COMMISSION OF INQUIRY

ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

MAY 14, 2008

Appearances:

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

Rolf Pritchard/Megan Collins . . . . Her Majesty in Right of NL

Peter Browne . . . . Doctors Kara Laing et al

Daniel Simmons/Sarah Learmonth . . . 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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1 COMMISSIONER:
2 Q. Please be seated. Mr. Coffey.
3 COFFEY, Q.C.:
4 Q. Thank you, Commissioner. The next witness is
5 Dr. Robert Williams.
6 COMMISSIONER:
7 Q. Swear in Dr. Williams, please?
8 DR. ROBERT WILLIAMS (SWORN) EXAMINATION-IN-CHIEF BY
9 BERNARD COFFEY, Q.C.
10 REGISTRAR:
11 Q. Would you please state and spell your complete
12 name for the Commissioner?
13 DR. WILLIAMS:
14 A. Robert James Williams. R-O-B-E-R-T, J-A-M-E-
15 S, W-I-L-L-I-A-M-S.
16 REGISTRAR:
17 Q. Thank you.
18 COFFEY, Q.C.:
19 Q. Good morning, Dr. Williams. Dr. Williams,
20 first of all, before we get going, I got to
21 deal with the Registrar and the Commissioner.
22 COMMISSIONER:
23 Q. We're an inconvenience, but you have to deal
24 with us. Now, Mr. Coffey.
25 COFFEY, Q.C.:

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1 Q. Thank you, Commissioner. There are a number
2 of exhibits, Commissioner, I'm going to ask to
3 be entered. I'd ask you to bear with me,
4 please. It's P-0900 through 0904.
5 COMMISSIONER:
6 Q. Um-hm.
7 COFFEY, Q.C.:
8 Q. And then P-0906 through 0911, inclusive; P-
9 0914 through 0917, inclusive; P-0919 through
10 0932; P-0934 through, I believe, 0944,
11 inclusive.
12 COMMISSIONER:
13 Q. Um-hm.
14 COFFEY, Q.C.:
15 Q. P-1280 to 1284, inclusive; P-1286 through
16 1302, inclusive; P-1304 through 1316,
17 inclusive; P-1318 through 1344, inclusive; P-
18 1346; and then P-1348 through 1356, inclusive;
19 P-1358 through 1363, inclusive; P-1365 through
20 1367, inclusive; P-1369 through 1383,
21 inclusive; and P-1385 to 1389, inclusive.
22 COMMISSIONER:
23 Q. Entered.
24 EXHIBITS P-0900 THROUGH P-0904, INCLUSIVE, ENTERED INTO
25 EVIDENCE.

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1 EXHIBITS P-0906 THROUGH P-0911, INCLUSIVE, ENTERED INTO
2 EVIDENCE.
3 EXHIBITS P-0914 THROUGH P-0917, INCLUSIVE, ENTERED INTO
4 EVIDENCE.
5 EXHIBITS P-0919 THROUGH P-0932, INCLUSIVE, ENTERED INTO
6 EVIDENCE.
7 EXHIBITS P-0934 THROUGH P-0944, INCLUSIVE, ENTERED INTO
8 EVIDENCE.
9 EXHIBITS P-1280 THROUGH P-1284, INCLUSIVE, ENTERED INTO
10 EVIDENCE.
11 EXHIBITS P-1286 THROUGH P-1302, INCLUSIVE, ENTERED INTO
12 EVIDENCE.
13 EXHIBITS P-1304 THROUGH P-1316, INCLUSIVE, ENTERED INTO
14 EVIDENCE.
15 EXHIBITS P-1318 THROUGH P-1344, INCLUSIVE, ENTERED INTO
16 EVIDENCE.
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19 EVIDENCE.
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23 EVIDENCE.
24 EXHIBIT P-1369 THROUGH P-1383, INCLUSIVE, ENTERED INTO
25 EVIDENCE.

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1 EXHIBITS P-1385 THROUGH P-1389, INCLUSIVE, ENTERED INTO
2 EVIDENCE.
3 COFFEY, Q.C.:
4 Q. Thank you, Commissioner.
5 COMMISSIONER:
6 Q. Thank you.
7 COFFEY, Q.C.:
8 Q. And that having been done, Dr. Williams, I'm
9 going to ask you to identify a document, okay.
10 It's Exhibit P-1280. And, Doctor -
11 COMMISSIONER:
12 Q. It'll come up on the screen in front of you, I
13 think, Doctor.
14 COFFEY, Q.C.:
15 Q. Yes. There are, as it turns out there's the
16 binder, of course, is there in front of you.
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. That has a paper copy of a number or exhibits,
21 but it will not necessarily include all of
22 them, Doctor, that you may be referred to. As
23 well, of course, it will come up on the screen
24 from time to time, the documents. As well,
25 Doctor, if at any time documents on the screen

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1 and you need to or feel the need to scroll
2 down through it, that little mouse there in
3 front of you, you will actually be able to
4 control through the wheel, okay, going up and
5 down the screen. Doctor, what is this
6 document?
7 DR. WILLIAMS:
8 A. That's my curriculum vitae.
9 COFFEY, Q.C.:
10 Q. And if you could then, please, and if you need
11 that to assist you or otherwise just from
12 memory tell the Commissioner, please, kind of
13 about the--your background, educational
14 background and the background and your
15 professional career, training and your career?
16 DR. WILLIAMS:
17 A. Okay.
18 COFFEY, Q.C.:
19 Q. Go ahead.
20 DR. WILLIAMS:
21 A. Well we get onto my career in medicine rather
22 than just go through everything else. I
23 graduated from Dalhousie University Medical
24 School in 1969 after having completed my
25 internship, so the degree was not awarded

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1 until after the internship at that time.
2 Right now the degree is awarded and then you
3 do your internship after. Then that would
4 have taken place in May, around May of 1969.
5 I received one of the bursaries that the
6 government of the day had in place to try to
7 entice doctors to go to rural parts of the
8 province, so I proceeded then to go to Burin
9 as an assistant medical officer in July of
10 1969, and I occupied that position for two
11 years until July of 1971. At about January or
12 so of 1971 I applied for a surgical residency
13 at the General Hospital and was accepted into
14 that residency because I only needed to do two
15 years in rural practice. But the Department
16 of Health contacted me and offered me the
17 position of senior medical officer in Come By
18 Chance. As I hadn't accepted the residency
19 yet, I accepted that position in 1971 and
20 became senior medical officer in Come By
21 Chance, a position I occupied until 1979. On
22 about 1975 or '74, I'm not sure if it was '74,
23 '75, after five years in medical practice as
24 general practitioner one was able to challenge
25 the College of Family Physicians exam. Right

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1 now you usually have to have a residency of
2 two years, but there was no family practice
3 residency at the time, so I was able to
4 challenge for the examination in family
5 practice. I was awarded the certification of
6 the College of Family Practitioners, I think,
7 in 1974. I don't have it right in front of
8 me, but it would be five years in practice. I
9 stayed as senior medical officer in Come By
10 Chance until the summer of 1979 when I was
11 offered a secondment to the Department of
12 Health as a medical consultant. That was a
13 one-year appointment in a sense that I had the
14 right, ability to go back to Come By Chance
15 back in practice in my old position if I so
16 desired, but I stayed on at the Department of
17 Health. And in 1981 in September I, with the
18 Department of Health support, I went to
19 Harvard University and did a masters in public
20 health from 1981 to 1982. I came back to the
21 Department of Health in 1982 and became the
22 associate deputy minister for medical services
23 and community health--sorry, public health at
24 the time it was called. And then in 1979 the
25 new premier of the day, the Honourable Clyde

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1 Wells, approached me -
2 COFFEY, Q.C.:
3 Q. That would be 1989, I take it?
4 DR. WILLIAMS:
5 A. Sorry, yes, '89.
6 COFFEY, Q.C.:
7 Q. No, no. Because there was another--you went
8 back in '79 -
9 DR. WILLIAMS:
10 A. Yes, I'm back ten years.
11 COFFEY, Q.C.:
12 Q. Okay.
13 DR. WILLIAMS:
14 A. 1989, and invited me to the office and asked
15 me to accept the position of deputy minister
16 of health, which I did and I was deputy
17 minister of health from 1989 to 1998. In 1998
18 the vice president of medical services had
19 resigned from the Health Care Corporation of
20 St. John's and Sister Elizabeth Davis asked me
21 if I was interested in that position. I did
22 apply for the position, I had to apply for it
23 and had an interview for it and I was accepted
24 into that position and I joined the Health
25 Care Corporation of St. John's in May of 1998,

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1 and that position continued. In the fall of
2 2004, I think, government announced their
3 intention to restructure the health system and
4 Mr. George Tilley became the new CEO of a new
5 entity called Eastern Health. I think he
6 accepted that position in January of 2005.
7 When he left the Health Care Corporation of
8 St. John's, he--because there was going to be
9 a time when Eastern Health was trying to get
10 things together before they actually assumed
11 responsibility, so he asked me if I would take
12 over as CEO for the Health Care Corporation of
13 St. John's and also as CEO of the Cancer
14 Foundation because their CEO had left in
15 December, at the end of December, 2004 and as
16 an interim basis he wasn't going to replace
17 that person until Eastern Health came into
18 effect and he was going to look at the new
19 organization structure. So really, starting
20 in January, 2005 until I left the organization
21 in September, 2006, that 21 month period is a
22 real blur because a lot of things were
23 happening in that organization. The former
24 organization, new organizations, and Eastern
25 Health, there was a lot--obviously if you're

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1 bringing together an organization such as
2 Eastern Health, it's a complicated thing to
3 do. The biggest restructuring that had taken
4 place prior to this was in the mid '90s, 1995,
5 to be exact, when the Health Care Corporation
6 of St. John's was formed from seven different
7 organizations. But these seven different
8 organizations were really involved in the same
9 business, acute care services in a defined
10 geographic area in St. John's whereas the new
11 organization, Eastern Health, was much more
12 complex in terms of taking into account
13 community health, long-term care in a big
14 geographic area and with a different focus
15 because the focus was not only on acute care
16 or tertiary level, secondary level services,
17 but on rural health care and primary health
18 care services. So that was, to bring that
19 organization together represented a major
20 challenge. Now, there's two approaches you
21 can take to reorganization. You can take the
22 approach if you're going to do it anyway,
23 let's knock things together fairly quickly, or
24 the other approach is that I think is more
25 valid to use in health care is that health

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1 care is a complex and sensitive area and when
2 you make change, you can often cause problems,
3 so I think a slower approach probably is more
4 relevant, especially when you're bringing
5 together such a big organization as that. So
6 this, everything, and then we had the major
7 issue with the current issue we're dealing
8 with here occurred in May, June of 2005 just
9 as this organization is coming together in May
10 of 2005. There was a little difference in how
11 this was done. In 1995 the Health Care
12 Corporation of St. John's board was appointed
13 around April, 1995 and they had a year to
14 organize themselves, hire their CEO, get their
15 organizational structure together and they
16 assumed responsibility on April 1st, 2006,
17 whereas in this situation, this new entity
18 came together in a much shorter time frame and
19 there wasn't as much time to get the
20 organization together. So we're trying to
21 bring an organization together that's very
22 complex, that's very diverse in terms of its
23 role and responsibilities and in terms of its
24 geography.
25 COFFEY, Q.C.:

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1 Q. Now, sir, if I could in terms of your career,
2 have you ever been away from work while you
3 were working with either the Health Care
4 Corporation of St. John's or Eastern Health
5 for any extended period of time?
6 DR. WILLIAMS:
7 A. Yes, I was.
8 COFFEY, Q.C.:
9 Q. Okay. Could you tell the Commissioner about
10 when that was?
11 DR. WILLIAMS:
12 A. Sure. I only had one sick my live back when I
13 was in Burin. And the next issue I had was in
14 May of 2003 I began to take ill. I was off
15 for three or four days, three days or so, I
16 think.
17 COFFEY, Q.C.:
18 Q. Yes.
19 DR. WILLIAMS:
20 A. I came back to work and seemed to settle away
21 for a few days and then over the next few
22 weeks near the end of May and early June my
23 condition got progressively worse and I was
24 under investigation and my physician, as we
25 were investigating, felt that I should be put

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1 off work. In fact, I wasn't able to work.
2 COFFEY, Q.C.:
3 Q. Do you recall when it was that you were off
4 then in June of -
5 DR. WILLIAMS:
6 A. Yes, I would say around the 7th or 9th of June
7 I was put off work. I expected to be off work
8 for a couple of months based upon the
9 investigations they were doing and the
10 findings at the time, and I really wasn't in
11 any condition to work because of the illness
12 that I had. I was able to come back to work
13 in late August, but I took a week or so or ten
14 days off before I came back because I wanted
15 to--I felt a needed a break at the time, so I
16 didn't return to work until the day after
17 Labour Day.
18 COFFEY, Q.C.:
19 Q. Which would be the beginning of September of
20 2003?
21 DR. WILLIAMS:
22 A. Yes, correct.
23 COFFEY, Q.C.:
24 Q. Okay. And while you were off on sick leave,
25 during what I'll refer to as the summer of

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1 '03.
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Was there anyone replacing you at the time?
6 Because at the time I gather you were the, I
7 get this right, you were the vice president,
8 medical services, Health Care Corporation of
9 St. John's?
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. That's what you would have been called?
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Did anyone replace you at that time?
18 DR. WILLIAMS:
19 A. No, I don't think anyone was--I talked to the
20 CEO and told him that I would be off for an
21 extended period of time. I did also meet with
22 him on at least one occassion when I was off,
23 sometime when I was starting to feel better.
24 I, when I started to get a little bit better,
25 you know, I think I got a few calls from the

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1 office, but the clinical--I had done the--
2 before I left, we done all the credentials and
3 things like that for the MAC meeting in June.
4 I think I actually attended the MAC meeting in
5 June because it's usually the first Wednesday
6 of June, so those issues were attended to.
7 The clinical chiefs, we sent around an e-mail
8 to all the clinical chiefs and people that
9 reported to me saying that I would be off.
10 But I don't think anybody was formally
11 designated. If anything happened, I think it
12 was handled by the people remaining in the
13 organization.
14 COFFEY, Q.C.:
15 Q. While you were away from work during that time
16 period, because there is going to be some
17 matters that came up, or at least one memo
18 during that time period that will be of
19 relevance to the Commission, I anticipate,
20 were you doing--or how much were you
21 interacting with your office during the time
22 you were off?
23 DR. WILLIAMS:
24 A. Not a lot, not a lot. I was -
25 COFFEY, Q.C.:

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1 Q. And who were you dealing with?
2 DR. WILLIAMS:
3 A. I would have only been dealing with Sharon or
4 Denise if they phoned me or anything like
5 that.
6 COFFEY, Q.C.:
7 Q. Sharon?
8 DR. WILLIAMS:
9 A. Sharon would--Sharon Hopkins would be the
10 executive assistant dealing with medical
11 matters, credentialling, this kind of thing.
12 And Denise would have been my executive
13 assistant.
14 COFFEY, Q.C.:
15 Q. That's Denise?
16 DR. WILLIAMS:
17 A. Dunn.
18 COFFEY, Q.C.:
19 Q. Dunn, okay. Because her name will come up on
20 various documents.
21 DR. WILLIAMS:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. Throughout this. During that period what, if
25 any, was your understanding did you have with

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1 the CEO of the day, which would be George
2 Tilley?
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. I take it you reported directly to Mr. Tilley?
7 DR. WILLIAMS:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. In your position. What understanding did you
11 have with him and with your two support staff
12 as to what sorts of things they should contact
13 you about, if at all during your sick time?
14 DR. WILLIAMS:
15 A. I'm not sure, to be honest. When I was
16 feeling better, I said, look, is there any
17 real things that are a problem, you know, if
18 you can't find anybody, you can always give me
19 a shout. But for awhile, first on, I really
20 wasn't thinking much about the office, I was
21 thinking based upon the--my medical condition
22 and what people were thinking about what the
23 diagnosis might be of could be. I guess -
24 COFFEY, Q.C.:
25 Q. You were concentrating on your own health?

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1 DR. WILLIAMS:
2 A. Yes, I was concentrating on own health, I
3 think that's a fair statement to make.
4 COFFEY, Q.C.:
5 Q. Yeah, makes sense. Now, at the time again, so
6 the Commissioner can get some sense, a kind of
7 snapshot, you know, at the time, in the middle
8 of '03, Dr. Williams, leading into that time
9 period, you had been VP, and I'll refer to it
10 as VP for vice president of medical services,
11 for a number of years then, since 1998?
12 DR. WILLIAMS:
13 A. Correct.
14 COFFEY, Q.C.:
15 Q. Had your job function changed during that
16 five-year period, really?
17 DR. WILLIAMS:
18 A. Yes, it did.
19 COFFEY, Q.C.:
20 Q. Okay.
21 DR. WILLIAMS:
22 A. It depended. From time to time I had
23 responsibilities for different program areas.
24 COFFEY, Q.C.:
25 Q. Okay, and I'll take you then through that,

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1 okay, as we--and I'll do that chronologically
2 as we go, but when you went off on sick leave,
3 as you've indicated, well, as best you can
4 recall, you'd had your early June MAC meeting.
5 DR. WILLIAMS:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. You were obviously involved in the MAC.
9 DR. WILLIAMS:
10 A. I'm pretty sure, I had that. I'd have to go
11 back and look, but I'm pretty sure I did.
12 COFFEY, Q.C.:
13 Q. At that time, when would the MAC meet again?
14 DR. WILLIAMS:
15 A. They would not meet again until September.
16 COFFEY, Q.C.:
17 Q. September, okay, so that was--your
18 responsibilities in that regard would have
19 been put to rest then until the -
20 DR. WILLIAMS:
21 A. Yes, and the chair of MAC, anything to do with
22 MAC, the chair of MAC, Dr. Whitman, was
23 available to deal with issues like that Sharon
24 to go to Dr. Whitman.
25 COFFEY, Q.C.:

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1 Q. At that time, when you went off on leave, who
2 was directly reporting to you?
3 DR. WILLIAMS:
4 A. It would have been obviously Denise Dunn and
5 Sharon Hopkins in the office, the leadership
6 team of Laboratory Medicine.
7 COFFEY, Q.C.:
8 Q. So who was that at the time?
9 DR. WILLIAMS:
10 A. Dr. Cook, and Mr. Gulliver.
11 COFFEY, Q.C.:
12 Q. That would be Dr. Donald Cook?
13 DR. WILLIAMS:
14 A. Yes, and Mr. Terry Gulliver.
15 COFFEY, Q.C.:
16 Q. And Terry Gulliver, the program director?
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Go ahead.
21 DR. WILLIAMS:
22 A. And in radiology, diagnostic imaging, it would
23 be Mr. Shawn Thomas and Dr. Geoff Higgins at
24 the time.
25 COFFEY, Q.C.:

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1 Q. And so they're four individuals -
2 DR. WILLIAMS:
3 A. Yes, and then there would be linkages with the
4 13 or 14 or 15 clinical chiefs, because it
5 changed over time as we downsized the number
6 of programs. So the clinical chiefs would
7 report up to their own program, with their own
8 program director to one of the other VPs, but
9 there would be linkages between the clinical
10 chiefs on a various number of issues and the
11 office, the position that I occupied.
12 COFFEY, Q.C.:
13 Q. So the clinical chiefs, for example, the
14 clinical chief of, I'll pick, say, surgery,
15 would there be such a thing as a clinical
16 chief of surgery?
17 DR. WILLIAMS:
18 A. Yes, Dr. Felix.
19 COFFEY, Q.C.:
20 Q. At that point in the organization, in the
21 middle of 2003, would he report directly to
22 you?
23 DR. WILLIAMS:
24 A. No, we sort of had a matrix organization
25 really that the clinical chiefs--we had a

Page 25

1 clinical chiefs committee which met ten times,
2 every month but July and August, such the same
3 in the time frame as the MAC. So the clinical
4 chiefs meeting would be probably the third
5 Tuesday of the month and then reports would
6 come to the clinical chiefs committee from
7 clinical chiefs and other issues would come to
8 the clinical chiefs committee. They would be
9 discussed and then these reports and any
10 issues discussed at clinical chiefs that were
11 felt should go to MAC, would go to the MAC at
12 the next meeting in the first Wednesday of the
13 month.
14 COFFEY, Q.C.:
15 Q. So the clinical chiefs, other than the
16 diagnostic imaging and clinical laboratory -
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. - which you just, those two individuals, other
21 than--they are the two that would report
22 directly to you?
23 DR. WILLIAMS:
24 A. Yes. Now, I'm not sure going back. I'd have
25 to go back and look at my records, but over

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1 time, in addition to those, I was responsible
2 at one stage for the medicine program, but not
3 at this time, I don't think.
4 COFFEY, Q.C.:
5 Q. Not in the middle of '03.
6 DR. WILLIAMS:
7 A. The Women's Health program. I was responsible
8 for respiratory therapy at various times,
9 nutrition program and the pharmacy program.
10 COFFEY, Q.C.:
11 Q. So any -
12 DR. WILLIAMS:
13 A. Now I may have been responsible for the
14 pharmacy program in 2003. I'm not sure of
15 that, because there was a change in the
16 structure around that time, but pharmacy may
17 have been one that I was responsible for in
18 2003. I'd have to go and look at the records.
19 COFFEY, Q.C.:
20 Q. So I take it then that if you--if from time to
21 time any particular program that you were
22 responsible for, and that changed over time,
23 you're saying?
24 DR. WILLIAMS:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. Depending on which year and month you pick, it
3 might not have been your responsibility, that
4 if there was a clinical chief within that
5 program, then they would be reporting to you
6 because you were responsible for the program?
7 DR. WILLIAMS:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. Other times, if that program got moved to
11 another COO or VP, then it was his or her
12 responsibility?
13 DR. WILLIAMS:
14 A. Correct.
15 COFFEY, Q.C.:
16 Q. Okay.
17 DR. WILLIAMS:
18 A. But there was a linkage between all the
19 clinical chiefs in the office for good
20 reasons.
21 COFFEY, Q.C.:
22 Q. And sir, just to--if I could, again from the--
23 to help give the Commissioner some sense of
24 your own background and experience, in family
25 medicine, I take it, you have--would you

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1 describe yourself as, at least, earlier in
2 your career, you had a fair amount of
3 experience?
4 DR. WILLIAMS:
5 A. Yes, in rural Newfoundland health care, and
6 subsequent to that, I kept my license by doing
7 locums for a physician in St. John's and in
8 Clarenville early on. Part of my job with the
9 Health Care Corporation of St. John's and
10 Eastern Health required that I maintain my
11 medical licensure in the province. So that
12 meant I had to meet the requirements for
13 medical licensure and I had to practice
14 medicine a certain--in keeping with that, I
15 had to continue doing some locums in order to
16 maintain my license. That was a requirement
17 of the job, so during this period of time,
18 ever since I went to the Department of Health
19 in 1979 until currently, I have done medical
20 locums so that my license as a physician is
21 maintained. There are requirements at the
22 medical board that you have to meet to
23 maintain your license.
24 COFFEY, Q.C.:
25 Q. If we could look, please, at page six of this

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1 exhibit? Now during the period of time that
2 you were medical consultant with the
3 Department of Health and looking back, that
4 apparently covers the period 1979 to 1982,
5 you've written in your CV that you were
6 initially responsible for consulting on
7 medical and technology issues in the
8 institutional sector.
9 DR. WILLIAMS:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. As well as the liaison on medical education
13 issues with the medical school and medical
14 affairs, with the provincial medical
15 association, medical licensing board and the
16 provincial Medicare program.
17 DR. WILLIAMS:
18 A. Um-hm.
19 COFFEY, Q.C.:
20 Q. In a practical way, what did that involve,
21 what sorts of activities?
22 DR. WILLIAMS:
23 A. Basically, if there was issues that were
24 coming up with the hospitals and things like
25 that, I would become involved in them, if the

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1 Department was involved and if they wanted
2 some input from the Department or if the
3 Department wanted some input. I also was
4 involved, it doesn't say here, but we operated
5 the cottage hospitals still in that time
6 frame. The Department of Health operated a
7 number of cottage hospitals, so I would have
8 been involved with the director of hospital
9 and medical services in dealing with some
10 physician issues that might arise and other
11 issues that might arise in the cottage
12 hospitals at that time.
13 COFFEY, Q.C.:
14 Q. And then you had a period as associate deputy
15 minister, and that would cover the period 1982
16 to 1989, you know, looking at page two of your
17 CV. Again, in a practical way, what--you
18 know, at least at the time you were the
19 associate deputy minister, in that seven to
20 eight-year period, what did you actually do?
21 DR. WILLIAMS:
22 A. Well, one of the--let's look--let's break it
23 down into the medical services side. Really,
24 we had some direct responsibility at that time
25 for medical services through the cottage

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1 hospitals. We worked closely with the
2 Newfoundland and Labrador Medical Association,
3 in terms of negotiations. Although the
4 Medicare program was in place to deal with
5 issues of pay and benefits for fee-for-service
6 physicians, we had a lot of salary physicians
7 in the province, so I was heavily involved in
8 dealing with salaried physician issues,
9 negotiations. We also became involved--we
10 merged the fee-for-service negotiations with
11 the salaried negotiations sometime around
12 there, heavily involved in that. Involved
13 with the medical board in terms of licensure
14 issues in the province, and -
15 COFFEY, Q.C.:
16 Q. When you say "involved" involved from which
17 respect?
18 DR. WILLIAMS:
19 A. From--well, the legislation rested with
20 government. The medical board had
21 legislation, this type of thing, so any
22 changes in the regulations or legislation was
23 required, we would become involved in that.
24 There would be issues that we might have with
25 the medical board on behalf of physicians that

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1 we operated directly, we might become involved
2 in that. So there was a lot of interaction.
3 COFFEY, Q.C.:
4 Q. When you say in terms of fee-for-service and
5 salaries -
6 DR. WILLIAMS:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. - physicians remuneration, you would be--in
10 whose interest would you be acting at that
11 time, in the sense of coming at it from the
12 perspective of the payer or the payee?
13 DR. WILLIAMS:
14 A. The payer, I guess, in a sense. But you had
15 to keep in mind that if you were trying to
16 maintain medical services in the province, the
17 position of the payee would be very important
18 as well. So although you're coming at it from
19 the payer's perspective, you had to be mindful
20 of the position of the payee, because all
21 during our history here, we've had difficulty
22 maintaining medical services in some of the
23 specialties and especially in rural parts of
24 the province. So you couldn't just be looking
25 at the payee side. I think you had to look at

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1 both sides.
2 The other issue was that we were--we had
3 the public health laboratories reporting
4 directly--although they were operated under
5 the General Hospital's banner, in terms of
6 reporting through the director of the public
7 health labs, that position reported in to the
8 associate deputy minister for public health.
9 COFFEY, Q.C.:
10 Q. I'm just thinking through you.
11 DR. WILLIAMS:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Okay, go ahead.
15 DR. WILLIAMS:
16 A. Although the staff were, I think, on the
17 payroll of the General, I can't remember,
18 there was an--but from the view of reporting
19 and responsibility, the director of the public
20 health labs would report into the Department
21 of Health.
22 And emergency health services in the
23 province, we were--there was always issues in
24 that area. We had responsibility for the air
25 ambulance and road ambulance programs and

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1 there was a lot of activities under way in
2 that area, trying to improve road and air
3 ambulance services in the province.
4 It's unique in--well, I look at the job
5 description, it's unique in our province that
6 the medical school is funded directly by the
7 Department of Health. In other provinces, the
8 medical school is funded through university
9 and that's usually funded by the Department of
10 Education. But when the medical school was
11 set up in our province, it was funded directly
12 through the Department of Health, so that we
13 had a lot of interaction with the medical
14 school in terms--not only in terms of their
15 budget, but in terms of some of the
16 activities, especially the educational
17 activities, and we would be sitting down--the
18 position I occupied, my job was to sit down
19 regularly with the assistant dean for post-
20 graduate medical education.
21 COFFEY, Q.C.:
22 Q. Which is your residency programs, I take it?
23 DR. WILLIAMS:
24 A. Yes, to look at the number of people that we
25 would be able to fund in any given year and

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1 the number of residencies we could approve and
2 in what disciplines, tried to link that
3 somewhat into our needs in the province for
4 different physicians in different specialties.
5 COFFEY, Q.C.:
6 Q. And that would include, for example, training
7 and -
8 DR. WILLIAMS:
9 A. Yes, training program for orthopedic surgery
10 or things like that.
11 COFFEY, Q.C.:
12 Q. Or for pathologists?
13 DR. WILLIAMS:
14 A. Yes. Yes, that's right, yes, yeah.
15 COFFEY, Q.C.:
16 Q. Okay. There's also a reference at the bottom
17 paragraph there on page six to a shift -
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. - from a centralized mode of public health
22 services to a regional public health unit
23 structure?
24 DR. WILLIAMS:
25 A. Yes, I'll tell you about that, if you want.

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1 COFFEY, Q.C.:
2 Q. So this is public health? This is not acute
3 care?
4 DR. WILLIAMS:
5 A. No, this is public health.
6 COFFEY, Q.C.:
7 Q. Public health.
8 DR. WILLIAMS:
9 A. Before I get into that, I'll just explain too
10 that we were divesting ourselves, during this
11 period of time, from operating directly the
12 cottage hospitals to having them come under
13 various boards that were around the province.
14 So that was part of the activity at the time,
15 as well.
16 COFFEY, Q.C.:
17 Q. Yes.
18 DR. WILLIAMS:
19 A. That says it there, I think, in the job
20 description. But yes, and -
21 COFFEY, Q.C.:
22 Q. And not that the public health is not
23 important, but I was going to ask you, because
24 I just wanted to clarify with you, that would
25 not involve acute care?

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1 DR. WILLIAMS:
2 A. No, it would not.
3 COFFEY, Q.C.:
4 Q. Sure. The cottage hospitals, at times would
5 they involve acute care?
6 DR. WILLIAMS:
7 A. Oh yes, cottage hospitals would always involve
8 acute care, acute primary care, the service
9 would be provided by primary care physicians.
10 Although there was things that primary care
11 physicians in larger centres would not do, the
12 cottage hospitals would do some surgery, in-
13 patient care, obstetrical care and outpatient
14 care and services, house calls, things like
15 that. There was a close working relationship
16 in many of the cottage hospitals with the
17 public health nurses who were in the region,
18 in terms of child care and other issues, yes.
19 COFFEY, Q.C.:
20 Q. Now the second last paragraph on page six, in
21 particular, I'd like to explore with you. It
22 indicates, you say that "as associate deputy
23 minister, I was involved in government's
24 policy to shift responsibility for the direct
25 delivery of acute health care services from

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1 government to health care boards. A network
2 of smaller facilities previously operated by
3 the Department was merged with larger district
4 and regional hospitals to form district and
5 regional health care boards responsible for
6 planning, administration and the delivery of
7 acute and chronic health care services."
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Which is, I take it, the cottage hospital
12 reference?
13 DR. WILLIAMS:
14 A. Yes, correct.
15 COFFEY, Q.C.:
16 Q. They were, I take it, responsibility, direct
17 responsibility for them was moved to these
18 regional health authorities?
19 DR. WILLIAMS:
20 A. Correct.
21 COFFEY, Q.C.:
22 Q. And the management of these regional health
23 authorities was centred--tended to be centred
24 where, in the larger centres?
25 DR. WILLIAMS:

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1 A. Yes. For instance, in Corner Brook, in Grand
2 Falls, in Gander, places like that. So you
3 would--for instance, Harbour Breton Cottage
4 Hospital would be down on the Connaigre
5 Peninsula in Harbour Breton, that was operated
6 by the Department of Health at one stage, and
7 then in discussions with the board operating
8 facilities in Grand Falls, that became--was
9 shifted, the responsibility for operating that
10 hospital shifted to Grand Falls. As well, the
11 cottage hospital in Botwood became the
12 responsibility of Grand Falls and the cottage
13 hospital in Springdale would have become the
14 responsibility of the hospital board in Grand
15 Falls, and they would then expand the number
16 of people on the board to make sure they had
17 people on the board from those areas.
18 COFFEY, Q.C.:
19 Q. And at that point, because as you've
20 indicated, as associate deputy minister, you
21 had been responsible at one point for the
22 cottage hospitals, in your position as
23 associate deputy?
24 DR. WILLIAMS:
25 A. Correct.

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1 COFFEY, Q.C.:
2 Q. Who at that time was responsible for the
3 hospital in Grand Falls, for example, from the
4 Department's perspective? Who was liaison?
5 DR. WILLIAMS:
6 A. There was an assistant deputy minister
7 institutions. That person would work with the
8 various CEOs around the province in terms of
9 operational and financial issues and policy
10 issues with respect to the operation of
11 hospitals in the province.
12 COFFEY, Q.C.:
13 Q. And how about physician services within those
14 hospitals?
15 DR. WILLIAMS:
16 A. These hospitals would have a medical director.
17 COFFEY, Q.C.:
18 Q. Okay.
19 DR. WILLIAMS:
20 A. Who would deal with physician issues. If the
21 physician issues were issues that were broader
22 or they had some difficulty dealing with them
23 and couldn't probably resolve them at the
24 local area, then it might be referred by the
25 ADM Institutions to sort of I might become

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1 involved.
2 COFFEY, Q.C.:
3 Q. You might?
4 DR. WILLIAMS:
5 A. Yes, become involved, yes, at that stage.
6 COFFEY, Q.C.:
7 Q. Even back as far as the mid to late 80s -
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. - if it involved something about, I take it,
12 requiring some clinical knowledge, or at least
13 a basic clinical knowledge -
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. - the ADM for institutions might consult with
18 you about it?
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Okay.
23 DR. WILLIAMS:
24 A. Most of it would be not about the individual
25 care issues, but it might be about maybe more

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1 administrative, pay and benefits, other issues
2 of that kind of nature because you had a
3 medical director who would deal with all the
4 so-called medical issues there.
5 COFFEY, Q.C.:
6 Q. And so as the cottage hospitals then, I take
7 it, moved really from your direct
8 responsibility over time to the ADM
9 Institutions when they become, for example,
10 under Grand Falls, the board in Grand Falls,
11 that was what happened over time?
12 DR. WILLIAMS:
13 A. Yes, they would--we divested ourselves at the
14 Department from the day-to-day operations and
15 became not an operational department but more
16 of a policy formulation department.
17 COFFEY, Q.C.:
18 Q. If we could, please, page seven? Thank you,
19 Registrar. Your period then as deputy
20 minister, you've indicated that, I believe,
21 you were deputy minister from 1989 -
22 DR. WILLIAMS:
23 A. To 1998.
24 COFFEY, Q.C.:
25 Q. Yes. Now I have a number of questions about

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1 your experience as the deputy minister.
2 DR. WILLIAMS:
3 A. Uh-hm.
4 COFFEY, Q.C.:
5 Q. And if I could, please, and this might assist,
6 if we could bring up exhibit P-0947 please?
7 And I can tell you, Doctor, we've received
8 this from--recently from counsel for Her
9 Majesty, okay.
10 DR. WILLIAMS:
11 A. Oh yes.
12 COFFEY, Q.C.:
13 Q. And it may have been awhile since you've seen
14 it. This is a position description for the
15 Deputy Minister, Dr. Robert Williams,
16 Department of Health, division is executive,
17 location, St. John's. The date is May 24th,
18 1995, okay?
19 DR. WILLIAMS:
20 A. Uh-hm.
21 COFFEY, Q.C.:
22 Q. And I just wanted to alert you to this being
23 here in case you do need or feel the need to
24 consult it. As the Deputy Minister in the
25 Department of Health during the 1990's, how

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1 did you see your role?
2 DR. WILLIAMS:
3 A. Really I saw my role in keeping with the
4 mandate of what I felt the Department of
5 Health's mandate was as a department of
6 government. I think my role was to, you know,
7 we didn't make policy, but we certainly got
8 information together and advised on policy.
9 COFFEY, Q.C.:
10 Q. And advised whom in your -
11 DR. WILLIAMS:
12 A. Advised the Minister and if necessary, we were
13 called up to meetings of Cabinet and things
14 like that to advise government in the broader
15 sense. The main role was then to make sure
16 that the policy, as developed by government,
17 was implemented within the government policy
18 and within the fiscal parameters and that,
19 that we were given.
20 COFFEY, Q.C.:
21 Q. And were there any major initiatives
22 throughout that period? You can appreciate
23 this is a broad strokes question as opposed to
24 nitty gritty, because we'll be here for the
25 next year if you had to recount that.

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1 DR. WILLIAMS:
2 A. Sure.
3 COFFEY, Q.C.:
4 Q. But in the general -
5 DR. WILLIAMS:
6 A. There were a couple of highlights that I could
7 bring out to you.
8 COFFEY, Q.C.:
9 Q. If you could, please.
10 DR. WILLIAMS:
11 A. That just tells you about the framework in
12 which we were operating. We were operating in
13 a very difficult fiscal situation for the
14 years I was Deputy Minister of Health, very
15 tight. I'll just give you an example of how--
16 I remember one time I thought the medical
17 school was, just as I was leaving it, we were
18 under funding our medical school and I was
19 going to bring in a former dean of medicine
20 and a former deputy minister of Manitoba, Dr.
21 Wade, to work with one of our financial people
22 to work with the medical school to determine,
23 in fact, what the funding should be. I
24 remember talking to the secretary of Treasury
25 Board of the day and I said, I think we're

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1 under funding the medical school. And she
2 said, "Bob, everything that government funds
3 is underfunded, so you don't need to prove to
4 me, you know, that we've got a problem, you
5 may have some problems there." So we were
6 operating in that kind of a parameter. In 19-
7 -
8 COFFEY, Q.C.:
9 Q. And this would have been in the mid to late
10 90's, I take it?
11 DR. WILLIAMS:
12 A. Yes, all throughout the 90's, there was some -
13 COFFEY, Q.C.:
14 Q. No, but this medical school reference -
15 DR. WILLIAMS:
16 A. Yes, was the late 90's because I was getting a
17 bit concerned before I left that we needed to
18 take a look at that. But all throughout a
19 tenure there, there was a lot of pressure on
20 us fiscally. In 1989 when the government
21 changed, there was, in the first year or so of
22 their mandate, there was some, you know, I
23 guess some more resources applied to Health
24 Care, but I remember in 1991, '92, the Premier
25 went on public television and told the people

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1 about the serious fiscal situation facing the
2 province. I think that was in the fall of
3 '91, I stand to be corrected on that, but
4 that's my timeframe, and that we had to--we
5 had to make changes in all the government
6 services and programs that we delivered in the
7 province. And that the upcoming budget would
8 be very, very severe. And as one of the major
9 spenders with education of government funds,
10 we were told in the Department of Health that
11 we would have to take a major fiscal hit, you
12 know, in delivering services. The minister of
13 the day was the Honourable Chris Decker, we
14 were trying to deal with that and preparing
15 for a budget that would come down and input
16 into the budget that would come down in the
17 spring of 2002--yes, that year--wait now,
18 spring of 1992, sorry. And he set up a
19 resource committee which had some
20 representation from the general public through
21 some of the Board members. Some of the CEOs
22 of our Boards were involved, leaders in the
23 nursing professions were involved, leaders in
24 the medical profession were involved and
25 representatives from the medical school were

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1 involved. And that committee, called a
2 Resource Committee, and that committee met
3 over several months, usually on the weekends
4 because most of the people were from outside
5 the department. And so we'd meet on Saturdays
6 and Sundays, this type of thing, and all
7 programs that the Department of Health offered
8 were presented to the Resource Committee by
9 the people who were responsible for those
10 programs in detail, and the Recourse Committee
11 reviewed totally what the situation was and
12 made some broad recommendations to the
13 Minister. Most of them would try to deal
14 with--the best way to deal with our fiscal
15 situation, but to try to protect the integrity
16 of our health care system at the time and
17 probably try to impact on quality in more of a
18 positive way. And that resulted in the budget
19 that came down in 2002. There was a lot of
20 changes in the way services were delivered, I
21 think there was about a 20 percent--I may be
22 wrong on that, but up to 20 percent reduction
23 in our acute care beds, things like that
24 throughout the province. There was some
25 changes in how we delivered rural health care

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1 and, obviously, around a budget like that,
2 there was a lot of angst and issues within the
3 province at the time. That was implemented
4 and then really over the next number of years,
5 the emphasis was always on "we're in a tough
6 fiscal situation" and every year then, there
7 were issues that we had to deal with, mostly
8 fiscal issues, in terms of government revenues
9 not--and government not being able to--not
10 that they wanted to do some of these things,
11 but I don't think they had any choice, given
12 our fiscal situation. So there was changes
13 over time and then the Federal government, I
14 think around that time, made some major
15 adjustments to the cost-sharing formulas and
16 there was some negative impacts on our fiscal
17 situation in the province as well at the time.
18 So the government had a difficult situation,
19 in my view, throughout the 1990's in terms of
20 trying to deliver public services to residents
21 of our province, but in a serious fiscal
22 restraint situation.
23 COFFEY, Q.C.:
24 Q. And now as a deputy minister, as you indicated
25 your role would be to implement what

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1 government decides is policy.
2 DR. WILLIAMS:
3 A. Yes, once they determine--now you'd lobby, I
4 felt my role in a lot of occasions was to make
5 sure, go to Treasury Board a lot and make sure
6 that the people who are making the decisions
7 knew what the impacts of those decisions would
8 be, to try to lobby on behalf of the system.
9 So you were an advocate for the system and
10 would have some input to government, but at
11 the end of the day, once the government made
12 the policy decisions, then your job as deputy
13 was to make sure those policy decisions were
14 implemented.
15 COFFEY, Q.C.:
16 Q. So from your perspective, if I could, you saw
17 your role as deputy minister to ensure that
18 the decision-makers, for example, Treasury
19 Board, understood the ramifications or
20 potential ramifications of -
21 DR. WILLIAMS:
22 A. Yes, ensure our Minister was well briefed and
23 understood the issues, Treasury Board
24 understood the issues and if we were called to
25 Cabinet, which we were in some years at the

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1 budget, that we fully briefed them on the
2 implications of some of the issues.
3 COFFEY, Q.C.:
4 Q. Now when you say that, would you be telling
5 them at times that they could have a negative
6 impact?
7 DR. WILLIAMS:
8 A. Oh sometimes, yes, of course, you'd have to
9 tell them what you thought the impact would
10 be.
11 COFFEY, Q.C.:
12 Q. And if it was negative, you would say?
13 DR. WILLIAMS:
14 A. Yes, you'd say what you thought was the
15 problem.
16 COFFEY, Q.C.:
17 Q. Now, sir, I gather then that--well we've heard
18 that in the middle of the 1990s, the Health
19 Care Corporation of St. John's was formed.
20 DR. WILLIAMS:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Could you tell the Commissioner, please, about
24 your involvement, if any, in that and the lead
25 up to it and how it then unrolled, as it did?

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1 DR. WILLIAMS:
2 A. Yes, there was an organization in St. John's
3 that was sort of looking at trying to get the
4 co-operation of the Hospital Council, I think
5 St. John's Hospital Council, that was the name
6 of it, and they were looking at issues and
7 trying to get consensus, trying to build co-
8 operation and this type of thing. Government
9 had some issues to deal with at the time, in
10 terms of its financial situation. It was
11 known that a number of facilities in St.
12 John's were aging and would require
13 significant input of capital to redevelop, and
14 this type of thing. And there was issues
15 about some duplication of services, co-
16 operation around services, for instance at one
17 stage, which we corrected before 1995, we had
18 an obstetrical unit in one hospital with a
19 nursery and then up the road, you had another
20 obstetrical unit with nursery and then down at
21 the Janeway you had the provincial neonatal
22 nursery with high risk patients would come in
23 from out of the province and be looked after,
24 in that nursery. It became difficult to staff
25 three nurseries with neonatologists, look

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1 after pretty sick patients because some of the
2 sick women who were sick, you know, had a
3 problem during their obstetrical care, would
4 often be referred to some of these hospitals
5 for delivery, knowing that the baby that was
6 born might be in some difficulties and yet you
7 had to try to duplicate three nurseries at a
8 high level, these kind of things were going on
9 at the time.
10 COFFEY, Q.C.:
11 Q. That's just one example.
12 DR. WILLIAMS:
13 A. Just one example. The neonatologists were
14 certainly pushing hard at the time from a
15 quality of care perspective, we should really
16 have all our nurseries and obstetrical care
17 and sick babies on the one site. So these are
18 the kind of things that led to the 1995
19 decision to merge the seven Boards in St.
20 John's into one Board called the Health Care
21 Corporation of St. John's. When that was
22 done, there was provision to make sure that
23 initially there was representation on that
24 Board from the various groups that had come
25 together, including the owners of the St.

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1 Clare's site, Sisters of Mercy, and the owners
2 of the Grace site, the Salvation Army were
3 members of that Board. There was a lot of
4 discussion about that, leading up to that
5 decision. The St. John's Hospital Council had
6 presented a number of options, I think there
7 were nine options that they presented in terms
8 of redevelopment in St. John's and coming
9 together in St. John's, and government looked
10 at those in the process of making that
11 decision, obviously there had to be some
12 discussion leading up to that and after that
13 with the Salvation Army and we had to travel
14 to--I remember the Minister and myself
15 travelling to Toronto to talk to the head of
16 the Salvation Army. There was meetings with
17 the Sisters of Mercy because, again, they
18 were--as well as the leaders of the other
19 hospital boards. So it's a complicated issue
20 when you have facilities that are owned by
21 government and other facilities that are owned
22 by other parties, but the total funding came
23 from government.
24 COFFEY, Q.C.:
25 Q. So that, I take it, did get addressed.

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1 DR. WILLIAMS:
2 A. Did get a lot of discussion, a lot of
3 discussion and did get addressed.
4 COFFEY, Q.C.:
5 Q. Now you've indicated to the Commissioner that
6 there was about a year's lead time.
7 DR. WILLIAMS:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. Whose decision was that, do you recall?
11 DR. WILLIAMS:
12 A. I can't say it was any one person's decision,
13 it was probably a feeling that this is the
14 first time we'd gone into any major
15 restructuring and that it made sense to,
16 because of the issues that this new Board
17 would face, why not give them a year to do
18 their planning, because there was issues about
19 redevelopment in St. John's that needed to be
20 dealt with, that if you're set up from day one
21 to take responsibility from day one and you've
22 got all these operational issues coming on
23 your plate, maybe you won't get a chance to
24 look at some of the strategic long-term
25 issues. So it was felt that maybe we should

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1 give them considerable time to look, get an
2 understanding of what's going on here and when
3 they're ready to take over the
4 responsibilities and have a good understanding
5 and have done some planning, and they'll be
6 ready to move forward. So they were given a
7 year, they hired their CEO sometime that
8 summer.
9 COFFEY, Q.C.:
10 Q. And that was?
11 DR. WILLIAMS:
12 A. Sister Elizabeth Davis.
13 COFFEY, Q.C.:
14 Q. Go ahead.
15 DR. WILLIAMS:
16 A. And then she worked with the Board in terms of
17 the broad strategy and planning, got her
18 executive committee together over that
19 timeframe and had some--were able to work on
20 some issues, common issues like looking at the
21 medical staff issues, having focus groups,
22 this kind of thing, as they moved in to taking
23 on their responsibility. Now I can't tell you
24 exactly because I wasn't there at the time,
25 the timeframes of that.

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1 COFFEY, Q.C.:
2 Q. I appreciate, you're the deputy minister kind
3 of outside or from the Confederation Building
4 out looking at this.
5 DR. WILLIAMS:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. And you understand it's going on. Elsewhere
9 in the province, what was going on? Was there
10 any other amalgamation going on of Boards?
11 DR. WILLIAMS:
12 A. Yes, there was.
13 COFFEY, Q.C.:
14 Q. Perhaps you could you tell the Commissioner
15 about that?
16 DR. WILLIAMS:
17 A. Amalgamation was going on in Central and in
18 Western and up North. Now my memory is fading
19 a little bit, but I'll do my best. For
20 instance, in Western, we were looking at
21 bringing the long-term care and acute-care
22 together. Some of the people in Western
23 wanted to bring together community health
24 services at that time and have what they have
25 now, a regionalized, integrated health

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1 services organization. We felt at the
2 department at the time that that was too much
3 change too quickly and that maybe it's better
4 to bring the institutional side together,
5 long-term care and acute-care before you take
6 the next step. And in Central, the Central
7 West Board was working with the long-term
8 care. We went out for a number of meetings
9 out there, I know that, we went out to Gander
10 for a number of meetings and meetings all
11 around the province to try and facilitate that
12 approach at the time. And I can't remember
13 the timeframes of those Boards being appointed
14 and how much time they had, but I know in St.
15 John's they gave them a year.
16 COFFEY, Q.C.:
17 Q. So on the west coast of Newfoundland it was,
18 at least the west coast from Corner Brook area
19 itself, was long-term care and acute care.
20 DR. WILLIAMS:
21 A. Yes, up as far as Bonne Bay, I think.
22 COFFEY, Q.C.:
23 Q. Up as far as Bonne Bay. In Central
24 Newfoundland the amalgamation was of just the
25 acute-care facilities or was long-term -

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1 DR. WILLIAMS:
2 A. In St. John's?
3 COFFEY, Q.C.:
4 Q. No, no, in Central?
5 DR. WILLIAMS:
6 A. Yes, in Central it was long term and yes, we
7 had at the time, I think, a few "doubting
8 Thomases" about that approach in some of the
9 long-term care boards, but eventually that was
10 resolved in Central.
11 COFFEY, Q.C.:
12 Q. And St. John's, the Health Care Corporation of
13 St. John's, I take it, was an amalgamation
14 really of the acute-care hospitals?
15 DR. WILLIAMS:
16 A. Correct, there was no contemplation of doing
17 long-term care--half the long-care term beds,
18 over a thousand beds were in St. John's. Most
19 of these long-term care facilities were
20 owner/operated type thing. And "owner" means
21 different things, but anyway it's
22 owner/operated and it was felt that that was
23 just too much to deal with.
24 COFFEY, Q.C.:
25 Q. And how about on the Northern Peninsula and

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1 Labrador?
2 DR. WILLIAMS:
3 A. Grenfell was really almost an integrated
4 organization from day one. There was some
5 issues about Labrador West if I can recall it
6 correctly, the Salvation Army operated the
7 hospital in Labrador West. There was some
8 discussion with them at the time. I remember
9 meeting with them in my office and with the
10 Minister in his office and I think the
11 Labrador West was brought into that
12 organization, but Grenfell really was doing
13 the full scope, they had public health at the
14 time and they had acute-care services, I think
15 maybe long-term care was a little bit on the
16 periphery, so I'd have to go back and check my
17 notes exactly what happened, but the Grenfell
18 was, in terms of Northern health care, was
19 already -
20 COFFEY, Q.C.:
21 Q. On its way, as it were.
22 DR. WILLIAMS:
23 A. Yes, were already operating like that to a
24 certain extent.
25 COFFEY, Q.C.:

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1 Q. Now if I could, because you've referred to
2 both the medical school in the 1990s and
3 otherwise earlier referred to tertiary care.
4 During the period you were Deputy Minister of
5 Health, tertiary medical care--well, first of
6 all, could you tell the Commissioner what,
7 from your perspective that is?
8 DR. WILLIAMS:
9 A. Well, tertiary care is care that's really
10 above secondary--I would call secondary level
11 care, surgery, obstetrics type of thing.
12 Tertiary level care is care that's really only
13 available at once centre, it's really sub-
14 specialized care that you deliver at a
15 centralized location, in a province like our
16 province, would be St. John's. So, tertiary
17 level services, in my view, would be something
18 like neurosurgery. You don't have a
19 population base to duplicate it anywhere else.
20 It's a very high level, highly technical,
21 requires, you know, sub-speciality trained
22 people. So, that would be an example of
23 tertiary level service. Cardiac surgery would
24 be another example tertiary level services.
25 High risk perinatal care would be another

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1 example. This is care to mothers and unborn
2 infants that requires very detailed and sub-
3 specialized care and monitoring that would
4 probably be only delivered at one site. In
5 the best interest of providing the optimum
6 type of service in the province like ours.
7 You could only deliver those services at
8 certain--at one site probably.
9 COFFEY, Q.C.:
10 Q. And then in the--at the time the Health Care
11 Corporation of St. John's was formed, back
12 just before it was formed, what hospital was
13 providing the bulk of the tertiary care
14 service for the province?
15 DR. WILLIAMS:
16 A. I would say that the General Hospital, as I
17 call it, people call it the Health Sciences
18 Centre, but it's really the General Hospital.
19 The General Hospital is one entity on the
20 Health Sciences Centre site.
21 COFFEY, Q.C.:
22 Q. That's where, in the main it would have been.
23 DR. WILLIAMS:
24 A. Yes, but not totally.
25 COFFEY, Q.C.:

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1 Q. Not totally, and I appreciate that. And then
2 after the Health Care Corporation of St.
3 John's was formed, of course that included the
4 General Hospital itself -
5 DR. WILLIAMS:
6 A. Yes, that's correct.
7 COFFEY, Q.C.:
8 Q. - the facilities. So, the bulk then of the
9 tertiary health care services in the Province
10 would have been located in the Health Care
11 Corporation of St. John's, particularly in the
12 General Hospital.
13 DR. WILLIAMS:
14 A. Yes, but not totally.
15 COFFEY, Q.C.:
16 Q. Not totally. In particular--and this is
17 before your time as VP now, getting back to
18 when you were Deputy Minister--laboratory
19 services, tertiary clinical laboratory
20 service, where were they being provided from?
21 As Deputy Minister, first of all, did you know
22 at the time?
23 DR. WILLIAMS:
24 A. Yes, I would have some knowledge at the time.
25 Some tests that would only be performed in St.

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1 John's and then there was a number of other
2 tests that we wouldn't even do there, but we'd
3 refer out of the Province for testing.
4 COFFEY, Q.C.:
5 Q. And could you tell the Commissioner, please,
6 during the period you were Deputy Minister,
7 what your understanding was as to how those
8 decisions were made; who was making them?
9 DR. WILLIAMS:
10 A. In what sense?
11 COFFEY, Q.C.:
12 Q. In terms of well, what types of tests will we
13 do within the Province, in the clinical
14 laboratory, even specialized ones and which
15 ones will be done elsewhere.
16 DR. WILLIAMS:
17 A. I would -
18 COFFEY, Q.C.:
19 Q. And I'm asking you, back in your days of DM.
20 DR. WILLIAMS:
21 A. Yes, I would think that those--we didn't get
22 involved in those decisions at the department.
23 They were really left to the boards to deal
24 with and I guess there was some, probably,
25 discussion between the various boards about,

1 you know, certain tests would be done in a
2 centralized location because it made sense.
3 They were low volume tests or for other
4 reasons they might be done there.
5 COFFEY, Q.C.:
6 Q. During the period you were Deputy Minister, in
7 the 1990s, was there anyone within your
8 department whose responsibility it was to be
9 informed about that sort of matter?
10 DR. WILLIAMS:
11 A. I would say the ADM institutions would
12 probably be more involved in that. And they
13 would have had, in the ADM institution, some
14 kind of a lab consultant who is a part time
15 person who worked in the system, I know
16 working with them on these issues.
17 COFFEY, Q.C.:
18 Q. And so, during that period, a decision, for
19 example, about whether or not to offer a
20 particular type of or to perform a particular
21 type of clinical laboratory service,
22 particular type of test and/or interpretation
23 of the test, was being made, you understood at
24 what level?
25 DR. WILLIAMS:

1 A. I would think that would be made out in the
2 system by the professionals out there. But if
3 there was issues about funding that maybe the
4 General Hospital CEO might bring it in to the
5 ADM institutions in terms of a funding issue.
6 I expect, but I can't be sure, I can't.
7 COFFEY, Q.C.:
8 Q. And a concrete example related to why we're
9 here in the larger sense, immunohistochemical
10 testing.
11 DR. WILLIAMS:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. During the period you were Deputy Minister--
15 well, first of all, did you know what IHC was?
16 DR. WILLIAMS:
17 A. No.
18 COFFEY, Q.C.:
19 Q. You had not.
20 DR. WILLIAMS:
21 A. No, would not know.
22 COFFEY, Q.C.:
23 Q. Okay.
24 DR. WILLIAMS:
25 A. Wouldn't be things, as a GP, that you'd be

1 involved in.
2 COFFEY, Q.C.:
3 Q. And to perhaps, again, so the Commissioner can
4 get some sense of this because as you point
5 out, you had been a GP back in the '80s, '70s
6 and '80s and you had maintained your license
7 over the years -
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. - doing locums. What, if at all, knowledge
12 from your perspective over the decades would a
13 family practitioner have of IHC testing?
14 DR. WILLIAMS:
15 A. I'd say very little because those tests would
16 be ordered by specialist people rather than
17 general practitioners and the reports would go
18 back to the ordering physician. So, -
19 COFFEY, Q.C.:
20 Q. Which is the specialist who ordered it in the
21 first place.
22 DR. WILLIAMS:
23 A. Yes, yes. The locums I did for the GPs
24 practice I did, I've never come across any of
25 those tests.

1 COFFEY, Q.C.:
2 Q. And while you were Deputy Minister, did you
3 continue to do locums?
4 DR. WILLIAMS:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. In order to maintain your -
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Well, keep your finger in -
12 DR. WILLIAMS:
13 A. I would take my holiday time to do that.
14 COFFEY, Q.C.:
15 Q. During your period as Deputy Minister, do you
16 ever recall any issue involving clinical
17 laboratory services coming to your attention
18 as Deputy Minister?
19 DR. WILLIAMS:
20 A. We had, at one time, Ken Janes who did work as
21 a laboratory consultant in the department and
22 I know we were looking at, what we call an SMA
23 12 machine that the General Hospital were
24 using and other hospitals were using that,
25 even though you might want one test, it did a

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1 battery of tests. So, if you wanted on test,
2 you'd get results on 12 other tests or ten
3 other tests, whatever it was. And there was
4 some discussion about whether that's the most
5 effective way to provide services because then
6 you--if you do, I'm sure if you do tests on
7 any member of the general public
8 indiscriminately or just to order a battery of
9 tests, you're going to find that some of them
10 might be a little bit out of kilter, which may
11 mean nothing, just that there's a little
12 variant. So, that was leading to a lot of
13 repeat testing and this type of thing. And
14 the question came up whether we should be
15 using discreet testing. If we want tests on
16 the liver, get a liver profile test which is
17 two or three tests on the liver or tests on
18 some other area, go to that way. So, there
19 was some discussion around that time with--Mr.
20 Janes was leading the discussion with the labs
21 about moving away from the SMA 12 machine.
22 That would have been some time, gee whiz, I
23 don't know if it was it the late '80s, early
24 '90s. And they moved--they don't use that
25 kind of equipment anymore, they do to discreet

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1 things. If you want liver test, you get liver
2 test. If you want this kind of test, you'll
3 get that--you get what you want.
4 COFFEY, Q.C.:
5 Q. So, the position--Mr. Janes was his name?
6 DR. WILLIAMS:
7 A. Ken Janes.
8 COFFEY, Q.C.:
9 Q. Ken Janes, was he a physician?
10 DR. WILLIAMS:
11 A. No, no, he was the director of laboratories in
12 Gander, but -
13 COFFEY, Q.C.:
14 Q. Director of Laboratories in Gander and he was
15 also -
16 DR. WILLIAMS:
17 A. He was a consultant to the institutions branch
18 at the department, part time basis.
19 COFFEY, Q.C.:
20 Q. Of the Department of Health.
21 DR. WILLIAMS:
22 A. Yes, that was a part time basis. That's my
23 recollection of what he was involved in at the
24 time.
25 COFFEY, Q.C.:

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1 Q. And do you recall whether or not the
2 Department of Health at the time had any
3 policies concerning what types of tests should
4 be performed in the Province, tertiary care,
5 clinical laboratory tests, should be done in
6 the Province, which should be done outside or
7 was there any -
8 DR. WILLIAMS:
9 A. I would say no, there was not, but you know, I
10 can't remember, but I don't think there was.
11 COFFEY, Q.C.:
12 Q. Okay. Then as the Deputy Minister in the
13 1990s, do you know whether there was any
14 policies in force or followed in terms of--
15 that required an evaluation of the
16 advisability of getting involved in certain
17 types of tests?
18 DR. WILLIAMS:
19 A. No, I can't remember that coming up as an
20 issue. It may have, but I can't remember it.
21 COFFEY, Q.C.:
22 Q. Okay. During the 1990s was there any other
23 issue, any issues at all involving laboratory
24 (unintelligible) that you can recall? And I'm
25 not suggesting there were, just -

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1 DR. WILLIAMS:
2 A. Not that I can--I remember the SMA 12 machine
3 as being an issue that--it's a provincial
4 issue that Mr. Janes was working on. It was
5 resolved.
6 COFFEY, Q.C.:
7 Q. The Health Care Corporation was established
8 and came into operation?
9 DR. WILLIAMS:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. In its first several years in operation which
13 would have been--carried into the period '95
14 to '98.
15 DR. WILLIAMS:
16 A. Um-hm.
17 COFFEY, Q.C.:
18 Q. Okay. As the Deputy Minister, were you ever
19 involved in or called upon to get involved in
20 its operations?
21 DR. WILLIAMS:
22 A. Sometimes you'd be called upon. We didn't
23 feel that that was our role to get involved in
24 the day-to-day operations. There were some
25 issues that would come up from time to time,

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1 I'm sure, when you're setting up a new
2 organization from scratch. But we felt that
3 responsibility there would rest with Sister
4 Elizabeth and her executive in operational
5 issues that we wouldn't get involved with
6 those operational issues.
7 COFFEY, Q.C.:
8 Q. Now, I understand--now, everybody here in the
9 room would know that the Janeway Hospital that
10 you've referred to already, was relocated.
11 DR. WILLIAMS:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. When did that occur?
15 DR. WILLIAMS:
16 A. That was always part of the plan.
17 COFFEY, Q.C.:
18 Q. Okay, that's going back to -
19 DR. WILLIAMS:
20 A. In 1996, in June of '96 after the new board
21 took over in St. John's, the Health Care
22 Corporation, Ms. Eileen Young was the Chair of
23 that Board, they made a presentation to
24 government about a division for health care
25 delivery in St. John's and also for the

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1 Province. And that involved a restructuring
2 of facilities in St. John's. And one of them
3 was to relocate the Janeway contiguous to the
4 General Hospital site and contiguous to the
5 Women's Health Centre that had been relocated
6 to the General site. And there's obviously
7 very, very good reasons for that. Number one
8 is it would promote having one high level
9 neonatal nursery for the Province and for the
10 City, contiguous with the obstetrical unit.
11 Also, a lot of the specialists who provided
12 service, like neurosurgeons for the Province,
13 also provided the services at the Janeway for
14 children with neurosurgical problems. So,
15 that would bring the children on the same site
16 as the neurosurgeons were because most of the
17 work was in Health--so that would facilitate,
18 I think, better, closer working relationships,
19 probably better quality of care. And so that
20 was the presentation that was made.
21 COFFEY, Q.C.:
22 Q. Made to whom?
23 DR. WILLIAMS:
24 A. Made to government, like, to the Cabinet by
25 Eileen Young, chair of the board, Sister

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1 Elizabeth was there during the presentation.
2 And government reviewed it and a decision was
3 made to go with their plan. By bringing all
4 these organizations together, there was
5 obviously some savings involved. And the
6 amortization of the 135 million dollar cost to
7 redevelop the Janeway, doing some redeveloping
8 at St. Clare's, redevelopment at the General
9 Hospital was funded through a ten million
10 dollar amount of money that was saved in
11 bringing those organizations together. So,
12 all the new facilities that you see in St.
13 John's are being funded by savings by
14 consolidating services and an amount was put
15 aside for that. The Janeway was part of the
16 plan, planning started, construction started.
17 There was some kind of a strike or something.
18 And there was some delay in getting the
19 Janeway completed enough for it to take on its
20 responsibilities at the timeframe it was
21 envisioned for it to take on. So, I was at
22 the Health Care Corporation at that time.
23 That caused us a lot of problems.
24 COFFEY, Q.C.:
25 Q. That's by the time--because you had switched

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1 rolls.
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. So, the idea of relocating the Janeway first
6 surfaced and was accepted by government while
7 you were Deputy Minister of Health?
8 DR. WILLIAMS:
9 A. Correct.
10 COFFEY, Q.C.:
11 Q. And by the time it actually got implemented,
12 you were working with the Health Care
13 Corporation.
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. And I'll be speaking to you about that. What
18 about the Grace Hospital?
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Because, of course, it did eventually close.
23 When did that idea first come up?
24 DR. WILLIAMS:
25 A. That was part of the plan that was presented

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1 by the Board when they made a presentation to
2 government in June of 2006.
3 COFFEY, Q.C.:
4 Q. Sorry?
5 DR. WILLIAMS:
6 A. That was part of their proposal in June of
7 2006.
8 COFFEY, Q.C.:
9 Q. June of 19 -
10 DR. WILLIAMS:
11 A. June of 1996, yes, I'm sorry, yes.
12 COFFEY, Q.C.:
13 Q. And government accepted that at the time?
14 DR. WILLIAMS:
15 A. I guess they considered and then they accepted
16 it, yes.
17 COFFEY, Q.C.:
18 Q. Was it accepted while you were Deputy
19 Minister?
20 DR. WILLIAMS:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. And what was that plan?
24 DR. WILLIAMS:
25 A. That plan was to decant the services from the

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1 Grace to other sites. The plan was that
2 obstetrical care at the Grace and neonatal
3 services would move to the General Hospital
4 site contiguous with the new Janeway Hospital.
5 That vascular surgery that was at the Grace
6 would move to the St. Clare's site. And that
7 head and neck, ENT services that were at the
8 Grace site would move to the St. Clare's site.
9 I'm just trying to think of any others. The
10 rest of the program was general surgery,
11 general medicine. The dermatology, the Grace
12 had responsibility--the dermatology next to
13 the Grace, there was very little in-patient
14 work done on dermatology. So, I think
15 dermatology, if there was going to be any in-
16 patient admissions would probably be at St.
17 Clare's, but that wasn't a big consideration.
18 COFFEY, Q.C.:
19 Q. I gather than general surgery would include
20 surgery for breast cancer?
21 DR. WILLIAMS:
22 A. Yes, general surgery.
23 COFFEY, Q.C.:
24 Q. So they would be relocated--the people doing
25 that at -

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1 DR. WILLIAMS:
2 A. At the -
3 COFFEY, Q.C.:
4 Q. - Grace -
5 DR. WILLIAMS:
6 A. - Grace site would be mostly relocated to the
7 St. Clare's site. So, St. Clare's really
8 would, at the end--and thoracic surgery which
9 was always at St. Clare's, would stay at St.
10 Clare's. In essence, the St. Clare's Hospital
11 became a major centre for surgery, general
12 surgery and thoracic surgery. Gynacological
13 surgery from the Grace went to the Health
14 Sciences, General Hospital.
15 COFFEY, Q.C.:
16 Q. Yeah, there are certain, I take it, particular
17 types of services which you've described got
18 relocated -
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. - in their entirety really to the General
23 Hospital and the remaining generally devolved
24 upon St. Clare's.
25 DR. WILLIAMS:

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1 A. Yes. Head and neck was a big service at the
2 Grace Hospital and that was sent to St.
3 Clare's. Vascular surgery was a significant
4 service at the Grace and that was decanted to
5 St. Clare's. And the general surgery
6 component of the Grace would have gone to St.
7 Clare's. Obstetrics and gynacology would have
8 gone to the Health Sciences Centre.
9 COFFEY, Q.C.:
10 Q. How about the laboratory, clinical laboratory
11 at the Grace Hospital?
12 DR. WILLIAMS:
13 A. The work there would probably be divided. The
14 pathologists, I know, some went to the Grace
15 and some went to St. Clare's and contiguous
16 with what was felt to be the volume of work
17 that would have gone from the Grace, of a
18 surgical nature, to those two sites.
19 COFFEY, Q.C.:
20 Q. So, accordingly, kind of -
21 DR. WILLIAMS:
22 A. Sort of, yes. That decision obviously would
23 be left to the clinical people, how to divide
24 up the number of pathologists from site to
25 site.

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1 COFFEY, Q.C.:
2 Q. And that only, that actually, finally occurred
3 when?
4 DR. WILLIAMS:
5 A. That finally occurred when the Grace closed in
6 2002.
7 COFFEY, Q.C.:
8 Q. By which point you were already with the
9 Health Care Corporation, but the idea for it
10 has its origin in 1996.
11 DR. WILLIAMS:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And it finally got implemented around 2002.
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. Now, as Deputy Minister, after the Health Care
19 Corporation of St. John's was formed, how
20 much, if any, interaction would you have with
21 the executive of the Health Care Corporation?
22 This would be from about 1996 onward, '95 or
23 '96 onward. What was your experience as
24 Deputy Minister?
25 DR. WILLIAMS:

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1 A. I would have interaction with Sister Elizabeth
2 Davis on issues that would, you know, need--
3 the day-to-day relationship would probably be
4 with the ADM responsible for institutions.
5 COFFEY, Q.C.:
6 Q. Between Sister -
7 DR. WILLIAMS:
8 A. Elizabeth, yes.
9 COFFEY, Q.C.:
10 Q. - Elizabeth Davis and your ADM?
11 DR. WILLIAMS:
12 A. Yes, yes, on the day-to-day issues. If there
13 was broader issues that I needed to involved
14 in, I might be involved in it. If Dr. Parson,
15 who was vice-president of medical had some
16 issues, he might involve me because of my
17 medical background or he might go to Dr.
18 Windsor who was our medical consultant at the
19 time.
20 COFFEY, Q.C.:
21 Q. And who was your ADM?
22 DR. WILLIAMS:
23 A. ADM changed over that time. So, I'm having to
24 say that it was, let me see, Primrose Bishop
25 would have been an ADM at the time, in

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1 institutions. And after Primrose, it would be
2 Roy Manuel, ADM institutions. I'm not sure
3 about -
4 COFFEY, Q.C.:
5 Q. So, it altered over time. There was no one
6 person -
7 DR. WILLIAMS:
8 A. Yes, Primrose, I think retired, and Roy took
9 over, but I don't know, I can't tell you what
10 the exact timeframes were.
11 COFFEY, Q.C.:
12 Q. What sorts of things, can you give an example
13 please to the Commissioner of what sorts of
14 things as the Deputy Minister you might be
15 called upon to deal with, of the head of the
16 Health Care Corporation or the head of any
17 other CEO of any of the other health
18 authorities or boards at the time?
19 DR. WILLIAMS:
20 A. I would think it would be issues that were
21 broad, maybe involving policy or something
22 like that that Sister might want to run by me
23 before her board dealt with it or before he
24 board chair came in to talk to the minister,
25 things like that. I can't remember. If you

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1 ask me some specifics, I can't remember, but
2 that's the kind of nature and relationship
3 that I would have had with the CEO, whether it
4 was Sister Elizabeth or Don Keats who was out
5 in Central at the time.
6 COFFEY, Q.C.:
7 Q. Would you get involved in operational issues?
8 DR. WILLIAMS:
9 A. No, I wouldn't get--the operational issues
10 would devolve to the executive at the
11 organizations. Now, some people might want us
12 to get involved, but I would try to talk to
13 them and deflect them to the appropriate
14 people in the region.
15 COFFEY, Q.C.:
16 Q. And what about if a matter contained some
17 public or involved some public controversy, an
18 operational issue within one of the hospital,
19 or hospital authorities or boards operations
20 and it became a matter of, you know, public
21 controversy. Would you as Deputy Minister get
22 involved in that?
23 DR. WILLIAMS:
24 A. Yes, we would and maybe the minister as well,
25 depending on the issue. We'd expect the

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1 boards to bring to our attention any issues
2 that they felt were problematic.
3 COFFEY, Q.C.:
4 Q. And how was that done? What was the
5 expectation in that regard?
6 DR. WILLIAMS:
7 A. I would expect that the CEO would contact our
8 ADM institutions or myself, if that person
9 wasn't available, just to give us a heads up,
10 probably we'd talk about it. Now, again I
11 can't tell you any specific -
12 COFFEY, Q.C.:
13 Q. Sure.
14 DR. WILLIAMS:
15 A. - example or whether it was some other board.
16 And sometimes there was meetings between the
17 minister and the CEO which--sorry, minister
18 and the board chair. And the CEO and myself
19 would often attend those meetings.
20 COFFEY, Q.C.:
21 Q. And your view of your role during such
22 meetings was what?
23 DR. WILLIAMS:
24 A. Well my role with meeting usually between the
25 CEO and minister because the minister

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1 appoints--sorry, the board chair and the
2 minister, the Minister appoints the board
3 chair. My role would be, you know, provide
4 advice to the minister or have a discussion
5 with the minister so he'd know what our
6 position may be on that particular issue.
7 COFFEY, Q.C.:
8 Q. Now, we've heard, Commissioner and counsel and
9 others present here have heard a number of
10 references, certainly in the 2000s, to
11 communications directors and--I see you smile
12 a little bit--could you tell us please, you
13 know, back in your day as Deputy Minister
14 what, if any, role, looking back on it, they
15 played or people equivalent to what are now
16 known as communications directors.
17 DR. WILLIAMS:
18 A. Yes. I know when we went through all the
19 restructuring in the mid 1990s, most of the--
20 we had a particular ADM who was good at
21 communication, you know, good at pen to paper,
22 good at wording things. And that person would
23 be doing a lot of, you know, letters and
24 response to vacuum (phonetic), letters and
25 response to issues that had come up and issues

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1 such as that. Communications directors would
2 have come on late in my tenure at the
3 department. So, I left in 1998, probably in
4 the last two to three years, the role of
5 communications directors, they would have been
6 new people to our organization. And the
7 ministers, my experience with them, that the
8 last minister I had certainly had a
9 communications director.
10 COFFEY, Q.C.:
11 Q. Now, whose idea were they? Were they--I say
12 within your own department, was it your idea?
13 DR. WILLIAMS:
14 A. No, we didn't -
15 COFFEY, Q.C.:
16 Q. It wasn't?
17 DR. WILLIAMS:
18 A. No, that was a, I guess, a government, sort
19 of, initiative or direction that they
20 undertook. It wasn't an issue that was
21 brought up by the Department of Health.
22 That's my recollection of it. It was a
23 broader initiative throughout government.
24 COFFEY, Q.C.:
25 Q. And what was your understanding when you were

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1 Deputy Minister as to, well, first of all, do
2 you recall the first communications director,
3 who that was?
4 DR. WILLIAMS:
5 A. It was a Mr. Paul Chislett.
6 COFFEY, Q.C.:
7 Q. And who did Mr. Chislett work for and who did
8 he report to and who did he actually work for?
9 DR. WILLIAMS:
10 A. I'd have to go and look. I can't recollect.
11 The last communications director was Mr. Glen
12 Bruce and he clearly worked for the Minister.
13 But -
14 COFFEY, Q.C.:
15 Q. Did he report to you or -
16 DR. WILLIAMS:
17 A. No, he didn't report to me. We had a good
18 liaison function. I saw his role reporting to
19 the Minister as the Minister's communication
20 director, but we worked closely together.
21 THE COMMISSIONER:
22 Q. If I can just jump in.
23 COFFEY, Q.C.:
24 Q. Sure.
25 THE COMMISSIONER:

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1 Q. My recollection is that communications people,
2 over time, were at one time considered to be
3 part of the, if you will, political end of
4 things.
5 DR. WILLIAMS:
6 A. Yes, um-hm.
7 THE COMMISSIONER:
8 Q. And other periods of time considered part of
9 the department -
10 DR. WILLIAMS:
11 A. Yes.
12 THE COMMISSIONER:
13 Q. - although their work might be primarily
14 related to the minister's function.
15 DR. WILLIAMS:
16 A. Yes.
17 THE COMMISSIONER:
18 Q. Do you recall if, in your period of time Mr.
19 Chislett or Mr. -
20 DR. WILLIAMS:
21 A. Bruce, Glen Bruce.
22 THE COMMISSIONER:
23 Q. - Bruce were on the political wing or were
24 they on the departmental wing?
25 DR. WILLIAMS:

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1 A. I think Mr. Chislett--again, I can be
2 corrected because we're going back quite a
3 while--was on the departmental end. Mr. Bruce
4 was more on the ministerial end, political
5 end, but they might have been considered
6 employees, but worked closely with the
7 minister. I'd have to be refreshed on that.
8 COFFEY, Q.C.:
9 Q. And what their formal categorization at the
10 time, their status, whether they were civil
11 servants or political staff, you just can't
12 recall? Dr. Williams, you indicated certainly
13 Mr.--was it -
14 DR. WILLIAMS:
15 A. Glen Bruce.
16 COFFEY, Q.C.:
17 Q. - Glen Bruce, you recall, a good working
18 relationship with him.
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. What sorts of things would you be involved
23 with with Mr. Bruce?
24 DR. WILLIAMS:
25 A. Well, issues of the day that affected the

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1 health system and there was plenty of those;
2 you know, briefings with the minister on
3 contemporary health issues that may come up in
4 the House; and developing an overall
5 communication strategy for the minister's
6 office and the department. Most of the--in
7 our system, most of the communications would
8 be obviously from the minister's office. In
9 our political system, you know the deputy
10 office is not out dealing with these issues.
11 There's a lot of media issues for a minister
12 and any department, but especially in health.
13 So, there's a lot of issues for the minister
14 at the day, no matter what the minister--who
15 the minister was.
16 COFFEY, Q.C.:
17 Q. And do you recall whether or not you were
18 aware of--let's go back a bit--just before you
19 left government service in the Confederation
20 Building, late '97, early '98, was there any
21 centralized, what is now known as the
22 Consultation and Communication Branch of
23 Cabinet Secretariat, did that organization
24 exist or one comparable to it?
25 DR. WILLIAMS:

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1 A. Let me just -
2 COFFEY, Q.C.:
3 Q. Sure.
4 DR. WILLIAMS:
5 A. When Mr. Chislett was appointed--now starting
6 to push some button here -
7 COFFEY, Q.C.:
8 Q. Sure.
9 DR. WILLIAMS:
10 A. Ms. Foote, Judy Foote was in the Premier's
11 office as communications director and I think
12 that these people, Mr. Chislett and others
13 were departmental people, but there was some
14 linkage to a central--you they did have some -
15 COFFEY, Q.C.:
16 Q. To the office of Ms. Foote?
17 DR. WILLIAMS:
18 A. Yes. There was some linkages there, but
19 mostly they were in the department on a day-
20 to-day basis helping the department with, and
21 the minister's office in particular because
22 that's where a lot of the communications would
23 come from, in terms of communications. That
24 was sort of in its infancy, starting to
25 develop. When I left Mr. Bruce was still

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1 there, he come with the minister of the day,
2 was still there. And I thought Mr. Bruce's
3 interaction was mostly with the Minister and
4 with the department. I don't recollect it was
5 a lot of central linkages, but I'm not sure.
6 I could be corrected on that.
7 COFFEY, Q.C.:
8 Q. Okay. Now, when you were deputy minister and
9 particularly the period, say '95 through '98,
10 you would have, I take it--would you have
11 daily interaction with the minister?
12 DR. WILLIAMS:
13 A. Depending. The minister's office was here and
14 the deputy's office is here. So you could
15 pretty well see the minister every day. When
16 the House is open, some ministers had a
17 different approach. Some ministers wanted,
18 you know, make sure that you at least touch
19 base that day the House is open in case there
20 was any new issues emerging or on the horizon.
21 Some ministers didn't, but pretty well had an
22 interaction--the ministers I was there with,
23 we sort of had an open-door policy. You know,
24 if I had an issue, I wouldn't have to
25 formalize an appointment with the minister.

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1 I'd just talk to his secretary and see him for
2 a few minutes, or her for a few minutes and
3 drop in and vice versa. So I can remember
4 sort of a, not a formalized arrangement, but
5 people would drop in or walk across, I
6 suppose, across the hall, across a room,
7 either way, the minister had a problem, the
8 minister might just pop out to the office or I
9 get a message from the minister's secretary to
10 pop over there, it just depended.
11 COFFEY, Q.C.:
12 Q. And as deputy minister of health, in again,
13 the period, say, you know, '96 through '98,
14 what if any contact would you have with the
15 Cabinet Secretariat and the Premier's office?
16 How much--on what sorts of issues?
17 DR. WILLIAMS:
18 A. If we, the minister, the department had a
19 paper in the system authored by the minister,
20 then sometimes there would obviously be
21 Treasury Board phoning us, there'd be social
22 policy committee phoning us because of that.
23 Sometimes we would get calls from, you know,
24 Malcolm Rowe, who was the clerk of the
25 Executive Council, the last person when I was

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1 there. I would say I had more interaction,
2 probably, with Mr. Rowe than I would have had
3 with the former individuals there. But I did
4 have interaction, I saw the clerk of the
5 Executive Council as the senior public servant
6 and sometimes if I had some issues that I
7 wanted to bounce off, I might go to that
8 person as a sort of a mentor senior person,
9 advisor, type of thing.
10 COFFEY, Q.C.:
11 Q. Um-hm. And while you were deputy minister if
12 the--again, during that same, what, in the
13 last three-year period, if the clerk of the
14 council of the day gave you instructions to do
15 something, or even advice as to what to do,
16 what was your understanding as to whether or
17 not you were expected to carry that out?
18 DR. WILLIAMS:
19 A. Well, it depends on where the--if the
20 direction came from the premier's office, I
21 was expected to carry it out. I would
22 certainly have some, probably some discussion
23 with the minister about it if there was an
24 issue that, you know, I had some concerns
25 about.

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1 COFFEY, Q.C.:
2 Q. But if you had no concerns about it, you'd
3 certainly go ahead and do it, I take it?
4 DR. WILLIAMS:
5 A. Yes, yeah, if it came and, you know, in that
6 sense.
7 COFFEY, Q.C.:
8 Q. So that would be from the premier's office or
9 from the clerk?
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Of the Cabinet Secretariat?
14 DR. WILLIAMS:
15 A. Sure. When I was appointed deputy minister by
16 Premier Wells, I was told that, you know,
17 obviously I had to work with the minister and
18 this type of thing and he expected that to
19 happen, but if I ever had a problem, then I
20 could come directly to him on a major issue.
21 I didn't have to do that.
22 COFFEY, Q.C.:
23 Q. But that was your basic understanding of -
24 DR. WILLIAMS:
25 A. When I was appointed.

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1 COFFEY, Q.C.:
2 Q. Of your own position?
3 DR. WILLIAMS:
4 A. Yes. I was appointed by the premier.
5 COFFEY, Q.C.:
6 Q. Sir, if we could, please, look at page 7 of P-
7 1280? If I could, now, I take it that March
8 of 1998 you moved?
9 DR. WILLIAMS:
10 A. May.
11 COFFEY, Q.C.:
12 Q. I apologize, May, 1998. And you've described
13 to the Commissioner how you came to be
14 approached about applying for the VPs
15 position. What did you find, then, when you
16 first took up your duties as Vice President of
17 Medical Services, what was your role?
18 DR. WILLIAMS:
19 A. Well, I took--you know, I didn't have--the
20 person who I replaced had left at the time, so
21 I took awhile to get--I didn't have somebody
22 around to brief me or orientate me, but I did
23 get orientated by Sister Elizabeth and other
24 members of the executive. I had to do it by
25 meeting with people and going around and

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1 meeting with the various program people,
2 especially the people, the programs that I was
3 responsible for. My office was located on the
4 Grace Hospital site. And the reason Sister
5 told me that she wanted me to be at the Grace
6 Hospital site rather than at the General site
7 was that the Grace was designated to close,
8 the physicians over there were upset, there
9 was going to be some problems as you try to
10 close a site, she anticipated there would be
11 problems on that site and that she felt that
12 it would be better for me to be on the site
13 and work closely with the--because I knew the
14 physicians and work closely with the
15 physicians on that site to make the transition
16 go as well as possible.
17 COFFEY, Q.C.:
18 Q. So that was explained as to why you were going
19 to be over there?
20 DR. WILLIAMS:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. What did you--what did you find or understand
24 from Sister Davis or subsequently about why
25 the physicians were upset?

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1 DR. WILLIAMS:
2 A. Well, you're going to close their facility, a
3 lot of them had worked in the facility for
4 their career, their full career, so you can
5 expect somebody, if you take, you know, take
6 something away, that they would be like that.
7 Obviously as you're changing the role of a
8 facility, until there's some changes that it
9 goes through in terms of, for instance,
10 internal medicine, because people knew that
11 the facility was going to be closed as well at
12 that time we had problems staffing all three
13 emergency departments in the city, so that
14 presented some problems in that. By the time
15 I arrived the Grace was, emergency department
16 was only operating 18 or 16 of 24 hours, it
17 would close at 10 or 11 o'clock in the night.
18 That presented some problems with, you know,
19 making sure people didn't show there in an
20 emergency situation expecting to get cared
21 for. Also the right of referral slowed down
22 for some of the specialists there, especially
23 the internists who, general internists who
24 were there because people would say, we're not
25 open 24 hours, less referrals there, that had

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1 an impact on, you know, on these physicians.
2 COFFEY, Q.C.:
3 Q. In what way?
4 DR. WILLIAMS:
5 A. In what way? Because they--it would impact in
6 their amount of beds they had filled, their
7 patients they had sometimes. It was an income
8 issue, a little bit of an income issue. The
9 other issue was because that was happening,
10 the medical school, I think the number of
11 interns or residents that were rotating
12 through there had decreased, so we had to hire
13 a GP who provided some of this extra
14 assistance in helping care for the patients.
15 So all these things were, it's sort of the
16 thing that happen when you designate a site
17 for a change, and the change had designated a
18 couple of years ahead of when it happens. So
19 that's why she wanted me over on that site, to
20 have a physical presence and to be able to
21 interact with the physicians on that site.
22 COFFEY, Q.C.:
23 Q. So could you tell the Commissioner then,
24 please, I take it then you were--you
25 understood from Sister Davis that one of your

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1 functions as the VP, because of where you were
2 located, was to facilitate the closure?
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. In the least disruptive means possible?
7 DR. WILLIAMS:
8 A. Right, yes.
9 COFFEY, Q.C.:
10 Q. I take it that was -
11 DR. WILLIAMS:
12 A. That's correct.
13 COFFEY, Q.C.:
14 Q. And that would have involved, again, I take
15 it, dealing with these individuals on an
16 interpersonal way?
17 DR. WILLIAMS:
18 A. A lot of that, yes.
19 COFFEY, Q.C.:
20 Q. A lot of that to reassure them?
21 DR. WILLIAMS:
22 A. Yes. And that we'd try to work with them and
23 make the transition. And there was a lot of
24 issues that came up there.
25 COFFEY, Q.C.:

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1 Q. Okay.
2 DR. WILLIAMS:
3 A. I could list them all out, but I don't think
4 you need to hear.
5 COFFEY, Q.C.:
6 Q. Yes.
7 DR. WILLIAMS:
8 A. Just that there was issues.
9 COFFEY, Q.C.:
10 Q. There were. And the Grace finally did close
11 when?
12 DR. WILLIAMS:
13 A. The Grace closed around September, August,
14 September, 2000, in 2000. There was a problem
15 in that the Janeway, because of the strike,
16 was not ready to accommodate patients.
17 However, we had an obstetrical and
18 gynaecological service and a neonatal service
19 that had to be moved off the Grace site.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. WILLIAMS:
23 A. The problem with the Grace is that once you
24 start in a process, it's--and you're changing
25 a role, we had to move off the Grace site

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1 because we couldn't maintain some of the
2 surgical services and other services because
3 we couldn't maintain the medical service. So
4 one thing leads to another. If you don't have
5 a general internal medical service, it's hard
6 to run a hospital where you got surgical
7 patients and an intensive care unit and other
8 things. So we really had to--we couldn't
9 maintain the service at the Grace any longer
10 so it forced us to move off site when the
11 Janeway, because of a strike and other things,
12 wasn't ready to be fully operational. So what
13 we had to do was, as a makeshift, we had to
14 take at the General site they had built a new
15 cardiac care unit that they hadn't occupied at
16 the time, they were still operating in a
17 cardiac care unit that was upstairs, so we had
18 to commandeer that cardiac care unit and we
19 had to commandeer and wall off part of the
20 prep recovery area in the surgical area at the
21 General Hospital site to accommodate
22 obstetrical and neonatal care. We had a lot of
23 problems. We finally worked with a lot of the
24 physicians and one of them came up with this
25 solution as a way we could bridge the gap for

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1 three or four months until the Janeway opened
2 up in January, February. So what we had is
3 obstetrical care in the designated cardiac
4 care unit and we had neonatal care in part of
5 a recovery area, prep area for the day
6 surgery.
7 COMMISSIONER:
8 Q. And this was 2002?
9 DR. WILLIAMS:
10 A. 2000.
11 COMMISSIONER:
12 Q. Or 2000?
13 DR. WILLIAMS:
14 A. 2000. That's my recollection.
15 COMMISSIONER:
16 Q. I thought you'd said earlier that the Grace--I
17 confess, I have no memory of it myself. I
18 thought you had said earlier it closed in
19 2002, but it's 2000 it closed?
20 DR. WILLIAMS:
21 A. Yes.
22 COMMISSIONER:
23 Q. Thank you.
24 DR. WILLIAMS:
25 A. That's my recollection. I'd have to -

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1 COMMISSIONER:
2 Q. No, yours would be better than mine.
3 DR. WILLIAMS:
4 A. I may be wrong, but I think it's 2000.
5 COFFEY, Q.C.:
6 Q. Doctor -
7 DR. WILLIAMS:
8 A. Now that was expected to happen earlier than
9 that, but because of delays on the Janeway,
10 when I went to the Grace, Sister said you'd be
11 here for about one and a half years, 18
12 months, she figured.
13 COFFEY, Q.C.:
14 Q. That would be from May of '98?
15 DR. WILLIAMS:
16 A.
17 COFFEY, Q.C.:
18 Q. And you finally left there in?
19 DR. WILLIAMS:
20 A. I didn't leave there until November. We were
21 the only--or office was pretty the only thing
22 on the Grace. The whole hospital was closed,
23 but they didn't have a space for me to occupy,
24 so they left my office with my staff at the
25 Grace site. So we were the only people over

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1 there except for the people that were looking
2 after the building.
3 COFFEY, Q.C.:
4 Q. I take it you were, I suppose, in a proverbial
5 sense, the people who turned off the lights?
6 DR. WILLIAMS:
7 A. Correct, yes. We had a hospital that had no
8 patients in it. But we were there, our office
9 was there until, I think it's November, 2000
10 our office moved.
11 COFFEY, Q.C.:
12 Q. And you moved from there to where?
13 DR. WILLIAMS:
14 A. Moved to the General site in--well, moved to
15 the General site, put it that way. I could
16 tell you where it was, but it's--that's
17 redeveloped, too, now so it's not there any
18 more.
19 COFFEY, Q.C.:
20 Q. Now, in closing the Grace the clinical
21 laboratory services, what happened to the--I
22 take it the clinical laboratory at the Grace
23 would have been comprised of, as you were
24 working there, or stationed there as the VP
25 was comprised of what source of individuals?

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1 DR. WILLIAMS:
2 A. Technologists and pathologists and support
3 staff.
4 COFFEY, Q.C.:
5 Q. And were you at all involved in the
6 reallocation of them to other facilities in
7 St. John's?
8 DR. WILLIAMS:
9 A. To the point that that--who we would
10 reallocate here was left to the program
11 leadership team of Laboratory Medicine to
12 reallocate, like Dr. Cook would reallocate the
13 pathologists from one site to the other and
14 Mr. Gulliver, the technologist. There'd be
15 some discussions, obviously, between them on
16 how things were going to evolved. It would be
17 done, too, on the basis of what things were
18 decanted from that site, where they were
19 decanted, whether they were decanted to St.
20 Clare's or the General site.
21 COFFEY, Q.C.:
22 Q. Do you recall whether or not there were any
23 issues brought up, brought to your attention
24 at the time as VP medical?
25 DR. WILLIAMS:

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1 A. I can't recall, no. There were--you know, I
2 recall that Dr., I think Dr. Cook was there at
3 the time filling in for Dr. Haegert, who had
4 been on sabbatical and who was coming back at
5 around that time, but I expect Dr. Cook made
6 the decision on how many pathologists would be
7 located to each site. I didn't hear anything
8 from Dr. Haegert when he came back about the
9 issue, so I presume that he didn't have a
10 problem with it.
11 COFFEY, Q.C.:
12 Q. And with respect to the Janeway, which would
13 have had its own clinical laboratory?
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Down in Pleasantville?
18 DR. WILLIAMS:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. When that was relocated to the General
22 Hospital site, what happened with their
23 clinical laboratory services, the Janeway's?
24 DR. WILLIAMS:
25 A. There was some centralization of some of the

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1 services to--now, the blood taking services
2 was user friendly to children, so people who
3 were taking blood and this type of thing would
4 be people who were working at the Janeway and
5 working exclusively in the child program. I
6 think a lot of the, you know, the testing
7 would probably go to the General site.
8 COFFEY, Q.C.:
9 Q. So the pathologists -
10 DR. WILLIAMS:
11 A. It would go, you know, a lot of it, some of it
12 would go to, anyway.
13 COFFEY, Q.C.:
14 Q. The pathologists at the Janeway -
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. - just would have moved to the General?
19 DR. WILLIAMS:
20 A. Yeah, there was one pathologist.
21 COFFEY, Q.C.:
22 Q. Okay.
23 DR. WILLIAMS:
24 A. And she would have moved to the General site.
25 COFFEY, Q.C.:

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1 Q. And the technologists?
2 DR. WILLIAMS:
3 A. They would have moved, I don't know if they
4 all moved to the General site, but they would
5 have moved off the Janeway site. I can't
6 remember the details on that.
7 COFFEY, Q.C.:
8 Q. Sir, if you could, please, when you took over
9 as VP medical, would you tell the Commissioner
10 when you settled in, what your primary role
11 was then in terms of who you were dealing
12 with, who reported to you?
13 DR. WILLIAMS:
14 A. Yes. When I settled in, obviously you had a
15 medical role, which was you had two arms of
16 the medical staff, one is the Medical Staff
17 Association and one is the Medical Advisory
18 Committee. The Medical Advisory Committee was
19 composed of a chair and clinical chiefs and
20 discipline chairs at the medical school and
21 there was a couple of representatives from
22 professional practice areas on our Medical
23 Advisory Committee. And the professional
24 practice representative on the Medical
25 Advisory Committee rotated on a two-year

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1 basis, so maybe for two years you might have
2 somebody from physiotherapy, the discipline of
3 physiotherapy and then you might have somebody
4 from the discipline of respiratory therapy.
5 And we had the CEO was ex officio, Sister
6 Elizabeth. I would have been ex officio and -
7 COFFEY, Q.C.:
8 Q. And your role as VP ex officio member was what
9 on the MAC?
10 DR. WILLIAMS:
11 A. Well, we would work with the chair of MAC, our
12 office, to make sure the functions and roles
13 of MAC were carried out. The chair of the MAC
14 would chair the meetings, prepare the minutes,
15 decide on the agenda, the agenda was, a lot of
16 it was pretty well fixed, and facilitate the
17 work of the MAC through the credential
18 committee, the infection control committee,
19 the P and T committee, the -
20 COMMISSIONER:
21 Q. (Inaudible).
22 DR. WILLIAMS:
23 A. The pharmacy and therapeutics committee.
24 COMMISSIONER:
25 Q. Thank you.

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1 DR. WILLIAMS:
2 A. The CPR committee, which is cardio pulmonary
3 resuscitation committee and the transfusion
4 committee. They would report in probably
5 every second meeting to the MAC, alternating,
6 and they would usually produce an annual
7 report every year to the MAC. The MAC would
8 deal with credentials at all their meetings
9 and they would deal with the clinical chiefs'
10 reports. Now, that happened over time after I
11 got there that the clinical chiefs would
12 report in to the MAC. When I got there, there
13 was no formalized structure for clinical
14 chiefs, but after we set up regular meetings
15 of clinical chiefs which would meet on the
16 third Tuesday of every month, every second
17 meeting the clinical chief would have to
18 report. So maybe one meeting the lab medicine
19 reported and the next meeting of MAC the
20 diagnostic imaging committee reported and then
21 laboratory medicine, so you'd have half your
22 programs reporting at one meeting and half at
23 the other. They would be, those reports would
24 be discussed at the clinical chiefs' and
25 thoroughly reviewed and then they would go on

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1 to the MAC. At the MAC you'd still have your
2 clinical chiefs there, but also you'd have
3 your discipline chairs there and the other
4 people I mentioned would be there. The MAC
5 met ten times a year. And then the Medical
6 Staff Association again they were supported
7 out of the office that I worked in, Sharon
8 Hopkins supported them.
9 COFFEY, Q.C.:
10 Q. And while we're on that, when you say
11 supported, because the MAC, I take it, was
12 supported out of your, the office you worked
13 in?
14 DR. WILLIAMS:
15 A. Yes, correct.
16 COFFEY, Q.C.:
17 Q. What does the word "support" mean in this
18 context?
19 DR. WILLIAMS:
20 A. Well, you know, you'd, Sharon Hopkins would
21 attend all their meetings, take all the
22 minutes.
23 COFFEY, Q.C.:
24 Q. Sorry, Sharon?
25 DR. WILLIAMS:

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1 A. Sharon Hopkins, our office, would attend all
2 the meetings, take all the minutes and -
3 COFFEY, Q.C.:
4 Q. Type all the minutes?
5 DR. WILLIAMS:
6 A. Type all the minutes. Dr. Whitman would then
7 prepare a report in her day and then other
8 people were there besides here, would prepare
9 a report to go to the board.
10 COFFEY, Q.C.:
11 Q. Did the MAC have its own staff?
12 DR. WILLIAMS:
13 A. No, the MAC didn't have its own staff. The
14 staff were, the staff of the MAC were in the
15 office I occupied.
16 COMMISSIONER:
17 Q. (Inaudible).
18 DR. WILLIAMS:
19 A. Yes, really. And so Sharon Hopkins was
20 dealing with that. Sharon would also deal
21 with the clinical chiefs, she would come to
22 the clinical chiefs' meetings and take all the
23 minutes for that. She would come and get
24 things ready for the credentials committee and
25 take the minutes for that. And she would also

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1 support the Medical Staff Association. Now,
2 the appointed officers of the Health Care
3 Corporation were the members, were the
4 clinical chiefs and the discipline chairs were
5 appointed by the--really appointees by the
6 positions they held on the MAC. So they were
7 called appointed officers of the appointed
8 medical people for the organization by the
9 board. The other -
10 COFFEY, Q.C.:
11 Q. If I could, just because I can tell you, this
12 is the first time the Commissioner has heard
13 kind of in a detailed way this kind of the
14 nitty gritty of how people -
15 DR. WILLIAMS:
16 A. Okay.
17 COFFEY, Q.C.:
18 Q. - who appointed who to these committees and
19 how. So you'd have the MAC, you've indicated,
20 be chaired by whoever the chair happened to
21 be?
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Who picked the chair of the MAC?

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1 DR. WILLIAMS:
2 A. The chair of the MAC could not be an officer
3 of the corporation, so it couldn't--the person
4 who chaired the MAC couldn't be a clinical
5 chief or a discipline chair, somebody who
6 would normally sit on the MAC, it had to be
7 some other active member of the medical staff.
8 The process that was used was that members of
9 the MAC would sort of form a small
10 subcommittee and would look at people who
11 might be good chairs of the MAC who might have
12 an interest in the work of the MAC. I would
13 sort of be supporting that group. And then we
14 would, one of us or something, if we had two
15 or three people that we thought might be good
16 people, one of us would approach them and then
17 we'd get back together and if we got somebody
18 that was felt was good, then that would be
19 recommended to the CEO to see if there was any
20 problems there. Then that appointee would go
21 on to the board.
22 COFFEY, Q.C.:
23 Q. And -
24 DR. WILLIAMS:
25 A. The nomination from the MAC.

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1 COFFEY, Q.C.:
2 Q. Okay. And -
3 DR. WILLIAMS:
4 A. For the new chair, for the new chair of the
5 MAC.
6 COFFEY, Q.C.:
7 Q. So the MAC would nominate a -
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. The chair?
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. And the board would have to approve of it?
16 DR. WILLIAMS:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. The board of the Health Care Corporation?
20 DR. WILLIAMS:
21 A. Yes, correct.
22 COFFEY, Q.C.:
23 Q. What about the--you started to tell us about
24 appointment of the clinical chiefs, who did
25 that?

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1 DR. WILLIAMS:
2 A. Yes. The clinical chiefs again were, we'd set
3 up a search committee and the recommendation
4 would go to Mr. Tilley. If he had no trouble
5 with it, then it would go on to the board.
6 COFFEY, Q.C.:
7 Q. Who would make the recommendation, who is the
8 we in this?
9 DR. WILLIAMS:
10 A. Search committee.
11 COFFEY, Q.C.:
12 Q. Okay.
13 DR. WILLIAMS:
14 A. The search committee in that case.
15 COFFEY, Q.C.:
16 Q. And what, if any, involvement would your
17 office have in that?
18 DR. WILLIAMS:
19 A. I would sit on the search committee for all
20 the clinical chiefs.
21 COFFEY, Q.C.:
22 Q. And, for example, the search committee for
23 something such as the clinical chief of the
24 clinical laboratory?
25 DR. WILLIAMS:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. The lab medicine program, what sorts of people
4 would be on the search committee?
5 DR. WILLIAMS:
6 A. Usually the search committee was a sponsored
7 (phonetic) committee and it would be the
8 discipline chair of the medical school, a
9 representative from human resources.
10 COFFEY, Q.C.:
11 Q. Discipline chair from that program?
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. Okay.
16 DR. WILLIAMS:
17 A. So laboratory medicine program at the medical
18 school. Now, when I got there, people were in
19 position so I wasn't involved in the initial
20 appointments.
21 COFFEY, Q.C.:
22 Q. Yes.
23 DR. WILLIAMS:
24 A. But for subsequent ones that came up, we'd
25 usually have the discipline chair of the

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1 medical school and I would be there and
2 somebody from human resources to make sure the
3 proper process was followed. They
4 participated, a senior member of human
5 resources, they participated in the selection
6 process.
7 COFFEY, Q.C.:
8 Q. And so this search committee or search group
9 would identify one or two people?
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Nominate somebody and the nomination would go
14 to the -
15 DR. WILLIAMS:
16 A. To Mr. Tilley.
17 COFFEY, Q.C.:
18 Q. Tilley. And if he was accepted that -
19 DR. WILLIAMS:
20 A. Then we'd tell the person that it was
21 accepted. He'd take it to the board then to
22 see if there was any, any problems, but
23 clinical chiefs are appointees.
24 COFFEY, Q.C.:
25 Q. Of the board?

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1 DR. WILLIAMS:
2 A. Yes. That's my recollection of what happened.
3 COFFEY, Q.C.:
4 Q. And -
5 DR. WILLIAMS:
6 A. Who would take it to the board as we were
7 wanting to appoint Dr. X to be clinical chief
8 of this program.
9 COFFEY, Q.C.:
10 Q. And I presume if they had any questions, you'd
11 answer them and -
12 DR. WILLIAMS:
13 A. I was able to, yes, deal with it.
14 COFFEY, Q.C.:
15 Q. And it would just--I take it in the normal
16 course the board would be expected to approve
17 of the nominee?
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. How about the discipline chiefs?
22 DR. WILLIAMS:
23 A. The discipline chiefs, discipline chairs, they
24 were appointed by the medical school.
25 COFFEY, Q.C.:

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1 Q. I apologize, just one chair, I apologize.
2 DR. WILLIAMS:
3 A. Yeah, they were medical school appointments.
4 We had--they had a process that again that
5 took a lot of my time because the medical
6 school, when they appoint a discipline chief,
7 a discipline chair, sorry, for, say, the
8 pathology program at the medical school or the
9 medicine program, they set up a search
10 committee that's very all encompassing. I
11 would be asked to sit on that search committee
12 representing the Health Care Corporation of
13 St. John's. They would, the dean would
14 appoint an independent chair, somebody from a
15 different discipline. So if we were
16 appointing somebody from medicine, the person
17 who might chair the search committee for
18 medicine might be a surgeon or something like
19 that, some senior person at the medical
20 school, and there would be a number of people
21 from, on the search committee from that
22 particular discipline. So if you're
23 appointing a surgeon, there'd be a number of
24 people from the surgery, discipline of surgery
25 within the medical school. So it would

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1 usually be an independent--a chair that was
2 appointed by the dean, a number of people from
3 that program, I think appointed by the dean,
4 and somebody from, usually me, from Health
5 Care Corporation of St. John's, and that
6 process could take a year or more, by the time
7 they went through the process. They brought
8 in people from outside the province. There
9 had to be presentations and this type of
10 thing, yes.
11 COFFEY, Q.C.:
12 Q. The appointment or recruitment process, as it
13 were, appointment process for the discipline
14 chairs compared to the process for choosing
15 the clinical chiefs, how do they compare?
16 DR. WILLIAMS:
17 A. They were quite a bit different. The
18 discipline chair had--goes through the
19 university process, I guess the same as they
20 do in the university generally, I expect, and
21 the person had to--they looked at the person's
22 clinical, but they also looked at their
23 academic in great detail and, you know, this
24 type of thing, right.
25 THE COMMISSIONER:

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1 Q. Mr. Coffey, whenever you can find a convenient
2 spot.
3 COFFEY, Q.C.:
4 Q. Yes, thank you. And how would you--the actual
5 choice of any one discipline chair was whose
6 choice?
7 DR. WILLIAMS:
8 A. The dean's.
9 COFFEY, Q.C.:
10 Q. The dean, finally -
11 DR. WILLIAMS:
12 A. But he'd come to Health Care Corporation
13 before he'd make a final appointment and ask
14 if we had a problem. We have a document that
15 is done that lays out this between the
16 university--it's a signed document that lays
17 out the functions of the medical school and
18 Eastern Health, well Health Care Corporation
19 of St. John's, in appointing physicians.
20 COFFEY, Q.C.:
21 Q. I believe the other organization was the
22 Medical Staff -
23 DR. WILLIAMS:
24 A. Association.
25 COFFEY, Q.C.:

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1 Q. - Association. Well, we'll take up the
2 Medical Staff Association when we come back.
3 Thank you.
4 DR. WILLIAMS:
5 A. Okay.
6 THE COMMISSIONER:
7 Q. 15 minutes.
8 (BREAK)
9 THE COMMISSIONER:
10 Q. Please be seated. Mr. Coffey.
11 COFFEY, Q.C.:
12 Q. Thank you, Commissioner. Now Dr. Williams,
13 you were about to tell us about the Medical
14 Staff Association.
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. As you found it, you know, it's structure and
19 so on, as you found it when you took over as
20 VP Medical.
21 DR. WILLIAMS:
22 A. Yes. The Medical Staff Association is not an
23 appointed arm of the Board of the Health Care
24 Corporation, but it's the--almost like a
25 unionized situation for physicians. It's a

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1 group that has a president, vice-president,
2 secretary and treasurer, that carries out the
3 affairs of the medical staff and is supposed
4 to represent the concerns of the medical staff
5 through the president of the Medical Staff
6 Association to the Board. The president and
7 vice-president of the Medical Staff
8 Association would sit on the MAC, although not
9 appointed officers, and the president would
10 also be invited to the Board meetings of the
11 Health Care Corporation of St. John's. So
12 really at any Board meeting of the Health Care
13 Corporation of St. John's, you'd have the
14 chair of MAC presenting a report, mostly on
15 quality issues, credentialling and medical
16 staff issues, and could respond to any
17 questions from the Board about medical staff
18 and how that's working from that perspective.
19 And then the president of the Medical Staff
20 Association would be asked to give a short
21 report on activities of the Medical Staff
22 Association.
23 The Medical Staff Association, in their
24 modus operandi, which would be laid out in the
25 text of the bylaws somewhere, would meet four

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1 times a year, four meetings a year, in
2 September, December, March and June. The June
3 meeting would be the annual meeting of the
4 Medical Staff Association where they would
5 elect their executive. They would be a forum
6 for really any gripes or problems that
7 physicians would have. They could come along
8 to the Medical Staff Association and bring
9 them up. The chair of MAC would attend the
10 Medical Staff Association and give a report to
11 the Medical Staff Association on issues from
12 the MAC emanating from the MAC, what's going
13 on at the MAC, what's going on at the Board
14 related to the MAC. I would come along and
15 give a report from the office of Vice
16 President Medical Services to the quarterly
17 Medical--to each quarterly Medical Staff
18 meeting, and would listen to the concerns and
19 try to address some of the concerns that would
20 be raised on the floor.
21 They would meet in the auditorium,
22 usually, of the--at the Health Sciences
23 Centre. Sometimes they would meet at the St.
24 Clare's site. They would always have a
25 problem getting a large number of attendees.

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1 To have any more than 60 or 70 would be
2 unusual. Even though we had a medical staff
3 of some five to six hundred, we'd have a small
4 turn out. Over the years, they've tried to
5 figure out why that is. I think some of the
6 reason is that we have clinical chiefs for
7 each of the programs that they're in and they
8 bring a lot of their concerns up to the
9 clinical chief and maybe get them addressed
10 that way. I'm not--we were never sure why,
11 but these meetings would last about an hour,
12 and they had some other activities too that
13 they--they had to pay $100 a year and they
14 used some of that money for scholarships and
15 things like that in the medical area.
16 Mostly it was a forum where members of
17 the medical staff could bring their concerns
18 forward and hopefully have them addressed, and
19 then if they weren't addressed there, then
20 their president could bring them up at the
21 Board level.
22 And the other place where the medical
23 staff could impact on the Board was the Joint
24 Conference Committee, which is a committee of
25 the Board which has equal representation from

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1 the Board and medical staff.
2 COFFEY, Q.C.:
3 Q. Joint Conference Committee?
4 DR. WILLIAMS:
5 A. Joint Conference Committee. That would be
6 laid out in the documents, the package that we
7 had. It's in the binder, bylaws, rules and
8 regulations with the Health Care Corporation
9 of St. John's.
10 COFFEY, Q.C.:
11 Q. How often would they meet?
12 DR. WILLIAMS:
13 A. They met infrequently. Really, we were at the
14 call of either if the president of the Medical
15 Staff Association wanted to call it or Chair
16 of the Board wanted to call it and vice versa.
17 But they did not meet that often. There was a
18 couple--they've had a number of meetings when
19 I was there, but not that often, not on a
20 regular basis.
21 COFFEY, Q.C.:
22 Q. Do you recall whether or not that Joint
23 Conference Committee ever dealt with
24 particular issues relating to pathology
25 staffing?

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1 DR. WILLIAMS:
2 A. No.
3 COFFEY, Q.C.:
4 Q. ER/PR?
5 DR. WILLIAMS:
6 A. No.
7 COFFEY, Q.C.:
8 Q. Okay.
9 DR. WILLIAMS:
10 A. That's not the kind of things that would come
11 up there.
12 COFFEY, Q.C.:
13 Q. Or the clinical laboratory program?
14 DR. WILLIAMS:
15 A. No.
16 COFFEY, Q.C.:
17 Q. Okay. The president of the Medical Staff
18 Association is chosen how? I'm sorry.
19 DR. WILLIAMS:
20 A. They would elect that person at their annual
21 meeting in June.
22 COFFEY, Q.C.:
23 Q. Okay. We've also at very--in some of the
24 documents, there's a reference to the
25 Newfoundland and Labrador Association of

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1 Pathologists or Pathologists' Association.
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. What sort of an entity was that, from your
6 perspective?
7 DR. WILLIAMS:
8 A. Yes, the Newfoundland and Labrador
9 Pathologists Association are an arm of the
10 Newfoundland and Labrador Medical Association,
11 I think. They're affiliated with the
12 Newfoundland and Labrador Medical Association.
13 My only interaction with them during my tenure
14 in Eastern Health was I was asked to chair a
15 committee in 2005, the summer of 2005, on the
16 issue of retention and recruitment of
17 pathologists and working conditions of
18 pathologists and the Newfoundland and Labrador
19 Association of Pathologists had three
20 representatives on that committee.
21 COFFEY, Q.C.:
22 Q. And I will be canvassing that with you with
23 the Commissioner, certainly.
24 DR. WILLIAMS:
25 A. Okay.

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1 COFFEY, Q.C.:
2 Q. But that's your one interaction as VP Medical
3 with that group?
4 DR. WILLIAMS:
5 A. Yes, with that group, that's correct.
6 COFFEY, Q.C.:
7 Q. Now that you mentioned the NLMA -
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. - as the VP Medical, what, if any, interaction
12 would you have with the NLMA?
13 DR. WILLIAMS:
14 A. Regular interaction with the NLMA on a lot of
15 occasions.
16 COFFEY, Q.C.:
17 Q. Of what sort?
18 DR. WILLIAMS:
19 A. Well, we, I guess, at the Health Care
20 Corporation now and Eastern Health, we had 575
21 physicians on our medical staff and then when
22 Eastern Health was created, we got another 130
23 on our medical staff. So we had well over 600
24 medical staff members, close to 700 at the
25 time, and that's 70 percent of the physicians

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1 in the province were on our medical staff. We
2 had the responsibility for tertiary care
3 medical services, responsibility for child
4 health services and there was always issues in
5 terms of child health services because volumes
6 are low and the fee-for-service modus operandi
7 may not address the concerns of us being able
8 to keep physicians in our province on that
9 basis.
10 So we had a lot of interaction with the
11 Medical Association because they had the
12 bargaining power with government for paying
13 benefits for our physicians. We felt we had a
14 role to advocate on behalf of our physicians
15 and in doing that, we advocated to the
16 Department of Health, but also worked closely
17 with the NLMA on developing a number of what
18 we call alternate payment plans for a lot of
19 our physicians in Eastern Health, and we also
20 worked on, in terms of salaried physicians,
21 on-call benefits, all these things that they
22 had a mandate for and working with government,
23 we had to work with government and work with
24 the NLMA. So we had a lot of interaction with
25 the NLMA, pretty well on a regular basis.

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1 COFFEY, Q.C.:
2 Q. How about issues relating to quality of care?
3 Did you have any interaction with them on
4 that?
5 DR. WILLIAMS:
6 A. Not a lot. When I was at the Department and
7 such, we had some interactions with the Joint
8 Management Committee on a number of quality of
9 care issues, but I guess in terms of quality
10 of care, you know, one of the basic things is
11 you got to have people that are well trained
12 and properly trained in the right numbers to
13 provide care. So on that basis, I think a lot
14 of the work we probably did was for quality
15 reasons.
16 COFFEY, Q.C.:
17 Q. Okay, indirectly then.
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. I believe there is an e-mail we're going to
22 see later in July of 2005 where there's a
23 reference to John Abbott, I believe, telling
24 George Tilley to give you a heads up that Rob
25 Ritter was going to contact you about -

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1 DR. WILLIAMS:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. - I gather about ER/PR. So I'll deal with
5 that in detail, okay, later, if I could, but
6 in terms of the idea that Mr. Ritter from the
7 NLMA might contact you on a particular matter
8 involving a clinical issue, over the years,
9 and I'm just going back then to '98 onward,
10 over the years, how much interaction would
11 there have been on those sorts of things?
12 DR. WILLIAMS:
13 A. Would have been a fair bit of interaction with
14 Mr. Ritter and his predecessor, Mr. Squires,
15 when I was at Health Care Corporation, on
16 issues on a regular basis because obviously he
17 represented physicians in the province and we
18 were employers of a lot of those physicians in
19 the province or the physicians were
20 credentialed with us. So there'd be a lot of
21 interaction on a regular basis, like I say,
22 around pay and benefits, alternate payment
23 payments, some problems that his physicians
24 might be experiencing and he might want to
25 alert me to that and see if we could resolve

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1 them.
2 COFFEY, Q.C.:
3 Q. Okay. The College of Physicians?
4 DR. WILLIAMS:
5 A. Yes, again I'd have interaction with them when
6 I was at the Department of Health obviously
7 because they report to the Minister, in my
8 view, in terms of their legislation is
9 embodied by government.
10 COFFEY, Q.C.:
11 Q. And their role was what?
12 DR. WILLIAMS:
13 A. Their role is the licensing of physicians in
14 the province. If you can't get a license in
15 the province, you can't practice with our
16 organization. Now we'd have a secondary
17 issue. We'd have to credential the physicians
18 from our perspective, but first of all, they'd
19 have to get a license and we would interact
20 with Dr. Young and his staff on a regular
21 basis in terms of -
22 COFFEY, Q.C.:
23 Q. With Dr. Robert Young?
24 DR. WILLIAMS:
25 A. He's the registrar at the Medical Board, on a

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1 regular basis because we, with over 500
2 physicians and now around 700 physicians, we'd
3 have a lot of the work of the Medical Board
4 would be with our organization.
5 COFFEY, Q.C.:
6 Q. And you had had interaction with the College
7 going back to your time as deputy minister?
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. And you understood that as deputy minister, it
12 was your view that the College, in effect,
13 reported to the Minister in terms of
14 responsibility?
15 DR. WILLIAMS:
16 A. Well, they had a responsibility to, I think,
17 government to--I think government had a
18 responsibility too to make sure they were
19 doing their job, in terms of what the
20 legislation required them to do. They were
21 self-governing, but still I think that there
22 is a relationship, yes.
23 COFFEY, Q.C.:
24 Q. And did that ever change during the period you
25 were VP or did that just continue, your

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1 understanding, that relationship?
2 DR. WILLIAMS:
3 A. That continued on. They had some--a new
4 Medical Act put in place, and I'd have to
5 refresh my memory about the details of that,
6 but there was some changes. We'd be looking
7 to them to say "look, we've got Dr. X here and
8 here's Dr. X's curriculum vitae. Do you think
9 there's any point in us pursuing Dr. X? Do you
10 think that there's a likelihood Dr. X can get
11 a license here?" Because if there wasn't a
12 likelihood or there was something that they
13 could say right away that they didn't that
14 person could get a license, then we wouldn't
15 pursue it any more. So they sort of helped us
16 with a screening thing upfront and obviously
17 it's their decision to make in the final run,
18 but we wouldn't go any farther with our
19 recruitment.
20 COFFEY, Q.C.:
21 Q. And so the Commissioner has some understanding
22 of this, you just referred to it, the College,
23 the Newfoundland College would be involved in
24 issuing a license to practice medicine?
25 DR. WILLIAMS:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. To, I take it, whoever applied to be so
4 licensed?
5 DR. WILLIAMS:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Are there different categories of licenses?
9 DR. WILLIAMS:
10 A. Yes. There's full licensure, which you can--
11 if you're GP, you can do the full scope of
12 general practice work. If you're a
13 provisional license, you have to provide
14 services under the direction of some health
15 board or this type of thing, or some
16 sponsoring authority, whether it's the
17 Department of Health or one of the health
18 boards, yes.
19 COFFEY, Q.C.:
20 Q. And what about licensing for specialties or
21 specialists, how does that work?
22 DR. WILLIAMS:
23 A. They would put them on the specialist register
24 if they felt that they were qualified to be
25 put on the specialist register. Some would be

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1 put on temporarily because they've completed
2 the program and were waiting to do their exams
3 or had done their exams but they were still
4 being able to write their exams. Some would
5 be put on the specialist register pretty well
6 permanently because they've fulfilled the
7 requirements to be put on the specialist
8 register by the Medical Board.
9 COFFEY, Q.C.:
10 Q. Now there is a specialist register, I take it?
11 DR. WILLIAMS:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And within that registry are there different
15 categories for different specialists?
16 DR. WILLIAMS:
17 A. There's different specialists laid out, yes.
18 COFFEY, Q.C.:
19 Q. So you're licensed as, for example, a
20 neurosurgeon?
21 DR. WILLIAMS:
22 A. Yeah, you're licensed as a physician and then
23 you're on the specialist register as a
24 neurosurgeon, yes.
25 COFFEY, Q.C.:

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1 Q. Okay, and whether or not you are so enrolled
2 is the determination of the College?
3 DR. WILLIAMS:
4 A. Yes, determination of the College. What you
5 do in the health organization is the
6 determination of the health organization, to
7 an certain extent.
8 COFFEY, Q.C.:
9 Q. Now just so the Registrar (sic.) has some
10 understanding of this, now I gather that the
11 MAC would make recommendations to the Board of
12 Trustees of the Health Care Corporation or
13 Eastern Health as to credentials?
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. And so they were involved in what you call
18 credentialling?
19 DR. WILLIAMS:
20 A. Yes, there was a credentials committee.
21 COFFEY, Q.C.:
22 Q. Okay.
23 DR. WILLIAMS:
24 A. A subcommittee of the MAC.
25 COFFEY, Q.C.:

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1 Q. And the work for the credentials committee was
2 performed by?
3 DR. WILLIAMS:
4 A. The office that I -
5 COFFEY, Q.C.:
6 Q. Support -
7 DR. WILLIAMS:
8 A. Yeah, supports, that we would make sure they
9 were licensed, number one. Make sure that
10 they malpractice insurance, number two. We
11 had to make sure their forms were filled out
12 and all the information that they're supposed
13 to provide us were there, number three. And
14 make sure we had letters of reference on file
15 from them to support their working with our
16 organization.
17 COFFEY, Q.C.:
18 Q. And credentialling then, for example, within
19 the Health Care Corporation would the
20 credentialling occur in relation to a
21 specialization?
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. You were credentialed as what is what, I

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1 suppose, I'm trying to ask you.
2 DR. WILLIAMS:
3 A. Yes, okay, you were credentialed within a
4 program.
5 COFFEY, Q.C.:
6 Q. Okay.
7 DR. WILLIAMS:
8 A. So let's take, for example, the -
9 COFFEY, Q.C.:
10 Q. We'll take the clinical laboratory program.
11 DR. WILLIAMS:
12 A. You want to take that, sure.
13 COFFEY, Q.C.:
14 Q. If you would, please.
15 DR. WILLIAMS:
16 A. In the clinical laboratory program, you know,
17 somebody would apply for a position or we'd
18 have a position and somebody would apply, and
19 the clinical chief, once--our office did a lot
20 of the leg work, putting out the ads. We
21 didn't expect the clinical chief to do that,
22 or receive the applications. We'd get them in
23 order and then the clinical chief would look
24 at them, interview any of the candidates and
25 if we had more than one candidate, which was--

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1 you know, lots of times we didn't, but if
2 there was more than one, there'd be
3 interviews. If there was one, there would
4 still be an interview. And then the clinical
5 chief would make a recommendation through the
6 credentials committee and onto the MAC that
7 Dr. X, we would recommend Dr. X be appointed
8 as a pathologist in the Laboratory Medicine
9 program.
10 COFFEY, Q.C.:
11 Q. And if the credentials committee accepted that
12 -
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. - they would do what?
17 DR. WILLIAMS:
18 A. They would--at the credentials committee, all
19 the charts would be on the table and they
20 could review letters of references and
21 anything in that physician's file. They would
22 review it. The credentials committee was
23 chaired by the MAC chair, and if they approved
24 it, then the credentials committee report
25 would go to the MAC recommending that -

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1 COFFEY, Q.C.:
2 Q. Dr. X -
3 DR. WILLIAMS:
4 A. - it would go by program, Dr. X in pathology,
5 sorry, in the Laboratory Medicine program, or
6 Dr. Y in the Medicine program, be appointed to
7 the medical staff of the Health Care
8 Corporation.
9 COFFEY, Q.C.:
10 Q. And in being so--that was approved finally by
11 the Board?
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. I take it, in your experience, the--do you
16 ever recall the Board rejecting a
17 recommendation of the MAC in relation to
18 credentialling?
19 DR. WILLIAMS:
20 A. No, I don't recall.
21 COFFEY, Q.C.:
22 Q. The understanding was because it involved
23 clinical experience and judgment?
24 DR. WILLIAMS:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. And knowledge, that they would accept the
3 MAC's considered view?
4 DR. WILLIAMS:
5 A. They rely on the MAC and the credentials
6 committee to follow a due process, a sensible
7 process to do this.
8 COFFEY, Q.C.:
9 Q. Now sir, the credentialling, because we've--
10 and the Commissioner will see, in relation to
11 the clinical laboratory program, appointments
12 of various individual doctors.
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. In the different periods of time or different
17 periods.
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. How did that work?
22 DR. WILLIAMS:
23 A. Well, first of all, we had certain basic
24 criteria that we wanted. We wanted letters of
25 reference.

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1 COFFEY, Q.C.:
2 Q. Sure.
3 DR. WILLIAMS:
4 A. But our basic premise is that in the Health
5 Care Corporation of St. John's we wanted them
6 to either be certified by the Royal College of
7 Physicians and Surgeons of Canada as having
8 completed an appropriate residency training
9 program and passed the Royal College exams or
10 be eligible for Royal College exams, but we'd
11 take them in on the basis--we'll take you in
12 on your--you've completed all your residency
13 training, you're eligible for the exams and
14 we'll grant you privileges, you know. There
15 may be a few--and I'll talk about that in a
16 minute--a few in that category, or else they
17 had their American Board of Pathology, and
18 that's a similar situation.
19 The medical schools in the U.S. and the
20 medical schools in Canada are credentialed by
21 the same body. So a medical school in the
22 U.S. and a medical school in Canada--for
23 instance, when our medical school comes up for
24 certification every four or five years, often
25 one of the surveyors coming in to survey the

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1 medical school at Memorial for accreditation
2 will be an American, who's from their
3 accreditation body in the States, and I'm sure
4 when an American medical school gets
5 credentialed, it'll be a Canadian on that
6 board. So there's a cross--so we can--we feel
7 there's reciprocity between medical schools in
8 Canadian and medical schools in the U.S. and
9 the specialty training requirements in the
10 U.S. and in Canada. So we would accept either
11 an American Board in Pathology or
12 certification by the Royal College in
13 Pathology as our basis requirements. Now
14 there's a couple of occasions when we had to
15 deviate from that and we can talk about that,
16 if you wish.
17 COFFEY, Q.C.:
18 Q. Okay, if you could, please, while we're on the
19 topic.
20 DR. WILLIAMS:
21 A. There was two that I can recollect in the days
22 I was there. One was a physician who was
23 trained elsewhere, but went through the
24 medical school requirements at Memorial
25 University in a residency program. That

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1 person didn't get her exams. Was working in
2 St. John's and ended up working in a facility
3 outside St. John's. Because of the shortage
4 of pathologists, we were having a --I mean,
5 you know we were having problems over the
6 years. Dr. Cook reviewed that, felt that
7 based upon the fact that the people in St.
8 John's had trained her, they knew she was good
9 and proficient, that recommended that she be
10 appointed. There was a discussion and debate
11 at the credentials and the MAC, but she was
12 appointed and she did get her exams
13 subsequently.
14 COFFEY, Q.C.:
15 Q. I'm sorry, she?
16 DR. WILLIAMS:
17 A. She did get her Canadian exams. She did, yes,
18 and stayed with the organization for a while
19 after and has now left the province.
20 A second one was somebody just before I
21 left, again, given our situation. Was a
22 person who was trained in Calgary, in a
23 residency training program. The people in
24 Calgary and our people had talked about that
25 person. Didn't get her exams, but they felt

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1 that she was a good person and had good
2 knowledge and they appointed her for a year,
3 with a requirement that if the exams weren't
4 passed, then at the end of that year, the
5 person may not be kept on, renewed. It was a
6 year appointment rather than the normal three
7 years appointment.
8 As you know, we were sending tissue
9 samples out of the province starting in
10 January or December/January 2004--sorry, 2005-
11 2006, to--we had to scramble to find somebody
12 to take these samples. We were sending them
13 to Gamma-Dynacare in Ottawa because of the
14 shortage of pathologists.
15 COFFEY, Q.C.:
16 Q. I'll be getting to that with you, okay.
17 DR. WILLIAMS:
18 A. Okay.
19 COFFEY, Q.C.:
20 Q. And this second individual, I take it, was
21 working here in St. John's when you retired
22 finally?
23 DR. WILLIAMS:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Okay. Now you just referred to the normal
2 three-year appointment.
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. And credentialling. Could you tell the
7 Commissioner, please, how that works?
8 DR. WILLIAMS:
9 A. Yes. Somebody coming on initially in our
10 organization, my office would have the
11 authority, based on everything being in order,
12 especially if there's no MAC over the summer,
13 to give them up to three months' appointment
14 pending the next MAC meeting, on a temporary
15 basis. Then if the MAC, at the credentials
16 committee and the MAC concur, they're put on
17 the associate medical staff for a year.
18 That's a one-year appointment.
19 COFFEY, Q.C.:
20 Q. Okay. So if I could, okay, so a temporary
21 permit, as it were -
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. - in exigent circumstances, i.e. the MAC is

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1 not meeting -
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. - you could appoint for up to three months,
6 yourself?
7 DR. WILLIAMS:
8 A. Yes, because there's some exigencies where
9 you've got to do that. Then it would go to
10 the next credentials meeting in MAC, they
11 would appoint that person--or they could
12 appoint him to any--they might say well we're
13 going to put your temporary for three more
14 months or do this or do that, but normally the
15 procedure was go in the associate medical
16 staff for a year.
17 COFFEY, Q.C.:
18 Q. For one year.
19 DR. WILLIAMS:
20 A. If you were on the associate medical staff for
21 a year and the clinical chief felt that, you
22 know, things were working well, that the
23 person was competent and that, then the
24 clinical chief would come back and recommend
25 an active staff appointment.

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1 COFFEY, Q.C.:
2 Q. That's the clinical chief would -
3 DR. WILLIAMS:
4 A. Yes. And then the active staff would go to
5 that for two years, I think. Now I'd have to-
6 -because we changed our requirements when,
7 before that, the appointments were for one or
8 two years, when Eastern Health came in and you
9 had, instead of so many people going to the
10 Board, if you had credentials going every
11 year, if everybody had to be appointed on an
12 annual basis, you would have, I mean the Board
13 meetings taking up tonnes of paper. So we
14 looked at an article that was in the Canadian
15 Medical Association Journal that talked about
16 appointments for a little longer period of
17 time, and so we adopted that format.
18 COFFEY, Q.C.:
19 Q. And so by the time you left your position as
20 VP Medical with Eastern Health -
21 DR. WILLIAMS:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. It was up to a three-year appointment -
25 DR. WILLIAMS:

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1 A. I'd have to go back, I may be wrong, I think
2 they would be appointed to the active staff
3 for a year or two and then for three years,
4 but I'd have to go back and look, I'm sorry.
5 COFFEY, Q.C.:
6 Q. And the records would bear that out, anyway, I
7 appreciate that, Doctor. To go back then to,
8 and again dealing with pathologists and either
9 the Health Care Corporation or in Eastern
10 Health, was there such a thing as locums?
11 DR. WILLIAMS:
12 A. There was locums, yes, in our organization.
13 COFFEY, Q.C.:
14 Q. And how did that work, can you tell the
15 Commissioner please?
16 DR. WILLIAMS:
17 A. Somebody was coming in to replace somebody for
18 three months, say we, in the summer
19 especially, we had to cover the Emergency
20 Department in 7/24 at our hospitals, so people
21 wanted vacation, a lot of them wanted it in
22 the summer, so we might have a locum coming in
23 for a month and working in the Emergency
24 Department, so that person would be given a
25 locum for a month. It would go, even though

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1 it might happen over the summer and I could
2 approve them, all of them would go to the
3 credentials and MAC process afterwards, even
4 if it was after the fact.
5 COFFEY, Q.C.:
6 Q. Retroactively approved.
7 DR. WILLIAMS:
8 A. Yes, sometimes you had to do that.
9 COFFEY, Q.C.:
10 Q. And what about pathologists, were there
11 pathology locums occasionally?
12 DR. WILLIAMS:
13 A. If I answer the question, I may not be giving
14 you the right answer. I don't know the
15 answer, I'd have to go back and look to see,
16 pathology locum -
17 COFFEY, Q.C.:
18 Q. If it happened, it would be rare.
19 DR. WILLIAMS:
20 A. Probably by unusual, I think it would be
21 unusual. Some other locums would be common in
22 Emergency Department.
23 COFFEY, Q.C.:
24 Q. Now, Doctor, we will come to it in some detail
25 but I'm on the kind of general topic of the

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1 Medical Staff Association and the MAC and
2 you've already referred to it earlier at times
3 the staffing levels for pathologists in the
4 Health Care Corporation or in Eastern Health
5 varied significantly over time.
6 DR. WILLIAMS:
7 A. Correct.
8 COFFEY, Q.C.:
9 Q. Over your time as VP Medical.
10 DR. WILLIAMS:
11 A. Yes. Back in 2003 when I was looking at a
12 performance review for Dr. Cook, for instance,
13 he advised me that then we had all the
14 positions filled, and then the next year we
15 were in a real bind and other health boards
16 were in a real bind in 2005, so -
17 COFFEY, Q.C.:
18 Q. So it varied over time?
19 DR. WILLIAMS:
20 A. It varied over time, yes.
21 COFFEY, Q.C.:
22 Q. I take it that when it was at its ebb, the
23 times that have--there'd be shortages of or
24 vacancies, a number of vacancies in
25 pathologists' positions, was it ever brought

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1 to your attention as VP Medical, that that was
2 causing stress amongst the staff, keeping up
3 with the workload is what I'm getting at.
4 DR. WILLIAMS:
5 A. I don't recall, having shortages of positions
6 wouldn't be unique to pathology either, I'd
7 say that.
8 COFFEY, Q.C.:
9 Q. Sure.
10 DR. WILLIAMS:
11 A. I'd have to go back -
12 COFFEY, Q.C.:
13 Q. And I appreciate that, but here's what I'm
14 getting at, Doctor, if there were to be
15 concerns expressed, complaints at the hands-on
16 level of people actually doing the work, how--
17 through what mechanism would you have expected
18 that to be brought to your attention? Would
19 it be the MS -
20 DR. WILLIAMS:
21 A. No, that would come up through the clinical
22 chief, Cook. It may be, if we look at his
23 reports, it may have been captured in some of
24 his reports. Every second month he'd report
25 to the clinical chiefs and MAC and every month

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1 I would meet with him and Mr. Gulliver to
2 discuss issues. So I would have to go back
3 and look at my notes.
4 COFFEY, Q.C.:
5 Q. So it would come up that way, as opposed to
6 the Medical Staff Association generally?
7 DR. WILLIAMS:
8 A. Yes, really I would expect it to come up
9 through the program. Now, Doctor, when you
10 first took over as the VP Medical, who was
11 the--well I take it at the time the Health
12 Care Corporation had already gone to a program
13 based structure?
14 DR. WILLIAMS:
15 A. Yes, uh-hm.
16 COFFEY, Q.C.:
17 Q. Who was the head of the clinical laboratory or
18 Laboratory Medicine Program at the time, the
19 people -
20 DR. WILLIAMS:
21 A. The clinical chief you mean?
22 COFFEY, Q.C.:
23 Q. Yes.
24 DR. WILLIAMS:
25 A. Dr. Haegert.

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1 COFFEY, Q.C.:
2 Q. Doctor David Haegert and where was he
3 physically located?
4 DR. WILLIAMS:
5 A. He was located at the General site because he
6 was discipline chair at the medical school.
7 He had two positions at the time.
8 COFFEY, Q.C.:
9 Q. So he was wearing both hats.
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. And the program director was?
14 DR. WILLIAMS:
15 A. Was Mr. Vern Whalen.
16 COFFEY, Q.C.:
17 Q. And where was Mr. Whalen located?
18 DR. WILLIAMS:
19 A. His office is located at the General site.
20 COFFEY, Q.C.:
21 Q. They're both at the General.
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. I'm going to refer to it as the General

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1 Hospital site and you're at the Grace?
2 DR. WILLIAMS:
3 A. I was at the Grace at the time, yes.
4 COFFEY, Q.C.:
5 Q. How much interaction then would you have with
6 them?
7 DR. WILLIAMS:
8 A. I would have had meetings with them, I don't
9 know because I went back to try and find the
10 minutes and, you know, I think they might,
11 probably are there, but probably thrown out or
12 something going back that number of years. I
13 would have had meetings with Dr. Haegert and
14 Mr. Whalen. I do not think they were of the
15 same frequency as I was having with Dr. Cook
16 and -
17 COFFEY, Q.C.:
18 Q. As you subsequently did years later.
19 DR. WILLIAMS:
20 A. Yes, I subsequently, you know, after I was
21 there for a few years we sort of formalized
22 the clinical chiefs and did more, in terms of
23 meetings and this type of thing.
24 COFFEY, Q.C.:
25 Q. And so when you first took over, Mr. Whalen,

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1 as the program director would have had been
2 responsible for the clinical laboratories at
3 the Janeway, St. Clare's -
4 DR. WILLIAMS:
5 A. The Grace.
6 COFFEY, Q.C.:
7 Q. The Grace and the General, would that be -
8 DR. WILLIAMS:
9 A. Yes, I think the laboratories were under, at
10 the Janeway, were under Laboratory Medicine
11 Program, yes.
12 COFFEY, Q.C.:
13 Q. And Dr. Haegert -
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Clinical chief, were there such a thing as
18 site chiefs?
19 DR. WILLIAMS:
20 A. Yes, there were site chief. Dr. Cook was site
21 chief at St. Clare's, Dr. Parai was site chief
22 when I was at the Grace and I'm not sure of
23 the site chief, I'd have to check and see
24 whether there was a site chief at the General
25 when Dr. Haegert was clinical chief.

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1 COFFEY, Q.C.:
2 Q. And in your role as VP Medical in the early
3 days, '98, '99, how often, if at all, would
4 you meet with the site chiefs?
5 DR. WILLIAMS:
6 A. I would not meet with the site--the site
7 chiefs would be people that the clinical chief
8 might meet with or this type of thing, but I
9 did not meet with the site chiefs.
10 COFFEY, Q.C.:
11 Q. Now Mr. Whalen, would he have individuals on
12 site responsible for each of the labs?
13 DR. WILLIAMS:
14 A. Yes, Mr. Whalen--I'm not sure if he had a site
15 chief or if he had--what he'd was maybe by,
16 he'd have somebody who was manager of
17 microbiology, say, at St. Clare's or a manger
18 of pathologists at St. Clare's. I don't know
19 if he had a site chief, I'd have to -
20 COFFEY, Q.C.:
21 Q. Or the equivalent of -
22 DR. WILLIAMS:
23 A. Yeah, the manager for this particular service
24 and the manager for that particular service,
25 yes.

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1 COFFEY, Q.C.:
2 Q. And how was pathology set up, anatomical
3 pathology set up at that time, in terms of the
4 program?
5 DR. WILLIAMS:
6 A. My recollection it was site chief at St.
7 Clare's when I got there, site chief at the
8 General, probably and a site chief at the
9 Grace.
10 COFFEY, Q.C.:
11 Q. How about the technologists, that end of it?
12 DR. WILLIAMS:
13 A. I know I got a briefing back in 1998 from Mr.
14 Whalen and Dr. Haegert because I would have
15 gotten this from every program, but I can't be
16 sure of that. The structure we have now is
17 managers, I would expect it was the same then.
18 COFFEY, Q.C.:
19 Q. And that would be a manager of each particular
20 -
21 DR. WILLIAMS:
22 A. Yeah, it would be a manager for, I think for
23 whatever service we were talking about, but
24 I'd really have to go back. I don't know if
25 I'd have any notes to reflect that, but right

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1 now we're on that Basis.
2 THE COMMISSIONER:
3 Q. Managers on each site?
4 DR. WILLIAMS:
5 A. A manager for, say at the Grace, if Grace had
6 microbiology on the site, they'd have a
7 manager of microbiology. I don't know whether
8 there would be a site manager for all
9 functions there after program base. Before
10 program base, there would be.
11 THE COMMISSIONER:
12 Q. Okay and there similarly would be one at the
13 other, separate institutions?
14 DR. WILLIAMS:
15 A. Yes, if we had a microbiology service, they'd
16 have a manager for microbiology at St.
17 Clare's. That's all changed now, of course.
18 THE COMMISSIONER:
19 Q. All with lightening speed, it would seem. It
20 doesn't happen on the ground that way, does
21 it? It just seems from the perspective of
22 somebody who is coming at it completely from
23 the outside that you didn't quite have it all
24 pulled together for Health Care Corp, and then
25 all of a sudden, it's out the window, so for

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1 the people on the ground, like they must have
2 been left spinning, were they?
3 DR. WILLIAMS:
4 A. Well it took awhile for the Health Care
5 Corporation to come together, that's correct.
6 It took a long time for it to come together
7 because you're making some major changes and
8 then there's always the question of when
9 you're now going to make another change,
10 whether the timing is right, whether you spend
11 enough time up front in planning, that's an
12 issue, yes.
13 COFFEY, Q.C.:
14 Q. And you happened to be there, I suppose from
15 the outside, as the Deputy Minister in the
16 first go round and were involved in the actual
17 nitty gritty of getting it done, in terms of
18 the Grace and the Janeway in particular.
19 DR. WILLIAMS:
20 A. Yes, yes.
21 COFFEY, Q.C.:
22 Q. And then were there, as a VP, during the
23 switch over to Eastern Health -
24 DR. WILLIAMS:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. And in fact as the acting CEO.
3 DR. WILLIAMS:
4 A. Yes. And that was, as I said, from January
5 2005 to September 2006 with just a big blur of
6 everything that was happening at the time.
7 COFFEY, Q.C.:
8 Q. And I will be visiting that with you, try to
9 help you recall for the Commissioner what, you
10 know, what you can recall of it. Looking back
11 on it, Doctor, the Janeway did get relocated.
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. The Grace did get closed and the services
16 relocated.
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. I'm going to ask you now to direct your mind
21 to St. Clare's Hospital.
22 DR. WILLIAMS:
23 A. Uh-hm.
24 COFFEY, Q.C.:
25 Q. What do you recall, if anything, about what

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1 you're being told as a VP Medical about
2 concerns amongst the St. Clare's staff about
3 downsizing, as it were, at St. Clare's or -
4 DR. WILLIAMS:
5 A. St. Clare's staff and Mr. Tilley and myself
6 had a number of meetings with the medical
7 staff over there, were concerned that maybe
8 over time that they will be the poor cousins
9 of the General site and they were concerned
10 with the viability of St. Clare's site on a
11 long-term basis, yes.
12 COFFEY, Q.C.:
13 Q. And can you tell the Commissioner what you
14 recall about that, how, like when it first
15 came to your attention as VP Medical and then
16 how it developed over time.
17 DR. WILLIAMS:
18 A. Uh-hm. Well some of that discussion ensued at
19 the MAC. I think there was not an agreement
20 at the MAC that this was, you know, MAC people
21 would come from the various backgrounds and
22 this type of thing.
23 COFFEY, Q.C.:
24 Q. And from each of the hospitals too, I take it?
25 DR. WILLIAMS:

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1 A. Yes, that's right. So there was some concern
2 about issues at St. Clare's. I remember
3 meeting with the medical staff. I remember
4 Mr. Tilley joining us for a meeting with the
5 medical staff on one occasion. There was
6 always, even when Sister Elizabeth was there,
7 some issues of growing pains and this type of
8 thing. And there was also some concerns
9 about, well we really need to look to the
10 future now and we need to be really told what
11 is the future of St. Clare's and what's going
12 to happen and what's the vision of the Health
13 Care Corporation now, Eastern Health for St.
14 Clare's. And we visited, meaning Mr. Tilley
15 and a number of the other executive, visited
16 Kingston in the early part of 2006 to get a
17 handle on what they done in Kingston, because
18 we knew there had been some major changes,
19 that the Kingston General Hospital had one
20 function and the Hotel Dieu Hospital had
21 another function. The Hotel Dieu would be
22 mostly an ambulatory care facility with an
23 emergency department and a diagnostic facility
24 and most of the in-patients would be at the
25 Kingston General site. So our executive team

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1 went up and met with their CEO and executive
2 team for two or three days. We took the
3 program directors and some of the clinical
4 chiefs up to look at their set up, up there,
5 to see if there was anything that we could
6 learn from there that could be applied to the
7 situation in St. John's. And some people were
8 supportive, some of our clinical chiefs were
9 supportive of some of the things they had done
10 up there and felt that that could apply to us;
11 and some others were not that supportive and
12 said no, what they've done up there might work
13 for them, but not for us. It was decided
14 sometime before I left that we were going to
15 start the next phase of a planning initiative
16 for St. John's, which would see what the long-
17 term strategy was for hospital services in St.
18 John's, and I think that's actually ongoing,
19 but I can't be sure of that because it was
20 being set up before I left.
21 COFFEY, Q.C.:
22 Q. So the concerns, which as you've indicated of
23 St. Clare's staff, particularly the medical
24 staff, you can recall them first hearing those
25 being voiced going all the way back to Sister

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1 Elizabeth's time.
2 DR. WILLIAMS:
3 A. Sure.
4 COFFEY, Q.C.:
5 Q. I take it, the fact that the Grace was being
6 closed would have alerted them to the fact
7 that things might change.
8 DR. WILLIAMS:
9 A. Yes. But I wouldn't say that all the medical
10 staff--I didn't sense that from the surgical,
11 people who were in the surgery program. They
12 felt they had a strong program, they had a big
13 program, it was mostly, I think, people from
14 the medical program who had some concerns and
15 then there was the issue of--and it's still an
16 issue and becoming more of an issue, it's the
17 interphase with the medical school and that's
18 why I think Dr. Rourke joined us in Kingston
19 as well for those meetings, because the
20 medical school plays a vital part here. The
21 medical school has a residency training
22 program in all the major disciplines,
23 medicine, surgery, obstetrics and gynocology.
24 The big one for St. Clare's is the medicine
25 program. They have 16 residents, they want to

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1 expose these residents more and more to
2 hospitals in Grand Falls, Corner Brook and
3 Gander as part of their training and that
4 means there's less residents to provide
5 coverage in St. John's. So the issue of
6 coverage at St. Clare's was always an issue,
7 running a big--fairly big medical program and
8 always worried whether we have enough interns
9 and residents to provide coverage on that
10 site. So that became an issue, it's still an
11 issue and is an issue that's been worked on,
12 as far as I know, worked on as we speak.
13 COFFEY, Q.C.:
14 Q. Doctor, the clinical or the lab medicine
15 program, were there ever any concerns that you
16 got involved in or expressed, that you got
17 involved in as VP Medical with either the
18 Health Care Corporation and then going into
19 your days with Eastern Health in the same
20 position, involving the St. Clare's lab and
21 the personnel there? You know, in relation to
22 their function, continued function and their
23 relationship with the General Hospital
24 DR. WILLIAMS:
25 A. There were some before I left the department

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1 and people, you know, did not maybe like the
2 way the structure was going to take place, the
3 decisions that were made.
4 COFFEY, Q.C.:
5 Q. Before you left?
6 DR. WILLIAMS:
7 A. Sorry, before I left the Department of Health,
8 yes.
9 COFFEY, Q.C.:
10 Q. As VP.
11 DR. WILLIAMS:
12 A. Before I left the Department of Health.
13 COFFEY, Q.C.:
14 Q. Oh, going back to the Department of Health
15 time is this?
16 DR. WILLIAMS:
17 A. Yes, there were some concerns expressed by
18 some physicians that they didn't like the
19 arrangements that were being made say, for
20 head and neck to go to St. Clare's site, that
21 was a decision that the Board and executive
22 had made about that, right.
23 COFFEY, Q.C.:
24 Q. What I'm particularly interested in, Doctor,
25 is the lab program itself.

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1 DR. WILLIAMS:
2 A. I don't recall anything back to that.
3 COFFEY, Q.C.:
4 Q. Okay, after you took over as VP Medical in
5 '98, '99 and 2000 -
6 DR. WILLIAMS:
7 A. Uh-hm.
8 COFFEY, Q.C.:
9 Q. Were there ever any concerns expressed to you
10 or brought to your attention about the
11 continued viability of the lab medicine
12 program at St. Clare's?
13 DR. WILLIAMS:
14 A. Not from that perspective, no. It was a
15 general perspective of what's the viability of
16 St. Clare's, where are we heading? Dr. Cook
17 would be the person who has always worked on
18 St. Clare's, would be one of the people who
19 would be concerned about that and some other
20 people. Most of it came from medicine.
21 Surgery, I didn't think there was--I didn't
22 get those expressions of concern from Dr.
23 Felix, who was our clinical chief of surgery,
24 for instance.
25 COFFEY, Q.C.:

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1 Q. How about consolidation of the laboratory or
2 the lab services, and the idea of planning for
3 that, whether it should be all located at St.
4 Clare's or the General Hospital or continue on
5 at both, did that ever come up?
6 DR. WILLIAMS:
7 A. Yes, there were some issues came up there.
8 COFFEY, Q.C.:
9 Q. Could you tell the Commissioner what you
10 recall about that?
11 DR. WILLIAMS:
12 A. One of them was trying to, as part of a lab
13 planning day in March of 2002, I think, there
14 was a lab planning day held, that's one of the
15 issues I think was on the agenda, about
16 probably centralizing tissue processing at the
17 General Hospital site. The pathologist would
18 still stay on at St. Clare's and read the
19 slides and do what they normally do, but the
20 processing of the slides, try to centralize it
21 and there was maybe some economies of scale in
22 doing that. So that was being pursued. Dr.
23 Cook had some concerns about that from a
24 safety perspective and this type of thing. We
25 asked Quality, Heather Predham, to review

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1 those concerns and Heather Predham reviewed
2 the concern and didn't feel there was a
3 quality issue. There was a lot of specimens
4 have to be transported and this type of thing
5 and when you're doing that, there's some
6 issues of losing things or things like that.
7 COFFEY, Q.C.:
8 Q. So, I'm sorry, Ms. Predham reported that -
9 DR. WILLIAMS:
10 A. Yeah, that she didn't feel there was any
11 quality issues at the time. We had a meeting,
12 the lab leadership team and myself with Mr.
13 Tilley just to explore that and as Dr. Cook
14 wasn't comfortable with that at the time, we
15 decided to defer any decision of that. And
16 subsequently -
17 COFFEY, Q.C.:
18 Q. And by that point, what position did he hold?
19 DR. WILLIAMS:
20 A. He was clinical chief.
21 COFFEY, Q.C.:
22 Q. I'm sorry, go ahead.
23 DR. WILLIAMS:
24 A. Subsequently Dr. Cook agreed that that could
25 take place and actually in fact supported it.

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1 COFFEY, Q.C.:
2 Q. And when was that, do you know?
3 DR. WILLIAMS:
4 A. Either 2004, 2005. I could look it up and
5 find the -
6 COFFEY, Q.C.:
7 Q. If you could, perhaps over the lunch hour.
8 DR. WILLIAMS:
9 A. Yeah, I might be able to find where it's
10 located in some--one of his reports, I think,
11 to the clinical chiefs and MAC would be there.
12 The other thing we had some discussion on at
13 certain points of time, was the whole issue of
14 we've got a group of pathologists here and a
15 group of pathologists there -
16 COFFEY, Q.C.:
17 Q. Here being St. Clare's, there being the
18 General.
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Go ahead.
23 DR. WILLIAMS:
24 A. And maybe it would make sense to have all of
25 the pathologists on the same site, they could

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1 work more closely together, this type of
2 thing.
3 COFFEY, Q.C.:
4 Q. When did that idea first arise?
5 DR. WILLIAMS:
6 A. I would not be able to tell you, Mr. Coffey
7 when that idea first crystallized.
8 COFFEY, Q.C.:
9 Q. Do you recall who--was there any one person or
10 persons who was a proponent, an advocator of
11 that?
12 DR. WILLIAMS:
13 A. It might have been me, I don't know. It might
14 have been me, I don't know of any other
15 proponents of it, I don't recall, but it was a
16 thought because -
17 COFFEY, Q.C.:
18 Q. What advantage did you see in that, sir?
19 DR. WILLIAMS:
20 A. I would see you would have, you know, we have
21 a small number of people working in pathology,
22 although I call 18, 20 physicians a small
23 number in the program, in our sense, they
24 could work together, they could probably
25 discuss cases together, they could walk across

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1 the corridor and see one of their colleagues
2 who might have a little bit more experience in
3 this area than another. I saw some synergies
4 to doing that among the pathologists, but you
5 would still have to have a pathologist who
6 would rotate to the other site, wherever you
7 decided to centralize them, at the St. Clare's
8 or the General, because you had to do frozen
9 sections and that requires a pathologist on
10 site.
11 COFFEY, Q.C.:
12 Q. Actually, I take it, if you could just explain
13 to the Commissioner, because we will hear
14 references to this frozen sections at times.
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. What practically does that involve?
19 DR. WILLIAMS:
20 A. That involves really, say a surgeon is in the
21 OR, has what looks like a tumor or is not
22 sure, they'll take a small section of that, it
23 can be processed very quickly, it's cut up and
24 it's frozen and I don't know the details of
25 it, but it's called a frozen section, and they

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1 are up in the OR with a patient waiting for a
2 quick turn-around time down at the lab. And
3 it requires the services of a pathologist and
4 a technologist, so if you're going to
5 centralize pathology services, you'd have to
6 have a technologist always on that site and a
7 technologist wouldn't have enough frozen
8 sections in that day to have a productive day,
9 but that pathologist could be set up in a room
10 where they could read some slides that they
11 would normally read at the General site. So
12 we have to account for that service that needs
13 to be provided at that time, but -
14 COFFEY, Q.C.:
15 Q. Ancillary to wherever the surgery rooms, the
16 ORs were.
17 DR. WILLIAMS:
18 A. Right, but still you could still provide the
19 surgeons a good clinical pathology service,
20 but yet -
21 THE COMMISSIONER:
22 Q. I read a report somewhere where in some
23 institutions the person who does that is right
24 next door to the ORs.
25 DR. WILLIAMS:

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1 A. Yes, they could very well be.
2 THE COMMISSIONER:
3 Q. So that it's a matter of moving the tissue
4 next door and while everybody waits around and
5 -
6 DR. WILLIAMS:
7 A. Yes, so it could be continuous, it could be
8 downstairs and have to go down in an elevator,
9 but it's possible to, you know, you could do
10 that by having somebody assigned over there
11 and they could rotate a week at a time or
12 something, so that's possible, yes.
13 COFFEY, Q.C.:
14 Q. So you had that idea -
15 DR. WILLIAMS:
16 A. Yeah, I can't remember if it came from anybody
17 else, so it might have just been my thoughts
18 that maybe that makes a bit of sense, it made
19 a bit of sense to me, I don't know if it made
20 sense to some other people. I threw it out at
21 one time, in terms of a suggestion, but I
22 can't remember when, but it's now--just before
23 I left, Dr. Denic had taken over clinical
24 chief and we had some discussions. I wrote
25 Mr. Tilley, I think in July or August of 2006

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1 and said that we want--this should be
2 something we should pursue and we need the
3 facilities' people to get moving on it now.
4 The problem is at the General site, if that's
5 going to be the site, it's pretty confined
6 down in the lab area and they would have to
7 re-identify some space down there and move
8 some people around or move some people out of
9 the General site, or around the General site
10 to accommodate that, but that was--the
11 clinical chief supported it at that time and I
12 understand that he ran that by the
13 pathologists at the time--Mr. Tilley.
14 COFFEY, Q.C.:
15 Q. That was by 2006.
16 DR. WILLIAMS:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. Had there ever been such a--facilities'
20 people, they're, I take it, the people who
21 actually plan the lay out of space?
22 DR. WILLIAMS:
23 A. Yes, they're facilities' people, yes.
24 COFFEY, Q.C.:
25 Q. Had they ever been asked to look at that

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1 before?
2 DR. WILLIAMS:
3 A. I can't remember. If I answer the question,
4 I'm not sure I'd answer it correctly, so -
5 COFFEY, Q.C.:
6 Q. Okay.
7 DR. WILLIAMS:
8 A. They'd been asked to look at a lot of things,
9 facilities in the lab.
10 COFFEY, Q.C.:
11 Q. But in terms of the idea of consolidating the
12 facilities either at the Grace--I'm sorry, at
13 St. Clare's or the General Hospital and this
14 would have been in the early--well it would
15 have been well before 2006. Why I'm raising
16 it with you, Doctor, is I understand what some
17 other people are going, I anticipate are going
18 to come along and talk about here.
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. This discussion about possibly consolidating
23 services, did that ever involve the
24 technologists or their representatives, Mr.
25 Gulliver--or their ultimate manager, Mr.

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1 Gulliver, was he ever involved in?
2 DR. WILLIAMS:
3 A. Well Mr. Gulliver certainly was pushing
4 consolidating tech services for sure on the
5 one site, yes. But that's different than the
6 pathology services, with the pathologists,
7 yes. He was an advocate of moving the
8 technical services. He might have been an
9 advocate of moving the pathology services too
10 onto one site.
11 COFFEY, Q.C.:
12 Q. And the idea, for example, having facilities'
13 people look at coming up with options for
14 consolidating all the technical services, did
15 that ever arise?
16 DR. WILLIAMS:
17 A. Yes, we certainly discussed that.
18 COFFEY, Q.C.:
19 Q. Okay, do you recall when that first came up?
20 DR. WILLIAMS:
21 A. I am not sure, I can remember discussing it
22 and looking at that might free up some space
23 at St. Clare's that we could use for another
24 service, but it probably would have been
25 around the time that we were thinking about

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1 consolidating the processing piece at the
2 General site.
3 COFFEY, Q.C.:
4 Q. And that was circa what time?
5 DR. WILLIAMS:
6 A. Circa, after they had their laboratory
7 planning day in 2003, 2002, somewhere around
8 there.
9 COFFEY, Q.C.:
10 Q. Okay, 2002, so it would go back to that time
11 period, 2002.
12 DR. WILLIAMS:
13 A. Yes. Whenever their lab planning day was, I
14 think it was in March, but it might have been
15 2003.
16 COFFEY, Q.C.:
17 Q. So the centralization of the tissue
18 processing, the idea of having it at the
19 General Hospital site, did that actually occur
20 finally?
21 DR. WILLIAMS:
22 A. Yes, it did occur.
23 COFFEY, Q.C.:
24 Q. And when was that, I'm sorry?
25 DR. WILLIAMS:

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1 A. Dr. Cook had supported it, so it was before he
2 left the position of clinical chief.
3 COFFEY, Q.C.:
4 Q. And that would have been in early '06, I take
5 it?
6 DR. WILLIAMS:
7 A. It could have been or it could have been at
8 some other -
9 COFFEY, Q.C.:
10 Q. He left in '06.
11 DR. WILLIAMS:
12 A. It was sometime before that.
13 COFFEY, Q.C.:
14 Q. Okay. Had that occurred before July of 2005,
15 by the time the ER/PR came up, was an issue,
16 where was--at the time ER/PR came up as an
17 issue in 2005, where was the tissue processing
18 being done? Was it still being done at both
19 sites?
20 DR. WILLIAMS:
21 A. I would think so, but I would have to look
22 back and see.
23 COFFEY, Q.C.:
24 Q. If we could, please, I did want to ask you
25 about, as I have many other witnesses, about

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1 in what context you met various individuals
2 who will testify here or are referred to in
3 here.
4 DR. WILLIAMS:
5 A. Sure.
6 COFFEY, Q.C.:
7 Q. So if you would bear with me, please. And you
8 just mentioned Mr. Tilley's name, I'll ask you
9 about him.
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. How do you know Mr. Tilley?
14 DR. WILLIAMS:
15 A. Mr. Tilley was an executive in the hospital
16 system when I was at the Department of Health.
17 He laterally, I think, was the CEO of the
18 Janeway just before the Janeway was folded
19 into the Health Care Corporation of St.
20 John's, and he then became the senior VP of
21 the Health Care Corporation of St. John's. I
22 would have known him then. I know before that
23 he was with the hospital, Newfoundland and
24 Labrador Hospital Boards Association. I don't
25 think I would have known him there. I might

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1 have known him when he worked at the
2 Waterford, but I think my contact with him was
3 probably when he became--when he came to the
4 Janeway.
5 COFFEY, Q.C.:
6 Q. And when you, in 1998 when you became VP
7 medical of Health Care Corporation, Sister
8 Davis was the CEO?
9 DR. WILLIAMS:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. What was Mr. Tilley at that time?
13 DR. WILLIAMS:
14 A. He was the senior vice president for corporate
15 affairs.
16 COFFEY, Q.C.:
17 Q. And at that time senior vice president meant
18 what, did you report to him?
19 DR. WILLIAMS:
20 A. No.
21 COFFEY, Q.C.:
22 Q. Okay.
23 DR. WILLIAMS:
24 A. It was just--and he might take over if Sister
25 Elizabeth was away.

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1 COFFEY, Q.C.:
2 Q. Okay.
3 DR. WILLIAMS:
4 A. I think that's where it was--what really
5 meant.
6 COFFEY, Q.C.:
7 Q. Go ahead then, sir. So you joined the
8 organization?
9 DR. WILLIAMS:
10 A. And he was around the executive table with us.
11 COFFEY, Q.C.:
12 Q. Okay. And then Sister Davis retired or moved
13 on?
14 DR. WILLIAMS:
15 A. Yes. Well, George, Mr. Tilley moved on, too.
16 COFFEY, Q.C.:
17 Q. Yes.
18 DR. WILLIAMS:
19 A. He moved on in--I came in '98, he moved on in
20 1999 to the Workers' Compensation Commission.
21 Sister Elizabeth moved on in 2000, I think,
22 and Mr. Tilley came back as CEO.
23 COFFEY, Q.C.:
24 Q. And he remained in that position?
25 DR. WILLIAMS:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. And then in Eastern Health until -
4 DR. WILLIAMS:
5 A. And in Eastern Health, yes.
6 COFFEY, Q.C.:
7 Q. - you retired. Joan Dawe?
8 DR. WILLIAMS:
9 A. Joan Dawe would have been the executive
10 director to St. John's Hospital Council when I
11 first met her. That was the planning group
12 that was involved in trying to develop a plan
13 for hospital facilities in St. John's prior to
14 the creation of the Health Care Corporation of
15 St. John's. Then I would have next made
16 contact with Joan Dawe when we were looking
17 for an assistant deputy minister for public
18 health.
19 COFFEY, Q.C.:
20 Q. And when you say "we"?
21 DR. WILLIAMS:
22 A. The department.
23 COFFEY, Q.C.:
24 Q. The department. You were the DM at the -
25 DR. WILLIAMS:

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1 A. Yes, I was DM at the department at the time.
2 COFFEY, Q.C.:
3 Q. Okay. Go ahead, sir.
4 DR. WILLIAMS:
5 A. And we were looking for an assistant deputy
6 minister of community health. I would think
7 that was probably around the mid '90s. And
8 she took that position for a few years.
9 COFFEY, Q.C.:
10 Q. She would have reported to you as -
11 DR. WILLIAMS:
12 A. Yes. And then she took a position of deputy
13 minister in the Department of Social Services
14 probably about 1997ish, maybe, I'm not sure.
15 COFFEY, Q.C.:
16 Q. So you were fellow DMs?
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. And go ahead then, sir.
21 DR. WILLIAMS:
22 A. And then I think she retired. Then I left the
23 department.
24 COFFEY, Q.C.:
25 Q. Yes.

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1 DR. WILLIAMS:
2 A. And then she came out of retirement to take
3 over as deputy minister of Health and
4 Community Services for a year because by that
5 time it was called Health and Community
6 Services, or longer, I'm not sure how long she
7 was there. Then she was chair of the
8 Community Health Board in St. John's. I'm
9 trying to think if she was a cross appointee,
10 if she was a cross appointee on the Health
11 Care Corporation of St. John's Board sometime
12 after '92, '93, something like that.
13 COFFEY, Q.C.:
14 Q. Okay, a cross appointee would have meant she,
15 I take it, sat on the or attended meetings of
16 the Health Care Corporation?
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. St. John's Board of Directors, Board of
21 Trustees?
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And you would, as VP medical, attend those

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1 meetings?
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Okay. And then?
6 DR. WILLIAMS:
7 A. She became the first chair of the Eastern
8 Regional Integrated Health Authority.
9 COFFEY, Q.C.:
10 Q. And you would have, again, as VP medical,
11 attended those meetings?
12 DR. WILLIAMS:
13 A. Attended those meetings, yeah.
14 COFFEY, Q.C.:
15 Q. Let's see. Dr. Cook?
16 DR. WILLIAMS:
17 A. Yes. First met Dr. Cook when he was a
18 resident in pathology and he would have
19 applied to the bursary committee that year to
20 get a bursary.
21 COFFEY, Q.C.:
22 Q. Okay.
23 DR. WILLIAMS:
24 A. And then subsequent to that I would have known
25 him, I guess, because he's a pathologist in

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1 St. John's, and then in his role as, when I
2 came to Health Care Corporation, Dr. Haegert
3 stepped down and did a sabbatical level for a
4 year and Dr. Cook was acting clinical chief
5 for a year.
6 COFFEY, Q.C.:
7 Q. And he would have reported to you in your role
8 as VP medical then?
9 DR. WILLIAMS:
10 A. Yes, correct. And then Dr. Haegert came back
11 and he stepped down again, Dr. Haegert, in
12 2002. Didn't have enough time to recruit
13 somebody so Dr. Cook stepped in because he'd
14 done it before. And then we set up a search
15 committee with Dr. Haegert and somebody from
16 human resources and myself, we had a couple of
17 candidates to interview and Dr. Cook was
18 appointed to the job.
19 COFFEY, Q.C.:
20 Q. And he was there, I take it, until early '06?
21 DR. WILLIAMS:
22 A. Yes, his tenure would normally be for three
23 years, from October to October, 2005, but
24 because of the situation we were in, he stayed
25 an extra six months.

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1 COFFEY, Q.C.:
2 Q. And Dr. Ejeckam?
3 DR. WILLIAMS:
4 A. Dr. Ejeckam, I first met him when he came
5 here, I think it's 2002, because what we were
6 doing is that all new physicians I try to meet
7 personally. We had an orientation program for
8 them. A remember meeting him, he was telling
9 me, he was saying he worked at the Grace
10 before, which I didn't know.
11 COFFEY, Q.C.:
12 Q. Oh, so he had worked at the Grace while you
13 were -
14 DR. WILLIAMS:
15 A. Yes. Not while I was there, no.
16 COFFEY, Q.C.:
17 Q. No, I understand.
18 DR. WILLIAMS:
19 A. Before I was there.
20 COFFEY, Q.C.:
21 Q. Oh, this is -
22 DR. WILLIAMS:
23 A. Before 1998 he worked at the Grace. I don't
24 know when, he had worked in Qatar, he was from
25 Nigeria and I remember most of our discussion

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1 centred around a personal matter, a family
2 matter that he wanted me to try to help him
3 with.
4 COFFEY, Q.C.:
5 Q. Okay. So I take it -
6 DR. WILLIAMS:
7 A. Which I did.
8 COFFEY, Q.C.:
9 Q. I take it that, as you just indicated,
10 Commissioner, as the VP medical, when you
11 settled into your role, you, one thing you did
12 try to do was meet all -
13 DR. WILLIAMS:
14 A. All new positions who were credentialed.
15 COFFEY, Q.C.:
16 Q. Sure.
17 DR. WILLIAMS:
18 A. We had an orientation package they had to
19 complete and part of it, I gave part of it was
20 that I would meet with them. Now, afterwards
21 we did it as a group, rather than one on one,
22 it was more effective to do it as a group, so
23 I might do it with three or four people in a
24 room. And I would go through telling them
25 what's happening, how health care services are

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1 organized in the province, how they were
2 organized in St. John's, what's going on in
3 St. John's and a bit about the milieu in the
4 province and some of the things they should
5 keep, keep in their head.
6 COFFEY, Q.C.:
7 Q. And you met Dr. Ejeckam through that?
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Process. And then Dr. Ejeckam when you first
12 met him was working physically where?
13 DR. WILLIAMS:
14 A. He would have been recruited, I think, for the
15 General site.
16 COFFEY, Q.C.:
17 Q. And that was by then the same place, would you
18 have had your office there by then?
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. And you say that then at some point after that
23 you were able to, you were asked to assist him
24 in a matter involving a relative of his, I
25 take it?

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1 DR. WILLIAMS:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Personal matter?
5 DR. WILLIAMS:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Okay. And in his role as a pathologist, would
9 you have had any interaction with him in that
10 regard?
11 DR. WILLIAMS:
12 A. No, only on his role as a pathologist, the
13 review committee -
14 COFFEY, Q.C.:
15 Q. Yeah, and we'll get to that.
16 DR. WILLIAMS:
17 A. - and Dr. Cook and myself met with him. And
18 when he was going to put in his resignation,
19 he came to see me and said, "Look, I'm going
20 to be retiring. I'm going to Nigeria, I'm
21 going to do a locum in Gander first."
22 COFFEY, Q.C.:
23 Q. Okay.
24 DR. WILLIAMS:
25 A. And we had some discussion then about him, at

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1 that time it was 2006, coming back and in-
2 servicing Dr. Elms or one of the other people
3 who were going to take over his role.
4 COFFEY, Q.C.:
5 Q. And I'll come to that in due course. Peter
6 Dawe?
7 DR. WILLIAMS:
8 A. Peter Dawe was on the board of Health Care
9 Corporation.
10 COFFEY, Q.C.:
11 Q. In your role as VP medical, did you ever have
12 any dealings with -
13 DR. WILLIAMS:
14 A. Yes. I know I met with him once about a
15 national cancer strategy.
16 COFFEY, Q.C.:
17 Q. Okay. So and I'll canvass, I'll come to that.
18 You knew him in that context?
19 DR. WILLIAMS:
20 A. That context, and as a member of the board,
21 but I don't know him personally, but I know
22 him as a member of the board and in the
23 context of his role as executive director and
24 I did have some liaison function with him
25 during this process, yes.

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1 COFFEY, Q.C.:
2 Q. Sure. Moira Hennessey?
3 DR. WILLIAMS:
4 A. Moira Hennessey was with the Department of
5 Health when I was there. She was a hospital
6 consultant.
7 COFFEY, Q.C.:
8 Q. What does that mean?
9 DR. WILLIAMS:
10 A. Well, she would have a portfolio of hospitals
11 that she would liaise closely with the
12 management there on various issues and report
13 to the director of hospital services. Might
14 be dealing with special projects that the
15 department and a hospital might be dealing
16 with or something like that.
17 COFFEY, Q.C.:
18 Q. And that would have been why you were deputy
19 minister of health?
20 DR. WILLIAMS:
21 A. Yes, and maybe even before I was deputy, I'm
22 not sure. She was there and then she left and
23 then she came back.
24 COFFEY, Q.C.:
25 Q. And then subsequently while you were VP

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1 medical?
2 DR. WILLIAMS:
3 A. I would see her sometimes there'd be meetings
4 with the Department of Health and our
5 executive team, so she might have come to some
6 of those meetings, yes, probably did.
7 COFFEY, Q.C.:
8 Q. I gather she did become, at some point, the
9 ADM?
10 DR. WILLIAMS:
11 A. Yes, sometime a few years ago; I don't know
12 exactly when.
13 COFFEY, Q.C.:
14 Q. Would you have had any interaction with her in
15 her role as ADM?
16 DR. WILLIAMS:
17 A. Not really because most of my liaison at the
18 Department of Health, to be honest with you,
19 was with Dr. Bradbury at MCP.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. WILLIAMS:
23 A. Dr. Hunt and Dr. Fleming would be my key
24 contacts at the Department of Health.
25 COFFEY, Q.C.:

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1 Q. Okay. I'll be asking you about those. Robert
2 Thompson?
3 DR. WILLIAMS:
4 A. Robert Thompson, the first time I met Robert
5 Thompson was when he was with Intergovernment
6 Affairs and he was Intergovernment Affairs rep
7 when Mr. Decker had to represent the Premier,
8 Mr. Wells, at a meeting of premiers that was
9 held in PEI, sometime when Mr. Decker was
10 minister of health. It would have been in the
11 late '80s, early '90s. And because it was a
12 meeting, Mr. Decker--they were mostly going to
13 discuss agenda. I think the agenda was
14 health, but the premier couldn't go so Mr.
15 Decker went and represented him and because it
16 was an intergovernmental issue that Mr.
17 Thompson was there.
18 COFFEY, Q.C.:
19 Q. And then subsequent?
20 DR. WILLIAMS:
21 A. Subsequently he became deputy minister of
22 health and I was on a committee that he
23 chaired, but I forget the name of the
24 committee.
25 COFFEY, Q.C.:

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1 Q. And you were on the committee -
2 DR. WILLIAMS:
3 A. That Robert Thompson chaired.
4 COFFEY, Q.C.:
5 Q. I'm sorry, so he became deputy minister of
6 health?
7 DR. WILLIAMS:
8 A. Yes. And he chaired a committee in the health
9 system.
10 COFFEY, Q.C.:
11 Q. Oh, okay.
12 DR. WILLIAMS:
13 A. And I became a member of that committee but I
14 forget the name of the committee.
15 COFFEY, Q.C.:
16 Q. Okay. And then?
17 DR. WILLIAMS:
18 A. I don't know if there's any then after -
19 COFFEY, Q.C.:
20 Q. I'm not suggesting. If there isn't -
21 DR. WILLIAMS:
22 A. Yeah. I can't remember -
23 COFFEY, Q.C.:
24 Q. Anything else. He subsequent--he's told the
25 Commissioner he subsequently became clerk of

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1 the Executive Council.
2 DR. WILLIAMS:
3 A. Yeah.
4 COFFEY, Q.C.:
5 Q. So you would have had no dealings with him in
6 that regard?
7 DR. WILLIAMS:
8 A. No.
9 COFFEY, Q.C.:
10 Q. John Abbott?
11 DR. WILLIAMS:
12 A. John Abbott was in Treasury Board when I met
13 him first. He was responsible at one stage,
14 assistant deputy minister of Treasury Board
15 responsible for finance. As well, he--we had
16 a Joint Management Committee between the
17 Newfoundland and Labrador Medical Association
18 and government. We had--it was again in the
19 tough times in the early 1990s and we had a
20 five-year agreement with the Newfoundland and
21 Labrador Medical Association that required
22 monitoring and follow up. The deputy minister
23 was a designate on the committee, Lou White,
24 but he, after coming to a few meetings, he
25 decided that he would--his designate would be

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1 John Abbott. So, John attended as Treasury
2 Board's representative on the Joint Management
3 Committee. Lots of things would have to go
4 from that committee eventually to government
5 and to Treasury Board, so it was very helpful
6 having a representative of Treasury Board on
7 the committee. And then John Abbott, I think,
8 left government. He became a deputy minister
9 in Transportation, I think, and then he left
10 government, and ended up back in the province-
11 -he was gone for a while and ended up back in
12 the province doing some consulting work and
13 then appeared as Board Chair of Health Care
14 Corporation of St. John's in January 2002 or
15 something like that, I think that's about it.
16 COFFEY, Q.C.:
17 Q. And then?
18 DR. WILLIAMS:
19 A. Then he left there and became Deputy Minister
20 of Health.
21 COFFEY, Q.C.:
22 Q. Did you have any interaction with him while he
23 was Deputy Minister of Health?
24 DR. WILLIAMS:
25 A. Yes, I did, and I would normally not have

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1 interaction with a deputy minister of Health
2 in my role. That was the role of the CEO.
3 COFFEY, Q.C.:
4 Q. Yes.
5 DR. WILLIAMS:
6 A. But when we prepared that paper on
7 pathologists and we sent it to--when I chaired
8 the working group on pathology issues, we sent
9 it to the Service Coverage Committee, who in
10 turn sent it to the liaison committee between
11 the Department of Health and government. I
12 was concerned--I felt that it needed to be
13 dealed with on an expeditious basis, so I
14 talked to George. I said "George, can you
15 lobby the deputy to see if we can get that
16 report dealt with?" and George said "Well,
17 Bob, you know John pretty well. Why don't you
18 do it? I'll give you--you can go ahead and do
19 that." So I did have a number of discussions
20 with him on that issue.
21 COFFEY, Q.C.:
22 Q. That's about trying to improve the
23 remuneration for pathologists?
24 DR. WILLIAMS:
25 A. Yes. We anticipated a major problem in the

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1 paper and there was a number of strategies we
2 enunciated that we thought might help deal
3 with it, and so I felt that we needed to move
4 on that. So I was lobbying him. At that
5 time, unfortunately, the Department had
6 published or were publishing or had published
7 in 2005/2006 a document that said we probably
8 only needed 12 pathologists in Eastern Health
9 and we had about 20. We had about 17 or 18 in
10 St. John's.
11 COFFEY, Q.C.:
12 Q. I'm sorry, who published that?
13 DR. WILLIAMS:
14 A. The Department.
15 COFFEY, Q.C.:
16 Q. The Department?
17 DR. WILLIAMS:
18 A. Yes, there was a joint committee on human
19 resource planning between the NLMA and the
20 Department, and that called--they had a number
21 of 12 in there. We didn't agree with it
22 obviously. But, we--so that was one of the
23 issues--that was an issue that we--that was an
24 issue at the time. What happened then -
25 COFFEY, Q.C.:

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1 Q. Do you recall when that was exactly, as best
2 you can?
3 DR. WILLIAMS:
4 A. 2005/2006, because I remember having meetings,
5 because I had to bring in Dr. Arthur from out
6 around Burin and had to bring Gary Baker in
7 and all the clinical chiefs in around the
8 table to deal with Dr. Hunt and the Department
9 and the NLMA and that document. So there is a
10 document. It's 2005/2006. Probably can get
11 it for you, if you -
12 COFFEY, Q.C.:
13 Q. Do you think you'd still have a copy of it?
14 DR. WILLIAMS:
15 A. I wouldn't have it at home.
16 COFFEY, Q.C.:
17 Q. No, I appreciate, but -
18 DR. WILLIAMS:
19 A. It would be in the office up there.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. WILLIAMS:
23 A. I could phone somebody and see if we can get
24 that for you.
25 COFFEY, Q.C.:

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1 Q. Well, certainly. Just a moment please, if I
2 could.
3 MR. SIMMONS:
4 Q. We don't have -
5 THE COMMISSIONER:
6 Q. Is it ringing bells, Mr. Simmons?
7 MR. SIMMONS:
8 Q. I think I've heard of it. I think from Dr. -
9 DR. WILLIAMS:
10 A. He wouldn't have given it to you, no.
11 MR. SIMMONS:
12 Q. If you mention who the author was, that might
13 help us.
14 DR. WILLIAMS:
15 A. It would come from the Department of Health.
16 It was a joint committee of the NLMA,
17 Department of Health and Dr. Hunt's office
18 would have it.
19 MR. SIMMONS:
20 Q. Okay.
21 DR. WILLIAMS:
22 A. He's retired, Dr. Hunt.
23 COFFEY, Q.C.:
24 Q. I appreciate -
25 THE COMMISSIONER:

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1 Q. Perhaps, Mr. Pritchard, do you think you could
2 assist us with that document?
3 MR. PRITCHARD:
4 Q. (Inaudible) yes.
5 THE COMMISSIONER:
6 Q. Thank you.
7 DR. WILLIAMS:
8 A. Dr. Bradbury would have it, Mr. Pritchard, I
9 would suspect. I can probably get it from my
10 office.
11 COFFEY, Q.C.:
12 Q. Well, we'd certainly--we'll come back to it.
13 DR. WILLIAMS:
14 A. I was talking to Mr. Abbott about that, and
15 then the issue of Treasury Board--Mr. Abbott
16 was very supportive, okay, of getting this
17 through. Treasury Board had some problems
18 with it, and there was a hang up on do we need
19 that many pathologists, and I was saying
20 "well, if we don't improve the thing--we got
21 four or five vacancies or three or four
22 vacancies, just do something because we're
23 going to lose more and then do a manpower
24 study," and then I can remember having brought
25 to my attention Dr. Maung, M-A-U-N-G, he was,

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1 I think, a pathologist from out in B.C. way -
2 COFFEY, Q.C.:
3 Q. And I will be dealing with you on that in some
4 detail.
5 DR. WILLIAMS:
6 A. Okay. We sent his paper in to the Department,
7 okay.
8 COFFEY, Q.C.:
9 Q. But in terms of John Abbott, the individual -
10 DR. WILLIAMS:
11 A. John was--I phoned John Abbott a number of
12 times, I know that. The problem is I didn't
13 have to lobby Mr. Abbott. He'd already--he
14 was supportive, and Mr. Ritter, of course,
15 from the NLMA, was dealing with it. We
16 weren't dealing--we weren't involved in the
17 loop of dealing with government on it, but I
18 was just advocating on behalf of the people
19 that worked in our organization.
20 COFFEY, Q.C.:
21 Q. Now you've already referred to Ms. Predham in
22 another context here.
23 DR. WILLIAMS:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. You would have met her when you went to work
2 as VP Medical?
3 DR. WILLIAMS:
4 A. Yes, I had never met her before. I don't know
5 along the way what time I would have met her.
6 COFFEY, Q.C.:
7 Q. Within that. Another name we've heard is Ms.
8 Bonnell, Susan Bonnell.
9 DR. WILLIAMS:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. You would have met her when you went to work
13 with the--as VP Medical?
14 DR. WILLIAMS:
15 A. Yes, whenever she joined the Health Care
16 Corporation. I don't know when that was.
17 COFFEY, Q.C.:
18 Q. Patricia Pilgrim?
19 DR. WILLIAMS:
20 A. I knew Ms. Pilgrim, I think, from probably
21 some--before I went to Eastern, I'm pretty
22 sure. Some interactions we might have had at
23 the Department with the General Hospital, but
24 I can't be specific.
25 COFFEY, Q.C.:

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1 Q. I take it but most of your interaction with
2 her would have been while she was--after you
3 became VP Medical?
4 DR. WILLIAMS:
5 A. Yes, she was actually--when I came into the
6 Health Care Corporation in 1998, Ms. Pilgrim
7 was program director for medicine and Dr.
8 Duguid was clinical chief and medicine, Sister
9 Elizabeth Davis asked me to take on the
10 medicine program because she felt the medicine
11 issue was the problematic issue for the Grace
12 when we were trying to close the Grace. So
13 that's why--so that's when I would have had
14 more interaction with Ms. Pilgrim.
15 COFFEY, Q.C.:
16 Q. And your replacement, Dr. Howell, Oscar
17 Howell?
18 DR. WILLIAMS:
19 A. Dr. Howell was--well, I knew Dr. Howell when
20 he was practising in St. John's as a
21 acquaintance, I think maybe on some activities
22 we might have had with the Medical
23 Association, I'm not sure about that. He was
24 the physician on contract doing occupational
25 health and safety with the Health Care

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1 Corporation of St. John's. I didn't have a
2 lot of interaction with him in that role
3 because he reported to Steve Dodge, human
4 resource person, but one or two issues I may
5 have had some dealings with him then.
6 COFFEY, Q.C.:
7 Q. And were you involved in recruiting Dr.
8 Howell?
9 DR. WILLIAMS:
10 A. Not in terms of interviewing formally, but I
11 was making some calls, trying to get somebody
12 to replace me.
13 COFFEY, Q.C.:
14 Q. Okay.
15 DR. WILLIAMS:
16 A. When I was trying to get retired, so he would
17 have been one of the people I talked to, among
18 others.
19 COFFEY, Q.C.:
20 Q. And was there some overlap in your positions?
21 DR. WILLIAMS:
22 A. Yes, only to the extent that he took over on
23 September 5th and I stayed around because
24 there was a lot of--I felt it was--I felt an
25 obligation to stay around for a month to brief

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1 him. Now he, over the summer, I know we met
2 and I was doing some briefings for him on what
3 the issues were. But when he came, I had a
4 series of files here and documents that I had
5 organized and I had at the top sheet that said
6 what they were, and all the files he needed to
7 be briefed on, and then I would be available
8 during that month to brief him. He asked me
9 to attend one credentials committee meeting,
10 because he couldn't attend and wanted--he had-
11 -somebody had to be there, so I did that for
12 him. My main role then, to be honest with
13 you, was to develop a set of medical staff
14 bylaws for Eastern Health, which I did.
15 COFFEY, Q.C.:
16 Q. And you would have dealt with him on that?
17 DR. WILLIAMS:
18 A. Not a lot, no, because that required a lot of
19 time being spent away from operational issues.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. WILLIAMS:
23 A. So I was there, around the corner, in an
24 office dealing with that, but I wasn't dealing

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1 with him on a day-to-day basis with that.
2 What I was getting for him is a final product
3 that I'd been there all that time and I didn't
4 have--I didn't get a chance to get at that,
5 neither did anybody else in the other boards,
6 I don't think, as well, in any great degree.
7 We were trying to meld in what we felt was
8 good about Eastern Health, the various
9 organizations that came together, and what the
10 Department wanted in there from a draft set of
11 bylaws that they had in Saskatchewan.
12 COFFEY, Q.C.:
13 Q. John Ottenheimer?
14 DR. WILLIAMS:
15 A. I would say the--I don't think I met Mr.
16 Ottenheimer before he was Minister of Health.
17 COFFEY, Q.C.:
18 Q. Okay. Tom Osborne?
19 DR. WILLIAMS:
20 A. I don't think I ever met Tom Osborne. I never
21 was at meeting with Tom Osborne. I was at
22 some--he opened up MRI or new MRI at the
23 Janeway. I don't know if I even met him then,
24 but he came along to open it. I've not met
25 with him.

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1 COFFEY, Q.C.:
2 Q. And for the sake of completeness, Ross
3 Wiseman?
4 DR. WILLIAMS:
5 A. Ross Wiseman is a relative, a second cousin or
6 something, to be honest with you. But I knew
7 Ross Wiseman when he worked in Clarenville,
8 but I knew Ross Wiseman as an MHA because
9 every now and then he'd phone me about some
10 issues with one of his constituents, as did a
11 lot of other MHAs, and I tried to be
12 facilitating and helpful in trying to sort out
13 that stuff. I feel that was part of my role.
14 COFFEY, Q.C.:
15 Q. And this was part of your days as the -
16 DR. WILLIAMS:
17 A. Medical director at the--sorry, vice-president
18 Medical at Health Care Corporation.
19 COFFEY, Q.C.:
20 Q. Health Care Corporation at that point.
21 DR. WILLIAMS:
22 A. Before he became Minister.
23 COFFEY, Q.C.:
24 Q. Mr. Williams, Danny Williams?
25 DR. WILLIAMS:

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1 A. I met him once. He did a--his law office did
2 a property thing for me back in the 80s.
3 COFFEY, Q.C.:
4 Q. Okay, so you just -
5 DR. WILLIAMS:
6 A. And the next time I met Mr. Williams was when
7 the doctors' strike was on, and we went over
8 to -
9 COFFEY, Q.C.:
10 Q. And what year was that? Because we've heard
11 reference to that in passing here at times.
12 Do you recall when that was?
13 DR. WILLIAMS:
14 A. No, I may--I don't want to mislead you.
15 COFFEY, Q.C.:
16 Q. Okay, well perhaps you can--maybe even -
17 DR. WILLIAMS:
18 A. Sometime in the 90s, but it was after Mr.
19 Williams became Premier, so it had to be -
20 COFFEY, Q.C.:
21 Q. After '03 then that would be.
22 DR. WILLIAMS:
23 A. Yeah. Is that when he became -
24 COFFEY, Q.C.:
25 Q. He became Premier in October of 2003.

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1 DR. WILLIAMS:
2 A. 2003, October. So it was after that date, the
3 doctors had a strike. I don't know what year
4 it was, maybe 2003-2004, and I met him at the
5 offices of the NLMA because there was a group
6 of physicians-- and we were getting together a
7 group of physicians, we were--there was
8 concern then, I guess, about patient care
9 suffering, so I was part of a group of three
10 or four physicians who were meeting him about
11 that issue.
12 COFFEY, Q.C.:
13 Q. And subsequently?
14 DR. WILLIAMS:
15 A. I think it was--no, it wasn't the--maybe it
16 wasn't the physicians strike. It might have
17 been the NAPE strike.
18 COFFEY, Q.C.:
19 Q. NAPE strike?
20 DR. WILLIAMS:
21 A. Yeah, I think it was the NAPE strike actually,
22 and that might have been--I don't know. It's
23 about some strike anyway, and it was about
24 concerns about patient care. So it might have
25 been the NAPE strike.

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1 COFFEY, Q.C.:
2 Q. And then?
3 DR. WILLIAMS:
4 A. I'm not sure I've -
5 COFFEY, Q.C.:
6 Q. And I'm not suggesting you have.
7 DR. WILLIAMS:
8 A. The only other time is when there was a
9 ceremony at the Rooms to celebrate the
10 contribution of cottage hospitals to the
11 province.
12 COFFEY, Q.C.:
13 Q. It had nothing to do with clinical care of
14 patients then?
15 DR. WILLIAMS:
16 A. No.
17 COFFEY, Q.C.:
18 Q. Okay, and in the sense that we're here about.
19 DR. WILLIAMS:
20 A. No.
21 COFFEY, Q.C.:
22 Q. Okay, Commissioner, I'm -
23 THE COMMISSIONER:
24 Q. Luncheon break?
25 COFFEY, Q.C.:

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1 Q. Yes, please, if we could.
2 THE COMMISSIONER:
3 Q. 2:10, thank you.
4 (LUNCH BREAK)
5 THE COMMISSIONER:
6 Q. Please be seated. Mr. Coffey.
7 COFFEY, Q.C.:
8 Q. Thank you, Commissioner. Dr. Williams, and I
9 understand, Doctor, that over the lunch hour,
10 you've located that document and it will be
11 provided later today?
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. Thank you very much. That's the document, I
16 think, referencing the pathology positions,
17 Commissioner.
18 THE COMMISSIONER:
19 Q. Yes, thank you.
20 COFFEY, Q.C.:
21 Q. Doctor, I'd like to take you back now then to,
22 in particular, the Laboratory Medicine
23 program, and the Health Care Corporation of
24 St. John's, okay.
25 DR. WILLIAMS:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. If I could, please, if we could have Exhibit
4 P-0900 please?
5 THE COMMISSIONER:
6 Q. That one is in your book, if you wish to have
7 that there.
8 COFFEY, Q.C.:
9 Q. And generally in the book, they're numbered
10 according to the--yes, exhibit numbers, top of
11 the page. Doctor, just for the Commissioner's
12 benefit, because this has a particular
13 formatting. See the block of the top, then
14 there's some text, obviously typed, then
15 there's, I suppose, percentage signs really
16 running across the page and then there's
17 another date and a from, and then more
18 percentage signs. They're obviously demarking
19 one part of the document from the other. See
20 that right there?
21 DR. WILLIAMS:
22 A. Um-hm.
23 COFFEY, Q.C.:
24 Q. And then there's another date and another from
25 and then a memorandum. What sort of system

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1 generates this, do you know?
2 DR. WILLIAMS:
3 A. I don't know the answer to that, I'm sorry.
4 COFFEY, Q.C.:
5 Q. You don't know, okay, and in terms of
6 information systems at the General Hospital
7 and within the Health Care Corporation of St.
8 John's, we've heard references to Meditech
9 here.
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Can you tell the Commissioner, please--well,
14 first of all, was the Meditech system always
15 there while you were VP Medical?
16 DR. WILLIAMS:
17 A. Meditech system was there when I arrived, and
18 there were some dealings at the Department
19 with the Meditech system with different boards
20 throughout the province before I left.
21 COFFEY, Q.C.:
22 Q. By the time you arrived at the--as VP Medical
23 in 1998, what was your understanding--what
24 were you given to understand about the ability
25 of the Meditech system in say the Grace

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1 Hospital to communicate with the Meditech
2 system at the General Hospital?
3 DR. WILLIAMS:
4 A. I can't remember. I don't -
5 COFFEY, Q.C.:
6 Q. Did it ever come up as an issue, do you
7 recall, when you were VP Medical?
8 DR. WILLIAMS:
9 A. Not that I can remember, no.
10 COFFEY, Q.C.:
11 Q. And I just picked the Grace then. It could be
12 St. Clare's or -
13 DR. WILLIAMS:
14 A. Yes. I don't recollect having any knowledge
15 about that issue.
16 COFFEY, Q.C.:
17 Q. Is there any other computer system that's used
18 by doctors to record information, or by
19 technical staff?
20 DR. WILLIAMS:
21 A. I'm not aware of that. I understand, when I
22 was at the Department, the Health Care
23 Corporation that we invested a lot of time and
24 effort in the Meditech system. Meditech group
25 are out of the U.S., I think, Boston, and that

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1 that was the state of the art, as far as I
2 understood, in terms of hospital based
3 systems.
4 COFFEY, Q.C.:
5 Q. And this is while you were with the
6 Department?
7 DR. WILLIAMS:
8 A. Yes. There was some discussion about the
9 Meditech and trying to standardize that across
10 the province.
11 COFFEY, Q.C.:
12 Q. And how did that work out?
13 DR. WILLIAMS:
14 A. Well, I can't remember. I know there was some
15 discussion about it. I'm not sure if one of
16 the other health boards was on Meditech or
17 not. It strikes me that maybe Western was
18 not, but I may be wrong on that. I'm just--I
19 was at, in a sense, a little bit on the
20 periphery in terms of information systems, but
21 I remember some discussions.
22 COFFEY, Q.C.:
23 Q. And during the period you were deputy minister
24 of Health, do you recall whether there were
25 any concerns raised with you or to your

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1 knowledge within the Department about
2 inadequacies in the data management systems
3 for health care?
4 DR. WILLIAMS:
5 A. Not that I can recollect, no. Specifically,
6 there's--that's not saying there wasn't, but I
7 cannot remember if there was. Now there may
8 have been, because that's why we heavily went
9 with the Meditech system, I know. There was a
10 lot of discussion about it.
11 COFFEY, Q.C.:
12 Q. Do you recall, as deputy minister, whether or
13 not the Meditech system would have--well, I
14 should ask you, how much, if anything, do you
15 really know about the Meditech system?
16 DR. WILLIAMS:
17 A. Not a lot, to be honest with you.
18 COFFEY, Q.C.:
19 Q. Okay.
20 DR. WILLIAMS:
21 A. I guess, it's not an area that I got deeply
22 involved with. We had other people there in
23 the department who were specialists in that
24 area and I sort of left that to them in the
25 hospital services division.

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1 COFFEY, Q.C.:
2 Q. And while you were with the Health Care
3 Corporation of St. John's or Eastern Health,
4 would you actually use the Meditech system
5 yourself?
6 DR. WILLIAMS:
7 A. For e-mails and things like that, but not--I
8 never used it to look up information on
9 patients or anything.
10 COFFEY, Q.C.:
11 Q. But the Meditech system itself, not only has
12 or is capable of processing, storing and
13 processing information on individual patients
14 -
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. - and lab results and so on.
19 DR. WILLIAMS:
20 A. It can do that, yes, it does.
21 COFFEY, Q.C.:
22 Q. But as well, I take it, it has other uses,
23 such as e-mail?
24 DR. WILLIAMS:
25 A. Yes, e-mail and things like that, yes.

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1 COFFEY, Q.C.:
2 Q. Okay. There is another--perhaps, my fellow
3 counsel, there's another word used for the--
4 the oncologists routinely use.
5 MR. BROWNE:
6 Q. Opus
7 DR. WILLIAMS:
8 A. Opus, yes.
9 THE COMMISSIONER:
10 Q. Opus, that was the name. Thank you. How
11 about Opus, are you familiar -
12 DR. WILLIAMS:
13 A. I only heard about that when I was at the
14 Health Care Corporation and we knew that the
15 Cancer Foundation had invested heavily in an
16 Opus system. I probably would have heard of
17 that from Paul Gardiner. Paul was the medical
18 director of the Cancer Foundation and he was a
19 member of our MAC, so he may have been
20 reporting at that at one of our MAC meetings.
21 I'm not sure. But I've heard about the Opus
22 system, yes.
23 COFFEY, Q.C.:
24 Q. Now looking at P-0900, this is from Heather
25 Hanrahan directed to yourself.

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1 DR. WILLIAMS:
2 A. Yeah.
3 COFFEY, Q.C.:
4 Q. Wednesday, October 10th, 2001, at 12:45 p.m.
5 Anyway, it just simply says--I'm sorry, it's
6 for, not from you. It's for you. "Hi, Terry.
7 I make your appointment effective today when I
8 do your letter," and then I take it below the
9 text reads "that I am pleased to advise"--it's
10 actually directed to all staff from George
11 Tilley, the CEO, to all staff and physicians,
12 "re: appointment of director of Laboratory
13 Medicine program. I'm pleased to advise you
14 that Terry Gulliver has been appointed as
15 program director Laboratory Medicine," and he
16 goes on to talk about his background.
17 DR. WILLIAMS:
18 A. Um-hm.
19 COFFEY, Q.C.:
20 Q. And it says "Terry is replacing Mr. Vern
21 Whalen who recently retired following," I
22 believe it's "38 years of service," and Mr.
23 Tilley wishes Mr. Gulliver all the best. And
24 at the bottom there, it says it's sent--this
25 message is sent to Terry Gulliver and

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1 yourself.
2 DR. WILLIAMS:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. So that, I take it, is the appointment of Mr.
6 Gulliver into the position of director of Lab
7 Medicine?
8 DR. WILLIAMS:
9 A. Yeah. Yes, that is.
10 COFFEY, Q.C.:
11 Q. If I could, please, page two? This is a
12 memorandum on Eastern Health letterhead to all
13 staff from Stephen Dodge who's the vice-
14 president People and Information Systems, re:
15 director appointment, September 20th, 2005
16 it's dated. He says "I am very pleased to
17 bring you up to date on a number of
18 appointments to director positions with
19 Eastern Health. The second of those is
20 director of Laboratory Medicine, Terry
21 Gulliver" and it's handwritten September 30th,
22 I believe.
23 DR. WILLIAMS:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. And there's some handwriting here. What is
2 that?
3 DR. WILLIAMS:
4 A. It says "Denise, please set up one hour
5 meeting with each of these."
6 COFFEY, Q.C.:
7 Q. Okay, and these are the times of the meetings,
8 I believe?
9 DR. WILLIAMS:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And it goes on to say, "the above individuals
13 will commence their new roles immediately and
14 you should expect a transitional period for a
15 number of weeks. Unless otherwise indicated,
16 reporting relationships in these departments
17 will remain the same until the new
18 organizational structures are established."
19 And it's signed by--it goes on to say some
20 other things, and it's signed by Mr. Dodge.
21 And then, if we could, please, reading at
22 page three in this exhibit, it's a letter
23 October 17th 2005 addressed to Mr. Gulliver,
24 and it's--he's hereby--Mr. Dodge signed it
25 saying "it is with great pleasure that I offer

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1 you the position of Director Laboratory
2 Medicine with Eastern Health. The effective
3 date for this position was September 20tn,
4 2005" and now, sir, just on this latter point,
5 because Mr. Gulliver had been the director
6 during--from October of '01 until September of
7 '05 with the Health Care Corporation. He had
8 been the director of Lab Medicine, of
9 Laboratory Medicine, yes, and now he was being
10 made the Director in Eastern Health. Same
11 position?
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. This is what this reflects. What was going on
16 here? Can you tell the Commissioner why the
17 need for the changeover?
18 DR. WILLIAMS:
19 A. Okay. Because Eastern Health assumed
20 responsibility for the labs in Carbonear, the
21 lab in Clarenville, the lab in Burin and the
22 small lab in Bonavista.
23 COFFEY, Q.C.:
24 Q. And so Mr. Gulliver, I take it, in September
25 of '05, was taking on responsibility for the

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1 technologists and other support staff in those
2 labs?
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. In addition to his pre-existing duties?
7 DR. WILLIAMS:
8 A. Yes, there was a--the job was advertised and
9 he had to apply along with some other
10 candidates.
11 COFFEY, Q.C.:
12 Q. Okay, and -
13 THE COMMISSIONER:
14 Q. Clarenville, Carbonear and Bonavista?
15 DR. WILLIAMS:
16 A. Yes, Clarenville, Bonavista, Carbonear, Burin,
17 because Eastern Health would extend to
18 encompass all those places.
19 THE COMMISSIONER:
20 Q. So Eastern Health extends to Bonavista?
21 DR. WILLIAMS:
22 A. Oh yes, and extends down to St. Lawrence and
23 the tip of the Peninsula. It goes right out
24 to the Park.
25 THE COMMISSIONER:

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1 Q. I knew you went south. I didn't realize you
2 went that far north.
3 DR. WILLIAMS:
4 A. No, no, we're everything--the two peninsulas,
5 three peninsulas, Avalon, Bonavista and Burin
6 Peninsula, everything there is Eastern Health.
7 COFFEY, Q.C.:
8 Q. Now sir, up to the time that he was appointed
9 director of Laboratory Medicine in Eastern
10 Health, Eastern Health had been in existence
11 from April 1, 2005.
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. For the past -
16 DR. WILLIAMS:
17 A. Well, Eastern Health really -
18 COFFEY, Q.C.:
19 Q. - six months.
20 DR. WILLIAMS:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. So I take it no one had held that position
24 within Eastern Health?
25 DR. WILLIAMS:

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1 A. No, really the Board of Eastern Health didn't
2 take over until May. That's my recollection.
3 COFFEY, Q.C.:
4 Q. Yes, May of '05.
5 DR. WILLIAMS:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. But in the meantime, say, May, June, July,
9 August, September of '05 -
10 DR. WILLIAMS:
11 A. No.
12 COFFEY, Q.C.:
13 Q. - who was the director of Laboratory Medicine
14 for the Health Care Corporation?
15 DR. WILLIAMS:
16 A. Mr. Gulliver.
17 COFFEY, Q.C.:
18 Q. Gulliver, okay, and I take it with his
19 appointment now, that position was vacated?
20 DR. WILLIAMS:
21 A. Yes, that position -
22 COFFEY, Q.C.:
23 Q. With the Health Care Corporation.
24 DR. WILLIAMS:
25 A. - subsumed that position.

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1 COFFEY, Q.C.:
2 Q. Okay.
3 THE COMMISSIONER:
4 Q. Okay, let's make sure I understand what's
5 going on here. Mr. Gulliver was appointed
6 Director of Laboratory Medicine program in
7 2001, at which point it was the Health Care
8 Corporation?
9 DR. WILLIAMS:
10 A. Yes.
11 THE COMMISSIONER:
12 Q. And that would have included responsibility
13 for laboratories in all of the institutions
14 under the umbrella, which would have included
15 a lab?
16 DR. WILLIAMS:
17 A. Yes, Health Care Corporation.
18 THE COMMISSIONER:
19 Q. Okay, and then after what we have been
20 calling, for brevity, Eastern Health was
21 created, he had to apply, in effect, for his
22 old job plus these extra institutions?
23 DR. WILLIAMS:
24 A. Yes, correct.
25 THE COMMISSIONER:

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1 Q. And the last exhibit we looked at is the
2 confirmation of his appointment for that
3 purpose?
4 DR. WILLIAMS:
5 A. Yes.
6 THE COMMISSIONER:
7 Q. All right. Now is there a person on site at
8 Carbonear, Clarenville, Burin and Bonavista
9 that has a title other than pathologist?
10 DR. WILLIAMS:
11 A. There's no patho -
12 THE COMMISSIONER:
13 Q. Sorry, not pathologist, technician or
14 something. Is there -
15 DR. WILLIAMS:
16 A. We have technologists at all those sites.
17 THE COMMISSIONER:
18 Q. Yes, but is there a supervisor or something?
19 DR. WILLIAMS:
20 A. Yeah, there would be a manager -
21 THE COMMISSIONER:
22 Q. Manager.
23 DR. WILLIAMS:
24 A. - for Clarenville, Burin. I don't know how
25 it's worked out now, a manager for Carbonear

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1 area, and I think the manager at Clarenville
2 would subsume a management role for the
3 Bonavista site because there would be only two
4 or three technologists down there.
5 THE COMMISSIONER:
6 Q. Okay, and would there be a manager within the
7 -
8 DR. WILLIAMS:
9 A. The former Health Care Corporation?
10 THE COMMISSIONER:
11 Q. Well, General Hospital or the former Health
12 Care Corporation.
13 DR. WILLIAMS:
14 A. There are managers based upon divisions. So
15 we'd have a manager who'd be responsible for
16 biochemistry for all of St. John's, a manager
17 responsible for microbiology for all of St.
18 John's, a manager responsible for pathology
19 for all of St. John's, a manager responsible
20 for immunology, genetics for all of St.
21 John's, and a manager responsible for
22 hematology for all of St. John's, and attached
23 to some of those programs would be--there
24 would be Dr. Whitman, for instance, would be
25 sort of like a medical director in the

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1 hematology area. She's a pathologist and
2 internist. In microbiology, we'd have Dr. Jim
3 Hutchinson, who'd be a medical person in the
4 microbiology division. In the biochemistry
5 area, Dr. Ed Randell who's a Ph.D. in that
6 area would be in charge and this type of
7 thing.
8 THE COMMISSIONER:
9 Q. So outside of St. John's and Carbonear and
10 Clarenville, Burin and Bonavista, the manager
11 is the manager for that particular
12 institution?
13 DR. WILLIAMS:
14 A. So it's a generic type manager, yes,
15 responsible
16 THE COMMISSIONER:
17 Q. Okay, within St. John's, the manager level
18 depends on the particular, if you will,
19 specialty -
20 DR. WILLIAMS:
21 A. Yes.
22 THE COMMISSIONER:
23 Q. That is--in which--available within the City?
24 DR. WILLIAMS:
25 A. Yes.

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1 THE COMMISSIONER:
2 Q. And if you're a manager for a particular type,
3 you might, in fact, have people reporting to
4 you from St. Clare's or from the site in the
5 General Hospital?
6 DR. WILLIAMS:
7 A. Yes. The position that Mr. Gulliver occupies,
8 he could have the manager from the Clarenville
9 area reporting to him on all issues related to
10 laboratory medicine in Clarenville, whereas in
11 St. John's, he would have a manager reporting
12 to him who'd be like from biochemistry, for
13 instance, but that manager would only be
14 responsible for biochemistry portion of the
15 lab.
16 THE COMMISSIONER:
17 Q. Yes, and even though the people who work in
18 biochemistry may not just be in the place
19 where that manager is, they might be anywhere
20 in the City -
21 DR. WILLIAMS:
22 A. Yes, they could be.
23 THE COMMISSIONER:
24 Q. - which has the laboratory?
25 DR. WILLIAMS:

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1 A. Yes. We've centralized a lot of services in
2 the City. So where there was microbiology on
3 the Grace, St. Clare's and General site,
4 there's now only microbiology at the General
5 site, with one manager.
6 THE COMMISSIONER:
7 Q. All right. I have this vision of some little
8 truck that runs around the city with all kinds
9 of bits and pieces of people delivering and
10 picking up. Is that the way it runs?
11 DR. WILLIAMS:
12 A. There would be some specimens, yes,
13 transported to the General site. We're
14 running a core lab function, for instance, now
15 as part of the things we've done, a core lab,
16 a basic lab function at St. Clare's, but some
17 of the more specialized procedures would be
18 transported to the General site to do.
19 COMMISSIONER:
20 Q. Okay, and so would there be all kinds of
21 procedures for transport?
22 DR. WILLIAMS:
23 A. There would be procedures -
24 COMMISSIONER:
25 Q. Is that that complicated in that way?

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1 DR. WILLIAMS:
2 A. - for transport across the city, I don't--I
3 can't tell you the specifics of them, but,
4 yes.
5 COMMISSIONER:
6 Q. Thank you.
7 COFFEY, Q.C.:
8 Q. Okay.
9 COMMISSIONER:
10 Q. Sorry, Mr. Coffey.
11 COFFEY, Q.C.:
12 Q. No. So that's Mr. Gulliver's appointments.
13 If I could, please, Exhibit P-0903? This is a
14 letter dated October 11th, 2002, it's on
15 Health Care Corporation of St. John's
16 letterhead to Dr. Donald Cook, Clinical Chief,
17 Laboratory Medicine Program, and it's,
18 actually, it's three pages long, it's from--
19 two and a half pages long, it's from yourself
20 as the vice president of medical services.
21 It's copied to Mr. George Tilley. And it
22 says, you begin by saying, "I'm delighted to
23 advise you that the board of trustees has
24 confirmed that the recommendations of a search
25 committee of the medical advisory committee

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1 and the CEO that you be appointed clinical
2 chief of the laboratory medicine program."
3 And it goes on at--it goes on to say, "I would
4 like to welcome you to the position. I am
5 confident you will continue to do the
6 excellent job that you have been doing over
7 the past few months and prior to this when you
8 were in an acting position for the year that
9 Dr. David Haegert was on sabbatical leave."
10 And you say, "I have attached a generic job
11 description with respect to the role of
12 clinical chiefs within this organization and
13 one of the main responsibility areas of the
14 position you are assuming is insuring the
15 quality of medical care services provided by."
16 And the first of those listed here is,
17 "Insuring appropriate standards of medical
18 care are pursued in the laboratory medicine
19 program." And talks about liaison with other
20 individuals and bodies. And "Insuring that
21 the work of the medical staff is done on an
22 expeditious and timely basis, setting up a
23 tissue auditing system within the Health Care
24 Corporation. Insuring adequate physician
25 resources and performance. This would include

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1 an annual review of all physicians in the
2 laboratory medicine program." And you go on
3 to say, "In keeping with these four broad
4 areas dealing with quality medical services
5 our expectation is that you will assume a
6 strong clinical leadership role in the
7 laboratory medicine program which will include
8 active participation in the recruitment and
9 the credentially process for physicians
10 working in the laboratory medicine program at
11 all sites of this organization." Now, sir,
12 and this does go on at some--if I could.
13 Thanks--some length. Now, sir, was this a
14 generic sort of letter or -
15 DR. WILLIAMS:
16 A. No, that's not a generic sort of letter. The
17 generic component was the attached when I came
18 to the Health Care Corporation, we had a
19 generic job description for program directors
20 and for clinical chiefs. So I attached the
21 generic description and then flushed it out a
22 bit more in this letter.
23 COFFEY, Q.C.:
24 Q. Yes.
25 DR. WILLIAMS:

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1 A. So the generic description I don't have it in
2 front of me, I don't know if it's here, would
3 encompass those issues that I laid out in the
4 letter. I just wanted to flush these out and
5 expand upon them a bit. So, you know,
6 obviously quality was one of the issues,
7 recruitment of physicians was another issue,
8 there was liaison with the medical school and
9 teaching and things like that. I don't know
10 if I flushed all of these out, but I certainly
11 have, yeah, linkages with the Faculty of
12 Medicine. These are all in the generic job
13 description, but I wanted to expand upon them
14 and just lay it out in a comprehensive letter.
15 COFFEY, Q.C.:
16 Q. Thank you. My mouse seems to have -
17 REGISTRAR:
18 Q. Died?
19 COFFEY, Q.C.:
20 Q. Died.
21 REGISTRAR:
22 Q. (Inaudible) left button. No. Anyway.
23 Thanks. Perhaps that explains it, perhaps
24 it's just the wrong mouse.
25 REGISTRAR:

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1 Q. No, it's not the wrong mouse.
2 COFFEY, Q.C.:
3 Q. Okay. No, not going to do it. Okay.
4 COMMISSIONER:
5 Q. We'll get some batteries at the break.
6 COFFEY, Q.C.:
7 Q. If we could, please, Doctor, in the second
8 paragraph on the second page you begin by
9 saying, "An important aspect of carrying out
10 your job is a good ongoing working
11 relationship with senior leadership in the
12 other program areas, especially the clinical
13 chiefs." Now, Doctor, in your past
14 professional life as a physician, what, if
15 any, exposure to experience with laboratory
16 medicine had you had?
17 DR. WILLIAMS:
18 A. My exposure would be in the cottage hospital
19 setting.
20 COFFEY, Q.C.:
21 Q. And that would have been -
22 DR. WILLIAMS:
23 A. That's pretty basic.
24 COFFEY, Q.C.:
25 Q. That would have been decades before, or a

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1 decade and a half to two decades before?
2 DR. WILLIAMS:
3 A. Would have been up until '69 to '79, yes.
4 COFFEY, Q.C.:
5 Q. Okay, so -
6 DR. WILLIAMS:
7 A. In a very basic service.
8 COFFEY, Q.C.:
9 Q. And even then I take it that you wouldn't have
10 actually been involved in doing anything in
11 the lab itself, would you?
12 DR. WILLIAMS:
13 A. No, as a medical student you could do--it had
14 a haemoglobinometer, you could check
15 somebody's haemoglobin and you could actually
16 do a white blood cell count through a pipet
17 and a few things like that. But, no, very
18 basic stuff and very basic stuff in the
19 cottage hospital. We'd just send most of the
20 requests in to St. John's for processing from
21 Come by Chance where I worked or from Burin
22 where I worked.
23 COFFEY, Q.C.:
24 Q. So as the vice president of medical, in terms
25 of actual technical or clinical knowledge

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1 relevant, whom would you be relying upon?
2 DR. WILLIAMS:
3 A. I'd be relying on the leadership team for
4 those facets, yes.
5 COFFEY, Q.C.:
6 Q. What was your understanding of the role of the
7 laboratory medicine program in terms of the
8 acute care hospitals?
9 DR. WILLIAMS:
10 A. I looked at the laboratory medicine program,
11 the diagnostic imaging program and the
12 perioperative program as support programs for
13 everything else that was going on in the
14 organization, basically. Without diagnostic
15 services the other programs can't operate
16 properly. So they were, you know, what I'd
17 call a support program, a clinical support
18 program area, those three programs, I'd sort
19 of lump them together.
20 COFFEY, Q.C.:
21 Q. Okay. Sir, at the time that Dr. Cook was
22 appointed, which was, well, October of '02,
23 what, from your perspective as the VP medical
24 to whom he was reporting, what were the most
25 significant challenges he faced at the time as

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1 clinical chief, from your perspective as the
2 VP?
3 DR. WILLIAMS:
4 A. Well, working within an environment in an
5 academic health sciences centre, a large
6 laboratory, a diverse laboratory area, and
7 working in an environment of continued
8 restraint.
9 COFFEY, Q.C.:
10 Q. Now, your understanding was who reported to
11 Dr. Cook?
12 DR. WILLIAMS:
13 A. My understanding Dr. Cook would have a site
14 chief for both sites. He was the site chief
15 for St. Clare's and reported to Dr. Haegert in
16 his day and there was a site chief at the
17 General site.
18 COFFEY, Q.C.:
19 Q. And who reported to the site chiefs?
20 DR. WILLIAMS:
21 A. The pathologists on those sites, that was my
22 understanding.
23 COFFEY, Q.C.:
24 Q. Your understanding?
25 DR. WILLIAMS:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Okay.
4 DR. WILLIAMS:
5 A. And then the site chiefs, in turn, would
6 report to the clinical chief.
7 COFFEY, Q.C.:
8 Q. Sir -
9 COMMISSIONER:
10 Q. What would you--can you comment or we can wait
11 until Dr. Cook arrives, on what a site chief
12 does?
13 DR. WILLIAMS:
14 A. Well, yes and no. He'd be more conversant
15 than me. But the site chief would be
16 responsible for the pathology services on that
17 site, would deal with any issues on that site
18 and would report to the clinical chief if
19 there was any issues that couldn't be
20 resolved, this type of thing. That would be
21 my expectation.
22 COMMISSIONER:
23 Q. Well, for instance, as they say, would site
24 chiefs be involved in organization of
25 workloads, who gets to do what, when and

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1 where?
2 DR. WILLIAMS:
3 A. I would expect that the site chief would be
4 more involved in that, yes, and if there was
5 any issues, then he or she would consult with
6 the clinical chief.
7 COMMISSIONER:
8 Q. Okay.
9 DR. WILLIAMS:
10 A. Now, overall, the allocation of pathology
11 resources across both sites I think would be
12 done in consultation by the clinical chief and
13 consultation with the two site chiefs.
14 COMMISSIONER:
15 Q. Okay. So because one site chief might be
16 saying you're not giving me enough resource
17 here -
18 DR. WILLIAMS:
19 A. Yeah, there could be issues.
20 COMMISSIONER:
21 Q. - you're hogging it all at the General or
22 whatever place -
23 DR. WILLIAMS:
24 A. Yes. So there -
25 COMMISSIONER:

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1 Q. - and vice versa?
2 DR. WILLIAMS:
3 A. So there'd have to be a working relationship
4 there not too dissimilar to what it would be
5 in some of the other programs.
6 COMMISSIONER:
7 Q. And you mentioned this earlier, I think, but I
8 just want--in the sense of if there's
9 specialization, because as I understand it,
10 there may be some specialization in, sub-
11 specialization in pathology?
12 DR. WILLIAMS:
13 A. Yes.
14 COMMISSIONER:
15 Q. Would one be expecting that certain sub-
16 specializations would be located at one place
17 and other at another or would you divide them
18 between the two institutions?
19 DR. WILLIAMS:
20 A. Well, we didn't have -
21 COMMISSIONER:
22 Q. Or you didn't have two of any -
23 DR. WILLIAMS:
24 A. - a lot of sub-specialization -
25 COMMISSIONER:

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1 Q. Or did you not have two of any one sub-
2 specialty?
3 DR. WILLIAMS:
4 A. I recall that we had two sub-specialists, if I
5 can recollect correctly, at the time in or
6 organization. One would be Dr. Pushpanathan
7 who was a paediatric pathologist whose work
8 would be at the Janeway, but would be a member
9 of the laboratory medicine program. And the
10 second would be Dr. Gordon Matheson, who
11 retired and was replaced by Dr. Barron. And
12 Dr. Matheson was a neuropathologist.
13 COMMISSIONER:
14 Q. Okay.
15 DR. WILLIAMS:
16 A. And so some of the work of a neuropathologist,
17 I understand, is pretty specialized so that's
18 why when Dr. Matheson stepped down, we had Dr.
19 Barron. And Dr. Barron would also share call
20 with Dr. Pushpanathan so that it was difficult
21 to have a paediatric pathologist and the
22 person had to be on call 7/24, so part of Dr.
23 Barron's role as well as doing neuropathology
24 was to spell off Dr. Pushpanathan in terms of
25 some assistance with call and this type of

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1 thing. That's my recollection of details.
2 COMMISSIONER:
3 Q. Is there a lab at the Janeway or are all the
4 labs in the old General -
5 DR. WILLIAMS:
6 A. I think, my understanding, there might be some
7 stat things done at the Janeway. But the
8 Janeway, there's a dedicated blood collection
9 service for the Janeway because you're dealing
10 with people who need to be specialized in
11 taking blood from infants and this type of
12 thing.
13 COMMISSIONER:
14 Q. Yes.
15 DR. WILLIAMS:
16 A. But I think the -
17 COMMISSIONER:
18 Q. The actual blood work is not done there, is
19 it?
20 DR. WILLIAMS:
21 A. Transported to the General site, it's on the
22 same site.
23 COMMISSIONER:
24 Q. Well, actually, I had a tour of it and one of
25 the things that I thought I was shown was a

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1 special feature related to doing blood work
2 for children, particularly infants.
3 DR. WILLIAMS:
4 A. Yes.
5 COMMISSIONER:
6 Q. So I guess I just jumped to the conclusion
7 that the Janeway work was done at that site.
8 DR. WILLIAMS:
9 A. I think there's some stat work but I think
10 most of the basic stuff goes to the General.
11 The blood is collected at the Janeway.
12 COMMISSIONER:
13 Q. Okay.
14 DR. WILLIAMS:
15 A. I may be wrong, and that's my understanding.
16 COMMISSIONER:
17 Q. Well, we can check further later. It's not
18 really relevant to this, I just was interested
19 in terms of workloads, that's all. Mr.
20 Coffey.
21 COFFEY, Q.C.:
22 Q. Doctor, while we're on the subject of sub-
23 specialization, okay, particularly amongst
24 pathologists, were you ever--was it ever
25 brought to your attention--first of all, you

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1 know who Dr. Bev Carter is?
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. She's a breast pathologist?
6 DR. WILLIAMS:
7 A. Yes. I met her.
8 COFFEY, Q.C.:
9 Q. Do you know whether there was ever any attempt
10 to utilize her particular talents in terms of
11 workload for breast pathology, was that ever
12 brought to your attention?
13 DR. WILLIAMS:
14 A. Well, I met Dr. Carter the first time she came
15 here and interviewed her for a job but she
16 never took that job. She took a job in
17 McMaster and then came back subsequently. I
18 didn't--I don't think I met her the second
19 time around, at least to the level I met her
20 the first time. I knew her background. I
21 don't recall any discussion with a view to
22 making her, you know, just do breast pathology
23 or anything. I don't recall any discussion.
24 COFFEY, Q.C.:
25 Q. Okay.

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1 DR. WILLIAMS:
2 A. Now, I've had a lot of discussion after what
3 happened happened, but.
4 COFFEY, Q.C.:
5 Q. Yes.
6 DR. WILLIAMS:
7 A. But before that time, no, I can't recall that.
8 COFFEY, Q.C.:
9 Q. Okay.
10 DR. WILLIAMS:
11 A. And, you know, I've reviewed the minutes of
12 our meetings before I came here, but I didn't-
13 -I don't see anything there, but I may have
14 missed it.
15 COFFEY, Q.C.:
16 Q. In particular, a request by her, probably in
17 2004, that she look at all the ER/PR slides?
18 DR. WILLIAMS:
19 A. I don't remember that.
20 COFFEY, Q.C.:
21 Q. Like a suggestion by her that she, you know,
22 requested -
23 DR. WILLIAMS:
24 A. I don't think it came to my attention.
25 COFFEY, Q.C.:

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1 Q. Okay, that's what I'm asking, was it ever--you
2 don't recall?
3 DR. WILLIAMS:
4 A. And I don't see it in the minutes.
5 COFFEY, Q.C.:
6 Q. And, okay -
7 DR. WILLIAMS:
8 A. Of any of our meetings, so I don't -
9 COFFEY, Q.C.:
10 Q. And I just say that to see if it jogs any
11 memory.
12 DR. WILLIAMS:
13 A. No, it doesn't jog any memory with me.
14 COFFEY, Q.C.:
15 Q. Okay, Doctor, if we could, while we're
16 looking--if we could look at page 1 of this
17 exhibit, please? Thank you. Scroll down a
18 bit. Could you tell the Commissioner, please,
19 what a tissue auditing system is?
20 DR. WILLIAMS:
21 A. Yes. I explained it in probably as, I think
22 it as simple as I can. What you want to do in
23 any organization is it's like an audit
24 function, it is an audit function. So I'll
25 take, for example, say you take out 100

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1 appendixes a year. You set up a system
2 whereby you'd review a certain proportion of
3 those appendectomies, the pathology from them,
4 to correlate that with the clinical side and
5 to find out if actually you're taking, most of
6 the appendixes you take out are normal or
7 they're abnormal. If you're taking out a lot
8 of normal appendixes, then you might consider,
9 well, maybe we're operating too much.
10 COFFEY, Q.C.:
11 Q. Um-hm.
12 DR. WILLIAMS:
13 A. So that's an explanation that you try to
14 correlate the pathological findings with the
15 clinical findings in terms of an audit to see
16 if, in fact, your pathology and your clinic
17 match up. So I'm just using the simplest one
18 I can think of, which is an appendectomy. So
19 you go and audit so many appendectomies to see
20 if, in fact, if--you know, what's--there's
21 probably some data published that of 100
22 appendectomies are taken out, you know that
23 some of them are going to be normal because
24 not everything is the diagnostic criteria are
25 pretty hard sometimes in an appendectomy and

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1 sometimes you think you somebody has an
2 appendix, the signs are there, and yet you get
3 in and it's not inflamed appendix, but you're
4 there now, you sometimes take it out anyway.
5 COMMISSIONER:
6 Q. Yeah, you're not going to leave it there with
7 that scar?
8 DR. WILLIAMS:
9 A. No. Yeah, so you take it out anyway
10 sometimes. But so there may be some things
11 you can compare how we're doing in some of
12 these. Now, when it comes to appendectomies,
13 I'm just using that as an example.
14 COFFEY, Q.C.:
15 Q. As an example, yeah.
16 DR. WILLIAMS:
17 A. It's not so hard to diagnose as it used to be
18 because they have a thing called a CAT scan
19 which people use and it takes all of your
20 clinical judgment, a lot of the clinical
21 judgment out of it that we used to use when we
22 were in practice out of it. So a CAT scan can
23 pre-diagnostic sometimes for appendix.
24 COFFEY, Q.C.:
25 Q. So what was the--this is the fall of 2002.

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1 DR. WILLIAMS:
2 A. Yeah.
3 COFFEY, Q.C.:
4 Q. Okay. And you're asking Dr. Williams or
5 describing to Dr.--I'm sorry, to Dr. Cook, I'm
6 sorry.
7 DR. WILLIAMS:
8 A. Yeah.
9 COFFEY, Q.C.:
10 Q. That one of his main responsibility areas of
11 the position he's about to assume is to set up
12 a tissue auditing system?
13 DR. WILLIAMS:
14 A. Yeah, I think that Dr. Cook may have had that
15 on his mind, too.
16 COFFEY, Q.C.:
17 Q. Yeah, I was going to ask you about that. In
18 terms of there are five bullets here, a couple
19 of them are generic.
20 DR. WILLIAMS:
21 A. Yeah.
22 COFFEY, Q.C.:
23 Q. Particularly "ensuring appropriate standards
24 of medical care" presumably would be a
25 somewhat generic suggestion. Liaison,

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1 liaisoning, I'm sorry, with various
2 families/patients and other program chiefs, or
3 clinical chiefs, would be fairly generic.
4 "Ensuring the work of medical staff is done
5 expeditiously and timely", that would be
6 fairly generic. The last two, though,
7 "setting up the tissue ordering system" which
8 is--I'll just ask you about, are you saying
9 that that in fact might have been Donald
10 Cook's own idea?
11 DR. WILLIAMS:
12 A. It might have been his own idea. We did have
13 a tissue audit committee, by the way, this is
14 not something new. I think Dr. Abedi chaired
15 it before and he left, so that may be
16 something that Dr. Cook thought would be good
17 to explore.
18 COFFEY, Q.C.:
19 Q. So how was this different than what had been
20 there before?
21 DR. WILLIAMS:
22 A. I think he just wanted to get at the
23 forefront, make it part and he could say
24 probably to people that this is an important
25 issue, we need to get on with and I've been

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1 mandated by the VP to do it--maybe, you would
2 probably have to ask him the details of that.
3 COFFEY, Q.C.:
4 Q. I appreciate that, but as you are the author
5 of the letter, I thought, well -
6 DR. WILLIAMS:
7 A. Sure.
8 COFFEY, Q.C.:
9 Q. I'd try to get from you what you can recall.
10 "Ensuring adequate physician resources and
11 performance. And staffing levels, I take it
12 that relates to.
13 DR. WILLIAMS:
14 A. Yes, that would be, you know, anticipating if
15 we knew we're going to have a retirement next
16 year and so we each said, look, I'm retiring,
17 then anticipating that and trying to get out
18 front--now we wouldn't expect Dr. Cook to get
19 out and do any of the leg work, our office
20 would do that in terms of getting out the ads,
21 trying to do the recruitment. He'd have to
22 tell us what kinds of things he wanted in the
23 ad and this type of thing, but we'd do all
24 that.
25 COFFEY, Q.C.:

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1 Q. "And this would include an annual review of
2 all physicians in the laboratory medicine
3 program." Now was that particular to this
4 program or was that generic?
5 DR. WILLIAMS:
6 A. No, we were trying to encourage--get that into
7 other programs as well.
8 COFFEY, Q.C.:
9 Q. Had that been done before this?
10 DR. WILLIAMS:
11 A. No, that was Dr. Haegert when he was there,
12 not that I can recollect, no. It was
13 something I wanted to get in.
14 COFFEY, Q.C.:
15 Q. And so, as you say, something from your--this
16 is "I", you, yourself -
17 DR. WILLIAMS:
18 A. Yeah, I thought it would be, it's a small
19 program in terms of numbers of people, 17 or
20 18 people and I wanted to try and get that in,
21 yes.
22 COFFEY, Q.C.:
23 Q. What's the purpose of such an annual review?
24 DR. WILLIAMS:
25 A. It works on a two-way street, I think, always

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1 looking at, it's a chance for the person who
2 is being reviewed to get their comments
3 towards the person who is up the line, just in
4 case it doesn't happen, and it's a chance for
5 the person who is doing the review to give
6 comments to the person who is being reviewed
7 and a chance to lay out some issues that need
8 to be explored or worked on, this type of
9 thing.
10 COFFEY, Q.C.:
11 Q. Would that evolve things such as--might it
12 include constructive criticism?
13 DR. WILLIAMS:
14 A. Yes, some of it would include, like your
15 reports, you're a little bit tardy in your
16 reporting, because, you know, turn-around
17 times are important. Some people may be more
18 attentive to that than others, so things like
19 that.
20 COFFEY, Q.C.:
21 Q. Now, sir, in relation to this particular
22 program, what if any quality control measures
23 were you aware, as the VP Medical, that were
24 being utilized in an anatomical pathology
25 aspect of the lab?

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1 DR. WILLIAMS:
2 A. In the lab, my understanding was that's the
3 kind of briefing I would have got when I came
4 here, that from the technical side--there's
5 two sides, the technical side, our
6 organization was participating in proficiency
7 testing, which really is the quality way that
8 labs--same as we did in the Public Health lab
9 when I was at the department, that we would
10 get unknowns sent in and we would have to
11 analyze them and report--it's like an exam and
12 then you get graded on those.
13 COFFEY, Q.C.:
14 Q. Who is "we"?
15 DR. WILLIAMS:
16 A. Our lab.
17 COFFEY, Q.C.:
18 Q. Who in the lab, what types of -
19 DR. WILLIAMS:
20 A. All different services, whether it was
21 biochemistry, microbiology, these services.
22 COFFEY, Q.C.:
23 Q. And pathology too?
24 DR. WILLIAMS:
25 A. Yes, pathology would be done by individual

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1 pathologists, I think, it was individual and
2 program based, they would be done by the
3 College of American Pathologists for the
4 General site and the Association of Clinical
5 Pathologists or something--there's another
6 group that I think the St. Clare's site was
7 done by, but it gave a rating of your
8 pathologists, that's my understanding. Now I
9 don't know the details of that, but it gave
10 feedback as to what kind of quality was being
11 performed in anatomical pathology and what
12 kind of quality was being performed in the,
13 you know, technical areas of the lab, that's
14 my understanding.
15 COFFEY, Q.C.:
16 Q. Sure. And this is when you first showed up.
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. As time went on, how did that evolve?
21 DR. WILLIAMS:
22 A. And as time went on, we continued to
23 participate, as far as I know, well Dr. Cook's
24 performance review brings out all the things
25 that you're doing in the pathology area. But

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1 I knew that the other areas were--it's just
2 sort of a standard format and I also presumed
3 that when the accreditors would come around
4 every three years, they would want to make
5 sure that you were participating, you had to,
6 I think show that you were participating,
7 that's my understanding.
8 COFFEY, Q.C.:
9 Q. Now which accreditors are they?
10 DR. WILLIAMS:
11 A. The Canadian Council of Accreditation, the
12 people that come around every three years. I
13 would think they would ask, I'm not sure.
14 COFFEY, Q.C.:
15 Q. Were you aware of whether or not they were
16 accrediting or looking at the lab, pathology
17 under the lab?
18 DR. WILLIAMS:
19 A. I'm aware of what they did in 2004 because I
20 asked Mr. Gulliver, once we got our
21 accreditation in 2004, that would be only the
22 second accreditation I went through. There
23 was one done in 2001 and just at the time I
24 was getting here in 1998, but 2004 I asked how
25 it was going and Mr. Gulliver said that the

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1 lab was doing great, but I asked him what they
2 did and they didn't do very much in a sense,
3 so that led to something else, but anyway we
4 can talk about that later.
5 COFFEY, Q.C.:
6 Q. Okay, what was that?
7 DR. WILLIAMS:
8 A. Well, I think there were some follow-up
9 discussion in the quality committee on, you
10 know, looking at lab accreditation, the fact
11 that the feedback that I got from Mr. Gulliver
12 only said they were good and everything was
13 fine, I don't think they spent any more than
14 ten or fifteen minutes or half an hour in the
15 lab. Now that's my understanding, I may be
16 wrong -
17 COFFEY, Q.C.:
18 Q. This is what Mr. Gulliver was reporting to
19 you?
20 DR. WILLIAMS:
21 A. Yes. You'd have to ask him in more detail.
22 COFFEY, Q.C.:
23 Q. And we will, but I'm just, from your sense in
24 being the VP, what you were being told?
25 DR. WILLIAMS:

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1 A. Yeah, and I can remember--now we're going back
2 to 2004, but I can remember something to that
3 level.
4 COFFEY, Q.C.:
5 Q. Doctor, Mr. Gulliver didn't--in what he told
6 you, I gather, didn't seem overly impressed by
7 the amount of time that they spent looking at
8 -
9 DR. WILLIAMS:
10 A. He didn't make a lot of comment on it, I just
11 asked him how much time they spent. I can't,
12 you know, I can't remember all the details,
13 but I think there were some, I think there was
14 something came out of that.
15 COFFEY, Q.C.:
16 Q. So what then, what do you recall, if anything,
17 then transpired?
18 DR. WILLIAMS:
19 A. There was some follow-up in quality committee
20 that we had in the Health Care Corporation at
21 the time, because we had other things that
22 were accredited. We were all accredited by
23 the Canadian Council and Hospital
24 Accreditation, all the hospitals--all the
25 facilities in Canada, I presume, but -

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1 COFFEY, Q.C.:
2 Q. How about in terms of, like accreditation for
3 laboratories?
4 DR. WILLIAMS:
5 A. Yeah, we discussed that, we followed it up and
6 -
7 COFFEY, Q.C.:
8 Q. What did you find?
9 DR. WILLIAMS:
10 A. Well, what I was able to find was that there
11 wasn't much done across the country, except
12 Ontario seemed to have a good program, that's
13 what I can recollect. Alberta may have been
14 doing something, but I understood Ontario had
15 a good program in laboratory accreditation,
16 that's my recollection at the time.
17 COFFEY, Q.C.:
18 Q. And did you--do you recall whether or not the
19 option of or the possibility of participating
20 in those programs was ever explored at that
21 time, '04 and '05? Like, before the ER/PR
22 became an issue in the middle of '05?
23 DR. WILLIAMS:
24 A. I think we were following through it in the
25 quality committee and I think it was bumped up

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1 to Mr. Tilley, who was the CEO to discuss the
2 possibility of perhaps, because I knew he met
3 with the other CEOs and the Deputy Minister
4 every two weeks or so, because there were only
5 four CEOs at that time and we were sort of in
6 between being part of Eastern Health and still
7 being the Health Care Corporation.
8 COFFEY, Q.C.:
9 Q. Yes.
10 DR. WILLIAMS:
11 A. So I think we--that was--he was made aware of
12 that, I'm pretty sure, but I don't know if it
13 was in writing or just in a verbal sense that
14 it might be a good idea for labs in our
15 province to be involved in that process. And
16 subsequently to that, I remember talking to
17 Dr. Richardson who was the head--he was head
18 of the Quality Laboratory Program in Ontario,
19 which was run jointly by the CMA and had got
20 some stuff from him, and I think I sent that
21 to Mr. Tilley as well.
22 COFFEY, Q.C.:
23 Q. Was that before the ER/PR -
24 DR. WILLIAMS:
25 A. That was just at the time.

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1 COFFEY, Q.C.:
2 Q. Just at that time and I think we'll see some
3 of that in the materials. If we could,
4 please, exhibit P-0903, page 4. And if we
5 could, this is a letter of January 5th, 2006
6 from Dr. Cook to yourself and in it, he says,
7 "I'm writing to inform you of my decision to
8 step down as clinical chief for the Laboratory
9 Medicine Program effective February 28th,
10 2006." And he says, "I have been in the
11 position of clinical chief, including acting
12 clinical chief since March 12th, 2002." And
13 he concludes the first paragraph by saying, "I
14 will be continuing on as a staff pathologist
15 and site chief for the St. Clare's site and
16 will offer my full support for the new
17 clinical chief." The reference there to site
18 chief, who appointed the site chiefs?
19 DR. WILLIAMS:
20 A. The site chiefs I think were probably there
21 even before the Health Care Corporation came
22 on, I think that was the case. I can't be
23 sure of that because Dr. Cook was site chief
24 when I got there, but the site chiefs after
25 Dr. Cook's stay, he would appoint the site

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1 chief.
2 COFFEY, Q.C.:
3 Q. The clinical chief would appoint the site
4 chiefs.
5 DR. WILLIAMS:
6 A. Yes, it would usually come up to the MAC for
7 their concurrence, but -
8 COFFEY, Q.C.:
9 Q. And you may have already mentioned that, okay.
10 And if we could look, please, at page 5, this
11 is an e-mail from Denise Dunn, Thursday,
12 January 5, 2006, 5 p.m. to Mr. Tilley and she
13 writes: "As George has discussed, this is Dr.
14 Cook's letter of resignation. I am looking at
15 appointing Dr. Denic for a six-month interim
16 basis until we're in a position to appoint a
17 clinical chief for the long term." Signed
18 Bob.
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Now this is just, in fact might be a good
23 example of some things so the Commissioner has
24 some sense of the way you actually worked from
25 day to day.

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1 DR. WILLIAMS:
2 A. Uh-hm.
3 COFFEY, Q.C.:
4 Q. Obviously this was scanned, that's Dr. Cook's
5 letter and it went on as an attachment,
6 according to this. Do you see that little,
7 right here, I can't point because I don't have
8 anything--yes, that's it, right there, the
9 little image, yourself, Doctor, did you use a
10 computer yourself?
11 DR. WILLIAMS:
12 A. Yes, I did to pick up my e-mail, I would often
13 look at it, but I wasn't sending out letters
14 or typing things up. I didn't think that was
15 a valuable use of my time, given the minutes
16 and the meetings I had to go to and everything
17 else.
18 COFFEY, Q.C.:
19 Q. Sure.
20 DR. WILLIAMS:
21 A. I'd be very, very slow at it and cumbersome,
22 so I didn't -
23 COFFEY, Q.C.:
24 Q. So you would utilize anything that was going
25 to take any time to type or formatting and so

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1 on, you would utilize Ms. Dunn?
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Now if we could, please -
6 DR. WILLIAMS:
7 A. And the reason for that, Dr. Denic for six
8 months, we can talk about that if you want to.
9 COFFEY, Q.C.:
10 Q. Yes. Because he was appointed--well this
11 would be the beginning of '06, so I take it,
12 yes, because you were there more than six
13 months, beyond that, what then happened with
14 respect to Dr. Denic's appointment?
15 DR. WILLIAMS:
16 A. What I really did was, I thought at that time
17 that we were going to have my replacement in
18 place before that six month period expired,
19 that was the plan and I had submitted my
20 resignation back in September. When I took
21 the job, I sort of was planning to give it up
22 when the Health Care Corporation of St. John's
23 ceased to exist in May of 2005 and Mr. Tilley
24 came to me and asked me if I would agree to
25 stay, okay, in February -

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1 COFFEY, Q.C.:
2 Q. This would be '05.
3 DR. WILLIAMS:
4 A. Yes, and I told him that -
5 COFFEY, Q.C.:
6 Q. Just so I'm able to follow the chronology and
7 forgive me, so you knew, of course in the fall
8 of '04 that there was going to be this big
9 reorganization -
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. And you eventually would have learned probably
14 effective April 1, '05.
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And you had planned to -
19 DR. WILLIAMS:
20 A. Well what I planned to do is that I didn't see
21 myself giving a three to five year commitment
22 to a new organization and I really wanted to
23 step down and not get involved. Mr. Tilley
24 came to me in February, you had to have your
25 application in at the end of February and I

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1 told him I really hoped that he would get
2 somebody and that my preference was to step
3 down when the new organization came into
4 existence. He said, look, apply for it anyway
5 just in case I don't get somebody, maybe, you
6 know, you'd stay on for a few months. So I
7 did apply just a day or two before the date
8 for not applying, I guess the expiration date.
9 COFFEY, Q.C.:
10 Q. The deadline.
11 DR. WILLIAMS:
12 A. And we had some discussion in March when he
13 was doing some interviews and I told him I was
14 not prepared to make any, you know, if he
15 couldn't get anybody, I would stay on and help
16 out, but I wasn't prepared to commit beyond a
17 transition year and he said he would accept
18 that if I stayed on for a year and to let him
19 know in September if my decision was that I
20 wasn't going to stay on any longer than a year
21 because then it would give him plenty of time
22 to get a replacement for me, so that's what
23 happened.
24 COFFEY, Q.C.:
25 Q. So you took the position on that

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1 understanding.
2 DR. WILLIAMS:
3 A. Under the understanding that I had no more
4 commitment than one year.
5 COFFEY, Q.C.:
6 Q. And September of '05 rolled around finally -
7 DR. WILLIAMS:
8 A. I wrote him, as he told me to let him know in
9 September and I did.
10 COFFEY, Q.C.:
11 Q. And what did you tell him in September?
12 DR. WILLIAMS:
13 A. I told him that I would be stepping down, if I
14 needed to stay on for a couple of extra months
15 past my year commitment, I'd do that, but you
16 know, that's all I committed to.
17 COFFEY, Q.C.:
18 Q. Okay. So in September of '05 in effect you
19 were telling Mr. Tilley that look, come March
20 31st '06, I want to be gone and I might stay
21 on a little bit beyond, a month or two beyond
22 that.
23 DR. WILLIAMS:
24 A. If he got stuck, sure.
25 COFFEY, Q.C.:

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1 Q. And then it ended up being about an extra five
2 or six months.
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. As it turned out.
7 DR. WILLIAMS:
8 A. I couldn't--I didn't feel I could leave
9 without him having a replacement.
10 COFFEY, Q.C.:
11 Q. Now, Doctor, if we could please, exhibit P-
12 0901? Now this is on Health Care Corporation
13 of St. John's letterhead, it's a document
14 March 3rd, 2002. It's addressed to yourself
15 as VP Medical Services, it's from Terry
16 Gulliver who was then the program director of
17 laboratory medicine. The subject is "Second
18 response to Hay operational review".
19 DR. WILLIAMS:
20 A. Uh-hm.
21 COFFEY, Q.C.:
22 Q. And he begins by saying, "Further to our
23 meeting of February 22nd, 2002, following some
24 more detailed response to the Hay operational
25 review report based upon revised statistics as

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1 provided by Ms. Sharon Lear, Director of
2 Budgeting." And then there are quite a number
3 of figures and if we could go to the second
4 page please, there's a reference to the "Core
5 Lab Concept" in the heading and he talks,
6 gives some commentary upon that, including a
7 sub-heading "Plan for core lab at St.
8 Clare's." Towards the bottom of the page
9 there's a section entitled "Operations". If
10 we go to page 4, please, there's a heading
11 "Impact of facilities and equipment"; another
12 heading "Productivity comparisons" and he goes
13 on at some length about that. And to page 6,
14 where there are a series of recommendations
15 and a group of numberings on the side,
16 handwritten.
17 DR. WILLIAMS:
18 A. Uh-hm.
19 COFFEY, Q.C.:
20 Q. Whose handwriting is that, do you know?
21 DR. WILLIAMS:
22 A. I'm not sure.
23 COFFEY, Q.C.:
24 Q. Okay. Now I asked this because the letter was
25 addressed to yourself, so -

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1 DR. WILLIAMS:
2 A. Okay, it might be mine.
3 COFFEY, Q.C.:
4 Q. And if we could, please, go to page 7, there
5 under "Overall Comments", Mr. Gulliver has
6 written "As a line above, I agree with many of
7 the recommendations and suggestions in the
8 report"--presumably that's the Hay report,
9 "that deal with the operations of the program,
10 improve deficiencies and the impact of
11 facilities and equipment, and the concept of a
12 core lab at St. Clare's. Many, if not all, of
13 these suggestions are either in progress or
14 have already been discussed at a program level
15 and we would have moved forward with those
16 operational improvements regardless." And
17 then he says, "The total impact of staff
18 reductions over the next year or so on the
19 laboratory medicine program are as follows"--
20 and one of them is the division of pathology,
21 one fulltime equivalent. "Please do not
22 hesitate to contact me should you need further
23 assistance." This idea of a core lab at St.
24 Clare's back then in 2002, I take it that
25 based upon these comments, that seems to

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1 suggest that that was something that came out
2 of the Hay report, the Hay review?
3 DR. WILLIAMS:
4 A. It may or it may have come out of some of our
5 own discussions, I'd have to go back and look
6 at our meetings that we had every month.
7 COFFEY, Q.C.:
8 Q. Was that actually implemented at that time?
9 DR. WILLIAMS:
10 A. The core lab was set up at St. Clare's. I'm
11 not sure exactly when it was implemented.
12 COFFEY, Q.C.:
13 Q. Okay. So, it certainly wasn't before this, it
14 was some point afterward.
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And you can't recall whether it was
19 immediately or a period of years afterward?
20 DR. WILLIAMS:
21 A. I'm not sure.
22 COFFEY, Q.C.:
23 Q. Okay.
24 THE COMMISSIONER:
25 Q. What's a core lab?.

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1 COFFEY, Q.C.:
2 Q. Yes.
3 DR. WILLIAMS:
4 A. That's basically you try to do the high -
5 COFFEY, Q.C.:
6 Q. If we could just, Doctor, page 2 please,
7 Commissioner and maybe that might assist you
8 to -
9 THE COMMISSIONER:
10 Q. Oh, that (inaudible) thank you. And you -
11 COFFEY, Q.C.:
12 Q. I'm sorry, go ahead.
13 THE COMMISSIONER:
14 Q. I'm sorry -
15 DR. WILLIAMS:
16 A. My understanding of a core lab is that it does
17 the basic functions and tests that are of high
18 volume and needed on a day-to-day basis on
19 that site and other things that can wait and
20 can be consolidated, another site, that
21 shouldn't impact patient care, could be done--
22 it has some operational efficiencies. That's
23 my understanding of a core lab.
24 THE COMMISSIONER:
25 Q. Does core lab relate to the complexity of the

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1 work or is there another function that
2 determines it?
3 DR. WILLIAMS:
4 A. I think a core lab basically is doing high
5 volume things that are needed on a day-to-day
6 basis at that site, but try to consolidate
7 some of the other services at one site. That
8 was my understanding of a core lab. It may be
9 able to be explained better by somebody else
10 than me, but -
11 THE COMMISSIONER:
12 Q. Yes, because it does talk about the automated
13 equipment.
14 DR. WILLIAMS:
15 A. It talks about the lab as a rapid response,
16 that lab, that would provide the basic
17 hematology, chemistry, coagulation, blood
18 banking and grand stain testing, things that
19 you'd use that are high volume things that you
20 need for patient care on a day-to-day basis
21 and have your sub-speciality and stuff done on
22 another site.
23 THE COMMISSIONER:
24 Q. Well, I think that's why I'm trying to get a
25 picture for, as whether or not--I don't want

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1 to insult anybody here, but whether or not the
2 core lab is the stuff that's done at such
3 volume that it perhaps doesn't require the
4 specialized skills of other things. Is it
5 that kind of thing or--but I don't know
6 because maybe very specialized skills are
7 required for something that's done everyday.
8 DR. WILLIAMS:
9 A. No, I think it's your bread and butter tests
10 that are done in high volume that you need to
11 run a hospital.
12 THE COMMISSIONER:
13 Q. Okay.
14 DR. WILLIAMS:
15 A. That's my--the best I can put it. I may be
16 wrong in that, but that's my -
17 COFFEY, Q.C.:
18 Q. And most informed people in that regard -
19 DR. WILLIAMS:
20 A. Would be people who are professionals in the -
21 COFFEY, Q.C.:
22 Q. Mr. Gulliver and -
23 DR. WILLIAMS:
24 A. Mr. Gulliver and Dr. Cook.
25 COFFEY, Q.C.:

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1 Q. - Dr. Cook. Thank you.
2 DR. WILLIAMS:
3 A. I'm, like I said, they are the professionals
4 and we have to rely on them for that kind of
5 information.
6 COFFEY, Q.C.:
7 Q. If we could look at page 3 please. You notice
8 the fifth bullet, it says, "I agree"--this is
9 "I", this is Mr. Gulliver--"I agree that acute
10 care laboratory services being provided by the
11 public health laboratory should be
12 consolidated with the Health Care Corporation
13 of St. John's".
14 DR. WILLIAMS:
15 A. Um-hm.
16 COFFEY, Q.C.:
17 Q. "This can be achieved when renovations are
18 completed at the General site and staffing
19 will have to move with the workload from the
20 public health labs". So, I take it there were
21 things coming in from -
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. - the public health lab.

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1 DR. WILLIAMS:
2 A. I didn't agree with that recommendation.
3 THE COMMISSIONER:
4 Q. Why was that?
5 DR. WILLIAMS:
6 A. Why was that? Because when I worked at the
7 department, we had responsibility at the
8 department. I was worried about and still
9 would be worried about if they tried to put
10 that into an acute general hospital setting,
11 is that the public health function of that lab
12 would be subliminated and may be lost. And I
13 think it's important to have a lab that's
14 there for investigating food outbreaks and
15 doing a high level of virology and things like
16 that in our province, from a public health
17 perspective. That's responsive to public
18 health needs. And I was a bit concerned about
19 putting that into an acute care facility.
20 Some of that might be lost. Now that's my
21 view.
22 THE COMMISSIONER:
23 Q. In the everyday process of not priorizing
24 what's going on, maybe public health wouldn't
25 get the priority -

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1 DR. WILLIAMS:
2 A. Would get pushed down the agenda and the acute
3 care stuff that had to be done today would get
4 pushed up on the agenda and we'd lose that
5 function and our public health lab, as maybe
6 some people know, maybe they don't know, has
7 been instrumental in the Province in detecting
8 that major cheese outbreak in 1989, 1990, 2000
9 when it had cheese that was produced in a
10 dairy in Prince Edward Island, was exported
11 across the country. We had a massive outbreak
12 of food poisoning in many provinces. Our
13 province had over a thousand cases. Our
14 public health system was good here with public
15 health inspectors at the time and this type of
16 thing. We uncovered the cause of the
17 outbreak. This province took the cheese off
18 the market, fully 10 to 12 days before the
19 Federal Government took it off the market.
20 Now, even though they agreed with us taking it
21 off the market because the political situation
22 in Prince Edward Island, which linked back to
23 a dairy in Prince Edward Island, it's almost a
24 swiss cheese effect in a dairy where they had
25 new pasteurizing equipment put in place. A

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1 new person come on who was trained in the
2 pasteurizing equipment, but shut off the
3 equipment too early. And somewhere in the
4 herd, they had some cows who had salmonella.
5 So put all three together and we had some milk
6 and cheese products that got out in the public
7 and people got quite ill and there were some
8 deaths and that over it. So I think our
9 public health lab was instrumental in tracking
10 that down before anybody else in Canada did,
11 and so I think we need to protect that
12 function.
13 COFFEY, Q.C.:
14 Q. So your--did this recommendation -
15 DR. WILLIAMS:
16 A. I would not agree with that.
17 COFFEY, Q.C.:
18 Q. And when you say--well, if you wouldn't agree,
19 then it didn't happen, I take it?
20 DR. WILLIAMS:
21 A. Well, I wouldn't support it, no, but I felt I
22 had enough information not to support it.
23 COFFEY, Q.C.:
24 Q. Oh yes.
25 DR. WILLIAMS:

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1 A. The other things I wouldn't, I had to rely on
2 the professionals, but on that, with my
3 background in the Department of Health and in
4 public health, I wanted to protect that.
5 COFFEY, Q.C.:
6 Q. So did it happen at the time?
7 DR. WILLIAMS:
8 A. Didn't happen. Hasn't happened yet.
9 COFFEY, Q.C.:
10 Q. Okay. If we could, please, page six? Now
11 Doctor, these are, again, the listing of
12 recommendations here. If we could, please,
13 recommendation number, apparently (88) and
14 then there's a number 93 is written next to
15 it. Doctor, I'm sorry, Mr. Gulliver has said
16 "I disagree with having a single manager for
17 pathology and cytology for the Health Care
18 Corporation of St. John's. This means that
19 one manager would have responsibility for
20 almost 80--I'm sorry, 70 staff." and he goes
21 on to say "the laboratory program has recently
22 down sized from ten division managers to
23 seven. This allows for only one manager for
24 each division corporate wide. The proposed
25 new core lab at St. Clare's which would have

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1 combined hematology chemistry functions would
2 be managed by one of the existing managers."
3 So can you tell the Commissioner, please, what
4 had happened then in relation to these ten
5 division managers going down to seven?
6 DR. WILLIAMS:
7 A. Over time, when things changed, and I'd have
8 to go back because some of this would have
9 happened maybe before I came there, as a
10 result of--and some happened after I came
11 there. As a result of consolidation and
12 closing the Grace lab and this type of thing,
13 and consolidating services, you're able to
14 reduce managers, because you might have a
15 manager at the Grace site for seven or eight
16 people in that function and you'd take that
17 function out of there and you transfer three
18 or four staff to one site and three or four to
19 another, within that manager's scope of
20 responsibilities, it may not be too broad so
21 you can reduce from three managers to two
22 managers, those kind of things. I'm pretty
23 sure that's what he's referencing there.
24 COFFEY, Q.C.:
25 Q. What was a division manager doing?

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1 DR. WILLIAMS:
2 A. Division manager would be really responsible
3 for supervising the staff and making sure that
4 work was performed efficiently and the quality
5 issues and things were looked after in that
6 particular area. Being on top of the
7 situation, I guess.
8 COFFEY, Q.C.:
9 Q. And in the context of breast pathology, ER/PR
10 testing, IHC testing, who would the division
11 manager be in this context?
12 DR. WILLIAMS:
13 A. In that area, I would expect it would be in
14 the pathology area, I think.
15 COFFEY, Q.C.:
16 Q. So -
17 DR. WILLIAMS:
18 A. Barry Dyer, I think.
19 COFFEY, Q.C.:
20 Q. Probably Mr. Dyer?
21 DR. WILLIAMS:
22 A. Yeah. I don't know what the situation was at
23 that time. I'd have to trace it back.
24 COFFEY, Q.C.:
25 Q. And just the idea that--relating to the idea

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1 of if a manager--there are only so many hours
2 in a day.
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. No matter who the person is. The idea of, you
7 know, having a manager manage more and more
8 people or be responsible directly or
9 indirectly for more and more people and more
10 and more functions perhaps or same function
11 but at more sites, was there--during the years
12 from '98 through 2005, was there ever any
13 discussion that you engaged in wherein the
14 topic arose as to whether or not this was
15 really a good idea, bearing in mind that the
16 manager, division managers might not have
17 enough time to carry out their job function in
18 a satisfactory manner? Was there ever
19 discussions about that?
20 DR. WILLIAMS:
21 A. I don't remember any discussions about that.
22 I think, again, once we were in a financial
23 squeeze, after HAY reported, I think we lost--
24 we were on--I don't think Terry Gulliver was
25 ever able to balance the budget after Hay.

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1 Every year, we'd be looking at increases of
2 six to seven percent in the -
3 COFFEY, Q.C.:
4 Q. In actual.
5 DR. WILLIAMS:
6 A. - in requests coming into the lab. We have no
7 control over tests. A physician orders a
8 test, how can we tell him the lab where that
9 test needs to be done? We can't make that
10 judgment call. Tests in the lab are done--
11 they're not done by a booked--they're not
12 booked ahead. We can deal with it by booking
13 them out six weeks in advance. Tests in the
14 lab are really--a lot of them need to be done
15 today or tomorrow or really within a day or
16 two. That's the way the lab works. So we
17 were under constant pressure to get the
18 workload done and try to address the issues
19 there, and we tried to protect as many
20 frontline staff as we could, and we tried to
21 take advantages of automation, to down size
22 staff where we could, to live within our
23 budget. But I think if you go back and look
24 every year at our budget, I don't think we
25 balanced--I don't think we were able to

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1 balance the budget and every--I was--I and Mr.
2 Gulliver, with our financial people, trying to
3 get an adjustment to our budget pretty well
4 every year, in that time frame. That's my
5 recollection of it.
6 COFFEY, Q.C.:
7 Q. And so with that as the backdrop or the actual
8 reality, I take it, the idea of or questioning
9 the wisdom perhaps of whether or not it was
10 advisable to burden individual managers with
11 more and more work, I take it, never really
12 came up because -
13 DR. WILLIAMS:
14 A. It was felt that by consolidating people,
15 rather than having three sites and having
16 three managers, if you went down to two site,
17 you could have two managers.
18 COFFEY, Q.C.:
19 Q. Um-hm.
20 DR. WILLIAMS:
21 A. And when we moved microbiology from, to only
22 the one site at the General, we had one
23 manager there. Now, microbiology is not as a
24 big number of technologists in the
25 microbiology services, but when an

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1 organization gets challenged that's providing
2 services, you often try to maintain the
3 services by seeing where else you can trim.
4 And we trimmed in the management side. That's
5 what we did. I don't remember any discussion
6 that that's the wrong thing to do, but we try
7 to--the biggest thing that was facing our
8 organization then was a lot of pressure from
9 government, as you know, to balance the
10 budgets. The government had no money at that
11 time either; they just didn't have the money.
12 (Unintelligible) spends a lot of money.
13 COFFEY, Q.C.:
14 Q. In terms of the division managers, a person
15 like Mr. Dyer, for example, his role would
16 involve, you just referred to is, quality
17 assurance, thinking about trying, you know -
18 DR. WILLIAMS:
19 A. Making sure the work is carried out
20 efficiently, getting it done, trying to make
21 sure it's done properly, this type of thin.
22 COFFEY, Q.C.:
23 Q. We will hear from Mr. Dyer eventually, of
24 course, himself, but bearing in mind what you
25 know about the way the hospitals got

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1 relocated, closed -
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. - services centralized, as the VP medical, do
6 you have any thoughts on, I mean looking back
7 on it, as to whether or not Mr. Dyer's, at the
8 time available for him to think about quality
9 measures would have been--stayed the same
10 throughout the time or decreased throughout
11 the time.
12 DR. WILLIAMS:
13 A. For me to answer that question, to be honest,
14 might be speculation.
15 COFFEY, Q.C.:
16 Q. Sure.
17 DR. WILLIAMS:
18 A. That's a question that would be better put to
19 Mr. Gulliver and Mr. Dyer.
20 COFFEY, Q.C.:
21 Q. Okay. I'll -
22 DR. WILLIAMS:
23 A. I can't remember anything coming up at the
24 meetings that Mr. Dyer was this or somebody
25 else we had down sized too much in the

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1 management. I can't remember any discussions
2 like that to be honest with you.
3 COFFEY, Q.C.:
4 Q. So, if they were feeling any burden, they
5 shouldered it.
6 DR. WILLIAMS:
7 A. They shouldered or Mr. Gulliver shouldered it.
8 I can't remember it coming up.
9 COFFEY, Q.C.:
10 Q. If we could please, as well, if we could just
11 look further the page please. The
12 recommendation 91 in brackets is 96 in
13 handwriting. It says, "this recommendation
14 appears to"--this is Mr. Gulliver speaking--
15 "this recommendation appears to be a trade off
16 for three technologists, full time equivalence
17 to be replaced by three pathology assistants.
18 While having three pathology assistants would
19 be beneficial in reducing pathologist
20 workload, it would have an increased financial
21 implication on the division as pathology
22 assistants are paid much more in Canada than
23 technologists. What we have already
24 implemented in pathology at the General site
25 is that we have trained technologists who do

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1 more than 50 percent of grossing of surgical
2 specimens which is part of the work of a
3 pathology assistant. It is important to note
4 that this additional work assigned to our
5 technologist IIs also reduces their unit
6 producing time. Also, at the General site are
7 two autopsy technicians, go far beyond their
8 scope of duties in performing post mortems to
9 the point that by and large the pathologists
10 have to spend less time performing this
11 function. Please see my plan for reductions
12 of FTEs in anatomical pathology as outline
13 earlier in the report". And now sir, what was
14 this about? Because he's referring to Hay
15 Report and obviously a suggestion in the Hay
16 Report of perhaps using three pathology
17 assistants.
18 DR. WILLIAMS:
19 A. I think there was recommendation in the Hay
20 Report that said you can reduce in the
21 management position here and something else
22 here, take these three positions and have
23 pathology assistants. And I don't think that
24 he was agreeing with that.
25 COFFEY, Q.C.:

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1 Q. And did you have any understanding of what a
2 pathology assistant was?
3 DR. WILLIAMS:
4 A. Well, only what I would read there at the
5 time, yes.
6 COFFEY, Q.C.:
7 Q. Okay.
8 DR. WILLIAMS:
9 A. But I think at the end of the day, there was a
10 recommendation in Hay that you trade off these
11 three positions and have three pathology
12 assistants. And from what I can recollect,
13 Mr. Gulliver recommended that we not do that.
14 COFFEY, Q.C.:
15 Q. And now has Dr. Cook asked for any input on
16 this?
17 DR. WILLIAMS:
18 A. He would have been at meetings as clinical
19 chief with Mr. Gulliver. I don't think he had
20 input into this response because I think it
21 was left to the laboratory director.
22 COFFEY, Q.C.:
23 Q. I'm really asking you about is, do you recall
24 how the pathologists or what you understood
25 about how the pathologists, back in 2002, felt

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1 about the idea of pathology assistants.
2 DR. WILLIAMS:
3 A. Yeah, I've read some of documents that you've
4 given me since.
5 COFFEY, Q.C.:
6 Q. So, how did they feel back then about it?
7 DR. WILLIAMS:
8 A. Well, they were looking to get pathology
9 assistants to help with their workload, yes.
10 That became prominent around 2004, I think,
11 when Dr. Robb brought us forward.
12 COFFEY, Q.C.:
13 Q. Yes. If I could please, just one moment
14 please, Commissioner.
15 THE COMMISSIONER:
16 Q. In the budgetary process which I assume you
17 would have been fairly heavily involved -
18 DR. WILLIAMS:
19 A. Um-hm.
20 THE COMMISSIONER:
21 Q. - and recognizing that during, I suspect, this
22 period of time, but certainly during the
23 period of time where you were either with
24 Health Care Corporation or with Eastern
25 Health, financially things were, let us say,

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1 tight?
2 DR. WILLIAMS:
3 A. Yes.
4 THE COMMISSIONER:
5 Q. And we have the period of the Hay Report which
6 was, let us say, probably primarily directed
7 towards financial interest rather than other
8 kinds?
9 DR. WILLIAMS:
10 A. That's correct.
11 THE COMMISSIONER:
12 Q. When the message went back up through the
13 process to the Department of Health and then
14 on to financial institutions--and you may be
15 able to help me with this from either your
16 experience in the department or in the
17 organizations of institutions--does it go back
18 up with a tag, we can do this, but?
19 DR. WILLIAMS:
20 A. My recollection is that leading up to the Hay
21 report, that our board was very concerned that
22 we had the financial resources and could
23 actually balance our budget in the interest of
24 patient care.
25 THE COMMISSIONER:

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1 Q. Um-hm.
2 DR. WILLIAMS:
3 A. And my recollection is the Hay report was
4 commissioned in November of 2001 and finished
5 their activities early in the new year of 2002
6 with a view to, impacting the budget for 2002/
7 2003. My recollection is that our board at
8 the time were very concerned about that and
9 unfortunately, they were replaced in December
10 of 2001, most of them, not all of them because
11 some of them were there because they
12 represented the Sisters of Mercy, Salvation
13 Army, but a large number of our board members
14 were -
15 THE COMMISSIONER:
16 Q. Here's -
17 DR. WILLIAMS:
18 A. There were some messages going back and forth
19 at the time, yes.
20 THE COMMISSIONER:
21 Q. Okay. Perhaps--all right. But it's just that
22 it seems to me that, you know, if you want to
23 bring it down to your basic personal level and
24 you got X number of dollars to spend and
25 you're weighing it off, you know, are we going

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1 to eat or are we going to pay the light bill
2 this month? Well, putting it in the greater
3 context of health care, you might have to say
4 to somebody, we can do this with the dollars,
5 but if we take this choice, here's the danger
6 you're running. Does anybody do that?
7 DR. WILLIAMS:
8 A. I think there was some discussion with the
9 board that they didn't feel that, you know,
10 that they could live with the dollars they had
11 and the budget that they had and they were
12 very, very concerned. And then Hay was
13 brought in. Our organization, I think, lost
14 about 20 million. I stand to be corrected on
15 that and it put more financial pressure on us
16 at the time, to be honest with you. But we
17 were under--I realize that governments of the
18 day had very, very difficult decisions to make
19 in terms of the resources they had. I mean,
20 having worked in government I understand that
21 from we used to get the message of gloom and
22 doom from Treasury Board and the deputy
23 minister of finance every year about our
24 balance of payments, how much debt we were
25 carrying and this type of thing. So, I know

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1 the position government was in. The board was
2 pushing back because they had some concerns.
3 That emanated up through people who worked in
4 the organization and, you know, decisions were
5 made based upon, we got a service to provide,
6 let's keep as much of our--let's put as much
7 of resources on the front line as we can, so
8 that if somebody comes in for a blood test, we
9 can actually do that blood test. If someone
10 comes in for an x-ray, we can do that. I
11 mean, it's not too dissimilar from some of the
12 things we had to do in terms of management
13 structures and that and x-ray in the
14 diagnostic imaging department, just to try to-
15 -now, I know that pretty well every year Mr.
16 Gulliver and myself were meeting with Sharon
17 Lear and our budget analysts from finance
18 saying that well, we're going to be over
19 budget, we just can't meet the targets. And
20 if you see Mr. Gulliver's goals and
21 objectives, a lot of them are set based upon
22 productivity and use of automation and how can
23 you crib here to get a little savings here and
24 do this type of thing. So, you know, but the
25 main, I think, focus was on let's keep people

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1 on the front lines as best we can so we can
2 deliver the services on the front lines.
3 COFFEY, Q.C.:
4 Q. The basic services -
5 DR. WILLIAMS:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. - required. And I take it that, at times
9 though would mean that not as much attention
10 might be paid to or people wouldn't have as
11 much time to think about the quality of the
12 service they were able to deliver.
13 DR. WILLIAMS:
14 A. You can get into that situation, I'm sure.
15 COFFEY, Q.C.:
16 Q. It can be -
17 DR. WILLIAMS:
18 A. I mean, I guess the focus is trying to get
19 service and then--we were caught--you know, I
20 know government is caught between a rock and a
21 hard place. I mean, that's a fact of our
22 governments in our province over the years and
23 I know that. And then we were caught, you
24 know, we were caught--had to make some
25 choices.

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1 COFFEY, Q.C.:
2 Q. Now, in terms of--what the Commissioner was
3 just asking you about, would there, in sending
4 the message back up the line or a message, you
5 would understand was going to go back up
6 through the administrative and political
7 hierarchy -
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Okay. It's one thing to say, I'm going to
12 suggest to you that, you know, we can cut 2
13 million or we can cut 4 million, okay?
14 DR. WILLIAMS:
15 A. Okay.
16 COFFEY, Q.C.:
17 Q. But to say we can cut 2 million and this is
18 the potential effect and to say, alternative
19 B, we can cut 4 million and this is, these are
20 the other possible effects of that. The idea
21 of actually spelling out those effects, would
22 that occur?
23 DR. WILLIAMS:
24 A. I'm pretty sure that if you looked at all the
25 documentation, some of these things occurred.

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1 The implications of a budget of this amount,
2 an implication of a budget of that amount,
3 this type of thing. I'm pretty sure that was
4 spelled out with discussions with the
5 department and certainly for our board. I
6 know at our board meetings there were various
7 presentations.
8 THE COMMISSIONER:
9 Q. Put on your hat as a former deputy for a
10 second, let's face the folk of Treasury Board
11 aren't known for being generous.
12 DR. WILLIAMS:
13 A. Yes.
14 THE COMMISSIONER:
15 Q. Santa doesn't live at Treasury Board.
16 DR. WILLIAMS:
17 A. No.
18 THE COMMISSIONER:
19 Q. So, if you're putting a presentation to
20 Treasury Board from the department, do you say
21 to Treasury Board the same kind of information
22 by the time it's coming out of the department,
23 are the folk in the department so hammered by
24 trying to deal with the Treasury Board that
25 they say, we know we're not even going to get

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1 what we're looking for, so we're really
2 working on what we're going to cut and hoping
3 they're not going to cut us as much as we
4 anticipates they will.
5 DR. WILLIAMS:
6 A. I can only comment about the time when I was
7 deputy.
8 THE COMMISSIONER:
9 Q. Um-hm.
10 DR. WILLIAMS:
11 A. And it was a time when we had a lot of
12 restraints, back when the government had to
13 cut 60, 70 million out of the health care
14 system which was a lot of money back in
15 1991/1992. The minister got this resource
16 committee together. So, we had some good
17 ammunition in terms of involving people from
18 the system. It wasn't just people who worked
19 in the Department of Health. It was broad
20 based. When I worked at deputy, I felt that
21 my role was to be an advocate for the system
22 because the mandate was to provide health care
23 and have people's health optimized as best we
24 could. That was our mandate. So, I felt it
25 was my role as deputy carry out government

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1 policy once government decided on the policy,
2 but also to be an advocate in terms of the
3 system. So, often I could use, being with a
4 medical background, I could use some of the
5 arguments and sort of, put it in--not in
6 medical terms, but use some scenarios that I
7 thought could be effect in meeting with
8 ministers who were responsible for Treasury
9 Board.
10 COMMISSIONER:
11 Q. Um-hm.
12 DR. WILLIAMS:
13 A. And, you know, Treasury Board is one thing,
14 the officials, and they have a job to do just
15 like I had a job to do in health. But
16 ministers, you know, we took the opportunity
17 when we could and when we were asked and when
18 we could to try to present and advocate for
19 the system where we felt there was problems.
20 COFFEY, Q.C.:
21 Q. You just referred to in response to a question
22 I asked you, you were pretty certain that at
23 time it would have been--come up in
24 discussions, you know, the spelling out the
25 potential ramifications of -

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1 DR. WILLIAMS:
2 A. Yes. I would -
3 COFFEY, Q.C.:
4 Q. - of under funding something or cutting
5 funding. What I'm going to ask you is this,
6 it's one thing to say it, because that just--
7 unless you're being recorded, it just passes
8 off and disappears into the air, but how about
9 to actually write it down because then it has
10 a certain permanence and there's a permanent
11 record then of a warning, as it were. Do you
12 recall whether there was a lot of that kind of
13 stuff, people prepared to actually write down
14 the potential -
15 DR. WILLIAMS:
16 A. I know there was, when the budget submission
17 would go into the department and we'd look
18 around the table, I'm pretty sure some of the
19 verbiage that went in with it, there was
20 issues like that laid out. But whether
21 they're available now to see, because a lot
22 of that would be budget, shredded and once the
23 budget, the deciding has ended. But I'm sure
24 we had, around our executive table, I know we
25 had a lot of discussions.

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1 COFFEY, Q.C.:
2 Q. Yes.
3 DR. WILLIAMS:
4 A. And how much we put in into what went in with
5 the figures and what the implications were.
6 COFFEY, Q.C.:
7 Q. You can't recall?
8 DR. WILLIAMS:
9 A. No, I can't recall, but I know there was some
10 discussions like that, and I know when I was
11 deputy, there was discussions like that coming
12 in from the boards.
13 COFFEY, Q.C.:
14 Q. If we could, please, look at -
15 COMMISSIONER:
16 Q. Mr. Coffey.
17 COFFEY, Q.C.:
18 Q. I apologize.
19 COMMISSIONER:
20 Q. I've nattered on and we're long past the
21 afternoon break, so whenever you find a
22 convenient spot.
23 COFFEY, Q.C.:
24 Q. Yes. If I could, please, Exhibit P-0902, page
25 2, please? This is apparently handwritten

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1 notes of a meeting of April 2nd, 2002
2 involving yourself, Dr. Cook and Mr. Gulliver?
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. And if we look back at page 1, it's, I take it
7 that that's really an agenda, as it were. And
8 these are your own notes, page 2?
9 DR. WILLIAMS:
10 A. Yes. Well, let me see the--yes.
11 COFFEY, Q.C.:
12 Q. Yes.
13 DR. WILLIAMS:
14 A. Okay.
15 COFFEY, Q.C.:
16 Q. Is that your handwriting?
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Just a couple of different things, because
21 there are many topics covered here. No. 1 is
22 the "clarification role of clinical chief re"
23 something, re -
24 DR. WILLIAMS:
25 A. "Status of recruitment."

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1 COFFEY, Q.C.:
2 Q. "Status of recruitment"?
3 DR. WILLIAMS:
4 A. I would think so.
5 COFFEY, Q.C.:
6 Q. Okay. So Dr. Cook at that point -
7 DR. WILLIAMS:
8 A. Was acting.
9 COFFEY, Q.C.:
10 Q. Is acting and he wanted to know like what role
11 do I have?
12 DR. WILLIAMS:
13 A. Pretty sure he was -
14 COFFEY, Q.C.:
15 Q. He was. You got a good memory. We've seen
16 the document. October, '02 was when he was
17 appointed.
18 DR. WILLIAMS:
19 A. Okay.
20 COFFEY, Q.C.:
21 Q. Finally. He would have been seeking
22 clarification?
23 DR. WILLIAMS:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. In his role there. No. 5, there's a reference
2 to a resignation of a particular doctor and
3 then there's a "salary offer made to Dr.
4 Ejeckam"?
5 DR. WILLIAMS:
6 A. To replace Dr. Abedi, yes.
7 COFFEY, Q.C.:
8 Q. Okay. What was that about, do you -
9 DR. WILLIAMS:
10 A. Doctor, he was just updating us on the
11 recruitment efforts.
12 COFFEY, Q.C.:
13 Q. Oh, okay.
14 DR. WILLIAMS:
15 A. Dr. Abedi was a pathologist who had come in
16 from Grand Falls to work for us. He'd been
17 there for a couple of years and then he moved
18 off, I think he moved to the U.S. or Ontario
19 and they must have made an offer to Dr.
20 Ejeckam to take up his position, that's all.
21 COFFEY, Q.C.:
22 Q. Okay, so this was Dr. Ejeckam -
23 DR. WILLIAMS:
24 A. Yeah.
25 COFFEY, Q.C.:

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1 Q. - arriving. And the No. 7 is "The search
2 committee for the clinical chief"?
3 DR. WILLIAMS:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. I take it?
7 DR. WILLIAMS:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. As--and finally, if you could look at page 3
11 of the exhibit, please, the bottom of the
12 page. Under "Information management" there's
13 a reference there to "Meditech medi net."
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. _"To link to other centres."
18 DR. WILLIAMS:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. So what was -
22 DR. WILLIAMS:
23 A. That's a project that was, Mr. Gulliver had a
24 special interest in and he was going to link
25 our pathology laboratory through our Meditech

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1 system to other centres around the province,
2 so when the report was produced, we wouldn't
3 have to send it out in the mail, we could just
4 hook it up and their computer system would
5 capture our report right in their computer
6 system.
7 COFFEY, Q.C.:
8 Q. Um-hm.
9 DR. WILLIAMS:
10 A. So it's called med net.
11 COFFEY, Q.C.:
12 Q. Med net, I'm sorry.
13 DR. WILLIAMS:
14 A. Yeah. So that was the particular interest of
15 his to, I guess, cut down on the amount of
16 paper being transported around the province
17 and this type of thing.
18 COFFEY, Q.C.:
19 Q. Did that actually occur?
20 DR. WILLIAMS:
21 A. Oh, yes, I'm pretty sure. I think it started
22 with Carbonear but you'd have to ask him. He
23 was working on that.
24 COFFEY, Q.C.:
25 Q. Thank you, Commissioner. Break.

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1 COMMISSIONER:
2 Q. Fifteen minutes.
3 (RECESS)
4 COMMISSIONER:
5 Q. Now, Mr. Coffey, do you want to check that
6 mouse?
7 COFFEY, Q.C.:
8 Q. Oh, it's working. I--the registrar had me do
9 that before we came in.
10 COMMISSIONER:
11 Q. Thank you.
12 COFFEY, Q.C.:
13 Q. And I want to thank the technical people,
14 whomever they may be, for having attended to
15 that. If we could, Exhibit P-0914, please?
16 And, Dr. Williams, this is an e-mail of
17 November 1, 2004 from Barbara Morrison to
18 yourself. It says, "Subject, as mentioned,
19 Fraser Health Authority, VP Quality Medical
20 Leadership." I take it that this is--she goes
21 on to say, "Thank you very much for your voice
22 message. I have attached a document re the
23 Fraser Health Authority." So this is that
24 documentation relating to the -
25 DR. WILLIAMS:

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1 A. New organization, yes.
2 COFFEY, Q.C.:
3 Q. New organization.
4 DR. WILLIAMS:
5 A. We were going to go into.
6 COFFEY, Q.C.:
7 Q. If we could, please, just one moment,
8 Commissioner, I apologize. Ah, Exhibit P-
9 0915, please? Sir, this is a letter November
10 17th, 2004, it's from Dr. Desmond Robb, who
11 signs himself, "Chair, Discipline of
12 Laboratory Medicine."
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. And it's copied to Dr. Don Cook, Terry
17 Gulliver and Barry Dyer.
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. And he's the chair, Discipline of Laboratory
22 Medicine. And now, Doctor, just so--I take it
23 Dr. Robb has since died?
24 DR. WILLIAMS:
25 A. Yes, he died on December 10th, 2004.

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1 COFFEY, Q.C.:
2 Q. Okay.
3 DR. WILLIAMS:
4 A. Unfortunately.
5 COFFEY, Q.C.:
6 Q. Just about, less than a month, actually, after
7 this?
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. And the subject matter here is "Request for
12 funding to provide the salaries of two
13 pathologist's assistants for the anatomic
14 pathology division of laboratory medicine
15 program" And we've seen, I take it, that this
16 subject matter came up back with the Hay
17 Report?
18 DR. WILLIAMS:
19 A. Yes, um-hm.
20 COFFEY, Q.C.:
21 Q. And, in fact, the Hay Group recommended three?
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Pathology assistants?

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1 DR. WILLIAMS:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. And -
5 DR. WILLIAMS:
6 A. We trade off three positions for it.
7 COFFEY, Q.C.:
8 Q. Sure. And that didn't happen back then?
9 DR. WILLIAMS:
10 A. No.
11 COFFEY, Q.C.:
12 Q. And the reason it didn't happen back then was
13 because of -
14 DR. WILLIAMS:
15 A. Well, Mr. Gulliver recommended that we not do
16 it at that time and we didn't--we couldn't let
17 those positions go. One of them was a
18 manager, I think he outlined the span of
19 control might have been too much.
20 COFFEY, Q.C.:
21 Q. Sure. Now, here, I'll go back to 2002 for a
22 moment. What was your understanding as to
23 what the advantage of using pathology
24 assistants might be?
25 DR. WILLIAMS:

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1 A. At the time Hay recommended it was an
2 efficiency type of thing, they'd speed up -
3 COFFEY, Q.C.:
4 Q. I'm sorry, go ahead.
5 DR. WILLIAMS:
6 A. They'd speed up some of the processes for the
7 pathologists.
8 COFFEY, Q.C.:
9 Q. Okay. So I understood that the Hay Group,
10 whose mandate was, whatever else it was, was
11 if they could to cut costs, okay?
12 DR. WILLIAMS:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. That's what I understand from some evidence
16 we've heard. In this instance they would have
17 known that a pathology assistant was more
18 expensive than a technologist?
19 DR. WILLIAMS:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. Yet, they were recommending -
23 DR. WILLIAMS:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. - that more money be spent on individual
2 positions. And the advantage, you understood,
3 was what?
4 DR. WILLIAMS:
5 A. That they could remove some of the
6 pathologists' time in doing some of this
7 stuff.
8 COFFEY, Q.C.:
9 Q. Okay.
10 DR. WILLIAMS:
11 A. That's my understanding of it. There was also
12 a meeting with Dr. Robb on October, in
13 October, I don't know if you have that
14 document where -
15 COFFEY, Q.C.:
16 Q. This would be October of '02?
17 DR. WILLIAMS:
18 A. No, October of '04.
19 COFFEY, Q.C.:
20 Q. '04, I apologize.
21 DR. WILLIAMS:
22 A. This is what this letter is based on.
23 COFFEY, Q.C.:
24 Q. Okay.
25 DR. WILLIAMS:

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1 A. There was a meeting with Dr. Robb. If you
2 want the document, I have it. And there was
3 three or four items on the agenda, one of
4 which was a pathology assistant, one was a
5 scientist for the university and immunology
6 lab and there was two other, one or two other
7 issues on the agenda. And this was the
8 follow-up letter in follow up to that meeting.
9 COFFEY, Q.C.:
10 Q. Now, here--and Dr. Robb other than--now, I
11 appreciate he raised it in October, okay, the
12 month before with you.
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. Had he ever raised it before that?
17 DR. WILLIAMS:
18 A. I can't remember. I know he raised it in
19 October because we had a meeting about it and
20 it's documented. I don't have any other
21 documentation on t, but he may have raised it.
22 I can only say that I know he raised it
23 because I've got it in writing.
24 COFFEY, Q.C.:
25 Q. Yes. And as discipline -

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1 DR. WILLIAMS:
2 A. Discipline chair.
3 COFFEY, Q.C.:
4 Q. Chair, that's the word, chair. What was your-
5 -from your perspective, what was his role?
6 DR. WILLIAMS:
7 A. Well, we would -
8 COFFEY, Q.C.:
9 Q. Or the role of discipline chair?
10 DR. WILLIAMS:
11 A. Yeah. We would meet with Dr. Robb, the
12 leadership team from time to time, Dr. Cook
13 and myself. His role as discipline chair was
14 mainly in -
15 COFFEY, Q.C.:
16 Q. If I could, we, the leadership team?
17 DR. WILLIAMS:
18 A. Was usually Dr. Cook and myself.
19 COFFEY, Q.C.:
20 Q. Yes.
21 DR. WILLIAMS:
22 A. Would meet with Dr. Robb.
23 COFFEY, Q.C.:
24 Q. And you think of the trio of individuals as
25 the leadership team?

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1 DR. WILLIAMS:
2 A. Yes. I think at the meeting with Dr. Robb in
3 October, but I can get it out if -
4 COFFEY, Q.C.:
5 Q. Yeah, no, I--but Dr. Robb, the discipline
6 chair, would he be part of the leadership
7 team?
8 DR. WILLIAMS:
9 A. I think he probably would have been a member
10 of the leadership team had he--he only had a
11 short tenure and he died, unfortunately. I
12 think we, Don Cook and myself had a number of
13 meetings with him when he became discipline
14 chair about a number of issues from time to
15 time. And I think it was just Dr. Cook and
16 myself at that meeting in October and there
17 was three or four issues that we discussed,
18 one of them which was this.
19 COFFEY, Q.C.:
20 Q. If I could, just so--because, of course--what
21 evidence I anticipate will come forward on
22 this will come either from yourself or Dr.
23 Cook.
24 DR. WILLIAMS:
25 A. Um-hm.

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1 COFFEY, Q.C.:
2 Q. Really, on this point. Dr. Haegert had been
3 there?
4 DR. WILLIAMS:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. And holding two, wearing two hats?
8 DR. WILLIAMS:
9 A. Correct.
10 COFFEY, Q.C.:
11 Q. Discipline chair and clinical chief?
12 DR. WILLIAMS:
13 A. Yeah.
14 COFFEY, Q.C.:
15 Q. He went on sabbatical?
16 DR. WILLIAMS:
17 A. Um-hm.
18 COFFEY, Q.C.:
19 Q. Dr. Cook replaced him as interim clinical
20 chief?
21 DR. WILLIAMS:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. And no one replaced him as discipline chair
25 for the sabbatical time?

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1 DR. WILLIAMS:
2 A. I would say somebody replaced him, yes, but I
3 don't know who it would be. They would have
4 to have a discipline chair at MUN. The person
5 who usually replaces somebody there is Dr.
6 Fernandez, she seems to be the person that
7 steps in on two or three occasions. I don't
8 know if she did or not.
9 COFFEY, Q.C.:
10 Q. Okay. On an interim basis?
11 DR. WILLIAMS:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Okay. Because you've explained to the
15 Commissioner that the actual search for a
16 permanent discipline chair might take up to a
17 year -
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. WILLIAMS:
23 A. So when he left, when he left in--you asked to
24 know when he left?
25 COFFEY, Q.C.:

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1 Q. Yes.
2 DR. WILLIAMS:
3 A. Yeah, I suspect it was maybe Dr. Fernandez
4 stepped in as an acting. And there was a
5 search set up and that went on and on and on.
6 And finally I suspect that Dr. Robb was
7 appointed probably the late fall or winter of
8 2003 or 2004, early 2004, sometime in that
9 time frame.
10 COFFEY, Q.C.:
11 Q. Okay. And this, in effect, then, would have
12 been really, this letter would have been at
13 the tail end of his first year?
14 DR. WILLIAMS:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. As discipline chair?
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. WILLIAMS:
23 A. We had a number of meetings with him.
24 COFFEY, Q.C.:
25 Q. Sure.

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1 DR. WILLIAMS:
2 A. That was one.
3 COFFEY, Q.C.:
4 Q. Now, his then role by the fall of '04 was
5 what, what was he bringing to the table?
6 DR. WILLIAMS:
7 A. Issues basically that he would have from the
8 university perspective.
9 COFFEY, Q.C.:
10 Q. Um-hm.
11 DR. WILLIAMS:
12 A. And on occassion he might have issues from his
13 immunology perspective because he did some
14 immunology work. One of them, one of the
15 issues on the agenda now for October was some
16 secretarial support, part-time secretarial
17 support, I can remember.
18 COFFEY, Q.C.:
19 Q. And what was--why was that necessary?
20 DR. WILLIAMS:
21 A. Because I'd have to look at the notes, but
22 there was--that was one of the issues he
23 wanted addressed, and I think we addressed
24 that, I think we did.
25 COFFEY, Q.C.:

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1 Q. Now, here he writes, "I am writing to request
2 the provision of the next budget--into the
3 next budget template application of $130,000
4 per annum to supply the salaries, including
5 benefits, of two pathologist's assistants in
6 the division of anatomic pathology of the
7 laboratory medicine program. Pathologist's
8 assistants now play a major role in the
9 delivery of surgical pathology services within
10 the nation's main teaching centres. They
11 interact with pathologists in the same manner
12 that physician's assistants carry out their
13 duties under the direction of physicians in
14 surgical and medical practice. Pathologist's
15 assistants contribute to the overall
16 efficiency of the laboratory or pathology
17 practice in a cost-effective manner by
18 performing a variety of tasks consisting
19 primarily of the gross examination of surgical
20 pathology specimens and the performance of
21 autopsies. Within our laboratory medicine
22 program pathologist's assistants could be
23 expected to concentrate mainly on the grossing
24 of surgical specimens for those days on which
25 our residents are not scheduled for grossing.

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1 Other duties performed by the pathologist's
2 assistants would be at the discretion of the
3 site chief. Our staff pathologists are
4 prepared to devote sufficient time and
5 patience to any necessary preliminary training
6 of selected individuals in the procedures of
7 specimen grossing. Currently staff
8 pathologists and residents gross about 70
9 percent of all surgical specimens with the
10 contribution from staff pathologists amounting
11 to 30 to 35 percent of the total. The
12 remainder of the gross workload is carried by
13 selected pathology technologists. The
14 contribution to grossing by staff pathologists
15 represents a considerable extra workload which
16 erode significantly into the individual staff
17 pathologists' time needed for surgical
18 pathology sign out and the teaching of
19 residents as well as other duties related to
20 undergraduate teaching research and
21 administration. Alleviation of pathologist's
22 grossing workload will lead to shorter case
23 turnaround times, improved patient care and
24 reduce time and expense for the
25 hospitalization of patients. In addition

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1 pathologists will be able to devote more time
2 and care to the teaching of residents, as
3 significant factor in our efforts to improve
4 the standard of diagnosis by the recruitment
5 of high-quality well-trained pathologists."
6 He goes on on the second page, "As a teaching
7 institution we have a responsibility to foster
8 various staff academic and scholarly
9 activities including teaching and research, a
10 process which also would be greatly
11 facilitated by eliminating the necessary"--I'm
12 sorry, "the current necessity for the time
13 consuming grossing of surgical specimens.
14 Finally, the acquisition of pathologist's
15 assistants would free up a significant amount
16 of valuable technologist's time currently
17 taken up by specimen grossing." So you
18 received this in November of 2004?
19 DR. WILLIAMS:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. What happened?
23 DR. WILLIAMS:
24 A. We discussed it at the leadership team
25 meeting.

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1 COFFEY, Q.C.:
2 Q. That would be with?
3 DR. WILLIAMS:
4 A. Dr. Cook and Mr. Gulliver.
5 COFFEY, Q.C.:
6 Q. Yes.
7 DR. WILLIAMS:
8 A. In December it didn't get, didn't make it--I
9 don't think we finished our agenda, so it go
10 onto the January agenda.
11 COFFEY, Q.C.:
12 Q. Yes.
13 DR. WILLIAMS:
14 A. I don't know if they're in here or not.
15 COFFEY, Q.C.:
16 Q. And then what happened with it overall though?
17 DR. WILLIAMS:
18 A. I can't remember the discussion on it, I only
19 reviewed the minutes of the meetings. And Mr.
20 Gulliver was going to train two techs to take
21 on some of this responsibility as a way to
22 help. And I stand to be corrected, but I
23 think it was put in our budget proposal for
24 2004, 2005, I think. I'd have to go back and
25 look at that.

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1 COFFEY, Q.C.:
2 Q. Was anyone resisting implementing this?
3 DR. WILLIAMS:
4 A. I don't recall if anybody was resisting
5 implementing it, no.
6 COFFEY, Q.C.:
7 Q. Okay. Did it -
8 DR. WILLIAMS:
9 A. I'd have to--I think it was put in the 2004,
10 2005 budget submission. But Mr. Gulliver
11 would be better able to answer that because he
12 did up the budget to see if we could get
13 funding.
14 COFFEY, Q.C.:
15 Q. Did it, in fact, get implemented at that time?
16 DR. WILLIAMS:
17 A. What, funding for this?
18 COFFEY, Q.C.:
19 Q. Yes, and -
20 DR. WILLIAMS:
21 A. No, didn't have the assistants in place in
22 2005, no.
23 COFFEY, Q.C.:
24 Q. Your sense, at the time, as the VP Medical,
25 and Dr. Robb is pushing this obviously, or his

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1 letter, what was your understanding as to the
2 pathologist in general, their view of it?
3 DR. WILLIAMS:
4 A. I would think that they would support this
5 because it would support their work, yes.
6 COFFEY, Q.C.:
7 Q. And the technologists, as represented by Mr.
8 Gulliver, how did they feel about it?
9 DR. WILLIAMS:
10 A. I'm not sure how they would feel about it.
11 COFFEY, Q.C.:
12 Q. And I say "how did they feel" in the sense of
13 how it was reported to you, if anything?
14 DR. WILLIAMS:
15 A. I think--I don't see why they would object to
16 it. It's more staffing, but it would require
17 a budget adjustment or laying off other staff
18 to do this.
19 COFFEY, Q.C.:
20 Q. And in this context, the other staff would be-
21 -likely be technologists, I take it?
22 DR. WILLIAMS:
23 A. Technologists or other support staff, yes, and
24 I don't think, at that time, we could identify
25 any way. We know we were under budget

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1 pressures at the time.
2 COFFEY, Q.C.:
3 Q. Now if we could, please, look at Exhibit P--
4 let me see here, perhaps P-0922? Now these
5 are titled pathology working group minutes,
6 June 21st 2005, 9 a.m. to 11 a.m. The
7 attendees are yourself, Dr. Denic, Dr. M--that
8 would be Maurice Dalton?
9 DR. WILLIAMS:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. A pathologist in Grand Falls?
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. Dr. P. Neil would be Paul Neil?
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. And Mr. S. Jerrett and Mr. S. Brown, who are
21 Mr. Jerrett and Mr. Brown?
22 DR. WILLIAMS:
23 A. Mr. Jerrett is director of economics at the
24 Newfoundland and Labrador Medical Association,
25 and Mr. Brown is one of the staff members at

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1 the Newfoundland and Labrador Medical
2 Association.
3 COFFEY, Q.C.:
4 Q. What was the pathology working group?
5 DR. WILLIAMS:
6 A. There was, in the negotiations that took place
7 in 2004 between Newfoundland and Labrador
8 Medical Association and government, there was
9 a committee set up that was a liaison
10 committee between senior people in the
11 Department of Health and senior people at the
12 NLMA to look at issues between negotiations
13 around physicians. That was sort of a forum
14 where they could together to discuss issues
15 rather than let things smoulder and heat up.
16 And that was jointly co-chaired, I think by
17 the deputy minister of Health and executive
18 director or president of the NLMA. As a
19 subcommittee of that -
20 COFFEY, Q.C.:
21 Q. I'm sorry, so when did this happen?
22 DR. WILLIAMS:
23 A. This would have happened around 2004, late
24 2004, early 2005. And under that committee,
25 they set up what they called a--you have to

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1 give me a minute to think of the name of this
2 committee.
3 COFFEY, Q.C.:
4 Q. Sure.
5 DR. WILLIAMS:
6 A. It was a committee, I forget the name of it.
7 COFFEY, Q.C.:
8 Q. And we will come across it in some of the
9 documents.
10 DR. WILLIAMS:
11 A. That deals with implications where there's a
12 shortage of physicians and service delivery.
13 So it might be the service delivery committee,
14 something like that, and that was chaired by
15 Dr. Ken Jenkins of--the Vice-President Medical
16 for Western, and that was composed of equal
17 representatives from the NLMA and medical
18 administration in hospitals. The two past
19 presidents of the NLMA, Dr. Haggie and Dr.
20 Susan King, were on that committee from the
21 NLMA, along with Mr. Jerrett and three or four
22 of us vice-president medical types. And that
23 committee was charged with looking at issues
24 where service coverage could result in a
25 detriment to patient care or service delivery

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1 in our province.
2 COFFEY, Q.C.:
3 Q. Yes.
4 DR. WILLIAMS:
5 A. And early on in that working--that committee's
6 life, there was a presentation by the
7 Newfoundland and Labrador Association of
8 Pathologists that the Pathology Association in
9 the province, or the pathology situation in
10 the province, sorry, was becoming an issue, in
11 terms of recruitment and retention and a
12 prediction that it might get worse in the
13 future.
14 COFFEY, Q.C.:
15 Q. Now that was approximately when now, this
16 presentation?
17 DR. WILLIAMS:
18 A. That presentation would have been probably
19 April 2005.
20 COFFEY, Q.C.:
21 Q. Okay.
22 DR. WILLIAMS:
23 A. In response to that presentation, and I don't
24 know if they made it to the service coverage
25 committee or to this joint liaison with the

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1 government and--I'm not sure who they made it
2 to, but in response to that, the service
3 coverage committee felt that that was an issue
4 that needed to be followed up on. So they
5 created a working group on pathology that I
6 was asked to chair, and so I suspect this is
7 the first meeting of that group.
8 COFFEY, Q.C.:
9 Q. And this is the group that you chaired?
10 DR. WILLIAMS:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. And the goal of--your understanding of the
14 goal of this working group was what?
15 DR. WILLIAMS:
16 A. The goal of this working group was to look at
17 this problem, analyze this problem, see how
18 serious this problem is and make
19 recommendations, if you think it's serious, to
20 deal with it. That's basically as I phrase
21 it.
22 COFFEY, Q.C.:
23 Q. Now sir, did this working group ever produce a
24 report?
25 DR. WILLIAMS:

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1 A. Yes, it did.
2 COFFEY, Q.C.:
3 Q. And whom did that report go to?
4 DR. WILLIAMS:
5 A. The first place it went was back to the
6 service coverage committee, and once they put
7 their stamp of approval on it, then my
8 understanding, it was sent to the joint
9 liaison committee that was between the NLMA
10 and the Department of Health and Community
11 Services. So the leadership in the NLMA and
12 the leadership in the Health Department would
13 have had that report by September 2005.
14 That's my recollection.
15 COFFEY, Q.C.:
16 Q. By what?
17 DR. WILLIAMS:
18 A. September 2005.
19 COFFEY, Q.C.:
20 Q. September 2005?
21 DR. WILLIAMS:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. So the committee didn't waste any time, as it
25 were, from June?

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1 DR. WILLIAMS:
2 A. No, we had three meetings over the summer. We
3 did most of--we did our meetings on the
4 conference calls. A lot of the work, we were
5 able to get a lot of the work done by Mr.
6 Brown because he was seconded to the working
7 group. So we had to come up with the ideas
8 and suggestions and what information we
9 wanted, and he did all the work in getting it
10 together for us.
11 COFFEY, Q.C.:
12 Q. And just to help put this in perspective now
13 for the Commissioner, up until, you know, the
14 establishment of this pathology working group,
15 which is a subcommittee of the service -
16 DR. WILLIAMS:
17 A. Coverage committee.
18 COFFEY, Q.C.:
19 Q. - coverage committee, had the situation in
20 relation to the number of pathologists working
21 in the province been a matter that had
22 involved you getting involved in it?
23 DR. WILLIAMS:
24 A. Not at the provincial level, but at our level
25 in former Health Care Corporation of St.

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1 John's, in 2003, 2002, there were some
2 discussions with Dr. Robb and Dr. Cook and
3 myself. We know from time to time there was
4 loss of a number of pathologists, but yet, the
5 work was expected to be picked up by the other
6 pathologists. So we wanted to look at
7 probably an alternate funding arrangement.
8 All the funding would be put in the budget
9 for--say we had 17 or 18 pathologists -
10 COFFEY, Q.C.:
11 Q. You mean 17 or 18 pathologists or positions?
12 DR. WILLIAMS:
13 A. Positions.
14 COFFEY, Q.C.:
15 Q. Positions, okay.
16 DR. WILLIAMS:
17 A. But say we had 17 or 18 -
18 COFFEY, Q.C.:
19 Q. We'll just--we'll pick a figure, 18, okay.
20 DR. WILLIAMS:
21 A. Okay. We'll have 18. We funded--we would
22 have a budget that would fund 18 positions,
23 and if we were down to 16 positions, but the
24 other 16 continued to do the workload of the
25 18 and produce that on a timely basis, they

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1 might have to do overtime and this type of
2 thing, that money would be there to share. At
3 least there'd be some recompense for the
4 pathologists who were picking up the extra
5 workload, because they were on a salary
6 system. That was the theory.
7 COFFEY, Q.C.:
8 Q. Yes.
9 DR. WILLIAMS:
10 A. Or go to an alternate funding system that -
11 COFFEY, Q.C.:
12 Q. So that wasn't in fact the case, was it?
13 DR. WILLIAMS:
14 A. No, it wasn't the case.
15 COFFEY, Q.C.:
16 Q. So I take it that if there were 18, and I'll
17 just use the figure -
18 DR. WILLIAMS:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. - 18 positions funded.
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And whatever the salary for a pathologist at

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1 the time was -
2 DR. WILLIAMS:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. - it would be that salary times 18?
6 DR. WILLIAMS:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. And that would be the Health Care
10 Corporation's budget.
11 DR. WILLIAMS:
12 A. Put into a pot, yeah, and it would be
13 administered. Now we don't know who would
14 administer it, but it could be administered.
15 We had some thoughts about that.
16 COFFEY, Q.C.:
17 Q. Okay, if I could, just to get some sense of
18 the way it actually worked, as opposed to the
19 way you wanted it or suggested it might work.
20 DR. WILLIAMS:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. And for example, just take a figure, say there
24 were, in any one point in time, there were 15
25 pathologists.

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1 DR. WILLIAMS:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Actually working for the Health Care
5 Corporation, and the three positions remained
6 vacant for three months, I'll just pick a
7 period of time. In the meantime, as the VP
8 Medical, your understanding was that those 15
9 pathologists would be doing the work of the 18
10 positions?
11 DR. WILLIAMS:
12 A. Yes, my understanding was--now, the turnaround
13 time might be slower, obviously, this type of
14 thing, yes.
15 COFFEY, Q.C.:
16 Q. But that was--there was no actual step taken,
17 at least in the early stages, to send work
18 out?
19 DR. WILLIAMS:
20 A. No, what we did -
21 COFFEY, Q.C.:
22 Q. I'll get to that.
23 DR. WILLIAMS:
24 A. Okay.
25 COFFEY, Q.C.:

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1 Q. I appreciate that.
2 DR. WILLIAMS:
3 A. We did do that.
4 COFFEY, Q.C.:
5 Q. In the beginning though, and just so the
6 Commissioner is clear on this, if it got down
7 to 15 or 14 pathologists at any one point in
8 time, then that group was--the system, the way
9 it was set up, they were supposed to actually
10 do the work of 18 individuals?
11 DR. WILLIAMS:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. Okay, and they were not--at least in the early
15 stages, weren't being paid for the extra work?
16 DR. WILLIAMS:
17 A. No, not the work they were doing for us, no.
18 COFFEY, Q.C.:
19 Q. For the same salary?
20 DR. WILLIAMS:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. They weren't getting overtime?
24 DR. WILLIAMS:
25 A. Not that I can recollect, no.

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1 COFFEY, Q.C.:
2 Q. Okay.
3 DR. WILLIAMS:
4 A. There was some provision in the negotiations
5 with the NLMA and government for additional
6 workload, but I don't know how that worked in
7 that situation. You'd have to be down quite a
8 number in a large--if you had three or four
9 people and you were down one or two, you could
10 get additional workload. I can't remember all
11 the details of that.
12 COFFEY, Q.C.:
13 Q. And Commissioner, on that point, just so
14 you're aware, Commissioner, there will be
15 evidence from some of the pathologists working
16 in other parts of Newfoundland who worked in
17 these two or three or four-person centres who
18 will be able to advise you about that, but in
19 terms of your situation in St. John's, Doctor?
20 DR. WILLIAMS:
21 A. We had so many that additional--I forget--to
22 be honest with you, since I left the
23 organization, I don't remember all the
24 details, but if you have a large group, you
25 really got to get down, way down to -

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1 COFFEY, Q.C.:
2 Q. Before any extra -
3 DR. WILLIAMS:
4 A. - that kicks in, yes.
5 COFFEY, Q.C.:
6 Q. - any extra remuneration kicks in.
7 DR. WILLIAMS:
8 A. Correct, that's my take on it.
9 COFFEY, Q.C.:
10 Q. So you were aware of this. I'm sorry, you
11 were about to tell the Commissioner you had
12 some--some people had some ideas. What was
13 that about?
14 DR. WILLIAMS:
15 A. Yes. Well, what we were looking at is having
16 an alternate payment plan so that if we had 18
17 positions, we'd fund for 18 positions with the
18 pay and benefits and then similar to--Halifax
19 is on some kind of a system like that. Dr.
20 Fontaine told us about it. He thought about
21 it. Dr. Robb was involved, Dr. Cook and
22 myself, and Dr. Robb was going to do some
23 research on it and we had some meetings, I
24 know that, with a view to looking at an
25 alternate payment plan arrangement for all our

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1 pathologists, the university and the non-
2 university full time faculty, and I did write
3 Dr. Bradbury and Dr. Hunt at the Department,
4 because I had the--I've got the documents, and
5 it was copied to the NLMA.
6 COFFEY, Q.C.:
7 Q. Do you recall what the response was?
8 DR. WILLIAMS:
9 A. Well, the issue is that I think there was--I
10 think the proposal was Dr. Bradbury might
11 chair a working group to look at that, but
12 it's not something that--we could only take it
13 so far with the Health Care Corporation
14 because we didn't have a mandate to negotiate
15 for physicians. We had no mandate. We didn't
16 share it with anybody because it was the
17 NLMA's mandate. That's why, I think, along
18 the process, it was their members, Dr. Cook
19 and Dr. Robb were doing this, we contacted
20 them, and that's where the trail ends in May
21 2003. There's some letter from me to Dr.
22 Bradbury, I think, and then I got sick and I
23 don't know what happened. I suspect that the
24 NLMA probably picked up the ball and were
25 going to bring that forward in the 2004

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1 negotiations, but I may be wrong on that.
2 COFFEY, Q.C.:
3 Q. Do you have any reason to believe that, in
4 fact, it got addressed in the 2004
5 negotiations? Addressed in the sense of
6 settled.
7 DR. WILLIAMS:
8 A. No, I was under the understanding that--and I
9 may be wrong, that it was brought up through
10 the NLMA but didn't get addressed to their
11 members' satisfaction. That's my--I may be
12 wrong on that.
13 COFFEY, Q.C.:
14 Q. Hence, Exhibit P-0922? By the middle of ' 05
15 again -
16 DR. WILLIAMS:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. - you're involved in this again.
20 DR. WILLIAMS:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Now here, under discussion of issues, it says
24 "each of the members," that's of the
25 committee, "gave an overview of the current

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1 situation in their region with regard to
2 pathology services. This included a review of
3 the current complement, upcoming retirement,
4 stability of the group, ability to recruit or
5 lack thereof, major problems/issues, possible
6 solutions to local problems, review of the
7 national pathology situation, etcetera."
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. "Some of the common issues/points raised were:
12 the low number of residents entering the
13 pathology specialties nationally, the high
14 level of retirements that will occur in the
15 near future, the aging of the population,
16 higher incidence of disease in the local
17 population, the increased level of testing and
18 reporting necessary in today's work
19 environment, the current inability to fully
20 recruit the complement necessary/easing of
21 restriction on J1 visa applicants by other
22 provinces, the aggressive recruitment of our
23 pathologists by other provinces, the
24 relatively low wage levels compared to other
25 provinces/better locum payments available in

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1 other jurisdictions, etcetera." If I could
2 please, I'm just going to--and then there's
3 probable--there's a heading probable solutions
4 proposed for further investigation.
5 First bullet, "better promotion of the
6 laboratory medicine program at Memorial
7 University, including: increased under
8 graduate exposure, compulsory exposure to lab
9 medicine, the training of clinical
10 specialists, ability, flexibility to transfer
11 to lab medicine during residency programs,
12 financial assistance/return in service
13 arrangements offered in the first year.
14 Second bullet, "The possible introduction
15 of a stipend, similar to oncology. This would
16 help to ensure service stability and the
17 continued future viability of the service."
18 And the third bullet, "The possible
19 introduction of a block funding type
20 arrangement for pathology." And it goes on to
21 say, "It was also suggested that we consider
22 establishing a FFS schedule for pathology."
23 What is that?
24 DR. WILLIAMS:
25 A. Fee for service.

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1 COFFEY, Q.C.:
2 Q. "However, after review, this avenue was deemed
3 to be the least attractive as other avenues
4 suggested it should yield better results and
5 require less effort, less uncertainty." And
6 then finally, "The decision, all members felt
7 they had a very good grasp of the issues, it
8 was determined that with a little more
9 research, we would be in a position to move
10 ahead on this file; therefore Mr. Browne was
11 asked to begin the development of a draft
12 report based upon this meeting and all other
13 information gathered." And then there's
14 finally a work plan and it sets out the goal
15 as to having the initial work done within
16 approximately four weeks. So, sir, is your
17 recollection that that group produced a report
18 by September of '05?
19 DR. WILLIAMS:
20 A. Yes, we produced it before September '05, but
21 it had to go back to the service coverage
22 committee because that's who we reported to,
23 but I think it got in the hands of the joint
24 liaison committee by September '05. That's
25 why I was lobbying Mr. Abbott on it.

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1 COFFEY, Q.C.:
2 Q. So, sir, and we have heard from, I believe,
3 Mr. Abbott and others in terms of what
4 happened when it got into government's hands
5 at the time. By the time you had retired,
6 finally, had the matter actually been
7 addressed?
8 DR. WILLIAMS:
9 A. No.
10 COFFEY, Q.C.:
11 Q. It had not?
12 DR. WILLIAMS:
13 A. No.
14 COFFEY, Q.C.:
15 Q. And that would be September or--or October of
16 '06?
17 DR. WILLIAMS:
18 A. Yes, September of '06 I finished up.
19 COFFEY, Q.C.:
20 Q. Do you have any understanding as to when it
21 finally got addressed?
22 DR. WILLIAMS:
23 A. Yeah, I heard it in the news in May of 2007, I
24 think.
25 COFFEY, Q.C.:

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1 Q. And that's with the oncology -
2 DR. WILLIAMS:
3 A. Stipend. Maybe we didn't go--in retrospect
4 now, I'm looking that we probably didn't go
5 far enough and strong enough in the
6 recommendations back in 2005.
7 COFFEY, Q.C.:
8 Q. Well, in terms of that, when we look at this,
9 probable solutions proposed in this first
10 meeting, the second bullet does say "the
11 possible introduction of a stipend similar to
12 oncologists".
13 DR. WILLIAMS:
14 A. Yes, it did say that.
15 COFFEY, Q.C.:
16 Q. So as it turns out, it was the actual oncology
17 staff.
18 DR. WILLIAMS:
19 A. That was probably a recommendation--you would
20 have had our recommendations, probably.
21 COFFEY, Q.C.:
22 Q. Sure. Now, Doctor, without going blow by blow
23 through each of these meetings that you would
24 have attended, okay, with these pathologists
25 and this group, what was your overall sense

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1 from the time you got involved in it, in terms
2 of the pathologists' views on this, how
3 strongly they felt about it, the situation
4 they were in.
5 DR. WILLIAMS:
6 A. Well with the people around the table, we had-
7 -so I think it was they felt it was an
8 important issue, they were there at every
9 meeting, they participated in every meeting.
10 The pathologists were the senior people, Paul
11 Neil was in charge out in Corner Brook,
12 Maurice Dalton in Grand Falls and Nash Denic
13 was president and a respective pathologist in
14 our organization. I guess we felt that
15 looking a the situation and given that the
16 pathology work loads are expanding, different
17 than in other specialties, I think I can make
18 a case for that because--and at the end of the
19 day with the oncologists, when we sent in our
20 report, the oncologists sent a letter of
21 support with the report because what happens
22 in pathology, it's a difficult specialty. A
23 lot of people don't go into it because you're
24 not dealing with patients. And you have to
25 make a lot of judgment calls. There's a lot

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1 of grey areas in pathology, I don't know if
2 people recognize that, they're not all black
3 and white, there's a lot of grey in between.
4 And so you're in a position where you might
5 ask a colleague, but at the end of the day you
6 have to make a decision that's very important
7 for people and so it's a difficult specialty
8 in that sense to recruit somebody for. And
9 the work load is expanding a lot. We had more
10 oncologists in the province than we ever had
11 before, that increases their workload.
12 There's more different tests that are done now
13 than there used to be ten, fifteen years ago
14 and five years ago.
15 COFFEY, Q.C.:
16 Q. And they are pathology tests.
17 DR. WILLIAMS:
18 A. Yes. So the pathology workload is not a
19 static situation, it's a dynamic situation and
20 yet, we had information from the national
21 level on residency programs and possible
22 retirements, there was a document published by
23 the Canadian Association of Pathologists and
24 that, that we had access, and we had a lot of
25 information on pay and benefits in other

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1 jurisdictions, so we felt that, I guess there
2 was an agreement that this was an area that
3 wanted attention and that would probably get
4 worse before it would get better. Because
5 even if you're going to impact on the number
6 of people going into residency, and lots of
7 times our pathology residency program is not
8 filled here. Most other residency programs
9 are matched across the country by CARMS and
10 they're sought after and filled; pathology
11 residency programs are usually not filled and
12 then the ones that are not filled, we
13 sometimes fill them, you know, we're able to
14 fill them with four medical graduates to a
15 certain extent, but lots of times our
16 pathology programs would have up to eight
17 residents in the programs, we might have three
18 or four sometimes or less.
19 COFFEY, Q.C.:
20 Q. And that's during the time you were VP
21 Medical?
22 DR. WILLIAMS:
23 A. Yes, now we had some good years where we, a
24 little earlier in the day, probably in the
25 early '98, '99, 2000, 2001 when we had a large

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1 group of people who had roots down in the
2 province, went through the pathology program
3 here and they stayed here, like Dr. Denic, who
4 came here and put his roots down or Dr. Elms,
5 people like that who were coming out of the
6 local residency program. But in the last few
7 years, I think some of it's dried up and a lot
8 of people have roots in other provinces, but
9 they come here to get into the program here.
10 But when they finish up, their roots take them
11 back somewhere else. So it's harder to
12 recruit these people and you're in a
13 competitive market. We knew there was a
14 shortage of pathologists right across Canada
15 and into the U.S. because of the same reason,
16 hard to get pathologists to enrole in
17 residency training program and the workload
18 was expanding and that was putting more
19 pressure on the system.
20 COFFEY, Q.C.:
21 Q. And was it your experience, was there ever any
22 reticence that you saw by the pathologists in
23 terms of voicing their views?
24 DR. WILLIAMS:
25 A. No, we had three strong representatives, they

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1 weren't jumping up and down -
2 COFFEY, Q.C.:
3 Q. Yeah, they weren't pounding the table or
4 anything like that.
5 DR. WILLIAMS:
6 A. No, they were sitting down and doing an
7 analysis in a reasonable fashion, I would say.
8 COFFEY, Q.C.:
9 Q. But they were, I take it, forceful in putting
10 forward their positions?
11 DR. WILLIAMS:
12 A. Oh yes, sure. There wasn't any disagreement
13 among the people on the committee, I don't
14 think.
15 COFFEY, Q.C.:
16 Q. If we could, please, exhibit P-0905? It's
17 not, okay, I'll come back to that, I
18 apologize, it wasn't exhibited, I'm sorry,
19 I'll come back to that tomorrow. Now if we
20 could, please, Doctor could you tell me what
21 you recall then the first time you heard of
22 ER/PR, estrogen receptors, progesterone
23 receptors? Now I'm not asking about when you
24 might have heard as a medical student or, you
25 know, in your days as a GP, but in terms of

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1 the matter that brings us here today, when do
2 you recall -
3 DR. WILLIAMS:
4 A. When it happened, however there's some minutes
5 I went over before that referenced it.
6 COFFEY, Q.C.:
7 Q. But in terms of your own involvement--in terms
8 of your recollection of, who first brought it
9 to your attention and what do you recall?
10 DR. WILLIAMS:
11 A. A phone call from Dr. Cook, but I'd like to go
12 back to 2003 in a minute, but we'll talk about
13 that.
14 COFFEY, Q.C.:
15 Q. Okay, we'll go back to that because there is
16 other material in some of those--materials
17 that is under review, at least we'll paint a
18 full picture of the time we do that, so in '03
19 and so on. ER/PR as a subject matter in 2003,
20 do you have any conscious recollection of that
21 now, it coming up -
22 DR. WILLIAMS:
23 A. No, I don't, but there was some minutes came
24 to me when I got back from sick leave -
25 COFFEY, Q.C.:

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1 Q. Okay, and I'll deal with those then tomorrow,
2 if I could, because there are other things
3 related to it.
4 DR. WILLIAMS:
5 A. Okay.
6 COFFEY, Q.C.:
7 Q. But in terms of '05, if we could take it up
8 there?
9 DR. WILLIAMS:
10 A. I had a call from Dr. Cook in May of '05. I
11 didn't make a note at the time because when
12 Dr. Cook told me about it, I said that he--I
13 wanted him to do a full report because I
14 wanted to be--have quality involved from day
15 one, so I would see that report that Dr. Cook
16 did as the occurrence report, basically and on
17 the phone I told him if, I asked him if he
18 would do a full report for me and I was going
19 to involve quality.
20 COFFEY, Q.C.:
21 Q. So right from the outset, I take it that it
22 would be an occurrence report, so you
23 understood -
24 DR. WILLIAMS:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. - partway into the conversation that this was
3 an occurrence -
4 DR. WILLIAMS:
5 A. Yes, and that's why I asked him to do a full
6 report and that's why he did a full report.
7 COFFEY, Q.C.:
8 Q. Okay, go ahead, I'm sorry, Doctor.
9 DR. WILLIAMS:
10 A. He phoned me on the phone and he said we've
11 got a problem. And he told me that there was
12 a patient of Dr. Laing's who was quite ill.
13 Dr. Laing had consulted outside the province
14 and had consulted with Sloan-Kettering--she
15 consulted elsewhere too, but she consulted
16 with Sloan-Kettering and she was getting some
17 advice and one of the questions asked was
18 what's the patient's ER/PR status. And Dr.
19 Laing said negative and the person at Sloan-
20 Kettering said we've got some new information
21 that all people with this particular type of
22 breast cancer are ER positive, their receptor
23 status is positive. So that caused that
24 patient, Dr. Laing--or Dr. McCarthy says in
25 the letter, but I was on the phone -

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1 COFFEY, Q.C.:
2 Q. On the phone, that's what -
3 DR. WILLIAMS:
4 A. With Mr. Laing.
5 COFFEY, Q.C.:
6 Q. Whatever may be written here and if there's a
7 difference, you can point that out.
8 DR. WILLIAMS:
9 A. Yes, that patient was retested and the patient
10 was positive and that he told me the kind of
11 breast cancer the patient had. And I asked
12 some questions about how it could happen and
13 how the test was done, and he told me
14 something about how the test was done, but he
15 told me they were running, I said, well kind
16 of system have we got in place, checks and
17 balances, and he told me that they had
18 controls and that the controls, you know, were
19 checked every day. And so we talked about it
20 and thought maybe it's just a bad batch, that
21 they were going to do some more testing at the
22 time.
23 COFFEY, Q.C.:
24 Q. Now bad batch in the context would mean what?
25 DR. WILLIAMS:

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1 A. Would mean well maybe something went through
2 at that time and something happened and I knew
3 there was more than one test done in any one
4 run, so that's what I meant by sort of bad
5 batch, maybe something got through there that
6 would normally not get through.
7 COFFEY, Q.C.:
8 Q. And so you would have been, at this point in
9 time in your office in the General Hospital?
10 DR. WILLIAMS:
11 A. In the General Hospital, yes.
12 COFFEY, Q.C.:
13 Q. And Dr. Cook was located--his office was
14 located where at that time?
15 DR. WILLIAMS:
16 A. At St. Clare's.
17 COFFEY, Q.C.:
18 Q. And he was calling you in his capacity as
19 clinical chief?
20 DR. WILLIAMS:
21 A. Yes, he was.
22 COFFEY, Q.C.:
23 Q. How many, at that time, how many patients did
24 you understand were involved?
25 DR. WILLIAMS:

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1 A. When the phone call was made, I understood it
2 was one. I think he must have phoned me right
3 away. I asked him to do a report, he did do a
4 report and it says on the report I asked
5 Denise to set up a meeting with Heather
6 Predham and him and myself. And I don't have
7 any notes of that meeting, so I don't know if
8 the meeting was held, I suspect it was held, I
9 suspect it was.
10 COFFEY, Q.C.:
11 Q. We'll have a look at that now. If we could,
12 exhibit P-0067 please? Now, Doctor, this is--
13 is this the report that came out of or
14 pursuant to your request?
15 DR. WILLIAMS:
16 A. Yes, it would be the first letter from him.
17 COFFEY, Q.C.:
18 Q. Okay. And at the top of the page, well first
19 of all, the letter is dated May 24th, 2005.
20 It's stamped "Vice-president, Medical
21 Services, May 25, 2005."
22 DR. WILLIAMS:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And then at the top right-hand side, there's

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1 something written there, what's that?
2 DR. WILLIAMS:
3 A. May 27th.
4 COFFEY, Q.C.:
5 Q. 2005 and what does that say?
6 DR. WILLIAMS:
7 A. "Copy Heather Predham, set up meeting with Dr.
8 Cook, Ms. Predham and myself."
9 COFFEY, Q.C.:
10 Q. So after the first phone--and you hung up the
11 phone, you had asked Dr. Cook to prepare a
12 report.
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. Do you recall how long it was after that that
17 you received the report?
18 DR. WILLIAMS:
19 A. No, I don't know, it was stamped May 25th, but
20 I didn't make a note of when Dr. Cook phoned
21 me.
22 COFFEY, Q.C.:
23 Q. Do you have any sense of how long might have
24 passed? Was it like a week, or a day or -
25 DR. WILLIAMS:

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1 A. It would be hearsay if I--no, I can't.
2 COFFEY, Q.C.:
3 Q. You can't recall.
4 DR. WILLIAMS:
5 A. We're going back three years. If I gave you
6 an answer, I don't -
7 COFFEY, Q.C.:
8 Q. You'd be guessing.
9 DR. WILLIAMS:
10 A. - think it would be credible. Yes, I would be
11 guessing. Knowing Dr. Cook, I don't think it
12 would be too long, but -
13 COFFEY, Q.C.:
14 Q. And just on that point, you said as it was Dr.
15 Cook, you didn't think it would be too long.
16 Why is that?
17 DR. WILLIAMS:
18 A. Dr. Cook is pretty judicious and I thought he
19 was focused on his job, yes.
20 COFFEY, Q.C.:
21 Q. This is addressed to you as acting CEO and
22 Vice-President of Medical Services?
23 DR. WILLIAMS:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. So I take it at this point in time you were
2 the acting CEO for the Health Care
3 Corporation?
4 DR. WILLIAMS:
5 A. No, I think that's what I was, but on May 9th,
6 I think I was appointed as Eastern Health -
7 COFFEY, Q.C.:
8 Q. Oh, okay, so just before that you had.
9 DR. WILLIAMS:
10 A. Yeah, so I think he wrote me in that capacity
11 without--by that time, George Tilley had taken
12 over and we were really Eastern Health -
13 COFFEY, Q.C.:
14 Q. And your days as acting CEO, in fact you had
15 already been -
16 DR. WILLIAMS:
17 A. My days as acting CEO were over, yes.
18 COFFEY, Q.C.:
19 Q. You were actually being rehired as the Vice
20 President of Medical Services for Eastern
21 Health?
22 DR. WILLIAMS:
23 A. Yes, correct.
24 COFFEY, Q.C.:
25 Q. And what date was that?

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1 DR. WILLIAMS:
2 A. I think it was May 9th.
3 COFFEY, Q.C.:
4 Q. May 9th, okay.
5 DR. WILLIAMS:
6 A. I may be wrong, but I thought it was early
7 May.
8 COFFEY, Q.C.:
9 Q. Now Doctor, if I could, please, you get the
10 first phone call, what's your next
11 recollection of this? Was it the report or
12 were there any other phone calls or meetings?
13 DR. WILLIAMS:
14 A. No, I don't recollect any other phone calls.
15 I got the report and -
16 COFFEY, Q.C.:
17 Q. And you say if this meeting occurred, this
18 would have occurred after, so -
19 DR. WILLIAMS:
20 A. The meeting, I doubt if the meeting didn't
21 occur because I asked for the meeting to occur
22 and I don't know why it wouldn't have
23 occurred, but I didn't make any notes of when
24 we met.
25 COFFEY, Q.C.:

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1 Q. What would the purpose have been on May 27th
2 of meeting with Heather Predham?
3 DR. WILLIAMS:
4 A. Well, because Heather Predham was in charge of
5 quality. I saw this as a quality issue, and
6 we were going to start the process of filing
7 an occurrence report and dealing with it as a
8 quality issue in our organization.
9 COFFEY, Q.C.:
10 Q. What does that--in that time, at that time in
11 that context, what does that mean?
12 DR. WILLIAMS:
13 A. That means that we were going to open a file
14 on it and get on with the investigation.
15 COFFEY, Q.C.:
16 Q. And what, if any, role would, at that point,
17 Heather Predham have in this?
18 DR. WILLIAMS:
19 A. Because it's the quality issue. I wanted her
20 involved right from day one to make sure, you
21 know, we followed normal procedures that we
22 had to investigate an occurrence and move
23 forward.
24 COFFEY, Q.C.:
25 Q. And what involvement would she have in that?

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1 DR. WILLIAMS:
2 A. Well, she was in charge of quality. Quality
3 reported to Ms. Pilgrim at the time, and
4 eventually reported to me, but I wanted
5 quality involved from day one.
6 COFFEY, Q.C.:
7 Q. Just in terms of Ms. Predham's background,
8 what, if anything, would she, at that point,
9 have brought to an investigation of this sort
10 of matter? She's not a technologist nor
11 pathologist.
12 DR. WILLIAMS:
13 A. No, but only the fact that she was in quality
14 and I wanted quality involved.
15 COFFEY, Q.C.:
16 Q. Would she liaison with anybody else, do you
17 know, in her role?
18 DR. WILLIAMS:
19 A. Not at this point in time, I don't think. She
20 may liaise with Mrs. Pilgrim, but I'm not sure
21 in this case, but in any event, when we do
22 have quality problems, we try to involve
23 somebody from the quality initiatives
24 department.
25 COFFEY, Q.C.:

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1 Q. And so if we could just look at this, there's
2 a--it's entitled--well, the title is "False
3 negative results for estrogen and progesterone
4 receptors, ER and PR." Before you got the
5 report, like during your phone call with Dr.
6 Cook, did you get any understanding of what
7 the significance of ER and PR was, from a
8 clinical perspective?
9 DR. WILLIAMS:
10 A. I would think I would. It's not written in
11 the letter, I don't think, but I would have--
12 maybe it is written there, I'll have to look.
13 But I would--that would have been my first
14 introduction to it.
15 COFFEY, Q.C.:
16 Q. I take it when somebody like Dr. Cook would
17 call you about such a thing and, up to that
18 point, you had no clinical knowledge of this
19 -
20 DR. WILLIAMS:
21 A. No.
22 COFFEY, Q.C.:
23 Q. - aspect of medicine?
24 DR. WILLIAMS:
25 A. No, that would have been new to me.

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1 COFFEY, Q.C.:
2 Q. And I take it by the time you--you'd spoken to
3 Dr. Cook. He had explained the general
4 background, ER/PR. Would you have understood,
5 by the time you hung up the phone, that it had
6 implications for what?
7 DR. WILLIAMS:
8 A. It had implications for patient care and
9 treatment, yes.
10 COFFEY, Q.C.:
11 Q. And anything in particular about that?
12 DR. WILLIAMS:
13 A. Well, that we needed to investigate it.
14 COFFEY, Q.C.:
15 Q. Oh no, I appreciate that, something had to be
16 done, but in terms of patient care, what
17 aspect of--how important--what was your
18 understanding as to how important it was to
19 patient care?
20 DR. WILLIAMS:
21 A. It was an important factor in deciding what
22 the course of treatment would be.
23 COFFEY, Q.C.:
24 Q. I'm sorry, so Doctor, just looking at the
25 actual, if I could, the letter is entitled

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1 confidential. Why would it be confidential?
2 DR. WILLIAMS:
3 A. I don't know why he would write confidential
4 on it. You'd have to ask him.
5 COFFEY, Q.C.:
6 Q. Okay. Just well, it's addressed to you,
7 that's why I'm asking.
8 DR. WILLIAMS:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. It says "on May 11th, 2005, I received a phone
12 call from Dr. Joy McCarthy, a medical
13 oncologist, informing me of an ER and PR
14 reported negative in a patient with
15 infiltrating lobular carcinoma of the breast
16 diagnosed in 2002. When retested in May 2005,
17 the ER and PR were reported as strongly
18 positive. Dr. McCarthy also expressed concern
19 over what appears to be a high rate of
20 infiltrating lobular carcinomas that were
21 reported as ER and PR negative. She stated
22 that usually 95 percent of lobular carcinomas
23 are ER and PR positive, while five percent are
24 negative. Dr. McCarthy requested that two
25 other patients with infiltrating lobular

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1 carcinoma who were reported as ER and PR
2 negative in 2002 also be retested. I also
3 expressed concern over this and suggested that
4 we meet to discuss this further." Of course,
5 the I in this context would be Dr. Cook.
6 How did that compare with what you had
7 been told on the phone by Dr. Cook?
8 DR. WILLIAMS:
9 A. I just remember being told about the first
10 patient.
11 COFFEY, Q.C.:
12 Q. Which would be Dr. Laing's patient?
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. And now, do you know, sir, when we look
17 through this letter and when you looked
18 through it at the time--I'll just go on to
19 read the next two sentences. "On May 17th,
20 2005, a meeting was held which included
21 myself, Dr. Bev Carter, a resource person for
22 breast pathology, Mr. Barry Dyer, divisional
23 manager for anatomical pathology, and Doctors
24 Joy McCarthy and Kara Laing, medical
25 oncologists. During that meeting, I brought

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1 forth," that is I, Dr. Cook, "brought forth
2 that the second patient originally reported as
3 ER and PR negative in 2002 were now strongly
4 positive for breast receptors on retesting."
5 Then he goes on to talk about some other
6 aspects of the matter.
7 So having read this letter, you
8 understood how many patients had converted?
9 DR. WILLIAMS:
10 A. A couple at the time.
11 COFFEY, Q.C.:
12 Q. A couple?
13 DR. WILLIAMS:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. That's fine. He goes on to explain to you,
17 "it is estimated that approximately 50 to 85
18 percent of all breast cancers, particularly
19 infiltrating ductal and lobular carcinomas,
20 exhibit estrogen receptors and as such tumours
21 are commonly found in post-menopausal women.
22 A high percentage of tumours with estrogen
23 receptors may regress after hormonal
24 manipulation, whereas only a small number,
25 approximately five percent of those that are

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1 negative respond. Highest response rates are
2 in patients with tumours exhibiting both ER
3 and PR receptors. Breast cancer patients with
4 high level hormone receptors have a slightly
5 better prognosis than those without
6 receptors."
7 He then says "receptor status will
8 influence at what stage chemotherapy will be
9 given to a patient. Those patients that are
10 ER and PR negative should be given"--I'm
11 sorry, "would be given chemotherapy with its
12 side effects much earlier in the course of
13 treatment. It is possible that the patient
14 who is ER and PR positive and responds
15 favourably to hormone manipulation may not
16 require the full chemotherapeutic regime."
17 And then he says "prior to March/April
18 2004, all ER and PR receptors in this province
19 were tested using a DAKO manual system for
20 immunoperoxidase staining on paraffin embedded
21 tissue. This staining procedure took place at
22 the histology lab at the General Hospital
23 site. Interpretation of these stains were
24 made by those pathologists who were assigned
25 the cases. These stains were also circulated

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1 to pathologists across the province, according
2 to which lab the cases originated from."
3 And then someone has written, "did we
4 make determination"
5 DR. WILLIAMS:
6 A. I don't know whose writing -
7 COFFEY, Q.C.:
8 Q. You see that?
9 DR. WILLIAMS:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Okay, that's not your handwriting?
13 DR. WILLIAMS:
14 A. No.
15 COFFEY, Q.C.:
16 Q. Okay. Do you recognize the handwriting?
17 DR. WILLIAMS:
18 A. No.
19 COFFEY, Q.C.:
20 Q. And he goes on to say "around March/April
21 2004, the DAKO manual system was replaced with
22 a new Ventana automated system. This system
23 provided more sensitivity and standardization
24 than the old manual technique. The cases that
25 were previously reported as ER and PR negative

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1 are now retested using the new automated
2 procedure. It is my understanding that all
3 previously reported ER negative patients under
4 the old manual technique have positive
5 controls." I take it that's the reference to
6 -
7 DR. WILLIAMS:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. - external controls. And then there's a
11 paragraph which explains in some detail the
12 actual process, refers to peroxidase, coupling
13 of peroxidase label to a primary antibody
14 which binds to a specific antigen in the
15 cancerous lesion, and it goes on from there.
16 Do you see that?
17 DR. WILLIAMS:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Now he, in the middle of the paragraph, then
21 says "the immunoperoxidase technique is widely
22 used in many histology labs across North
23 America with more diagnostic weight being
24 placed on these stains than our conventional
25 histochemical stains. However, like any other

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1 technique, the immunoperoxidase stains have
2 potential pitfalls. Many of these pitfalls
3 can be avoided by scrupulous quality control,
4 periodic checking of antibody activity and
5 proper use of negative and positive controls."
6 And I'm just, I just stop at this point and
7 ask you, you would have understood, I take it,
8 that, from this letter that the IHC testing or
9 staining process was being conducted at the
10 General Hospital site?
11 DR. WILLIAMS:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Then, Dr., I'm sorry, Cook goes on to say, "In
15 early 2003 Dr. Gershon Ejeckam, our point man
16 for immunoperoxidase testing at the General
17 Hospital site discontinued testing of the
18 ER/PR receptors with the manual method for a
19 six-week period. A memo was circulated to all
20 pathologists across the province stating this.
21 The technique was temporarily halted because
22 of erratic staining which required
23 readjustments of titration and staining times.
24 Once Dr. Ejeckam felt confident of the
25 reliability of staining the test was

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1 reintroduced." And somebody has written on
2 this, "Why ? was it looked in the past?" And
3 then there's another, to the left-hand side it
4 says, "Came in September, 2002." And the
5 "came" in this context would be Dr. Ejeckam, I
6 take it?
7 DR. WILLIAMS:
8 A. Right, yeah.
9 COFFEY, Q.C.:
10 Q. And at the bottom of the page there's
11 something written, "Controls go through all
12 the same process but they are optimally a
13 fixed tissue." The bottom of the page, you
14 see that?
15 DR. WILLIAMS:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And then Dr. Cook concludes with, "At the
19 conclusion of the May 17th meeting it was
20 decided to retest all negative ERs and PRs for
21 the year 2002 and possibly 2001. I have no
22 idea at this point in time in knowing whether
23 these are a few isolated cases or whether we
24 are dealing with a much bigger issue. For now
25 we've agreed that if there is a receptor

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1 conversion, the oncologists would inform the
2 patient that we have retested the ER and PR
3 receptors under our new more sensitive
4 technique. However, if it is identified that
5 we have a much more significant conversion
6 factor, a problem involving many patients, we
7 would need to seek advice and guidance from
8 QI," that would be quality initiatives?
9 DR. WILLIAMS:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. Okay. "On how best to disclose this
13 information as this involves breast cancer
14 patients across the province. In closing I
15 would like to make the following
16 recommendations for immunoperoxidase testing:
17 (1) The immediate establishment of an external
18 proficiency testing and monitoring program for
19 immunoperoxidase testing. (2) The
20 establishment of a separate immunoperoxidase
21 service with at least three technologists
22 solely dedicated to immunoperoxidase testing
23 with separate facilities. (3) Training of
24 immunoperoxidase technologists in a major
25 immuno referral lab, that has a well-

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1 established quality control and
2 troubleshooting program. (4) Appropriate CME
3 funding for these immuno technologists." And
4 he concludes with, "These preliminary
5 recommendations will no doubt require
6 additional manpower and funding levels than
7 currently--additionally, and manpower and
8 funding levels than currently exist. I will
9 keep you updated as more information becomes
10 available. Respectfully submitted, Dr. Cook."
11 Now, Doctor, before we break for the day, I
12 appreciate that you sent a copy to Ms. Predham
13 and wanted to meet with Dr. Cook and Ms.
14 Predham. Your understanding, you know, at the
15 time, having read the letter, when you got the
16 letter, did you speak to Dr. Cook about it?
17 DR. WILLIAMS:
18 A. Oh, yes, I spoke to Dr. Cook, and I think face
19 to face.
20 COFFEY, Q.C.:
21 Q. Okay. So you got the letter and what happens
22 during -
23 DR. WILLIAMS:
24 A. Now, I didn't record it. We were going to do
25 some more testing as quick as we could.

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1 COFFEY, Q.C.:
2 Q. So this meeting would have been when -
3 DR. WILLIAMS:
4 A. Just after I got the letter.
5 COFFEY, Q.C.:
6 Q. Oh, just after you got the letter, yes.
7 DR. WILLIAMS:
8 A. I suspect Heather Predham -
9 COFFEY, Q.C.:
10 Q. He came over -
11 DR. WILLIAMS:
12 A. Yes. I suspect he would have come over, we
13 would have talked, and we would have had other
14 discussions on the phone. But he wrote me a
15 subsequent letter just updating me -
16 COFFEY, Q.C.:
17 Q. Yes. So in the initial meetings what
18 happened?
19 DR. WILLIAMS:
20 A. Well, the initial meetings I think we were
21 going to retest.
22 COFFEY, Q.C.:
23 Q. Retest what?
24 DR. WILLIAMS:
25 A. Retest as outlined here. Start the retesting

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1 process to see what we found and how much of a
2 problem we had and then make a decision on
3 where we were going.
4 COFFEY, Q.C.:
5 Q. Now, at the top of the page here, page 3, Dr.
6 Cook has written "At the conclusion of the May
7 17th meeting," and that's the meeting
8 involving Dr. Cook, Dr. Bev Carter, a resource
9 person for breast pathology, Barry Dyer and
10 Doctors McCarthy and Laing. You had not
11 attended that meeting?
12 DR. WILLIAMS:
13 A. No, I didn't, no.
14 COFFEY, Q.C.:
15 Q. No. So, it was apparent, you were being
16 advised now, May 24th or 5th that it was
17 decided back then to retest all negative ERs
18 and PRs for the year 2002?
19 DR. WILLIAMS:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. And possibly 2001. Did you ask Dr. Cook,
23 well, you've only so far retested two people?
24 DR. WILLIAMS:
25 A. Um-hm, yes.

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1 COFFEY, Q.C.:
2 Q. Why are we doing a full year and if not a full
3 two years?
4 DR. WILLIAMS:
5 A. Well I guess we had somebody from 2002, they
6 wanted to go back as quickly as possible and
7 see what was going on. So retest people would
8 be the best way to do it.
9 COFFEY, Q.C.:
10 Q. Oh yes, did you ask Dr. Cook about, because
11 you had understood originally in your first
12 call that maybe it was a bad batch, as you
13 used that phrase, I take it by this point in
14 time, in late May of 2005, Dr. Cook was
15 suggesting to you it wasn't a bad batch?
16 DR. WILLIAMS:
17 A. Well we had a couple of patients at the time,
18 so obviously that's two different incidents
19 and we needed to go back and retest. And
20 which I concurred with.
21 COFFEY, Q.C.:
22 Q. Why 2002, did he explain why?
23 DR. WILLIAMS:
24 A. Well he said that the incident case had come
25 from 2002. I don't know--and they did

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1 subsequently, they did cases from other years
2 as well.
3 COFFEY, Q.C.:
4 Q. Yes.
5 DR. WILLIAMS:
6 A. Related to the type of breast cancer the
7 patient had.
8 COFFEY, Q.C.:
9 Q. Initially, I take it, in looking at patients
10 that concentrated on particular types of
11 cancer.
12 DR. WILLIAMS:
13 A. Yes, so there were some patients that were
14 done in different years, as we move along, and
15 it was concentrating on 2002 -
16 COFFEY, Q.C.:
17 Q. I'm just asking -
18 DR. WILLIAMS:
19 A. Probably related it to the fact that things
20 were stopped in 2003, he may have related it
21 to--I'm not sure.
22 COFFEY, Q.C.:
23 Q. Okay, I'm just asking, did you discuss that
24 with him, that's what I'm -
25 DR. WILLIAMS:

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1 A. I don't recall any detailed discussion, I
2 think what we discussed was let's get on with
3 this as quick as we can and let's get some
4 tests done and see where we are, let's try to
5 define the problem and see what the issues
6 are.
7 COFFEY, Q.C.:
8 Q. And his rationale as to why '02 and possibly
9 '01, you didn't discuss that -
10 DR. WILLIAMS:
11 A. At the time, we might have discussed it, but I
12 can't recollect. I knew some of it related to
13 the time that the patient convert--it was
14 tested, converted. He may have related it to
15 the stopping of the test in 2003.
16 COFFEY, Q.C.:
17 Q. Which is in early, you're advised here at the
18 bottom of page two, in early 2002.
19 DR. WILLIAMS:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Dr. Ejeckam had discontinued -
23 DR. WILLIAMS:
24 A. Early 2003, I'm sorry.
25 COFFEY, Q.C.:

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1 Q. I'm sorry, early 2003, I apologize,
2 discontinued testing. Now up to this point in
3 time, this is May of '05, had you known that
4 Dr. Ejeckam was a point man for
5 immunoperoxidase testing at the General
6 Hospital site?
7 DR. WILLIAMS:
8 A. No, I did not.
9 COFFEY, Q.C.:
10 Q. And did you have any understanding, before May
11 of 2005 as to who, if anyone, was responsible
12 for immunoperoxidase testing at the General,
13 in the sense of from a pathologist's
14 perspective?
15 DR. WILLIAMS:
16 A. I wouldn't have that knowledge, no. I knew we
17 had site chiefs on each site, but getting into
18 that, no.
19 COFFEY, Q.C.:
20 Q. And in terms of, except as a general concept,
21 immunoperoxidase testing, did you have any
22 knowledge actually of what that was involved -
23 DR. WILLIAMS:
24 A. Well we need to go back, I want to go back to
25 2003 because that's something I think I missed

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1 in the minutes, but no.
2 COFFEY, Q.C.:
3 Q. And perhaps if we could come back to this in
4 the morning?
5 THE COMMISSIONER:
6 Q. Sure.
7 COFFEY, Q.C.:
8 Q. And we'll take it from there.
9 THE COMMISSIONER:
10 Q. 9:30.

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1 CERTIFICATE
2 I, Judy Moss, hereby certify that the foregoing is
3 a true and correct transcript in the matter of the
4 Commission of Inquiry on Hormone Receptor Testing,
5 heard on the 14th day of May, A.D., 2008 before the
6 Honourable Justice Margaret A. Cameron,
7 Commissioner, at the Commission of Inquiry, St.
8 John's, Newfoundland and Labrador and was
9 transcribed by me to the best of my ability by
10 means of a sound apparatus.
11 Dated at St. John's, Newfoundland and Labrador
12 this 14th day of May, A.D., 2008
13 Judy Moss

-$-

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