COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

June 3, 2008

Appearances:

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

Rolf Pritchard/Stephen Mills . . . . Her Majesty in Right of NL

Jane Hennebury . . . . . Doctors Kara Laing et al

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

Pamela Taylor . . . . . Members of the Breast Cancer
. . . . . Testing Class Action

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

LIST OF EXHIBITS

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THE COMMISSIONER:

Q. Please be seated. Ms. Newbury.

MS. SUSAN BONNELL, EXAMINATION BY MS. JENNIFER NEWBURY (CONTINUED)

MS. NEWBURY:

Q. Thank you. Can we go to P-0616 please? This is the letter that you had drafted. I understand the intention was that this could be used for the NLMA website as a letter for physicians. And we looked at that yesterday. Paragraph 6 of the letter states that "Only a small percentage of breast cancer patients may be affected by this retesting. Approximately 75 percent of all breast cancer patients already tested positive for ER and PR receptors. From the results that we have retested thus far we are anticipating that less than 10 percent of all breast cancer patients will convert from a negative to a positive and may experience a change or addition to their cancer therapy. Patients with positive ER and PR results or those who previously received hormone therapy for their cancer are not impacted." When you drafted that letter there, was this a concept that you

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came up with yourself or is that information that had been provided to you by Dr. Williams or someone else?

MS. BONNELL:

A. This was the information at--what is the date on this letter, Ms. Newbury?

MS. NEWBURY:

Q. That date, the e-mail, I believe, is October the 4th.

MS. BONNELL:

A. October 4th, yeah. At that point in time I guess that's what we believed might be the case, although I don't--I think I indicated to Mr. Coffey that I don't believe this letter was ever sent.

MS. NEWBURY:

Q. Right. Yes, I understand that. But at the time you were drafting it, it would potentially be placed on the website?

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. Okay. And this was shortly before the various media reports dated October 5th up through to October 14th where Dr. Williams made similar

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comments about the 10 percent -

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. - are expected to convert. And you'd indicated that you later suggested to Dr. Williams that he should stay away from using that percentage figure as it might cause -

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. - some confusion. You didn't think about that at the time you were preparing this letter, were you?

MS. BONNELL:

A. No, I think that's where, that's where--you know, what I indicated to Dr. Williams was that the 10 percent was being misinterpreted.

MS. NEWBURY:

Q. Okay.

MS. BONNELL:

A. And that it was best just to avoid numbers as we were trying to predict, anyway, and had no way of knowing. The test results may have all come back with no change. I mean, we had no

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way of knowing. They may have all come back all changed. At that point it would all be supposition.

MS. NEWBURY:

Q. Sure.

MS. BONNELL:

A. And in the meantime this letter was not set, to my knowledge.

MS. NEWBURY:

Q. Right, okay. But you hadn't tuned into the fact that this could possibly be misinterpreted when you prepared this draft?

MS. BONNELL:

A. The letter wasn't sent, Ms. Newbury.

MS. NEWBURY:

Q. No.

MS. BONNELL:

A. So, you know, in the end it's not part of what happened, anyway. But I don't recall where my head was when that particular memo was written or letter was written, drafted.

MS. NEWBURY:

Q. With regard to management of the ER/PR problem, generally speaking, you'd mentioned that in your view it was Dr. Williams who

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handled that until his retirement?

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. And subsequent to his retirement, who took over management of the ER/PR issues?

MS. BONNELL:

A. After he retired?

MS. NEWBURY:

Q. Yes.

MS. BONNELL:

A. It would have been Dr. Howell.

MS. NEWBURY:

Q. Okay. Did he take over all aspects, all of the same aspects of the ER/PR issues that Dr. Williams had previously been handling?

MS. BONNELL:

A. He took over Dr. Williams portfolio, so it would be my understanding that he did.

MS. NEWBURY:

Q. Okay. You're not aware that any part of the ER/PR problem was -

MS. BONNELL:

A. I know that Ms. Pilgrim became more involved when Dr. Williams left the organization, but

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Dr. Williams had quality as part of his portfolio and Dr. Howell did not.

MS. NEWBURY:

Q. Okay. Were there any other differences in terms of what Dr. Howell had assumed in terms of management of the ER/PR issues?

MS. BONNELL:

A. I can't speak to that, Ms. Newbury.

MS. NEWBURY:

Q. Now, there was some evidence given by you about your communication with Carolyn Chaplin in around July 22nd and 23rd. And you'd indicated at that time there was some to and fro, you thought that the problem was serious and you had contacted Ms. Chaplin just to give her the heads up that there might be some press coming up in the next few days?

MS. BONNELL:

A. I think that was actually the week before that.

MS. NEWBURY:

Q. Okay.

MS. BONNELL:

A. The meeting with the minister, I believe, was on the 23rd. Am I correct in that?

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MS. NEWBURY:

Q. Correct.

MS. BONNELL:

A. So it would have been the week before that.

MS. NEWBURY:

Q. The week before that, July 19th, I believe was the date.

MS. BONNELL:

A. Okay.

MS. NEWBURY:

Q. And then when you--I think, or maybe it was July the 18th. But in the next couple of days you had gone back and forth and you had indicated that the problem reverted back to being more serious. And I understood from your evidence that you did not call Ms. Chaplin back to tell her that it was now considered more serious because you were not planning to do a press conference?

MS. BONNELL:

A. I believe that following the meeting with the minister on the 23rd, if I'm right on my date, really what happened at that meeting was that we made a decision that we weren't going to make a decision at that point. Do you know

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what I mean? Like, at that meeting we said that the decision on what we would do, press conference, whatever option it was, was delayed until we could gather more information, so in the subsequent days we gained new information. There was a meeting on the 1st of August in the organization at which point we made a decision to redo--well, it was at that point or around that point that the decision was made to do, in fact, what we did, you know, the group that we were going to do and that we weren't going to use our own internal system to redo the testing, that we would halt, all those sort of decisions were sort of fermented at that time. And I did not contact Ms. Chaplin myself, but I was aware that the organization was in contact with the department through Dr. Williams and Mr. Tilley and others.

MS. NEWBURY:

Q. So you didn't think at the time that the impression that you left with Ms. Chaplin with when you last spoke with her is that this is less serious, perhaps I should call her back even though we don't plan to do a press

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conference, perhaps I should call her back just to let her know that -

MS. BONNELL:

A. No, no, I -

MS. NEWBURY:

Q. - we again think this is more serious?

MS. BONNELL:

A. No.

MS. NEWBURY:

Q. Okay. Is there any reason why you would not have thought it important to do that?

MS. BONNELL:

A. Because it wasn't my role do to that. If I was asked to do that, I would have done that, but it was my understanding that someone else was making contact with the department other than myself to Ms. Chaplin.

MS. NEWBURY:

Q. But you had contacted her initially. Was that on your own initiative that you contacted Ms. Chaplin?

MS. BONNELL:

A. No. I was asked to call Ms. Chaplin.

MS. NEWBURY:

Q. Okay. And did you know that someone would be

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calling her back to let her know that the problem was again more serious?

MS. BONNELL:

A. Ms. Chaplin is within the department, so we would assume that she would hear that through her own -

MS. NEWBURY:

Q. If I could have Exhibit 0361, please? This is an e-mail that you forwarded to Joan Dawe and George Tilley and copied to Dr. Williams about an interview. You've already been shown this and given some evidence about that. Do you know how the interview with Ms. Kearney came about, whether that was something arranged by Eastern Health?

MS. BONNELL:

A. I don't believe it was arranged by Eastern Health. If we don't have a record of the call coming in to us, it would not have been arranged by us. I don't believe it was arranged by us.

MS. NEWBURY:

Q. Okay. And how did you become involved in this issue?

MS. BONNELL:

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A. There are e-mails prior to this one in which Ms. Dawe had heard about it occuring. We then had subsequent phone calls with Ms. Kearney because she was concerned about being put in a situation of having to address ER/PR, given her role within the organization. And we made some calls on her behalf and were--she called Mr. Dawe and together they made a decision that they weren't going to be talking about ER/PR, so that was my only involvement. She wanted--I remember her wanting to not do it because she was afraid of being questioned on something which she knew nothing about and my encouraging her to do it because I felt that it was something that she really wanted to do and it was a topic, I think this October might be breast cancer awareness month, is it?

MS. NEWBURY:

Q. Um-hm.

MS. BONNELL:

A. And it was a really good opportunity to get messages out about breast screening, and so everybody involved, Mr. Dawe, Ms. Kearney and Anne Budgell were all committed to talking on that topic.

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MS. NEWBURY:

Q. Okay. Now I see there on the second line it states, "We have prepared a few messages in the event that she gets calls regarding this issue."

MS. BONNELL:

A. Um-hm.

MS. NEWBURY:

Q. And I assume that refers to the ER/PR issue?

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. Okay. And what form were those messages provided to her?

MS. BONNELL:

A. I don't recall. If they're not, if they're not in an e-mail, then it might have been that we gave her a few things that she might say if she were called.

MS. NEWBURY:

Q. So that would have been verbally as opposed to in writing?

MS. BONNELL:

A. Yeah.

MS. NEWBURY:

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Q. And do you -

MS. BONNELL:

A. There was probably--you know, if you have--you know, I would suspect what I would have said to her is something like, you know, I'm not a spokesperson on this issue, if you have questions, I'd suggest you call the patient relations officer, that sort of a general--that would have been the kind of thing we would have given her and others who may be questioned on ER/PR.

MS. NEWBURY:

Q. Okay. And were you the one that gave that message to Ms. Kearney?

MS. BONNELL:

A. I don't recall if it was me or Ms. Thomas. I think it was me.

MS. NEWBURY:

Q. Okay.

MS. BONNELL:

A. I'm trying to--it's two, three years ago now.

MS. NEWBURY:

Q. Sure.

MS. BONNELL:

A. I don't remember. But I do remember having a

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conversation with her at that time.
MS. NEWBURY:
Q. Okay. And do you know if anyone else within Eastern Health would have had any occassion to talk to her about this particular interview?
MS. BONNELL:
A. I doubt it very much.
MS. NEWBURY:
Q. Okay. Thank you. Now, it was your evidence, and you've spoken about this a couple of times, that a strategic plan would have been advisable and that as part of that strategic plan you would have included communication with advocacy groups such as the Canadian Cancer Society. And that would be proactive communication, I assume, as opposed to reactive communication?
MS. BONNELL:
A. Yes.
MS. NEWBURY:
Q. And would that communication be for providing information to those advocacy groups or would it also seek input or feedback from these groups?
MS. BONNELL:

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A. It could be both.
MS. NEWBURY:
Q. Okay. Generally speaking, what would you do in a strategic plan, would you--would it be a two-way conversation?
MS. BONNELL:
A. We always encourage two-way communication. We always encourage involvement so that stakeholders feel engaged in an issue. So it would be hard to predict what I would -
MS. NEWBURY:
Q. So even though that you didn't have a strategic plan in place, then, you know, including dealing with the Cancer Society as an advocacy group, in 2005 Peter Dawe was seen in the media on behalf of the Canadian Cancer Society providing some of his views and concerns about the ER/PR issue. Why not, at that time, whether you have a strategic plan or not, take an initiative to involve the Cancer Society in -
MS. BONNELL:
A. Well, I believe he -
MS. NEWBURY:
Q. - to engage at that point in time?

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

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Dawe.
MS. NEWBURY:
Q. So you have no idea what the communication was?
MS. BONNELL:
A. No. I think he was given information on what was happening at that point in time. Whether he was asked for feedback or not, I don't know.
MS. NEWBURY:
Q. And given your role in communications, do you think it would have been important to try to find out? These are the types of things I understand you would do in a strategic plan, you would have communication with the group -
MS. BONNELL:
A. Um-hm.
MS. NEWBURY:
Q. Even though that you're aware some other people in your organization might be briefing him, do you think at that point in time it might have been appropriate to take it a step further and try to open the lines of communication from the communications department perspective with the Cancer

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

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

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being the spokesperson and conducting that meeting. The communications department's role in that is to help facilitate, it's to organize, to help prepare messaging, to make sure there's enough chairs in the room, to make sure the media are invited, that, you know, it's a facilitation role.
MS. NEWBURY:
Q. So the strategic plan for communications that you noted was absent in this case -
MS. BONNELL:
A. Would be an organizational plan.
MS. NEWBURY:
Q. Okay. So you would not be directly involved in the communications with the stakeholders, the stakeholder mapping that you mentioned, you would just indicate to other members or other departments of the organization this is what you should now do?
MS. BONNELL:
A. I think I indicated to Mr. Coffey a couple of days go that it's not my role within the organization to be a spokesperson for the organization, it's not my role to be a leader in actually conducting the communications.

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It's a facilitation role and a building role and a consultancy role and an advisory role.
MS. NEWBURY:
Q. And part of that role is to make sure that it gets done?
MS. BONNELL:
A. Yes, indeed.
MS. NEWBURY:
Q. If you see that there's a need for communication with -
MS. BONNELL:
A. Yes.
MS. NEWBURY:
Q. - stakeholders, then -
MS. BONNELL:
A. It's to encourage that those things get done, yes.
MS. NEWBURY:
Q. And as part of that strategic communications plan, do you think that there is a role for the communications department or others in the organization making sure that they understand what the issues and concerns are of the various advocacy groups?
MS. BONNELL:

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A. Yes, I do.
MS. NEWBURY:
Q. And if you have a formal plan or not, I take it that you can still seek feedback and input from advocacy groups, even if you haven't had the opportunity or had overlooked getting a strategic plan in place?
MS. BONNELL:
A. Yes, of course.
MS. NEWBURY:
Q. Okay, and did you at any time after October 2005, when Mr. Dawe, on behalf of the Cancer Society was reporting in the media, did you take an effort to find out yourself what exactly the issues and concerns were of the Cancer Society?
MS. BONNELL:
A. I was certainly informed by individuals who work more closely with Mr. Dawe, individuals from the Cancer Program, doctors in the Cancer Program, leaders in the Cancer Program who work more closely with him, what some of his concerns and issues were, yes.
MS. NEWBURY:
Q. Okay, but not from Mr. Dawe? He might have a

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

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A. Yes, I don't even know if it was a briefing, phone call, if they brought him in for a meeting, I'm not sure. I was told that they had met with Mr. Dawe.
MS. NEWBURY:
Q. And you didn't seek a report of what happened in that meeting?
MS. BONNELL:
A. From my CEO, no.
MS. NEWBURY:
Q. Or indirectly through someone else who might know what had happened?
MS. BONNELL:
A. No, I was told that Mr. Dawe was brought in and told what was going on, but I didn't ask my CEO for a report, no.
MS. NEWBURY:
Q. And he didn't offer one?
MS. BONNELL:
A. Other than that, no.
MS. NEWBURY:
Q. If I could have Exhibit 0304, please? This is the memo that you've seen a few times, July 22nd 2005. This is page three of the exhibit, and there's a reference there at the bottom of

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

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annual leave.
MS. BONNELL:
A. Right.
MS. NEWBURY:
Q. And then you respond to Heather, Ms. Barrington and Ms. Smith, I'm not sure if it ever got sent back to Ms. Pilgrim.
MS. BONNELL:
A. Dianne Smith is Pat Pilgrim's assistant.
MS. NEWBURY:
Q. So she would have received it, okay.
MS. BONNELL:
A. Yes.
MS. NEWBURY:
Q. And in that, you indicate "why don't you e-mail him?" and I think that refers to Mr. Dawe -
MS. BONNELL:
A. Um-hm.
MS. NEWBURY:
Q. - "and let him know there have been some new developments in the media and that if he has any questions or concerns, he can get in touch with you. Put the ball back in his court."
MS. BONNELL:

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

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

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

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causing confusion and we're getting calls asking about this. There is a new level of fear and anxiety that Peter Dawe is creating and then blaming us for."

Now I know that you've offered explanations on these various e-mails at the time to perhaps explain that those are isolated events in a moment of frustration or perhaps to neutralize the tone or explain the meaning behind those e-mails. I'm wondering if you had offered the explanations to those recipients of these e-mails at the time?

MS. BONNELL:

A. At the time that the e-mail was written?

MS. NEWBURY:

Q. Yes.

MS. BONNELL:

A. Did I offer an explanation?

MS. NEWBURY:

Q. To those people. I mean, did you say to Mr. Tilley, "don't mind my e-mail this morning. I was up all night. I was tired"? It might leave the impression in the mind of the person reading these e-mails that Peter Dawe and the Canadian Cancer Society is not held in

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particularly high regard, and you've offered explanations over the last couple of days to explain that that's not really how you felt, but I'm wondering if the recipients of these e-mails at the time had the benefit of those explanations?

MS. BONNELL:

A. No, they didn't get an explanation from me. I wasn't questioned on this e-mail.

MS. NEWBURY:

Q. Okay. But you didn't take the initiative to say, "listen, I spoke a little hastily this morning. I was frustrated. You know, I really do think Mr. Dawe and Ches Crosbie and Geri Rogers are credible, but"--you know, to explain it, just as you have done yesterday?

MS. BONNELL:

A. As I said yesterday, and I'll say it again, that although it would appear that that sentence indicates that I believe that Mr. Dawe is not a credible individual, Ms. Rogers, or Mr. Crosbie, I do not feel that way and the sentence doesn't say "the media will look for less credible people like Peter Dawe," it says "hence, all these people are doing stories."

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I think that, you know, as I've indicated already, I do not feel that these people are less credible individuals. I was making the point that they--that the individuals with the credibility, in terms of speaking from an Eastern Health's perspective, should be the individuals who work for Eastern Health.

And the last bullet, I also explained at great length yesterday and did attempt to say that it's patently false and when I read it, it was never an impression of the organization. I'm not speaking on behalf of anybody else here, and this e-mail, when I see it, is extremely embarrassing to me as someone who tries to always deport themselves in a professional way, and that I was even thinking that at 4:25 on May 16th is somewhat of an embarrassment to me. But I can tell you at 4:30 and 5:00, I was not thinking these things, and I've worked with Mr. Tilley for eight years, I've worked with Mr. Dodge for the same amount of time, a shorter amount of time with Dr. Howell. These individuals know me. They know what I am like and I would suspect if you were to ask them, and not me,

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that they would indicate to you that they did not feel that I felt this way and that I would hope, and certainly my own boss has indicated to me in private conversations about this since this has become such a big media story in the last couple of months, that he never felt that I believed that way and that they knew that I was frustrated, and they knew that I was upset and that the inaction of the organization to speak at this point, we all felt some culpability for that and that's where our heads were at that point in time.

As to the issue with Ms. Mundon, I indicated to Mr. Coffey yesterday that I wrote that in a moment of frustration. I believe I discovered after that point that Mr. Dawe had actually spoken to the media prior to our informing him that he was going to--that there were going to be briefings. The issue of briefing somebody so far in advance puts an individual who is as public as Mr. Dawe is in a very awkward position, in that if we were to brief him two weeks in advance of the media briefing and for him to have that information would put him in an awkward position. We made

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a decision that we would not do the briefing that far in advance, and that was the decision that we made.

MS. NEWBURY:

Q. But the tone of your e-mail, you have to admit -

MS. BONNELL:

A. Oh, I totally agree, yes.

MS. NEWBURY:

Q. - is a bit different from that.

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. And again, I appreciate that you've offered some explanations and indicated that this is not really how you felt, but upon reviewing the various e-mails within the communications department of Eastern Health, I guess I'm more concerned about what I'm not seeing, which is, you know, "let's see what Peter Dawe has to say on behalf of the Cancer Society. Maybe we should try to find out what are the basis of his concerns here. He's made some comments in the media. Let's try to sort out where he's getting these concerns, and is there anything

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we can do to perhaps ease those concerns and try to find some sort of balance here in terms of communications on these issues?" So it's not just the fact that there's some e-mails here that appear to show that the communications department didn't hold the Cancer Society in high regard.

MS. BONNELL:

A. But that's not -

MS. NEWBURY:

Q. There's also the absence -

MS. BONNELL:

A. That's not fair, and I have spoken to that.

MS. NEWBURY:

Q. That's an interpretation of that, and I appreciate that. That's an interpretation of these e-mails.

MS. BONNELL:

A. And I have written--you know, in providing the e-mails to the Commission, with all due respect, I've written thousands of e-mails in the eight years that I've been in the organization and I attend hundreds of meetings, and all I can say to you is that what we are looking at on the record are a

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series of two or three e-mails that seem to present an impression of the organization and of me in one particular light. I've indicated to you that we could have done a better job of dealing with the Canadian Cancer Society as a stakeholder, but I've also indicated to you that I do not hold Mr. Dawe or the Canadian Cancer Society in poor ill regard, and so have other people who've spoken to the Commission have indicated to you that they consider the Canadian Cancer Society to be an important stakeholder and it's unfortunate that after all this time that the impression that's being left with you and with others is that I am an unprofessional person who feels that Mr. Dawe is less credible and is responsible for this issue. I've tried, over the last three days of testimony, to indicate to you that at Eastern Health, I certainly take responsibility for my part in this and we have all looked at this and welcomed this Commission and the opportunity to go through all of this. I've tried, to the best of my ability, to do that.

MS. NEWBURY:

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Q. Yes, I do appreciate the explanations that you've given. I guess my concern is that people reading this might have their own interpretation on it, including the recipients at the time, and again, you've offered the explanation that you think that these people know you better, but my next question is perhaps can you explain why there are not e-mails or other documentation to show that, aside from these aberrant comments that there were actually steps taken by the communications department to say "listen, we really need to find out what the Canadian Cancer Society is concerned about. What are they hearing from their patients? What is it that they need to know? Why is Mr. Dawe making these comments in the media about that?" To delve into what his concerns are.

MS. BONNELL:

A. No, I can't show you any e-mails to say that, other than to say to you that when briefings were conducted, I was certainly encouraging the organization to do those things, and we followed up on concerns that Mr. Dawe expressed in the media by following up with

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individuals within the organization. So when a concern was expressed about something, we would go follow up with that concern and say "why is Peter Dawe saying this? Is there an issue with notification? Is there an issue with this? Is there an issue with that?" So that follow up was done.

MS. NEWBURY:

Q. Did you follow up directly with Mr. Dawe or did you ask that someone make sure that they follow up with Mr. Dawe?

MS. BONNELL:

A. In the three years, I think I've probably had one or two conversations with Mr. Dawe, usually about a media issue. But as I indicated to you earlier, it wouldn't be my role to speak directly with advocates. It would be better for the Director of the Cancer Program or the Vice President responsible for the Cancer Program or the physicians in the Cancer Program to make that contact and have that phone conversation because they're more intimately involved in the program than I would be. That would not be my role.

MS. NEWBURY:

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Q. And was it your role to make sure that it was done and that you, as the communications director, are aware of what those concerns are, as it may have some impact upon -

MS. BONNELL:

A. I was aware of concerns that were raised, that were brought back through that process, but Ms. Newbury, I'm not even a member of executive, so I'm in no position to go tell Kara Laing that she has to report back to me on a conversation that she has with Mr. Dawe or to ask one of my executives to report back to me on a conversation that they would have.

MS. NEWBURY:

Q. But you do have the ability, if you had saw fit to do so from the beginning, to implement a strategic communications plan where you would perhaps advise that this should be done. Obviously, you can't force someone to -

MS. BONNELL:

A. I could have written the plan and I agree and I've indicated that the plan should have been written. Whether the plan would have been followed to the letter, you know -

MS. NEWBURY:

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Q. You can put it out there, but you can't control it. Sure.

MS. BONNELL:

A. I can't speak to--you can't--I can't control it.

MS. NEWBURY:

Q. I appreciate that.

MS. BONNELL:

A. I'm not the CEO, so you know, there's a limit to the amount of control that I can have within an organization. I can make advice, I can consult, but there is a limit to the amount of control that I have.

MS. NEWBURY:

Q. Do you think, looking back on it, that perhaps the communications department could have considered the Cancer Society's views in a more positive light?

MS. BONNELL:

A. That would indicate, I guess, by answering that question that we didn't consider the Cancer Society's views in a positive light, which I don't think is -

MS. NEWBURY:

Q. So you think you saw the Cancer Society's

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views in a positive light?

MS. BONNELL:

A. I think that we saw the Cancer Society's views, like the views of other advocates, you know, there are individuals advocating on any number of issues. They have important perspectives to bring forward and it's not a matter of viewing things in a positive or a negative light. You know, there were times during this three-year period that I was frustrated, I was frustrated by the coverage and, you know, what we're looking at are these moments in time.

MS. NEWBURY:

Q. If I could have exhibit P-0196 please, page 14 of that exhibit. This is not an e-mail that you saw or received or had any involvement in that I'm aware of, I'm just going to show this to you, not to ask you anything about how that was generated or why, it's an e-mail from Darrell Hynes is the original message to Tansy Mundon and attached is a transcript, you can see down here at the bottom, it's a transcript of December 11th, 2006 from CBC News and in that there are some comments attributed to Mr.

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Dawe and Mr. Dawe at the end of that report says, "Not receiving this treatment could very well mean a life and death issue for people going through the process." And then he, in the next paragraph, "The lack of disclosure raises questions" said Dawe, "about what the problem is and how it can be fixed." And in forwarding this to Tansy Mundon, Mr. Hynes says, "I hate to say it, but Peter has a point." And Ms. Mundon says, "He does indeed." Now I haven't seen any e-mails of that sort or communication of that sort within the communications department itself or Eastern Health. Do you feel that in the communications department there was also an appreciation that Mr. Dawe had a point, as Mr. Hynes is saying here to Tansy Mundon?

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. Okay.

MS. BONNELL:

A. And I indicated yesterday in talking about our preparation for the briefing that certainly from the beginning of August, an e-mail you

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showed me moments ago, that it was my understanding that at the briefing we would be a position to talk about causative factors and that I did want to release more information than we were able to do for that December 11th briefing.

MS. NEWBURY:

Q. Did you ever think of perhaps relying on the fact that you've got an advocate for cancer patients out there in the media asking questions and raising questions. Did you ever think at anywhere along that continuum from October, 2005, to recommend that listen, you know, we've got someone here who is an advocate for cancer patients calling for more information and calling for it more quickly, to use that as support for trying to get out there with as much information as possible?

MS. BONNELL:

A. I certainly did advocate within the organization for us to release more information in as quickly as possible, but in 2005, we made a commitment that we would notify all patients first before we talked about it publicly and we stuck by that

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commitment in as much as we could until May of 2006 when all the patients were finally notified of their changed test results. After that point, I did start advocating for and you'll see indications that we were planning for a more public announcement at that point.

MS. NEWBURY:

Q. That was after -

MS. BONNELL:

A. I don't recall ever saying, you know, mentioning Mr. Dawe or the Canadian Cancer Society by name, but, you know, there are lots of advocates, I understand that's the Canadian Cancer Society's role, but the physicians within the cancer programs are advocates for cancer patients and cancer as well, and so are others. And we certainly did feel, that is the communications department certainly did feel that we would have liked to have released information faster than we did. I've indicated that to Mr. Coffey repeatedly.

MS. NEWBURY:

Q. Yes, you have, but you never thought, well let's use the fact that Peter Dawe is out there speaking on behalf of -

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MS. BONNELL:

A. I didn't have to use the fact that Peter Dawe was out there because it was part of everybody's understanding that Mr. Dawe was pushing and that others were pushing.

MS. NEWBURY:

Q. But some of the e-mails you would have to -

MS. BONNELL:

A. I guess it's implicit that if you're pressing that the pressure that the Canadian Cancer Society was applying was part of that pressure to make us, you know, to encourage us to speak.

MS. NEWBURY:

Q. But would you agree that perhaps some people reading, you know, some of the e-mails which didn't put a whole lot of credence into some of the things that Mr. Dawe was saying, that perhaps they don't appreciate that, this is a reason why we should get out there with more information, more quickly?

MS. BONNELL:

A. My communication on ER/PR and on many issues is more than what is seen in e-mail and all I can tell you is what I have said over the last

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couple of days in this regard, that we were applying pressure and that the organization was struggling with other issues through the summer and fall of 2006, which distracted them from being able to move more quickly on the ER/PR issue. And I don't know what more I can say to you other than the fact that everybody was aware that Mr. Dawe was anxious for there to be information presented publicly, as well as others.

MS. NEWBURY:

Q. But was everyone aware that there's a very good reason why Mr. Dawe is anxious for it -

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. - and what those reasons are?

MS. BONNELL:

A. Yes, I believe every -

MS. NEWBURY:

Q. You feel that everyone was aware of that?

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. And notwithstanding some of the, I guess the

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negative tones in some of your e-mails, you feel that other people would know that you agree with some of the concerns as expressed by Peter Dawe and the legitimacy of those concerns?

MS. BONNELL:

A. Yes.

MS. NEWBURY:

Q. And in terms of the issue of resources, you had indicated that it was a resource issue in 2006 that prevented the organization from getting out there earlier. Was anything done to -

MS. BONNELL:

A. No, I didn't--if I did suggest that, I didn't mean to suggest that.

MS. NEWBURY:

Q. So why didn't they get out earlier in 2006?

MS. BONNELL:

A. Well in the summer of 2006 and into the fall, I said that the organization was distracted by other major issues that it was dealing with. It wasn't a resource issue other than the fact that there's only so much that any organization can handle at one time from a

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public perspective and we had to deal with the release of the Markenstein report, we had a shortage in our pharmacists, we had a crisis with our paramedics and I've forgotten what else, but there were a number of issues in August and September and July that were causing a great amount of effort to be drawn or energy to be drawn away from moving forward with this briefing.

MS. NEWBURY:

Q. Do you mean energy from a human resource perspective?

MS. BONNELL:

A. Yes, I guess so, yes.

MS. NEWBURY:

Q. Did you think at that time of perhaps approaching an external consultant, as you did on another occasion?

MS. BONNELL:

A. Well that was the same time, that was that summer of 2006.

MS. NEWBURY:

Q. Right, but you didn't engage that consultant.

MS. BONNELL:

A. No.

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MS. NEWBURY:

Q. I was thinking about in 2007 finally Bristol was engaged, why not have engaged them in 2006?

MS. BONNELL:

A. I should have. I should have engaged a consultant much earlier, I should have engaged a consultant in 2005, I think.

MS. NEWBURY:

Q. Okay, and do you think there would ever be a role for the Department of Health perhaps to lend some assistance in terms of human resources?

MS. BONNELL:

A. No.

MS. NEWBURY:

Q. Okay, so it would have to be an external consultant from your point of view?

MS. BONNELL:

A. Or additional resources, but hiring a crisis-- when you're looking at crisis communications skills, you know, a publicly funded organization is never going to be able to afford to have a crisis communications expert on staff. That's a financial issue.

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

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from the public. I believe that is the role of this organization. And do I understand that you would have received the e-mail at the time that George Tilley replied to you as one of the recipients?
MS. BONNELL:
A. Yes.
MS. NEWBURY:
Q. Okay, so that would have been October 20th, 2005?
MS. BONNELL:
A. Uh-hm.
MS. NEWBURY:
Q. So you're aware at this point in time for sure, which is fairly early on in the communications feature of this issue, that the perspectives of the Canadian Cancer Society are actually reflective of what the public is communicating to Mr. Dawe and the Canadian Cancer Society?
MS. BONNELL:
A. Certainly.
MS. NEWBURY:
Q. Okay, and did you assume that that would be consistent throughout 2005, 2006, 2007?

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MS. BONNELL:
A. Yes.
MS. NEWBURY:
Q. And would you assume that the public would include cancer patients?
MS. BONNELL:
A. Of course.
MS. NEWBURY:
Q. Do you know what comments had triggered this e-mail?
MS. BONNELL:
A. No, I don't.
MS. NEWBURY:
Q. Had you expressed any concerns about Mr. Dawe's media involvement prior to this?
MS. BONNELL:
A. No, I don't recall what triggered this.
MS. NEWBURY:
Q. If I could have exhibit P-0348 please? This is an e-mail, again October 2005, October 6th, 2005. This is an e-mail from you to Mr. Tilley and this has to do with the Globe and Mail article and you had indicated that on October 6th, 2005 at 9:30 a.m. there's a note there, "I thought the Globe piece was

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

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

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A. Yes.
MS. NEWBURY:
Q. And what about that article is negative? Very negative I think your e-mail had indicated.
MS. BONNELL:
A. It isn't very negative. I don't know why I said that. "Peter Dawe warns this has a potential"--I don't know what I thought was negative about it. The coverage at that time was relatively positive, it was relatively positive, so maybe in context of all the other coverage, this was a more negative comment, but it's not very negative.
MS. NEWBURY:
Q. And there's nothing unwarranted in what he has said here?
MS. BONNELL:
A. No.
MS. NEWBURY:
Q. Do you think that the ultimate eruption, I think you have a reference to this being like a volcano erupting, do you think that the ultimate eruption of this issue in May of 2007 could have been less severe or less significant had the concerns expressed by Mr.

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Dawe and other spokespeople, such as Mr. Crosbie, Ms. Rogers been heeded and addressed earlier than it was?
MS. BONNELL:
A. I think that's part of it, yes.
MS. NEWBURY:
Q. Okay, and what other parts would have made it less severe, less significant an eruption?
MS. NEWBURY:
Q. Well what would have made it less significant was our reaction to that, as opposed to just a matter of heeding the comments, it's the way in which we communicated information.
MS. NEWBURY:
Q. So it was a bit of a red flag that Mr. Dawe threw out was saying this is what people want to know, they want to know causes, they want to know more information about the numbers involved.
MS. BONNELL:
A. Yes, I suppose so, yes. We were aware of that, though, I mean, I've indicated that we were aware that that's what people wanted to know. I knew because I was in contact with the media myself and I listened to what

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

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profession.
MS. BONNELL:
A. No, what I think I--if I did say that, that's not what I intended to say.
MR. PIKE:
Q. Well what did you intend?
MS. BONNELL:
A. That within our organization that was certainly the traditionally held belief and practice that when a matter was before litigation that we wouldn't speak to it, yes.
MR. PIKE:
Q. So that's a tradition at Eastern Health, but not in communications in general?
MS. BONNELL:
A. No.
MR. PIKE:
Q. What's the reason for that concept of not commenting?
MS. BONNELL:
A. Well my understanding of it is that you would be concerned that anything that you could say might in some way prejudice the case, and I'm not a legal person, but that's sort of my understanding of why you wouldn't speak.

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MR. PIKE:
Q. That you might influence the judge you mean deciding the case?
MS. BONNELL:
A. No, that you may, in some way, prejudice the case that -
MR. PIKE:
Q. You might do harm to your case or -
MS. BONNELL:
A. Things may be said that may, in some way, have an impact on what was before the courts.
MR. PIKE:
Q. So, it's part of the risk, managing the risk of litigation that you might give away something that would otherwise be unknown to the other party and put your client at a disadvantage.
MS. BONNELL:
A. Yes.
MR. PIKE:
Q. Nothing to do with the concept of contempt of court?
MS. BONNELL:
A. You'd have to explain to me what you mean in that sense.

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

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Q. Well, in a given case, how would you decide when to comment and when not?
MS. BONNELL:
A. Well, in the case of ER/PR we had to make a decision based on the impact that it was having on the public's trust of the organization, in a sense. I mean, it was clear to us that we were doing greater damage to the organization by not speaking than would ever be caused by any litigation.
MR. PIKE:
Q. So, it's when the stakes are higher and the risk is greater that it overrides your concern about harming your interests.
MS. BONNELL:
A. Yes.
MR. PIKE:
Q. Thank you.
THE COMMISSIONER:
Q. Thank you, Mr. Pike. Mr. Simmons?
MS. SUSAN BONNELL, EXAMINATION BY DANIEL SIMMONS
MR. SIMMONS
Q. Good morning, Ms. Bonnell.
MS. BONNELL:
A. Good morning.

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

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MR. SIMMONS
Q. - that affected the evaluation of the issue at that point. You described it being a roller coaster up and down with new information coming forward frequently.
MS. BONNELL:
A. Yes.
MR. SIMMONS
Q. On the same day, if we can also go, please to Exhibit 0329, please. You were shown this before, this is Mr. Tilley's note of speaking to you on that day and it says, "Susan B., today's meeting revealed the potential that scope of problem restricted on basis of a review of percent, positive results for 2003 being 75 percent which is consistent with national benchmarks". And it says, "discussion with Carolyn re: announcement and concerns of minister".

Now, you were asked about this new information concerning the percentage of positivity of results and it was presented to you that the 75 percent results for 2003 which were within national benchmarks, while that information might be useful, there were still

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

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Q. And I think you were shown it during the course of your examination a couple of days ago. And it says, it's a review of ER/PR stats from 2000 to 2004/5 and there are five columns there for different years with statistics under those columns leading down to the second last row which is a total positivity number.
MS. BONNELL:
A. Um-hm.
MR. SIMMONS
Q. Actually, I'll go up to the middle, if you go to the middle, it says, number positive and then it says percentage positive and if you follow across that row for 2003, 75 percent is there.
MS. BONNELL:
A. Right.
MR. SIMMONS
Q. Do you see that?
MS. BONNELL:
A. Um-hm.
MR. SIMMONS
Q. And if you look back at the other rows, there are lower numbers there. The retesting is

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going to be for 1997 all the way to 2004 at this point. Were the positivity figures for 1997, 1998, and 1999 known on the 19th and 20th?

MS. BONNELL:

A. I don't believe they were. I believe that this was all the information that we had at that point in time.

MR. SIMMONS

Q. Right.

MS. BONNELL:

A. But the better person to ask that would be Mr. Gulliver.

MR. SIMMONS

Q. Right, okay. So, at the point on the 19th when there was a perception that maybe the extent of the problem won't be so bad as we were thinking the day before, was were all the positivity numbers for the entire period known then or where there still numbers to come?

MS. BONNELL:

A. I would say there were still numbers to come as this clearly indicates 2000 to 2004/5.

MR. SIMMONS

Q. Right, okay. So, at that point then on the

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19th and the 20th, was the thinking then that we know the problem isn't as big as we thought it was a couple of days ago or was the thinking that it may not be as big and we need to do more work in order to find that out?

MS. BONNELL:

A. I would say more the latter in that we really didn't know what we were dealing with now. There was some information that was pointing in a different direction.

MR. SIMMONS

Q. Okay.

THE COMMISSIONER:

Q. Pointing in a different direction from what?

MS. BONNELL:

A. Just that -

THE COMMISSIONER:

Q. Did you know this information before that date?

MS. BONNELL:

A. No, ma'am, I don't believe I did, no.

THE COMMISSIONER:

Q. So, before that date you were working on the information which was essentially about what happened in 2002.

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MS. BONNELL:

A. That's right, yes.

THE COMMISSIONER:

Q. Okay, thank you.

MR. SIMMONS

Q. Now, a couple of days ago when you were talking about the results of the meeting with the minister on the 21st of July.

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. You had some discussions with the Commissioner about what was placed on hold -

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. - as a result of that meeting. Now, at that point, was a decision made that a public announcement would be placed on hold in the sense that it was decided on the 21st that there would be no public announcement or was what happened on the 21st that the decision about what to do was placed on hold temporarily until more information was obtained?

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MS. BONNELL:

A. It was that there was no--it was that the decision was not made. It was that we went away from the meeting on the 21st seeking more information with which to make a decision.

MR. SIMMONS

Q. Okay. And that, by mid August though, that decision was made.

MS. BONNELL:

A. Yes, that's correct.

MR. SIMMONS

Q. And between the meeting with the minister on the 21st and mid August when the decision was made, do I take it from your evidence that a new factor that came to bear was the opinions of the oncologists regarding contact with the patients and the effect of contacting patients before their individual test results were known.

MS. BONNELL:

A. Yes, that is one of the factors that came to bear in that period of time, yes.

MR. SIMMONS

Q. Can I show you exhibit P-0566, please. These were some notes you kept of a meeting of

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August 20 which you've been referred to earlier, just in that time period we just spoke of. And on the bottom there's an arrow there and a note written diagonally across the bottom of the page. That's your note, is it?

MS. BONNELL:

A. It is.

MR. SIMMONS

Q. Okay. And I believe it says "striking balance between waiting and giving patients good info. or speaking publicly to soon and creating undo anxiety".

MS. BONNELL:

A. This is-

MR. SIMMONS

Q. Why did you make that note there at that time on the 10th of August?

MS. BONNELL:

A. Because I guess that sort of captured for me what it was that we were trying to do which was find the appropriate place to be in which we're giving patients the right information about their own health and having that dealt with in an appropriate manner which is in the setting between physician and patient. And

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going out so soon that we create people who don't need to be anxious about this, create a level of anxiety--that to us was the balance.

MR. SIMMONS

Q. Was this just your personal view that you -

MS. BONNELL:

A. No.

MR. SIMMONS

Q. - or was this a view and an issue that was openly discussed in this way among the group?

MS. BONNELL:

A. It was openly discussed. This is me trying to put words around the opinions that were being expressed by the group.

MR. SIMMONS

Q. Okay. Was it clear to anyone in the group that it was obvious which way to go on this issue?

MS. BONNELL:

A. Yes, in that we knew that there was a risk inherent with not speaking publicly, but that we felt that the weight of the balance came down on the obligation that we had to the patients. And the opinions expressed by the experts were that if we were doing a

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disclosure with one person who had an adverse event that that person would be afforded certain privacy and, you know, they'd be handled in a certain way is what I'm trying to say. And that we felt that regardless of the fact that there were hundreds, potentially, that they deserved the same opportunity.

MR. SIMMONS

Q. Now, you've told us -

MS. BONNELL:

A. But I think we knew, Mr. Simmons, that there was inherent risk in that because of the size of the numbers.

MR. SIMMONS

Q. Yes. You've told us that your role as a communications professional within the organization was to look out--part of what you had to do was look out for the overall interests of the organization, the way that it was perceived in the public and communication of issues related to the organization to the public.

MS. BONNELL:

A. Yes.

MR. SIMMONS

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Q. And that was part of your job?

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. And would you agree with me that that is a bit of a different role from that fulfilled by most other people within a health care organization like Eastern Health?

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. And the other participants in these discussions in July of 2005 included physicians.

MS. BONNELL:

A. Um-hm.

MR. SIMMONS

Q. Correct? Administration people?

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. Technical people, quality assurance?

MS. BONNELL:

A. Yes, and nurses.

MR. SIMMONS:

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Q. And nurses. From your familiarity with working with those peoples in their positions, do you have any observation about what their perspective would be on the issue of priorities of patient interests versus public interests?

MS. BONNELL:

A. It would be patient interest above all else.

MR. SIMMONS

Q. Um-hm.

MS. BONNELL:

A. It would be patient interest above all else and their concern would be in doing what they felt was right from a patient perspective.

MR. SIMMONS

Q. Yes. During these discussions in July and into August of ’05, did you see anything different from them in their contributions to those discussions?

THE COMMISSIONER:

Q. Are you asking the witness if she saw that any differently over time?

MR. SIMMONS

Q. Yes, any differently during that time.

MS. BONNELL:

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A. No. You know, when you’re dealing with an issue like this, you have moments where you have heated discussions, you have moments of concern being expressed about, you know, personal, professional, organizational reputation. But these are moments and at the end of the day it’s always put aside in favour of what’s right for the patient.

MR. SIMMONS

Q. Okay. Exhibit 0304 again, please, sorry to have to bring you back to this one, but I do have a question for you about it and we’ll go to page four please. This your memo of July 22nd written to Mr. Tilley and copied to Dr. Williams. And it followed the previous day, that meeting with the minister where you’ve told us there was really no decision made about whether there was going to be or when there was going to be a public announcement. The thing was just on hold as the investigation continued.

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. And at the end of this memo, at the very bottom, in the last paragraph, second last paragraph, you make some recommendations about how to proceed.

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. And the first one says, "we notify patients of the retesting either through formal letter or by some other means deemed appropriate by the oncologists".

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. Were you, at that point, recommending contacting patients to inform them that their samples would be retested or was this a recommendation to contact them once the results of their retesting were known?

MS. BONNELL:

A. No, I was of the belief that we should have notified them of the retesting itself.

MR. SIMMONS

Q. And this, of course, is the 22nd of July which is before the oncologists involved, what we spoke of earlier-

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MS. BONNELL:

A. That’s correct.

MR. SIMMONS

Q. - which influenced a change in the decision.

MS. BONNELL:

A. That’s right.

MR. SIMMONS

Q. So, at this point, despite whatever else is said in this memo, your recommendation is by one means or another notify the people that their samples are going to be retested?

MS. BONNELL:

A. That’s how I felt, yes.

MR. SIMMONS

Q. Okay. Then you say in two, "we move fast to identify and retest the individuals". Three, "contact oncologists and surgeons immediately with new test results". And then it goes on to four and five to make sure that measures are taken to make sure that patients are made aware of the test results.

Now, the paragraph above that is the one you’ve been questioned on to some extent, which says, "a full public disclosure with a press conference, information line, letters to

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all impacted patients in support of ministerial comment is not recommended".

MS. BONNELL:

A. Today.

MR. SIMMONS

Q. Because you could read those and say it's a contra diction.

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. Because in point one below you say "notify the patients either through a formal letter or by some other means".

MS. BONNELL:

A. Um-hm.

MR. SIMMONS

Q. But in the paragraph above you can read it as saying, "letters to impact the patients are not recommended".

MS. BONNELL:

A. Yes.

MR. SIMMONS

Q. And your explanation is that in the paragraph above, if I understand it, you've said your recommendation was not to make that kind of

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public announcement today.

MS. BONNELL:

A. That's correct.

MR. SIMMONS

Q. And to proceed as outlined below.

MS. BONNELL:

A. That's correct because as you would recall, we were in discussions with the minister at that point in time, had just come from a meeting with the minister, had certainly indicated a week before that we were going to do a press conference. So, I was just making the point that doing that right now is not what I would recommend.

MR. SIMMONS

Q. Right, okay.

MS. BONNELL:

A. Mr. Simmons, if I may also -

MR. SIMMONS

Q. Yes, go ahead.

MS. BONNELL:

A. - the amount of weight that has been put on this memo is unbelievable. It's just one memo. It's just not that important.

MR. SIMMONS

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Q. Did it surface again in the discussions that followed during the course of that summer and into the fall?

MS. BONNELL:

A. No.

MR. SIMMONS

Q. Did anyone ever put it on the table at any meeting and sit down and discuss it?

MS. BONNELL:

A. No, never.

MR. SIMMONS

Q. Did Mr. Tilley even get back to you afterwards -

MS. BONNELL:

A. No.

MR. SIMMONS

Q. - to discuss any of this with you -

MS. BONNELL:

A. Never.

MR. SIMMONS

Q. Okay. You were asked a number of questions regarding your understanding of whether a change in technology was understood to be part of the background reasons, I guess, for the changes in test results that ultimately

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occurred. And I've understood you to say that you learned through the course of this or understood through the course of this that it wasn't simply the change from one set of machinery to another -

MS. BONNELL:

A. No.

MR. SIMMONS

Q. - that could be attributed to--and you've told us about that quite a bit. But my question is, did that change from the DAKO system to the Ventana system, nevertheless play a part in the story that had to be told about how these retests came to be done?

MS. BONNELL:

A. Yes, because it was--certainly, it was because of the change from one technology to another that the original changes were identified.

MR. SIMMONS

Q. Um-hm. So, in commenting on this in -

THE COMMISSIONER:

Q. I'm sorry, I thought you had said earlier that that was not the reason that the original changes had been identified? If you go back to the index case, for example, -

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MS. BONNELL:
A. The index -
THE COMMISSIONER:
Q. - did that have anything to do -
MS. BONNELL:
A. Well, the index case was identified to be changed from a second opinion. That was a consultation. But in the original 525 or 30, however many it was that we did in the original group, those changes were--that was identified using the Ventana. It was the Ventana that was involved in retesting, if I'm correct.
MR. SIMMONS
Q. So, regardless -
THE COMMISSIONER:
Q. Okay. Perhaps I'm confusing what instrument was used in a particular test with a question which I thought Mr. Simmons was asking and perhaps he wasn't. Because I thought you were saying that somehow you thought the reason for the change was connected to the Ventana as opposed to the fact that the Ventana was a method or an instrument which was going to be used in identifying changes, if any had

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occurred.
MS. BONNELL:
A. There was a point in time when we weren't sure if, in fact, -
THE COMMISSIONER:
Q. The Ventana was overcalling?
MS. BONNELL:
A. No, that the Ventana was picking up things that---there was a point in time where we wondered, where I certainly wondered if the Ventana, being a more sensitive system was doing a better job than the DAKO. There was a point in time where we did wonder if that was the case.
THE COMMISSIONER:
Q. Yes, I'd understood that. Okay, perhaps I didn't understand your question, Mr. Simmons. Why don't you try it again and it may be clearer.
MS. BONNELL:
A. That would have been prior to us making the decision to retest the Ventana as well.
MR. SIMMONS
Q. Even after that point, in order to tell the story about what had led to retesting, story

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of the index case and so on.
MS. BONNELL:
A. Um-hm.
MS. BONNELL:
A. Was the switch from DAKO to Ventana still part of the story?
MS. BONNELL:
A. It's part of the story, yes, that there was a change in the lab, yes.
MR. SIMMONS:
Q. And even though it was your understanding that there wasn't anything inherent in the machinery which made the Ventana a better system than the DAKO for identifying the results, I understand that, nevertheless, I think you'd also said that you'd understood that the Ventana system was more automated and -
MS. BONNELL:
A. Yes.
MR. SIMMONS:
Q. - removed some opportunities for -
MS. BONNELL:
A. That's right.
MR. SIMMONS:

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Q. - human error, I'll say?
MS. BONNELL:
A. That's right.
MR. SIMMONS:
Q. Yeah, okay. So in the fall of '05, then, in having Dr. Williams speak to the media about this story, would you have expected him to leave those parts of it out of the story altogether or the fact that there had been a DAKO machine and a Ventana machine still have played part in what he -
MS. BONNELL:
A. That's part of the story, yes.
MR. SIMMONS:
Q. Yes.
COMMISSIONER:
Q. But was it a part of the story for the purpose of saying if you're worried about what's happening now, we have this new machine, or was it the part of the story for another reason?
MS. BONNELL:
A. Well at that point -
COMMISSIONER:
Q. In the sense of is--did you view the Ventana

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as part of reassuring the public in terms of the--and during the time frame now, of course, when you were actually going to do it internally before you made the decision to send everything out?

MS. BONNELL:

A. Yes.

COMMISSIONER:

Q. Were the references to the Ventana part of your, what you would perceive as assuring the public about the current testing or was it for another reason?

MS. BONNELL:

A. Prior to the story becoming public, prior to our decision to retest the samples that had been done using the Ventana, as well.

COMMISSIONER:

Q. Um-hm.

MS. BONNELL:

A. Because originally we were going to use the Ventana to do the retest of the other numbers.

COMMISSIONER:

Q. Yes, that's what I understood.

MS. BONNELL:

A. So prior to that decision being made we'll

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certainly see drafts of press releases and things in that nature where we sort of say, you know, due to new improved technology, because that's what we were thinking we could be able to say at that point in time, whereas following the decision to retest even those samples that had been done on the Ventana, the issue of reassuring individuals that we had new technology didn't really, it wasn't really the issue in that we weren't doing any testing in the laboratory at that particular time anyway. All testing had been halted while tests were being sent to Mount Sinai. Even new ones that were coming in were being sent to Mount Sinai at that point. We weren't using our technology in the laboratory at that point in time, and that was certainly indicated by Dr. Williams. But all along, I think, the feeling was that the implementation or the purchase of the Ventana was a positive move for the organization.

MR. SIMMONS:

Q. Um-hm.

MS. BONNELL:

A. That is was being presented as a piece of

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technology that ensured more consistency in results because of the lack of manipulation of the--I'm outside my league.

MR. SIMMONS:

Q. Yes.

MS. BONNELL:

A. Because of the lack of manipulation of the test that it was one of these things that was being touted as something that would be--that we were sort of leading the edge in Newfoundland because we had implemented this new piece of technology.

MR. SIMMONS:

Q. Okay. I'm going to go on now to end of September, beginning of October, '05. And you've told us that when the call came, or when you were told of the call from The Independent, you were actually meeting with Ms. Predham reviewing form of a letter?

MS. BONNELL:

A. Yes.

MR. SIMMONS:

Q. At that time. Now, we know that by mid August the decision had been made to obtain test results and inform patients before making any

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kind of a public announcement and before making any kind of general communication to people to say, you are going to be retested?

MS. BONNELL:

A. Yes.

MR. SIMMONS:

Q. That that had been changed. What had changed by the 30th of September for you and Ms. Predham to be sitting down essentially revisiting that decision about a letter to all the patients?

MS. BONNELL:

A. The fact that we were getting very close to the promised deadline for getting the test results back and we weren't seeing them coming in the fashion that we had hoped.

MR. SIMMONS:

Q. So how widely discussed at that point was the idea of revising the decision about whether or not to inform patients that their tests were going to be retested?

MS. BONNELL:

A. It wasn't widely in discussion at that, we hadn't reached the point yet of sitting down and saying this is taking too long.

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

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individuals.
MR. SIMMONS:
Q. Um-hm.
MS. BONNELL:
A. And I was feeling uncomfortable, I was starting to feel like there's probably too many disclosures being done that we can't anticipate that this is going to be able to wrap itself up in the way we originally envisioned.
MR. SIMMONS:
Q. So -
MS. BONNELL:
A. But I don't think it had gone beyond that point. And where it would have gone, it would be difficult for me to suppose. I guess the next step would have been for the group to get back together and revisit it and talk about what the implications would be of changing our minds.
MR. SIMMONS:
Q. And I presume there would have been no point in you and Ms. Predham looking at the letter unless there'd been some thought, at least between the two of you, of suggesting that

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

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

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them.
MR. SIMMONS:
Q. Right.
MS. BONNELL:
A. Regardless of what he says here.
MR. SIMMONS:
Q. So if the concern was notification, whether by letter or by other means, was that view then followed by Eastern Health?
MS. BONNELL:
A. No.
MR. SIMMONS:
Q. No. And, in fact, within a couple of days phone calls were being made to patients to notify them that their samples were being retested?
MS. BONNELL:
A. That's correct.
MR. SIMMONS:
Q. Exhibit P-1402, please, second page? This was an e-mail message from Ms. Predham. And this is October 26th, 2006. By this point there's been probably six days of phone calls being made and a fairly intensive effort to make contact with patients by telephone. Ms.

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Predham is doing a report to a number of people here, including you. You were referred earlier to the last paragraph and you were read the first sentence and the last sentence, but I'm going to read the whole thing for you. "This entire ER/PR review has been very difficult and drawn out." This is Ms. Predham speaking. "With constant hard and difficult decisions being made. The only thing making it bearable at all is that we were doing what we had to do to make it right for our patients. We were always doing the right thing. Personally, this combined with the two situations involving Dr. Ganguly in the past two weeks has left me totally and absolutely disheartened." Now, the middle sentence there about the only thing making it bearable was that we were doing the right thing by the patients and always doing the right thing, was that a sentiment that you heard expressed at any other times by anyone else throughout this entire process?
MS. BONNELL:
A. Yes, by everybody, Mr. Coffey (sic.), by all the doctors who spent their nights panelling,

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by all the administrators, by all the support people, by everybody in the lab, by everybody.
MR. SIMMONS:
Q. Okay. And also refer you to P-0189, please? This is, on the bottom of it there's an e-mail message from you to Mr. Tilley and others on December 9th when you sent them the materials for the media briefing on the 11th. And in the middle there's a reply from Mr. Tilley on Sunday, December 10th about 3:00 in the afternoon. He says, "This is very comprehensive. I appreciate the efforts you are all putting into this. In the end we need to keep reminding ourselves that we are here to do the best for our patients, despite what the media may choose to present. Good luck. George." Is that a view that you heard Mr. Tilley express on any other occasions, as well?
MS. BONNELL:
A. I indicated to you or to Mr. Coffey a couple of days ago now that when Mr. Tilley said in August of 2005, "If we can help one patient, then we need to do this retest and we need to deal with everything that comes out of it," I

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heard Mr. Tilley say that and this many, many times. And all of the people who worked on this issue did so with that in their, in the foremost.
MR. SIMMONS:
Q. Okay.
MS. BONNELL:
A. Part of their minds.
MR. SIMMONS:
Q. Good. Now, I have a couple of questions for you about that media briefing on the 11th of December, in particular in relation to the discussion about trying to develop an error or conversion rate for presentation to the media. First of all, in all the meetings and discussions that you were participating in up to that time are you--did anyone ever suggest or raise as an issue that there was any clinical reason to have to define a rate, a percentage change rate for these results, any clinical reason that would affect patient care that was driving, defining a rate?
MS. BONNELL:
A. No.
MR. SIMMONS:

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Q. Okay. Did you have reports from time to time from the people in quality concerning the types of things they were hearing from the patients that they spoke to, that the patients relations officer was, and others were hearing from the people they were speaking to?

MS. BONNELL:

A. Yes.

MR. SIMMONS:

Q. Was it ever reported back to you that there were requests from patients specifically for a rate or a percentage of change?

MS. BONNELL:

A. No.

MR. SIMMONS:

Q. Okay. Now, from your point of view you've told us that you anticipated that the media would have an interest in such a rate?

MS. BONNELL:

A. Yes.

MR. SIMMONS:

Q. Okay. In December of '06 would there have been any purpose calculating and settling on such a rate other than for the purpose of disclosing it to the media in response to

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their request so that they could then communicate it more publicly?

MS. BONNELL:

A. No.

MR. SIMMONS:

Q. Okay. You've told us something about the discussions that went into looking at the numbers that were known of the retest results and discussions about potential ways to calculate a rate?

MS. BONNELL:

A. Yes.

MR. SIMMONS:

Q. Would it be fair to say that there would be a range of rates that could be calculated depending on what tests were included and excluded from both the numerator and the denominator?

MS. BONNELL:

A. Absolutely, yeah, we did a lot of that, trying to figure out, yes.

MR. SIMMONS:

Q. Would it be fair to say that those rates would range anywhere from 10 or 11 percent up to the 42 percent that was eventually reported by the

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media in May?

MS. BONNELL:

A. Yes, depending on what you exclude and include.

MR. SIMMONS:

Q. Okay. Was there ever any consideration given to using a rate which would be viewed as reflecting more favourably on the organization than any other rate?

MS. BONNELL:

A. No.

MR. SIMMONS:

Q. Was that part of the discussion?

MS. BONNELL:

A. No, absolutely not.

MR. SIMMONS:

Q. And at the media briefing on December 11th, I believe you've told us already that the media were informed explicitly that they were not being told the total number of changed tests?

MS. BONNELL:

A. Yes, and they reported it at that time.

MR. SIMMONS:

Q. At that time, right. Was any suggestion made to the media at all about what the rate of

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change for test results was?

MS. BONNELL:

A. No, never.

MR. SIMMONS:

Q. And are you aware that in May of '07 that there were media reports which said that in December of '06 Eastern Health had predicted a 10 percent change?

MS. BONNELL:

A. Yes, yes. I was aware of those. There was a CBC story for sure I recall that being said in, and it certainly became part of the general discussion, I believe, in the House of Assembly as well, rate of error and percentages and that sort of thing.

MR. SIMMONS:

Q. And had Eastern Health made any such representation at the December press conference?

MS. BONNELL:

A. No, we did not.

MR. SIMMONS:

Q. Since October of '05 when Dr. Williams had said that it was possible that ten percent of all the change--all the tests done could

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change, had there been any public statements from Eastern Health predicting any kind of rate of change?

MS. BONNELL:

A. No, there had not.

MR. SIMMONS:

Q. Okay. I'm going to ask you some look-back questions now, and first, about the time period, the first, what I'll call the first decision making period here, which for you would start when you were first involved in early July of 2005, late June?

MS. BONNELL:

A. No, I was involved in late May.

MR. SIMMONS:

Q. In late May, and leading up to the decision in mid August, which adopted the plan which was no immediate public announcement, get test results, inform patients first -

MS. BONNELL:

A. Yes.

MR. SIMMONS:

Q. Looking back at that time period, what would you identify as being the most difficult questions or issues that were faced by the

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people making decisions about what information to release publicly and how to inform the patients?

MS. BONNELL:

A. Well, certainly the decision as to whether we should make a public announcement ahead of making contact with anybody specifically was a very difficult decision to make. What way to go about making this public information was a very difficult decision to make.

MR. SIMMONS:

Q. That decision at the time had to be made known on the information--had to be made based on the information known then.

MS. BONNELL:

A. Um-hm.

MR. SIMMONS:

Q. Looking back now, with the benefit of everything we learned in the meantime, do you have any comment on what sort of considerations you would now see that would be useful to bring to bear if there were such a situation to be confronted again? What would some of the competing interests be that would have to be taken into account?

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MS. BONNELL:

A. Competing interests? Competing interests in that time, I guess, were principles of confidentiality and the principle of transparency and open accountability. I mean, there is some inherent contradictions in those two values of the organization and trying to-- I'm back to the strike a balance, I guess.

MR. SIMMONS:

Q. Yes.

MS. BONNELL:

A. Trying to strike a balance between knowing that you're communicating with good information, that you're not going out and saying "we think we have an issue. We don't know what it is. We don't know how many people it impacts." It's uncomfortable from the perspective of making any kind of a public announcement. And also the other side of that being, do patients have a right to learn about their own health care and their own health in a way that we would all want to learn issues that may or may not impact our own individual treatment? Would I want to hear about this in the media? No, I would not want to hear about

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this in the media. And so we made a decision based on that. Unfortunately, circumstances conspired against that principle and perhaps we should have been--we should have predicted that more. We shouldn't have expected that the tests could get done in the timely fashion that we had expected they would.

I think it's also, you know, the organization was formed on April 2007. Going into this, we were half Health Care Corporation, we were--and six other boards and half--Mr. Gulliver was a director of the lab in St. John's in May of 2005. He was not the director of the labs across Eastern Health. Ms. Predham didn't know what her job was, and in the midst of all this, had to apply for a job. You know, of all of them, I was the only one who knew how it was going to pan out for me. That can't be underestimated, the impact that restructuring and this having at the same time.

We didn't have in place the kinds of formalized plans and strategies. Ms. Newbury asked me this morning about strategic planning, and you know, those things--a

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strategic plan for the organization was not in place. A plan for this wasn't developed. Those are essential--if we look at an issue now, I can't think of an issue, certainly while I was director of strategic communications, that we dealt with that didn't have a communications strategy attached to it. I think it was the timing of this, the fact that there wasn't staff in place.

It's hard to look back and say with retrospect "I'd have done this differently and I'd have done that differently." But I think what we do do is we look at this and say "what can we learn from this? What did we learn from the release of the Markenstein report?" Well, the way that we learned things from that about how to effectively manage staff within an organization, there were lessons learned in that, and during the Commission of Inquiry, Eastern Health is doing a better job in that regard. I think you learn from these experiences and you move forward.

MR. SIMMONS:

Q. Okay. Ms. Bonnell, anything else that you feel you'd like to--you've had to say quite a

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bit since you've been here, but if there's anything else you feel you'd like to add, there's an opportunity now to do it.

MS. BONNELL:

A. No, thank you very much. I thank you all for the opportunity to speak to you.

MR. SIMMONS:

Q. Thank you.

THE COMMISSIONER:

Q. Do you have anything arising, Mr. Coffey?

COFFEY, Q.C.:

Q. I do, Commissioner.

THE COMMISSIONER:

Q. While Mr. Coffey is coming around, there's a point you raised this morning that I just wanted to be sure that I'm clear on. It's another one of those little details that I want to be clear about, because when Ms. Newbury was asking you about certain events in July of 2005, you were responding by saying that, you know, "at that point, I thought we were going to be talking about causation."

MS. BONNELL:

A. That was in--she brought me to an e-mail of 2006, I believe.

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THE COMMISSIONER:

Q. I thought it was a 2005 one, but I'll just double check now. Maybe you're right. P-1500. You might have been talking about that. It was in the context of looking at this document, so we'll just double check. It was 2006 memo. You're right, okay. So you were saying, in the context of your discussion with Ms. Newbury at that point that you thought that you were going to be in a position to talk about causative factors, but you never were, as I understand it.

MS. BONNELL:

A. No.

THE COMMISSIONER:

Q. From the organizational point of view.

MS. BONNELL:

A. Yes.

THE COMMISSIONER:

Q. And what I wanted to clarify was at what point it came home to you that that was not going to be something that you could talk about?

MS. BONNELL:

A. When we started to prepare for the media briefing, which would have been in, I think,

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probably late in that fall, maybe in October sometime.

THE COMMISSIONER:

Q. So in the preparation leading up to the media briefing, somewhere around October, it came home to you that you would not be in a position to talk about causative factors?

MS. BONNELL:

A. That's right.

THE COMMISSIONER:

Q. And what was it that drove that home to you?

MS. BONNELL:

A. Certainly conversations with legal counsel did, and also the fact that I was under the impression that we would probably release the external reviews publicly, and was not aware that those were being protected under the Evidence Act as peer reviews.

THE COMMISSIONER:

Q. Okay, and was it also around that period of time that you realized that that was the position in respect of the external reviews?

MS. BONNELL:

A. Yes.

THE COMMISSIONER:

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

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

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A. Yes.
COFFEY, Q.C.:
Q. And to be told privately what had gone wrong?
MS. BONNELL:
A. Yes, or well, that it--I mean, I guess the primary thing is that it would be between the physician and the patient to have that conversation.
COFFEY, Q.C.:
Q. But we looked at the adverse event -
MS. BONNELL:
A. Policy.
COFFEY, Q.C.:
Q. - policy, you were shown that. And that involves the patient being notified as to what went wrong, why it went wrong, if it's known.
MS. BONNELL:
A. Yes, yes.
COFFEY, Q.C.:
Q. And what's proposed to be done about it, in terms of future treatment?
MS. BONNELL:
A. Yes.
COFFEY, Q.C.:
Q. So here, though, I take it that the whole of

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

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things publicly.
COFFEY, Q.C.:
Q. And do you have any reason to believe that they were talked about privately?
MS. BONNELL:
A. I have no reason to believe one way or the other if they were or weren't.
COFFEY, Q.C.:
Q. Okay, well we'll have to hear then from the oncologists on that point, but I'm going to suggest to you that it certainly wasn't talked about openly within the group as to the reasons for test failure.
MS. BONNELL:
A. Not -
COFFEY, Q.C.:
Q. Not like Dr. Banerjee set it out.
MS. BONNELL:
A. No.
COFFEY, Q.C.:
Q. When did the group last meet before September 30th, 2005, do you know? Mr. Simmons was asking you about, you know, the phone call that you received that day and what was done. You made a reference to, in the context, the

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

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

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

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positive and may experience a change or addition to their cancer therapy."

MS. BONNELL:

A. Uh-hm.

COFFEY, Q.C.:

Q. And if you can look back, please, that's the one that apparently went up on the NLMA website, look back at P-0616, if you look at the corresponding part of that letter, there are a couple of words changed in the beginning of the letter, but when we look down at that same paragraph, the fourth last paragraph, "We see from the results that we have retested thus far, we are anticipating that less than 10 percent of all breast cancer patients will convert from a negative to a positive and may experience a change or addition to their cancer therapy."

MS. BONNELL:

A. Uh-hm.

COFFEY, Q.C.:

Q. So that that apparently was, at least as of October 4th, the letter that you had drafted for Dr. Williams?

MS. BONNELL:

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A. I apologize.

COFFEY, Q.C.:

Q. That's fine, it's just a point of clarification. You were also asked a question concerning inaccuracies in media coverage in October of '05 and you were asked whether reporters were contacted to correct such inadequacies or inaccuracies, I'm sorry. Do you recall what reporters in October of '05 you or your department contacted?

MS. BONNELL:

A. About an inaccuracy?

COFFEY, Q.C.:

Q. Yes.

MS. BONNELL:

A. The only inaccuracy that we corrected was one that was on the CBC website in my recollection.

COFFEY, Q.C.:

Q. Okay, that's the one we looked at, one of the e-mails here when I was asking you about -

MS. BONNELL:

A. Yes.

COFFEY, Q.C.:

Q. Okay.

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MS. BONNELL:

A. And I don't know if, I think Deborah would have done that and I don't know she would have even spoken to a reporter because sometimes information is posted on the website and you can--and there is an individual, well I guess he's a reporter, but he's an individual who is responsible for posting information on the web and that contact may have been made directly with that individual, I'm not sure.

COFFEY, Q.C.:

Q. Okay. You, as well in a response to a question indicated that, I believe your words were to the effect "there are so many issues that one can deal with at any one point in time from an organization's perspective"?

MS. BONNELL:

A. Yes.

COFFEY, Q.C.:

Q. I take it that's issues involving sort of bad news issues?

MS. BONNELL:

A. No, not necessarily.

COFFEY, Q.C.:

Q. In commenting on it, you did refer to, what

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can only be seen as negative issues, the Turner report, Markenstein's Turner report and others, that you -

MS. BONNELL:

A. Those happened to be big news stories. I mean, the pharmacy issue wasn't necessarily a negative one. It began of, you know, in that sort of a way, but it's about capacity, I think, and perhaps is the better word to use than--and I certainly struggled with capacity issues. I don't think in the last three years I've worked less than 50 or 60 hours a week, every week, you know. It just can't be done.

COFFEY, Q.C.:

Q. And if I could, Commissioner, and this is just for point of--well three different exhibits. In my examination of Ms. Bonnell, we did refer to them, but I'd like to just identify them for your own purposes and counsel's purposes. Exhibit P-1211 and I apologize, Ms. Bonnell, I should have had them brought up when you asked about them in the first place, I won't ask you--just to have you identify them. P-1211 please? This is a May 7th '07 media statistics form, this would be the date, the

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contact date for Mark Quinn involving the court documents, I think you did refer to your conversation with Mr. Quinn and what happened as a result.

MS. BONNELL:

A. Yes.

COFFEY, Q.C.:

Q. This is the form of that day.

MS. BONNELL:

A. Yes.

COFFEY, Q.C.:

Q. And as well if we could, P-1212? And this is a form dated May 14th, 2007 involving Heather Barrett of The Current, CBC Radio, The Current, and this is again your record that day of your dealings with her.

MS. BONNELL:

A. Yes.

COFFEY, Q.C.:

Q. Okay, and finally, Commissioner, there is an exhibit, it hasn't been entered, but for the sake of completeness, it's Ms. Bonnell's redacted calender and it's exhibit P-1565.

THE COMMISSIONER:

Q. And that's redacted by us?

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COFFEY, Q.C.:

Q. Well -

MR. SIMMONS:

Q. By agreement.

THE COMMISSIONER:

Q. By agreement.

COFFEY, Q.C.:

Q. I don't know by agreement, but who physically did the -

THE COMMISSIONER:

Q. But we don't want a continuing redaction problem.

COFFEY, Q.C.:

Q. Okay, I will check that Commissioner and we'll -

THE COMMISSIONER:

Q. Well why don't we just double check that before -

MR. SIMMONS:

Q. We marked them with opaque--with transparent markings, so if they're now opaque, it means they've been done here.

THE COMMISSIONER:

Q. We have done our own redaction.

COFFEY, Q.C.:

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Q. Thank you, Registrar. If we could have the exhibit -

THE COMMISSIONER:

Q. So the number again is P-1565? All right, entered.

EXHIBIT ENTERED AND MARKED P-1565

COFFEY, Q.C.:

Q. Thank you, Commissioner. Now before we break, I have no further questions for Ms. Bonnell. I have a comment, though, to the Commissioner, if I could.

THE COMMISSIONER:

Q. About other business?

COFFEY, Q.C.:

Q. Yes.

THE COMMISSIONER:

Q. All right. Thank you, Ms. Bonnell very much. As I've said it to other witnesses, we really do need to get the perspective of a lot of people on this issue and see how events unfolded from a number of different perspectives before I can even attempt to put it together and I very much thank you for your contribution to this process.

MS. BONNELL:

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A. Thank you very much.

THE COMMISSIONER:

Q. Thank you. Now, Mr. Coffey?

COFFEY, Q.C.:

Q. Yes, Commissioner, I'm going to ask, Commissioner, that we adjourn until 2:00 at which point we would begin the evidence of Dr. Ejeckam. He is, of course, had travelled from outside the country. I understand that he has met with his counsel yesterday and I gather again this morning, and -

THE COMMISSIONER:

Q. So I presume counsel and Dr. Ejeckam agreed to this change in scheduling?

COFFEY, Q.C.:

Q. Yes, we have and I've advised counsel--he was anticipated to be here tomorrow at 9:30 anyway. I've advised counsel in the room earlier this morning that that was going to happen.

THE COMMISSIONER:

Q. All right.

COFFEY, Q.C.:

Q. So if we could begin, and rather than start a witness now -

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THE COMMISSIONER:
Q. And then have to interrupt.
COFFEY, Q.C.:
Q. Yes, that was the -
THE COMMISSIONER:
Q. All right then, we'll adjourn until 2:00.
COFFEY, Q.C.:
Q. Thank you, Commissioner.
(ADJOURNED FOR LUNCH)
THE COMMISSIONER:
Q. Thank you. Please be seated. Mr. Coffey.
COFFEY, Q.C.:
Q. The next witness, Commissioner, is Gershon Ejeckam, Dr. Ejeckam.
MR. GERSHON EJECKAM (SWORN) EXAMINATION BY BERNARD COFFEY, Q.C.
DR. EJECKAM:
A. My name is Gershon Chukwuemeka Ejeckam. G-E-R-S-H-O-N C-H-U-K-W-U-E-M-E-K-A. The last name, E-J-E-C-K-A-M.
COFFEY, Q.C.:
Q. Thank you, Commissioner. Good afternoon, Dr. Ejeckam. Commissioner, just at the outside I wanted to say, I wanted to thank Dr. Ejeckam for having come from Africa, as he's come

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

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

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

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doing some research with him on immunoflorescense and he invited me, I came for an interview and I was selected, so I started as an assistant professor of pathology at Memorial University. And I was doing my pathology practice at Grace Hospital, now closed. I spent roughly three years and returned to Nigeria in 1983 and went back to the university that I left, University of Nigeria, and I was there for awhile and later on, about 1989, I moved to Doha, the capital of Qatar in the middle east and I spent 13 years there, working as an anatomic pathologist and held several positions within the department. And then, year 2002, I came back to St. John's and was re-hired as clinical associate professor of pathology at Memorial and then as staff pathologist at Health Sciences, General Hospital, and I remained there until I retired and went back to Nigeria in year 2006.

COFFEY, Q.C.:

Q. And, Doctor, what are you doing--what have you been doing since 2006?

DR. EJECKAM:

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A. I got involved with trying to help a new medical school, University of Enugu State University of Science and Technology, Medical School, so I'm the chief pathologist and head of clinical laboratories. So I teach, basically, I teach medical students.

COFFEY, Q.C.:

Q. Even today, you're still teaching medical students.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Now, Doctor, I understand that in preparing to come here to testify that you've prepared a short slide presentation on basic immunohistochemistry. Before I have you take us through that, looking at your CV, okay, and if we could, please, Registrar, page 9. Doctor, I'm not going to take you through it in detail, but I gather, Doctor, beginning at page 9 of your resume through 10, through 11, through 12, and 13 and 14 and into page 15 of the exhibit, which is page 14 of your resume, that you have published a number of articles, authored and co-authored a number of articles.

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DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And relating to pathology, pathology related matters and other aspects of medicine throughout your career?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Okay, Doctor, in terms of immunohistochemistry or histochemistry and in particular immunohistochemistry, have you had professional experience in that regard?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Could you tell the Commissioner then about how you got involved in it and what that experience is?

DR. EJECKAM:

A. Madam Commissioner, I got involved with immunohistochemistry quite early, I came in from my residency, then it was immunoflorescense that was being done and just simple interest. In our residency you had a

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

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

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good diagnostic (unintelligible) there and of course, when I came over -

COFFEY, Q.C.:

Q. So this was in Qatar.

DR. EJECKAM:

A. In Qatar.

COFFEY, Q.C.:

Q. In your area of time there.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. So when you went to Qatar, I take it, when you arrived there, do I understand you correctly that immunohistochemistry was not really developed within the laboratory -

DR. EJECKAM:

A. Yeah, it wasn't fully developed.

COFFEY, Q.C.:

Q. Fully developed within the lab there.

DR. EJECKAM:

A. Yeah, it was being done, but it wasn't, we had to--I had to take part in ensuring the overall development there, myself and Professor--Dr. Atalla (phonetic) who was the chairman of the department, but incidentally also an anatomic

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pathologist, but I was head of anatomic pathology division.

COFFEY, Q.C.:

Q. And as part of your duties in that regard, the IHC procedures were within your area of responsibility.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And so I understand you got a separate facility or a portion of a facility devoted to IHC, particular technologists devoted to it.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And you arranged for education, for example of them in the United States, in Florida.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Okay. And then over time, as the 90's went on, you developed, from your perspective what kind of quality lab did you develop?

DR. EJECKAM:

A. We developed a very good laboratory because

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having identified a structure and got equipment in, we trained our staff and in fact, we also encouraged them to go for conferences, so we worked hard on that and over a period, we developed a good laboratory and we also were registered with the CAP, College of American Pathologists for a standard of quality assurance. Later on we also hooked up with the British one, but the first was the CAP, so we had a kind of quality assurance going on and my supervisor, my technical supervisor encouraged hard to work hard and she--we developed a manual for immunohistochemistry and also a manual for the anatomic pathology generally, quality assurance manual.

COFFEY, Q.C.:

Q. Within your own--for your facility.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And, Doctor, and you say eventually when the British or the United Kingdom, UKNEQAS program stated it, you became part of that as well?

DR. EJECKAM:

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A. Yeah, but that was the tail end, I was about leaving by the time they hooked onto it, but I participated in encouraging them to hook up to that because seemed to have a fairly better program than the CAP one.

COFFEY, Q.C.:

Q. So, Doctor, if I could then, please, if we could bring up exhibit P-1603? Now this is just, of course the title page, "Basic Immunohistochemistry, IHC". If we could go to, please, to page 2, Registrar. Now I'm going to ask you then to take us through this, Doctor, and you can, of course, expand upon it as you see fit. You go ahead, sir.

DR. EJECKAM:

A. The first slide has three lines on it, three sentences, "IHC, Immunohistochemistry harnesses, the immunological mechanism in human beings in cold virus." What happens is we all have cold one time or the other and this is due to viruses. Now when the virus enters our body, it causes disease, but the body will recognize the virus as a foreign material. Now those whom we call immune competent, that's people whose immune system

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

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

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the antibody. So this is exactly what we do in the immunochemistry--my people, the companies take cells from different parts of the body and inject it in mice or rabbits, because we have to make sure that molecules is injected in a different species of animal, which will recognize that as foreign, that's important. If you recognize that as foreign, then to mount a defence against it and that defence is producing antibodies. So when injected in rabbit or mice, antibodies are produced.

COFFEY, Q.C.:

Q. Go ahead, Doctor, I'll show you right here, do you see that?

DR. EJECKAM:

A. Okay, okay. The antibodies will be produced and these antibodies will be combining specifically with those antigens. So what we've done now is we've taken a molecule from human beings, injected it in mice, it will produce antibodies. So now immunochemistry, what we now do is we have this antibodies marketed so that if I'm looking for a tumor from the skin or liver and if I get antibody

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against liver cell, I can then react it to the tumor. And if I do, if it attaches onto it, then I will know that tumor is from liver. Now, the process doesn't end there because that reaction you cannot see it, visualize it at the first stage, then you have to go further to amplify that. Now, just back to what you're saying, this is valuable to do with estrogen receptors here, that in breasts, the same type of molecules in the breast cells, when we start them, we inject them in rabbit, we get antibodies against estrogen and progesterone. So when we get those antibodies in the rabbit tumor that we have in the lab, then we try to react that and see whether there is presence of estrogen or progesterone receptor on that tumor because if they are there, that antibody produced will then combine with it. Then after the combination, then you need to highlight so they can see that.

Now, because you fix the tissues in formalin, normally if you get the tissue fresh, if you don't fix it, the cell membrane, because every cell had a cell membrane, once

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you take it from the body, the mechanism keeping that cell membrane intact while in the body would be removed, and if you don't fix it, the enzymes will elute out and destroy the cell. So we fix it in formalin. Now, this fixation in formalin sort of binds the protein and sort of marks the sites where these antigens are.

So we go through the process of processing the tissue and after we finish processing tissue, we use the number dye we use for staining histology, we call it HNE hematoxylin and eosin. Hematoxylin will stain the nucleus and eosin will stain the cell cytoplasm. Now, when you then look at those slides and pick the best one, that best one will contain the tumor that you want to examine, it should also contain no more tissue as an internal control for you. Then that, when you choose it, then you ask the technologist to pick the block from which that particular slide was produced to do the immunohistochemistry. And so what they would do is to cut sections and do what you call antibody retrieval, and the reason for this is

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this, if you try to do the stain to show those antibodies antigen sites that early, because of formalin fixation, you may have destroyed some of those sites or it may have been masked by reaction. So when what you call antigen retrieval is to put the sections and heat it up, there are many methods, either you boil them up in pressure cooker or use microwave, different methods in different laboratories. What you are trying to do is to unmask those sites, those molecules that were used to produce antibodies. So once you unmask it, then the antibodies that you using now will combine with it.

Now, after the combination you need to now visualize it. The reaction has taken place. So in this diagram here, the flat area where you have the small, small squares or triangles--squares, those are the sites of the antigen on the tissue. Now, the other figure on top of it is the antibody. The antibody has two light chains and two heavy chains, but we'll not go into that.

Now, in our reaction we get an antibody, we'll call it the primary antibody and put it

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on the tissue so it will react with the antigen, but you will still not be able to see it. Then you go to the next stage where you now add a second antibody. Now, in the first stage you can try to see by using a dye, but because it's limited, then what you see may be also limited, so we expand it by using secondary antibody. And secondary antibody will now contain material that will help us to visualize this reaction. So that is second stage.

Then you go to the next stage after the, everything has done, the reaction has been done, then you want to visualize it. This shows the antigen, antibody reaction already done there with the two antibodies there, but you cannot see it. Then all this Avidin, the one in green on top of there and the biotinylated peroxidase, the one in the red and blue, they need to combine to this antibody for us to see it. So the next stage is when this reaction goes on, you see what has happened, it has combined and is tightly attached to it. You still won't be able to see it under microscope because you need a

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

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is basically the, what we need to, what you do.

Now, what is the use of immunohistochemistry? I've listed here one, the differentiation of tumors. Why? Sometimes you get a biopsy that has small tumors in it, call it small or like cell tumors. Under a microscope you cannot tell whether it's coming from lymphoid origin or from a particular origin or from stromal origin, that's connective tissue origin. There is malignant, all right, but treatment would be different depending on what you call it. So for differentiation what they use antibodies produced against a particular molecule, lymphoid molecule, then stromal molecule because you should have a panel, it's not just doing one. Then that panel outside the staining, then you look at it and it tells you, oh, that tumor is of lymphoid origin, then leukocyte common antigen will be positive. A particular antigen like cytokeratin will be negative. The (unintelligible) for stromal will be negative. So you now have a diagnosis instead of saying

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undifferentiated carcinoma, you then say lymphoma.

Then of course you go further to classify the lymphoma, is it a B-cell lymphoma or a T-cell lymphoma because the treatment the oncologist will use will depend on what type. And there are also molecules in these lymphomas, lymphoid cells that are being used to produce antibodies. So for B-cell lymphomas will have antibodies like CD20, CD19, these are specific for B cells. For T cells you have CD3, so, or CD5. So you use this panel again to tell the oncologist that this tumor is a lymphoma and then give to them then, depending on if it's large or small or what type, and I say B-cell lymphoma because the treatment will be different if you said a T-cell lymphoma.

Then we look for original invasion of cancerous cells. Example, if someone has a tumor on his skin and I look at it and it's an a petalia (phonetic) tumor and it's not arising from the skin, then we need to find the primary. And the way it looks on the HNE, because that's the first thing you got to look

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

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

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cases do not respond to anti-estrogen treatment, and 10 percent of tumors that are negatives will respond. So, it's a question of putting everything on balance. So, I think that will summarize the use a what immunohistochemistry stands for and where we use it. Thank you.

COFFEY, Q.C.:

Q. Now, Doctor--no, thank you, Doctor. Could you tell us, please, what you've just described here, at what stage in your training or by what stage in your training would you have come to the understanding you just gave us?

DR. EJECKAM:

A. Well, it came on long over a period of time. There's no particular point where you can say, here I've got it, but this was being done along the line and I was doing immunoflorescense before. And the process is the same thing. But as you do it, you then look at--I mean, with years of experience then you will be able to gather some more information. I mean, it's a question of how much time you have been with it and how much you've been doing, working on it.

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COFFEY, Q.C.:

Q. In terms of, for example, in your period in Qatar.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Which would be effectively the 1990s?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Before the 1990s and just afterward, but effectively in your case throughout the 1990s, this approach to usage of IHC, was that, in effect, within your hospital at the time?

DR. EJECKAM:

A. I mean, the immunohistochemistry?

COFFEY, Q.C.:

Q. Yes, this approach.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Okay.

DR. EJECKAM:

A. That's what we used, that's what we used.

COFFEY, Q.C.:

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Q. Now, Doctor, again, to help put this in some perspective for the Commissioner, I take it when you began, as you say, it was immunoflorescense?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Was the precursor at the time to IHC?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. When you first got involved in IHC, approximately how many stains would there have been available when you first got involved?

DR. EJECKAM:

A. Oh, very few, very few, probably cytokeratin, S100 and very few of them.

COFFEY, Q.C.:

Q. Very few.

DR. EJECKAM:

A. But now probably, depending on how much money the laboratory has, some up to 150, some 200 antibodies in the market now. So it depends on the practice in the laboratory.

COFFEY, Q.C.:

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Q. So in the early days there would have been certainly less than a dozen?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.:
Q. In the very early days?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.
Q. And now it's 150, 160 and rising, I take it?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.
Q. Could you tell the Commissioner, please, again with your experience, during what period the number of stains that have come onto the market, has it come faster and faster as time has gone on? And if so, what period saw the greatest develop?
DR. EJECKAM:
A. I would say '80s, late '70s, early '80s, a lot of antibodies were being pushed into the market, some of them weren't completely useful. It's a question of when they come out, you buy it and try it in your laboratory

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

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amount of money to do it?
DR. EJECKAM:
A. Yes. The process works this way, whatever you needed and you requested for it, you will be required to justify that. If you justify it that this is for patient care and of diagnostic use, most of the times the budget committee will approve that and within three months, six months, they will send out for tender to procure that for you.
COFFEY, Q.C.
Q. Now, Doctor, when you were here, and I gather you were here in the 19--between about 1980 and '83?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.
Q. In St. John's, or at St. Clare's.
DR. EJECKAM:
A. Grace Hospital.
COFFEY, Q.C.
Q. I'm sorry, the Grace. I apologize. Was there any usage of IHC here at the time, that you recall?
DR. EJECKAM:

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A. Not for diagnosis purposes.
COFFEY, Q.C.
Q. Okay. And when you returned to Newfoundland in 2002, what did you find--well, first of all, where did you go to work first, in -
DR. EJECKAM:
A. General Hospital.
COFFEY, Q.C.
Q. General Hospital?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.
Q. And your position there at the time was what, exactly?
DR. EJECKAM:
A. Staff pathologist.
COFFEY, Q.C.
Q. Staff pathologist.
DR. EJECKAM:
A. And then a title, titled university associate clinical professor.
COFFEY, Q.C.
Q. Did you do any teaching?
DR. EJECKAM:
A. Yes.

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COFFEY, Q.C.
Q. And what sorts of level of students did you teach?
DR. EJECKAM:
A. Pathology, pathology students. They do pathology one time, I think, third or fourth year student, but pathology students end with (phonetic).
COFFEY, Q.C.
Q. Doctor, when you--that would be on the General Hospital site. Who was the clinical chief when you arrived?
DR. EJECKAM:
A. Dr. Don Cook.
COFFEY, Q.C.
Q. And was there a discipline chair at the time, do you recall?
DR. EJECKAM:
A. Chairman of the -
COFFEY, Q.C.
Q. Yes.
DR. EJECKAM:
A. Doctor Robb.
COFFEY, Q.C.
Q. And so you arrived, how was IHC--first of all

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when you arrived in Newfoundland in 2002, do you recall what month of year that was?
DR. EJECKAM:
A. I think I came in in August and started working in September.
COFFEY, Q.C.
Q. Okay. When you arrived, who, if anyone on the medical staff did you already know?
DR. EJECKAM:
A. I know Don, I knew -
COFFEY, Q.C.
Q. So, you know Doctor Cook from the -
DR. EJECKAM:
A. Yeah, because when I was--then the agency--the residents training then and descendant with Avis, those were residents.
COFFEY, Q.C.
Q. Who?
DR. EJECKAM:
A. Doctor Avis.
COFFEY, Q.C.
Q. Okay. Dr. Simon Avis.
DR. EJECKAM:
A. Yeah, Simon, yeah. I think both of them were residents in those days, these are the ones

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

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A. Yes, whatever comes the day I'm on.
COFFEY, Q.C.:
Q. At the time you arrived in Newfoundland in 2002, where in Newfoundland was IHC testing being done or processing being done?
DR. EJECKAM:
A. At the General Hospital.
COFFEY, Q.C.:
Q. When you first arrived and would have gone to work, I take it, in September of 2002, where was the IHC lab located?
DR. EJECKAM:
A. Within the laboratory, anatomical pathology laboratory, within the open laboratory.
COFFEY, Q.C.:
Q. And how would what you found there compare to what you had left in Qatar, the facility there?
DR. EJECKAM:
A. Well, what they had then was what you had initially in Qatar, before we moved to separate structure, separate room. So you know, it was--by the time I left Qatar, the institution was different.
COFFEY, Q.C.:

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Q. Yes, I appreciate that you said when you went to Qatar in the beginning, it was all -
DR. EJECKAM:
A. Yeah, same situation.
COFFEY, Q.C.:
Q. So what you found in St. John's in 2002 was similar to what you'd found in Qatar in 1989?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.:
Q. In the sense of the layout?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And the position or lack of isolation from the rest of the lab?
DR. EJECKAM:
A. Yeah, that was in the open laboratory.
COFFEY, Q.C.:
Q. What is the--why is it desirable to have IHC portion of the lab separate from the general lab facility?
DR. EJECKAM:
A. Well, for a number of reasons. Immunohistochemistry, I contend that it's not

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

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

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was at St. Clare's. He came over later. These two guys were responsible for this and they were also responsible for other duties in the laboratory.
COFFEY, Q.C.:
Q. I'm sorry, they were also?
DR. EJECKAM:
A. They were also responsible for other duties in the laboratory.
COFFEY, Q.C.:
Q. Other duties?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.:
Q. Okay, and in the fall of 2002, did you have any particular interaction with IHC portion of the lab, in the fall of 2002, any more so than other pathologists?
DR. EJECKAM:
A. No, not really. Well, I looked in once in a while, but not in particular.
COFFEY, Q.C.:
Q. Okay. Did you have any--now bearing in mind what you'd seen and done in Qatar throughout the 1990s, did you have any thoughts or

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feelings at the time about the desirability of what was going on in the IHC at that point, in the fall of '02?

DR. EJECKAM:

A. Yeah, well, I mean, in my mind, I thought that it would be nice to have the same situation as we finally achieved in Qatar.

COFFEY, Q.C.:

Q. Did you communicate that to anybody initially?

DR. EJECKAM:

A. No, because I mean, I wasn't particularly involved with this, so I didn't discuss that with anybody.

COFFEY, Q.C.:

Q. Doctor, if we could, again, if we could look, please, at Exhibit P-1600? And Doctor, this is--this will come on the screen in fact as well in front of you there, and now this is just a listing, Doctor. It relates to pathologists staff turnover, but it shows the--there's a list of incumbents, as it were, or list of pathologists. You'll recognize a number of names.

DR. EJECKAM:

A. Yeah.

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COFFEY, Q.C.:

Q. You'll see the cursor right here?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Gershon Ejeckam.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. And it has the start date, September 16th 2002 and what they refer to as the termination date, April 30th 2006, your retirement.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Okay, so that would bracket more or less the time you worked in St. John's?

DR. EJECKAM:

A. Yes, that reflects the time I was there.

COFFEY, Q.C.:

Q. At least the second time around. Just a moment, please. Just a moment, please, Commissioner. When you came to work in St. John's in 2002, is there any particular process you had to go through to apply and to

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get certified here, you know, to carry on as a pathologist in Newfoundland?

DR. EJECKAM:

A. I already have--I'm already a Fellow Royal College of Physicians of Canada.

COFFEY, Q.C.:

Q. Yes.

DR. EJECKAM:

A. I trained in Canada, so that qualifies me to work and then the sponsoring body sponsored me to the Newfoundland Medical Board for license to practice.

COFFEY, Q.C.:

Q. And if we could, please, Exhibit P-1570, in particular, I'm just going to go to--just a second. Actually, Doctor, just so you have some sense of this, this is a performance goals and objectives for clinical chiefs for 2002-2003 for Dr. Cook, but there's a--looking at page three of the exhibit, one of the objectives for Dr. Cook is to oversee the start up of a surgical pathology review committee, and the goal as of January 1, 2003 was the committee would be set up under the chairperson, yourself?

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DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. You chair it?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And they're hoping to have their first meeting by May or June of 2003, and there's a note here that by April 1st 2003, the committee had been operationalized or started or organized by that time, and by October 1st 2003, the committee was meeting on a regular basis and issues were referred to the clinical chief and VP Medical Services to follow up. So could you tell us, please, first of all, have you confirm, you did chair that committee?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Could you tell the Commissioner how the committee came about?

DR. EJECKAM:

A. During some of my discussions with Dr. Cook, because he would come over when I arrived and

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we would have general chatting about the general work process, about the need for quality assurance and the need for tissue audit, then based on that, I would suspect he set up this surgical review committee and I believe looking through my curriculum vitae, I was a chairman of tumor board and tissue committee and several in Doha. So he probably felt that I could wait and then requested me to chair the committee. So he went ahead and formed the composition of the committee and I believe he discussed it with the higher authorities and we had membership to this committee, representative from all--I think most of the clinical departments were there.

So, and we had a mandate, you know, to kind of conduct basically tissue audit and quality assurance process among the laboratory, specimens sent into the laboratory and as well as the reports going out of the laboratory.

COFFEY, Q.C.:

Q. And you say that when Dr. Cook, I take it, would come over to the General Hospital site, because he was at St. Clare's?

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DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Stationed in St. Clare's. That I gather this would be what, in the fall of 2002?

DR. EJECKAM:

A. Well, I can't put a date to that, but you know, he would come in, you know, either for meetings or whatever.

COFFEY, Q.C.:

Q. And the subject of quality control, quality assurance would come up?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. And the need for that?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Do you recall how that came about? I mean, the discussion about that.

DR. EJECKAM:

A. There was nothing other than, I believe, just he would come to my room chatting about the work process and I would probably have tell

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him--discussed my experience in Doha. There was no particular--I don't remember of any particular issue that made that happen.

COFFEY, Q.C.:

Q. Okay.

DR. EJECKAM:

A. It was based on general discussion.

COFFEY, Q.C.:

Q. And a general approach I take it?

DR. EJECKAM:

A. Yeah, yeah.

COFFEY, Q.C.:

Q. And in the course of talking about it, you would speak about your own experiences?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. In the '90s in particular?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. And it's your understanding that Dr. Cook, having listened to you talk about it, was interested in having you get involved in it?

DR. EJECKAM:

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A. I believe so.

COFFEY, Q.C.:

Q. Yes. Tissue audit, because you referred to that, could you tell the Commissioner, please, what a tissue audit is?

DR. EJECKAM:

A. Well, it may have different meaning to different people, but my understanding is that when you do tissue audit, we'd look at the surgical material, that is biopsies or whatever has been taken out from the patient, sent into the laboratory by the surgeons.

Now first of all, to see somebody may remove normal tissues, where they're so often, then of course, if there is no pathology in this, for instance, an appendix, a surgeon may be having a lot of appendixes removed and then if we keep saying no pathology in that appendix, then that may--we tend to flag it to see is he making a proper diagnosis before removing the appendix. The same things goes with people who may be doing hysterectomies. These are things that you look at.

Then of course, looking at the request for the surgical material when it comes down,

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we would look at the forms, whether they were properly completed, whether the information required by the pathologist were there or not, and then again, you should also look at the reports by the pathologist because the clinician may be unable with a report. This committee should be able to deal with that kind of complaints.

COFFEY, Q.C.:

Q. And when you -

THE COMMISSIONER:

Q. It worked both ways?

DR. EJECKAM:

A. Yes.

THE COMMISSIONER:

Q. The things that you could--your committee could look at what came from the surgeons who would be either sending samples or requests to you to see whether or not things were going well from that end, and the surgeons, if they had a problem with the information they were getting back from the pathologists, could raise that in this context as well?

DR. EJECKAM:

A. Yes, Commissioner, yeah.

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THE COMMISSIONER:

Q. Okay.

COFFEY, Q.C.:

Q. Now Doctor, when you arrived in St. John's in 2002 and went to work, what, if any, quality assurance or quality control programs did you see or understand the pathology department was involved in, from the perspective of anatomical pathology? Were they participating in anything, and if so, what do you recall?

DR. EJECKAM:

A. I don't recall any particular quality assurance process, but I would suspect that the laboratory was already registered with the CAP, College of American Pathologists. I don't know if that time they registered, so they could have registered before I came in, and that's a quality assurance process.

COFFEY, Q.C.:

Q. And do you know, at the time again you arrived and got involved in this surgical--or after you arrived and you got involved in this surgical pathology review committee, was there at that point any tissue audit process in place?

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DR. EJECKAM:

A. No, not that I--none that I know of.

COFFEY, Q.C.:

Q. Because you were about to start or embark upon it?

DR. EJECKAM:

A. Yes, yes.

COFFEY, Q.C.:

Q. You were being asked to do that. How about this issue of reports, written requests, requisitions coming in from surgeons for example, okay, and I will be referring you to some of that because there's material here on what you did about it, but did you have any concerns when you first arrived and started--you know, and got into the work here in 2002 as to deficiencies in that regard?

DR. EJECKAM:

A. This is not peculiar. Surgeons are notorious--well, I shouldn't use the word--surgeons are known--when you--most laboratories world over, if you talk to pathologists, they will tell you that they don't receive enough clinical details with the sample. So it's nothing peculiar, but it has to be cured. I mean, you

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have to pursue it, but it wasn't anything peculiar to St. John's or Memorial Hospital.

COFFEY, Q.C.:

Q. Okay, and your concern in that regard was to do what? I take it look for better--more and better information from the surgeons or requesting physicians?

DR. EJECKAM:

A. Yes, because some of the diagnosis that were made would depend on the clinical information given. I maintain that when a surgeon sends sample to the laboratory, it's a consultation, and when you consult a fellow physician, you should write and they do that, write the clinical history, and so that that would be a guidance for the physician that's going to come and look after your patient.

The same way, we would explain that if somebody sends a piece of bowel or uterus or keratin to the laboratory, they will also be some information because that may help in final evaluation of that tissue. In some instances, it may not matter what information he give, but in some areas, it may be very critical and every sample ought to come with

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that clinical information.

COFFEY, Q.C.:

Q. And so at least as part of the duties or activities of this surgical pathology review committee, the committee set out to remedy any deficiencies that they could?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Okay. What about the reports going out from pathology? Because you referred--the Commissioner asked you about that. You referred to it and she asked you to confirm that was the case.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. What were the concerns in the beginning when you got involved about that? What were the complaints, as it were, or concerns about what was coming out of the pathology department in terms of their reports?

DR. EJECKAM:

A. I'm not aware of any concerns about the reports, but if you have a surgical review

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committee, you don't review only the things that are coming in. You also set up to review what is going out. There was no concerns right then, but it was the surgeons' duty to now complaint or bring up case to the committee and there was none.

COFFEY, Q.C.:

Q. What, if anything, is your understanding--I mean, you have decades of experience as a pathologist, in making or filling out a pathology report, okay? Are there any basic criteria did you feel that have to be met by pathologists?

DR. EJECKAM:

A. It depends on the tissue. Each tissue has its own what has to be to make a complete report, and I believe that trained pathologists would do that. So if you take an efficient biopsy for tumor, besides diagonals in the tumor gradient, you also needed to talk about the margins, whether they were involved or not. So this is routine job for pathologists and there was no concern again about this.

COFFEY, Q.C.

Q. Now, on this point, in particular, dealing

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with ER/PR and breast cancer, because you did, in your opening remarks make reference to negative or positive and as well though, percentages.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. And there's a lot of material we're going to see here in the future dealing with some reports have just used the words negative and positive, one or the other. Others use percentages, sometimes combined with words and sometimes not. Is there any standards in that regard in relation to ER/PR that you are aware of?

DR. EJECKAM:

A. Each laboratory and the oncologist usually will set their own standard. The problem in the literature a lot of, I will say confusion because people will accept 30 percent positivity of the tumors as positive at one time. It came down to 10 percent, it came down to five percent and it came down with a study saying one percent and then consensus statement said, even one set as positive,

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that's an indication for trial of Tamoxifen, anti-estrogen medication. So, it's a question of the oncologist and the laboratory coming together to now have a cut off or the laboratory will report what they see and then the oncologist decides what he wants to do.

THE COMMISSIONER:

Q. So, would it be normal for a--perhaps it is dependent, but it seems to me that on the face of it, if there is this continuing discussion about what is positive or negative or what the cutoffs are, then there's the potential for a miscommunication unless you actually say what the percentages are as well, if you're using positive and negative.

DR. EJECKAM:

A. Well, yes, that's a possibility, but like I said, every laboratory, there's kind of dialogue between the oncologists and the pathologists. Now, there'd be no problem about being positive or negative because that's a fact of what you found there.

THE COMMISSIONER:

Q. Okay.

DR. EJECKAM:

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A. I interpret it as negative or interpret it as positive, but in terms of cut off -
THE COMMISSIONER:
Q. Um-hm.
DR. EJECKAM:
A. - then it's a question of a comment to say, we're a part of this as positive or negative and oncologists say that if it's positive, treat, or we'll say we have ten percent or twenty percent, the oncology will then determine what they want to do, or they come together, pathology and oncologists, have a merger and say, report as positive, give the percentage or ten percent or five percent, but that has to be agreed upon.
THE COMMISSIONER:
Q. Um-hm, okay.
COFFEY, Q.C.
Q. Now, in that regard, Doctor, what was the practice when you left Qatar in that regard, do you recall?
DR. EJECKAM:
A. We were reporting percentages.
COFFEY, Q.C.
Q. Percentages, whatever the percentage was -

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DR. EJECKAM:
A. Yes, yes.
COFFEY, Q.C.
Q. - you would give that figure and that would be it. The surgical pathological review committee, I take it, had surgeons and pathologists on it?
DR. EJECKAM:
A. Yes, radiologists, clinical medicine and gynecologists.
COFFEY, Q.C.
Q. Okay, so, the surgical pathology review committee wasn't limited to surgeons and pathologists, there were other disciplines on it.
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.
Q. I just want to clarify that because that can be misleading, you know, in a sense of you just see surgery and pathology and you assume it's--so, there were people from other disciplines.
DR. EJECKAM:
A. Yes.

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COFFEY, Q.C.
Q. Medicine, oncology.
DR. EJECKAM:
A. Radiology.
COFFEY, Q.C.
Q. Radiology.
DR. EJECKAM:
A. Gynecology.
COFFEY, Q.C.
Q. And so, Doctor, when you arrived again in the fall of '02 and this would be early '03, the committee, was there any particular mandate given that committee initially.
DR. EJECKAM:
A. The mandate, I know, is the terms of reference that are written to me, copied to members by the clinical chief.
COFFEY, Q.C.
Q. Okay. And it is in there, it's not in that material there, it is in the larger material and I'll refer you to that, but leaving aside any--because some times things that are written are not necessarily descriptive of what, in fact, the people involved understand, okay. So, from your perspective at the time

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

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routinely involved in? Like, I'm thinking about things like tumor boards and rounds and -

DR. EJECKAM:

A. Yes, there was a tumor round then. Pathologists will attend with the oncologists and I think there was the lymphoma rounds too where this was within the pathology group. And apart from that, we had Tuesdays teaching and divisional conferences within the laboratory where we review slides with residents, difficult slides, interesting slides were discussed on Tuesdays. One of the days, I think, well informal groups then other days you had the tumor board that pathologists attended.

COFFEY, Q.C.

Q. And this was when you first arrived, this was already organized?

DR. EJECKAM:

A. Yeah, it was there.

COFFEY, Q.C.

Q. Already there. Was it the rule that it would be attended or was it occasionally or sporadic that there'd be such sessions?

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DR. EJECKAM:

A. It was for a particular day.

COFFEY, Q.C.

Q. Okay.

DR. EJECKAM:

A. And people attended, especially if you had your case coming up for discussion.

COFFEY, Q.C.

Q. Who is responsible for organizing at the time?

DR. EJECKAM:

A. I don't know exactly who was responsible, but it was on.

COFFEY, Q.C.

Q. Okay. And Doctor, again, in the latter part of 2002 into early 2003 you've referred, for example, to the--within any one institution, there might be an understanding between the pathologists and the oncologists as to the reporting of positivity rates, positivity percentages, cut off percentages.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. When you arrived in St. John's in 2002, was there any such understanding that you could see at the time?

DR. EJECKAM:

A. I don't think so. I don't remember of any particular meeting specifying that kind of cut off, but I suspect that people were reporting percentages.

COFFEY, Q.C.

Q. And if I could please, Exhibit P-0904. And, Doctor, this is the first page of this, surgical pathology review committee, Health Science Centre, April 15, 2003, 2:00 p.m. and there's an agenda called the order in business. This is the agenda, I take it, for the first meeting.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. And the terms of references are stated to be, well, I'm going to refer to it as to "SPRC will review standardized reporting of pathology specimens. Number two, the SPRC will perform tissue audits on surgical specimens. Number three, the SPRC will serve as forum for interesting and/or difficult cases that can be reviewed on an individual

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basis or on a specific request. Number four, the SPRC will be chaired by a pathologist. Number five, the SPRC would meet once every two months. Number six, the SPRC would report directly to the Vice President of Medical Affairs. Number seven, the committee would make recommendations, if necessary. It's copied to Dr. R. Williams, Robert Williams and Dr. D. Cook, and then of course, the agenda sets out reference to new business and an adjournment.

So do you recall who drew up the agenda and the terms of reference?

DR. EJECKAM:

A. The terms of reference was sent to me by the clinical chief.

COFFEY, Q.C.:

Q. Okay, which was Don Cook.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. If we could, please, look at Exhibit P-0113? Now Doctor, this is a memo dated April 4th 2003. It's to pathologists, Health Sciences Centre, St. Clare's and out-of-town hospitals.

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It's from yourself, described as a pathologist at the Health Sciences Centre. The subject is immunohistochemical stains. It's dated April 4th 2003, and it's--sorry, Doctor, just go up a bit, and it's signed--initialled by yourself and copied to Barry Dyer and all technical staff on immunohistochemistry.

Doctor, when you came into St. John's in 2002, who was the non-clinician person in charge of the lab, the non-doctor, who was--how was the lab organized in terms of--you referred to Mr. Green and Ms. Butler, Mary Butler. Who did they report to?

DR. EJECKAM:

A. When I came in, there was a laboratory manager and the laboratory manager was Barry Dyer.

COFFEY, Q.C.:

Q. Yes.

DR. EJECKAM:

A. And all the technologists reported to him, and also the clerk, the clerical staff. Then there was a program manager, Terry Gulliver. I believe Barry reported to him, okay, and then we have site chief who looks sort of if there's problem among the pathologists.

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COFFEY, Q.C.:

Q. And the site chief at the time was?

DR. EJECKAM:

A. Dr. Parai.

COFFEY, Q.C.:

Q. Parai?

DR. EJECKAM:

A. Yeah, Sushil Parai, because there are two Parai's.

COFFEY, Q.C.:

Q. Yes, I was going to say, yes, there are two of them. So administratively then, you would have reported to the site chief, Dr. Parai, yourself?

DR. EJECKAM:

A. Yes, yes.

COFFEY, Q.C.:

Q. And he would have reported to Don Cook, the clinical chief?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. That kind of an arrangement or organization, how did that compare with what had existed in Qatar? How was Qatar organized?

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DR. EJECKAM:

A. The Qatar organization, I believe, is a lot better because the situation where the laboratory manager and the program manager reported straight to the vice president of the hospital, bypassing the pathologists in the laboratory, because they never reported to the site chief or to the clinical chief, I think was flawed because you're going to have parallel thinking here. But in Doha, a pathologist was in charge. We had we call them supervisors, they call them manager here. They report to the head of the anatomy pathology who is a doctor, who is a consultant pathologist and that was me, and then I reported to chairman who is a doctor who is also a pathologist. So there was no way that anything that happens in that division, you as the clinician person, you needed to know about it and take it on further if you think it was necessary. So it's a different system that was there.

COFFEY, Q.C.:

Q. Yes.

DR. EJECKAM:

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A. I wouldn't say it's bad or good. Actually it was a different system.

COFFEY, Q.C.:

Q. And the advantage that you saw in the situation at Qatar, the reporting situation was what, in terms of yourself in your position?

DR. EJECKAM:

A. It was--well, my advantage for me that was ease of operation and then it was a lot better actually from my standpoint that I knew what was going on in my laboratory because if my supervisor didn't report to me, the equipments would be bought without my knowing and -

COFFEY, Q.C.:

Q. I'm sorry, what?

DR. EJECKAM:

A. Equipments would be bought without my knowing about it.

COFFEY, Q.C.:

Q. Would or would not be?

DR. EJECKAM:

A. Would be bought.

COFFEY, Q.C.:

Q. Would be bought.

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

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wanted to renew anybody's contract and I will say to renew that, and if mine came up, then the medical director would ask the chairman whether he wanted to renew my contract and he would say renew. So it worked that way. So you knew that somebody was in charge of any particular section at that time.
COFFEY, Q.C.:
Q. Now Doctor, could you tell us, please, how it was that you came to--well, first of all, we'll get into that. You have copied this to Barry Dyer and all technical staff on immunohistochemistry. Well, Mr. Dyer, you've explained who he was. Who were the "all technical staff"?
DR. EJECKAM:
A. I think Mary Butler and -
COFFEY, Q.C.:
Q. Okay, it's the technologists that you're referring to?
DR. EJECKAM:
A. Technologists.
COFFEY, Q.C.:
Q. Okay, who are actually involved in doing IHC?
DR. EJECKAM:

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A. Yeah, in the actual--yeah.
COFFEY, Q.C.:
Q. And it's addressed to pathologists, Health Sciences Centre I take it is the General Hospital and -
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. - the pathologists at St. Clare's. The out-of-town hospitals, who were you trying to communicate with there?
DR. EJECKAM:
A. Immunohistochemistry in Newfoundland is done only at Health Sciences. So we would receive material for immunohistochemistry from Gander, Corner Brook, Clarenville. So those--Carbonear, all those other pathologists that are not within St. John's, they send material when they wish to. So this was to inform them about this.
COFFEY, Q.C.:
Q. Now, Doctor, at the time this was prepared and you initialled it, who did you give this to have--how did you expect this would be distributed?

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

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

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. And you would give it back to him or--well, her, I suspect.

DR. EJECKAM:

A. Yeah, right.

COFFEY, Q.C.:

Q. And you expected then that they somehow would have a system in place to distribute it?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And were you ever told, was it ever suggested

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

DR. EJECKAM:

A. No.

COFFEY, Q.C.:

Q. And the secretarial staff or administrative staff you would be relying upon, who did they work for?

DR. EJECKAM:

A. They worked for the department, but they reported directly to Barry.

COFFEY, Q.C.:

Q. Barry?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. So it would be Barry's staff or somebody who reported to Barry that would be the one who would be responsible for actually sending this out with the right addresses and so on?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Okay. If we could take a break, Doctor. We're going to have a short break.

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THE COMMISSIONER:

Q. Yes, okay then. We'll take 15 minutes.

(BREAK)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey.

COFFEY, Q.C.:

Q. Thank you, Commissioner. Doctor, just looking at this April 4th 2003 memo, you've had an opportunity to read this, of course, preparing in coming here today?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Okay. Doctor, could you tell us please about how this came to be written?

DR. EJECKAM:

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

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looking at lymphoma.

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

COFFEY, Q.C.:

Q. I'm sorry, there's no point in?

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DR. EJECKAM:
A. Using--doing the stain and not using them for diagnosis. So I had to stop the process of this antibodies. Now there are still lots of other antibodies that were being done. So we didn't shut down the immunohistochemistry laboratory. What we did was to stop some of the antibody stains to make sure that they are--we are having reproducible and interpretable results.
COFFEY, Q.C.:
Q. Now who is the "we" in this context?
DR. EJECKAM:
A. The pathologist.
COFFEY, Q.C.:
Q. Okay. So you say on these Tuesdays and Wednesdays, you'd have meetings?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Would they be at the General Hospital?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Okay. Would they involve the St. Clare's

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pathologists?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. So these meetings -
DR. EJECKAM:
A. The St. Clare's would be in on Wednesdays. Lymphoma rounds was done at the Health Sciences and they would come in for that discussion.
COFFEY, Q.C.:
Q. On Wednesdays?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And on Tuesdays?
DR. EJECKAM:
A. Tuesdays would be residents and the pathologists at Health Science. They have their own conference. All residents rotate through that too.
COFFEY, Q.C.:
Q. So Tuesdays, the conferences would be with the pathology residents and the local General Hospital pathologists?

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DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Kind of get together and look at particular cases and people would present difficult cases and so on, and discuss things?
DR. EJECKAM:
A. Right.
COFFEY, Q.C.:
Q. Okay, and on Wednesdays though, there were lymphoma rounds?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And that involved the pathologists from St. Clare's coming over as well?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And the General Hospital pathologists?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And as well then, just looking at this, which of these stains are lymphoma related stains?

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DR. EJECKAM:
A. Pardon?
COFFEY, Q.C.:
Q. Which of these are lymphoma related?
DR. EJECKAM:
A. The CD 3, CD 5, CD 20, CD 79a.
COFFEY, Q.C.:
Q. They're lymphomas, or they're lymphoma related stains?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And they are utilized to do what in relation to lymphoma?
DR. EJECKAM:
A. To classify lymphomas.
COFFEY, Q.C.:
Q. Okay.
DR. EJECKAM:
A. Whether it's a B cell lymphoma or T cell lymphoma.
COFFEY, Q.C.:
Q. Which you gave an example of earlier.
DR. EJECKAM:
A. Yes.

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COFFEY, Q.C.:
Q. Then there's a--I believe it's--well, it's CKHMW-34BE12, but I gather it's CK34 is?
DR. EJECKAM:
A. Yeah, that's (unintelligible), that's what that means.
COFFEY, Q.C.:
Q. Yes.
DR. EJECKAM:
A. CK (unintelligible) attach beta 12. This was used for prostate cancer.
COFFEY, Q.C.:
Q. And is that referred to in any shorthand way, CK--is that called CK34 in shorthand or is that--do you always spell it all the way out when you're referring to that particular -
DR. EJECKAM:
A. Yeah, the way we write in the laboratory, just 34 Beta 12
COFFEY, Q.C.:
Q. 34 Beta 12?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.:
Q. Okay. When in the discussions on Tuesdays and

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Wednesdays did the problem with that come up?
DR. EJECKAM:
A. The same process that were in Tuesdays when we review cases, we will have biopsies that people will bring in to get second opinion or to show the residents and then this stain would be helpful because what happens with this stain, like I explained initially the cancer cell--cancer glands in prostate are not curtailed by external cells. In the normal gland, you have the normal inner layer; they have the outer layer. That's normal prostate gland. This antibody will stain the outer layer of the normal gland. So if it's malignant, it's going to be absent.
So if you now have a few glands, normally three or four glands that you see in a corner and you are not 100 percent sure whether it is malignant or not, that's when you request for this stain. Now if it's--if it comes out okay and if it's negative, then that gives you an additional factor to say this is malignant. If it is positive, then that will tell you no, this is a benign gland. That's where we used it.

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COFFEY, Q.C.:
Q. And at the time perceived to be potential problems with the CK Beta--I'm sorry, 34 Beta 12, was that--the fact that there was such a problem or potential problem existing with that, was that your conclusion, your own personal conclusion?
DR. EJECKAM:
A. Not my personal, this was the consensus because other pathologists will do this, will request the same stain, okay, and then if they couldn't be sure that it was positive or negative, it wasn't then helpful.
COFFEY, Q.C.:
Q. And with respect to the four lymphoma stains that are listed here, was it--again, was that a consensus opinion?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. There was a problem with those stains?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. The CEA stain is for -

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DR. EJECKAM:
A. That is carcino embryonic antigen. This is also an antigen that's present in colon cancers, stomach cancer. You can also find it in other primary sites. So the stain has to be right. So it helps us to determine the presence of tumor from a particular site.
COFFEY, Q.C.:
Q. And so this again was identified, I take it, in relation to probably the Tuesday meetings?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And again, was that a consensus view?
DR. EJECKAM:
A. Yes, that's my understanding.
COFFEY, Q.C.:
Q. And the ER and PR, both the ER and PR, which are two different stains?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Okay. Relate to breast cancer, I take it, primarily?
DR. EJECKAM:

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

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

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

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it?
DR. EJECKAM:
A. There was no position to be taking care of it.
COFFEY, Q.C.:
Q. Yes, okay, so you offered to get involved and you saw--you encountered no resistance to that? Everybody was there, you understood agreed?
DR. EJECKAM:
A. Right.
COFFEY, Q.C.:
Q. There was no one that voiced any objections to you -
DR. EJECKAM:
A. No, no.
COFFEY, Q.C.:
Q. - getting involved? Did your colleagues, do you think--did you ever tell them about or explain to them the fact that you had had--you did have some experience with IHC?
DR. EJECKAM:
A. Well, I didn't think I needed to explain that to them because it was obvious during our meetings that I showed some interest and showed some degree of knowledge of what was

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going on, so you know, they decided that well, if you have this interest, why don't you look at this much more closely. That's my view. That's what I thought.

COFFEY, Q.C.:

Q. Oh yes, and that's again what I'm asking you for, in terms of that. So you're advising everybody to whom this memo is directed that "staining with these antibodies will stop forthwith until we can solve the reliability, sensitivity and specifity problems." Can you explain to the Commissioner what reliability problem? What are you talking about there?

DR. EJECKAM:

A. Well, I give an example, Commissioner, like the prostate one. If I have a benign gland that I can identify--mind you, immunohistochemistry is a secondary thing. You must look at initial hematoxylin and eosin slide and make a judgment. You are looking at this to help you to get across the line. So if I have a benign gland, I know that in a benign gland, the stain should be positive and then I do the stain and I find that benign glands are not picking up the stain, then it's

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unreliable because it's supposed to be positive and then maybe today--and I use that benign gland as a control. Tomorrow it will stain positive, next day may not stain. So it's not showing what it's supposed to show and that's what I mean by unreliable.

COFFEY, Q.C.:

Q. Sensitivity problem, what are you--because you do differentiate between reliability, sensitivity and specifity.

DR. EJECKAM:

A. Yeah, well -

COFFEY, Q.C.:

Q. So sensitivity in this context means what?

DR. EJECKAM:

A. Then it's supposed to be, in this context, in terms of prostate, supposed to stain prostate outside cells on the gland, outer layer. Now if, in that case, you find it staining other things, a number of other things, then it becomes a problem. Mind you, if you look at the literature, this antibody may stain other things, but in the context of evaluating a prostate section, then that's where we have to consider whether it is sensitive or not.

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COFFEY, Q.C.:

Q. Specifity problems?

DR. EJECKAM:

A. Well the same way that it stains only that particular antigen that raised the antibody, because if it's now staining other things, then it's not very specific because it could stain other stuff.

COFFEY, Q.C.:

Q. Doctor, you go on to say "efforts are under way, and hopefully a solution will be found within the next four to six weeks. You will be duly informed when such stains can resume."

Now Doctor, at the time you decided to do this, would all of the pathologists who had attended these--I'll back up a bit. Who knew that you were sending out this memo?

DR. EJECKAM:

A. You mean before it was sent?

COFFEY, Q.C.:

Q. Yes. Was anybody aware that you were going to do this? "I'm actually going to write a memo."

DR. EJECKAM:

A. No. Well, definitely during the discussion,

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we sort of agreed that the best thing to stop doing them until we are able to come up with something better.

COFFEY, Q.C.:

Q. And whom, if anyone, did you report to to tell them that "I'm going to stop the staining on these eight stains"? Did you tell Dr. Williams, for example?

DR. EJECKAM:

A. Bob Williams?

COFFEY, Q.C.:

Q. Yes.

DR. EJECKAM:

A. I didn't need to tell him. I mean, this is laboratory issue. He didn't need to know about it.

COFFEY, Q.C.:

Q. Within the laboratory, who had to know?

DR. EJECKAM:

A. This was sent to all the pathologists, so including site chiefs, clinical chiefs and all my colleagues.

COFFEY, Q.C.:

Q. During the intervening period, during what you then anticipated to be the next four to six

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

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So there was no question of saying somebody had cancer when he didn't have or something like that.
Then for this lymphoma group who had another test, flow cytometry, which was done by one of the pathologists, so if this didn't work, flow cytometry usually will work, and then you know, again, diagnosis would be given. And of course, for the other, the rest of them, the ER/PR, if it didn't work, then we didn't report anything -
COFFEY, Q.C.:
Q. If the stain -
DR. EJECKAM:
A. If the stain didn't work out the way it's supposed to work or that, you know, you couldn't interpret it, if we didn't have--it was only four to six weeks, you send it out. So there was again, no danger to anybody, in terms of this stoppage.
COFFEY, Q.C.:
Q. During the four to six-week period?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:

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Q. But in any case, there'd be no report, no slides, for example, ER/PR slides produced during that four to six-week period?
DR. EJECKAM:
A. We were (unintelligible) for diagnostic purposes, no.
COFFEY, Q.C.:
Q. No, for--and you were telling everybody in the meantime, the next four to six weeks, we will not be processing ER/PR -
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. - new cases?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And presumably the pathologists would make their own decisions then about whether they wanted to go to Halifax or wherever?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Okay, and you understood that would happen?
DR. EJECKAM:

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

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origin (phonetic) by good antigen retrieval. So, what we do was to change to titration with, say, I think we use three or four different times. We heat this tissue, ten minutes, 20 minutes, 30 minutes, in this order. We are trying to see which of the time give the best reaction. And when we are satisfied that we picked a particular time, which I can't remember right now, but give the best reaction and was producible (phonetic) then we now say that this resume.

COFFEY, Q.C.

Q. Do you recall -

DR. EJECKAM:

A. And the same thing was done with the rest of the antibodies.

COFFEY, Q.C.

Q. Okay. Now, which antibodies did you deal with first?

DR. EJECKAM:

A. ER/PR.

COFFEY, Q.C.

Q. ER/PR was the first one.

DR. EJECKAM:

A. Yeah.

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COFFEY, Q.C.

Q. And that would have been in April of '03.

DR. EJECKAM:

A. Pardon?

COFFEY, Q.C.

Q. That would have been in April of '03?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. Okay. So, do you recall who the technologist--was there any particular technologist involved in this?

DR. EJECKAM:

A. I think Mary Butler took most of it. They worked together, but I think Mary Butler did most of it, the titration.

COFFEY, Q.C.

Q. And do you recall whether or not DAKO was involved or DAKO's representatives were involved in any way?

DR. EJECKAM:

A. Not with this; I didn't involve them. If they came into the lab in my absence, I -

COFFEY, Q.C.

Q. Not so much came into the lab as communicated

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with them about the fact that the problems existed.

DR. EJECKAM:

A. I didn't invite them and I don't know that they came, but if they discussed with the techs, because they could call them on the phone if there's a problem. So, if they communicated with them, I have no knowledge of it.

COFFEY, Q.C.

Q. Okay. And there is, we're going to see a fax that, at least a fax anyway between a DAKO representative and some of the technologists and I believe Mr. Dyer. But if that happened, you weren't involved in that?

DR. EJECKAM:

A. No, they didn't let me know that.

COFFEY, Q.C.

Q. All right. So, your involvement--so, I take it you knew--and I'll just concentrate first of all on the ER and PR. To go about addressing the concerns, you first of all addressed what?

DR. EJECKAM:

A. I said ER/PR.

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COFFEY, Q.C.

Q. Yes, ER/PR, no, no, but what about ER for example. I'll just use ER, was it the time, the amount of time -

DR. EJECKAM:

A. Yeah, time of--first, get credible controls and then we looked at the timing of antigen retrieval.

COFFEY, Q.C.

Q. Okay.

DR. EJECKAM:

A. And there was--I think we--it was to change the dilutions of the secondary or primary antibodies.

COFFEY, Q.C.

Q. Yes, okay. So, it was the controls first and foremost because--the purpose of that is what? What's the importance of that?

DR. EJECKAM:

A. Well, I mean we need to have a credible control because if we cannot say that this is the positive control, then how can we now interpret this?

COFFEY, Q.C.

Q. Yes.

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DR. EJECKAM:
A. So, it was necessary to have a case that was positive as control and then, of course, we know that you can use tissue that are not breast as negative control.
COFFEY, Q.C.
Q. And so you would be looking to, first of all identify a good positive control tissue.
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.
Q. You would also utilize non breast tissue for, suitable non breast tissue for negative control.
DR. EJECKAM:
A. You could do that or you can use breast, but omits (phonetic) the primary antibodies.
COFFEY, Q.C.
Q. Okay.
DR. EJECKAM:
A. Because if you don't put the primary antibodies as explained, then the secondary will have nothing to latch onto. So, nothing will show.
COFFEY, Q.C.

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Q. Sure. And so you would address your minds to the controls first, positive and negative. You then looked at the antigen retrieval time.
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.
Q. Varying that, you experimented with that, I take it, varying amounts of time and would use a particular period of time, as an example, like eight minutes or so.
DR. EJECKAM:
A. Yeah, yeah.
COFFEY, Q.C.
Q. And see what that looked like on a slide.
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.
Q. And then you perhaps, at ten minutes and see what that looked like that.
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.
Q. And maybe six and got to go back and forth until you got, from your perspective, the best?

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DR. EJECKAM:
A. Yes.
COFFEY, Q.C.
Q. Okay. As well, the dilution?
DR. EJECKAM:
A. Yeah, I think we changed that dilution so either primary or secondary antibody, but I don't remember which right now, but one of the dilutions was changed to see because sometimes if it is too diluted or over-concentrated, you may have problem with that. So, have to titrate that.
COFFEY, Q.C.
Q. And again, this was done in a systematic way, I take it -
DR. EJECKAM:
A. Yes, yes.
COFFEY, Q.C.
Q. - in terms of you go about it--and it was under whose direction? Was it your direction? Your -
DR. EJECKAM:
A. Yes, I will discuss with them and write down what dilution would try and what time would try.

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COFFEY, Q.C.
Q. And the actual work then, in terms of utilizing, doing the heating, doing that dilution -
DR. EJECKAM:
A. That done by the technologists.
COFFEY, Q.C.
Q. The technologists would do that, they'd follow--your understand was that they would follow your instructions and -
DR. EJECKAM:
A. I believe they did.
COFFEY, Q.C.
Q. And this process then in terms of ER/PR went on for approximately how long?
DR. EJECKAM:
A. I can't tell you that, but it took most of the time within the first six weeks because within that period, I was happy that we had something that was credible, could go back to doing the stain.
COFFEY, Q.C.
Q. Now Doctor, we do have written record for the ER/PR because we'll see it subsequently, but the other six stains that are listed here in

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this memo, you've told the Commissioner that they also go dealt within, I take it, in due course.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. Okay. Was the same process followed for them?

DR. EJECKAM:

A. Yes, but not--mainly for antigen retrieval, we didn't change the dilutions on those ones and that was also okay.

COFFEY, Q.C.

Q. And how were people notified that the other six stains were re-instituted, do you recall?

DR. EJECKAM:

A. What? Putting them back into use?

COFFEY, Q.C.

Q. Yes.

DR. EJECKAM:

A. I mean, I did mention these at the conference, I don't think I put these in the second memo, but the ER/PR, was definitely a memo to cover that because of the nature of it. But the other ones, during a conference again will show the slides, showing that everything was

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okay and so, you know, we resume then.

COFFEY, Q.C.

Q. Okay. So, these conferences, you're able to bring out, kind of, your brand new, most recently produced slides as a result of this -

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.

Q. - effort you--and be able, in effect, show them off.

DR. EJECKAM:

A. Yeah, yeah, I would say that, yes.

COFFEY, Q.C.

Q. Okay. Doctor, at the time, from your perspective as a pathologist, your knowledge of IHC, how did you feel about the quality of the slides that you were producing, the lab was producing in the beginning of May of '03, after your effort?

DR. EJECKAM:

A. After we rectified the problem?

COFFEY, Q.C.

Q. Yes.

DR. EJECKAM:

A. I was satisfied with it. It was as good as

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anywhere else.

COFFEY, Q.C.

Q. If we could, please, I want to go to page two, Doctor of the--I'll just go ahead there. Now, this is a memo dated May 2, 2003 again, it's on Health Care Corporation of St. John's letterhead, this one to pathologists of the Health Sciences Centre, St. Clare's and out of town hospitals from yourself. That, I take it, is your initial?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.

Q. The subject is ER/PR immunohistochemical stains. It's dated May 2 of 2003 and it goes on for some three pages with your signature, initials and it's copied to the site chief of the Health Sciences Centre and St. Clare's to Barry Dyer and to all technical staff on immunohistochemistry. So, I take it this is the technologists?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.

Q. Mr. Dyer is their boss, immediate boss.

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DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. And the site chiefs were Doctor Parai and -

DR. EJECKAM:

A. Don Cook was -

COFFEY, Q.C.

Q. Don Cook was St. Clare's site chief as well as -

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. Now, you would have had the opportunity to review this before coming here today.

DR. EJECKAM:

A. Yeah, I looked at it.

COFFEY, Q.C.

Q. Doctor, you begin by saying, "I'm glad to inform you that we have rectified the difficulties related to the immunostain or ER/PR. Therefore, we can now resume regular requests for these antibody stains. I will, however, like to bring the following information to your attention". And then you have a list beginning with paragraph one,

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"results of the immunostains may be affected by (a) delayed fixation, (b) over fixation, (c) under fixation, (d) uneven fixation, (e) inadequate tissue dehydration, and (f) tissue reprocessing". Now, you then go on at some length then about that, Doctor. Paragraph two though goes on to note "ER/PR false negative results increase in core biopsies therefore, where possible, restrict request to excision biopsies. Three is check normal breast acini".

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.

Q. Okay, "in your sections as internal controls. This is a second level control, nuclear staining in normal breast tissue is heterogeneous and varies with menstrual cycle". And then you point out, "in carcinoma of the breast, most PR positive tumors are also ER positive", and you go on and explain that further. "Reporting of ER/PR" and you talk about different reporting criteria or cut off points, I'll refer to it as. And then you note that higher staining intensity does not

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reflect better results and you go on and talk about that. And then ER positive tumors, you list a number of them, four of them here and I take it as well that the fifth which would be listed here would be lobular.

DR. EJECKAM:

A. Yes, this an exhaustive list.

COFFEY, Q.C.

Q. Yes, and I appreciate that, Doctor. And number eight you finally note, "low nuclear grade tumors are usually positive for ER/PR and negative for Her2Neu, while high grade tumors tend to be positive for Her2Neu and negative for ER/PR". And you note finally, "we are working on the remaining antibodies and hopefully all normal immunostains will resume soon". Okay?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. Now Doctor, other than the obvious which is to point out to everybody that you've resumed ER/PR testing in St. John's or processing in St. John's, why did you write this memo? Because you could have stopped it right here

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where I've got the cursor right now, which is after the first two sentences. So, why did you continue on?

DR. EJECKAM:

A. I was just simply providing information as a source person at that point, I saw nothing wrong providing information. My colleagues would have probably known this information or if they didn't know, but I think probably they knew that, but it's just information. That's all I provided.

COFFEY, Q.C.

Q. Did you ever write any other memo with similar detail to this to pathologists throughout Newfoundland?

DR. EJECKAM:

A. It wasn't necessary, I didn't do that.

COFFEY, Q.C.

Q. No, you didn't--for example, for the other stains, the other six stains, when you re-instituted those.

DR. EJECKAM:

A. No, I didn't do that because I mean, what I have here covers every other stain, not ER/PR only.

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COFFEY, Q.C.

Q. Yes. And I appreciate it has a wider potential, some aspects of it do have a wide application than just ER/PR, don't they?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. And I'll just deal first of all with the paragraphs one (a) through (f), particularly (a) to (d) is certainly fixation is a concur for all types of stains.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. And "inadequate tissue dehydration", (e) and "tissue reprocessing" as well could apply to, if not all, certainly most other stains.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.

Q. Did anyone else know that you were going to draft and send this memo, this May 2 one?

DR. EJECKAM:

A. Before it was sent?

COFFEY, Q.C.

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

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Q. Now you weren't asking here for any feedback, I appreciate that in your -
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.
Q. Well, I'm just asking you, in terms of that, having taken it upon yourself to prepare it and to send it out, there is no one came back to you, one way or the other, saying great job, Gershon, what are you talking about; or anything like that? There was no feedback one way or the other on this?
DR. EJECKAM:
A. No, not the way you put it.
COFFEY, Q.C.
Q. Well, any other way on this one?
DR. EJECKAM:
A. No, I said that the people were happy, that during the discussion, that we now have stain that work and for me that was some kind of feedback. I wasn't expecting a letter or congratulations from anyone.
COFFEY, Q.C.
Q. Well, Doctor, if we could, please, just on some of this because you have to appreciate,

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

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

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wax before you cut it, you can imperforate, you cannot get a good impregnation and that is going to affect the stain. But this is chemical reaction and if it's not properly processed, then that area will be soft and well, I'll put it--well, not necrose, but it's going to be soggy in a way, you know, (unintelligible) and going to be soggy, and when it's soggy, you can't--the stain will not have paculation of stain and that area may be darker than the stain than what you expect, and then they were thinking it's real, but it's not real because of this problem.

COFFEY, Q.C.:

Q. Okay, and the problem with inadequate tissue dehydration, if that was to--if that is to be addressed, that is addressed where physically? Who has to do that? Is that within the laboratory itself?

DR. EJECKAM:

A. Yeah, laboratory, that would be a thing that any technologist will have to deal with in the tissue processor. So that means that we should be changing the solution in the tissue processor fairly regularly, depending on the

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volume that you put through it. Again, this is something that it will depend on the volume of the tissue that go through it.

COFFEY, Q.C.:

Q. Now the problem, the reference to delayed, over, under and uneven fixation, who or what sort of individual or professional would be expected to deal with those problems?

DR. EJECKAM:

A. Now the delayed fixation will come from the OR.

COFFEY, Q.C.:

Q. OR.

DR. EJECKAM:

A. When they take it and they don't put it in formalin quickly, that may be delayed fixation. Then over fixation, of course, if it is already in formalin and left in the laboratory for a long time. Now like I said, the optimal period we said 18 to 24 hours. Now there are information in the literature saying that you can fix for six hours, seven hours and still get a good result. So it's a question of the experimentation is going on and to shorten this time, so it depends on how

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much effort you put in it and which laboratory you are in. But generally speaking, most people will tell you that optimal period of fixation will be 18 to 24 hours.

COFFEY, Q.C.:

Q. And so that's over and under. Uneven fixation is a problem, who would have to attend to that?

DR. EJECKAM:

A. If you put in an big tissue in formalin in a container, some areas will fix, some areas will not fix, so that's why he needs to cut clean section and then immerse the tissue completely in formalin.

COFFEY, Q.C.:

Q. You do go on to point out "The optimum fixation time for immunostains is 18 to 24 hours."

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Now, you knew that at the time, why, where would get that figure?

DR. EJECKAM:

A. In the literature.

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COFFEY, Q.C.:

Q. And was that literature readily available to pathologists?

DR. EJECKAM:

A. I believe so.

COFFEY, Q.C.:

Q. Now, you've underlined "In 10 percent neutral buffered formalin." Why is that?

DR. EJECKAM:

A. Well, that is the usual--you see 10 percent formalin is what we use for fixation. Some people may use alcohol and alcohol fixation will destroy the antigen. And there are other fixatives, so I just wanted to highlight the fixative of first choice.

COFFEY, Q.C.:

Q. You say, "It is advisable to maintain a regular check on the pH of the buffered formalin even if it is procured commercially. Regular check and change of grades of alcohol in the tissue processor will eliminate inadequate tissue dehydration." You spoke to us about that. Why did you feel it necessary to refer to a regular check of the pH of buffered formalin, even commercial?

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Commercially procured should be checked. Why would you have to point that out?

DR. EJECKAM:

A. Well, it is again offering information that may be of practical use, of practical importance. If you buy a gallon of radiant and leave it on the desk where it's supposed to be in the open lab and if it has not been used up, there's a possibility if it's been there for quite awhile that the pH may change, so it's necessary to monitor those.

COFFEY, Q.C.:

Q. And what can be the possible effect of that be, if the pH is not being monitored and maintained properly, what's the down side?

DR. EJECKAM:

A. Yeah, fixation capability of the formalin.

COFFEY, Q.C.:

Q. It'll lessen, I take it?

DR. EJECKAM:

A. Yeah, it would lessen, yeah.

COFFEY, Q.C.:

Q. Now, there's a reference there to tissue reprocessing, what is that?

DR. EJECKAM:

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

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COFFEY, Q.C.:

Q. So tissue reprocessing in terms of immunostains -

DR. EJECKAM:

A. But in immuno, you're going to create problem -

COFFEY, Q.C.:

Q. Immuno, yes.

DR. EJECKAM:

A. But generally speaking, it causes interpretative problem when you do that.

COFFEY, Q.C.:

Q. It's something, if possible, to be avoided?

DR. EJECKAM:

A. Yes. It's not done very commonly, actually. This again is information from literature, but in most laboratories they don't do any more reprocessing because poor (unintelligible) if you have good solution and everything, you don't have to run into that kind of trouble.

COFFEY, Q.C.:

Q. Now, how much tissue reprocessing did you observe as going on at the General Hospital?

DR. EJECKAM:

A. None. None?

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COFFEY, Q.C.:

Q. Oh, one word, none, okay. Do you know if there was any going on elsewhere, like, for example, at St. Clare's?

DR. EJECKAM:

A. No, I have no information to that, but I don't believe they were doing it.

COFFEY, Q.C.:

Q. Sir, in terms of the slides, because I take it having made this fairly lengthy reference to fixation and related matters here on this first page, was there anything that you'd seen that caused you to believe that fixation was a problem at the time, in 2003?

DR. EJECKAM:

A. No. This memo was simply to provide information to my colleagues. It wasn't based on any findings of any stains.

COFFEY, Q.C.:

Q. Now, up to this point in time, which would be, well, April and May of '03, in terms of ER and PR slides, okay, you would have had occassion to read whose ER and PR slides, what sorts of patients? Would you just read your own patients' slides?

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DR. EJECKAM:
A. I would look at my own.
COFFEY, Q.C.:
Q. Yes.
DR. EJECKAM:
A. And then I would look at the--during the time we were trying to optimize the stain, I would look at it with a technologist before they pass them on, especially those that came in from outside of St. John's. But you have to send the slides back to the pathologist, so I would look at it with them to satisfy that it is a good stain before they send them out.
COFFEY, Q.C.:
Q. And when was that occuring?
DR. EJECKAM:
A. Within the--it wasn't a particular period, but during--it was a process that was going on.
COFFEY, Q.C.:
Q. This is during April and May, I take it?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. For ER/PR?
DR. EJECKAM:

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A. Yeah.
COFFEY, Q.C.:
Q. Okay. So after that did you have occassion to review ER and PR slides for pathologists from outside St. John's?
DR. EJECKAM:
A. The word "review", I mean, I didn't have to. Just if--after the staining, I would look at it with the technologist to satisfy that it's okay. I wasn't reviewing to make any report.
COFFEY, Q.C.:
Q. Yeah, and it's -
DR. EJECKAM:
A. If it was technically okay, then I would ask them to send it on.
COFFEY, Q.C.:
Q. How long did that continue for in terms of ER and PR slides that you would -
DR. EJECKAM:
A. It continued, that continued until we stopped doing it. It was--a (unintelligible) would come into my room with it, I would look at it. It wasn't a formal type of thing, they will bring sections of stain to my room to look at and I would look at it and say that's fine,

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then they will go ahead and send them out.
COFFEY, Q.C.:
Q. Was there any procedure in place that they-- requiring them to come, requiring them to come to you with all ER and PR slides?
DR. EJECKAM:
A. I don't remember it was mandatory for them to do, but they knew that they needed to show them to me before they go out. The in-house pathologists would look at theirs and it's not a problem there, they needed to consult me, they would come to me, but there was probably no need for it. But since we were sending the slides out to people outside St. John's and they are not here physically, I thought that was necessary to look at the section before they go.
COFFEY, Q.C.:
Q. So what would you be looking for in relation to the ER and PR slides?
DR. EJECKAM:
A. The controls.
COFFEY, Q.C.:
Q. So what type of controls?
DR. EJECKAM:

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A. If I'm doing internal controls and external controls, internal controls that mean when I say look at asini, the asini in normal breasts will stain positively and if the stain was done and it's negative, then it has to be repeated before we send it out. It has to be positive.
COFFEY, Q.C.:
Q. So and would you look at the external controls too?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Okay. To make sure that they were staining positive, external positive controls -
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. - were staining positive? Was the fact that you had looked at those, was that recorded in any way?
DR. EJECKAM:
A. No, we didn't keep logbook about any of those.
COFFEY, Q.C.:
Q. And in terms of the ER and PR slides for the

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local pathologists, say at the St. Clare's and the General Hospital pathologists, ER/PR and slides, would you be asked by the technologists to review them?

DR. EJECKAM:

A. Not really. You know, it was mainly the ones going out.

COFFEY, Q.C.:

Q. Out. Anything that was going out of town?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. You'd have a look at. And that would involve Mary Butler and Ken Green?

DR. EJECKAM:

A. And when Les joined -

COFFEY, Q.C.:

Q. And when Les joined?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Les would, as well. If we could, please, the ER/PR false negative results at paragraph 2, "Increase in core biopsies, therefore, were possible, restricting ER/PR requests to

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excision biopsies." Could you explain that to the Commissioner generally what that was about?

DR. EJECKAM:

A. Commissioner, the core biopsy is obtained by needle approach. And sometimes the needle goes through the tumor and obtains good volume of tumor. Sometimes it may glance through a fibrous tissue and then it doesn't obtain enough cells and they may obtain only fibrous tissue or necrotic tissue. Or they may obtain some tumor cells that may biologically be negative. So if you did the stain and find that you don't have so much of tumor volume and those tumor cells that you've done show negative, then you report it as negative, in actual fact the bulk of the tumor, if you excised it, may show positivity. So unless it is imperative--have, I've seen publications now where people are saying core biopsy no problem, (unintelligible) no problem, but at this time we know this can happen, you know, the person who is taking it and how much volume of the tumor that was obtained and this tumor may have estrogen 80 when it comes out.

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So it may just look negative and then the positive ones are back in the patient.

COFFEY, Q.C.:

Q. So I take it the overall idea then was the more tumor tissue, the better?

DR. EJECKAM:

A. Yes, the variety -

COFFEY, Q.C.:

Q. From your perspective?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. To be able to analyze it?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Okay. Paragraph 3 refers to, you pointed out, internal controls, normal breast acini. Now, this usage of internal controls in relation to ER/PR, which is what this is about, isn't it?

DR. EJECKAM:

A. Yes, yes, yes.

COFFEY, Q.C.:

Q. How long had you known about this, the idea of using internal controls for ER/PR?

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DR. EJECKAM:

A. I don't know the time, but if you do immunohistochemistry of breasts, then it's important that you recognize that quite early. Now, we did that in Doha, so you know, it wasn't something I recognized here.

COFFEY, Q.C.:

Q. No. So this, you knew this back in the '90s in Doha?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. That would be when your laboratory was involved in this?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. You were aware of it. How did you become aware of the necessity to have internal controls?

DR. EJECKAM:

A. Well, I mean, if you--again, when you choose the block, that's why when you get several sections on the HNE, then you look at it first before you choose the block that will work for

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immunohistochemistry. In the process, part of it is that you choose a good block, and what makes a good block is that that section should contain tumor and no more tissue.

COFFEY, Q.C.:

Q. Yeah, and I appreciate that, Doctor. But you learned that when, yourself?

DR. EJECKAM:

A. Again, before I came here, I mean, we were doing this as routine, so we knew that it wasn't something new for anybody taking section of a breast biopsy, I mean, breast sections for immunohistochemistry.

COFFEY, Q.C.:

Q. So from your perspective, back in the 1990s in Doha that as anybody doing ER/PR tests, any pathologists picking a block for that would know to be aware to pick the block with normal tissue, normal breast, asini, in the block and look for the staining or non-staining of the internal controls back in the '90s?

DR. EJECKAM:

A. I wouldn't say any pathologist. The way I look at it that if you are doing immunohistochemistry -

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COFFEY, Q.C.:

Q. If you're going to order -

DR. EJECKAM:

A. If you are working with immunohistochemistry, then you needed to know this.

COFFEY, Q.C.:

Q. Yes.

DR. EJECKAM:

A. But a pathologist who doesn't work with it, then you see the sample, they simply look at a section and give you a section that contains a lot of tumor and believe that you probably would have the external control. But if your formalin is not control, but on a different slide may not affect what is in the tumor bad, so the best thing is to have a second level of control and that really is more critical for me, that even if the slide control is okay, and internal control contained in a slide negative then that doesn't go because there's something wrong there. That's more critical in evaluating the controls than the external one.

COFFEY, Q.C.:

Q. So from your perspective--I'm sorry, go ahead, Commissioner.

COMMISSIONER:

Q. I want to make sure I understand how many levels of control there are. There's an external control?

DR. EJECKAM:

A. Yes. Yes, that's true, Commissioner.

COMMISSIONER:

Q. And the slide you would have a piece of material which you would choose as having been tumor?

DR. EJECKAM:

A. Yes.

COMMISSIONER:

Q. And you would have a piece of normal tissue taken from that same block?

DR. EJECKAM:

A. No. It is one section.

COMMISSIONER:

Q. Um-hm.

DR. EJECKAM:

A. When you taken the section of the tumor, maybe two millimetre, when you section it, you should (unintelligible) that tumor with normal tissue both ways.

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THE COMMISSIONER:

Q. So, you have the piece of material, for want of a better word, that you are looking at, you are confident has on it both normal and -

DR. EJECKAM:

A. Tumor.

COMMISSIONER:

Q. - normal material?

DR. EJECKAM:

A. Yes.

COMMISSIONER:

Q. And material which you're trying to determine whether or not it is malignant?

DR. EJECKAM:

A. Well, no, I would have notice malignant before doing immunohistochemistry.

COMMISSIONER:

Q. Okay, all right.

DR. EJECKAM:

A. You look at HNE and that tell me it's malignant.

COMMISSIONER:

Q. Okay. So you have something you know is malignant?

DR. EJECKAM:

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A. Yes.
COMMISSIONER:
Q. Just looking at--you're right, yes, I wasn't thinking. And you have attached to it normal material?
DR. EJECKAM:
A. Yes.
COMMISSIONER:
Q. And in addition you have on that same slide something that you know should stain positive, correct?
DR. EJECKAM:
A. Yes, yes.
COMMISSIONER:
Q. And you also have one that you know should stain negative?
DR. EJECKAM:
A. Yes. But not all of them on the same slide. I introduced having the positive control on the same test slide. Initially we used to have two slides, one is the diagnostic slide.
COMMISSIONER:
Q. Yes.
DR. EJECKAM:
A. The patient slide. Then on the second slide

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is the control. That is fine, but I found that over a period in Doha, you may get a better handle of the control by having both sections on the same slide, so it's that one slide goes through the same process.
COMMISSIONER:
Q. Um-hm.
DR. EJECKAM:
A. Then you're much more confident that they are under--they went through under same conditions. So what we are doing now is to put the piece of tumor within that tumor and the size of it to contain normal tissue.
COMMISSIONER:
Q. Um-hm.
DR. EJECKAM:
A. That is the diagnosive tissue. Then few millimetres away there's another breast tissue that is positive, we already know is positive for whatever we're trying to check out, then that would be--so when we put it under microscope, you go through to the (unintelligible) control is not on the section of the tumor, look at it, then you go back to the tumor and look for the internal control.

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Then when you have--when you've satisfied yourself that internal control is okay and that the slide is okay, then that's when you should go assessing the tumor for positivity or negativity.
COMMISSIONER:
Q. Okay. So you have external control, you have--which would be outside of the slide and within the slide you have -
DR. EJECKAM:
A. Not outside the slide. Outside of the diagnosive tissue.
COMMISSIONER:
Q. External control?
DR. EJECKAM:
A. Yeah. Let me put it this way.
COFFEY, Q.C.:
Q. Sure.
DR. EJECKAM:
A. If that is slide.
COMMISSIONER:
Q. Yeah.
DR. EJECKAM:
A. Then you go from there to there. And I would put the diagnosive tissue here.

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COMMISSIONER:
Q. Um-hm.
DR. EJECKAM:
A. It has tumor and it has normal tissue.
COMMISSIONER:
Q. Yeah.
DR. EJECKAM:
A. Then I put my control here, external control. This is a piece of tissue that I know is positive.
COMMISSIONER:
Q. Okay.
DR. EJECKAM:
A. But they're all on the same slide.
MR. BROWNE:
Q. Commissioner, I think the external control is actually from another case, a known case of -
COMMISSIONER:
Q. I understand that.
MR. BROWNE:
Q. Okay.
COMMISSIONER:
Q. I'm just trying to figure out whether I'm dealing with three controls or two controls.
DR. EJECKAM:

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A. Two controls, just two controls. The slide is there and that's the diagnosive tissue, the tumor is there, and then this is normal (unintelligible) -
COMMISSIONER:
Q. Yes, and that's -
DR. EJECKAM:
A. Then that -
COMMISSIONER:
Q. - what you call the secondary control, is it?
DR. EJECKAM:
A. Yeah, this is secondary control or internal control.
THE COMMISSIONER:
Q. Yeah.
DR. EJECKAM:
A. Then this is the external control.
THE COMMISSIONER:
Q. Yes.
DR. EJECKAM:
A. Which is not in this tissue, but on the same slide.
THE COMMISSIONER:
Q. Okay.
DR. EJECKAM:

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A. Then I know this is positive.
THE COMMISSIONER:
Q. Yes, I understand that.
DR. EJECKAM:
A. That if I need a negative control, I'll do the same thing, then I will put either on the same known positive case, then I will do one of two things, I will mix the primary antibody.
THE COMMISSIONER:
Q. Okay.
DR. EJECKAM:
A. But see if I do that, there'll be no reaction or I will just take stain or something that I know is -
THE COMMISSIONER:
Q. Is going to be negative.
DR. EJECKAM:
A. React with ER/PR and put on another slide as a negative control.
THE COMMISSIONER:
Q. And the purpose of doing that is because that is the best way of ensuring that what you're looking at is your controls -
DR. EJECKAM:
A. Yes.

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THE COMMISSIONER:
Q. Went through exactly the same process as the tissue that you are trying to determine whether or not is positive or negative?
DR. EJECKAM:
A. Yes, Commissioner.
THE COMMISSIONER:
Q. Thank you.
COFFEY, Q.C.:
Q. And the purpose and the importance of that internal control is what, from your perspective, you know, as a physician?
DR. EJECKAM:
A. I think it is more critical for me than the external because it's within the tumor itself and if it's negative, then it is difficult to interpret what is being stained on the tumor, so I think it's a critical portion of this evaluation.
COFFEY, Q.C.:
Q. And you've known that for many years, I take it, long before you came to St. John's?
DR. EJECKAM:
A. Yes, yes.
COFFEY, Q.C.:

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

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the pathologists throughout Newfoundland know that internal controls, usage of them in this context was a good idea?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And was that information, other than being in your memo here, was that readily ascertainable from the literature?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And had it been so for awhile?

DR. EJECKAM:

A. I don't know what they got in the books, but most immunohistochemistry literature textbooks or those who do recite on this subject will recognize this.

COFFEY, Q.C.:

Q. Okay, and Doctor, if I could move on, you then talked about the relative positivity of PR and ER for different or certain types of tumors or certain--well you do point out, I'm sorry, that carcinoma of the breast, most PR positive tumors are also ER positive, however ten

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percent of PR positive tumors are ER negative. Those figures, that ten percent figure, you would have gotten that from where at the time?

DR. EJECKAM:

A. Literature.

COFFEY, Q.C.:

Q. At the time.

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Then the reporting, Doctor, and you do then, you say for several formula are in the literature, what was your purpose in having this here, because the different categories for positive results, you've got ER positive greater or equal to five percent nuclear staining, ten percent of tumor staining, one percent shown to benefit. Why would you point out the three of them and give this consensus statement?

DR. EJECKAM:

A. My intention here was, like I said from the beginning, to provide information to my colleagues. They may have known this, so probably wouldn't be necessary for them, but I

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didn't know who knew that or who didn't know.

COFFEY, Q.C.:

Q. And you got this information from where?

DR. EJECKAM:

A. From the literature, Babb's.

COFFEY, Q.C.:

Q. Could you spell that please?

DR. EJECKAM:

A. B-A-B-B-S.

COFFEY, Q.C.:

Q. Thank you. And then you point out that "higher staining intensity does not reflect better results and this is a function of staining procedure and may alter all cytoplasmic staining in ER and PR immunostain are to be considered as negative." I take it that's particular to ER and PR?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Or one of the things that's -

DR. EJECKAM:

A. The nucleus stain.

COFFEY, Q.C.:

Q. And you were alerting people to this for

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informational purposes.

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. The idea that "higher staining intensity does not reflect better results", what were you cautioning against there, Doctor?

DR. EJECKAM:

A. All the immunohistochemistry for breasts, you find a differentiates of positivity, so sometimes you have very dark nucleus, then sometimes brown, sometimes faint and maybe if you're not familiar with this, somebody may be waiting to have very dark stain to call it positive. So my, again, given information that it doesn't have to be that dark and that being dark doesn't mean it's a better stain, all you need to do is to identify nuclear stain, that it crisp, it may be faint and in actual fact, you should not have a uniformed stain, you should have a variation of stain because each of those cells is in a different stage of activity; therefore, they should not have uniformed dark stain. Some may be light, some may be darker.

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COFFEY, Q.C.:
Q. And then on the next page, Doctor, if I could, you list a number of ER positive tumors and you've got four of them there and as well you've pointed out that lobular would be one that would normally be included -
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And in fact, as you've pointed out, this was not meant to be an exhaustive research paper at the time.
DR. EJECKAM:
A. Right, right.
COFFEY, Q.C.:
Q. Why would you be pointing that out to the pathologists, even listing any of them? You've listed four and you could have listed five?
DR. EJECKAM:
A. Well again, is process to give them information because if someone has tubular carcinoma, for instance and the stain is negative, like I say, you will look at HNE, many diagonals of malignancy anyways, this

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doesn't help you to make that judgment and if you see a tubular carcinoma with a low grade malignancy, ought to be positive and then you find it negative, then you show, it really doesn't, not controlled, thereby it probably is time to have a consultation. So this again, process of -
COFFEY, Q.C.:
Q. With a view to doing what, a consultation with a view to doing what?
DR. EJECKAM:
A. To repeat the test, to repeat it. It could, a the end of the day, it may be negative but you have to satisfy yourself that that was a spurious result.
THE COMMISSIONER:
Q. So in the process of doing what pathologists do and assessing the results of your process, you had to think about the particular kind of tumor you're dealing with and the likely result, as well as what you see, is that right?
DR. EJECKAM:
A. Yes, it makes life easier if I know that, my HNE says a tubular carcinoma, or lobular

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carcinoma and I know it ought to be positive and I find a negative, that helps me to say no, there's something going on here, but if I didn't have that information, I may just let it go and say nothing as a result of the test.
THE COMMISSIONER:
Q. Okay.
COFFEY, Q.C.:
Q. And, Doctor, just to finish this particular memo, you've noted in paragraph 8, low grade-- low nuclear grade tumors are usually positive for ER/PR and negative for HER2/neu and you go on about that. I take it was this--why was this here? Was this for the same purpose as your reference in paragraph seven?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Okay.
DR. EJECKAM:
A. Because the information that most of those listed on seven are low grade tumors anyway.
COFFEY, Q.C.:
Q. Doctor, in other places that you've worked, do people keep track of, the lab keep track or

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the pathologist keep track of the ER and PR positivity rates for different types of tumors or just generally within the lab?
DR. EJECKAM:
A. I don't understand the question.
COFFEY, Q.C.:
Q. Okay, and I apologize. In other laboratories where you have worked outside of St. John's -
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Did they keep track of ER and PR positivity rates?
DR. EJECKAM:
A. I wouldn't know that.
COFFEY, Q.C.:
Q. Okay, so if they were doing it, they weren't letting you know.
DR. EJECKAM:
A. They would not send us any feedback on that, we just did the test and sent it to them to evaluate.
COFFEY, Q.C.:
Q. Okay, and that was, I take it in Qatar as well, is what I'm asking you about, in Qatar

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you weren't keeping track of the statistics?
DR. EJECKAM:
A. No, we would keep at the end of it, what our own year, you can then do your statistics, but you don't keep track, I mean, the results are final and if you wanted to get them and do a statistics on them, then you can do that.
COFFEY, Q.C.:
Q. Okay, and you'd do that, I take it, by accessing the computer system and -
DR. EJECKAM:
A. Yeah, and I would get a copy or go to the computer.
COFFEY, Q.C.:
Q. And, Doctor, with respect to the reference in paragraph one here, you referred to over and under fixation, is either of those types of fixation problem more associated with the possibility of a false negative? Is either more apt or likely to give you a false negative if the tissues was -
DR. EJECKAM:
A. Possibly over fixation.
COFFEY, Q.C.:
Q. I'm sorry?

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

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COFFEY, Q.C.:
Q. You were working there, okay. And so in effect I take it you're telling the Commissioner, look, when you did get involved in April of 2003, your experience with the technologists was they were happy to have you there?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. And you say as a reference point, I take it as a person that they could go to and to talk to?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. About any concerns that they would have?
DR. EJECKAM:
A. Yes, that's what happened.
COFFEY, Q.C.:
Q. What--did they give you any understanding about what the state of affairs had been before you got involved in that regard?
DR. EJECKAM:
A. Well really they just said that they didn't have anybody to go to to iron out problems,

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

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signed it, actually your full name this time, and it's copied to Dr. Desmond Robb who is the chair discipline of Laboratory Medicine; Dr. D. Cook, clinical chief and site chief, St. Clare's; Dr. S. Parai, site chief at the Health Sciences Centre and to Barry Dyer, the manager of histopathology. And, Doctor, how is that that you--or why did you come to write this memo?

DR. EJECKAM:

A. I did this because after working with a technologist and trying to get some good stains and I still realized that we don't have an optimal condition and to have optimal condition would be to move the immunohistochemistry into a different room, have dedicated staff and then have a number of them that would need to -

COFFEY, Q.C.:

Q. Are listed here, yes.

DR. EJECKAM:

A. Yeah, so that was the reason. I mean, I was just trying to ensure that we recognize even though we're getting some good stains that this is not optimal and that we need to look

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at the future and look at what we have and work to improve and make sure we have optimal condition.

COFFEY, Q.C.:

Q. By this point, by June 19th 2003, the other six stains that are referred to in your April 4th memo, had the concerns with them been addressed by that point?

DR. EJECKAM:

A. Oh yeah, oh yeah.

COFFEY, Q.C.:

Q. By the time you came to write the June 19th one, the immediate problem of the eight stains was addressed?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Did anyone ask you to write this?

DR. EJECKAM:

A. No.

COFFEY, Q.C.:

Q. Okay. So it was your idea?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

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Q. Having written it, did you ever get any feedback or anybody ever ask you about it? Any response?

DR. EJECKAM:

A. Not in terms of written feedback, but I remember after some days when I didn't get any reply, I ran into Dr. Robb in the corridor and I asked him if he got the letter. He said "yes, I got it, and I think it was a good letter" and that he was going to have a meeting. Unfortunately, he was ill and went off in January for surgery and didn't make it back, and then also the same process with Terry. I saw him in the lab and said "did you get a letter?" He said "yes" and he told me "I'm going to reply to you" and that was the follow up that I had and that was all the response that I got from this.

COFFEY, Q.C.:

Q. So that was--so you spoke to Dr. Robb and as you just pointed out, he was going to get back to you. Dr. Robb unfortunately was ill and got iller and I gather died shortly thereafter.

DR. EJECKAM:

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A. Yeah.

COFFEY, Q.C.:

Q. And you also spoke to Mr. Gulliver?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And he said he expected to act upon it and he would get back to you?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. And that was the last you heard from him about it?

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. Did you ever hear from anybody else about it?

DR. EJECKAM:

A. No. Well, I know--I think Dr. Don Cook may have discussed it, but not written communication.

COFFEY, Q.C.:

Q. Anyone--and I appreciate it's not addressed to the VP Medical, Dr. Williams or anybody else in the administration, did you ever speak to

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

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

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And then--now Doctor, in this first meeting, was there a concern about the reporting format for ER and PR receptors?
DR. EJECKAM:
A. I think it was a discussion about when to do it and then how to report it.
COFFEY, Q.C.:
Q. Okay, so when to do ER/PR?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.:
Q. Order it?
DR. EJECKAM:
A. Yeah.
COFFEY, Q.C.:
Q. And I take it so at that point in time, even as late as April of '03, was the request for ER and PR tests on breast cancer automatic or not at that time?
DR. EJECKAM:
A. I can't be sure of the dates, but I know that normally the pathologists, if you received a breast cancer case, you automatically fill out the request to the laboratory, immunohistochemistry laboratory for ER/PR.

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But occasionally you get a request from the oncologist sometimes, especially patients that have been done elsewhere.
COFFEY, Q.C.:
Q. Oh, okay.
DR. EJECKAM:
A. They would fill out a form and send it to the laboratory.
COFFEY, Q.C.:
Q. So it was agreed then, I take it, at this meeting that ER and PR receptors would be done on all breast surgery cases?
DR. EJECKAM:
A. Yes.
COFFEY, Q.C.:
Q. Pathologists would just do it routinely?
DR. EJECKAM:
A. Yeah, you didn't have to wait for any more requests or anything. Once you have a case of breast cancer, part of the report has to be ER/PR findings.
COFFEY, Q.C.:
Q. The clinical information, "Dr. G. Ejeckam circulated a form listing ten requirements a properly completed specimen requisition form

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should include, and all members agreed those requirements would benefit the clinician and pathologist for improved patient care." So I take it this is the opening in the effort, the long campaign to get people to fill out the forms properly?

DR. EJECKAM:

A. Yeah.

COFFEY, Q.C.:

Q. Okay, and if we could, please, Commissioner, paragraph three, new business, "3.1 ER/PR--and PR receptors. Dr. G. Ejeckam stated that ER and PR receptors are not being performed for the next six weeks due to a technical problem. If a solution cannot be found, these tests will be sent outside St. John's. He stated it is being considered to send one or two technologists to Halifax or Toronto for training." So I take it that as of mid April, this was just a note you were telling everybody at your meeting -

DR. EJECKAM:

A. Yes.

COFFEY, Q.C.:

Q. - what was going on, was in your April 4th

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memo, because some of the people at the meeting are not pathologists?

DR. EJECKAM:

A. Oh yes.

COFFEY, Q.C.:

Q. A number of them aren't, so you have to tell them that. The technologists, by mid April, did you think there was a need for the technologists to have special training?

DR. EJECKAM:

A. Yes, I mean, the people who are doing immunohistochemistry, if there's a chance of possibly to go to a bigger laboratory that has more volume, that would be helpful. It doesn't mean they are not doing good job, but it's good to see what other people are doing.

COFFEY, Q.C.:

Q. So I take it, as you described, is in fact what happened in Qatar? You sent people to Florida?

DR. EJECKAM:

A. Yeah, yeah, I sent to Florida to have a look at a bigger set up.

COFFEY, Q.C.:

Q. Your observation in early 2003 when you began

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to deal with the technologists related to this ER/PR matter initially, what was, from your perspective, their relative state of knowledge concerning immunohistochemistry and in particular, ER/PR, but immunohistochemistry generally? Compared to, for example, Qatar where you had just come--spent more than a dozen years.

DR. EJECKAM:

A. Well, they were doing their stains okay. In this type of process, it's a continual effort to understand the system and to be able to troubleshoot if there's any problem. It requires reading. We are trying to get them books, and I let them borrow my book, but later on, we had to order textbook for them, much later. So you know, they have a reasonable knowledge for what they are doing, but that doesn't mean that they wouldn't benefit from improving their knowledge.

COFFEY, Q.C.:

Q. And in 2003, was there an effort to get them sent to another lab?

DR. EJECKAM:

A. That's when I suggested they could go--I

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discussed it with Don and they could go to either Toronto or Halifax or Montreal, but I don't think they were able to go then for probably budget problem or, I don't know, and the work process. They were probably short staffed, but I don't know the details of that.

COFFEY, Q.C.:

Q. Okay, so at that time anyway, your memory is they didn't get to go then?

DR. EJECKAM:

A. No, no.

COFFEY, Q.C.:

Q. Okay. If we could, tomorrow morning, Commissioner.

THE COMMISSIONER:

Q. Okay.

COFFEY, Q.C.:

Q. Thank you.

THE COMMISSIONER:

Q. We'll adjourn until 9:30 in the morning. Thank you.

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 3rd day of June, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 3rd day of June, A.D., 2008

Judy Moss

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