DR. EJECKAM:
 7 A. Yes, the variety -
 8 COFFEY, Q.C.:
 9 Q. From your perspective?
 10 DR. EJECKAM:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. To be able to analyze it?
 14 DR. EJECKAM:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. Okay. Paragraph 3 refers to, you pointed out,
 18 internal controls, normal breast acini. Now,
 19 this usage of internal controls in relation to
 20 ER/PR, which is what this is about, isn't it?
 21 DR. EJECKAM:
 22 A. Yes, yes, yes.
 23 COFFEY, Q.C.:
 24 Q. How long had you known about this, the idea of
 25 using internal controls for ER/PR?

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1 DR. EJECKAM:
 2 A. I don't know the time, but if you do
 3 immunohistochemistry of breasts, then it's
 4 important that you recognize that quite early.
 5 Now, we did that in Doha, so you know, it
 6 wasn't something I recognized here.
 7 COFFEY, Q.C.:
 8 Q. No. So this, you knew this back in the '90s
 9 in Doha?
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.:
 13 Q. That would be when your laboratory was
 14 involved in this?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. You were aware of it. How did you become
 19 aware of the necessity to have internal
 20 controls?
 21 DR. EJECKAM:
 22 A. Well, I mean, if you--again, when you choose
 23 the block, that's why when you get several
 24 sections on the HNE, then you look at it first
 25 before you choose the block that will work for

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1 immunohistochemistry. In the process, part of
 2 it is that you choose a good block, and what
 3 makes a good block is that that section should
 4 contain tumor and no more tissue.
 5 COFFEY, Q.C.:
 6 Q. Yeah, and I appreciate that, Doctor. But you
 7 learned that when, yourself?
 8 DR. EJECKAM:
 9 A. Again, before I came here, I mean, we were
 10 doing this as routine, so we knew that it
 11 wasn't something new for anybody taking
 12 section of a breast biopsy, I mean, breast
 13 sections for immunohistochemistry.
 14 COFFEY, Q.C.:
 15 Q. So from your perspective, back in the 1990s in
 16 Doha that as anybody doing ER/PR tests, any
 17 pathologists picking a block for that would
 18 know to be aware to pick the block with normal
 19 tissue, normal breast, asini, in the block and
 20 look for the staining or non-staining of the
 21 internal controls back in the '90s?
 22 DR. EJECKAM:
 23 A. I wouldn't say any pathologist. The way I
 24 look at it that if you are doing
 25 immunohistochemistry -

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1 COFFEY, Q.C.:
 2 Q. If you're going to order -
 3 DR. EJECKAM:
 4 A. If you are working with immunohistochemistry,
 5 then you needed to know this.
 6 COFFEY, Q.C.:
 7 Q. Yes.
 8 DR. EJECKAM:
 9 A. But a pathologist who doesn't work with it,
 10 then you see the sample, they simply look at a
 11 section and give you a section that contains a
 12 lot of tumor and believe that you probably
 13 would have the external control. But if your
 14 formalin is not control, but on a different
 15 slide may not affect what is in the tumor bad,
 16 so the best thing is to have a second level of
 17 control and that really is more critical for
 18 me, that even if the slide control is okay,
 19 and internal control contained in a slide
 20 negative then that doesn't go because there's
 21 something wrong there. That's more critical
 22 in evaluating the controls than the external
 23 one.
 24 COFFEY, Q.C.:
 25 Q. So from your perspective--I'm sorry, go ahead,

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1 Commissioner.
 2 COMMISSIONER:
 3 Q. I want to make sure I understand how many
 4 levels of control there are. There's an
 5 external control?
 6 DR. EJECKAM:
 7 A. Yes. Yes, that's true, Commissioner.
 8 COMMISSIONER:
 9 Q. And the slide you would have a piece of
 10 material which you would choose as having been
 11 tumor?
 12 DR. EJECKAM:
 13 A. Yes.
 14 COMMISSIONER:
 15 Q. And you would have a piece of normal tissue
 16 taken from that same block?
 17 DR. EJECKAM:
 18 A. No. It is one section.
 19 COMMISSIONER:
 20 Q. Um-hm.
 21 DR. EJECKAM:
 22 A. When you taken the section of the tumor, maybe
 23 two millimetre, when you section it, you
 24 should (unintelligible) that tumor with normal
 25 tissue both ways.

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1 THE COMMISSIONER:
 2 Q. So, you have the piece of material, for want
 3 of a better word, that you are looking at, you
 4 are confident has on it both normal and -
 5 DR. EJECKAM:
 6 A. Tumor.
 7 COMMISSIONER:
 8 Q. - normal material?
 9 DR. EJECKAM:
 10 A. Yes.
 11 COMMISSIONER:
 12 Q. And material which you're trying to determine
 13 whether or not it is malignant?
 14 DR. EJECKAM:
 15 A. Well, no, I would have notice malignant before
 16 doing immunohistochemistry.
 17 COMMISSIONER:
 18 Q. Okay, all right.
 19 DR. EJECKAM:
 20 A. You look at HNE and that tell me it's
 21 malignant.
 22 COMMISSIONER:
 23 Q. Okay. So you have something you know is
 24 malignant?
 25 DR. EJECKAM:

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1 A. Yes.
 2 COMMISSIONER:
 3 Q. Just looking at--you're right, yes, I wasn't
 4 thinking. And you have attached to it normal
 5 material?
 6 DR. EJECKAM:
 7 A. Yes.
 8 COMMISSIONER:
 9 Q. And in addition you have on that same slide
 10 something that you know should stain positive,
 11 correct?
 12 DR. EJECKAM:
 13 A. Yes, yes.
 14 COMMISSIONER:
 15 Q. And you also have one that you know should
 16 stain negative?
 17 DR. EJECKAM:
 18 A. Yes. But not all of them on the same slide.
 19 I introduced having the positive control on
 20 the same test slide. Initially we used to
 21 have two slides, one is the diagnostic slide.
 22 COMMISSIONER:
 23 Q. Yes.
 24 DR. EJECKAM:
 25 A. The patient slide. Then on the second slide

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1 is the control. That is fine, but I found
 2 that over a period in Doha, you may get a
 3 better handle of the control by having both
 4 sections on the same slide, so it's that one
 5 slide goes through the same process.
 6 COMMISSIONER:
 7 Q. Um-hm.
 8 DR. EJECKAM:
 9 A. Then you're much more confident that they are
 10 under--they went through under same
 11 conditions. So what we are doing now is to
 12 put the piece of tumor within that tumor and
 13 the size of it to contain normal tissue.
 14 COMMISSIONER:
 15 Q. Um-hm.
 16 DR. EJECKAM:
 17 A. That is the diagnostic tissue. Then few
 18 millimetres away there's another breast tissue
 19 that is positive, we already know is positive
 20 for whatever we're trying to check out, then
 21 that would be--so when we put it under
 22 microscope, you go through to the
 23 (unintelligible) control is not on the section
 24 of the tumor, look at it, then you go back to
 25 the tumor and look for the internal control.

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1 Then when you have--when you've satisfied
 2 yourself that internal control is okay and
 3 that the slide is okay, then that's when you
 4 should go assessing the tumor for positivity
 5 or negativity.
 6 COMMISSIONER:
 7 Q. Okay. So you have external control, you have--
 8 --which would be outside of the slide and
 9 within the slide you have -
 10 DR. EJECKAM:
 11 A. Not outside the slide. Outside of the
 12 diagnostic tissue.
 13 COMMISSIONER:
 14 Q. External control?
 15 DR. EJECKAM:
 16 A. Yeah. Let me put it this way.
 17 COFFEY, Q.C.:
 18 Q. Sure.
 19 DR. EJECKAM:
 20 A. If that is slide.
 21 COMMISSIONER:
 22 Q. Yeah.
 23 DR. EJECKAM:
 24 A. Then you go from there to there. And I would
 25 put the diagnostic tissue here.

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1 COMMISSIONER:
 2 Q. Um-hm.
 3 DR. EJECKAM:
 4 A. It has tumor and it has normal tissue.
 5 COMMISSIONER:
 6 Q. Yeah.
 7 DR. EJECKAM:
 8 A. Then I put my control here, external control.
 9 This is a piece of tissue that I know is
 10 positive.
 11 COMMISSIONER:
 12 Q. Okay.
 13 DR. EJECKAM:
 14 A. But they're all on the same slide.
 15 MR. BROWNE:
 16 Q. Commissioner, I think the external control is
 17 actually from another case, a known case of -
 18 COMMISSIONER:
 19 Q. I understand that.
 20 MR. BROWNE:
 21 Q. Okay.
 22 COMMISSIONER:
 23 Q. I'm just trying to figure out whether I'm
 24 dealing with three controls or two controls.
 25 DR. EJECKAM:

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1 A. Two controls, just two controls. The slide is
 2 there and that's the diagnostic tissue, the
 3 tumor is there, and then this is normal
 4 (unintelligible) -
 5 COMMISSIONER:
 6 Q. Yes, and that's -
 7 DR. EJECKAM:
 8 A. Then that -
 9 COMMISSIONER:
 10 Q. - what you call the secondary control, is it?
 11 DR. EJECKAM:
 12 A. Yeah, this is secondary control or internal
 13 control.
 14 THE COMMISSIONER:
 15 Q. Yeah.
 16 DR. EJECKAM:
 17 A. Then this is the external control.
 18 THE COMMISSIONER:
 19 Q. Yes.
 20 DR. EJECKAM:
 21 A. Which is not in this tissue, but on the same
 22 slide.
 23 THE COMMISSIONER:
 24 Q. Okay.
 25 DR. EJECKAM:

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1 A. Then I know this is positive.
 2 THE COMMISSIONER:
 3 Q. Yes, I understand that.
 4 DR. EJECKAM:
 5 A. That if I need a negative control, I'll do the
 6 same thing, then I will put either on the same
 7 known positive case, then I will do one of two
 8 things, I will mix the primary antibody.
 9 THE COMMISSIONER:
 10 Q. Okay.
 11 DR. EJECKAM:
 12 A. But see if I do that, there'll be no reaction
 13 or I will just take stain or something that I
 14 know is -
 15 THE COMMISSIONER:
 16 Q. Is going to be negative.
 17 DR. EJECKAM:
 18 A. React with ER/PR and put on another slide as a
 19 negative control.
 20 THE COMMISSIONER:
 21 Q. And the purpose of doing that is because that
 22 is the best way of ensuring that what you're
 23 looking at is your controls -
 24 DR. EJECKAM:
 25 A. Yes.

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1 THE COMMISSIONER:
 2 Q. Went through exactly the same process as the
 3 tissue that you are trying to determine
 4 whether or not is positive or negative?
 5 DR. EJECKAM:
 6 A. Yes, Commissioner.
 7 THE COMMISSIONER:
 8 Q. Thank you.
 9 COFFEY, Q.C.:
 10 Q. And the purpose and the importance of that
 11 internal control is what, from your
 12 perspective, you know, as a physician?
 13 DR. EJECKAM:
 14 A. I think it is more critical for me than the
 15 external because it's within the tumor itself
 16 and if it's negative, then it is difficult to
 17 interpret what is being stained on the tumor,
 18 so I think it's a critical portion of this
 19 evaluation.
 20 COFFEY, Q.C.:
 21 Q. And you've known that for many years, I take
 22 it, long before you came to St. John's?
 23 DR. EJECKAM:
 24 A. Yes, yes.
 25 COFFEY, Q.C.:

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1 Q. And I take it then that that knowledge from
 2 your perspective, any pathologist who was
 3 looking at interpreting an ER slide or a PR
 4 slide, interpreting it and making a report,
 5 should have that level of knowledge?
 6 DR. EJECKAM:
 7 A. Not necessarily.
 8 COFFEY, Q.C.:
 9 Q. Okay, well how much should they know?
 10 DR. EJECKAM:
 11 A. Well they should be able to know that what is
 12 positive control nuclear stain, that is
 13 variable, they are able to evaluate it and
 14 then know that cytoplasmic stain is negative
 15 and they would be able to see what the
 16 background, but in terms of knowing that
 17 internal control has to be positive or
 18 negative, it's something you acquire when you
 19 are a little bit more associated with the
 20 process. I am not going to quarrel with a
 21 colleague who doesn't do breasts all the time
 22 and who doesn't know this information.
 23 COFFEY, Q.C.:
 24 Q. And the purpose in drafting paragraph 3 was, I
 25 take it to, for informational purposes to let

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1 the pathologists throughout Newfoundland know
 2 that internal controls, usage of them in this
 3 context was a good idea?
 4 DR. EJECKAM:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. And was that information, other than being in
 8 your memo here, was that readily ascertainable
 9 from the literature?
 10 DR. EJECKAM:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. And had it been so for awhile?
 14 DR. EJECKAM:
 15 A. I don't know what they got in the books, but
 16 most immunohistochemistry literature textbooks
 17 or those who do recite on this subject will
 18 recognize this.
 19 COFFEY, Q.C.:
 20 Q. Okay, and Doctor, if I could move on, you then
 21 talked about the relative positivity of PR and
 22 ER for different or certain types of tumors or
 23 certain--well you do point out, I'm sorry,
 24 that carcinoma of the breast, most PR positive
 25 tumors are also ER positive, however ten

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1 percent of PR positive tumors are ER negative.
 2 Those figures, that ten percent figure, you
 3 would have gotten that from where at the time?
 4 DR. EJECKAM:
 5 A. Literature.
 6 COFFEY, Q.C.:
 7 Q. At the time.
 8 DR. EJECKAM:
 9 A. Yeah.
 10 COFFEY, Q.C.:
 11 Q. Then the reporting, Doctor, and you do then,
 12 you say for several formula are in the
 13 literature, what was your purpose in having
 14 this here, because the different categories
 15 for positive results, you've got ER positive
 16 greater or equal to five percent nuclear
 17 staining, ten percent of tumor staining, one
 18 percent shown to benefit. Why would you point
 19 out the three of them and give this consensus
 20 statement?
 21 DR. EJECKAM:
 22 A. My intention here was, like I said from the
 23 beginning, to provide information to my
 24 colleagues. They may have known this, so
 25 probably wouldn't be necessary for them, but I

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1 didn't know who knew that or who didn't know.
 2 COFFEY, Q.C.:
 3 Q. And you got this information from where?
 4 DR. EJECKAM:
 5 A. From the literature, Babb's.
 6 COFFEY, Q.C.:
 7 Q. Could you spell that please?
 8 DR. EJECKAM:
 9 A. B-A-B-B-S.
 10 COFFEY, Q.C.:
 11 Q. Thank you. And then you point out that
 12 "higher staining intensity does not reflect
 13 better results and this is a function of
 14 staining procedure and may alter all
 15 cytoplasmic staining in ER and PR immunostain
 16 are to be considered as negative." I take it
 17 that's particular to ER and PR?
 18 DR. EJECKAM:
 19 A. Yeah.
 20 COFFEY, Q.C.:
 21 Q. Or one of the things that's -
 22 DR. EJECKAM:
 23 A. The nucleus stain.
 24 COFFEY, Q.C.:
 25 Q. And you were alerting people to this for

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1 informational purposes.
 2 DR. EJECKAM:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. The idea that "higher staining intensity does
 6 not reflect better results", what were you
 7 cautioning against there, Doctor?
 8 DR. EJECKAM:
 9 A. All the immunohistochemistry for breasts, you
 10 find a differentiates of positivity, so
 11 sometimes you have very dark nucleus, then
 12 sometimes brown, sometimes faint and maybe if
 13 you're not familiar with this, somebody may be
 14 waiting to have very dark stain to call it
 15 positive. So my, again, given information
 16 that it doesn't have to be that dark and that
 17 being dark doesn't mean it's a better stain,
 18 all you need to do is to identify nuclear
 19 stain, that it crisp, it may be faint and in
 20 actual fact, you should not have a uniformed
 21 stain, you should have a variation of stain
 22 because each of those cells is in a different
 23 stage of activity; therefore, they should not
 24 have uniformed dark stain. Some may be light,
 25 some may be darker.

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1 COFFEY, Q.C.:

2 Q. And then on the next page, Doctor, if I could,

3 you list a number of ER positive tumors and

4 you've got four of them there and as well

5 you've pointed out that lobular would be one

6 that would normally be included -

7 DR. EJECKAM:

8 A. Yes.

9 COFFEY, Q.C.:

10 Q. And in fact, as you've pointed out, this was

11 not meant to be an exhaustive research paper

12 at the time.

13 DR. EJECKAM:

14 A. Right, right.

15 COFFEY, Q.C.:

16 Q. Why would you be pointing that out to the

17 pathologists, even listing any of them?

18 You've listed four and you could have listed

19 five?

20 DR. EJECKAM:

21 A. Well again, is process to give them

22 information because if someone has tubular

23 carcinoma, for instance and the stain is

24 negative, like I say, you will look at HNE,

25 many diagonals of malignancy anyways, this

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1 doesn't help you to make that judgment and if

2 you see a tubular carcinoma with a low grade

3 malignancy, ought to be positive and then you

4 find it negative, then you show, it really

5 doesn't, not controlled, thereby it probably

6 is time to have a consultation. So this

7 again, process of -

8 COFFEY, Q.C.:

9 Q. With a view to doing what, a consultation with

10 a view to doing what?

11 DR. EJECKAM:

12 A. To repeat the test, to repeat it. It could, a

13 the end of the day, it may be negative but you

14 have to satisfy yourself that that was a

15 spurious result.

16 THE COMMISSIONER:

17 Q. So in the process of doing what pathologists

18 do and assessing the results of your process,

19 you had to think about the particular kind of

20 tumor you're dealing with and the likely

21 result, as well as what you see, is that

22 right?

23 DR. EJECKAM:

24 A. Yes, it makes life easier if I know that, my

25 HNE says a tubular carcinoma, or lobular

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1 carcinoma and I know it ought to be positive

2 and I find a negative, that helps me to say

3 no, there's something going on here, but if I

4 didn't have that information, I may just let

5 it go and say nothing as a result of the test.

6 THE COMMISSIONER:

7 Q. Okay.

8 COFFEY, Q.C.:

9 Q. And, Doctor, just to finish this particular

10 memo, you've noted in paragraph 8, low grade--

11 low nuclear grade tumors are usually positive

12 for ER/PR and negative for HER2/neu and you go

13 on about that. I take it was this--why was

14 this here? Was this for the same purpose as

15 your reference in paragraph seven?

16 DR. EJECKAM:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. Okay.

20 DR. EJECKAM:

21 A. Because the information that most of those

22 listed on seven are low grade tumors anyway.

23 COFFEY, Q.C.:

24 Q. Doctor, in other places that you've worked, do

25 people keep track of, the lab keep track or

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1 the pathologist keep track of the ER and PR

2 positivity rates for different types of tumors

3 or just generally within the lab?

4 DR. EJECKAM:

5 A. I don't understand the question.

6 COFFEY, Q.C.:

7 Q. Okay, and I apologize. In other laboratories

8 where you have worked outside of St. John's -

9 DR. EJECKAM:

10 A. Yes.

11 COFFEY, Q.C.:

12 Q. Did they keep track of ER and PR positivity

13 rates?

14 DR. EJECKAM:

15 A. I wouldn't know that.

16 COFFEY, Q.C.:

17 Q. Okay, so if they were doing it, they weren't

18 letting you know.

19 DR. EJECKAM:

20 A. They would not send us any feedback on that,

21 we just did the test and sent it to them to

22 evaluate.

23 COFFEY, Q.C.:

24 Q. Okay, and that was, I take it in Qatar as

25 well, is what I'm asking you about, in Qatar

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1 you weren't keeping track of the statistics?
 2 DR. EJECKAM:
 3 A. No, we would keep at the end of it, what our
 4 own year, you can then do your statistics, but
 5 you don't keep track, I mean, the results are
 6 final and if you wanted to get them and do a
 7 statistics on them, then you can do that.
 8 COFFEY, Q.C.:
 9 Q. Okay, and you'd do that, I take it, by
 10 accessing the computer system and -
 11 DR. EJECKAM:
 12 A. Yeah, and I would get a copy or go to the
 13 computer.
 14 COFFEY, Q.C.:
 15 Q. And, Doctor, with respect to the reference in
 16 paragraph one here, you referred to over and
 17 under fixation, is either of those types of
 18 fixation problem more associated with the
 19 possibility of a false negative? Is either
 20 more apt or likely to give you a false
 21 negative if the tissues was -
 22 DR. EJECKAM:
 23 A. Possibly over fixation.
 24 COFFEY, Q.C.:
 25 Q. I'm sorry?

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1 DR. EJECKAM:
 2 A. Possibly over fixation might be, but again,
 3 like I said, it's probably no more a problem
 4 with a proper antigen retrieval.
 5 COFFEY, Q.C.:
 6 Q. With respect to the technologist at the time
 7 in 2003, at the time you were, in April and
 8 May when you were involved in this in the
 9 beginning, trying to fix or address the
 10 concerns, did the technologists express any
 11 concerns to you about IHC in general, ER/PR,
 12 particular IHC in general?
 13 DR. EJECKAM:
 14 A. The only concern that I could remember that
 15 when I came into help, they expressed
 16 happiness that someone, they have a reference
 17 point, but besides that, I mean, I am not
 18 aware of any other difficulties they were
 19 getting.
 20 COFFEY, Q.C.:
 21 Q. Okay, and how about afterward, did they ever
 22 come back to you expressing concerns?
 23 DR. EJECKAM:
 24 A. There was no need for it because I was already
 25 working with them.

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1 COFFEY, Q.C.:
 2 Q. You were working there, okay. And so in
 3 effect I take it you're telling the
 4 Commissioner, look, when you did get involved
 5 in April of 2003, your experience with the
 6 technologists was they were happy to have you
 7 there?
 8 DR. EJECKAM:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. And you say as a reference point, I take it as
 12 a person that they could go to and to talk to?
 13 DR. EJECKAM:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. About any concerns that they would have?
 17 DR. EJECKAM:
 18 A. Yes, that's what happened.
 19 COFFEY, Q.C.:
 20 Q. What--did they give you any understanding
 21 about what the state of affairs had been
 22 before you got involved in that regard?
 23 DR. EJECKAM:
 24 A. Well really they just said that they didn't
 25 have anybody to go to to iron out problems,

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1 some were blaming, bringing out problems of
 2 the stains.
 3 COFFEY, Q.C.:
 4 Q. In your experience with the technologists in
 5 St. John's, well as you've pointed out, your
 6 sense was they were happy to see you. How
 7 about as time went on, what was your sense of
 8 how willing they were to learn, how interested
 9 they were?
 10 DR. EJECKAM:
 11 A. I think they were willing to learn, the
 12 problem was that they probably had a lot of
 13 other things to do, so, you know, if you
 14 wanted to review cases with them, they
 15 probably had one that they were going to do
 16 gross, but when they got (unintelligible) they
 17 were quite happy, they were quite upfront
 18 about it.
 19 COFFEY, Q.C.:
 20 Q. If we can look, please, at page 5 of exhibit
 21 P-0113, this is a memo to Terry Gulliver from
 22 yourself and you initialled it. The subject
 23 is "Immunohistochemical Stains at the Health
 24 Sciences Centre". It's dated June 19th, 2003
 25 and this goes on for three pages, you've

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1 signed it, actually your full name this time,
 2 and it's copied to Dr. Desmond Robb who is the
 3 chair discipline of Laboratory Medicine; Dr.
 4 D. Cook, clinical chief and site chief, St.
 5 Clare's; Dr. S. Parai, site chief at the
 6 Health Sciences Centre and to Barry Dyer, the
 7 manager of histopathology. And, Doctor, how
 8 is that that you--or why did you come to write
 9 this memo?
 10 DR. EJECKAM:
 11 A. I did this because after working with a
 12 technologist and trying to get some good
 13 stains and I still realized that we don't have
 14 an optimal condition and to have optimal
 15 condition would be to move the
 16 immunohistochemistry into a different room,
 17 have dedicated staff and then have a number of
 18 them that would need to -
 19 COFFEY, Q.C.:
 20 Q. Are listed here, yes.
 21 DR. EJECKAM:
 22 A. Yeah, so that was the reason. I mean, I was
 23 just trying to ensure that we recognize even
 24 though we're getting some good stains that
 25 this is not optimal and that we need to look

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1 at the future and look at what we have and
 2 work to improve and make sure we have optimal
 3 condition.
 4 COFFEY, Q.C.:
 5 Q. By this point, by June 19th 2003, the other
 6 six stains that are referred to in your April
 7 4th memo, had the concerns with them been
 8 addressed by that point?
 9 DR. EJECKAM:
 10 A. Oh yeah, oh yeah.
 11 COFFEY, Q.C.:
 12 Q. By the time you came to write the June 19th
 13 one, the immediate problem of the eight stains
 14 was addressed?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. Did anyone ask you to write this?
 19 DR. EJECKAM:
 20 A. No.
 21 COFFEY, Q.C.:
 22 Q. Okay. So it was your idea?
 23 DR. EJECKAM:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Having written it, did you ever get any
 2 feedback or anybody ever ask you about it?
 3 Any response?
 4 DR. EJECKAM:
 5 A. Not in terms of written feedback, but I
 6 remember after some days when I didn't get any
 7 reply, I ran into Dr. Robb in the corridor and
 8 I asked him if he got the letter. He said
 9 "yes, I got it, and I think it was a good
 10 letter" and that he was going to have a
 11 meeting. Unfortunately, he was ill and went
 12 off in January for surgery and didn't make it
 13 back, and then also the same process with
 14 Terry. I saw him in the lab and said "did you
 15 get a letter?" He said "yes" and he told me
 16 "I'm going to reply to you" and that was the
 17 follow up that I had and that was all the
 18 response that I got from this.
 19 COFFEY, Q.C.:
 20 Q. So that was--so you spoke to Dr. Robb and as
 21 you just pointed out, he was going to get back
 22 to you. Dr. Robb unfortunately was ill and
 23 got iller and I gather died shortly
 24 thereafter.
 25 DR. EJECKAM:

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1 A. Yeah.
 2 COFFEY, Q.C.:
 3 Q. And you also spoke to Mr. Gulliver?
 4 DR. EJECKAM:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. And he said he expected to act upon it and he
 8 would get back to you?
 9 DR. EJECKAM:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. And that was the last you heard from him about
 13 it?
 14 DR. EJECKAM:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. Did you ever hear from anybody else about it?
 18 DR. EJECKAM:
 19 A. No. Well, I know--I think Dr. Don Cook may
 20 have discussed it, but not written
 21 communication.
 22 COFFEY, Q.C.:
 23 Q. Anyone--and I appreciate it's not addressed to
 24 the VP Medical, Dr. Williams or anybody else
 25 in the administration, did you ever speak to

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1 anybody in the administration about it?
 2 DR. EJECKAM:
 3 A. No.
 4 COFFEY, Q.C.:
 5 Q. Why not?
 6 DR. EJECKAM:
 7 A. I didn't think it was necessary. I don't
 8 report to them directly, so I made my memo to
 9 the authorities looking after the laboratory.
 10 If they needed to go to the VP, it's their
 11 decision to make, not mine.
 12 COFFEY, Q.C.:
 13 Q. Now if we could, before we conclude for the
 14 day, Exhibit P-1572? I'm going to come back
 15 to that memo, Doctor. I'll take it up in the
 16 morning, but there's a couple of things I
 17 would like to attend to first. This is a
 18 report of the minutes of a surgical pathology
 19 review committee meeting of April 15th 2003.
 20 In fact, we have the agenda for it. Present
 21 are yourself, Dr. Badcock, Dr. Dawson, Parai,
 22 Siddiqui, and Theresa Curtis, the secretary,
 23 and apologies from Dr. Thavanathan.
 24 DR. EJECKAM:
 25 A. Thavanathan.

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1 COFFEY, Q.C.:
 2 Q. Thavanathan, yes, I'm sorry. And Dr. Kwan.
 3 It's stamped Vice President, August 11th 2003,
 4 Medical Services, and that would be presumably
 5 the received by Vice President's office, and
 6 then it's handwritten out here to the side and
 7 dated September 2nd, 2003. I gather it's a
 8 note from Dr. Williams. But this under
 9 business arising, well, it says "call to
 10 order. The first meeting of the surgical
 11 pathology review committee was called to order
 12 by Dr. G. Ejeckam at 2:10 p.m. on April 15th.
 13 Business arising, terms of reference: (a)
 14 standardized reporting of pathology
 15 specimens."
 16 And you've written here, "Dr. Ejeckam
 17 asked the members for input for standardized
 18 reporting of pathology specimens. After much
 19 discussion, it was agreed that the ER and PR
 20 receptors be done automatically on breast
 21 surgery cases. Since HER2neu testing is
 22 expensive and only done when requested, it is
 23 suggested it should be performed automatically
 24 on patients with a past history of carcinoma
 25 of the breast."

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1 And then--now Doctor, in this first
 2 meeting, was there a concern about the
 3 reporting format for ER and PR receptors?
 4 DR. EJECKAM:
 5 A. I think it was a discussion about when to do
 6 it and then how to report it.
 7 COFFEY, Q.C.:
 8 Q. Okay, so when to do ER/PR?
 9 DR. EJECKAM:
 10 A. Yeah.
 11 COFFEY, Q.C.:
 12 Q. Order it?
 13 DR. EJECKAM:
 14 A. Yeah.
 15 COFFEY, Q.C.:
 16 Q. And I take it so at that point in time, even
 17 as late as April of '03, was the request for
 18 ER and PR tests on breast cancer automatic or
 19 not at that time?
 20 DR. EJECKAM:
 21 A. I can't be sure of the dates, but I know that
 22 normally the pathologists, if you received a
 23 breast cancer case, you automatically fill out
 24 the request to the laboratory,
 25 immunohistochemistry laboratory for ER/PR.

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1 But occasionally you get a request from the
 2 oncologist sometimes, especially patients that
 3 have been done elsewhere.
 4 COFFEY, Q.C.:
 5 Q. Oh, okay.
 6 DR. EJECKAM:
 7 A. They would fill out a form and send it to the
 8 laboratory.
 9 COFFEY, Q.C.:
 10 Q. So it was agreed then, I take it, at this
 11 meeting that ER and PR receptors would be done
 12 on all breast surgery cases?
 13 DR. EJECKAM:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. Pathologists would just do it routinely?
 17 DR. EJECKAM:
 18 A. Yeah, you didn't have to wait for any more
 19 requests or anything. Once you have a case of
 20 breast cancer, part of the report has to be
 21 ER/PR findings.
 22 COFFEY, Q.C.:
 23 Q. The clinical information, "Dr. G. Ejeckam
 24 circulated a form listing ten requirements a
 25 properly completed specimen requisition form

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1 should include, and all members agreed those
 2 requirements would benefit the clinician and
 3 pathologist for improved patient care." So I
 4 take it this is the opening in the effort, the
 5 long campaign to get people to fill out the
 6 forms properly?
 7 DR. EJECKAM:
 8 A. Yeah.
 9 COFFEY, Q.C.:
 10 Q. Okay, and if we could, please, Commissioner,
 11 paragraph three, new business, "3.1 ER/PR--and
 12 PR receptors. Dr. G. Ejeckam stated that ER
 13 and PR receptors are not being performed for
 14 the next six weeks due to a technical problem.
 15 If a solution cannot be found, these tests
 16 will be sent outside St. John's. He stated it
 17 is being considered to send one or two
 18 technologists to Halifax or Toronto for
 19 training." So I take it that as of mid April,
 20 this was just a note you were telling
 21 everybody at your meeting -
 22 DR. EJECKAM:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. - what was going on, was in your April 4th

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1 memo, because some of the people at the
 2 meeting are not pathologists?
 3 DR. EJECKAM:
 4 A. Oh yes.
 5 COFFEY, Q.C.:
 6 Q. A number of them aren't, so you have to tell
 7 them that. The technologists, by mid April,
 8 did you think there was a need for the
 9 technologists to have special training?
 10 DR. EJECKAM:
 11 A. Yes, I mean, the people who are doing
 12 immunohistochemistry, if there's a chance of
 13 possibly to go to a bigger laboratory that has
 14 more volume, that would be helpful. It
 15 doesn't mean they are not doing good job, but
 16 it's good to see what other people are doing.
 17 COFFEY, Q.C.:
 18 Q. So I take it, as you described, is in fact
 19 what happened in Qatar? You sent people to
 20 Florida?
 21 DR. EJECKAM:
 22 A. Yeah, yeah, I sent to Florida to have a look
 23 at a bigger set up.
 24 COFFEY, Q.C.:
 25 Q. Your observation in early 2003 when you began

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1 to deal with the technologists related to this
 2 ER/PR matter initially, what was, from your
 3 perspective, their relative state of knowledge
 4 concerning immunohistochemistry and in
 5 particular, ER/PR, but immunohistochemistry
 6 generally? Compared to, for example, Qatar
 7 where you had just come--spent more than a
 8 dozen years.
 9 DR. EJECKAM:
 10 A. Well, they were doing their stains okay. In
 11 this type of process, it's a continual effort
 12 to understand the system and to be able to
 13 troubleshoot if there's any problem. It
 14 requires reading. We are trying to get them
 15 books, and I let them borrow my book, but
 16 later on, we had to order textbook for them,
 17 much later. So you know, they have a
 18 reasonable knowledge for what they are doing,
 19 but that doesn't mean that they wouldn't
 20 benefit from improving their knowledge.
 21 COFFEY, Q.C.:
 22 Q. And in 2003, was there an effort to get them
 23 sent to another lab?
 24 DR. EJECKAM:
 25 A. That's when I suggested they could go--I

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1 discussed it with Don and they could go to
 2 either Toronto or Halifax or Montreal, but I
 3 don't think they were able to go then for
 4 probably budget problem or, I don't know, and
 5 the work process. They were probably short
 6 staffed, but I don't know the details of that.
 7 COFFEY, Q.C.:
 8 Q. Okay, so at that time anyway, your memory is
 9 they didn't get to go then?
 10 DR. EJECKAM:
 11 A. No, no.
 12 COFFEY, Q.C.:
 13 Q. Okay. If we could, tomorrow morning,
 14 Commissioner.
 15 THE COMMISSIONER:
 16 Q. Okay.
 17 COFFEY, Q.C.:
 18 Q. Thank you.
 19 THE COMMISSIONER:
 20 Q. We'll adjourn until 9:30 in the morning.
 21 Thank you.

CERTIFICATE

1
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 3rd day of June, A.D., 2008 before the
6 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 3rd day of June, A.D., 2008
13 Judy Moss

Inquiry on Hormone Receptor Testing

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