COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

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Regional Integrated Health Authorities

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DR. JEHAN SIDDIQUI, EXAMINATION BY SANDRA CHAYTOR, Q.C. (CONT'D)

THE COMMISSIONER:

Q. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Good morning, Commissioner. Good morning, Dr. Siddiqui.

DR. SIDDIQUI:

A. Good morning.

CHAYTOR, Q.C.:

Q. Doctor, are you aware of any correlation between ER positivity and PR positivity?

DR. SIDDIQUI:

A. Most of the ERs and PR, they should be positive at the same time.

CHAYTOR, Q.C.:

Q. And in terms of what percentage, in terms of what "most" might mean in that context, are you able to say?

DR. SIDDIQUI:

A. Another way to put that is that most of the PRs should also be ER positive. There is a small number, however, I would say roughly about five percent or so, that you could have ER positivity without being PR--sorry, you

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could have PR positivity without being ER positive.

CHAYTOR, Q.C.:

Q. Okay, and at what point in your training and work life would you have been aware of that?

DR. SIDDIQUI:

A. It's difficult to say. This is kind of a background information. I don't know when I get that. Sometimes during training or afterwards, it's difficult to point exact time when I got that.

CHAYTOR, Q.C.:

Q. Okay. So either sometime during your training or in your early years of practice?

DR. SIDDIQUI:

A. That's true.

CHAYTOR, Q.C.:

Q. Okay, and when you're trying to decide if a patient is a candidate for adjuvant hormonal therapy, what criteria is used?

DR. SIDDIQUI:

A. ER/PR is the most important thing. That is the first thing that has the highest predictor value for using hormonal therapy, and other things that you can think about is other

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factors such as age of the patient, would she be a candidate for some other treatment or not. Some patients who are elderly, even though their ER/PR may be less, but if they could not be a candidate for chemotherapy, you could treat them with hormone therapy by itself. So those would be the other factors, but ER positivity PR positivity would be the most important thing.

CHAYTOR, Q.C.:

Q. Okay, and if the patient is one of those few that would fall into the ER negative but PR positive category, would that patient normally be offered treatment?

DR. SIDDIQUI:

A. We do. For all clinical and practical purposes, we offer them hormone therapy.

CHAYTOR, Q.C.:

Q. Whether they're ER positive or PR positive, they're offered -

DR. SIDDIQUI:

A. That is correct.

CHAYTOR, Q.C.:

Q. Yes, okay, and was that a--has that been anything that's stipulated in terms of a

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guideline or a policy in dealing with breast cancer patients?

DR. SIDDIQUI:

A. What I remember is as a teaching when I was a fellow, we used to take either/or.

CHAYTOR, Q.C.:

Q. And the degree of positivity, if someone were, for example, 80 percent ER positive versus another person 20 percent ER positive, is the person who has a higher degree of positivity more likely to respond to treatment?

DR. SIDDIQUI:

A. That is true.

CHAYTOR, Q.C.:

Q. Last day, we spoke briefly about -

DR. SIDDIQUI:

A. Can I say one more thing?

CHAYTOR, Q.C.:

Q. I'm sorry, yes.

DR. SIDDIQUI:

A. Most of the data for that, I think, would be in the metastatic setting though. In the adjuvant, there may be some, but in the adjuvant has that been fully answered in literature, I'm not sure, but in metastatic

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setting, there definitely is data regarding that.

CHAYTOR, Q.C.:

Q. Okay, and last day, I mentioned briefly, we mentioned the issues that Dr. Ejeckam brought forward and had mentioned in the surgical pathology review committee that you sat on. Other than that, were you ever aware, at any time prior to 2005, of any issues regarding the lab or, for example, the reliability of tests being generated from the lab?

DR. SIDDIQUI:

A. No, I think other than the two cases that I brought up last time, one that T3/T4 and the other one was a lung, there is none that come on top of my head. There have been a few patients who have been sent for a referral outside of St. John's, but most of the time, they would decide about that. If they want to send that patient outside, they would do that.

CHAYTOR, Q.C.:

Q. Okay, and if we could have again, please, P-0113, and it's page five of the document today, please, Registrar? Doctor, this is the series of memos again that Dr. Ejeckam wrote

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back in 2003, and I've already brought you through the first two. The last one is dated June 19th, 2003 and it's not written to the pathologists generally this time. It's written to Mr. Terry Gulliver, and there's a number of concerns that are pointed out in this memo, and I'm not sure, Doctor, have you ever seen this memo or had a chance to read through this memo previously?

DR. SIDDIQUI:

A. I've seen that first time, I think, during my interview.

CHAYTOR, Q.C.:

Q. Yes, okay.

DR. SIDDIQUI:

A. And then you showed it to me, I think, last time as well, if I'm not mistaken.

CHAYTOR, Q.C.:

Q. Okay. So this is not something that was brought to your attention back in 2003?

DR. SIDDIQUI:

A. Not that I remember, no.

CHAYTOR, Q.C.:

Q. Okay, and Dr. Ejeckam wrote here in terms of his concerns, "finally, it is pertinent to

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mention that results of immunostains are extremely important to histopathological diagnosis, especially where a classification of lymphomas and determination of benign or malignancy of certain lesions, for example in the prostate biopsies, depend on crisp, reliable and reproducible staining results. Diagnosis based on inappropriate immunostain will surely jeopardize patient care and may even expose the Health Care Corporation of St. John's to litigation and therefore it will be ill-advised to operate an unreliable and erratic immunohistochemistry procedures in our laboratory."

The fact that Dr. Ejeckam had written this memo and had those concerns and took it to the point of putting in writing to Mr. Terry Gulliver those concerns, that didn't come up at any time in your surgical pathology review committee?

DR. SIDDIQUI:

A. No, I don't remember that.

CHAYTOR, Q.C.:

Q. Okay, and as an oncologist practising in the same hospital, would you have liked to have

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been aware of those concerns?

DR. SIDDIQUI:

A. What I would think is that first they have to evaluate it on their own. If they think that it is up to a point that it is affecting the patient care, then we should be informed.

CHAYTOR, Q.C.:

Q. Okay. If I could have then, please, P-1575? And this is the minutes of the meeting of surgical pathology review committee, September 23rd, 2003, and we see that Dr. Ejeckam and yourself and Dr. Parai, Dr. Tennant are in attendance, as well as the recording secretary, and under business arising, "estrogen and progesterone status. Dr. Ejeckam stated that the technical problem of staining for ER and PR stains has been solved." Do you remember, do you have any independent recollection of this meeting and the discussion that happened around the issue on that date?

DR. SIDDIQUI:

A. Basically what is in the minutes.

CHAYTOR, Q.C.:

Q. "And Dr. Siddiqui asked what were the

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standards for performing HER2/neu. Some discussion took place with regards to this. It was decided that ER and PR will be done at the time of diagnosis and HER2/neu will be done by request. Dr. Siddiqui asked about what turnaround time for HER2/neu. Dr. Ejeckam explained that HER2/neu will have to be done in batch because of costs associated with the test. It is usually performed once a week." What were your concerns at that time in terms of, it says here, the standards for performing HER2/neu?

DR. SIDDIQUI:

A. HER2/neu in the adjuvant setting, well Herceptin which is a drug which is used, if HER2/neu is over expressing in the adjuvant setting, I think by that time was not the standard of care. So there were not doing HER2/neu on every single breast specimen that was coming in. HER2/neu was mostly done when a patient became symptomatic. So what I would think is that that is probably what I was referring to, that they won't do the HER2/neu initially when the first specimen comes in. They will do HER2/neu only upon request, which

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will probably mean that a patient has become symptomatic now and may be a candidate for Herceptin, because initially Herceptin was used only in the metastatic setting. It has come into the adjuvant setting more recently, and ER/PR is something that you would need to know pretty much the first time that you see the patient and as I had said last time as well, that I do remember a few instances when the patient would come in. We are seeing them for the first time and the ER and PR were not done. So I remember putting -

CHAYTOR, Q.C.:

Q. And in that case--sorry, I didn't mean to cut off you off there.

DR. SIDDIQUI:

A. I remember putting in consults, I think, around that time, start of my work here, a few times for getting ER/PR done.

CHAYTOR, Q.C.:

Q. Okay, because it wasn't automatically done?

DR. SIDDIQUI:

A. It wasn't.

CHAYTOR, Q.C.:

Q. And you would then have to request it?

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DR. SIDDIQUI:

A. That's what my understanding would be.

CHAYTOR, Q.C.:

Q. Okay, and as time went on, I take it, that improved and that the ER/PR test was automatically done?

DR. SIDDIQUI:

A. That is correct, I think, most of them.

CHAYTOR, Q.C.:

Q. Doctor, the issue then about the technical problem with staining for the ER and PR stains having been solved, this is now, these minutes are September 23rd, 2003. Was this the first time you learned that the test had resumed?

DR. SIDDIQUI:

A. I think so, but again, since my interview, I have seen the other memos from Dr. Ejeckam and I think after the April one, there was another one, probably in May or June.

CHAYTOR, Q.C.:

Q. May 2nd, yes.

DR. SIDDIQUI:

A. Which had said that "I am glad to inform you that we are resumed," so I have seen that since, in the last six months.

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CHAYTOR, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. But by that time, I would think that that would be the first time.

CHAYTOR, Q.C.:

Q. Okay. So back in 2003, you would have been learning for the first time, at this meeting in September, that the tests had resumed?

DR. SIDDIQUI:

A. I would think so.

CHAYTOR, Q.C.:

Q. Okay. Did you ask any questions of Dr. Ejeckam at the time as to, "well, while it's been solved, what was the problem? And is it of any concern, in terms of any tests that have already been performed?"

DR. SIDDIQUI:

A. Again, according to the minutes, I did not, and I did not know much about how technically it is done. So from my point of view, it would be that can we use that.

CHAYTOR, Q.C.:

Q. And if we could have then, please, P-1909? And again, this is a meeting of the surgical

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pathological review committee. It's March 9th, 2004. So I take it this committee continued into 2004?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. And under new business, Section 4.3 on page three of the exhibit, "Dr. Siddiqui performed"--sorry, the topic is pathology reports addendum. "Dr. J. Siddiqui informed the committee of a situation regarding a case where the pathology report tumour summary stated a range of T3. Addendum stated T4. Then the pathology changed again to T3. He questioned if the pathologist should inform the doctor, because these changes could affect the treatment of the patient. He gave another example where a patient was diagnosed with non-small carcinoma to small cell carcinoma, which changes the patient's treatment to either surgery or just chemotherapy. It was also noted that there could be legal implications. It was recommended that the addendum reports should be sent to the oncologist by the physician. The pathologist

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should send a copy of the addendum directly to the requesting physician for a particular case, in addition to entering the addendum in the computer Meditech."

And Doctor, the idea that the pathologist should inform the doctor because these changes could affect the treatment of the patient, and you're recommending that the addendum reports obviously be sent directly to the oncologist, what was that all about? What was happening and what was your concern?

DR. SIDDIQUI:

A. On the pathology report, in the area where the name of the attending comes, usually it's the name of the surgeon over there, and the report would go, many of the times, to the surgeon, and sometimes they are not actively involved in the treatment of that patient at that particular time. They may send the report back to us, but it would just take an extra loop to come back to us, and if a patient is already on treatment, then we miss something. So that would have been the idea behind that, that the pathology should take the onus to find out who is the--if they're changing a

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report, to find out who is the oncologist treating the patient and let them inform as well.

CHAYTOR, Q.C.:

Q. Okay, and at the time, is there any concern that at the time that the pathology report is generated, the patient may not already have been assigned an oncologist?

DR. SIDDIQUI:

A. I guess that could happen sometimes. If they're not assigned, then probably the surgeon would be the right person to talk to or to be informed.

CHAYTOR, Q.C.:

Q. And then the onus would be on the surgeon to make sure the oncologist is informed about any addendum to the pathology?

DR. SIDDIQUI:

A. I would think so, if there is anything different than the time when they're first sending the consult, it would be better if they would let us know.

CHAYTOR, Q.C.:

Q. So you were--you had a patient or perhaps it's two patients, you've giving two examples here,

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and the pathology changed and you only learned about it because of your own efforts in going in and checking Meditech? Is that correct?

DR. SIDDIQUI:

A. The second one, I had requested the pathologist to give me an immediate report and they had given me immediate report, but then they had called Dr. Rorke, who was on the floor, so they called them self and they called Dr. Rorke, made him aware about the change and that was taken care of. The first one, I'm just trying to remember how I knew about that. What comes to my mind, and again, the best way to confirm that would be to look at the chart, but what comes to my mind is that radiation oncology probably also saw the patient and when I saw the patient, it was probably T3 or T4, one of the two, and when they saw, then it was different. So that's what comes to mind.

CHAYTOR, Q.C.:

Q. Okay, and do you know whether or not what was recommended here, in terms of the addendum report being sent directly to the oncologist, and it says by the physician, do I take it

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that means by the pathologist?

DR. SIDDIQUI:

A. It should be, yeah.

CHAYTOR, Q.C.:

Q. By the pathologist, okay. Do you know whether or not there was any policy put in place in keeping with the recommendation?

DR. SIDDIQUI:

A. I don't know of a policy, but I think there were still reports who had surgeon's name on them.

CHAYTOR, Q.C.:

Q. I'm sorry?

DR. SIDDIQUI:

A. I think there were still reports though who had surgeon's name on them.

CHAYTOR, Q.C.:

Q. The pathology reports had the surgeon's name?

DR. SIDDIQUI:

A. That's correct, yeah.

CHAYTOR, Q.C.:

Q. Yes, so up to that point in time, the surgeon's name wasn't even appearing on the pathology report?

DR. SIDDIQUI:

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A. They were, but what I have suggested was that at least put somewhere the name of the medical oncologist or the radiation oncologist, either write it down or put in the area of the attending physician. But I remember that there were still reports in whom the surgeon name was still appearing as attending physician.

CHAYTOR, Q.C.:

Q. Okay. So -

DR. SIDDIQUI:

A. So I don't know how were they dealing with that.

CHAYTOR, Q.C.:

Q. So there didn't seem to be any change in practice?

DR. SIDDIQUI:

A. Since this happened, very rarely, and like I have just these two cases in the first--this is 2003, I joined in 2001, which came to my mind. So what I could remember is that probably either one or twice the report still came in with the surgeon's name, and my name probably on the side on one and probably not on the other.

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CHAYTOR, Q.C.:

Q. Okay. So while it didn't--there was no formal policy, I guess, that came in place to address the issue at the time while this was a recommendation from your committee?

DR. SIDDIQUI:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And there continued to be, from time to time, a similar issue would arise?

DR. SIDDIQUI:

A. I can remember one.

CHAYTOR, Q.C.:

Q. And was there any discussion about bringing in a policy at the time, and was there anyone opposed to the idea?

DR. SIDDIQUI:

A. I can just rely on these minutes. I don't remember that.

CHAYTOR, Q.C.:

Q. Okay. Other than the issue regarding how to get the information to you, and of course that would be important in terms of making sure you're made aware of any changes, what about the fact that there were changes in and of

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itself? Did that raise any concern for you, the fact that the pathology was changing with respect to those patients? Did it cause you to question the reliability of the tests and the results of the tests?

DR. SIDDIQUI:

A. Not really. Here and there, you do find cases at times which fall in the grey area. If we look at them at two different times, you may think in two different ways, and this has happened twice in the last eight years that I could remember now, close to eight years, not eight years complete. So not really.

CHAYTOR, Q.C.:

Q. And when those occasions arose, did you have communication with the reporting pathologist to ask why, in fact, there had been a change?

DR. SIDDIQUI:

A. The first time I think we did, me and the radiation oncologist, but the second time, they had called the floor and they explained the whole thing to Dr. Rorke. I never spoke with them afterwards.

CHAYTOR, Q.C.:

Q. And this, of course, in 2003, you would have

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been having tumour board rounds. Did you ever have occasion to bring those instances up while the multidisciplinary team had assembled?

DR. SIDDIQUI:

A. Second one, I'm pretty sure, no. First one, I'm not sure. Maybe, maybe not. Because the second one was mostly a patient on the floor who was treated on the floor, and I don't remember that, for the second one, that we ever did that.

CHAYTOR, Q.C.:

Q. Okay, and you certainly raised it in this context, in front of pathologists?

DR. SIDDIQUI:

A. Um-hm.

CHAYTOR, Q.C.:

Q. Today then, Doctor, if there's an addendum to a pathology report, how is it brought to your attention?

DR. SIDDIQUI:

A. Usually that if there is one, there is a paper trail, a paper would come with an addendum on that, and that should go in the mail box.

CHAYTOR, Q.C.:

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Q. So a hard copy is placed in your mail box?
DR. SIDDIQUI:
A. That is correct.
CHAYTOR, Q.C.:
Q. And have you, yourself, then developed any practice to check to see whether or not there has been any change?
DR. SIDDIQUI:
A. When I start seeing a patient new, then probably first or second time, couple of times, I'll look at the Meditech, but afterwards, usually you don't because the patients, they stay with us for long times. You would have 15 to 20 minutes to see a patient, plus the charts get quite thick. Patients have--some patients have more than one volumes of chart. So if you know what you're looking, you could probably find that in the chart, but I would mostly rely on a hard copy that would come to my mail box.
CHAYTOR, Q.C.:
Q. Okay, and of course, the retesting of ER/PR in 2005 and through 2006, and a few cases beyond that, those reports would come as--any change in the ER/PR status or the result of the

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retest from Mount Sinai, would come in the way of an addendum, for the most part? There were some consults, but for the most part, it would be an addendum to the original pathology report?
DR. SIDDIQUI:
A. That is correct.
CHAYTOR, Q.C.:
Q. Okay, and so I guess, you would be expecting that there would be something coming on those patients. Did you have any practice for checking to see if the--for example, when a patient would arrive in your office, did you have a practice to check and see whether or not their retest results were back?
DR. SIDDIQUI:
A. Initially, I think because they have started doing it, so we were not sure which patients are sent, which are not, probably we may not have done that. In the later part, in Corner Brook, I remember asking the nurses for every single patient who are coming to make sure about that.
CHAYTOR, Q.C.:
Q. Okay. So you asked the nurses in Corner Brook

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to check on that for you?
DR. SIDDIQUI:
A. Yeah.
CHAYTOR, Q.C.:
Q. But you didn't do similar in St. John's for patient results?
DR. SIDDIQUI:
A. Not initially, because they had started doing it, and we didn't know which patients are done, which are not, and most of them would come as a hard copy to me. So I basically relied on the system that they would come in, if they are done.
CHAYTOR, Q.C.:
Q. Okay. So Doctor, when did you first hear that there was such a thing as the ER/PR issue or concern about the ER/PR test?
DR. SIDDIQUI:
A. I think that would be sometimes in 2005, probably middle to late 2005.
CHAYTOR, Q.C.:
Q. Okay. Now we know it--you say middle to late 2005. We know that, now know that Peggy Deane, who's been referred to the index case, her retest in-house took place sometime in

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April of 2005. Were you aware of that at the time?
DR. SIDDIQUI:
A. I think I was aware of that one, but as -
CHAYTOR, Q.C.:
Q. In April?
DR. SIDDIQUI:
A. Right, about--I don't know about which month, but I think was aware of that, and this was again, some sort of informal discussion among the colleagues. Whether it was in April, I'm not sure. It must be a bit later than that, but they are doing it on a huge number of patients, I think, about that middle to late part of October--middle to late part of 2005.
CHAYTOR, Q.C.:
Q. Okay. So it's into--when you say middle to late part of 2005, before you became aware of the massive retesting, you're talking October, that time period?
DR. SIDDIQUI:
A. I'm not sure.
CHAYTOR, Q.C.:
Q. Had it already become an issue of public discussion before you realized about the

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retesting?
DR. SIDDIQUI:
A. I was not doing the retesting myself, so I don't know when they started doing it.
CHAYTOR, Q.C.:
Q. Yes.
DR. SIDDIQUI:
A. But our offices, as I said, are very close by and we share clinic space as well, so probably some informal discussions among ourselves that I might have heard about that.
CHAYTOR, Q.C.:
Q. Yes, and that's--I'm just wondering about how oncologists such as yourself, medical oncologists, would have been communicated with around the issue. So let me back up a bit. Peggy Deane's case, who do you recall speaking to you about that?
DR. SIDDIQUI:
A. What comes to my mind is actually I was on call on one weekend and I saw Dr. Deane himself. He was my daughter's doctor as well, so I knew him. That is what comes to my mind. Who specifically told me, I can't really say.
CHAYTOR, Q.C.:

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Q. Okay. So you think it may have come from the patient's husband that you were initially -
DR. SIDDIQUI:
A. It's possible, because I remember talking to him on one of the weekends when I was on call.
CHAYTOR, Q.C.:
Q. Okay. So I take it, Doctor--well, Dr. McCarthy's office is right next to yours. Do you recall you and Dr. McCarthy speaking in that time frame about this whole issue?
DR. SIDDIQUI:
A. Not in particular. I mean, again, as I said, that we had several informal discussions during the day time and we share clinics as well. Whether it happened in our offices or it happened in the clinics, exactly what time, I can't put my finger on that.
CHAYTOR, Q.C.:
Q. Okay, and in terms of hearing then about the fact that there was going to be a massive retesting, was there any memo circulated amongst--to the oncologists, anything in writing?
DR. SIDDIQUI:
A. Well, not that I remember.

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CHAYTOR, Q.C.:
Q. And was there any meeting called, any meeting where you were all sat down in the one room and informed as to what exactly was happening?
DR. SIDDIQUI:
A. I don't remember one, but it doesn't mean that there wasn't any. I was doing quite a few GIs, so I taught myself a bit peripheral to this issue at that time, I think.
CHAYTOR, Q.C.:
Q. Okay. But, I mean, this would have involved patients from the past, not current.
DR. SIDDIQUI:
A. I understand.
CHAYTOR, Q.C.:
Q. Not current patients.
DR. SIDDIQUI:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay. So you're not aware of any meetings that were called for oncologists to get together and have an information session on the issue?
DR. SIDDIQUI:
A. I don't remember one.

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CHAYTOR, Q.C.:
Q. Okay. And if we could have, please, P-0500? This is a letter that's written to Dr. McCarthy, June 29th, 2005. And we've redacted the numbers and patients' names. And it's written by Doctors Carter and Cook. And you can see there's a number of people. I'm sorry, actually, this one is just Dr. Carter. And I think this is Dr. Cook signing here, as well. And there's a number, as you can see here, of patients who are being retested and this is in house on the Ventana system. So in June, late June, 2005 were you aware that this was happening?
DR. SIDDIQUI:
A. Again, as I said earlier, I knew about these things somewhere in the middle of, middle to late part of 2005. Exactly this date, I can't really say.
CHAYTOR, Q.C.:
Q. Okay. So your recollection on it is that it would have been sometime later than this?
DR. SIDDIQUI:
A. Could be around the same time, could be a bit later.

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CHAYTOR, Q.C.:
Q. Okay. Were you asked to try and identify any patients yourself who may be candidates for retesting?
DR. SIDDIQUI:
A. I think in the clinics that when we were seeing patients in follow-ups, we would do that on our own. Were we specifically asked about that, I don't remember that, but I think in our clinics we would do that, that's when we were following up a patient.
CHAYTOR, Q.C.:
Q. Okay. So in this, I'm just thinking in this June to July time period, because at this time period there's the tests weren't being sent out or there may have been a scattered test being sent out to Mount Sinai, but for the most part the tests were being done in house. At this point in time in terms of identifying patients, I'm just wondering if anyone came to you and said, you know, do you have any lobulars, do you have any metastatic people who you think might--should be retested, did anyone come to you and ask you to put forward any names?

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DR. SIDDIQUI:
A. No, I don't remember any such thing, no.
CHAYTOR, Q.C.:
Q. Okay. And you say your practice, though, became, once you became aware of the mass retesting, you then yourself, when the patients would come before you, you would try to identify whether or not they are somebody who should be retested?
DR. SIDDIQUI:
A. As much as we could.
CHAYTOR, Q.C.:
Q. Did you ever--and when you say that, I guess, as much as you could, how would you, how difficult would it be for you to do that, to be able to identify all your patients who had ER negative status?
DR. SIDDIQUI:
A. It would be difficult because many patients would have tests done outside. And again, as I said, as much as we could was were we doing that on routine, I'm not sure. Mostly my rely--I would rely on the tests coming to me and then follow up on the patient from then onwards. But if we happen to see some patient

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and something came up, we could, but mostly I would rely on the tests coming to me.
CHAYTOR, Q.C.:
Q. Okay. And when you would check, when on occasion when you would have the patient before you and you would check to see if their retest has been completed, were you ever able to identify any patients that had been missed?
DR. SIDDIQUI:
A. I don't remember any.
CHAYTOR, Q.C.:
Q. And how long did you continue to do that, do you now, for example, if you have a breast cancer patient coming before you that you haven't seen in awhile, do you still continue to check the chart to see whether or not the retest has been done?
DR. SIDDIQUI:
A. Now if I see a breast cancer patient now, I would say in the last few months or so, I go through pretty much all her record, all the papers that I can get hold of.
CHAYTOR, Q.C.:
Q. You go through everything?
DR. SIDDIQUI:

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A. Yeah, now.
CHAYTOR, Q.C.:
Q. Okay. And when did you start doing that?
DR. SIDDIQUI:
A. I would say in the last few months or so. And this is especially true for the Corner Brook patients.
CHAYTOR, Q.C.:
Q. And did anyone request you to do that or is that just your own initiative?
DR. SIDDIQUI:
A. Just my own initiative, I would think.
CHAYTOR, Q.C.:
Q. Okay. And again, in doing that have you identified any patients that weren't originally identified?
DR. SIDDIQUI:
A. And again, I would say in Corner Brook there were a few patients whose reports were not in the chart; I remember putting in consults for that. Many of the time they would have been done or would have been in the pipeline, that may go even a bit earlier in Corner Brook, though.
CHAYTOR, Q.C.:

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Q. Yes.
DR. SIDDIQUI:
A. Last year, as well. But I would just, if I am seeing the patient in Corner Brook--because in Corner Brook the practice is very much mixed. A patient may be seen by myself one time, by other physician the second time. So, and if it is not mentioned in the note from the other physician, I'll just look for that.
CHAYTOR, Q.C.:
Q. Okay. So there were a few or a couple of patients form Corner Brook that you didn't have a report on so you put in a consult yourself. And was that consult then to Mount Sinai to have the retest done?
DR. SIDDIQUI:
A. Not to the Mount Sinai. Most of the time, as I said, they would have been done; the nurses would not have, they'll find it, things like that.
CHAYTOR, Q.C.:
Q. Doctor, have you ever attended any meetings to discuss the ER/PR issue?
DR. SIDDIQUI:

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A. In Eastern Health?
CHAYTOR, Q.C.:
Q. Yes.
DR. SIDDIQUI:
A. Around any time?
CHAYTOR, Q.C.:
Q. Yes.
DR. SIDDIQUI:
A. Not really to discuss the issue. Since the Inquiry started, I think we have met a few times, but this was just to talk about -
CHAYTOR, Q.C.:
Q. Your attendance here?
DR. SIDDIQUI:
A. Right.
CHAYTOR, Q.C.:
Q. Yes, okay. No, I was thinking more along the way--along the lines of meeting to discuss the management, the retesting itself, how to communicate with patients, those issues?
DR. SIDDIQUI:
A. None that I remember.
CHAYTOR, Q.C.:
Q. Okay. And who did you understand then was handling or managing the issue on behalf of

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oncologists?
DR. SIDDIQUI:
A. Dr. Laing and Dr. McCarthy, they were very active, they were putting a lot of hours in that. And I think Dr. Zulfiqar was the other one who had spent some time on the physician review panel. So these were the three main.
CHAYTOR, Q.C.:
Q. Okay. And was there any mechanism in place for them, Dr. Laing or Dr. McCarthy to keep you apprised as to developments or anything that you would need to know in the treatment and management of your patients?
DR. SIDDIQUI:
A. My understanding would be the physician review panel letter.
CHAYTOR, Q.C.:
Q. Okay. So that was the communication you received was the letter?
DR. SIDDIQUI:
A. That would come.
CHAYTOR, Q.C.:
Q. Okay. Were there other, though, informal discussions happening within the department?
DR. SIDDIQUI:

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A. There were probably a couple of times. I think they had to meet over the weekend and in off hours, I think, about that.
CHAYTOR, Q.C.:
Q. Okay. Were you ever asked along the way your input into whether or not the patients should be informed beforehand that the retesting was taking place?
DR. SIDDIQUI:
A. No.
CHAYTOR, Q.C.:
Q. And if you had been, if you had been consulted on that issue, and maybe that's a difficult question for you now to ask in hindsight, but what would your inclination have been at the time, if you could put yourself back into 2005?
DR. SIDDIQUI:
A. I would have think that if that could be done very quickly, and I don't know the legality about a second consent, does the patient really need to give a consent for the same specimen to be looked at a second time or not, but thinking if not and if they can get it done very quickly, that would mean within

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weeks, then probably get it done. But if it's going to take that long and it has to be done in batches, then probably informing patients may be a reasonable idea.

CHAYTOR, Q.C.:

Q. I'm sorry?

DR. SIDDIQUI:

A. Then probably informing patients, if it's going to take that long, then informing patients that your test has gone and it would come back may be a reasonable idea. It would still keep a lot of people on the edges because I think most of them, majority of them would still come out the way that they were, but there would be a few changes. But it would keep a lot of people on the edges, though.

CHAYTOR, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. If everybody is informed.

CHAYTOR, Q.C.:

Q. Yes. And so, Doctor, you weren't consulted at the time. Do you recall any discussion at all around that issue back in the summer of 2005?

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DR. SIDDIQUI:

A. No, I don't remember any.

CHAYTOR, Q.C.:

Q. Okay. And in the fall of 2005 then external reviews took place of the laboratory medicine program or aspects of it. Were you aware that that process was taking place at the time?

DR. SIDDIQUI:

A. Not at that time. I had heard about those afterwards.

CHAYTOR, Q.C.:

Q. And do you know when -

DR. SIDDIQUI:

A. Exactly when, I don't know, but I heard about somebody, I think, coming from BC, if I'm not mistaken, and somebody from Ontario.

CHAYTOR, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. This was my understanding that two people came in. I don't know exactly what they were. I thought one of them was a chief technician of one of the places and the other one, I don't know. But I had just heard about them.

CHAYTOR, Q.C.:

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Q. Okay. And had you heard about that prior to-- the test we know was reinstituted at Eastern Health in February, 2007. Had you heard about the reviews prior to February of 2007?

DR. SIDDIQUI:

A. I'm not sure.

CHAYTOR, Q.C.:

Q. Okay. Were you ever told the results of the reviews?

DR. SIDDIQUI:

A. No.

CHAYTOR, Q.C.:

Q. And to this day do you know, have you seen the reports?

DR. SIDDIQUI:

A. I haven't seen the reports myself, not that I remember. And again, I can't really comment what exactly those were because nobody has told me officially what the results of the reviews were.

CHAYTOR, Q.C.:

Q. And have you asked anybody?

DR. SIDDIQUI:

A. I haven't asked anybody officially for that.

CHAYTOR, Q.C.:

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Q. You were aware that there was a physician review panel formed. Who informed you that there would be such a panel and what did you understand would be the purpose of the panel?

DR. SIDDIQUI:

A. I don't remember if anybody informed me before it was formed. In terms of the function of the panel, my understanding was that a panel would review the chart and they would have the ability to look at the reports, the repeat ones from Mount Sinai as well as the old ones and they would go through the chart and they would go through other parameters which I said earlier about ER/PR, not just the percentage positivity, and they would make any recommendations.

CHAYTOR, Q.C.:

Q. And what benefit to you as a treating oncologist would this panel have, what benefit would it be for you? Did you see it as being something beneficial?

DR. SIDDIQUI:

A. I think the biggest benefit would be that they identified the patient and they have looked at the chart. And the second would be that these

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three are our main breast physicians and they have gone through the charts, they have put their heads together and they have come up with a recommendation.

CHAYTOR, Q.C.:

Q. So who did you understand was to be on the panel in terms of oncologists?

DR. SIDDIQUI:

A. Dr. Laing, Dr. McCarthy and I think Dr. Zulfiqar. I'm not sure exactly how many attended, but these were three. Dr. Ahmad might have attended it once or twice, but these are the main. From radiation side, I'm not sure if Dr. Ganguly was probably initially part of it, he left, I'm not sure about that. But these were the four from our side.

CHAYTOR, Q.C.:

Q. And so was it your understanding that they would--there'd be a number of them at any given time that would consult and review the chart of each patient?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. And were you aware that on occasions

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there was only one oncologist present on the panel?

DR. SIDDIQUI:

A. No.

CHAYTOR, Q.C.:

Q. Okay. And in that situation were you aware there were pathologist on the panel?

DR. SIDDIQUI:

A. Yeah. Sorry, I forgot to say that initially.

CHAYTOR, Q.C.:

Q. And were you aware, as well, there were surgeons on the panel?

DR. SIDDIQUI:

A. I'm not sure about that. Pathologists, I think I was--I knew that Dr. Carter was on the panel. Surgeon part I'm not sure.

CHAYTOR, Q.C.:

Q. Okay. And you say you don't know if you knew about the panel before it actually got up and running. So I take it you weren't consulted as to whether or not you wanted your patients put through this process?

DR. SIDDIQUI:

A. No.

CHAYTOR, Q.C.:

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Q. Okay. Were you ever invited as the treating physician to come and sit in when your patients were being panelled, were you ever invited to come to those meetings?

DR. SIDDIQUI:

A. None that I can remember.

CHAYTOR, Q.C.:

Q. Did anyone ever come and ask you any questions about your patients, anyone from the panel ask for more information then they could glean from the chart?

DR. SIDDIQUI:

A. I'm just trying to think. None that I can remember.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. There was one case, I think, that on that case I had gotten the pathology report pretty quickly on that one and I think I had started that patient on treatment already and when I got the panel letter and the panel letter had no recommendations. So I think that's the one that comes to mind, that I had spoken with them and I had asked them about that and they

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had clarified that to me that they had looked at my note and they were aware that treatment is started, so that is why they had said that no recommendations or no change.

CHAYTOR, Q.C.:

Q. Okay. So when did that happen?

DR. SIDDIQUI:

A. I don't know the exact timing of that, sorry.

CHAYTOR, Q.C.:

Q. So you had, in fact, seen the patient, changed the treatment?

DR. SIDDIQUI:

A. That was, I think, the patient was in Labrador, I think. So I had spoken with the patient's physician and the patient.

CHAYTOR, Q.C.:

Q. Okay. So you had actually had--but you consulted with your patient?

DR. SIDDIQUI:

A. That's right.

CHAYTOR, Q.C.:

Q. And had acted upon the change in results and changed the treatment yourself?

DR. SIDDIQUI:

A. That's right.

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CHAYTOR, Q.C.:
Q. And then later you got a letter from the panel, physician review panel, saying no treatment change recommended?
DR. SIDDIQUI:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And I take it that then caused you concern because you had already changed the treatment?
DR. SIDDIQUI:
A. Right.
CHAYTOR, Q.C.:
Q. Okay. And who did you make any inquiry of about that case?
DR. SIDDIQUI:
A. I think Dr. Laing and she had explained the whole thing to me.
CHAYTOR, Q.C.:
Q. And so she explained that, in fact, the letter is saying no treatment change recommended because you had already made the change?
DR. SIDDIQUI:
A. That's right.
CHAYTOR, Q.C.:
Q. Okay. As opposed to the letter didn't say

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that this patient has already been treatment change as a result of the retest on such and such a date?
DR. SIDDIQUI:
A. I think it didn't not say that.
CHAYTOR, Q.C.:
Q. And if it had said that -
DR. SIDDIQUI:
A. Again, I'd have to look at for the exact words.
CHAYTOR, Q.C.:
Q. Yes.
DR. SIDDIQUI:
A. But this is the kind of events that come to mind, that that's how it happened. What exactly were the words in there, I'll have to look at the chart for those.
CHAYTOR, Q.C.:
Q. Yes. But I think it said words to the effect that no treatment was recommended or required and that caused you some concern because you had already changed the treatment?
DR. SIDDIQUI:
A. That's right.
CHAYTOR, Q.C.:

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Q. Okay. And, Doctor, in that particular case I take it you felt comfortable initiating the change for your patient without it having to go through any panelling process?
DR. SIDDIQUI:
A. That's right.
CHAYTOR, Q.C.:
Q. And if in the cases where I've indicated to you, and there are certainly four that I'm aware of, we don't have minutes for all of the meetings, but there are certainly four panel sessions where there was only one oncologist at those meetings, do you see any benefit in having the patient going through a panelling process in that situation as opposed to the results coming directly to you and you as the treating physician deciding what should happen and if you need any further input, you could consult one of your colleagues?
DR. SIDDIQUI:
A. I think during that situation there was some benefit because these are the three breast specialists from our centre and they have looked at the patient's chart and then the appropriate medical oncologist will look at

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the chart, as well. So if two people are thinking the same way, that's better than one.
CHAYTOR, Q.C.:
Q. So rather than you having--you looking at your patient's chart and making a determination and if you need assistance to pop into the office next door to Dr. McCarthy or go speak to Dr. Laing, you still see some benefit in having it go through a panelling process with an oncologist and pathologist?
DR. SIDDIQUI:
A. I think there is benefit to that. And the most important part of benefit from the panel, as I said earlier, was that they had a whole list of the patients and identification of those patients and going through all their changes and results, I think there was still benefit.
CHAYTOR, Q.C.:
Q. Okay. So them seeing a whole list of patients as opposed to you seeing just--being provided the names of your patients, you think there's benefit for them to see a number of the patients?
DR. SIDDIQUI:

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A. I think both things were done. We were seeing our own patients, as well, and they were going through the panel, as well. So I see benefit in that panel and they were looking at that.

CHAYTOR, Q.C.:

Q. And were there other occasions in which you initiated the change to your patient's treatment prior to the patient going through the panelling process?

DR. SIDDIQUI:

A. I'm trying to remember. There's none that comes to mind, other than the one that I've already told you about. But could there be any, I'm not sure, but I can't think of any right now.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. That I started treatment before panelling.

CHAYTOR, Q.C.:

Q. Okay, and were there ever any occasions when you disagreed with the recommendation of the panel?

DR. SIDDIQUI:

A. No.

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CHAYTOR, Q.C.:

Q. Were there ever any occasions when you asked further questions about, other than the one you've told us about, were there ever any occasions when you had to inquire of the panel to get further information?

DR. SIDDIQUI:

A. Not that I remember, no.

CHAYTOR, Q.C.:

Q. Okay. And do you think it would have been of some benefit for you to sit in on the sessions in which your patients were being panelled?

DR. SIDDIQUI:

A. I'm just not sure that logistically how that would have been done because just looking at the list and this list was actually shown to me by my lawyer, as well, three days ago when the list was given, so that would probably include patients from all the physicians. And that would be extremely difficult for everybody, all six or seven of us to sit there.

CHAYTOR, Q.C.:

Q. Yes, well, I guess it could be coordinated, though, that it could be two physicians one

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night and two another night and--or you'd come for part of the meeting that involved your patients, but -

DR. SIDDIQUI:

A. There could be some -

CHAYTOR, Q.C.:

Q. - I'm just wondering if logistics aside, whether or not you think that would be beneficial for you to have input and the panel to have your input while your patients are being panelled?

DR. SIDDIQUI:

A. Theoretically it could have been better, yeah.

CHAYTOR, Q.C.:

Q. Okay. And so after--the results of the retesting, how were the results, the actual results of the retesting communicated to you?

DR. SIDDIQUI:

A. The results would, most of them would come in our mailbox.

CHAYTOR, Q.C.:

Q. In your mailbox, so the addendum that we spoke about earlier would arrive in your mailbox?

DR. SIDDIQUI:

A. That's correct.

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CHAYTOR, Q.C.:

Q. A hard copy of it, okay. And what would you do when you received that?

DR. SIDDIQUI:

A. Most of the time when I received those, if there is a change in treatment, on the basis of that, just on the results, many of the times we did get panelling letters, sometimes, most of the times I would say before we got the results. But sometimes if we got the results first, if I would think a treatment change, I would try to contact the patient. If there is no treatment change, most of the times I tried to dictate a letter that I received the result that day and I dictate a letter.

CHAYTOR, Q.C.:

Q. Okay. And who would you send the letter to?

DR. SIDDIQUI:

A. The letter would be for the record and the letter usually goes to the same individuals on the letter as previously going to. It's usually the family physicians and the surgeon. And when I say letter, it basically means a note, it's more like a progress note kind of

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thing. And this is a document in the chart in terms of sequence of events that we receive the report and it's dictated.

CHAYTOR, Q.C.:

Q. So these are the patients who would not have had any change?

DR. SIDDIQUI:

A. If there is no change -

CHAYTOR, Q.C.:

Q. If there's no change?

DR. SIDDIQUI:

A. If there is no change that would affect their treatment.

CHAYTOR, Q.C.:

Q. Do you dictate a letter and send that letter to the family physician in that case?

DR. SIDDIQUI:

A. Most of the letters that do go--it's a progress note. When I say letter, it's basically a progress note. It is in the format of a progress note.

CHAYTOR, Q.C.:

Q. And that stays on the chart?

DR. SIDDIQUI:

A. That stays on the chart, but the copy usually

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goes to the physicians that the other copies have been already going to.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. It's usually the family physicians and the surgeon.

CHAYTOR, Q.C.:

Q. Okay. So that was your practice, to dictate a note onto the chart -

DR. SIDDIQUI:

A. I try to do that most of the time; that was my intention. I don't use the word "always" because I cannot be 100 percent.

CHAYTOR, Q.C.:

Q. Okay. So there may have been people who had no change in treatment that for whatever reason, you didn't get around to it or it didn't come to your attention, that there wasn't such a note sent to the family physician, that may have happened occasionally?

DR. SIDDIQUI:

A. I'm sorry, I didn't get that.

CHAYTOR, Q.C.:

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Q. In terms of your practice of dictating a progress note to the chart and having the copy then sent to the family physician, for those patients who had no change recommended there may have been occasions when the progress note didn't get done or the progress note didn't get sent to the family physician?

DR. SIDDIQUI:

A. I would think that if it is done, it usually should go to the family physician.

CHAYTOR, Q.C.:

Q. And was -

DR. SIDDIQUI:

A. Because that is something that I don't follow-up if I do a progress note and it says cc'ed and the names are there, medical record follows up on that.

CHAYTOR, Q.C.:

Q. And if you didn't--there may have been times when you didn't get the progress note done?

DR. SIDDIQUI:

A. It's possible.

CHAYTOR, Q.C.:

Q. And that's why you didn't want to use the word "always"?

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DR. SIDDIQUI:

A. That's right, that's possible.

CHAYTOR, Q.C.:

Q. Okay. That's the only--that's what I was trying to clarify. So when you received the addendum to the pathology report in your mailbox, if that arrived prior to getting any letter from the panel, would you hold the pathology report, hold the results and wait for the panel letter? I know in one case, in Labrador, you told us, you went ahead and initiated change of treatment. But normally what was your practice, would you hold the results and wait for a panel letter, what would you do?

DR. SIDDIQUI:

A. If there was no change in the repeat pathology report and the treatment decision was based on an unchanged report, I'm not going to hold that report. I'll try to dictate a note on that and that report would be signed and filed.

CHAYTOR, Q.C.:

Q. Okay. And for those in which you read the results and you think this is a change and a

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change that may involve treatment change, what would you do in those cases?

DR. SIDDIQUI:

A. If I got the pathology report first, then I'll--if I think a simple straightforward, I'll go ahead and change the treatment. If there is something else involved, more discussions, I'll probably wait for the tumour board panelling, as well. That would be theoretically I would do.

CHAYTOR, Q.C.:

Q. Okay. And were you told then in terms of did anyone tell you here's now we're going to handle the results and we want to handle this together in a uniform manner and here's how we're going to handle things, was there any communication given to you as to what you should do in those circumstances so that everyone is on the same page?

DR. SIDDIQUI:

A. Again, what I remember from the informal discussion was that what most of us were doing, if there is a change in treatment based on tumour panelling or on pathology reports, we'll actively pursue for the patient, look

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for the patient. If there is no change in the pathology report or in treatment, most of the time we'll make sure that there's a follow-up appointment made. We look in our electronic system which tells us about the appointments and if it is made, talk to the patient on that follow-up visit.

CHAYTOR, Q.C.:

Q. Okay, so you would wait until the person's next regularly scheduled appointment to come in?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. And then you would discuss the change in treatment then with the patient?

DR. SIDDIQUI:

A. No. If there is change in treatment, we'll actively look for the patient. But if the pathology report did not really change or the panel, the review panel did not recommend any change in treatment, we'll talk to the patient when they come in on the next scheduled appointment.

CHAYTOR, Q.C.:

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Q. So not only is the progress note on the file, you're also then going to speak to the patient about it when he or she comes through the door the next time? And if there's -

DR. SIDDIQUI:

A. If there is no change.

CHAYTOR, Q.C.:

Q. If there's no change, right. And if there's a change in treatment, you're going to initiate contact earlier than that. So tell us about those patients, how were they contacted, did you contact them personally yourself, how did that happen?

DR. SIDDIQUI:

A. I've conducted them personally myself, as well, a few patients. And many of them I would say that by the time we will get the report, they would already have an appointment made.

CHAYTOR, Q.C.:

Q. Okay, so I just want to be clear on that then. So some of the patients you contacted before you actually had their results back?

DR. SIDDIQUI:

A. Let me think specifically about a couple of

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patients that are coming to mind, how I did that. On first patient that comes to mind I did get the tumour panel--sorry, review panel report and I called the patient myself. Second patient that comes to my mind, the report had gone to the family physician because the patient was discharged from our clinic and the report was sent to our peripheral clinic in Corner Brook and was probably brought into my office in St. John's. And then I had requested for that patient to be booked to see me.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. So these are two instances that come to mind.

CHAYTOR, Q.C.:

Q. Where you personally made contact?

DR. SIDDIQUI:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay, and so in terms of the practice, then, for the other patients who are requiring a change in their treatment what was the normal practice for them, who would make contact?

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DR. SIDDIQUI:
A. Yes, one more thing, sorry, that I can add. I also remember another patient in whom there was some change. I called her myself, spoke with her, and offered her to come in. She's an elderly lady. And she did not want to come in. I spoke with her on phone and the whole thing was explained and what that meant and she did not want to come. And so that's a third one that comes to my mind.
CHAYTOR, Q.C.:
Q. Okay. And so when you would phone -
DR. SIDDIQUI:
A. I dictated a note on the same day that I spoke with her.
CHAYTOR, Q.C.:
Q. I'm sorry, and you did a note then?
DR. SIDDIQUI:
A. I did a note that day, yes.
CHAYTOR, Q.C.:
Q. And those who--and that note then would--a copy of that again would go to her family physician?
DR. SIDDIQUI:
A. Family physician.

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CHAYTOR, Q.C.:
Q. And in terms of phoning yourself, would you tell them on the phone that there's been a change or would you invite them to come in, that there's--you know, just tell them there's an issue you need to speak to them about and invite them to come in and talk to them face to face about it?
DR. SIDDIQUI:
A. I always invite them to come in, and these are the patients if they want to talk to me on the phone and they feel comfortable. If they ask me some questions on the phone and if I have an answer to it, I'll answer it to them.
CHAYTOR, Q.C.:
Q. Okay.
DR. SIDDIQUI:
A. But I always offer them to come in.
CHAYTOR, Q.C.:
Q. So your intent wasn't to tell them about the change necessarily on the phone, but if they asked you questions about that, then you provided the answers?
DR. SIDDIQUI:
A. My intent would be to get their attention as soon as possible.
CHAYTOR, Q.C.:
Q. Yes, and to get them to come in so you could communicate the information face to face with them?
DR. SIDDIQUI:
A. That's right, and if I have to leave a message somewhere for that basically to get their attention, I'll do that.
CHAYTOR, Q.C.:
Q. Okay, and I think we heard from Elizabeth White in that regard as to how she heard from you and there was a message left for her on her answering machine.
DR. SIDDIQUI:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And that's how she heard about that. Had she been your patient, Mrs. White, had you ever treated her before?
DR. SIDDIQUI:
A. Can I go back a little bit and talk about her?
CHAYTOR, Q.C.:
Q. Sure.
DR. SIDDIQUI:

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A. Mrs. White was diagnosed and seen, I think, in 1999, and she was seen by Dr. Alidina at that time, and she was also seen by radiation oncologist. She was not considered a candidate for hormonal treatment at that time. When Dr. Alidina left, which was in, I think, April of 2001, then I inherited many patients from him as well as from Dr. Gupta, who was another oncologist who had left before I came in. So she was one of those patients. I saw her in June of 2001, and I think I saw her one more time in 2001. After that, she was seen by Dr. Farrell and she was discharged back to her family physician. So she was not a patient of cancer clinic from the end of 2001 onwards. She was being followed by the family physician. She was--her pathology was reviewed, I believe, in 2007, because there was a letter generated by the physician review panel on December 12, 2007, and that came to me on December 14th. That's the date which is stamped on that, 2007, which was a Friday. Then I called her myself on the 17th, which is the following working day, and I called her home first, and again my intention would be to

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get the quickest possible way to get her attention. This is December 17th. Christmas is coming and New Year is coming and everything would be slowed down, so phone to me is the quickest way to get her attention. I left a message to the best of my judgment. I can't remember exactly what I said on that, but I left a message for her. I called her next of kin on the same day and I spoke with her sister-in-law. She was extremely helpful. She told me she is doing well, she is in New Brunswick, that's where she was on vacation. So I had told her that we need to speak with her as soon as she comes in. So this is what happened, and I think Mrs. White, her sister-in-law, she spoke with her husband and made her aware that we need to talk about some change, and she looked at her voice mail. We got what we wanted, we got her attention. I think she had called us as well before she came in, and then I saw her in January of 2008.

CHAYTOR, Q.C.:

Q. And the voice mail message then that you left with her wasn't just "please give us a call,

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it's important we talk to you, but don't be alarmed or over concerned", you actually told on the answering machine the change in her results, the results of her retest?

DR. SIDDIQUI:

A. My goal again would be to get her attention as quick as possible. Did I give any exact numbers? I'm not sure about that. I might have said we need to talk to you about some change possibly in your treatment. I cannot remember the exact words. She, herself, can tell what exactly was on that.

CHAYTOR, Q.C.:

Q. And in terms of her sister-in-law, did you also tell her sister-in-law the results, that she had had a change in her hormone receptor testing?

DR. SIDDIQUI:

A. I don't think I would do that. I don't think I would do that. I might have told her that there is some change that we need to talk about. Since pretty much everybody is aware of the changes, I don't think that I told her the numbers or things like that.

CHAYTOR, Q.C.:

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Q. Okay, and the idea, though, of leaving a phone message such as happened in her case, did that happen with other patients as well if you weren't able to contact them or your staff were trying to contact them? Were there messages left?

DR. SIDDIQUI:

A. The other two or three patients that I mentioned, I was able to talk to them on the phone. The other one that I mentioned in Labrador, I was able to talk to on the phone when I called her myself. There may be a few other patients that I also called in between. I dictated notes on the day that I called them that I was able to talk on the phone.

CHAYTOR, Q.C.:

Q. And your staff were also involved, I take it, in contacting patients to set up appointments to come in?

DR. SIDDIQUI:

A. Medical Records would do that, yes.

CHAYTOR, Q.C.:

Q. Medical Records would do that, okay, and whether or not there was any instruction given to them as to how to approach the issue, are

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you able to speak to that?

DR. SIDDIQUI:

A. There is a way of writing orders. When I'm writing an order for a patient to be booked, if I write "must" with it, this is the understanding that that's the way that we have been doing it, "This patient has to be booked on a particular day and cannot be moved". If they have to make any change in that at all, they have to bring the chart to that physician and tell them if they cannot get hold of the patient or if the patient cannot be booked for that day. So "must" means that that patient has to be booked for the day that the patient is specified for.

CHAYTOR, Q.C.:

Q. And how quickly after receiving the changes, or you becoming notified of the change in results, how quickly would patients be booked to come in to see you to discuss the issue?

DR. SIDDIQUI:

A. As I said, quite a few patients were already booked because I think their family physicians were getting copies or somebody else--like, surgeons might have been getting copies. So

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they were already booked by the time we got the physician panel review letters. If they were not--usually they were booked in quite quickly. There were very few instances. Again, there is just one that comes to my mind right now which did not happen that way.

CHAYTOR, Q.C.:

Q. In terms of what--how you would handle the situation, I take it, as the treating oncologist, it was left to your discretion as to how to communicate with your patients?

DR. SIDDIQUI:

A. You mean in terms of follow ups and to tell them what happened?

CHAYTOR, Q.C.:

Q. And what to tell them, yes.

DR. SIDDIQUI:

A. I think so.

CHAYTOR, Q.C.:

Q. Were you give any instruction or guidance by anyone as to here's how much you say over the phone, here's how much you say face to face, anything like that, were you given any instructions?

DR. SIDDIQUI:

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A. None that I remember, no.

CHAYTOR, Q.C.:

Q. So that was left to your own personal judgement?

DR. SIDDIQUI:

A. That's right.

CHAYTOR, Q.C.:

Q. And in terms of when they came before you then in your office or over the phone and had more questions for you, such as I'm sure, Doctor, you would have heard, "Well, why did this happen" or "how did this happen", were you given any guidance or assistance as to how you could answer that question?

DR. SIDDIQUI:

A. Everybody had a lot of questions. I had patients booked for 20 minutes that took an hour, hour and a half. There were times that I saw patients two or three times just for discussion of that. In terms of instruction what to tell them, I don't think that we had any.

CHAYTOR, Q.C.:

Q. So nobody--you weren't told anything as to what you could tell or how you could answer

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the questions. Now you've told us that you didn't--you've never known the results of the external reviews, for example. Were you told anything in terms of how this problem arose, what caused the problem?

DR. SIDDIQUI:

A. Again what I explained to the patient was that there were technical problems in terms of lab. For most of the patients, they would not know much about that. For them, their treating physicians are the face of cancer. There was a patient who told me that when she got that news, she thought that it was only my face that came to her mind. She did not know of a pathologist, radiologist, or anybody else. So they were angry. I'm sorry, I missed the first part of your question.

CHAYTOR, Q.C.:

Q. That's okay, I was just wondering in terms of --you're going to be asked that question and you were asked the question by your own patients, "what happened to cause this", and I'm wondering what you told them and what was the source of your information for that?

DR. SIDDIQUI:

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A. I would tell them that some technical problems with pathology, and I would tell them that for us seeing them depends upon the pathology report, and if the pathologist tell us that they don't have cancer, they won't even see us, they don't need to see us. So just like a radiologist and pathologist, they're very important and our treatment is dependent on the reports that we get. So there was a report initially which I would explain to them. Usually when I go through that, I will start with the first pathology report and then I'll take them, the treatment, if we did any, and what has happened now. So I'll them that first reports were like this, and then they are reviewed and the report are like that if there was a change, and this is the basis of the change that I'm going to suggest.

CHAYTOR, Q.C.:

Q. And what made you think there were technical problems?

DR. SIDDIQUI:

A. That's what I think sort of the general understanding was.

CHAYTOR, Q.C.:

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Q. I'm sorry?
DR. SIDDIQUI:
A. That's what the understanding was, that's what I thought.
CHAYTOR, Q.C.:
Q. Had someone told you that, that it was a technical problem?
DR. SIDDIQUI:
A. Not in that sense, but again I think somehow it sort of built up in my mind.
CHAYTOR, Q.C.:
Q. Were you ever told anything as to what the problems were, what caused the problems?
DR. SIDDIQUI:
A. No, not in an official kind of meeting what exactly that was.
CHAYTOR, Q.C.:
Q. What about in an informal discussion or other than an official meeting?
DR. SIDDIQUI:
A. I would think again the discussion among ourselves and sort of knowing about things afterwards about this immunohistochemistry, so that would have something that may be in the back of the mind.

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CHAYTOR, Q.C.:
Q. Did anyone ever suggest to you that the problem arose due to or that the problem was in any way connected to a change in technology?
DR. SIDDIQUI:
A. No one suggested to that, but again this--I can't really say that anybody suggested that.
CHAYTOR, Q.C.:
Q. What do you mean by technical problems?
DR. SIDDIQUI:
A. The problems that are involved in terms of doing a particular test.
CHAYTOR, Q.C.:
Q. And such as what, what could be a technical problem?
DR. SIDDIQUI:
A. Again what we know about immunohistochemistry part, so that would involve the different steps that are involved in doing a particular test.
CHAYTOR, Q.C.:
Q. And you would have little more knowledge of laboratory medicine than other oncologists in that you also did a hematology part of your

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residence.
DR. SIDDIQUI:
A. But that would be sort of a different kind of knowledge. I did coagulation lab and I did bit of blood banking. I did not do any of the general pathology labs.
CHAYTOR, Q.C.:
Q. So technical in your mind means what? Is it equipment? What does it mean?
DR. SIDDIQUI:
A. Equipment is the first thing, equipment, and the way the equipment is being used and the variables that are attached with it.
CHAYTOR, Q.C.:
Q. Doctor, other than--we've mentioned Ms. White's case and perhaps before we leave Ms. White's case, we'll just look at a document or two from her exhibits. If we could have, please, C-0047. Actually, if we could go back, please, C-0044, first, and this is the tumour board panel or the physician review panel letter, December 12, 2007, written to yourself by Dr. Laing and it's copied to Drs. Randell, Leung, and Peacock. It's written here, "Book for third week of January", I

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think it says. Is that your writing?
DR. SIDDIQUI:
A. That's right, '08.
CHAYTOR, Q.C.:
Q. January '08. So that's your writing?
DR. SIDDIQUI:
A. That is.
CHAYTOR, Q.C.:
Q. Okay, and this is indicating that she's had a change, the tumour is now 90 percent ER and 10 percent whereas originally it was 20 to 30 and 10 percent. So when you received this letter, the first thing you did was try to reach Mrs. White, is that right?
DR. SIDDIQUI:
A. That is correct. It came to me on the 14th and I called her on the 17th, if I'm not mistaken.
CHAYTOR, Q.C.:
Q. And when you couldn't reach her, you left a message at her home and then you contacted her sister-in-law to get the message to her?
DR. SIDDIQUI:
A. That's correct.
CHAYTOR, Q.C.:

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Q. And then if we could go then, please, to 47, C-0047, and this is February 14th, 2008, and she's already been in to see you at this point in time. She was last seen on January 17th, and she was offered that, and so I take it she did, in fact, come in on January 17th, the middle of January, and you saw her then?

DR. SIDDIQUI:

A. She did come in January, yes.

CHAYTOR, Q.C.:

Q. Okay. Other than Mrs. White, did you encounter any difficulty contacting any other patients?

DR. SIDDIQUI:

A. There is that other one, I think, that lady who is in Alberta. That was only other one. Other than that, I don't remember any on(sic) top of my head.

CHAYTOR, Q.C.:

Q. And that person was out of the province, had moved out of the province?

DR. SIDDIQUI:

A. Do you want me to talk more about that?

CHAYTOR, Q.C.:

Q. Okay, sure, without identifying, of course,

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the patient, just tell us generally the circumstances.

DR. SIDDIQUI:

A. This lady was seen by us in January of 2002. She received her treatment in Stephenville. She was last seen by medical oncology in February of 2004. She was doing well at that time and she was seen by Dr. Rorke, and according to our guidelines she was discharged from our clinic and she was not a patient of Cancer Clinic or Dr. Rorke or myself any more from February of 2004. She was given guidelines in terms of follow-up that we had developed, and her family physician was also sent guidelines in terms of follow-up from the onward. This was again brought into the picture, and again I think it's April of 2006, and when she was panelled, I think at that time, I stand corrected on that, but it was around that time, and the--yes, and the panel letter was sent to her family physician. I would think that the reason being that she was not our patient any more, and a copy was also sent to myself, but the copy went to Cancer Clinic, Corner Brook, and the copy which is in

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the chart is not signed by me, it just says a chart which is health records. Anyway, this was brought to my attention according to the e-mail which my secretary sent to me and she had tracked the charts. This was brought to me in April of 2006. The initial letter that was sent from the physician review panel to the family physician that has outlined the whole thing, that she should be considered for Tamoxifen, and if not Tamoxifen, then Aromatase inhibitor, and that also suggested that if the family physician would like, we'll be happy to see her on a consult. In the chart, there is no other consult that I could find, so my guess is that if that letter came to me just as it reflects, I would have asked them to book her to us again. Then the chart was tracked back from my office to the Medical Record and that was in April of 2006. I don't know what exactly happened there, but she was not booked with us at that time, and that was again brought to my attention in July of 2007. That was again on a Friday. I called her early the following week. She was in Alberta. I spoke with her. She was aware of the changes

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and she told me that her family physician had spoken with her in spring of last year, which would mean very shortly after the physician letter was sent to her, so she was aware of that according to her. I told her about that in detail, that she was already aware of. I suggested that she should be seen by a medical oncologist to discuss that a bit more if she hasn't, and at the time she told me that she was being worked up for some medical problem. There was some fluid accumulation. I told her that it's even more important that you should be seen by a medical oncologist. I called her family physician on the same day. I spoke with him. I told him about the whole thing, and I told him about the review panel, and then I send a letter both to this patient, as well as her family physician on the same day, and that outlined the things that we had talked about that day. The letter to the family physician was faxed as well as mailed, and that also included the pathology report and the physician review panel recommendations. After that, I think I spoke with her in September as well. We're talking

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about 2007. At that point she told me she was going to wait another month before she comes to Newfoundland. I still suggested to her to see somebody, or in the letter to family physician, I had suggested to them that they can start the treatment on their own if they cannot get a medical oncologist, and I send a letter as well dated, I think, 31st of July, 2007. She finally came back and I saw her in November of 2007 in Corner Brook. She was admitted to the hospital at that time and she had some fluid removed from the lung. I spoke with her about the treatment options. I offered her chemotherapy at that point. She was not much interested in chemo, so we went with hormone treatment, and we decided to go with aromatase inhibitor, Femara. I also booked her for a bone scan and she had some bony disease as well. I started her on a bisphosphonate as well a few days down the road. She was last seen by medical oncologist in Corner Brook in February of 2008, and after that it was on PRN basis because she divides her time between Alberta and Newfoundland. The last letter that I got on her was from a

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medical oncologist from June of 2008 from Alberta. She is still on the same treatment that I had started her on and she is doing well.

CHAYTOR, Q.C.:

Q. Okay, thank you. If we could look at P-2546, and that was a very detailed explanation, so, Doctor, I just wanted to show that there are some of those e-mails here that you were referring to. For example, this is the July 27, 2007, from Joyce McDonald. Is that your assistant?

DR. SIDDIQUI:

A. That's my secretary.

CHAYTOR, Q.C.:

Q. To yourself, and copied to Patsy Kelly, Michelle Gregory, and Sharon Smith. Do you know who Patsy Kelly is?

DR. SIDDIQUI:

A. She's a secretary as well.

CHAYTOR, Q.C.:

Q. And the subject is "possibly missed ER/PR patient. Welcome back, Dr. Siddiqui, hope you had a nice vacation", and then she goes on to say about having a phone call from Dr. Jenkins

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in Corner Brook and he wants you to call him. He wants to discuss the possibility of an overlooked patient in regards to the ER/PR retesting recommendations of Tamoxifen for your patient. I take it this is this patient that you've just told us --

DR. SIDDIQUI:

A. That is correct.

CHAYTOR, Q.C.:

Q. The detail about, and he writes, "Apparently a letter signed by Dr. Laing on March 6th, 2006, with recommendation for Tamoxifen went to the GP in Corner Brook, who in turn sent the letter to you at the peripheral clinic in Corner Brook on March 22nd, 2006. Then somebody in peripheral clinic faxed the letter in to you here at the Cancer Centre on March 29th, 2006. Her chart was tracked down to your office on April 26, 2006". Let me just stop there for a second. Doctor, why would it take, do you know, and maybe this is not a fair question for you, but why would it take a month for her chart to be tracked down? Is that because it's a peripheral clinic chart?

DR. SIDDIQUI:

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A. No, it should not make a difference. I cannot comment on that. When they would have the letters, the secretary should bring the chart.

CHAYTOR, Q.C.:

Q. So that seems like--in your experience, that would be an inordinately long period of time to have--tracking her chart down. That would indicate there must have been a problem locating her chart or something?

DR. SIDDIQUI:

A. It's possible. Sometimes the chart goes to Corner Brook as well, and they might have tried on one day, can't find on one day, another day, I can't--I don't know.

CHAYTOR, Q.C.:

Q. So you don't know the circumstances of why?

DR. SIDDIQUI:

A. No.

CHAYTOR, Q.C.:

Q. But that is longer than what it would normally take, I take it?

DR. SIDDIQUI:

A. I would think so, a little bit.

CHAYTOR, Q.C.:

Q. You, in turn, wrote an order on that date to

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have the patient seen in peripheral clinic, but although the chart was tracked down to the peripheral clinic coordinator on April 27th, the order was never signed off as being completed and the chart was filed back then in Health Records. I take it, when it was brought to your attention on April 26th, 2006, and you signed the order, for some reason the order was never signed off on and the chart was filed back?

DR. SIDDIQUI:

A. It was tracked from my office to the peripheral clinic coordinator. That is the way that clinics are booked, that I write an order, and as I said earlier, I put "must" on that, this patient must be booked for that following clinic in there, and the chart from my office did go to peripheral clinic coordinator.

CHAYTOR, Q.C.:

Q. Okay, and Dr. Jenkins indicates that the patient travels back and forth between Newfoundland and you've indicated Alberta, and is presently residing, and he does not have a contact number. He does have her GP's contact

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information. It goes on to say, "Neither yourself, Dr. Laing, or Sharon Smith was available. The secretaries in administration recommended I call Nancy Parsons to see if it was okay or leave it until you returned on Monday, but unfortunately, Nancy Parsons is not available on Friday, so they put me in contact with Heather Predham who wanted this looked after right away. So she requested I give it to the covering physician", which she did. "I gave the chart to Dr. Rorke, and he tried calling Heather Predham, but could not reach her, so he left the chart with me with instructions to pass it on to you first thing Monday morning when you returned with the contact information for the GP". So I take it then your response to this was that you, in fact, did contact the GP and you've told us that you learned the patient was aware of the circumstances?

DR. SIDDIQUI:

A. Right, and that is, I think, the main point here because when they wrote this e-mail, they were not aware that the patient was discharged, so the patient was not under our

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care. The patient was discharged back to family physician and according to patient, family physician had discussed with her about that.

CHAYTOR, Q.C.:

Q. And the --

DR. SIDDIQUI:

A. So she was made aware. She was offered Tamoxifen, tat's what she told me, but I'm just trying to remember - she had some peculiar history and she did not want that.

CHAYTOR, Q.C.:

Q. And if we could look also then, please, at P-2548, and this is an e-mail then from Sharon Smith to Heather Predham and Pat Pilgrim, and this appears to be about the same case, and it's written August 7th, 2007, "Just to update you on this situation, Dr. Siddiqui contacted this individual and she had been informed of her ER/PR status and treatment options were discussed with her. She was unable to take Tamoxifen because of pre-existing medical condition. Dr. Siddiqui has dictated a note in her medical chart". So, Doctor, in terms of receiving a panel letter, was her panel letter

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addressed to you?

DR. SIDDIQUI:

A. No.

CHAYTOR, Q.C.:

Q. You weren't --

DR. SIDDIQUI:

A. It was addressed to her family physician.

CHAYTOR, Q.C.:

Q. And copied to you.

DR. SIDDIQUI:

A. It was cc'd to me.

CHAYTOR, Q.C.:

Q. Yes, okay, and when you would receive a letter in that respect, you're not the person who is the primary recipient of the letter, you're just cc'd on the letter, do you do anything to check to make sure that the general practitioner or the person to whom the letter is addressed had, in fact, looked after the contact or would you see that as being the responsibility of the person to whom the letter was addressed?

DR. SIDDIQUI:

A. I think that person to whom the letter is addressed is the one who's actively taking

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care of the patient.
CHAYTOR, Q.C.:
Q. And in cases where the letter was addressed to you, you saw yourself as being the person primarily responsible and you initiated the contact with the patient?
DR. SIDDIQUI:
A. I would think so.
CHAYTOR, Q.C.:
Q. Yes. Did you ever check the system to see-- for example, if it's a patient that you haven't seen in a while, or a patient that's also being seen by a radiation oncologist at the same time, would you check the system to see whether or not they are scheduled for a meeting within a few days or within a short period of time with another physician? Did you ever have occasion to do that?
DR. SIDDIQUI:
A. There are some patients that alternate between medical and radiation oncologist. After active treatment is over, then they are in a follow up surveillance mode. So we have quite a few patients that alternate between medical and radiation oncologists. If a letter is

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there with no change and it is copied to the radiation oncologist as well, and the patient in near future is booked to see them and there is no change, they could probably discuss at that time.
CHAYTOR, Q.C.:
Q. Okay. So that's only for the patients where there is no change, and I take it the patients who will require a change, that's something for the medical oncologist to discuss with the patient?
DR. SIDDIQUI:
A. I would think so.
CHAYTOR, Q.C.:
Q. So in those cases, if it involved a change in treatment --
DR. SIDDIQUI:
A. If they're made aware of that.
CHAYTOR, Q.C.:
Q. I'm sorry?
DR. SIDDIQUI:
A. If they're made aware of the change.
CHAYTOR, Q.C.:
Q. So in the cases where it involved a change then in the patient's treatment, you wouldn't

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check to see if they're going to come see a radiation oncologist next week, you would, yourself, initiate the contact with the patient and deal with it in your own meeting with the patient?
DR. SIDDIQUI:
A. If there is a change.
CHAYTOR, Q.C.:
Q. Yes.
DR. SIDDIQUI:
A. Our radiation oncologists, again in peripheral clinics as well, they have seen patients, I think, even with change as well, and peripheral clinics, sometimes the next person coming in would be a month or sometimes it takes even longer. Like, we don't go there in December. So if that is that long, the could talk about that as well.
CHAYTOR, Q.C.:
Q. And for the patients in the peripheral clinics, was there any--did they have to wait then for the next regularly scheduled time that someone would be there, or was there any attempt made to inform them before that to get in touch with them and deal with it perhaps

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over the phone or make an unscheduled appointment to see if they could come to St. John's?
DR. SIDDIQUI:
A. I remember one patient who wanted to come to St. John's and she came to St. John's to talk to me. Other than that, nothing else comes to my mind. There was that one patient who came to St. John's from west coast.
CHAYTOR, Q.C.:
Q. Were they offered that, were the patients outside of St. John's offered an opportunity if they wanted to be seen quicker, to travel to St. John's to have an earlier appointment?
DR. SIDDIQUI:
A. I think basically we would write a letter-- sorry, an order to book them for a particular month's clinic. Again I'm thinking once they are told about that, if it is too far and they want to be seen earlier, they could definitely talk to the nurses in peripheral clinic or call back to us and to the Medical Records here. This is that one patient that comes to mind who wanted to come to St. John's and she did.

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CHAYTOR, Q.C.:
Q. And for patients who--I would take it your peripheral clinic is booked well in advance, you're going to be travelling there, and for patients who weren't to be seen on that particular month, would they then have to wait --how would they be scheduled in? Did the peripheral clinics get extended by a few days to accommodate these people, what happened?
DR. SIDDIQUI:
A. In the peripheral clinics what happens is they are booked, but the booking can change, and change in that way that if there is somebody who requires a treatment change, and that happens all the time, not just the ER/PR changes, if somebody had a CAT scan that has shown disease progression, those patients would be accommodated. On paper, those clinics start at about 8 or 8:30 and go to 4:30, but most of the times we don't take lunches and most of the times you are there by 6 or even 7 o'clock. So there are quite a few patients who are initially not booked, but since the time of booking to the time that you actually get there, something will identify,

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so they are booked in. My part would be that if there's a patient which is identified in that time should be booked in that peripheral clinic as an extra patient.
CHAYTOR, Q.C.:
Q. So if you received a letter regarding a patient who you had seen in the peripheral clinic and it wasn't your turn to go the next month, did you then communicate with the medical oncologists who were travelling to that area and ask them to see your patients?
DR. SIDDIQUI:
A. It has happened several times. I have seen patients, I think, who were initially not seen by myself.
CHAYTOR, Q.C.:
Q. And was there some organized effort, do you know, to make sure that those patients got on the list of patients to be seen in peripheral clinic next month regardless if it was the treating oncologist or not?
DR. SIDDIQUI:
A. I think that was the general thought that if there's a change like that, those patients would be booked to the next peripheral clinic

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if they want to be seen there.
CHAYTOR, Q.C.:
Q. Was there anything that came to you in the form of a memo or formal communication to say that that, in fact, would be the practise in how the patients outside of St. John's would be dealt with?
DR. SIDDIQUI:
A. Not in a written memo.
CHAYTOR, Q.C.:
Q. But that was your practice that you adopted if you've got a --
DR. SIDDIQUI:
A. I think most of us were doing it that way.
CHAYTOR, Q.C.:
Q. Okay. If we could have, please, P-2545. Doctor, in this exhibit there's just a number of those tumour board panel letters, and, of course, for example, of the types of issues that would have arisen through the letters, the names of the patients and identifying information has been redacted. In this particular one, November 4th, 2005, written to you, it indicates that the patient was diagnosed with cancer in the left breast in

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2000. "The original report of the estrogen/progesterone receptor showed negative staining for both, and a repeat report from Mount Sinai has shown the tumour to be estrogen and progesterone receptor positive at 40 percent and 10 percent respectively. This patient was discussed at the physician review panel on November 3rd, 2005. A review of the patient's chart revealed that she's currently being treated with Tamoxifen for right breast cancer. Tamoxifen is recommended for the left breast cancer as well". My question is, is this common for the receptor status to be different in the cancer in one breast as opposed to the other breast?
DR. SIDDIQUI:
A. There could be two possibilities. One could have a primary breast cancer in each breast and they could have a different set of receptors. That's one possibility. The second one is that breast cancer may start from one breast and may have metastasised to the other one. In that situation, the receptor status would be quite similar, however, there is some chance, and I would

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think there is roughly about 20 percent chance for metastasis to have a different receptor status, more in the form of losing original receptor.

CHAYTOR, Q.C.:

Q. So you'd go from positive to negative?

DR. SIDDIQUI:

A. There's a small chance for that. For the metastasis that could happen, but if it is in two separate breasts, having two separate primaries is quite possible and their ER/PR could be different from each other.

CHAYTOR, Q.C.:

Q. So if it's two different primaries, yes, this is possible?

DR. SIDDIQUI:

A. Right.

CHAYTOR, Q.C.:

Q. But it's a different cancer altogether, so it could have different hormone receptor status?

DR. SIDDIQUI:

A. And you would treat them at the same time. You would treat them with the one which is of the highest stage. You would treat them according to that.

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CHAYTOR, Q.C.:

Q. But if it was metastasis from the original cancer, it would be extremely unusual, if not unheard of for it to have gone from being negative hormone receptor status to positive?

DR. SIDDIQUI:

A. It would be very uncommon, but can it happen, I can't really say that it won't happen, but I would think that it probably would be less, from negative to positive.

CHAYTOR, Q.C.:

Q. And at the time of treating this person and the patient being placed on Tamoxifen for the right breast cancer, at that time did it occur to you to be unusual? Do you know if this was a metastasis or was there a second primary cancer?

DR. SIDDIQUI:

A. I'd have to look at the chart because there are several ways of looking at that. The first one would be the type of the breast cancer. If the two cancers are the same, we can ask the pathologist to look under the microscope and if the two cells look very similar, sometimes they could tell us. If

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they are different and there is some time interval between the time, it's possible it may be just a second primary.

CHAYTOR, Q.C.:

Q. Okay, and what do you interpret this to mean to say that Tamoxifen is recommended for the left breast cancer as well? If she's already on Tamoxifen, would the Tamoxifen be any different than for the --

DR. SIDDIQUI:

A. No, it would be the same. I think it's just the way that it has come up. If somebody is on Tamoxifen for one breast cancer, and if she has another cancer in the other breast which was also receptor positive, you're not going to increase the dose or give it in a different way. It would be the same dose of Tamoxifen done the same way.

CHAYTOR, Q.C.:

Q. And would you extend perhaps the length of the time then for --

DR. SIDDIQUI:

A. No, that would be still five years. Again the total length of Tamoxifen is usually five years. More recently there are some studies

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and we are switching after a certain two or three years with aromatase inhibitor as well. So there are different possibilities afterwards, but if you're just keeping the patient on Tamoxifen, you'll keep them on for five years.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. And this is especially if the two cancers have some overlap in terms of when they were diagnosed.

CHAYTOR, Q.C.:

Q. Okay. Doctor, the next letter then is a person who was diagnosed in 2003, originally ER 0 percent and PR 80 to 90 percent, and then a repeat from Mount Sinai had shown the tumour to be 25 percent ER positive and 2 percent progesterone receptor positive. Is it unusual to have a patient who would show 0 percent staining for estrogen and a very strong positivity for progesterone?

DR. SIDDIQUI:

A. You could have 5 percent of the breast cancers that would show up as negative for estrogen

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and positive for progesterone.

CHAYTOR, Q.C.:

Q. And to be absolutely zero for estrogen. This patient was already on Tamoxifen, so I take it this patient was treated, as we talked about earlier this morning, on the basis of her progesterone --

DR. SIDDIQUI:

A. Progesterone positivity.

CHAYTOR, Q.C.:

Q. Positivity. This letter speaks of a person diagnosed in 2000, and she was originally, or he, 5 percent staining for estrogen and negative for progesterone, and a repeat from Mount Sinai had shown the tumour to be estrogen receptor positive at 10, and progesterone receptor positive at less than 1 percent, and the recommendation of the panel that there be no change in the treatment plan. This decision is based on the fact that the person had been treated with Arimidex and had stopped treatment on her own.

DR. SIDDIQUI:

A. This is a patient I remember a little bit, and as I said earlier, the progesterone positivity

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up to a certain point is helpful in making decisions, but no two patients are alike. In some patients, who are elderly, who don't have any other treatment options, sometimes you treat them even with a lower number. I think this is one of those. This lady had refused chemotherapy, she was in her late 70s, and she had some swelling of the legs at that time which we had also investigated with dopplers, but she did not want to take Tamoxifen. The only thing that she would agree was this Arimidex, which was our standard at that time in 2000 and 2001.

CHAYTOR, Q.C.:

Q. And that was my question, if those were her original scores, why she would have been treated originally?

DR. SIDDIQUI:

A. Right.

CHAYTOR, Q.C.:

Q. And that's because she was an elderly patient?

DR. SIDDIQUI:

A. Elderly and she did not want chemotherapy, and I'll have to look at the pathology again to see exactly what the pathology was, but this

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would have been the only treatment at that point.

CHAYTOR, Q.C.:

Q. Okay. Now most of the letters, and with the one asking you to communicate the information to your client, this letter doesn't indicate that, and it may simply just be an oversight, but would you, in any event, have communicated this to your patient?

DR. SIDDIQUI:

A. I think this lady I had spoken with on the phone and a note was dictated on the day.

CHAYTOR, Q.C.:

Q. And I take it you agreed with the panel's recommendation with respect to her case?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. At page five, there's another letter, February 17th, 2006, and in this case the person was diagnosed in 2001, and she was originally negative for both ER and PR, and the repeat report is 20 percent and 0 percent ER/PR respectively. The physician review panel's recommendation is that the patient be

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seen and assessed for the possibility of starting treatment with Tamoxifen. In essence, I take it the decision with respect to this person was left up to your own judgment?

DR. SIDDIQUI:

A. Right, they think that hormone treatment should be used for this patient and this patient should be contacted.

CHAYTOR, Q.C.:

Q. And so in terms of this particular patient, and I don't know if you recall this person or not, but I'm just thinking if the recommendation is that she be assessed for the possibility of starting treatment with Tamoxifen or some other equivalent medication, how was the fact that the person was panelled of any benefit to you in terms of you being able to pick up her chart and make that determination which ultimately you would have to do yourself?

DR. SIDDIQUI:

A. There would be again a small group of patients who are sometimes in a grey zone, and as we talked about tumour board previously,

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sometimes you bring up those patients to get opinion from other medical oncologists that this patient is somebody who has an eight millimetre tumour, are you going to treat that if the recommendations are to treat anything which is bigger than one centimetre. So there are some patients which fall in those grey zones and you got a tumour board kind of opinion with all those oncologists at that time.

CHAYTOR, Q.C.:

Q. So this is a person who fell in a grey zone as opposed to it wasn't a situation where there wasn't enough information on her chart for them to be able to make any recommendation?

DR. SIDDIQUI:

A. This one doesn't look like in grey zone because they said for recommendation of the panel is that should be seen and assessed for possibility of starting treatment.

CHAYTOR, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. But what I'm saying is that some patients they are in grey zone so that physician review

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panel goes through their particular correctors and they can give their extra opinion that even though they may be now considered receptor positive, but are they really going to benefit from hormone treatment or not. So those are the ones that I mentioned. This one looks like that they thought that hormone treatment would be beneficial.

CHAYTOR, Q.C.:

Q. But for some reason the patient needed to be seen and assessed first?

DR. SIDDIQUI:

A. These, all these medications they carry a list of side effects with them and you have to be made aware, the patient has to be made aware about the side effect, and they have to understand completely what they're getting into. They are not very benign medications, so they have to be made aware before you could start.

CHAYTOR, Q.C.:

Q. And were all your patients seen and assessed before the recommendation of the panel was put in place? I was just thinking the case you told us about, Labrador, and you phoned and

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spoke to the patient. So I take it in that case you would have received a verbal update as to the patient's status if it's been some time since you've seen a patient, and a number of those, of course, were people that may have been some time?

DR. SIDDIQUI:

A. Correct.

CHAYTOR, Q.C.:

Q. So you'd get a verbal update over the phone. And were there other occasions where that would happen, where the patient wasn't actually assessed before the treatment change was put in place?

DR. SIDDIQUI:

A. That is again the Labrador one, that is the one that comes to my mind. And I think on that one I had spoken to her family physician, as well. So you'll talk to the patient, you'll try to get some history, you'll try to get some main features which are contraindication for one or the other form of treatment and the family physician would be involved. The patients would be offered to come in and see, but family physician would be

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involved.

CHAYTOR, Q.C.:

Q. Okay, so it would be expected that the patient would be seen and assessed if not by yourself, by the family physician before the treatment change was put in place?

DR. SIDDIQUI:

A. I would expect them to see the patient if I talked to them.

CHAYTOR, Q.C.:

Q. Okay, and this letter is March 6th, 2006.

THE COMMISSIONER:

Q. Excuse me, just before we go.

CHAYTOR, Q.C.:

Q. I'm sorry.

THE COMMISSIONER:

Q. From this letter. Dr. Siddiqui, would the information that you would need to discuss with your patient regarding contraindications for, for example, Tamoxifen, necessarily be on the file?

DR. SIDDIQUI:

A. Most of it should be, you're right. But sometimes if time has passed, if it is five years or six years, I just ask them did you

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have a blood clot for any reason or did you suffer a stroke or are you on a medication for osteoporosis, so that would tell you to go one way or the other.

THE COMMISSIONER:

Q. All right. So if the panel was looking at a chart where the origin of the cancer might have been sometime ago, there might, in fact, be an absence of the kind of information you would need to have to be in a position to properly make a recommendation to your patient as to whether or not Tamoxifen, for example, should be taken?

DR. SIDDIQUI:

A. That's right.

THE COMMISSIONER:

Q. Okay.

DR. SIDDIQUI:

A. And that what happened, I think, in Mrs. White's case. She was seen in 2001 and then in 2007, so we needed to be updated what happened in those six years.

THE COMMISSIONER:

Q. All right. Thank you.

CHAYTOR, Q.C.:

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Q. Okay, thank you, Commissioner. Then page 6 of this exhibit is the letter March 6th, 2006. And in this case looks like the patient was seen by you. She was diagnosed in 2002. The original report of her ER/PR is negative for ER and less than five percent for PR. And the report from Mount Sinai is 60 and 50 percent ER/PR, respectively. Patient was discussed by the panel. And the recommendation of the panel is that she should be treated with Tamoxifen or otherwise if not tolerated. And actually, this letter was not written to you, this letter looks like it was written to perhaps another--it was written to another physician, perhaps a GP and you were copied on the letter. And it indicates if you wish, the patient may be referred to one of our medical oncologists. And there's a handwritten note up here, April 10th, 2006, "Dr. Siddiqui called the patient in office a fact of her letter. I told him the recommendations verbally." And down here a note April 12th, 2006, "Received a call from the patient's daughter requesting reimbursement for her mother's travel." And I don't expect that you

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would have been involved in this aspect, about the travel expense. But April 10th it appears that the patient is now in your office and you're looking for a copy of the letter at that point and asking--so it's faxed over to you. So would you not have already received your copy of the letter? This is March 6th, so it's over a month later and you're looking for a copy.

DR. SIDDIQUI:

A. It says cc'ed, theoretically it should be.

CHAYTOR, Q.C.:

Q. And I take it when this person arrived in your office, however, you didn't have the copy and so you made contact to get a copy and were told the recommendations verbally. Do you recall -

DR. SIDDIQUI:

A. Some -

CHAYTOR, Q.C.:

Q. - who you spoke with, who the physician -

DR. SIDDIQUI:

A. I don't remember this particular patient. If I could be shown the chart, I may remember a bit more. But again, as we talked about one

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of the other patients, as well, if the patient saw in the peripheral clinic, sometimes the reports just went to the peripheral clinic and from there they'll travel the long way back here. So is it one of those, I don't know.

CHAYTOR, Q.C.:

Q. It appears to be somebody from outside the city if there's travel expenses involved.

DR. SIDDIQUI:

A. Right, right.

CHAYTOR, Q.C.:

Q. Yes. Doctor, so what was your practice then in getting a letter copied? If you had a chart on the patient, would the letter be put or placed in the patient's chart?

DR. SIDDIQUI:

A. Again, the letter, even if it is copied, it should come to my mailbox.

CHAYTOR, Q.C.:

Q. Yes, and what would you then do with it, though, after you received the letter?

DR. SIDDIQUI:

A. If it is directed to me, as I said earlier, and if there's a change in treatment, I'll try to get hold of the patient.

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CHAYTOR, Q.C.:
Q. But in the situation where this letter was not, you're not the primary recipient but you are copied on the letter, what would you do with your copy of this letter when you received it?
DR. SIDDIQUI:
A. It would be signed, it will go on the chart.
CHAYTOR, Q.C.:
Q. So you would place it on the chart regardless if you're the -
DR. SIDDIQUI:
A. Yeah, if I get that, I'll put that on the chart.
CHAYTOR, Q.C.:
Q. Regardless if you're just cc'ed or the primary recipient?
DR. SIDDIQUI:
A. Sure.
CHAYTOR, Q.C.:
Q. All letters from the tumour board panel that you received, it was your practice to place them on the chart?
DR. SIDDIQUI:
A. If I get a copy of it, I'll sign it and it

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will go on the chart.
CHAYTOR, Q.C.:
Q. And for some reason the--so you would sign it indicating that you had seen the letter?
DR. SIDDIQUI:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay. And for some reason on this occasion, a month after the letter is written, there wasn't a copy on her chart, it appears, for whatever reason?
DR. SIDDIQUI:
A. It looks like.
CHAYTOR, Q.C.:
Q. Okay. And the next page, page 7 is a letter of the same date and it's to yourself, written by Dr. Laing as the chair of the panel. And in this particular case the patient again had right breast cancer in 2002 and at that time her ER and PR receptors were negative staining for both. And this has been confirmed on retesting at Mount Sinai. And then in 2003 she was diagnosed with breast cancer of the left breast and the original report showed less than 20 for ER and 90 percent for PR and

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a repeat from Mount Sinai has shown the tumour to be ER and PR receptor positive at 50 percent and 70 percent respectively. The patient was discussed and review of the patient's health record revealed that she, or Ms. C is currently being treatment with Arimidex, therefore there's no impact on the patient's treatment and no treatment follow-up required. So it appears this patient was already placed on Arimidex, presumably, I take it, for the left breast cancer. And again, my question earlier, your answer would be the same, I would take it, that this is likely two different cancers, two different primaries as opposed to -
DR. SIDDIQUI:
A. That's right.
CHAYTOR, Q.C.:
Q. - a metastasis?
DR. SIDDIQUI:
A. They were different receptor status, it looks like.
CHAYTOR, Q.C.:
Q. Okay. The other thing about this letter then which caught my attention was, and we've left

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in initials here, but the names were wrong, so the first two names, but then the patient that is revealed, a review of the patient's health record revealed that a different named person is currently being treatment with Arimidex. What would you have done upon receipt of this letter, would you have--and that no further treatment follow-up is required. Would you have done anything to check to make sure that there hadn't been a mistake in terms of which file was being referred to? We understand the tumour physician review panel at any given time would have several files in front of it, most of the time. And would you do anything to ensure that, in fact, the right patient is being referred to given the mistake in the names in the names in letter?
DR. SIDDIQUI:
A. I think the main problem here is that was that mistaken name picked up. We usually look at on the top, when the patient's name is there and the MCP number is there, so those are the two things that you look at.
CHAYTOR, Q.C.:
Q. So you would go by the name that appeared

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here?
DR. SIDDIQUI:
A. Yeah, I mean, again, I have to look at the chart, but I'm not--because it doesn't ring a bell, I'm not sure if a different name was picked up or not. And again, the second thing is that is it the first name that she's using at some place, is it the last or the other, I don't know.
CHAYTOR, Q.C.:
Q. There's two different last names referred to in this letter.
DR. SIDDIQUI:
A. Right.
CHAYTOR, Q.C.:
Q. And I can tell you that the name that appeared in the subject line was the name which appears in the first two paragraphs, not the last paragraph. I'm just wondering what in that situation--first of all, you don't remember whether you would have caught that or not and had you caught it, what would you have--would you have done anything to ensure that it is the correct person that they're referring to has already been treated?

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DR. SIDDIQUI:
A. If that name mistake was picked up, I sure--if I picked it up, I would follow that and whoever picked it up, that's a basic thing, that mistake should have been followed up.
CHAYTOR, Q.C.:
Q. Okay. And then the last then tumour board letter I'd like to refer you to is dated the same date. And this again is a person who was diagnosed with breast cancer in her right and her left breast in 2002. The original report of the ER and PR receptors of the right breast showed zero percent staining for estrogen and less than five for progesterone. And a repeat from Mount Sinai showing the tumour to be ER/PR receptor positive at 30 percent and ten percent respectively. The original report of the ER and PR of the left breast showed 90 percent staining for estrogen and ten percent for progesterone and the tumour was not retested at Mount Sinai. The patient was discussed and a review of the health record revealed she was initially treated with Tamoxifen and subsequently Arimidex, therefore it's no impact on the patient's treatment and

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no treatment follow-up is required. Would it be unusual to have two different cancers in your two different breasts diagnosed at the same time?
DR. SIDDIQUI:
A. How often would that happen, I don't know the percentage, but I have seen that happening more than once.
CHAYTOR, Q.C.:
Q. And for there to be two different hormone receptor statuses based on the conversations we've had earlier -
DR. SIDDIQUI:
A. That suggests that they likely are two different kinds of cancer.
CHAYTOR, Q.C.:
Q. And is that something that would have occurred to you at the time, in 2002, that this is unusual, I'd better make sure it's two different cancers in terms of reviewing the pathology report?
DR. SIDDIQUI:
A. I would think not. If they are different under the microscope, if their histological characters are different, these are two

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different cancers, most likely then. And the patient would be on treatment for one cancer and if she's completely negative on the other side, then there is not much impact, but if there are any receptor positivity, she would benefit from that, as well.
CHAYTOR, Q.C.:
Q. Okay, Doctor, I wanted to turn now then to and ask you about another patient of yours.
THE COMMISSIONER:
Q. Before you start that, Ms. Chaytor, it's about the time for the morning break. Should we do that before you turn to this new area?
CHAYTOR, Q.C.:
Q. Sure, yes. And this is my last line of questioning for Dr. Siddiqui.
THE COMMISSIONER:
Q. All right, well, why don't we take the morning break first then.
(RECESS)
THE COMMISSIONER:
Q. Please be seated. Ms. Chaytor?
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. Dr. Siddiqui, before we do the last line of questioning that I had

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for you, I understand that there were a couple of points that you'd like to clarify and one is from your evidence last day regarding where you trained. And perhaps you could just speak to that, please?

DR. SIDDIQUI:

A. I think I said that my residency was State University of Detroit. If I said that, I'm sorry. It's actually Wayne State University.

CHAYTOR, Q.C.:

Q. Wayne State.

DR. SIDDIQUI:

A. That is in Detroit. It's not State University of Detroit.

CHAYTOR, Q.C.:

Q. So it's Wayne State in Detroit?

DR. SIDDIQUI:

A. Wayne State University in Detroit.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. And Sinai Medical Centre, that's the name of the hospital.

CHAYTOR, Q.C.:

Q. Okay. And C-0040, please? And this is not

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actually a point arising out of your prior evidence, it's just a question I have for you on this. Thank you. C-0040. This is one of the records from Elizabeth White, who we mentioned earlier in terms of your communications with her around her retest. And when Mrs. White was on the stand, on this progress note of June the 8th, 2001, there was one point that she took issue with and it's on the second page where it writes, "However, the weight gain is now gross and in my opinion if that persists, she may need to see a pulmonologist," is it?

DR. SIDDIQUI:

A. Right.

CHAYTOR, Q.C.:

Q. "And cardiologist." And she indicated that she didn't have any issues with her weight. Do you have any recollection on this or what that may be, in fact, referring to?

DR. SIDDIQUI:

A. I've gone through the note and if you go on the first paragraph.

CHAYTOR, Q.C.:

Q. Sure.

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DR. SIDDIQUI:

A. Towards the end of the first paragraph it says that she has the same weight on the last visit and she was 68.8 in December, '99 and she has the same weight on the last visit. Actually, in this visit she weighed 73 kilos on a visit prior to that, she was also 73 kilos. She was a bit short of breath and family physician had thought that that might be due to weight gain. But I mentioned over here that her weight has remained stable. And then going in the assessment and plan, it's actually, I think, a typographical error, it should have been, if we can go down in the assessment and plan, weight gain is not gross because I mention that the weight has remained stable on the two times, and that's why I said that the weight gain is not gross. If we change "now" to "not", that would explain everything else. And then I said that in my opinion if the shortness of breath persists, if it persists, then she should see a pulmonologist and a cardiologist.

CHAYTOR, Q.C.:

Q. Okay.

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DR. SIDDIQUI:

A. About why she's short of breath. Because I did not think that it was the weight gain that was explaining shortness of breath.

CHAYTOR, Q.C.:

Q. Okay. So that you're saying that you believe this to be a typographical error and that, in fact, it should say the weight gain is not gross?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. And what you're referring to, then, when you go on in the same sentence and say, "And in my opinion if that persists she may need to see a pulmonologist and a cardiologist."

DR. SIDDIQUI:

A. Right.

CHAYTOR, Q.C.:

Q. You're referring to if the shortness of breath -

DR. SIDDIQUI:

A. Shortness of breath and with her history, when she was being treated initially on chemotherapy by Dr. Alidina, her chemotherapy

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had to be switched midway because of some effect on the heart or there was some reason her chemo was switched.

CHAYTOR, Q.C.:

Q. Yes, and, Doctor, in terms of that, those progress notes, because, of course, and I do have a couple that I'll point out to you with respect to the next patient, as well, issues as to what may have been meant in the text of the progress note, it's noted that they're dictated but not read. So you would dictate those and then what happens to your--what happens after that, you dictate it. Does it come back to you for you to sign off on before it actually ends up on the patient's chart?

DR. SIDDIQUI:

A. If it says dictated but not read, that would mean that the note would go directly into the chart.

CHAYTOR, Q.C.:

Q. Okay. And so, in fact, if there's something like this which obviously it's one letter, but one letter could make a big difference between it's not gross as opposed to now gross.

DR. SIDDIQUI:

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A. That's correct.

CHAYTOR, Q.C.:

Q. And any other circumstances like that, in terms of the accuracy then of the note or how can you be sure that the person who is typing it, you know, has properly understood or interpreted what you have said?

DR. SIDDIQUI:

A. This does happen a few times. And most of us try to sign those, as well, but sometimes it is just the time restraints that you have and a note is needed somewhere, so they just do it, dictated but not read. The first assessment summaries, however, I always try to sign those just to make sure that the initial treatment plan which is made, that is read through before it is signed.

CHAYTOR, Q.C.:

Q. Okay. And those progress notes are intended, I take it, to be able to communicate with anyone else who would be treating the patient?

DR. SIDDIQUI:

A. That is correct.

CHAYTOR, Q.C.:

Q. And they're copied, as we've already spoken

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about, copied to other physicians, including family physicians, as well?

DR. SIDDIQUI:

A. That's right.

CHAYTOR, Q.C.:

Q. Okay. And so when the copy that's sent out to the other physicians, for example, would those also go out dictated but not read or would you have to sign them, sign off on it and ensure its accuracy before it's sent elsewhere?

DR. SIDDIQUI:

A. If it is signed this way and it's in the chart, it will go the same way to them, as well.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. And I think there's practice of it because we also get sometimes get note from other physicians, as well, which I think again due to some time restraints, we do get sometimes note like that. I try my best to sign them, but sometimes you just can't.

CHAYTOR, Q.C.:

Q. It's a matter of workload and priority?

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DR. SIDDIQUI:

A. It does happen sometimes, yeah.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. And I admit that we should probably read each one of them. We try to as much as we could.

CHAYTOR, Q.C.:

Q. Okay. And is there any policy or anything in place that says that that has to happen, that they have to be signed off before they go on the patient's chart?

DR. SIDDIQUI:

A. Not that I know of, but I think the assessment and plan, we all sign that. Some of us try to sign all the notes, others may not be able to sign all.

CHAYTOR, Q.C.:

Q. And do the progress notes come back to you before they end up in the patient's chart, would you get a hard copy, for example, in your mailbox again, is there some--would they come back to you?

DR. SIDDIQUI:

A. All the first assessment summaries, all the

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consults, they'll all come back and they won't go in the chart until they are signed. And again, it varies from physician to physician. One could ask the medical director not to put any note in the chart until it is signed. But again, the time restraints sometimes you could do that, sometimes you can't.

CHAYTOR, Q.C.:

Q. I'm just wondering how would you even know if the progress note was done with the high volume of patients that you have, unless it comes back to you to sign off on, how would you even know that it was completed?

DR. SIDDIQUI:

A. If I have dictated a note, it's very, very likely that it would get done. I would say that it would probably happen once or twice in two years, three years that the notes are lost in cyberspace, when I dictate and they don't end up on the other end, but otherwise I can dictate them pretty much from anywhere and they make it.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

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A. Again, the reliance on the system, it has worked quite well.

CHAYTOR, Q.C.:

Q. Okay, Doctor, and thank you for bringing that point to my attention. Doctor, Beverly Green is, I understand, still a patient of yours?

DR. SIDDIQUI:

A. She is.

CHAYTOR, Q.C.:

Q. And she's testified here before the Commission. And I'd just like to take you through some of her documentation and ask you a few questions. If we could have, please, C-0001, our very first exhibit way back when? And, Doctor, this is a pathology report with respect to Mrs. Green. And up here in the corner we see S-I-D-D, period. Can you tell us what that's in relation to and when would that have been written on the -

DR. SIDDIQUI:

A. I think it would be the first letters of my last name, first four letters, S-I-D-D.

CHAYTOR, Q.C.:

Q. Um-hm. And you didn't write that there, I take it?

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DR. SIDDIQUI:

A. That's not my handwriting.

CHAYTOR, Q.C.:

Q. Okay. And is this usually that you would see a pathology report or some consultation record with your initials or your name appearing on it?

DR. SIDDIQUI:

A. It's not unusual, I've seen that before.

CHAYTOR, Q.C.:

Q. Okay. So perhaps that might be somebody's practice in terms of indicating this to be your copy?

DR. SIDDIQUI:

A. That's possible. And I don't know where it happened, did it happen in pathology or did it happen in our medical records.

CHAYTOR, Q.C.:

Q. Okay. And in this pathology report the original pathology, and we understand that Mrs. Green had ER/PR tests on both her biopsy specimen as well as her mastectomy specimen. And the first addendum is Dr. Elms and it's dated January 29th, 2001. And it's indicated that her immunohistochemical stains for ER and

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PR revealed the tissue to be negative for ER but positive for progesterone. And we understand that to be the biopsy sample?

DR. SIDDIQUI:

A. That's right.

CHAYTOR, Q.C.:

Q. And there's an addendum too on, I believe it to be February 3rd, 2006, that that specimen had been retested at Mount Sinai, excuse me, and her ER protein is seen as zero percent and the PR protein is seen as zero percent. Previous report from the Health Science, St. John's, was reported as progesterone receptor positive. So she's, according to Mount Sinai, on her biopsy specimen now negative in both?

DR. SIDDIQUI:

A. That is correct.

CHAYTOR, Q.C.:

Q. Whereas originally she was PR positive. And then if we could have, please, Exhibit 002, C-0002? And this is another pathology report with respect to Mrs. Green, and we understand that this pertains to--the ER/PR report is included here on her mastectomy sample or specimen, and she was ER negative on her

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mastectomy specimen and her PR status was positive, "approximately 85 to 90 percent of invasive neoplastic cells show positive nuclear staining." So she was strongly PR positive. So again, consistent with the test at the time on her biopsy, she was ER negative and PR positive. And then addendum of the retest entered on October 20th, 2005, this specimen has been retested at Mount Sinai and she's found to be ER 20 percent of cells and previous report from the Health Care Corporation was reported as negative, and PR protein is seen in 70 percent of cells, and it indicates the previous report had been 85 to 90.

If we could have then, please, C-0005? Doctor, I'm not going to take you through every single exhibit with respect to her, but by all means, if there is an exhibit that you would like to draw my attention to along the way that I don't come to, let me know. And in this, this is a progress note of April 25th, 2001, and at that point, and I'll just show you here that you have signed this particular note, and this is called a consultation note,

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and you said it is your practice that those would be signed.

DR. SIDDIQUI:

A. That is the first time when I'm seeing the patient. We call that either first assessment or plan or consult.

CHAYTOR, Q.C.:

Q. Consult, yes, and the ER was negative you note, whereas PR was positive in 85 to 90 percent of the cells. Margins were negative and the closest margin was six millimetres. Then if we could have C-0007, please? And this then is a progress note of October 4th, 2001 and it's signed by yourself, and you've written, under assessment and plan, that "we will continue with the chemotherapy, the last cycle. Following that, she will come back to see us in about four to six weeks time. She had a strongly PR positive breast cancer. She is a candidate for Tamoxifen afterwards. We will discuss with her and have Tamoxifen discussion at that point, and she will return to see us back in four to six weeks." So at this point in time, October 4th, 2001, you're indicating her to be PR positive and a

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candidate for Tamoxifen?

DR. SIDDIQUI:

A. Correct.

CHAYTOR, Q.C.:

Q. And if we could have then, please, C-0008? And Ms. Green is seen then on November 29th, 2001 in the medical oncology clinic, and there's a note dictated, but not read, by Dr. Farrell, and perhaps you could tell us, it indicates Dr. G. Farrell, clinical associate. What does it mean to be a clinical associate?

DR. SIDDIQUI:

A. Dr. Gerard Farrell is a family physician who is working with us and he joined Cancer Centre, I think that probably needs to be checked, though I think about five years prior to myself, in '96 or '97, and he works as a general physician with the medical oncology group.

CHAYTOR, Q.C.:

Q. Okay, and why are family physicians or clinical associates used at the Cancer Clinic? What role do they fulfil?

DR. SIDDIQUI:

A. General physicians are called GPOs now,

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general physician oncology. They have been used more and more in most of the Canadian centres, and their role is that usually they follow up patients. Most of the time, the initial plan is made by an oncologist and then they follow up the patient and most of those, they won't do other general practice. They will basically do oncology with the oncology group.

CHAYTOR, Q.C.:

Q. Okay. So they do most of the follow up of patients. Is there any policy in place as to--at the cancer--or in the Cancer Care Program as to when it is appropriate for a clinical associate to see a patient, as opposed to when it's appropriate for the patient to be seen by the oncologist?

DR. SIDDIQUI:

A. The first time when a treatment decision is made, the patient has to be seen by a medical or radiation oncologist, and once a treatment plan has been made or if a patient is not on active treatment and they are coming in for follow up, they are seen by them. They do, however, also see patients on active treatment

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as well, and if there is some treatment change needed, they talk to the particular oncologist, whoever that patient is. They talk to them about that as well.

CHAYTOR, Q.C.:

Q. So if a patient is already being seen and going through chemotherapy, but there's to be any change in the patient's treatment or any adjuvant therapy beyond--or hormonal therapy in this case, offered, would that be for the medical oncologist to discuss with the patient or is the clinical associate permitted the latitude to have that discussion with the patient?

DR. SIDDIQUI:

A. Most of the times, the medical oncologist would do that and if the clinical associate is comfortable with that, they can do that as well.

CHAYTOR, Q.C.:

Q. So it would be left to the judgement of the clinical associate?

DR. SIDDIQUI:

A. Most of the time, as I said, a medical oncologist would try to do that. If it

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happened some day that the patient is booked and we are not able to come for that day for some reason, then they could see on that day as well.

CHAYTOR, Q.C.:

Q. Okay, and the idea that the clinical associate's role is one of follow up, patients once they're in their follow up phase of treatment, and that any first time--first time any treatment plan is laid out for the patient, that that's to be done by the oncologist. Is that in writing? Is there a policy stipulating that?

DR. SIDDIQUI:

A. I'm not sure about that, if it is in writing or not.

CHAYTOR, Q.C.:

Q. You've never seen it, if it is?

DR. SIDDIQUI:

A. I'm not sure about that. I don't remember seeing one though.

CHAYTOR, Q.C.:

Q. So in this case, Mrs. Green was seen and it's indicates she's ER negative PR positive. "We offered the benefit of Tamoxifen. We outlined

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to her the side effect profile, including DVT, hot flashes and endometrial cancer. Interestingly, there is two people in her family who had blood clots. I also outlined to her that benefits and the fact that she is not ER positive, therefore the benefit case is not as strong as it would be if she had been. She is on," and I think that should be "two minds as to whether she's going to take the Tamoxifen. However, after some discussion, she took her prescription for Tamoxifen and she will let us know when she returns whether she took it or not. And she's due to come back in three months time." Now on this occasion, did you see her together with Dr. Farrell or was this Dr. Farrell seeing her on his own?

DR. SIDDIQUI:

A. I don't see with him.

CHAYTOR, Q.C.:

Q. You don't see, okay.

DR. SIDDIQUI:

A. With him.

CHAYTOR, Q.C.:

Q. Okay. So this discussion about Tamoxifen and the first time she's written a prescription

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for Tamoxifen and any discussion around the benefits or the adverse effects of Tamoxifen, that discussion was had with her by Dr. Farrell?

DR. SIDDIQUI:

A. It looks like, yeah.

CHAYTOR, Q.C.:

Q. Okay, and that would not be the usual practice? Usually that would have been you would have had that discussion with her?

DR. SIDDIQUI:

A. Yeah, but if he's comfortable, because I think he has done on other patients as well, there are other patients as well. He is in the Cancer Clinic for about 11-12 years now, and oncology is the only thing that he does.

CHAYTOR, Q.C.:

Q. Okay, and this would be back now seven years ago, 2001. So he would have been there about -

DR. SIDDIQUI:

A. I would think at least four or five years. My guess is that he's there since 1996 or '97.

CHAYTOR, Q.C.:

Q. Okay, and the idea of concern regarding blood

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clots in her family and Dr. Farrell stipulating that she's not ER positive, therefore the benefit case is not as strong as it would be had she been, do you agree that those were risks that should be pointed out to Mrs. Green?

DR. SIDDIQUI:

A. The side effect risks?

CHAYTOR, Q.C.:

Q. Well, in terms of the family having had blood clots, do you know whether or not Mrs. Green herself ever had any issue with blood clots?

DR. SIDDIQUI:

A. She never had a blood clot on herself. What is said over here, this is a statement that he has made, and I think the important thing would be also the discussion what he had prior to that. When I saw her the following time, I had my own discussion with her as well.

CHAYTOR, Q.C.:

Q. Yes, and we'll come to that. So in terms of the idea then of it not being of the same benefit, the benefit case not being as strong, is the wording he uses, because she's ER negative, would you, in your discussion, have

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pointed out that out or emphasized that to Mrs. Green?

DR. SIDDIQUI:

A. It's difficult to say that I fully agree with that, that I would fully agree with these words, but as I said, that it's more important to see whole discussion held prior to that. I had another nine patients very similar to that, when I went--I was given a list of the patient to look at who were ER negative and PR positive and I had a very similar discussion with them. So I can tell you what kind of discussion I would have with the other patients who accepted the treatment in the same scenario who were ER negative and PR positive, and I would have the same discussion with her. What I tell them is that for all clinical and practical purposes, we take whichever hormone receptor is positive, we take that one. "You are very young." I think she was only 39 at that time. "You have node positive cancer and you have benefits to gain from it." Now this question whether ER negativity and PR positivity, the case is not as strong, I'm not sure if this question is

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answered with full depth in the literature yet or not. There is some data available for metastatic and there is some data available that is coming in in the last few years. From the metastatic setting, ER positivity PR positivity is better than either/or. But I would have my own discussion, which I did with her. I'll bring up the side effects as well. Those are the side effects which have been identified in multiple studies, and they come in with the drug insert, and she would be given a literature about the drug as well that she could go through on her own.

CHAYTOR, Q.C.:

Q. Okay, and there's no--if a patient--there's mention here, of course, of the issue about familial issue of blood clot. If there is a concern for blood clotting, is there an alternative to Tamoxifen which could be offered to the patient?

DR. SIDDIQUI:

A. This is 2001, November 2001, and then early 2002. At that time, Tamoxifen was the standard of care. ATAC is one of the bigger trials that was presented in December of 2001

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and ASCO did a technology assessment guideline in 2002, May, and that was published in June of 2002, and at that time, they did not consider any aromatase inhibiters like Arimidex or Letrozole as an alternative to that. So at that time, Tamoxifen was the only standard of care.

CHAYTOR, Q.C.:

Q. And so there was no alternative in November of 2001 for patients?

DR. SIDDIQUI:

A. No.

CHAYTOR, Q.C.:

Q. Who had risk of any kind of DVT.

DR. SIDDIQUI:

A. But this patient, she herself never had DVT.

CHAYTOR, Q.C.:

Q. Right.

DR. SIDDIQUI:

A. And that's a point that I wanted to bring to her, that one of her uncles had DVT, but I think that uncle also had cancer at the same time. When somebody has active cancer that increases the risk of having a blood clot. So for herself and the other one, I think, was

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her grandfather who was 80 years old when he had DVT, or the bottom line was that herself, she never had any such problem.

CHAYTOR, Q.C.:

Q. And that was the important point for you. So while Dr. Farrell made note of it in, this is somewhat of a brief progress note and says "interestingly, there's two people in her family who had blood clots," that would not have been of such import to you, and wasn't in -

DR. SIDDIQUI:

A. It would have been an important thing, and I would bring it up to her that there is some risk. There is some risk of DVT. In the studies which they did in which they first did Tamoxifen for two years, the risk was higher. I would say that "there is some risk for DVT and with your history there is, but you, yourself, never had a blood clot. You never had a blood clot when you had active cancer, which was not removed. So in your case, there is some risk of DVT, there is some risk of endometrial cancer, but they're small risks, and the benefit is much more, and you should

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give it a try."

CHAYTOR, Q.C.:

Q. Okay, and so then perhaps -

DR. SIDDIQUI:

A. And that's what I said to my eight or nine other patients and they all took Tamoxifen.

CHAYTOR, Q.C.:

Q. And do you know whether or not those other patients had been seen first by Dr. Farrell?

DR. SIDDIQUI:

A. I don't know that yet.

CHAYTOR, Q.C.:

Q. And could we have then, please, C-0009? And this is March 7th, 2002, and I believe Doctor, this is the progress note. You've signed this progress note, and this is where you have your discussion with Mrs. Green. "Today she comes in for follow up. On the last visit, she was seen by Dr. Farrell, which was November 29th, and she had a discussion about Tamoxifen at that point. However, she hasn't decided to start that." And then you continue on, under your assessment and plan, you write "she had a family history of blood clots as one of her grandparents had a blood clot at the age of

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80, and one of his uncles had one at the age of more than 50. However, this uncle also had breast cancer at the same time. I have told her that although Tamoxifen is associated with some side effects, which may include a DVT, as well as endometrial carcinoma, but usually the benefits are much," I guess that should be "are as much compared -

DR. SIDDIQUI:

A. Much means more.

CHAYTOR, Q.C.:

Q. "Are much as compared to the risk and she should probably give it a try. She hasn't yet decided about it. However, she already has a prescription and decides she will go ahead with it. She have also told her that she will need regular PAP smears when she's on that," meaning on the Tamoxifen, I take it. Okay. So Doctor, this is your discussion then following up on the discussion she had had back in November with Dr. Farrell, and it's written here that you've indicated to her that you think she should give it a try?

DR. SIDDIQUI:

A. Yeah.

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CHAYTOR, Q.C.:

Q. Okay, and that's consistent with what you recall telling her?

DR. SIDDIQUI:

A. Yes. sure.

CHAYTOR, Q.C.:

Q. And do you recall, did you have any discussion with her about the fact that she was ER negative?

DR. SIDDIQUI:

A. I don't recall any particular discussion. Again, most of the things that I would say, I would basically base them on the notes and what is mentioned in the notes, and what I tell to my patients in this scenario usually is that, as I said earlier, we take one or the second as being positive, and there are benefits to be gained if either one of them is positive, and that's what I tell all of them.

CHAYTOR, Q.C.:

Q. Okay, and so the notion that Dr. Farrell had mentioned that, the fact that she's not ER positive therefore the benefit not being as strong, you don't know whether or not you discussed that particular issue with Mrs.

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Green?
DR. SIDDIQUI:
A. If the patient wants to talk about that, I will definitely do that, and I tell them, I start usually with the positive receptor, that this receptor is strongly positive, and you would benefit from the treatment.
CHAYTOR, Q.C.:
Q. Okay, and then if we could have C-0010, please? And this is then a couple of months later, and she's decided at this point that she's not going to--"last time she was offered Tamoxifen. Today, she has decided she's not going to take it." So do you recall was there any further discussion with her then on May 16th?
DR. SIDDIQUI:
A. It is what is in the note.
CHAYTOR, Q.C.:
Q. Okay.
DR. SIDDIQUI:
A. She refused Tamoxifen, May 16th.
CHAYTOR, Q.C.:
Q. Okay, and if we could have C-0012, please? And you recall the last note was May 16th,

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2002. So I've gone ahead here. We're now up to December 22nd, 2005, and she's seen in clinic on that date by yourself, and it says here that she's a--gives the description and it says "ER negative, PR positive, treated with six cycles of chemotherapy. Her last cycle had started in October 2001. The patient refused Tamoxifen afterward. She has recently been worked up for some liver lesions. The last CAT scan of the abdomen and pelvis done on the 11th of May 2005 followed up on the three lesions mentioned previously on the MRI, CAT scan and ultrasounds." And at this point in time, December 22nd, 2005, of course, Doctor, the retesting is well underway and you were aware of that, of course, in December 2005. It's indicating that "the patient refused Tamoxifen afterward," I take it that's referring back to when she refused it back in May of 2002?
DR. SIDDIQUI:
A. That's correct.
CHAYTOR, Q.C.:
Q. Yes, okay, and this clearly says that she was ER negative. Do you recall, at this point in

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time, was this--keeping in mind what we've discussed earlier today about pulling patient's charts or noticing patient's charts to see whether or not they were in the retesting process, do you know whether or not you pulled Ms. Green's chart to see whether or not she was being retested?
DR. SIDDIQUI:
A. Again, as I also said that for most of the times, I would rely on the report is coming to me, and as the two early reports that you showed me, on the second report, which is from March, there is a signature on that and I have signed that report. So that report obviously came to me, and I signed that in March of 2006 and I dictated a note on the chart, which I also said that I usually do. The other report that was shown, which was the first one, those are not my signature, so probably that report did not come to me, and I would not have known about that report.
CHAYTOR, Q.C.:
Q. And I'm going to get to that and whether or not those reports came to your attention and why you think they may not have, or one of

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them may not have. I'm just wondering, when she came in to see you in December of 2005, did you look through her chart at that point to see what was there and whether or not she had already been retested?
DR. SIDDIQUI:
A. As I said earlier, again as well, that as patients stay with us, their charts get thicker and thicker, and you cannot look through the whole chart every single time. If you know that there is something specific that you are looking for, you could probably look at that. But again, as I said earlier as well, that I was relying on the reports will come to me and when they come to me, then we would know about those.
CHAYTOR, Q.C.:
Q. And Doctor, when something is filed in a chart, so for example, if her pathology report with the addendum had ended up in her chart, is there a certain section in the chart you would find the pathology report, where you could just flick to?
DR. SIDDIQUI:
A. There's a section there, yeah.

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CHAYTOR, Q.C.:
Q. Yes, and you could flip fairly easily to that section of the chart?
DR. SIDDIQUI:
A. It's possible, but again, as I said, that until something is flagged that needs to be looked at by you or until something comes to your mail box, you will not know that. There's a lot of blood work that goes to the chart as well and so until we are told about something that you have to look for that, you may not find that.
CHAYTOR, Q.C.:
Q. So what you're telling us then is that you don't recall if you would have checked, but it's unlikely, because you would have waited to see if something was flagged to your attention. So on December 22nd, 2005, there's no mention in your progress note that you spoke to her about the retesting process?
DR. SIDDIQUI:
A. It doesn't look like. I was not aware of that.
CHAYTOR, Q.C.:
Q. And you have no recollection of speaking to

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her about the retesting process underway?
DR. SIDDIQUI:
A. If it doesn't say there, I probably would not have.
CHAYTOR, Q.C.:
Q. And Doctor, she's not due to come back then until--you're not going to see her for a year's time, and if there's to be a change in her treatment, then you would be the person, the medical oncologist who would do that, and she's not to be seen by Dr. Greenland until another six months time. So while she was in on December 2005, why didn't you think at that stage to look to see if her tests had been repeated?
DR. SIDDIQUI:
A. Again, as I had said earlier as well, that most of the time, if they are done, they'll come to me and the tests were--some of those were done. Some were not done. Majority, if it was done, it would come to me, and I was relying more on those. As the other one that is in there, the first one from her biopsy specimen, from March, that did come to me. So I acknowledged that I knew about that. I

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signed that, and I put a note in there.
CHAYTOR, Q.C.:
Q. Okay, and if we could go back to C-0002, please? And this is December 22nd, 2005, and the addendum is entered on her chart, October 20th, 2005, the addendum which indicates that she is found to be now both ER and PR positive by Mount Sinai on the mastectomy specimen. So it's two months before you see her in December, and Doctor, are you saying that the addendum must not have been brought to your attention by December 22nd?
DR. SIDDIQUI:
A. Yes.
CHAYTOR, Q.C.:
Q. Either through it being placed on her chart or through it being in your mail box?
DR. SIDDIQUI:
A. The way to do that would be that if there is an addendum, that usually comes to my mail box. That would be the way to inform me, because in the chart, there are other things coming in. There are things from social work. There are things from dietary. They are putting those things in the chart as well. If

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there is something to my attention that will come to my mail box, and I'll sign that, and then that will go to her chart. This is chart keeping practice.
CHAYTOR, Q.C.:
Q. Okay. So what you're saying is that it must not have been placed in your mail box, but whether or not it was placed on her chart, you're not able to say?
DR. SIDDIQUI:
A. I can't say that, whether it was in there or not.
CHAYTOR, Q.C.:
Q. And if it were there, then on December 22nd, when she was in to see you, you didn't check? You didn't think to go look and see that whether or not it's there under the pathology section?
DR. SIDDIQUI:
A. Because most of the labs were coming the way that I told you that they come to my mail box first, and that's the way to get my attention or whomever physician they are looking for.
CHAYTOR, Q.C.:
Q. Okay. If we could have then, please, C-0013?

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And this is the progress note that you've referred to, March 26th, 2006.

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. And it's written, so then it's about three months after or a little bit over three months since you've seen her, and you have signed it. "The ER/PR receptor restaining done at Mount Sinai Hospital on February 3rd, 2006, entered in her chart, showed that the ER and PR both are negative, being zero percent. She was previously described to be ER receptor negative, but PR positive. However, she has refused Tamoxifen, so there is no change in treatment for Beverly." Doctor, was Ms. Green seen on this date?

DR. SIDDIQUI:

A. No.

CHAYTOR, Q.C.:

Q. So this is just a chart note that you made?

DR. SIDDIQUI:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay. Did you discuss this with Ms. Green?

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Did you phone her or have any discussion with her that there would be no change in treatment?

DR. SIDDIQUI:

A. No, and as I said that what our general practice at that time was, that if there was no change, we'll see if she's booked to see one of us and she was booked to see radiation oncologist a short while down the road, so that's why I did not book her to see me at that time. Can I take a step back and explain a couple of things?

CHAYTOR, Q.C.:

Q. Sure.

DR. SIDDIQUI:

A. As I said earlier that there are some patients that alternate between radiation and medical oncologists. Ms. Green, I started seeing her in April of 2001, and she was also seen by radiation oncology at that time. She received chemotherapy, completing in October of 2001, and after that, we have gone through those two notes about Tamoxifen. I saw her three times, I believe, in 2001 and three times in--sorry, three times in 2002 and three times in 2003.

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Towards the end of 2002, radiation oncologist suggested that we could alternate on her because we are doing similar thing. The recommendations or the guidelines were followed, but also to be seen once every three months for the first two to three years, and then once every six years, and a lot of patients like it that way, that they have to come in once, since both of us are doing the same thing. We do examination and go through blood work and ask what has happened since the last time. So finally, towards the end of, I believe, 2003, I started doing that, that we started alternating, and that's why I wrote in there that I'll see her in a year down the road from 2004, December onwards, and she was being followed by radiation oncologist every six months--every year, so she was seen by one of us every six months, and each one of us will go through when we see her. We'll go through whatever has happened by then or whatever has been--we are made aware of.

CHAYTOR, Q.C.:

Q. Okay. So Doctor, the fact that she had been retested, that wasn't something that, at that

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point in time, you thought you needed to pick up the phone and phone and tell her that there had been a retest, but there's no change?

DR. SIDDIQUI:

A. There was no change in treatment, so as I said earlier, for those patients, it was most of us were doing, if the patient is booked to see us, we'll bring that back and talk to them at that time.

CHAYTOR, Q.C.:

Q. And did you know whether or not there was any other process in place to notify patients who were having no change in treatment? Was somebody else responsible then for letting them know that?

DR. SIDDIQUI:

A. I don't know about that.

CHAYTOR, Q.C.:

Q. Okay. So you would have thought if she's going to be told, that it would be told by you?

DR. SIDDIQUI:

A. Whoever she's seeing next time.

CHAYTOR, Q.C.:

Q. Or Dr. Greenland?

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DR. SIDDIQUI:
A. Right.
CHAYTOR, Q.C.:
Q. Yes, okay, and the fact that--and if, did you discuss then with Dr. Greenland and ask him whether or not he would be relaying the news to her, talking to her about this?
DR. SIDDIQUI:
A. I don't remember discussing that with them. There are several patients that we alternate among ourselves, and there is not just this one. There are several patients for other specialties that alternate, other sites that we alternate among ourselves.
CHAYTOR, Q.C.:
Q. Now Doctor, of course, this is the retest on the biopsy, because as we've seen, the retest on the mastectomy specimen had been done quite a few months before that, back in October 2005. So this is the retest on the biopsy. How did this come to your attention? It's written here that "the restaining done at Mount Sinai on February 3rd, 2006, entered in her chart" showed it to be both negative. So it's confirming the--well, not confirming,

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it's saying that she's both ER and PR negative, and -
DR. SIDDIQUI:
A. It must have come -
CHAYTOR, Q.C.:
Q. - previously she'd been ER or PR positive.
DR. SIDDIQUI:
A. Right. It must have come to my mail box.
CHAYTOR, Q.C.:
Q. Okay, and so you think it must have come to your mail box, and you've written though that it was entered in her chart.
DR. SIDDIQUI:
A. I think that's what I meant by that, but it has to come through my mail box.
CHAYTOR, Q.C.:
Q. Okay. So do you recall, did you check the chart on this day?
DR. SIDDIQUI:
A. I don't recall that. If it came to my mail box, there's a pile of papers that will come in there. I take those and I'll go through those.
CHAYTOR, Q.C.:
Q. So that would mean that you've seen it entered

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in her chart because the addendum is on the piece of paper that you have, so it's entered in her chart? That's what you would mean by that, as opposed to physically the piece of paper is on the chart?
DR. SIDDIQUI:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay.
DR. SIDDIQUI:
A. Addendum separately from chart.
CHAYTOR, Q.C.:
Q. Okay.
DR. SIDDIQUI:
A. Because that's how they come. They come in the form of one or two pages or whatever is the length of that particular report, that's how they come and go to the mail box.
CHAYTOR, Q.C.:
Q. And the fact that she had been ER negative before and PR positive and her PR status has changed, that wasn't something that you thought you needed to communicate with her?
DR. SIDDIQUI:
A. If she was say on treatment before and then

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this turns out to be all negative, negative, that would have meant a change in treatment. I would have spoken with her. There was no change in treatment involved and this is March and she was booked to see radiation oncologist in May, I believe.
CHAYTOR, Q.C.:
Q. Okay, and you don't know whether or not you had the chart in front of you when you dictated this progress note?
DR. SIDDIQUI:
A. They come as a single or whatever is the length of the report and they come like that and they usually go to your mail box.
CHAYTOR, Q.C.:
Q. And when the progress report is given back to you, is it given back to you with the chart? You've actually signed this one.
DR. SIDDIQUI:
A. For signature? No, it again comes to another area. It's in the same room, but there's an area where the notes that you have dictated, they come to you for signing.
CHAYTOR, Q.C.:
Q. Okay.

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DR. SIDDIQUI:
A. They're not in the chart when they come to you.
CHAYTOR, Q.C.:
Q. So it's not on the chart?
DR. SIDDIQUI:
A. No.
CHAYTOR, Q.C.:
Q. So you could have done this on March 26th, 2006 without ever having seen her chart?
DR. SIDDIQUI:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. If we could have C-0014, please? This is the tumour board letter with respect to Ms. Green, dated May 8th, 2006, and this refers to her original status. "In the original report of the estrogen and progesterone receptors from the mastectomy, February 2001, showed zero for estrogen and 85 to 95 for progesterone. A repeat from Mount Sinai has shown the tumour to be estrogen and progesterone receptor positive at 20 and 70 percent respectively." So that's the repeat that we know, from looking at her chart, was

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done in October 2005 and entered on her chart in October 2005. "Review of Ms. Green's medical chart revealed that her diagnosis was based on the results of the mastectomy specimen and she was offered treatment with Tamoxifen, which she refused. Therefore the panel does not have any further treatment recommendations at this time. We would ask that you communicate this information to your patient as soon as possible" and it's copied to Dr. Woodland and Dr. Greenland.

The first paragraph refers to "the original report on the needle core biopsy in January 2001 showing negative staining for estrogen and positive for PR, and a repeat report from Mount Sinai showing both ER and PR to be negative." Doctor, do you know why-- this letter is May 8th, 2006. It's about seven months after the first retest result was entered on her chart. Do you know why the delay in having this letter come to you?
DR. SIDDIQUI:
A. This letter was actually received on June 14th. This one that you have, it doesn't have the stamp on that. The one in the chart, that

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has a stamp on it, and that is June 14th, 2006.
CHAYTOR, Q.C.:
Q. So it's actually another month after it's written before it arrived on the chart or to your attention?
DR. SIDDIQUI:
A. So June 14th would be the earliest time that it came to our medical record.
CHAYTOR, Q.C.:
Q. Okay, and you're right, there is another version of this.
DR. SIDDIQUI:
A. The stamp, the stamp means usually the day that it comes to the medical record and then they bring it to our attention afterwards.
CHAYTOR, Q.C.:
Q. Okay. So the stamp of June 14th, 2006 on the letter indicates that the earliest it could have been brought to your attention was June 14th, 2006?
DR. SIDDIQUI:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay, and do you know why it's June 2006

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before the issue of her first retesting, which showed her ER status in fact to have changed, that that was brought to your attention, that it's some eight months afterwards?
DR. SIDDIQUI:
A. Why it would take that long, I don't know.
CHAYTOR, Q.C.:
Q. Have you made any inquiries of anyone as to why that was the case?
DR. SIDDIQUI:
A. No, I haven't.
CHAYTOR, Q.C.:
Q. Doctor, the idea of the panel that because she was offered treatment with Tamoxifen which she refused at the time that she was ER negative and now she's ER positive, the idea that she would--the panel not having any further recommendation for treatment, did you agree with that assessment?
DR. SIDDIQUI:
A. I think it was a reasonable assessment.
CHAYTOR, Q.C.:
Q. And in terms of knowing in the chart Dr. Farrell's note which said about her being ER negative and the benefit therefore not being

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as strong a case for her, the idea of pointing out to her that "well now your ER status has changed to positive, does that affect your thinking or your decision in terms of taking Tamoxifen?" Do you think that that would be the kind of conversation that you should have with her before the determination is made as to whether or not she should be offered Tamoxifen?

DR. SIDDIQUI:

A. I think what--I don't know what exactly was in her mind that she did not want to take Tamoxifen for, what exactly was the thing in her mind, because when I saw her after this and I offered her Tamoxifen, she had refused at that time again, and it was in November of the same year. So whatever was in her mind about Tamoxifen, that probably made her do that, I don't know what exactly that was. She had mentioned that she had her own research done. In my note, and when I last saw her about Tamoxifen in 2001, I had suggested to her that "Tamoxifen is beneficial for you."

CHAYTOR, Q.C.:

Q. Okay, and I'll bring you to the November

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meeting with her and your note on that, and Doctor, if she did have concerns about Tamoxifen and perhaps, I think she's mentioned the issue of blood clotting was an issue in her mind, what about a discussion of another form of treatment for her? By 2006, there was other things available.

DR. SIDDIQUI:

A. Um-hm, and that's right, and when I saw her in December--in November, I had spoken with her basically about Tamoxifen. I could have and I would have probably done that, talked about something else. What I remember from that meeting is--I don't remember a whole lot of that, because I have seen her so many times in between, very similar situations. Second time, when she refused, what I remember is a bit of a shock kind of feeling, why would she refuse that. I wanted to talk to her again. I did some scans on her because she was losing weight at that time, and I would have spoken with her.

CHAYTOR, Q.C.:

Q. Okay, and if we could look then -

THE COMMISSIONER:

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Q. I'm sorry, when you're saying "second time, I had that discussion," you're referring to which year?

DR. SIDDIQUI:

A. November 2006.

THE COMMISSIONER:

Q. So you're saying when you saw her in November 2006, you once again had the discussion about the use of Tamoxifen or another -

DR. SIDDIQUI:

A. Tamoxifen.

CHAYTOR, Q.C.:

Q. And the first discussion having been back at the time of her original diagnosis?

DR. SIDDIQUI:

A. In 2002, when I spoke with her.

CHAYTOR, Q.C.:

Q. The first time you discussed with her, from your recollection and from your chart note, the first discussion you had with Ms. Green after the retesting process occurred in November, I believe it's November 17th 2006?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

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Q. Okay. If we could look, please, at C-0015?

THE COMMISSIONER:

Q. Just to be sure I'm straight, can we go back to that last exhibit for just a second? So while you received this letter sometime in June 2006, when you saw her again in November 2006, though the letter says no change is recommended, you recall raising with her again the use of--the possible use of Tamoxifen?

DR. SIDDIQUI:

A. That's right.

THE COMMISSIONER:

Q. Okay.

CHAYTOR, Q.C.:

Q. And while the letter says, the panel is asking that you "communicate this information to your patient as soon as possible," your first conversation with her, from your recollection, is November 2006?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay, and if we could look at C-0015, please? In those months, Doctor, what's going on with her cancer in the intervening months? Is

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there concern that she may have other things now happening?
DR. SIDDIQUI:
A. In which year?
CHAYTOR, Q.C.:
Q. Through 2006.
DR. SIDDIQUI:
A. The cancer can come back any time.
CHAYTOR, Q.C.:
Q. She was being -
DR. SIDDIQUI:
A. That is always a possibility.
CHAYTOR, Q.C.:
Q. And back, I believe when we looked at the March or the note which said that she was being investigated for lesions on her liver some months before, I take it that was being investigated for anything sinister that could be happening?
DR. SIDDIQUI:
A. I think it was 2003 or '04 and she had presented to me with some abdominal discomfort. Can I explain that a little bit more?
CHAYTOR, Q.C.:

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Q. Sure.
DR. SIDDIQUI:
A. With some chronological evidence to that. So I saw her three times in 2002 and three times in 2003 and then we switched to once every six months, between myself and Dr. Greenland. I think it was somewhere in 2004, I think in 2004 I saw her probably twice and that would be the second reason. She had some discomfort and I did a CAT scan. She was seen by Dr. Kwan as well, and I did an MRI as well on her. Those were reviewed by different radiologists and their consensus was that these are benign lesions, what were showing up on the liver. So she was thoroughly investigated at that time for whatever symptoms she had. So that was, I think, in 2004, and so after that, we started seeing her every six months from then onwards.
CHAYTOR, Q.C.:
Q. Okay, and I think it was the December 22nd, 2005 note which said at that point she was being investigated for lesions on her liver at that point, December 2005.
DR. SIDDIQUI:

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A. Is it 2005 or '04?
CHAYTOR, Q.C.:
Q. Do you want to go back to C-0012? She's recently been -
DR. SIDDIQUI:
A. I am just mentioning because the last scan there was in May of 2005 and there should be a note before that.
CHAYTOR, Q.C.:
Q. Okay. "She has recently been worked up for some liver lesions."
DR. SIDDIQUI:
A. Yes, and I mentioned there too the CAT scan is done on May of 2005, so I'm just putting the things in perspective.
CHAYTOR, Q.C.:
Q. That's right. So it's 2005.
DR. SIDDIQUI:
A. And so we started investigating her somewhere in 2004, and these should be the scans in 2004 and early 2005. So I might have seen her in early 2005 as well, so there should be a note in there, I think.
CHAYTOR, Q.C.:
Q. Okay. If we could go back then, please, to C-

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0015 and this is a note of Dr. Greenland, the radiation oncology clinic on May 26th, 2006, and he writes that she's "ER/PR negative. Treated with breast conservation in February 2001. Seen by follow up. Her path review has since confirmed her to be ER/PR negative. She has never been on hormonal therapy, although initially was called PR positive. She declined Tamoxifen at that time." So it appears that as of May 26th, 2006, the results of the second review, the review on her biopsy specimen has come to the attention of Dr. Greenland, and he's made a note on her chart to that effect.
DR. SIDDIQUI:
A. I think that would be my note in the chart. I don't know whether he looked at my note, which I had done in March and I had mentioned that biopsy which had come back to me.
CHAYTOR, Q.C.:
Q. Okay. So he may have been looking at your March note that you had made?
DR. SIDDIQUI:
A. It's possible.
CHAYTOR, Q.C.:

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Q. Yes, okay, and the idea that she's been confirmed to be ER/PR negative, and up here saying, it says "she's ER/PR negative," so I take it that's the current situation, according to what Dr. Greenland has seen on the chart in any event, whether it's through your progress note or otherwise. But the idea "she's confirmed to be ER/PR negative," she was never ER negative--I'm sorry, she was PR negative. She was always PR positive.

DR. SIDDIQUI:

A. On the first two specimens she was PR positive, the first biopsy, which was from February of 2001. And she was ER negative, PR positive in the first segmental mastectomy--sorry, biopsy was January, segmental mastectomy was February, 2001. She was also ER negative, PR positive on that one. And the review on the first one that is the biopsy, that's the one that I wrote a note on, that had said her to be ER negative and PR negative now. So what it looks like here is that that pathology from October, that is not aware of that, as well.

CHAYTOR, Q.C.:

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Q. No. And my point being, though, that she was never PR negative, she wasn't confirmed to be PR negative because her PR status, according to the biopsy specimen retest, changed?

DR. SIDDIQUI:

A. Right.

CHAYTOR, Q.C.:

Q. Right.

DR. SIDDIQUI:

A. But the initial biopsy report had reviewed to be ER negative and PR negative.

CHAYTOR, Q.C.:

Q. Yes. The retest?

DR. SIDDIQUI:

A. The retest on biopsy.

CHAYTOR, Q.C.:

Q. Yes. But she was never confirmed to be PR negative, she was PR positive and then it became PR negative on the biopsy specimen?

DR. SIDDIQUI:

A. That's right.

CHAYTOR, Q.C.:

Q. Yes. And this again is May 26th, 2006. And I showed you the panel letter which was dated May 8th, 2006. And there's no note in here in

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the content of Dr. Greenland's note as to the contents of the panel letter, even though it was copied to him, as well, it was copied to Dr. Greenland. But he makes no note of the retest on the mastectomy specimen which found her to be ER positive?

DR. SIDDIQUI:

A. Um-hm.

CHAYTOR, Q.C.:

Q. Okay. And I take it it could not or it appears not to have, or it escaped, anyhow, Dr. Greenland's attention up to May 26th. Do you know, have you had any discussion with Dr. Greenland around that and whether or not he also didn't receive the panel letter until June the 14th?

DR. SIDDIQUI:

A. I don't remember any discussion, but I don't remember any discussion with him.

CHAYTOR, Q.C.:

Q. Okay. And do you know whether or not on this date Dr. Greenland had any discussion with her about her--about the review of her pathology?

DR. SIDDIQUI:

A. I don't know if he had any discussion with

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her. But again, I was just looking at her testimony and there were a couple of points in there which were her take home message from this conversation, so I don't--it don't seem to be mentioned over here, though.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. And those were that her understanding was that if this is the case, she probably has a better outcome.

CHAYTOR, Q.C.:

Q. If she's ER -

DR. SIDDIQUI:

A. PR negative.

CHAYTOR, Q.C.:

Q. PR negative. And if we could look, please, at C-0016? And this is the note of November 17th, 2006. And, Doctor, is it your recollection that this is the date that you spoke with her about the content of the tumour board panel letter and the change in her pathology?

DR. SIDDIQUI:

A. I'll have to go with the note and -

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CHAYTOR, Q.C.:
Q. Sure.
DR. SIDDIQUI:
A. I spoke with earlier about that, so.
CHAYTOR, Q.C.:
Q. So do you have any independent recollection of it being this date or are you relying on your note?
DR. SIDDIQUI:
A. I've seen Ms. Green about 40 times so far since I started seeing her. I see on an average 200 new patients and about twelve to fourteen hundred follow-ups each year, so the last eight years, that means about ten, eleven thousand follow-ups. And sometimes I have 20 to 30 follow ups in one day. So that's why I dictate the detailed notes, whatever I do in them--with the patient, I try to dictate that. So I have to go with what my note said.
CHAYTOR, Q.C.:
Q. Fair enough, you have to rely on your note, I guess, okay. Fair enough, okay. So this is now November 17th, 2006. And so we're now--it's 13 months past the time that her original retest result which indicated her to be ER

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positive was first entered on her chart, according to the pathology report that we saw. So it's now 13 months later. And you say here, "On exam, in the presence of Nurse Bertha T. she does not seem to be in any distress." And you go on to say, "I spoke with Beverly again in detail about her reviewed pathologies from the prior studies." Now, Doctor, is that correct, had you spoken at any occasion prior to November 17th, 2006 to Ms. Green about her reviewed pathologies?
DR. SIDDIQUI:
A. I don't think so, according to the notes.
CHAYTOR, Q.C.:
Q. Okay. And "Her needle biopsy from January 17th, 2001 which was ER negative but PR positive was reviewed at Mount Sinai and found to be negative for both. The mastectomy specimen which was a segmental mastectomy from February 22nd, 2001 was negative for ER and 85 to 90 percent positive for PR, was found to be positive for ER 20 and P--sorry, ER 20 percent and PR at 70 percent. I have informed her about the status as her receptors have remained positive. I again talked with her

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about Tamoxifen but she is not interested." So when you say "I again talked with her about Tamoxifen, you're referring to the conversation you would have had with her back in 2002 about Tamoxifen?
DR. SIDDIQUI:
A. I think so.
CHAYTOR, Q.C.:
Q. Okay. "However, I think that since she's lost some weight and has this ongoing cough, we should do a scan on her to make sure that no sinister pathology is responsible for that. I will try to do a scan on her over the next two to three weeks and book her to come back and see us in a month." Doctor, it says that you talked to her about Tamoxifen. Do you recall did you talk to her about any other potential hormone therapy that might be available for her at this point in time?
DR. SIDDIQUI:
A. Again, according to the note it was just Tamoxifen discussion.
CHAYTOR, Q.C.:
Q. And the idea that you've informed her about that status as her receptors have remained

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positive, is that an accurate statement, was her ER status ever positive?
DR. SIDDIQUI:
A. No, but her PR was, so the PR was positive and, as I had mentioned earlier in my notes, we base our treatment on one of the two or both. Her PR was positive and I think that's what I'm referring to, that she was PR positive so we usually call that receptor positive.
CHAYTOR, Q.C.:
Q. Even though it says, though, you spoke to her about the status of her receptors, plural, have remain positive, and remain positive?
DR. SIDDIQUI:
A. She was PR positive and the main mastectomy specimen that remained positive and plus the ER was 20 percent on that, as well.
CHAYTOR, Q.C.:
Q. Okay. So did you discuss with her the fact that her ER status, in fact, had changed and that she was now ER positive as opposed to telling her that her status hadn't changed?
DR. SIDDIQUI:
A. It says over here if I described it that way,

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that she was ER--mastectomy specimen which was segmental mastectomy from February 22nd, so I would have told her that way.

CHAYTOR, Q.C.:

Q. I'm sorry?

DR. SIDDIQUI:

A. I would have told her that way, the way that it appeared on the review panel letter.

CHAYTOR, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. The changes.

CHAYTOR, Q.C.:

Q. And would you have told her that the panel was not recommending any change because she had refused Tamoxifen before and there was no further treatment that they could offer or recommend for her?

DR. SIDDIQUI:

A. Did I tell here that?

CHAYTOR, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. I don't remember that. But I still talked to her about restarting some hormone treatment,

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which was Tamoxifen at that time.

CHAYTOR, Q.C.:

Q. You had spoke to her about Tamoxifen?

DR. SIDDIQUI:

A. I did.

CHAYTOR, Q.C.:

Q. Yes. Okay, and if we could have, please, C-0017? And if Ms. Green's recollection is that the conversation about the change in her receptor status didn't happen in November, 2006, that she didn't have that discussion with you on that date, what do you say to that?

DR. SIDDIQUI:

A. I'm just surprised. I usually take a nurse with me, as well, most of the time and I document that, as well. I'm just surprised how would she say that.

CHAYTOR, Q.C.:

Q. And the next note is C-0017, December 14th, 2006. And the note is dictated but note read. And I take it on this date, Doctor, this wasn't good news what we read here, it's not good news for Ms. Green, is that fair?

DR. SIDDIQUI:

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A. That's correct.

CHAYTOR, Q.C.:

Q. That's correct. And the first line here says that she had used Tamoxifen on more than one occasion afterwards. Is that correct?

DR. SIDDIQUI:

A. I think this is a typographical error. It should be "refused".

CHAYTOR, Q.C.:

Q. I'm sorry, that should be refused?

DR. SIDDIQUI:

A. Yeah.

CHAYTOR, Q.C.:

Q. So that she'd refused Tamoxifen on more than one occasion afterwards?

DR. SIDDIQUI:

A. That's right.

CHAYTOR, Q.C.:

Q. So this says that the last one was in October of 2001, that's her last chemo treatment. "She was receptor positive on review. She had refused Tamoxifen on more than one occasion afterward." Now, did she refuse Tamoxifen on more than one occasion after the review up to this point in time?

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DR. SIDDIQUI:

A. No, I think this is total, the first one was in 2002, May, when she refused and the second one would have been the last time when I spoke with her.

CHAYTOR, Q.C.:

Q. Okay. And it says, "Today I had a long discussion with Beverly. I have requested her to think about it. At present she did not seem much interested in chemotherapy. But I informed her that if disease progresses, breast cancer is quite a treatable cancer, if not curable." So I take it at this point in time it's chemotherapy which you're recommending to her?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. Because she has had progression of her disease?

DR. SIDDIQUI:

A. Yeah.

CHAYTOR, Q.C.:

Q. At this point.

DR. SIDDIQUI:

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A. From that meeting of the previous one before that, November, a little bit what I remember from that and even as far back in 2001, I don't remember who was my nurse at that time, was just a feeling of shock and a bit helplessness because when she would say, a very young lady, very healthy otherwise and she would refuse a treatment so you felt a bit shocked. And that doesn't happen very often that people would refuse treatment.

CHAYTOR, Q.C.:

Q. Okay.

DR. SIDDIQUI:

A. And as the other eight or nine patients that I mentioned who were ER negative and PR positive and almost all of them had taken treatments. So that's what I remember from the November meeting, a little bit of feeling. And again, here in this particular one, on December 14th, again, what I a little bit remember from that meeting is that she said it's just going to prolong. And that's why I said that I requested her to think about it. She was not interested in chemo initially, she did not sign a consent form that day. Consent form

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was signed a month down the road, which was January 12th, 2007. And she did not seem much interested about any treatment at that time.

CHAYTOR, Q.C.:

Q. Okay. So you were surprised because she's young but she was thinking it's going to prolong things for her, was -

DR. SIDDIQUI:

A. That's what I remember from, just a little bit what I remember, and a feeling of shock and-- that's the meeting before.

CHAYTOR, Q.C.:

Q. Okay. And if we could have, please, C-0020? And this is a progress note of April 30th, 2007. And there's no indication here, I don't think, of her ER/PR status or any discussion about that in this particular note. You do indicate, however, "On exam in the presence of Nurse Cheryl, HEENT shows no palpable nodes."

DR. SIDDIQUI:

A. That's Cheryl is her first name.

CHAYTOR, Q.C.:

Q. Cheryl.

DR. SIDDIQUI:

A. And it's H-E-E-N-T.

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CHAYTOR, Q.C.:

Q. Yes, I'm sorry, yes, I ran that all together, didn't I? "HEENT shows no palpable nodes." Thank you, Doctor. Okay, so do you recall whether or not on this date that you had any discussion with her as to, I guess at this point it's not going to be discussed whether or not she's to take hormone therapy at this point in time, is that correct?

DR. SIDDIQUI:

A. We would at a point. What happened from December until now is that she was offered chemotherapy with Taxotere. We also did a HER2/neu, we requested for a HER2/neu staining for her that turned out to be negative for her. I had also requested for a liver biopsy on her that she had done towards the third week of January and that came back somewhere in February. That was a liver biopsy. So she had six cycles of chemotherapy up until this point and she had--she was running into some side effects at this point. She had some runny eyes and she had some tingling and numbness. So this was, I think, the last cycle number six of this particular chemotherapy, and when

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she came in on the follow-up which was in May, I had spoken with her about hormones again and she was put on hormones at that time.

CHAYTOR, Q.C.:

Q. And, Doctor, there's a portion of this chart which is left blank, "I have told her there is less than 1 percent risk of", and there is a blank described with this chemotherapy, and again your note is dictated, but not read. So where we see blanks in charts, what --

DR. SIDDIQUI:

A. I think it would be we are talking about --

CHAYTOR, Q.C.:

Q. And it's not so much what was being discussed at that point in time. I'm just thinking if there's something that the transcriber can't understand and there is a gap, would it be the practice to --

DR. SIDDIQUI:

A. I think would be referring to neuropathy from the chemo. That could happen.

CHAYTOR, Q.C.:

Q. I'm just wondering, though, is there a practice for the progress note to be brought to your attention so that it can, in fact, be

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completed before it's actually placed on the patient's chart?

DR. SIDDIQUI:

A. Most of the time, they do, but if it's dictated, but not read, sometimes it just goes to the chart.

CHAYTOR, Q.C.:

Q. Okay. If I could have, please, C-0021. Ms. Green is seen again on May 22nd, 2007, by yourself, and this note again is dictated, but not read, and there's several gaps again in this. In the second paragraph there's a blank and then another blank down under "assessment and plan".

DR. SIDDIQUI:

A. I think they're both pertaining to the same word which is "epiphora", which is running or tearing of eyes.

CHAYTOR, Q.C.:

Q. And do you have any independent recollection of this meeting with her?

DR. SIDDIQUI:

A. No, I'll have to go again with my assessment and plan.

CHAYTOR, Q.C.:

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Q. And on this assessment and plan, it refers to the pathology report again, "According to the pathology report, specimen number given, which was the main surgical specimen at segmental mastectomy, she was 20 percent positive on ER and 70 percent positive on PR. I have again offered her hormonal treatment with Femara and she has agreed to that. We discussed the side effects in detail", and you go on to say what those include. Doctor, it says that, "I have again offered her hormonal treatment with Femara". Was this the first time she was, in fact, offered Femara?

DR. SIDDIQUI:

A. That's correct.

CHAYTOR, Q.C.:

Q. If we could have C-0023, please. This is October 18th, 2007, and again under your assessment and plan, she had some neuropathy with Taxotere, is it; however, that completely disappeared. Again there is a gap, "There is a risk for that coming back. The other option will be to use", and it's another drug. "I have discussed both with her", and I believe at this point in time you've asked her to stop

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her Femara. So she's been asked to stop. Why would she be asked to come off the Femara at this point in time, what's happening here?

DR. SIDDIQUI:

A. The CAT scan here, which was done on the 27th of September, and that had shown disease progression. Between this and the May meeting, I think I have seen her one more time, which was in June, which was to review another CAT scan, and between that June and this CAT scan, she had progressed on Femara, so I spoke with her about different treatment options. This meeting I remember a little bit because she was upset, she cried on that day, and I remember that a little bit.

CHAYTOR, Q.C.:

Q. And I guess that's because again the disease had shown some progression?

DR. SIDDIQUI:

A. Disease had shown progression. It was not good new for her.

CHAYTOR, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. For this particular meeting, and for the

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meeting of the 30th of April, in the chart there are notes from the nurses as well. The nurse whose named I mentioned on the 30th of April, Cheryl Boone, there is a note in the chart from that day signed by the nurse, and there is also a note in the chart from October 18th, 2007, discussing similar events.

CHAYTOR, Q.C.:

Q. And you've reviewed those notes?

DR. SIDDIQUI:

A. I have seen those notes.

CHAYTOR, Q.C.:

Q. And those notes refer to her being upset on October 18th?

DR. SIDDIQUI:

A. That's right.

CHAYTOR, Q.C.:

Q. And do they refer to her being upset on either May 22nd visit or the April 30th visit?

DR. SIDDIQUI:

A. On May 22nd, I could not find a note, but on April 30th, there is a note in there and there is no mention of being upset on that date.

CHAYTOR, Q.C.:

Q. Okay. Do you recall in any of your meeting

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with Ms. Green that she requested documentation or information from her chart?

DR. SIDDIQUI:

A. I don't recall a particular event about that, but my patients do ask about that. When I go to the patient's room, I have the chart in my hand, and every chart and Ms. Green's chart the same way. It would have two main components to it. There is one component which I can bring from the computer like blood work, or if there is a CAT scan report. I carry that in my hand. If the patient asks for that, I give it to them. If there is something else in the chart which is a main part of the chart which cannot be removed, I order it up for them to Medical Records to get the rest of the chart photocopied. Did she ask for me on a particular day, I don't remember that. A lot of patients ask, and if I have something in my hand, I just give it to them, which is not from the main chart, that I don't have to tear out from the main chart.

CHAYTOR, Q.C.:

Q. And do you recall ever having any incident or any words with Ms. Green around the issue of

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her requesting any information from her chart?

DR. SIDDIQUI:

A. No, I don't remember. On the 30th of February meeting, I don't really remember anything after this all happened. Actually, I spoke with those nurses as well and I requested them that if there was anything that I forgot, and if I misbehave in any way, let me know, and I can come in and just say if that happened if they remembered anything. They did not remember anything on those days either, if I did any such thing.

CHAYTOR, Q.C.:

Q. Okay, and, Doctor, I just have a little portion then for you to be able to respond to in terms of what Ms. Green said, and this is from her evidence that she gave here before the Commission on March 19th, 2008, and she's quoted at page 73, "Well, what about my charts, and he said, well, there's--I told you there was no cure for this disease, right, like, without even--without anything else, that was the first thing. There is--I told you there is no cure for this disease, and I said, well, you know, I was under the

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understanding I had 80 to 90 percent chance of survival rate and that's what I've been concentrating on, and he said, well, the 20 percent, I guess that's what you'd fall into, the 20 percent". Do you recall any conversation along those lines?

MR. BROWNE:

Q. Commissioner, sorry to interrupt, is it possible to have that brought up on the screen?

CHAYTOR, Q.C.:

Q. Yes, sorry, absolutely. I'm sorry, I should have asked for that. It's March 19th, 2008, page 73. Thank you, Mr. Browne.

THE COMMISSIONER:

Q. What was the page number again?

CHAYTOR, Q.C.:

Q. 73.

THE COMMISSIONER:

Q. Thank you.

CHAYTOR, Q.C.:

Q. There we go, that's it. This is the portion here that I'm reading out to you.

THE COMMISSIONER:

Q. Starting at line 11, Doctor.

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CHAYTOR, Q.C.:

Q. Starting at line 11, right here, Doctor.

DR. SIDDIQUI:

A. Okay.

CHAYTOR, Q.C.:

Q. And I took you down as far as right here, "the 20 percent".

DR. SIDDIQUI:

A. As you saw in my note from December, that's the note when I had mentioned to her that this is not curable, but treatable. I don't know if she's referring to that. I don't know where these numbers are coming from, and this word "chance of survival rate", I would not really know what that means and where this number is coming from.

CHAYTOR, Q.C.:

Q. Okay, so you have no recollection --

DR. SIDDIQUI:

A. I don't remember saying anything like that.

CHAYTOR, Q.C.:

Q. Okay, and then, Doctor, it continues on and says that, "And then he said--he just turned around at me and he had the results from my liver biopsy and he took it and he said, is

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this what you want, and he threw it at me, threw it at me and he walked out the door, and that was pretty much when I was just angry, furious. I did not approach anyone on it, like, you know, mention to the nurse, all I wanted was a copy of my chart". Doctor, I'd like to offer you an opportunity to respond to that portion as well?

DR. SIDDIQUI:

A. Sure. I've never ever thrown anything on an patient, never. I have been working in this institution for close to eight years now, and my colleagues and my other staff, or other people who have been working with me, if they can identify a single incident that I was disrespectful to them, or I did anything which was misbehaving in any way, they won't be able to find one. I've never ever thrown anything on any patient. What I can tell you I usually do when I come into the room, usually I don't shake hands with the patient, some people like, some don't. If somebody initiates, I do that. I examine the patient and after that, I put the chart on the sink which is just next to the door, or sometimes on the table. I

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always wash my hands afterwards. If it's a female patient, I will leave the room for a minute to let them dress. This is my usual routine. I don't think I've done anything different than that. I never threw anything on anybody. If there is something that she's taking in a different way from what I have been doing usually which is--again that never involves throwing anything in any way. That is it.

CHAYTOR, Q.C.:

Q. And, Doctor, does Ms. Green continue to be your patient?

DR. SIDDIQUI:

A. Since this--other thing is that on that date she mentioned in the rest of her testimony there was a nurse present there, and again that nurse has documented a full note which is in the chart, and there is no mention of any such even in that note as well. From that until March 19th when she gave her testimony, I have seen her nine times in between that time period, and not even once--not even once has she brought up any such thing like that, that I was disrespectful to her in any way.

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After her testimony, I saw her the very next day which was March 20th, and that day I took again my nurse with me. She put her own patient note in the chart as well. I specifically asked Ms. Green do you have confidence or do you think you want to follow with any of the other medical oncologists. I offered her to be seen by any of the other medical oncologists, and she just asked me that "am I okay". I said that for me there is no problem, I'll go with her wishes, and she decided to stay with me. She's still my patient, I'm still taking care of her.

CHAYTOR, Q.C.:

Q. Thank you, Doctor. Those are my questions. Thank you, Doctor. Some of my colleagues may have questions.

THE COMMISSIONER:

Q. Mr. Pritchard.

MR. PRITCHARD:

Q. Thank you, Commissioner. I don't have any questions for Dr. Siddiqui.

THE COMMISSIONER:

Q. Mr. Simmons.

MR. SIMMONS:

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Q. Thank you, Commissioner.

DR. JEHAN SIDDIQUI - EXAMINATION BY MR. DAN SIMMONS

MR. SIMMONS:

Q. Good afternoon, Dr. Siddiqui.

DR. SIDDIQUI:

A. Good afternoon.

MR. SIMMONS:

Q. I'm here for Eastern Health, and I had just a few points that I wanted to follow up on you about. You were asked some questions about the arranging of appointments, in particular, those questions were asked to you about in the context of arranging for appointments for people whose test results had changed as part of the retesting program, and I was wondering if you can tell me, are there circumstances in the ordinary care of patients where they have to be called back or appointment made for them other than the scheduled appointments that may be coming up?

DR. SIDDIQUI:

A. I would think again if there is something that the patient wants to talk about, and this has happened, we saw them once and they had something in mind that they want to talk

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about, they'll call in again and we see them. They will talk to the nurse. If that satisfies, that's fine; otherwise, they'll come back and I'll see them.

MR. SIMMONS:

Q. Are there ever occasions where you may receive a test result that will cause you to want to have the patient contacted to make--to come in for an appointment? Maybe the patient is scheduled to come in in three months or six months and you want them to come in early, does that sort of thing happen in your ordinary practice?

DR. SIDDIQUI:

A. That has happened.

MR. SIMMONS:

Q. In those circumstances, what would the process be for contacting them and making those arrangements?

DR. SIDDIQUI:

A. I think again it depends on what kind of test is that. If there is something that requires urgent attention, then sometimes my nurse call them, and if it is something that requires an appointment in the next week or two, then we

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request for an appointment with the medical record and the other clerk who is taking care of the clinic, and they would make the appointment.

MR. SIMMONS:

Q. In the cases where you wanted to contact patients whose ER/PR results had changed, did you do anything different than that, or did you follow what would be your ordinary practice for contacting a patient that you needed to bring back in to discuss a test result with?

DR. SIDDIQUI:

A. I think I've called myself quite a few patients.

MR. SIMMONS:

Q. So that would be out of the ordinary, but otherwise, the type of contact would be a telephone call to arrange an appointment to come in to discuss a test result?

DR. SIDDIQUI:

A. Most of the time.

MR. SIMMONS:

Q. Okay. In the course of your practice, you have occasion to request many different types

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of laboratory tests and diagnostic imaging tests, I presume, for patients?

DR. SIDDIQUI:

A. Uh-hm.

MR. SIMMONS:

Q. And what's the normal way in which the results of those tests are communicated to you?

DR. SIDDIQUI:

A. If there is something really staggering in the test, they should give us a page and let us know.

MR. SIMMONS:

Q. Otherwise?

DR. SIDDIQUI:

A. If you are putting in a CAT scan for somebody who is having headache, a CT head, and if they find something in the head, you would expect a call from them and they usually do. Otherwise, it will go to our mailbox. A report would come in and will go to the mailbox.

MR. SIMMONS:

Q. Right. So having the addenda for the retest results for ER/PR testing come to you by having a report in your mailbox, was that any

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different than the way that you are notified for all the other types of tests that you do on a routine basis?

DR. SIDDIQUI:

A. I think a different thing would be if it was on a different colour paper. Most of the time I remember an orange colour paper in my mailbox.

MR. SIMMONS:

Q. Okay.

DR. SIDDIQUI:

A. But in terms of calling me if there was a big change, I don't think I ever got a call in terms of that.

MR. SIMMONS:

Q. But the system that's in place for communicating test results to you normally is to have the report come on a piece of paper into your mailbox which would come to your attention so that you can then act on it, and use it in deciding on the treatment for your patient?

DR. SIDDIQUI:

A. That's correct.

MR. SIMMONS:

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Q. And the ER/PR retest results came to you in the same way for you to act on?
DR. SIDDIQUI:
A. They did.
MR. SIMMONS:
Q. Okay.
DR. SIDDIQUI:
A. With the exception of, I think, the last ones that we talked, they were just brought directly to my attention, and the one in December of last year.
MR. SIMMONS:
Q. You were asked whether you were aware of any of your patients who had been missed in the retesting process and you told us that when you were at the peripheral clinic in Corner Brook, there were occasions when you saw in charts that there were no retest results, so you put in a consult to have a retest done for those patients. I just want to follow up on that. Do you know in those cases whether there had been a retest already requested for those patients, and it just wasn't back yet?
DR. SIDDIQUI:
A. I also said that most of the time they were in

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the pipeline. Most of the time we learned that they were done, and we just did not have those, but they were done, or they were somewhere. I think--I don't know if they were coming to St. John's first and then going, whatever it was, but most of the time they were done.
MR. SIMMONS:
Q. So before ordering those consults, you didn't have any investigation done to determine if this patient was already in the pipeline, you went ahead and ordered the consult, anyway, did you?
DR. SIDDIQUI:
A. If I had full known that this patient was in the pipeline, I probably might not have.
MR. SIMMONS:
Q. Okay. When you received the panel letters from the review panel that looked at the ER/PR results with the recommendations in it, did you feel that you were in any way bound to follow those recommendations?
DR. SIDDIQUI:
A. I think it's not completely binding, but tumour board decisions, they are probably the

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best suggestions from a group of expert doctors.
MR. SIMMONS:
Q. Did you feel that you were no longer able to bring your own judgment to bear in deciding what was the best course of treatment for your patient?
DR. SIDDIQUI:
A. I don't think so. I think you still had the liberty, but I would think that if you're going against it, it's a good idea to talk to them first, make sure that you're not missing a piece of information that they may have.
MR. SIMMONS:
Q. Okay. Thank you very much, Dr. Siddiqui. That's all the questions I have for you.
THE COMMISSIONER:
Q. Mr. Pritchett.
MR. PRITCHETT:
Q. No questions, Commissioner.
THE COMMISSIONER:
Q. Ms. Newbury, do you have any questions?
MS. NEWBURY:
Q. Yes, I do.
THE COMMISSIONER:

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Q. Let's assess how much time we're going to need. Could you give me a ball park?
MS. NEWBURY:
Q. About fifteen minutes.
THE COMMISSIONER:
Q. Ms. Brocklehurst.
MS. BROCKLEHURST:
Q. No questions.
THE COMMISSIONER:
Q. Mr. Pike.
MR. PIKE:
Q. No questions, Commissioner.
THE COMMISSIONER:
Q. Mr. Browne.
MR. BROWNE:
Q. About ten minutes. (Inaudible) to go over a couple of points.
THE COMMISSIONER:
Q. Okay. Well, let's just find out how inconvenient that's going to be for your witness, or do you know?
MR. BROWNE:
Q. I haven't been talking to him. I'm assuming--
THE COMMISSIONER:
Q. Well, I'm just wondering whether or not on the

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assumption that our--on the assumption that we will be finished with this witness.

MR. BROWNE:

Q. I'm not aware if Dr. Siddiqui had a clinic this afternoon.

DR. SIDDIQUI:

A. No, I'm okay.

THE COMMISSIONER:

Q. You're okay.

DR. SIDDIQUI:

A. Yes.

THE COMMISSIONER:

Q. Well, let's take the luncheon break in that case. The witness has been on the stand all morning. He's entitled to have his lunch. We'll meet again at 2:15.

(LUNCH BREAK)

THE COMMISSIONER:

Q. Ms. Newbury.

MS. NEWBURY:

Q. Thank you.

DR. JEHAN SIDDIQUI - EXAMINATION BY MS. JENNIFER NEWBURY

MS. NEWBURY:

Q. Good afternoon, Dr. Siddiqui. My name is Jennifer Newbury, and I represent the Canadian

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Cancer Society, Newfoundland and Labrador Division.

DR. SIDDIQUI:

A. Good afternoon.

MS. NEWBURY:

Q. Upon receipt of the panel letters, and just speaking about those letters generally, would you typically review the patient file to ascertain your own views regarding appropriate treatment for the patient, and then compare that with the panel's recommendation?

DR. SIDDIQUI:

A. If the patient is booked on a very near date, I'll do that on the day when the patient comes in to see us.

MS. NEWBURY:

Q. Okay. So if a patient wasn't scheduled to come in for a couple of months time, you would wait until closer to the actual date of the appointment?

DR. SIDDIQUI:

A. That would be in case there's no change of treatment suggested.

MS. NEWBURY:

Q. Okay, and if there was a change in treatment,

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would you immediately upon receipt of the letter, review the file?

DR. SIDDIQUI:

A. Those patients are booked very soon, so either the file would be looked at, or usually when they come in to see us, the file will be looked at at that time.

MS. NEWBURY:

Q. And would you look at the file with a view to seeing what your own recommendation or your own views would be on treatment, independent of the letter, and then do a comparison, or were you placing reliance upon the panel's recommendation?

DR. SIDDIQUI:

A. By that time, you would have the panel letter, anyway, so you cannot take that out of your mind.

MS. NEWBURY:

Q. Sure.

DR. SIDDIQUI:

A. You're aware of what they have suggested.

MS. NEWBURY:

Q. Okay.

DR. SIDDIQUI:

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A. So you go to the chart and see if there's any reason for a discrepancy.

MS. NEWBURY:

Q. So you would conduct your own analysis?

DR. SIDDIQUI:

A. You would.

MS. NEWBURY:

Q. And in terms of those patients whose treatment was not recommended to be changed, and who you would not see until the next regularly scheduled appointment, did you also conduct an analysis at around the time of that regular appointment to see if your views coincided with that of the panel?

DR. SIDDIQUI:

A. I think I'll go through that, yes.

MS. NEWBURY:

Q. Okay.

THE COMMISSIONER:

Q. I'm sorry, sir, I missed what you said.

DR. SIDDIQUI:

A. I will go through that.

MS. NEWBURY:

Q. And how frequent are regular appointments for patients, generally speaking? What is the

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range, I guess, of intervals between appointments for patients?

DR. SIDDIQUI:

A. It varies in what stage of the treatment a patient is.

MS. NEWBURY:

Q. Uh-hm.

DR. SIDDIQUI:

A. If the patient is seen first and the patient is on chemotherapy, then most of the chemotherapy cycles are done every three week; most, not all.

MS. NEWBURY:

Q. Uh-hm.

DR. SIDDIQUI:

A. So they would be seen every three weeks for those chemotherapy cycles. After that, if they are on hormonal treatment or no hormonal treatment, the recommendations are to see them every three months for the first two to three years and then every six months for a couple of years following that.

MS. NEWBURY:

Q. Okay.

DR. SIDDIQUI:

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A. So I would follow those guidelines.

MS. NEWBURY:

Q. Okay. So then at most a patient might have to wait perhaps six months or close to six months before the next scheduled appointment to find out his or her results if there's no change of treatment?

DR. SIDDIQUI:

A. That is the accreditation the oncologist is also following if there are two of us.

MS. NEWBURY:

Q. If there are two of you. Are there any situations where the patient might be seen less frequently than once a year by either oncologist?

DR. SIDDIQUI:

A. Less frequently means more than once in one year or less than --

MS. NEWBURY:

Q. Less than once in one year--less than twice in one year.

DR. SIDDIQUI:

A. I would doubt. Usually I don't extend it beyond a year unless there is some request by the patient.

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MS. NEWBURY:

Q. And for those patients who were no longer having regularly scheduled appointments who had gone beyond that point in time where they see an oncologist every six months, did you come across any of those cases for those patients for whom you received panel letters?

DR. SIDDIQUI:

A. The panel letters--there were few which were discharged, the two that we talked about today, the first two were discharged.

MS. NEWBURY:

Q. Okay.

DR. SIDDIQUI:

A. I don't know if I answered your question. Those were the discharged one.

MS. NEWBURY:

Q. Yes, and they were the ones that were handled by the family physician?

DR. SIDDIQUI:

A. That's right, one of them was sent to family physician, the other one was--letter was sent to me.

MS. NEWBURY:

Q. Do you know if the patients for whom you

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received panel letters would have been provided with any other information about the results of their testing or the fact that they were being retested prior to meeting with you, generally speaking?

DR. SIDDIQUI:

A. If I could think, I would think, and again I won't say always, but I think most of the times they were aware that there's a change in their status or in one of the tests. That's what they are there to talk about.

MS. NEWBURY:

Q. And how would they become aware of that change prior to meeting with you?

DR. SIDDIQUI:

A. I think there are different possibilities. One could be that their family physician told them, if a letter went to surgeon, if they met their surgeon. That would be one. Sometimes, and again I'm thinking that one of the options could be that if they got a call from Cancer Clinic, they might have asked why, and they might have been told. I'm just thinking, but I think family physicians and probably surgeons.

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MS. NEWBURY:
Q. But in the cases that you were the primary recipient of the panel letters, would you have been considered the main treating physician for that particular patient?
DR. SIDDIQUI:
A. I could be, but again there are exceptions to that, as the first lady that you talked about today--should I say the name?
THE COMMISSIONER:
Q. If it's not a lady whose name has been mentioned here --
DR. SIDDIQUI:
A. It's not the lady from Alberta, it's the other one. That lady was discharged from our clinic. She was discharged in 2001, and letter still came in my name in December of 2007. I don't know why that was, but it came to my name, so I had to take action on that.
MS. NEWBURY:
Q. So you received a letter, even though you were no longer the primary treating physician?
DR. SIDDIQUI:
A. She was discharged.
MS. NEWBURY:

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Q. But, I guess, my question is this, how reliable was your assumption that patients who had not yet had a chance to meet with you to discuss a panel's recommendation, how reliable is your assumption that someone else may have communicated information about their ER/PR test results to those patients?
DR. SIDDIQUI:
A. Personally, the one patient that I encountered, she was aware of that.
MS. NEWBURY:
Q. Okay.
DR. SIDDIQUI:
A. So this is my personal experience.
MS. NEWBURY:
Q. So that was one particular patient, and do you know if that was something that she learned because the protocol had been set up to advise her accordingly, or was that perhaps just a --
DR. SIDDIQUI:
A. That I don't know, but according to her, she had learned that, it looks like, within a reasonable time period from the time that the letter was sent to the family physician.
MS. NEWBURY:

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Q. Okay. So based upon perhaps that particular incident and maybe any other assumption that you made, was it your belief and understanding that patients were not waiting to see you to be informed of the retest results for their ER/PR status?
DR. SIDDIQUI:
A. If the letter came to me and there is a change, then I will talk to them, but if the letter was just carbon copied to me and was primarily directed to a different physician, same as I told that if a letter came to me, I think that other physicians would have thought the same way.
MS. NEWBURY:
Q. Okay. Perhaps I should focus on those patients for whom the panel did not recommend a treatment change and may have to wait upwards of six months to meet with you so that you could discuss those results with them, did you have any firm reason to believe that they would already know the results of their ER/PR retesting?
DR. SIDDIQUI:
A. Is there any particular patient because --

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MS. NEWBURY:
Q. No, just generally speaking. I personally don't have access to the information, so I'm just wondering if you could tell me what your understanding was, or if you even thought about that issue at all.
DR. SIDDIQUI:
A. The first thing is that I would not think that if the letter was done, the patient probably would not know for that long, because if it was sent to one physician and was carbon copied to at least one or two others, most of the patients would know.
MS. NEWBURY:
Q. So you would rely upon perhaps the physicians who had received carbon copies of the letters to notify the patient?
DR. SIDDIQUI:
A. If it is sent to me, then I will do that. In case of change, I will do that as soon as I could.
MS. NEWBURY:
Q. Okay.
DR. SIDDIQUI:
A. In case of no change, I will whenever they are

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next seen, either by myself; if they are in a peripheral clinic, then by my colleagues, or one of the radiation doctors.

MS. NEWBURY:

Q. In some cases, these patients may not have a regularly scheduled appointment for maybe four, five, or six months before they get to see you, and you're the person, the recipient of the letter. Do you have any reason to believe that in those cases that the physicians who have been copied on the letter, if there were any, would have contacted the patient to let them know about the ER/PR test results?

DR. SIDDIQUI:

A. I would not know about that. I would be speculating if I said one way or the other.

MS. NEWBURY:

Q. Okay, so there's nothing that--you weren't told by anyone that we've got a system put in place to immediately tell the patients the results and when you get around to seeing them, you know, in their regularly scheduled appointment, you can elaborate on that, but they already know the results? You had no

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reason to believe that that was actually taking place?

DR. SIDDIQUI:

A. Not that I know of.

MS. NEWBURY:

Q. Okay. Did you have any reason to be concerned that there are patients who might be anxious to receive the results of their ER/PR retesting?

DR. SIDDIQUI:

A. I'm sure there are.

MS. NEWBURY:

Q. Okay.

DR. SIDDIQUI:

A. And I can understand their point, of course.

MS. NEWBURY:

Q. And this morning you'd indicated that--I think I understand your evidence this morning in terms of the initial decision now to advise the patient that retesting was going to take place, you didn't take great issue with that so long as the retesting could take place rather quickly, and was that due to your concern about anxiety that patients might experience, not knowing what the results are?

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DR. SIDDIQUI:

A. What I mean is that if you can identify all the patients and you can get those done on a very priority basis, then get those done very quickly and start talking to people. If it's going to take a year or two to get those done and the patients know from January 1st, 2006, that theirs would be done, but then they are on the edge until December of 2007--I had a patient in December as well. So if you have control on how long would it take for those to get done, get those done very quickly as first priority, and then those should be told to the patients.

MS. NEWBURY:

Q. But in terms of once certain patients were channelled into the panel review process, some of those patients might ultimately have no change in their treatment, or that's the recommendation of the panel, and did you have any reason to believe that some of those patients might be on edge until they get the call from you or from the Cancer Clinic to come meet with them and to discuss the results, or did you assume that some other

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process was taking place that would advise them, you know, don't worry, there's no change, or there's going to be no change in your treatment?

DR. SIDDIQUI:

A. I don't know if there was a process in there, but the letter usually went to family physician as well.

MS. NEWBURY:

Q. Okay.

DR. SIDDIQUI:

A. If there is some patient who called and would like to see us earlier, we would do that. I don't remember anything on top of my head, but if it was something that you would ask me to do now or would have asked at that time, I would have done that.

MS. NEWBURY:

Q. Okay.

DR. SIDDIQUI:

A. If some patient calls in and they want to see me earlier, I would definitely do that.

MS. NEWBURY:

Q. But would the patients have any means of knowing that panel letters had actually been

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sent to various physicians? Perhaps they're just sitting waiting, they don't even know.

DR. SIDDIQUI:

A. It's possible.

MS. NEWBURY:

Q. Okay.

DR. SIDDIQUI:

A. It's possible, just going to their family physician.

MS. NEWBURY:

Q. And is it fair to say that you left those types of decisions in terms of deciding when and who should notify patients to others to determine, other than your role in contacting them once you received a panel letter?

DR. SIDDIQUI:

A. I had a small percentage of all those patients. As I mentioned earlier, my breast practice is not huge. I had seen a few patients in my first two or three years, but in the last four years or so, not a whole lot. So I had two patients from that time, but it was not a huge breast practice.

MS. NEWBURY:

Q. Okay.

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DR. SIDDIQUI:

A. So I did what's being done around at that time.

MS. NEWBURY:

Q. So you basically did what you were asked to do in terms of contacting patients when you received a panel letter, but you didn't question or have any particular concerns in your mind about those patients who might have to wait for four or five months before they met with you, those who didn't require treatment change, to learn what their results were? Did that not enter your mind at the time?

DR. SIDDIQUI:

A. I'm sorry, I didn't get it fully.

MS. NEWBURY:

Q. I'm just wondering if you had any concerns at all about those patients who may not get to meet with you for four or five months to learn what the results are of the retesting? Was that not in your mind at all?

DR. SIDDIQUI:

A. That is a concern. That is a concern.

MS. NEWBURY:

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Q. Were you thinking about that at the time, though, is my question?

DR. SIDDIQUI:

A. This would be a concern, and if the patient were aware that the tests have gone in, if they call in earlier, I would definitely see them.

MS. NEWBURY:

Q. Okay. So it would be up then to the patient to contact them if they have any particular concerns, contact the Cancer Clinic or one of their physicians?

DR. SIDDIQUI:

A. If they are very concerned, I would definitely see them whenever they want to come in.

MS. NEWBURY:

Q. And did you receive any of those calls?

DR. SIDDIQUI:

A. I'm trying to remember. Not that come to my mind right now.

MS. NEWBURY:

Q. You'd made reference this morning to the value of the tumour panel, and I believe in giving your evidence you made reference to the tumour board and I think you've indicated that that's

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very good information that comes as a result of a case being reviewed by the tumour board, and I wonder if you can tell me what your general practice is if you have a patient whose treatment or diagnosis is being considered by a tumour board, would you attend that particular session and present the case or observe the case if you might be one of a group of oncologists involved in that treatment or diagnosis?

DR. SIDDIQUI:

A. I'll try my best to attend that.

MS. NEWBURY:

Q. And why is that?

DR. SIDDIQUI:

A. Usually at tumour boards, the decisions are a little bit more complex. That is when you require a multi-modality approach, you require input, you have some questions about the radiology, you have some questions whether the surgeons would approach this patient or not, you have questions about radiation or if that's the best option for that or not. So there is usually multi-modality and more complex questions.

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MS. NEWBURY:
Q. Uh-hm.
DR. SIDDIQUI:
A. And you would like to be there to explain those, what is the reason of putting a patient to the tumour board.
MS. NEWBURY:
Q. Okay, and do you think that process might have been beneficial for the tumour panel process as well? I understand from your evidence this morning there might have been some impediments to that, it might have been difficult to do, but putting those obstacles aside, do you think it would have been beneficial for you to be present at these panel reviews?
DR. SIDDIQUI:
A. I would think that if they have information, what they think that they need, and they think then that they're going to make a recommendation with available information that they wanted, it would be reasonable for them to go ahead. If they want to involve that physician, that would definitely be a good idea, I'm not against that.
MS. NEWBURY:

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Q. So I understand that you're saying that it may not be necessary for the panel review to do that, but do you think there might be some benefit more than just being necessary, but actually have some sort of additional value to having you present there, maybe in terms of communicating with the patient when you ultimately meet with them?
DR. SIDDIQUI:
A. I would think that probably interview patient if somebody has progressed or something has happened by that time period. It may be a bit helpful, but it's usually in the chart. If the notes are in there, usually they can get information of what's going on.
MS. NEWBURY:
Q. Dr. Siddiqui, in terms of scheduling appointments, those who required treatment changes and those who didn't, how much time was set aside to meet with these patients to discuss the results of retesting and any impact on treatment?
DR. SIDDIQUI:
A. There are two things; what they were booked for, and second thing is how much time was

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actually given.
MS. NEWBURY:
Q. Uh-hm, yes.
DR. SIDDIQUI:
A. Our system books follow-up patients for twenty minutes.
MS. NEWBURY:
Q. Uh-hm.
DR. SIDDIQUI:
A. And new patients for one hour. So I think many of them were booked for follow-up, but I can speak from my side that I won't be out of the room until I say do you have any other questions.
MS. NEWBURY:
Q. Okay, and --
DR. SIDDIQUI:
A. And if they don't, then I leave the room.
MS. NEWBURY:
Q. And -
DR. SIDDIQUI:
A. So some of my conversations, I remember one or two patients lasted for more than an hour.
MS. NEWBURY:
Q. Yes, you indicated that this morning that some

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perhaps as long as an hour and a half.
DR. SIDDIQUI:
A. Yeah.
MS. NEWBURY:
Q. I'm wondering if that opportunity was given to all patients or maybe some of them may not have expressed a desire to stay a little bit longer than the 20 minutes, for example.
DR. SIDDIQUI:
A. They're never asked to leave at the end of 20 minutes. They are there for as long as they want to be and for as long, again I can speak for myself, as long as if they have any questions. I would never ask a patient to leave.
MS. NEWBURY:
Q. Okay.
DR. SIDDIQUI:
A. For as long as--usually it's not just for this. Whenever I see a patient, usually my first question is "anything new since I last saw you?" and the last thing is that "do you have any other questions?" It's only when that they say no, that I usually leave the room.

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MS. NEWBURY:
Q. And I think you indicated that some patients, you discussed this issue on more than one occasion in follow up visits. I'm wondering if that option was made available to all of your patients. Perhaps some of those may not even be returning for a regularly scheduled follow-up appointment. Would that option have been made available to them that "listen, if you have any questions -
DR. SIDDIQUI:
A. It's entirely up to the patient. I would say if they think that they get all the information and they were satisfied up to that extent, that could be the information that they needed. This particular patient that I pointed to, she wanted to talk to me again, so she was brought in again, whenever she wanted to.
MS. NEWBURY:
Q. So you feel comfortable then that all of the patients that you saw would have realized that they could come back and see you if they had any other questions?
DR. SIDDIQUI:

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A. They can still. They can come back any time.
MS. NEWBURY:
Q. I just wanted to ask you a couple of questions on some of the letters that you received from the panel, and that's Exhibit P-2545, please, and on page one, I'm not sure to what extent you can recall the patient behind this particular letter, and obviously nothing should be identified in terms of the individual there, or even if you could speak generally to how you might have proceeded in this case here, in terms of your communication with the patient, and I'm wondering whether the communication with the patient would have focused primarily on the information in this panel letter or if you would have elaborated on other information and, as an example, this is a case that you've mentioned this morning that the patient had a right breast cancer and had initially been diagnosed with left breast cancer, and this morning, I don't think you were able to say for sure whether there were two different primary cancers or whether one was -
DR. SIDDIQUI:

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A. You cannot say that just on the basis of that. You have to look at the chart. We're just speculating.
MS. NEWBURY:
Q. In the event that--and again, this is a bit of a hypothetical, but in the event that the left--or the right breast cancer was a recurrence of the left breast cancer, would there have been any sort of general discussion about what might have caused that or whether there was any impact by having any delay treatment with Tamoxifen as an example?
DR. SIDDIQUI:
A. First is that this particular patient, I don't really remember, so I'll have to look at the chart to see what exactly that patient has, and second, if you're asking that a delay in the treatment of Tamoxifen, would that have affected the outcome, that's possible, if it is spread over years. However, there are other things. It's not as simple as black and white. The overall benefit of Tamoxifen, if I'm not mistaken, and the breast specialist could probably confirm that, is about nine percent reduction in overall mortality in five

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years. So this is a number and chemotherapy itself has its own value too. So if the patient got chemo, Tamoxifen benefit would be additive to that. So all those things have to be considered before.
MS. NEWBURY:
Q. Right, and I can appreciate that they're certainly not black and white issues here, but I'm just wondering--I'm focusing on the communication with the patient and whether those types of factors would have been discussed with the patient at the time.
DR. SIDDIQUI:
A. What I usually--I can tell you what I do when I see those patients. What I usually did was that I started--I would start from the first pathology, that this was the first pathology, the treatment, if we did any treatment at that time, that this was the treatment that we offered to you or not offered, whatever happened at that time, and then this is your pathology report, which has come in, and then this letter, I'll talk about this letter, if I refer that with me, that this is the recommendations and do I agree with that or

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not, which I did most of the times.
MS. NEWBURY:
Q. Okay, and would you have recorded, in your patient file, all of the issues that you discussed with the patient? Perhaps not word for word, but at least to cover off all of the different categories?
DR. SIDDIQUI:
A. I tried to cover as much as I could, but every single question that patient asked, did I record every single question? Probably not.
MS. NEWBURY:
Q. The second letter, page two of that exhibit, and I think you indicated this morning that this patient would have been treated with Tamoxifen initially, and that was based upon the PR results that were positive on the initial testing back in 2003. I'm just wondering if the results of ER, negative ER back in 2003, whether that might have impacted other aspects of this patient's treatment, in terms of whether or not the same chemotherapy or radiation would have been provided to that patient?
DR. SIDDIQUI:

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A. Again, that I'll have to individualize and look at the chart, but I would think, and I can talk about the hormonal part over here, that if the patient was offered Tamoxifen and with this ER/PR of E being zero and P being 80 to 90 percent and at a later date, she was found to be ER at 25 and PR at two, so this is the actual report, so whatever benefit she was supposed to get, she is getting it because she was on the appropriate treatment right from the start.
MS. NEWBURY:
Q. Okay. So because she was on the proper treatment with Tamoxifen, would you say that she was also on the proper treatment in terms of the type of chemotherapy, if any?
DR. SIDDIQUI:
A. That again depends on number of things.
MS. NEWBURY:
Q. Okay.
DR. SIDDIQUI:
A. How old was the patient, how big was the tumour, were there any lymph node involved, was she ever offered any chemotherapy at any point, so these are a lot of variables.

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MS. NEWBURY:
Q. Okay, and would those variables have been discussed with the patient at the time? I'm just wondering whether the focus here was on the Tamoxifen, whether or not there should be any changes there with regard to hormonal treatment or whether there would be a reevaluation as to whether the initial other types of treatment such as chemotherapy and radiation was appropriate or not for her, just to let her know about it?
DR. SIDDIQUI:
A. Again, I'm just sort of hypothesizing.
MS. NEWBURY:
Q. Sure.
DR. SIDDIQUI:
A. That if there was a patient like that and a patient had a question, you would definitely address that. That's one thing, and again, if you are asking that on the basis of a change in hormone receptor was the chemo done or not done, I don't know. That would depend on individual patients you could talk about.
MS. NEWBURY:
Q. Would it be up to the patient to initiate that

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question as to whether or not the initial chemotherapy or radiation treatment was appropriate or would you take it upon yourself to review that information and advise the patient accordingly?
DR. SIDDIQUI:
A. I think it depends on patient to patient and physician to physician. I had a lot of patients who had asked that, and I even have patients now who ask that, since this all started. So people are more aware of these things. They ask those.
MS. NEWBURY:
Q. Okay, and those types of discussions, would you record that in the patient files, if you had a discussion about the other--the appropriateness of other treatment?
DR. SIDDIQUI:
A. I would record as much as I could, and again, if I have one-hour long discussion with the patient, description of that would probably take 20 pages.
MS. NEWBURY:
Q. But just generally to -
DR. SIDDIQUI:

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A. General -
MS. NEWBURY:
Q. - to point out the fact that it was discussed and perhaps not in detail in your notes, but you would at least highlight the fact that that type of discussion took place regarding appropriateness of other treatment, aside from hormonal treatment?
DR. SIDDIQUI:
A. Again, I think that would vary from patient to patient. If it was a big concern and a big discussion happened on that, I probably would.
MS. NEWBURY:
Q. Okay. Aside from communicating that information that you've just described a few minutes earlier to the patients, did you talk about some more general issues relating to the ER/PR retesting, the reasons for the retesting and the causes of problems which led to retesting? Did you have a practice of discussing that with each of your patients?
DR. SIDDIQUI:
A. Most of the time, I told them that there was a repeat done and as I said earlier today, if somebody asked, some technical difficulties, I

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think that's what we had up to so far, and if they asked me specifically what technical difficulties, I would tell them that because I still don't know exactly, we're trying to find that out.
MS. NEWBURY:
Q. Okay, and did you indicate to those patients who were inquiring about the nature of technical difficulties whether they would ultimately be advised as to the nature of that or that their questions would be answered somewhere down the road, or did you even have that information to give to them?
DR. SIDDIQUI:
A. Did I say that? I don't know if I said that or not, but I think if somebody is one of those patients who are--we are talking about today, I'm sure they would be following up what's going on.
MS. NEWBURY:
Q. Did you advise the patients that you met what was being done to address the problems that caused the ER/PR retesting?
DR. SIDDIQUI:
A. That I have what?

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MS. NEWBURY:
Q. Did you advise them what was being done by Eastern Health to address the problems?
DR. SIDDIQUI:
A. I don't think I really commented on that. I commented on my part and the test results and the panel letters.
MS. NEWBURY:
Q. Okay. So you were focusing on then, in your role on the treatment of the patients?
DR. SIDDIQUI:
A. Yeah. I don't remember talking to any patient about what Eastern Health had done.
MS. NEWBURY:
Q. Okay, or about any steps being taken in the lab to fix the problems with ER/PR retesting?
DR. SIDDIQUI:
A. I don't remember talking to anybody like that.
MS. NEWBURY:
Q. Did you offer an apology to your patients, as a general rule, either I guess on behalf of yourself or the system generally?
DR. SIDDIQUI:
A. I do feel sorry for them, but was there something that I did, I don't know. I don't

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think that there was something that we know that what actually happened and where the problem was. I really feel sorry for them.
MS. NEWBURY:
Q. Sure.
DR. SIDDIQUI:
A. But that's what I would feel, and I would say. I would empathise with them, which I do. I feel sorry for the hardship that they have to go through.
MS. NEWBURY:
Q. Okay, and you did express that to the patients?
DR. SIDDIQUI:
A. I would, and I think the one that we discussed today and yesterday, Mrs. White, she mentioned in her testimony as well that we had a lengthy discussion. All the questions were answered. All the informations were given.
MS. NEWBURY:
Q. And you feel you did that with each of the patients that you met with?
DR. SIDDIQUI:
A. As much as I could.
MS. NEWBURY:

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Q. Did you offer any information about any supportive resources that might be available through Eastern Health for the patients, if such resources were available?
DR. SIDDIQUI:
A. I don't know of any specific patient, but I would think, and again I would think that if there were some requirements, my nurses would refer them to a counsellor or a social worker, but it actually happened, I don't remember of any particular patient.
MS. NEWBURY:
Q. Do you know if anyone else at Eastern Health was given the task of meeting with patients or calling them or communicating with them in any way to advise them, for example, what might be done to address the problems in the lab with the ER/PR retesting or to offer an official apology on behalf of -
DR. SIDDIQUI:
A. With individual patients?
MS. NEWBURY:
Q. Yes.
DR. SIDDIQUI:
A. I don't know of that.

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MS. NEWBURY:
Q. You didn't know at the time that you were meeting with the patients whether anyone else at Eastern Health -
DR. SIDDIQUI:
A. I don't know if they ever did.
MS. NEWBURY:
Q. Okay. Were you provided with any resources yourself, anyone to call to assist you with your dialogue with the patients that you met to discuss the panel review results?
DR. SIDDIQUI:
A. You mean any prior -
MS. NEWBURY:
Q. Yes.
DR. SIDDIQUI:
A. - something in preparation from my part?
MS. NEWBURY:
Q. Or any time along the way, if you had a question and you weren't sure how to respond to certain inquiries from patients, were you given any resources or the name of an individual you could call for any advice or additional information?
DR. SIDDIQUI:

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A. For pathology, I called Dr. Denic a few times, and he was--I know that he was very swamped with work, but he was always responsive to that. I think I might have spoken with him once or twice.
MS. NEWBURY:
Q. Okay. How about the communication issues, how to communicate or what to communicate to the patients?
DR. SIDDIQUI:
A. I just basically told them what I knew.
MS. NEWBURY:
Q. Okay.
DR. SIDDIQUI:
A. And most of my conversations were about the treatment related part. Most of the patients, when they would come in, they would say that "we understand that this was not done by you." But since I am the one who is treating them before and I'm the one who is going to take care of them afterwards with this change, so they were a bit angry with me to start with. I had quite a few patients like that. But that, most of the time, was a short-lived thing.

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MS. NEWBURY:
Q. Dr. Siddiqui, this morning you'd referred to guidelines for follow up and you mentioned it again a few minutes ago. Are these written guidelines for follow up with patients?
DR. SIDDIQUI:
A. Yeah. There are more than one sources. These guidelines are, the first one there from, I think if I'm not mistaken, from American Society of Clinical Oncology, and that here in our institution, it has been reviewed and updated.
MS. NEWBURY:
Q. Okay. So Eastern Health has its own -
DR. SIDDIQUI:
A. We do have our guidelines in terms of follow up and discharge for breast cancer. We are trying to come up with other guidelines as well.
MS. NEWBURY:
Q. Do you know if there have been any modifications to those guidelines to address patients who were involved in the ER/PR retesting, just to acknowledge that perhaps they didn't receive the treatment in the

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normal course that they would have if their results had been known from the beginning?

DR. SIDDIQUI:

A. I don't think that there is any, and I don't know if they would really need any special guidelines.

MS. NEWBURY:

Q. And why is that?

DR. SIDDIQUI:

A. Say if somebody was picked up six years afterwards, the guidelines to follow up is that after five years, for the cancer part, they should be seen once a year. So right now, they would be seen more frequently than once a year anyway, right.

MS. NEWBURY:

Q. Because they're taking hormone therapy?

DR. SIDDIQUI:

A. They were picked up, and until they are settled. Once you start somebody on new treatment or even a new pill, you see them a couple of times afterwards to make sure that everything is fine. You review the blood work. You go through the toxicity profile. So those patients would be seen.

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MS. NEWBURY:

Q. So in your view then, the existing guidelines wouldn't have to be altered for any reason to specifically address those patients who were involved in ER/PR retesting?

DR. SIDDIQUI:

A. I think all those patients could be looked at individually. These guidelines are done as a general--if some, one particular patient has a particular need, patients are more important than the guidelines themselves.

MS. NEWBURY:

Q. Sure.

DR. SIDDIQUI:

A. And if one patient has any particular need, that could be modified for that one. It could be adjusted.

MS. NEWBURY:

Q. And is there any--do you think there will be any consideration as to whether or not there should be a bit of an analysis there to see whether or not the cancer clinic should look at following these patients more frequently, just to recognize the fact that they didn't have perhaps the same chemotherapy or hormone

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or radiation treatment program that they might otherwise have had?

DR. SIDDIQUI:

A. I don't know of one, but I don't think it would be a bad idea.

MS. NEWBURY:

Q. Now Dr. Siddiqui, when you were discussing the patient, Beverly Green, this morning, and I think you expressed some, I guess, shock or frustration because she hadn't accepted Tamoxifen from the beginning and you had indicated that you didn't know what was in her mind at the time, her reasons for refusing the Tamoxifen back in around 2002, would that have made it perhaps even more important to have met with Ms. Green right away, to let her know about the new results from Mount Sinai, given that you don't know what her reasons were for refusing it back in 2002, perhaps the new results might have had some impact upon her decision to reconsider that decision?

DR. SIDDIQUI:

A. I did that, and I offered her treatment and she refused again in November of 2006.

MS. NEWBURY:

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Q. Okay, but that, I think the meeting with her was some months after you received the letter from the panel. Do you think it might have been perhaps useful to have met with her earlier, in case that she wanted to reconsider the decision at that time?

DR. SIDDIQUI:

A. I mean, we can think about it in a different way now, but if she has refused in November, I'm not sure if she would have a different decision a bit earlier.

MS. NEWBURY:

Q. Right, but you didn't know that at the time?

DR. SIDDIQUI:

A. I did not know that at that time.

MS. NEWBURY:

Q. Okay. Thank you, Dr. Siddiqui. Those are all the questions I have for you.

THE COMMISSIONER:

Q. Mr. Browne?

MR. BROWNE:

Q. Thank you, Commissioner.

CROSBIE, Q.C.:

Q. I do have some questions, Commissioner. (inaudible) be in order.

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THE COMMISSIONER:
Q. Ms. Brocklehurst told me this morning there were no questions.
CROSBIE, Q.C.:
Q. That's before she spoke to me at lunch time.
THE COMMISSIONER:
Q. Mr. Browne, I'm afraid you're going to be delayed a bit. Come forward, Mr. Crosbie.
CROSBIE, Q.C.:
Q. Thank you.
DR. JEHAN SIDDIQUI, EXAMINATION BY CHESLEY CROSBIE, Q.C.
CROSBIE, Q.C.:
Q. Good afternoon, Dr. Siddiqui.
DR. SIDDIQUI:
A. Good afternoon.
CROSBIE, Q.C.:
Q. Ches Crosbie, I represent the members of the Breast Cancer Testing Class Action.
DR. SIDDIQUI:
A. Um-hm.
CROSBIE, Q.C.:
Q. Sir, I had some items of clarification from what you talked about this morning. Could I ask that document P-0113 be brought up, please, and page 8 of that? Here, sir, you'll

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note this is the surgical pathology review committee minutes of meeting, September 23, 2003, and your name is listed as present?
DR. SIDDIQUI:
A. Yes.
CROSBIE, Q.C.:
Q. And so obviously you were a member of that committee. When did you become a member of the committee?
DR. SIDDIQUI:
A. That was in April of 2003. And that was when, Doctor, would it be from--if we go to page 1 of that same document or same exhibit, that I think is the earliest in the chain of this exhibit, April 4th. In this memorandum Dr. Ejeckam, you can see it's signed by him. If you just bring it down there, is announcing the closing of the service. And you'll notice around line 3 he's talking about "Certain tests, including for ER and PR have remained unreliable, erratic and therefore unhelpful for diagnostic purposes." And saying that the staining with these antibodies will stop until the problem is sorted out. Were you a member--was the committee in existence at that point?

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DR. SIDDIQUI:
A. We can look at the dates again. I think the first meeting of the committee was on April 15th, 2003. And as you can see that this document was, I think, sent mostly towards pathologists. It would say probably on top of this document whom did that go to. Committee's first met,two pathologists -
CROSBIE, Q.C.:
Q. To pathologists. (phonetic)
DR. SIDDIQUI:
A. Yeah. And the committees member, basically there were two pathologists in that committee, if you look at the attendance in there. Myself, Dr. Tennant, Dr. Dawson and Dr. Battcock is another pathologist.
CROSBIE, Q.C.:
Q. I'm sorry, Doctor?
DR. SIDDIQUI:
A. The five names that I said, myself, Dr. Tennant, Dr. Dawson, Dr. Battcock and there were two other surgical members initially, Dr. Thava and Dr. Kwan.
CROSBIE, Q.C.:
Q. Yes.

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DR. SIDDIQUI:
A. They are not pathologists, so that memo would not have gone to them.
CROSBIE, Q.C.:
Q. Okay. Now that we're looking at page 8, you are, in fact, the only medical oncologist listed there?
DR. SIDDIQUI:
A. Yeah.
CROSBIE, Q.C.:
Q. So you're the only medical oncologist member for that committee?
DR. SIDDIQUI:
A. That's right.
CROSBIE, Q.C.:
Q. Did you see the memo that we just looked at from Dr. Ejeckam in which he announced suspension of the testing?
DR. SIDDIQUI:
A. I saw this first time when I was interviewed in March of this year.
CROSBIE, Q.C.:
Q. Just keep this straight now. In this exhibit it's page 1. This memo of April 4th, 2003 you say you only saw recently this year?

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DR. SIDDIQUI:
A. March of this year.
CROSBIE, Q.C.:
Q. What about if we go to page 2, there's another memo dated May 2nd, 2003 from Dr. Ejeckam, it's addressed to pathologists, do you recall reading this memorandum back in 2003?
DR. SIDDIQUI:
A. No. I also saw this for the first time in March of this year.
CROSBIE, Q.C.:
Q. And if we go ahead to page 5, there's another memo from Dr. Ejeckam addressed to Mr. Gulliver.
DR. SIDDIQUI:
A. I'm sorry, there's one correction.
CROSBIE, Q.C.:
Q. Yes.
DR. SIDDIQUI:
A. I saw both of those memos when I was interviewed. I think it was March, but I'll have to check the exact date whenever I was interviewed. It was just before that that I saw those.
CROSBIE, Q.C.:

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Q. Okay. My main point, though, or what I want to understand from you, is were you privy to these documents back in 2003 when the suspension occurred and then testing was reinstated, also the one at page 5, the June 19th, 2003 memo which is in front of you there, were you privy to this?
DR. SIDDIQUI:
A. No.
CROSBIE, Q.C.:
Q. All right. So this is the one which, of course, at page 7, if we can advance to page 7, finishes up under paragraph 6 by saying, halfway down paragraph 6, "Diagnosis based on inappropriate immunostain will surely jeopardize patient care and may even expose the hospital to litigation." You didn't see that one before this year?
DR. SIDDIQUI:
A. No.
CROSBIE, Q.C.:
Q. Despite being on the committee as of April, 2003?
DR. SIDDIQUI:
A. I don't remember that these memos are

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presented on that committee.
CROSBIE, Q.C.:
Q. They weren't tabled or discussed at any committee meeting which you attended, is that what you say?
DR. SIDDIQUI:
A. Dr. Ejeckam I think in the first meeting he had mentioned that they were--they had some technical difficulties, and that is my recollection of that. In the first meeting I think we can look at, confirm the dates again, that was, I think, in April of 2003, and that's when she had mentioned that there are some technical difficulties. And that would be my--that's what I would remember from that meeting.
CROSBIE, Q.C.:
Q. Just looking at the page we have in front of us which is page 7 in the exhibit, page 3 of that memo from June from Dr. Ejeckam, when he talks about "surely jeopardize patient care" it would seem that we're talking about more than really technical problems, would you agree?
DR. SIDDIQUI:

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A. I think it is technical problem that would eventually do that.
CROSBIE, Q.C.:
Q. Would eventually do that but not yet?
DR. SIDDIQUI:
A. I don't know.
CROSBIE, Q.C.:
Q. Was it discussed at your committee whether there was an issue of actual patient care live at that time, in 2003?
DR. SIDDIQUI:
A. And as I said on Friday, as well, what I remember from this committee is basically from what is in the minutes and I can look at the minute of each one of those and then I can answer your question, as well. And the minute of the--sorry, the April, 2003 one, Doctor, I think, Ejeckam, he had mentioned of that problem, that there's a technical problem. And I think in the follow-up one, which was in September he had mentioned that the technical problem is corrected.
CROSBIE, Q.C.:
Q. I gather from what you've said you didn't develop a concern that there was an issue

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about the reliability of ER/PR status testing in 2003?

DR. SIDDIQUI:

A. I would have to wait for them to let me know or actually let my department know. I get technical problems, as well, when we are making call schedules or some other things and sometimes I discuss with my colleagues as well about that. But we get those things done and it doesn't mean that they have to start coming and asking me every single day about that. I would think that these are the appropriate people who know the problem. And he had mentioned that sometime that they know how far the problem goes, that these are the ones that have to look at, to address the and to solve the issue. So if they know the problem, they know what exactly is wrong, they're looking at it, so my expectation and understanding would be that they'll take care of it. And if some point they feel it is up to such extent that patient care is directly affected, there is a way to do that and that would be that they would send a letter to our department or to individual oncologists and would ask them not

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to follow-up on those test results.

CROSBIE, Q.C.:

Q. What I'm getting from this is that you were depending on the pathologists to let you know as an oncologist whether there was a patient care issue?

DR. SIDDIQUI:

A. I'm sorry?

CROSBIE, Q.C.:

Q. You were depending on the pathologists to let you know if there's a patient care issue?

DR. SIDDIQUI:

A. I'm depending on the pathologists for the report.

CROSBIE, Q.C.:

Q. For a report?

DR. SIDDIQUI:

A. For the report and want the pathologist to take responsibility of their report. And if they are sending me a report, my understanding would be that they know about this problem, if they are sending me a report, they have looked at those things and if they are still sending it to me, they have considered all those things before it is coming to the surgeon or

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the medical oncologist or gyne or radiation oncologists.

CROSBIE, Q.C.:

Q. Again, you didn't get information coming to your attention as a member of the committee that said to you there is a patient care issue? That's what I'm taking from this?

DR. SIDDIQUI:

A. What I can say is that I was never asked to stop considering the results of those reports or not to take them into account when I'm treating patients or making decisions.

CROSBIE, Q.C.:

Q. What was your function on the committee as the sole medical oncologist?

DR. SIDDIQUI:

A. There were seven things in the mandate all what the committee wanted to do. Among others, my main concern would be a standardized reporting system. That is something which is very dear to us, all of us. And the second thing would be the discussion of important cases. Plus, there were others and of course, I would like to put my input into those, as well, but these two would be

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the most important to me.

CROSBIE, Q.C.:

Q. And again, what I'm taking from this is no pathologist or anyone else, for that matter, brought it squarely to your attention and consideration, here are the issues we've been facing in the lab, now as a person who works with that information to make treatment decisions and recommendations to patients on treatment, are you concerned about the reliability or accuracy of the testing? No one squarely brought that issue to your attention, is that what you're saying?

DR. SIDDIQUI:

A. I would be definitely concerned. But at the same time I know that the people who are eventually going to solve that issue, they know that and if he is still sending a report to he is aware of the problem, he has considered all those things before a report has come to me or to any of the other oncologists.

CROSBIE, Q.C.:

Q. And you got no information that would have given you a concern about quality of patient

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care in this context, as a member of the committee, that's what you're saying?

DR. SIDDIQUI:

A. My information was basically what is in the minutes of the committee, that on the first time he said that there are some technical problems and but they did not say of that should we stop seeing patients for that, no. In September they said that those technical problems had been solved.

CROSBIE, Q.C.:

Q. Had you, for example, been given a copy of this memorandum there and you see page 3 of that, would you have looked differently at the lab testing suspension and then reinstitution, would you have had more concern about quality of care issues?

DR. SIDDIQUI:

A. Again, the concern would definitely be there. But the second thing is that these are the same people which are looking into it right now and which would have--I would have asked the pathologists and Dr. Ejeckam would have been the best person to look into that. And he is the one who is aware of the issue,

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because I think the bigger problem would be that are they aware of the issue, is the diagnosis of the issue made. It looks like that they knew something about that. So I would be definitely concerned, that's for sure, but I would also know and would be somewhat reassured that the appropriate person, they know about that and they are working on that.

CROSBIE, Q.C.:

Q. And you'd be guided by Dr. Ejeckam, principally?

DR. SIDDIQUI:

A. By all the pathologists, but I just brought up his name because he's the one who looks like who is writing memos over here and he's following up on those.

CROSBIE, Q.C.:

Q. It never came up for discussion or in your mind the issue of doing a sample look back to make sure that the testing was reliable, as you had hoped?

DR. SIDDIQUI:

A. Again, in every department they have their own quality assurance means and their own quality

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assurance measures and I would not know that. They have to keep all those things standard on their own.

CROSBIE, Q.C.:

Q. Okay, I'd like to switch to another topic. And you spent some time discussing the case of Mr. Green this morning. And as you just mentioned, she was offered by you as the treater, you were here treater, her treating oncologist in 2002, sorry?

DR. SIDDIQUI:

A. That is correct.

CROSBIE, Q.C.:

Q. She was offered Tamoxifen then?

DR. SIDDIQUI:

A. That's correct.

CROSBIE, Q.C.:

Q. And that was on the basis of what kind of a reading, do you recall her report for hormone receptor status, what the values were?

DR. SIDDIQUI:

A. She had two different reports at that time. The first one, which was the biopsy which was from January of 2001, I think that was read as ER negative and PR positive. And the second

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one, which was a mastectomy specimen, which was from February, I think, 22nd, I'm not sure about the date, 2001, that was read as ER negative and I think PR were 80 to 90 percent, if I'm not mistaken. And for treatment purposes, as I had said earlier, as well, we take one or the other or both if they are both.

CROSBIE, Q.C.:

Q. For treatment purposes, just so I understand that, if you had a high PR, then that could justify a treatment recommendation to take Tamoxifen, is that what you're saying?

DR. SIDDIQUI:

A. If either one of them is considered positive, by the prevailing criteria.

CROSBIE, Q.C.:

Q. Yes.

DR. SIDDIQUI:

A. We would treat them, whether it's ER or PR.

CROSBIE, Q.C.:

Q. Was there at that time a cut off for the PR value?

DR. SIDDIQUI:

A. For both we use similar cut offs, which were

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about 30 percent or so.
CROSBIE, Q.C.:
Q. So if PR was greater than 30 percent but ER negative, then it was your practice to make a recommendation for Tamoxifen therapy?
DR. SIDDIQUI:
A. That's right.
CROSBIE, Q.C.:
Q. And that was your practice in 2002?
DR. SIDDIQUI:
A. That's right.
CROSBIE, Q.C.:
Q. And that guideline came from where, from the practice from our lab or from other standards or where?
DR. SIDDIQUI:
A. The Strickman Guideline has been that if even one of them is positive, that has been the traditional teaching and we have been doing that. I had eight or nine other patients in a similar scenario who were ER negative and PR positive and they were offered treatment and the majority of them had accepted that.
CROSBIE, Q.C.:
Q. Um-hm. In discussing a situation with a

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patient like Ms. Green where you have a negative ER and a positive PR, do you tell them that that weakens the case for taking Tamoxifen with a negative ER?
DR. SIDDIQUI:
A. As I'd said earlier today, that I do my own discretion and I tell them that there is benefit and the benefit is more than zero. Obvious there is benefit even if the PR is positive. I have done the same discussion for the other eight or nine patients that mentioned who had accepted the treatment. I have never said and I would not say that it's not beneficial. I've always said that it is beneficial even if one of them is positive.
CROSBIE, Q.C.:
Q. Sir, surely you'll have to tell us, but if you've got a strong positive in ER as well as PR, that must strengthen the case for Tamoxifen?
DR. SIDDIQUI:
A. Again, I think if we are talking about in terms of the available data, in the adjuvant setting I am not sure if this question is fully answered. We have some data available

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from the metastatic setting, in metastatic setting, that is the case. But in the adjuvant setting, I'm not sure if this question is fully answered. But I would think that that's what I had done even in late '90s, when I was a fellow, that even if one of them is positive, offer treatment, and that's what I have always done.
CROSBIE, Q.C.:
Q. Are you telling the Commission that your recommendation for treatment in a patient with positive PR but negative ER is no stronger than it would be or approximately of the same strength, let's put it that way, as it would be for a patient with a positive ER and a negative PR?
DR. SIDDIQUI:
A. The treatment would be Tamoxifen, would be the same dose of Tamoxifen and would be taken the same way.
CROSBIE, Q.C.:
Q. And you don't make a stronger recommendation in one case or the other?
DR. SIDDIQUI:
A. We are talking about one particular patient.

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CROSBIE, Q.C.:
Q. Um-hm.
DR. SIDDIQUI:
A. And in her case the information that we had that she was ER negative and PR positive, so that is the case that I had to discuss, and in that particular situation I had to tell her that you are ER positive so this it your positive point, which would benefit you.
CROSBIE, Q.C.:
Q. So again, this may seem repetitive, but do you stress the case for Tamoxifen any more highly, as a rule, if there's a positive ER than--and a negative PR than if there's a positive PR and a negative ER?
DR. SIDDIQUI:
A. If any one of them is positive and any one of them is more than the acceptable rate of positive at that time, I will stress the case for Tamoxifen even if a single one of them is positive. I will tell them that it is beneficial for you.
CROSBIE, Q.C.:
Q. I see. Do you know whether your colleagues at our institution approach the matter in the

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same way?
DR. SIDDIQUI:
A. I think that would be the general--if one of the two is positive, I think we do offer treatment.
CROSBIE, Q.C.:
Q. Um-hm. Thank you, sir.
THE COMMISSIONER:
Q. Mr. Browne.
DR. JEHAN SIDDIQUI, EXAMINATION BY MR. PETER BROWNE
MR. BROWNE:
Q. I guess you're wishing I would have not broke for lunch, are you, Dr. Siddiqui? Go back to Ms. Green. She has been the topic of conversation of questioning both this afternoon and this morning. And I want to ask some general questions and specific questions around her and her treatment. Going back to, first of all, the type of tumour that Ms. Green had. Can you tell the Commissioner what type of tumour she had?
DR. SIDDIQUI:
A. Ms. Green had infiltrating ductal carcinoma with some areas of lobular.
MR. BROWNE:

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Q. Okay. And I guess there's infiltrating and non-infiltrating ductals. The prognosis of infiltrating, can you explain that to the Commissioner, please?
DR. SIDDIQUI:
A. In terms of different infiltrating cancers like infiltrating we use the word "infiltrating" or "invasive" one or the other. So invasive ductal carcinoma as opposed to invasive lobular carcinoma, invasive lobular would have a better long-term prognosis.
MR. BROWNE:
Q. Okay. And you were shown, and I don't think it's necessary, you were shown a portion by Ms. Chaytor this morning of Ms. Green's transcript from her testimony back in March, on March 19th, where she references, and I think it's in relation to a conversation with you about the fact that you had mentioned an 80 to 90 percent chance for survival. Would that, given the type of tumour she had, would that be something you would have said to Ms. Green?
DR. SIDDIQUI:
A. In my note from December of 2006 that note

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says that I mentioned to her that this is not curable.
MR. BROWNE:
Q. Right.
DR. SIDDIQUI:
A. So I don't know where exactly those numbers are coming from.
MR. BROWNE:
Q. Right. And again, just to go back to the general topic, tumours, we've heard about various types of tumours and some tumours are more aggressive than others. What sort of considerations--and Ms. Chaytor asked you about in terms of, I think, considerations for hormonal therapy what sort of things you consider. What sort of considerations you mentioned, for instance, age and so on. What are the considerations for aggressiveness of a tumour?
DR. SIDDIQUI:
A. In terms of deciding, in terms of treatment and also helping somewhat in their aggressiveness age is one important thing.
MR. BROWNE:
Q. Okay.

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DR. SIDDIQUI:
A. Usually in younger patients they tend to be, not always, but there are a few other things that you can look at under microscopic, there are things like tumour grade and they are important -
MR. BROWNE:
Q. If you go back--can I stop you right there? The age, what's the significance of the age?
DR. SIDDIQUI:
A. Usually the younger ones, they tend to be a bit more aggressive.
MR. BROWNE:
Q. Okay.
DR. SIDDIQUI:
A. Nuclear grade is an important thing, tumour who are poorly differentiated or high nuclear grade, they tend to behave badly. Tumour size and T & M staging and lymph node, these are other features. ER/PR are also traditional teaching had been they have been important things. They have more of a predictive value, they would let you know if the patient would be a candidate for hormone.
MR. BROWNE:

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Q. Okay. And in--Mr. Crosbie asked you about this this afternoon, as well. In Ms. Green's case you had a discussion with her about the benefits of Tamoxifen based on her PR positivity?
DR. SIDDIQUI:
A. That's correct.
MR. BROWNE:
Q. And her PR positivity was quite high, it was actually between 80 and 90 percent?
DR. SIDDIQUI:
A. That is right.
MR. BROWNE:
Q. Okay. And you were asked about, I think, both by Ms. Chaytor and Ms. Newbury, about, you know, later on in 2006 when you got the results back, about the time that you--that sort of occurred between the time you got the, I guess, the panel letter in May and the meeting -
DR. SIDDIQUI:
A. June, it actually came to us -
MR. BROWNE:
Q. June, sorry, that's right.
DR. SIDDIQUI:

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A. - June 14th -
MR. BROWNE:
Q. It was dated May but you did not, you didn't receive it until June, and the meeting in November. In that case given that you had a discussion with Ms. Green, the converse of that, had you not had a previous discussion with the patient, say Ms. Green in this case, and you had a change in result and in Ms. Green's case the ER went from zero to 20, is that correct?
DR. SIDDIQUI:
A. That's correct.
MR. BROWNE:
Q. And you had not offered Tamoxifen, would you have acted differently?
DR. SIDDIQUI:
A. If it was not previously discussed with her, yeah, because if that case, that would been a change of treatment. Just as the other two patients that we have talked about that I called, I would have done that.
MR. BROWNE:
Q. Okay. Now, there in--Ms. Chaytor took you through a number of instances this morning

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about the occasions when you spoke to Ms. Green about Tamoxifen, the second occasion being again in November of 2006 and there's a note to your chart to that effect, and then on that occasion she was, indicated she was not interested in going on Tamoxifen. Since that time have you had any other occasion to discuss the issue of Tamoxifen with Ms. Green?
DR. SIDDIQUI:
A. The second time when she had chemotherapy around, which was from October until February of--October of 2007 until February of 2008, and at the end of that chemotherapy I had discussed her again in the tumour board and the board's suggestion was to offer her a hormone treatment if the CAT scan is stable. So I saw her on the 20th and the CAT scan was stable. The board had suggested with the options of Tamoxifen or Aromisin but the board thought more towards Tamoxifen because she had an Aromatase Inhibitor a few months ago. So I had told her about that, that the board has given these two options, but the board has talked of using Tamoxifen first, but she decided for Aromisin.

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MR. BROWNE:
Q. So, Doctor, there were--and we heard, I think, again, it's not necessary to go to the transcript, but Ms. Green testified, I think, initially back in 2002 if she had known she was ER positive, she would have taken Tamoxifen. Since that time you had two occasions, both November, 2006 and 2008 to discuss Tamoxifen with her, and at both of those occasions she knew her PR was positive?
DR. SIDDIQUI:
A. She did, in November, 2006 she did and again in March of 2008, she knew it by all accounts.
MR. BROWNE:
Q. And on both those occasions she still did not wish to take Tamoxifen?
DR. SIDDIQUI:
A. That's right.
MR. BROWNE:
Q. In terms of placing a patient on Tamoxifen, we saw an example again using--we can use Ms. Green as an illustration, unfortunately the next visit in December of 2006 it was evident that Ms. Green had a recurrence of her cancer. And at that time, I think at that visit or the

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next one there was a discussion about placing her on chemo?

DR. SIDDIQUI:

A. That's correct.

MR. BROWNE:

Q. Is that correct? What about the notion of having a patient who is on chemo and having them take Tamoxifen at the same time, would that occur, does it occur?

DR. SIDDIQUI:

A. No, we don't do both things at the same time.

MR. BROWNE:

Q. Is there a reason for not doing that?

DR. SIDDIQUI:

A. Usually for soft tissue disease such as lung involvement or other soft tissue or liver involvement we tend to go with chemotherapy first. If there is more of a bony disease, disease which is not a threat to life, we tend to go with hormone therapy first. And since she had quite a bit of disease in the liver, so I decided to go and treat her with chemo first.

MR. BROWNE:

Q. Okay. And then afterwards it was -

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DR. SIDDIQUI:

A. That's the problem with chemo, you can only give a number of cycles and after that once the side effects start to come up and the patient cannot tolerate, then you give a trial with hormone and that's what I did. From May 22nd, 2007 until somewhere in October she was on hormone.

MR. BROWNE:

Q. Right. And that was Femara?

DR. SIDDIQUI:

A. That was Femara.

MR. BROWNE:

Q. Did you go the full course of Femara with Ms. Green?

DR. SIDDIQUI:

A. This was about four months, I would say, three and a half to four months of Femara. And then she had a CAT scan done towards the end of September that had shown disease progression and at that time I had to change her from Femara and she was restarted on chemotherapy and on that she was on until I would say she had seven cycles of that, that would be toward the end of February or early March.

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MR. BROWNE:

Q. Again then, this morning Ms. Chaytor asked you about, again, referring to Ms. Green, as to whether or not--and you heard and have read Ms. Green's testimony about an incident that she alleges occurred about her asking for a report and you throwing some papers. Do you ever recall an incident where Ms. Green did ask you for a report and, if so, what your response was to her?

DR. SIDDIQUI:

A. That too has two things that I would like to say. The first one is that that is one that I remember very vividly and that one I had taken her to the monitor and shown her the CAT scan, she wanted to look at some CAT scan pictures, and printed a report for her. And the second is that as I said earlier, as well -

MR. BROWNE:

Q. Can I stop you there? When, do you recall when that particular occasion occurred?

DR. SIDDIQUI:

A. That was somewhere in 2008, I think.

MR. BROWNE:

Q. 2008, okay.

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DR. SIDDIQUI:

A. Eight, yeah.

MR. BROWNE:

Q. Sorry, I didn't mean to interrupt you.

DR. SIDDIQUI:

A. And the second is that, as I said earlier, that a lot of patients they ask for reports and it happens quite frequently and what I would do is that again if I have something in my hand that I can just print in my clinic--in our clinics we do not have a photocopy machine, we basically have fax machines and printers. If it's a CAT scan report or blood work that I can print, again, if I have it in my hand, I'll give it to the patients and there are so many other patients who ask for it and I give it to them. She might have asked for it and I might have given it to her. But if she is asking for something from the chart, that is something that I cannot--the chart is a permanent record, I'll have to direct her or whichever patient is asking for that, to go for medical records and get a copy from there.

MR. BROWNE:

Q. Now, Doctor, I know you've done some analysis

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of the patients that you believe, and again, it's not a precise analysis, I think you've told me, but total patients you had involved in the retest. Do you know the number of those patients?

DR. SIDDIQUI:

A. There was a list given to me at one time, I would say in 2006, and that had 18 patients on there. That's not an exhaustive list.

MR. BROWNE:

Q. No.

DR. SIDDIQUI:

A. I think I found probably a few more patients afterwards. But that list was of 18 patients.

MR. BROWNE:

Q. Um-hm. And how many of those were on Tamoxifen already at the time?

DR. SIDDIQUI:

A. Out of those patients there were nine such patients who were initially considered to be ER negative, PR positive, in similar situation as this other patient, and they were offered Tamoxifen, other hormonal treatment and they were already on that.

MR. BROWNE:

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Q. Okay. And what about there were others who were not on adjunctive--adjuvant treatment?

DR. SIDDIQUI:

A. There were five patients in that who had a real change, which was that they were not on any treatment and we had to put them on something new. And there were, I think, two or three remaining who had refuse, including Ms. Green.

MR. BROWNE:

Q. Okay. Of the five that you had a real change in treatment you described in, you discussed adjuvant therapy with them, what was their response?

DR. SIDDIQUI:

A. One of the ones was that, I just forgot, somebody had asked me about that patient, I had said that I had a meeting for about an hour who had come back again.

MR. BROWNE:

Q. Um-hm.

DR. SIDDIQUI:

A. One of them was that, that I had a meeting a couple of times. I just explained to them what I knew and I offered my services for

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future treatments and they are all of them are still with me.

MR. BROWNE:

Q. Okay. And you mentioned Ms. Green was of the group. How many actually refused to -

DR. SIDDIQUI:

A. I think there were a total of three.

MR. BROWNE:

Q. Okay. And that gives us, I think, rough calculation of 17. Was there another patient who had a unique sent of circumstances?

DR. SIDDIQUI:

A. Oh, there was one more patient who was diagnosed with another breast cancer on the other side and she was already on treatment for the second breast cancer when the change happened to the first one.

MR. BROWNE:

Q. Okay. Now, Doctor, you were asked a number of questions about the physician review panel and I think Ms. Chaytor asked you were you consulted prior to the creation of this body about your thoughts as to the role and purpose of this body. I think you indicated you

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weren't. But were you--would you have had any objections to what you understood its purpose was?

DR. SIDDIQUI:

A. No. I think it was a good exercise. I think that was helpful.

MR. BROWNE:

Q. Okay. Now, Dr. Siddiqui, it has been the practice of the Commissioner to invite witnesses to make any comments, recommendations or observations at this point in time, which means I'm finished questioning you, you'll be glad to know. Now, Ms. Chaytor may have some questions in follow-up, but this would be your opportunity, if you wish, to make any comments to the Commissioner or recommendations?

DR. SIDDIQUI:

A. Can I read it, something I've written?

THE COMMISSIONER:

Q. If you wish to do so, yes.

DR. SIDDIQUI:

A. Thank you. I'm thankful for giving me this opportunity to explain myself and to give my opinion. The treatment of cancer, as a whole,

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has improved significantly in the last few years. This field of medicine has seen unprecedented growth in the last decade, especially in the treatment of some of the common cancers such as breast and colon. All this growth and research also demands that we have to be aware of these new trends and treatments, and also should have the desire and means to bring it to our patients. To take advantage of these new developments, we need to expand our resources, both human and material. We need more professionals, including oncology nurses, pharmacists, and physicians. Pharmacists and nurses who are oncology dedicated are precious resources. We need to have more oncologists, both medical and radiation, as currently the new caseload is increasing at a steady pace and the number of patients that medical and radiation oncologists are following will lead to burn outs. My hopes are that with the recent changes in the compensation packages, we should be able to attract and retain more of them. Currently Corner Brook does not have a staff oncologist for eight years, as they are

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not able to attract one since the last one left. I would think that eventually on my wishlist, not just Corner Brook, but other larger centres such as Gander and Grand Falls should also have staff oncologists. We also need more resources for the delivery of chemotherapy and expansion of chemo suites. I can understand the mental, physical, and the financial difficulty through which a patient and his or her family goes through. I know that firsthand because I have gone through it myself twice. My father died of metastatic pancreatic cancer, and my wife's mother died of metastatic breast cancer. I have and I will continue to do my best to minimize those hardships for my patients. I'm extremely thankful to my colleagues in and out of Cancer Centre, the staff at the Cancer Centre, and especially the administration of the Cancer Centre for their support and I cannot thank them enough for that. I am an immigrant Canadian and Newfoundland is my chosen home. I have been here for about eight years and I consider myself a Newfoundlander, even though I still cannot talk like one and may never be

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able to do so. I still think that in Canada we have one of the better health systems. However, there is always room for improvement. I am sure that at the end of the day this Commission will be able to identify gaps in the system and will suggest ways to fill them. In the end, I am humbled by the support that my patients have shown to me during this difficult time, and I want to tell them that they're the reason that I'm here for, and I also want to let them know that I will be here. Thank you.

THE COMMISSIONER:

Q. Ms. Chaytor, is there anything arising?

DR. JEHAN SIDDIQUI - RE-EXAMINATION BY MS. SANDRA CHAYTOR, Q.C.:

CHAYTOR, Q.C.:

Q. Thank you, Dr. Siddiqui. Just one question. You mentioned that you were given a list of your patients that you had met with after the review. Who provided you with that list?

DR. SIDDIQUI:

A. I think that was faxed to me by Nancy Parsons.

CHAYTOR, Q.C.:

Q. And what was the purpose in providing you with

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such a list?

DR. SIDDIQUI:

A. I think they were just going through -- they may have a list somewhere, and these were the patients that might have been in my name. So I think that was meant to be that way, that I just follow-up on this list and make sure, and as I said, this is not an exhaustive list because there were a few other patients that I identified afterwards.

CHAYTOR, Q.C.:

Q. So were you being asked to take that list and compare it with your own knowledge of your patients and see if there was anyone who may have been overlooked?

DR. SIDDIQUI:

A. To compare -- to take that list and make sure that the recommendations were followed through.

CHAYTOR, Q.C.:

Q. And to make sure that --

DR. SIDDIQUI:

A. Recommendations are followed through.

CHAYTOR, Q.C.:

Q. And to make sure that?

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DR. SIDDIQUI:
A. Recommendations are followed through.
CHAYTOR, Q.C.:
Q. Okay, and do you know when you were given that list?
DR. SIDDIQUI:
A. That would be -- I have to look a the date, probably September of '06.
CHAYTOR, Q.C.:
Q. And do you still have a copy of that list?
DR. SIDDIQUI:
A. I can look for that.
CHAYTOR, Q.C.:
Q. And if you find it, would you mind passing it along to Mr. Browne?
DR. SIDDIQUI:
A. Sure.
CHAYTOR, Q.C.:
Q. Thank you. Do you know were all oncologists given such a list?
DR. SIDDIQUI:
A. I'm not aware of that.
CHAYTOR, Q.C.:
Q. Okay, thank you. That's it, Commissioner.
THE COMMISSIONER:

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Q. Thank you very much, Dr. Siddiqui, for adding your perspective to this rather grand and large, very large problem. I do appreciate you coming along.
DR. SIDDIQUI:
A. Thank you.
THE COMMISSIONER:
Q. Would you like to take the afternoon break before we begin with the next.
CHAYTOR, Q.C.:
Q. Yes, thank you.
THE COMMISSIONER:
Q. All right.
(BREAK)
THE COMMISSIONER:
Q. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. The next witness is Dr. Kara Laing.
DR. KARA ELIZABETH TAGGERT-LAING (SWORN) EXAMINATION BY SANDRA CHAYTOR, Q.C.
REGISTRAR:
Q. Would you please state and spell your complete name for the Commission.
DR. LAING:

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A. Kara Elizabeth Taggert-Laing, K-A-R-A E-L-I-Z-A-B-E-T-H T-A-G-G-A-R-T L-A-I-N-G.
CHAYTOR, Q.C.:
Q. Commissioner, there are a number of new exhibits that I would ask, please, to have entered this afternoon. C-0229, C-0231 through to C-0242 inclusive, P-2543, P-2550 to P-2559 inclusive, except for P-2566 and P-2587, and there's also P-2610.
THE COMMISSIONER:
Q. Okay, and there's -- 2510?
CHAYTOR, Q.C.:
Q. No, there's -- no, we're not down as low as 2510.
THE COMMISSIONER:
Q. I have 2599. What happens after that?
CHAYTOR, Q.C.:
Q. Yes, there is a 2610. That's a new exhibit.
THE COMMISSIONER:
Q. 2610.
CHAYTOR, Q.C.:
Q. Yes, that's a PowerPoint presentation that the doctor is going to take us through.
THE COMMISSIONER:
Q. All right then, entered.

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EXHIBIT ENTERED AND MARKED AS C-0229
EXHIBIT ENTERED AND MARKED AS C-0231 THROUGH TO C-0242
EXHIBIT ENTERED AND MARKED AS P-2543
EXHIBIT ENTERED AND MARKED AS P-2550 THROUGH TO P-2559
EXHIBIT ENTERED AND MARKED AS P-2610
CHAYTOR, Q.C.:
Q. Good afternoon, Doctor.
DR. LAING:
A. Good afternoon.
CHAYTOR, Q.C.:
Q. Perhaps we could begin with you taking us through your education and professional background.
DR. LAING:
A. Certainly. I attended Memorial University in my undergraduate years from 1987 to 1989, at which point I started my medical education at Memorial University of Newfoundland. I graduated fifteen years ago in 1993, and following that, I completed an internal medicine residency program at Memorial as well, and that brought me up to 1996. At that time, I went to the University of British Columbia with the BC Cancer Agency, and did a subspecialty fellowship training in medical

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oncology. I completed that in 1998, and then I did a research year with the National Cancer Institute of Canada as clinical trials group, and that was a research year in Phase III clinical trials. Then in August of 1999, I came back home to Newfoundland and started working as a medical oncologist at the then Newfoundland Cancer Treatment and Research Foundation. I still am a medical oncologist and practising there. In late 2001, I started in my role as Acting Director of Medical Oncology with the NCTRF. That position became a permanent position in October of 2002, and I stayed in that position until I took the role as Clinical Chief of the Cancer Care Program in January of 2006.

CHAYTOR, Q.C.:

Q. Okay, and actually we have P-2550, please, Registrar. You didn't need this, but we do have your CV that's an exhibit here, and I think you've taken us through the highlights certainly from 1993 onwards. Doctor, during your -- would it be called a subspecialty training in medical oncology?

DR. LAING:

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A. A fellowship, we usually refer to it as.

CHAYTOR, Q.C.:

Q. Fellowship, okay.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Did you complete any subspecialty in terms of any particular site of disease, for example, breast cancer?

DR. LAING:

A. Certainly. So during those two years, the core training of a medical oncology resident would include spending time working in all the various major tumour sites, so I would have spent three months in breast cancer, three months in gastrointestinal malignancies, three months with lymphoma, and so on. So most of the major sites, we would have spent three months training specifically in those areas.

CHAYTOR, Q.C.:

Q. And it would be an equal amount, equal three months on each disease -- the major disease sites?

DR. LAING:

A. It would be equal on the major disease sites,

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and then a -- most of the -- the way that our training was set up would be that while we were doing one of the major sites, we would also work alongside medical oncologists on some of the minor sites, such as the head and neck clinic, and the brain tumour clinic, and those sorts of less common malignancies.

CHAYTOR, Q.C.:

Q. Okay, and is it an option to go on for an extra year -- like the fellowship year that you did at the National Cancer Institute, is there an option that you could do an extra year and specialize in a particular disease site?

DR. LAING:

A. There certainly is. There are a number of opportunities for a third year, and it really just depends on what the individual is interested in. At that time, I was interested in Phase III clinical trials research, which is why I chose to go with the National Cancer Institute of Canada group, but certainly there are fellows who finish their subspecialty training in oncology who may do a year looking specifically at breast cancer, they may do a

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year looking at lung cancer. Most often, though, that year would be tied to a specific project, so they may work on research particularly pertaining to breast cancer, and they would have someone who was their supervisor and mentor, and a lot of that funding comes through things like -- the Canadian Association of Medical Oncology has funding that comes through the pharmaceutical companies and it's passed down to the residents. So most of them, I guess what I'm trying to say, are attached to a specific project.

CHAYTOR, Q.C.:

Q. And the oncologists currently practising here in the province, did any of the current oncologists do the extra year in breast oncology?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. And in terms of your exposure, you had your three months, the same as all medical oncologists would have?

DR. LAING:

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A. Yes.
CHAYTOR, Q.C.:
Q. And otherwise you've had exposure, I take it, through your practice?
DR. LAING:
A. Right. So even though during our training we have a set amount of exposure, we, of course, would have things like longitudinal clinics where you would look after patients through the entire two years, we did on call, we attended teaching rounds, conferences. So although we spent three months specifically assigned to the breast cancer team, we would have had exposure in various discipline aspects through our entire two years of our training.
CHAYTOR, Q.C.:
Q. Okay ,and did you have any exposure during your training or your medical education to laboratory medicine?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Would you have spent any time at all in the lab?

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DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And at the BC Cancer Agency where you did your two years of your residency, and we've heard from Dr. Banerjee as well, and I believe he's associated with the BC Cancer Agency --
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. I understand that organization is responsible for all of the cancer care within the province of British Columbia?
DR. LAING:
A. That's correct.
CHAYTOR, Q.C.:
Q. How does that compare to the situation in Newfoundland?
DR. LAING:
A. Certainly the BC Cancer Agency, which was initially the Cancer Control Agency of British Columbia when I was working there, is one of the oldest, if you will, formal cancer -- provincial cancer programs in this country, and it really has acted as a model for the

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rest of the country. If I look back, for example, at our provincial systemic therapy program, we model that after BC's program because of their successful outcomes. We have a provincial mandate within our Cancer Care Program as does the BC Cancer Agency. So that would be similar. We are responsible for all the delivery of systemic therapy across the province, so that would be the same. The difference would be that within the BC Cancer Agency where I trained in Vancouver, we were a separate standalone entity. So we had our own in-patient unit, we had our own radiology, we had our own pathology, all of that was housed under the one institution and in the one umbrella. Since that time in British Columbia, there are several other cancer centres that have opened. There's one in Fraser Valley, there's one in Kelowna, and now there's one in Abbotsford. So they're a slightly different model in that although they're attached to host hospitals, they're not necessarily all under the same roof, but it's more of a virtual connectivity, if you want. So I think that many of our programs now

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are similar to what's there in the BC Cancer Agency Program, but there are certainly things that they have that we do not have, and would like to, for example, a database. They probably have one of the largest and longest follow-up database of breast cancer patients in the country.
CHAYTOR, Q.C.:
Q. And would there be anything comparable here in Newfoundland and Labrador?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And so we've heard talk about the Cancer Registry -
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Would that be a similar type of database; if not, how is it different from what they're doing in British Columbia?
DR. LAING:
A. We have a Cancer Registry here in this province, and over the last few years there's really been a move to improve the quality of

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the data in the registry and there are national committees and national linkages to try and ensure that the basic data that's being collected across the country is the same because that's how we'll be able to do appropriate outcomes research on a national basis. The data that's in the -- so BC does have a registry, but the breast cancer dataset has a lot more information in it than would be in our registry. Most of the cancer registries collect information such as date of diagnosis, stage of disease, and we try and have that -- we follow the collaborative staging, so that we're collecting the same sorts of information so we can make cross country comparisons. We're continuously improving that. For example, we've just added a section that very clearly gathers the percent staining for estrogen/progesterone, and all the different possibilities for HER2 testing results so that we'll be able to go back and look at that more carefully. Also within the registry we've in the last couple of years spent a lot of time looking at death clearance, so that we can be sure of the

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outcome of patients within the registry. We also have something called "E" pathology. So as soon as a diagnosis is made, that information gets put right into our registry so that we think that we're capturing a lot more of the cancers diagnosed, and we're trying to improve the quality of that.

CHAYTOR, Q.C.:

Q. Is there anything else from the BC Cancer Agency or otherwise that you're aware of across the country that you think would be a good idea to adopt here?

DR. LAING:

A. Well, yes.

CHAYTOR, Q.C.:

Q. That's a broad question.

DR. LAING:

A. Yes, there certainly is. I mean, some of the things that come to mind right away would be a breast cancer database. My hope is that through this whole process that we will put the information that we have learned so far into a database, and as you know, that work has been started with the Newfoundland and Labrador Centre for Health Information.

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They've asked the clinicians, including myself and Dr. McCarthy, for some input into the data to be collected in that, and I think that that's important. They have a very good comprehensive cancer drug coverage program, and right now in this province our government gives us funding for the intravenous cancer drugs, but not for the oral drugs and in British Columbia, if you're diagnosed with cancer, all of your IV drugs are covered, as they are here in Newfoundland and Labrador, but not all of your oral medications. In BC, they're all entirely covered, so if somebody needs an aromatase inhibitor for their breast cancer, then they get that, prescription is filled and it's covered. So they really have one of the most comprehensive drug coverage programs. We've modelled our IV program after theirs and we look to them and work with them on an annual basis, looking at planning and forecasting for drug expenditure. We're about one-eighth the size of them, so we tend to sort of look at that, and we've had very similar growths in our drug budgets as BC has had in the last several years.

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They have an excellent pharmacy program. In fact, we use their pharmacy expertise quite a lot. They're a very generous group. We use their website, their drug information, their drug information handouts for patients, and you know, so I think that that's important. They do quite a lot of tumour board and I was involved with that as a resident and we're doing a lot of that now here, and you know, there's certainly a lot of interaction in that with the radiologists, pathologists, oncologists, surgeons, and we've certainly modelled ourselves after their approach. They have a provincial tumour board, as do we.

So you know, there's certainly a lot of things, and I think a lot of it comes from the fact that they've been around for so long, and that they've been very successful in attaining quite a lot of funding from the government to run their cancer program, because they've been very successful and because they have such a great database, they are actually able to show improvements in outcomes related to, you know, their experience. They can look and say,

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"let's look and see what happened since we've introduced adjuvant Herceptin, for example, and let's see how our breast cancer patients are doing." So they can look at a one-time period and then compare it to another one. So they do a lot of outcomes research and publish a lot of that, which is quite good.

CHAYTOR, Q.C.:

Q. Okay, are they also involved in prevention and screening?

DR. LAING:

A. They are. They certainly are involved with screening, as are we, and the whole idea of cancer prevention is something that's been recognized nationally through the Canadian Partnership Against Cancer as a priority, but of course, cancer prevention starts way outside the doors of our traditional, you know, cancer clinics and cancer agencies, but certainly they are involved and they do--they're involved with the breast cancer screening as are we, and are looking at setting up and coordinating colorectal cancer screening, which is the next big national effort for screening programs.

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CHAYTOR, Q.C.:

Q. The change that happened institutionally, I guess, with Eastern Health's formation and the old then NCTRF coming under the umbrella of Eastern Health, did that change the way in which you go about your job or in terms of the delivery of cancer care within the province?

DR. LAING:

A. Not a whole lot. That change with, I guess, the big transition year for us was 2005, and it was towards the end of that year that our program director, Ms. Sharon Smith, was appointed. It was earlier the next year that I was appointed as clinical chief, and really, you know, if you look at the day-to-day activities in the Cancer Centre, there really hasn't been a huge change. For example, we still have the same charts that we had, because we're moving towards an electronic health record. There's some very minor changes, but you know, that full transition, in terms of, you know, unions and all that sort of stuff, of course, hasn't happened yet, but from the day-to-day point of view, things are very similar.

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I guess one of the things that we've been trying to continue to do as we go along is to maintain a provincial cancer program and a provincial identity while being housed in one of the regional integrated health authorities, albeit the largest in the province.

CHAYTOR, Q.C.:

Q. Yes, okay. So in terms of the delivery of care then to the patients in the other regions -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - while it's no longer--while they may actually come from Western or Central or Labrador Grenfell, the only oncologists in the province are situate, as of right now, within Eastern Health?

DR. LAING:

A. That's correct. However, that's the way that it was when we were the NCTRF, but we do have regional clinics. So the regional clinics in Gander, in Grand Falls and in Corner Brook are actually fall now under the Cancer Care Program. So the employees report through to

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us and to the Cancer Care Program and we do regional clinics. So once a month, there's a medical oncologist and a radiation oncologist who travel from St. John's to do about a week-long clinic in each of those regions, and we all participate in that, all the radiation oncologists and medical oncologists. So that's what we call our peripheral clinics. So we do--and that hasn't changed with the new structure. We continue to do that work.

CHAYTOR, Q.C.:

Q. Okay, and in terms of yourself then, who is your employer or do you have one?

DR. LAING:

A. I do. So I'm actually considered to be an employee of Memorial University. That's because I have a full-time university appointment. So as a GFT, my employer is Memorial University. I belong to a consortium of physicians called the Medical Practice Associates. So I'm considered actually to be a fee-for-service physician and the MPA bills a fixed fee on my behalf to the government, which is similar to what a salary would be for someone who's not a full-time geographical

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person, and but I also, of course, am a member of the staff at Eastern Health and as clinical chief, I am an employee of Eastern Health, and I have privileges in Central Newfoundland because I do the clinics there.

CHAYTOR, Q.C.:

Q. Okay, and so as clinical chief, you'd be considered an employee of Eastern Health, but otherwise, your employment relationship is with Memorial University?

DR. LAING:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay, and your association, the Medical Practice Associates, does that involve physicians other than medical oncologists or other than oncologists?

DR. LAING:

A. Yes. It's all the geographical full-time physicians at Memorial University. So there's over 100 members and they're from all different disciplines, family physicians, other specialists.

CHAYTOR, Q.C.:

Q. Okay, and that's the route that would actually

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bill MCP for your services?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. Your university position -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - what's involved with that? How much of your time would be spent in your university position?

DR. LAING:

A. So I've been a faculty member since I came back in 1999, and so in that position, I've involved with teaching and research. So in terms of teaching, I do undergraduate teaching within the medical school, so clinical skills teaching of all the different years, and I also am involved with teaching when I'm looking after the in-patients. We belong to a clinical teaching unit, the medical oncologists do, and so we teach in that capacity. We also do post graduate teaching for the internal medicine program, as well as for the surgery program and the obstetrics and

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gynecology program, and so that keeps us fairly busy. So when things are, you know, now sort of starting up again in September, I would probably teach about twice a month. So that would be two half days a month, and then of course, there's a preparation and that around that.

In terms of research, we, of course, have an active clinical trials department. We do a lot of education, so I do a lot of continuing medical education for family physicians. I've done courses with, designed and been a contact expert on courses with the university as well.

CHAYTOR, Q.C.:

Q. Okay, and in terms of your own continuing education, how do you keep abreast of what's happening in medical oncology, and in particular in breast oncology?

DR. LAING:

A. So there's a number of different ways. We're expected to--it's a Royal College requirement that we have a maintenance of certification program, and each year, we report our number of hours through to the Royal College who logs that and keeps track of it. In that, there's

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a certain amount of conference attendance, attendance of our regular tumour board rounds, journal clubs, those sorts of events that count. There's self-directed learning and learning and research projects that we have to conclude. I attend probably one or two international conferences per year, which include the American Society of Clinical Oncology Conference and the San Antonio Breast Cancer Conference, because I don't -

CHAYTOR, Q.C.:

Q. So you would be--sorry, you'd be a regular attendee at those conferences?

DR. LAING:

A. Yes, at those conferences, and if I don't attend, because of various pregnancies and babies and that sort of thing, we usually get the virtual meeting or there's usually one of us who attends, and now, all of that meeting, you know, the abstracts, even oral presentations, you can see it all online now. So it's quite good.

We have an Atlantic Canada Oncology Group and we meet annually, and we've been doing it now for 11 years, and it's a conference and

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every third year, it's breast cancer. So it's lung, colorectal and breast that we rotate. I co-chair that. So that's really a great educational event for our local health care professionals in Atlantic Canada, but we have national and international speakers who come.

I attend a number of advisory boards and in that capacity, interact on a regular basis with my national counterparts, who have expertise in the area of breast cancer and CNS malignancies, which is my other major tumour site. Do a lot of journal reading and that sort of thing, and that's how I stay up to date.

CHAYTOR, Q.C.:

Q. Okay, and in terms of attendance at conferences, is there any requirement for anybody who would attend a conference to come back and do an in-house for the other oncologists?

DR. LAING:

A. Yes. So for the last couple of years, we've tended to have what we call a pro-ASCO, our post San Antonio. So we've been doing that now, I guess, for about four years or so,

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where when we come back from that conference, those who attended would be asked to give, you know, 10 or 15 minute presentation that really kind of highlights what was new at those meetings. So we certainly would do that. We do have some limited funding to attend conferences. Sometimes we have to look to industry for unrestricted educational grants, and usually--well, not usually, always a stipulation of that would be that you would come back and present the new knowledge that you gained at these meetings to your colleagues.

CHAYTOR, Q.C.:

Q. Okay, and in terms of the funding, has that changed over time? Has it increased over time? Has it increased over time?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. So it's still the same amount paid towards your continuing education as -

DR. LAING:

A. Since I started in '99.

CHAYTOR, Q.C.:

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Q. Since you started in 1999?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, and what, how much is that?

DR. LAING:

A. So as a medical or radiation oncologist, you get a--it's called a professional allowance, and of that, you're required to pay your various fees, which include the Canadian Medical Protective Association, American Society of Clinical Oncology, that sort of stuff. It's $9,000 a year and if you have to pay those fees, that usually takes about close to $6,000.

CHAYTOR, Q.C.:

Q. So the remainder then would be available for any -

DR. LAING:

A. Sure.

CHAYTOR, Q.C.:

Q. - conferences that you need to attend or any other continuing education endeavours?

DR. LAING:

A. Yes. Now because I belong to the Medical

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Practice Associates, through my funding mechanism, they pay those other fees for me. So I tend to have--I tend to not necessarily always spend the money that's in that. But we can use it for other educational things. We can use it for computers, subscriptions to medical journals, which can be quite expensive, subscriptions to Up to Date, those sorts of things.

CHAYTOR, Q.C.:

Q. Okay, and Doctor, I know I asked you about formal training in terms of doing the extra year in breast oncology, but do you otherwise consider yourself to be a subspecialist in breast oncology?

DR. LAING:

A. Once we attained a full complement of medical oncologists, I would say that was in about 2005, we started to really look at sort of subspecializing. So that each one of us has two major sites and a minor site that we focus on, and so really I would say since about 2005, you know, I would say, if someone said to me "would you consider yourself to have special interest" that sort of thing, in

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breast oncology, I would certainly say yes.
CHAYTOR, Q.C.:
Q. It's one of your two major sites that you -
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. - have chosen to concentrate on.
DR. LAING:
A. So I used to do colorectal cancer as well, but when I took over as clinical chief, I've stopped seeing new patients in colorectal cancer, although I still do have some patients in my practice. So my two major sites are breast and CNS or brain. That said, many of us, for example, when we do our peripheral clinics, when we look after the in-patients, when we're on call, we would see patients with all disease sites. But in terms of new referrals and the types of new patients that we would see in our practice, then we're certainly subspecialized, although there are some of my colleagues who still see, you know, three, four major sites.
CHAYTOR, Q.C.:
Q. Okay, and what percentage of your practice

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then would be breast cancer patients currently?
DR. LAING:
A. About 80 percent.
CHAYTOR, Q.C.:
Q. About 80 percent, okay.
DR. LAING:
A. Yeah, yeah.
CHAYTOR, Q.C.:
Q. And that, how would that compare to, say, in 2002-2003?
DR. LAING:
A. Oh, back then it was much smaller, even probably about a third of my practice.
CHAYTOR, Q.C.:
Q. Okay, and in terms of the oncologists at Eastern Health who are currently doing breast cancer as their major sites, how many would there be?
DR. LAING:
A. Five, I would say.
CHAYTOR, Q.C.:
Q. And who would they be?
DR. LAING:
A. So it would be myself, Dr. McCarthy, Dr.

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Zulfiqar, Dr. Zaidi, but he's left, Dr. Siddiqui still sees some breast, and Dr. Ahmad. Dr. David Saltman is our new medical oncologist and he doesn't see breast. His major site is GI, and Dr. Stewart Rorke is one of our medical oncologists and breast is not his major site.
CHAYTOR, Q.C.:
Q. Okay, and Dr. Siddiqui has told us that he's now concentrated more on GI.
DR. LAING:
A. GI and GU, yeah.
CHAYTOR, Q.C.:
Q. Okay, and Dr. Zaidi, is he left permanently?
DR. LAING:
A. He is. He went back to Pakistan to resume a practice there.
CHAYTOR, Q.C.:
Q. So it's yourself and Dr. Zulfiqar and Dr. McCarthy, Dr. Ahmad?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. Are the people currently concentrating on breast?

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DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And in terms of your continuing education requirements for the Royal College, is there any requirement that a certain percentage of the hours have to correspond with the type of practice or the area that you've chosen to concentrate your practice?
DR. LAING:
A. No, they don't specify exactly what you need to do, but they do--but there is a certain amount, I guess it's a type of learning. So it can't all be conference. It can't all be journal reading. It can't all be teaching. There's five different categories that you can put credits under and there's a certain maximum in some of those categories.
CHAYTOR, Q.C.:
Q. Okay, and in terms of what was available to you, if you think back in 1999 when you first came here, would you have had Pub-med available to you then?
DR. LAING:
A. I would say, yes. I can't remember when I

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didn't have Pub-med.
CHAYTOR, Q.C.:
Q. And I take it, it would always have been your practice to subscribe to journals?
DR. LAING:
A. Yes, so we, as members of the--so as medical oncologists, most of us would be members of the American Society of Clinical Oncology. So as a result of that membership, we would get the Journal of Clinical Oncology, and still do.
CHAYTOR, Q.C.:
Q. Okay, and then you've told us that you were the director of medical oncology, I believe that began in 2002?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And you stayed then--well you were acting although the year before that, 2001-2002. You stayed in that position then until you became clinical chief in 2006?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:

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Q. January 2006, I believe, from the records we've seen.
DR. LAING:
A. So it was actually late in 2001. It was December of 2001 that I took over as acting director of medical oncology.
CHAYTOR, Q.C.:
Q. Okay.
DR. LAING:
A. And then about not quite a year later, took it back as a permanent.
CHAYTOR, Q.C.:
Q. You became the director permanently?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. What are the duties of the clinical chief, and is it the clinical chief of oncology, is that--or of cancer care?
DR. LAING:
A. So currently in my role now?
CHAYTOR, Q.C.:
Q. Yes, what's your title, first of all?
DR. LAING:
A. It's clinical chief, Cancer Care Program.

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CHAYTOR, Q.C.:
Q. Okay.
DR. LAING:
A. Eastern Health.
CHAYTOR, Q.C.:
Q. Okay, so tell us what it is, what your current duties would be.
DR. LAING:
A. So within Eastern Health, there's program management. So the large clinical areas, such as cancer, cardiac care, have a physician lead who's a clinical chief and then a program director. So I'm that physician and the program director is Ms. Sharon Smith. So we work very closely together in the running, if you will, of the Cancer Care Program. It's a dual role. We work very closely together. We have a very good working relationship and we have, right from when I started in 2006. We have various responsibilities. We report through to the VP of Medical Affairs. We report through to the chief operating officer for cancer, and really our primary goal, of course, is to provide quality cancer care to the patients of this province and to do so on

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a provincial basis. In that role, of course, we look at things like quality improvement. We look at our relations with our patients. We try and build an environment in which our staff enjoy coming to work and enjoy looking after our cancer patients, because as you can imagine, that can sometimes be a stressful job.

We're responsible for financial things and really when I think about the finances of the Cancer Care Program, there's three big parts to that. There's an operating budget and there's capital equipment budget, and in oncology, most of our capital equipment is related to our radiation treatment and most of that capital equipment is extremely expensive and so we're always working with our Foundation and with government to continue to grow and expand our radiation treatment. And of course, a third part of it is our provincial systemic therapy budget. So we have the drug budget for the IV systemic therapy treatments for the entire province, and I lose track but it's somewhere around 11 million dollars or something now. It's always

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increasing, so we're responsible for that budget.

We're responsible for resource planning, both that sort of resource planning, but of course, very important, the human resources, not only within physicians but within all the other members of the health care team that are very important. Some of those include nurses, our other allied health care professionals, our therapists. There's a large team, if you will, that provides cancer care. We promote a multi-disciplinary approach to cancer care, which includes not only those within our program, but those on the outside in our regional cancer centres, but across the province that help us to provide the continuing of cancer care to our patients.

We're involved with research, promoting research, anything that happened within our cancer centre, liaising with the University for education, but also the education of our staff, the continuing education of our staff, the education of our patients. And again, having to do that on a provincial basis is, you know, is a challenge, but we try and do

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that. And I think that's--that keeps us busy.

CHAYTOR, Q.C.:

Q. Yes, in addition to your day job, and in terms of the--do you surround yourself then with a senior management team or an executive team to help assist get all of that done?

DR. LAING:

A. Yes. So within--so I guess within the Cancer Care program itself, we do have a senior management team. So there would be Ms. Smith and I. We have a divisional chief of medical oncology, who is Dr. Siddiqui. We have a divisional chief of radiation oncology, who is Dr. Ganguly. We have a director of clinical trials, who is Dr. McCarthy. We have a leader in nursing, who is Ms. Chris Power. One of the changes with the restructuring has been that our pharmacy now reports through to Eastern Health, but we still maintain a very close relationship with our pharmacy directors, and we have our head radiation treatment therapist as part of that group, our head medical physicist is part of that group. The head of our breast screening program is part of that group and I'm probably forgetting

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somebody, but, you know, so that's sort of our senior team.

Both Ms. Smith and I, of course, report through with the clinical chiefs and program directors. We meet on a monthly basis with Dr. Howell and that group. I report through to MAC, and we've only just hired a discipline chair for the discipline of oncology, who started work just a few months ago, Dr. David Saltman. So we're in the planning stages of really, you know, working out how--because it's the first time we've actually had a discipline chair. So we're working on that as well to -

CHAYTOR, Q.C.:

Q. Figuring out where he fits in?

DR. LAING:

A. - set up the--yes.

CHAYTOR, Q.C.:

Q. Yes, okay, and do you report then directly to Dr. Howell or do -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. You report directly to Dr. Howell, and the COO

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of Cancer Care, I guess that's Ms. Pat Pilgrim?

DR. LAING:

A. That is.

CHAYTOR, Q.C.:

Q. Ms. Smith, I guess, would report through to her?

DR. LAING:

A. Yes. However, you know, we do meet with Ms. Pilgrim on a regular basis, Ms. Smith and I, to talk about issues related to our program.

CHAYTOR, Q.C.:

Q. Okay, and you say you have a very good working relationship. So the program management type of structure works well for the oncology service or for the Cancer Care program?

DR. LAING:

A. Program management is new for us, within the Cancer Care Program. You'll recall that prior to having program management, we were a separate stand-alone entity.

CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

A. So, you know, there have been, you know,

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growing pains settling in, but for the--in terms of working well together and having very, you know, good working relationships, strong goals and really--you know, it's a great team, I really have to say that.

CHAYTOR, Q.C.:

Q. Okay, and so in terms of any--in terms of, we've heard some issues, as I'm sure you've heard through this process, about in the Laboratory Medicine Program, about there being really two separate tiers and at times over the years, the medical side not sure what the management side was doing. You haven't--since 2005-2006, when you've become part of the program, it hasn't--those issues haven't arisen for you?

DR. LAING:

A. No. I mean, in the previous structure, with the NCTRF, there certainly were those issues. I really started in their senior management in 2002, and it was shortly after that that we knew that we were going to transition into Eastern Health. So most of the problems that had come with administration and physicians in the days of the NCTRF were before my time

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there, and certainly before my role there as director of medical oncology.

CHAYTOR, Q.C.:

Q. And so what were the issues, do you know? Are you familiar with what the issues were, what the problems were at that time?

DR. LAING:

A. In the old days of the NCTRF?

CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

A. I think that there were some issues in terms of difference, if you will, of opinion and how to run a cancer care program, between physician leads and the then various CEOs of the cancer program. I wasn't part of it and, you know, I just know the stories and that sort of thing. That was my understanding of it at the time.

CHAYTOR, Q.C.:

Q. And I'm sorry, you probably already told me this, but how many medical oncologists do you currently have?

DR. LAING:

A. So currently, there are seven of us. But if

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you look at our FTE equivalents, there's six. Now a while ago, I mentioned that in 2005, we had our full complement. We now could very easily have ten medical oncologists and we're actively recruiting two more who will join us in 2009 and in 2010.

CHAYTOR, Q.C.:

Q. So you do have two people lined up for the next -

DR. LAING:

A. Yes, we do.

CHAYTOR, Q.C.:

Q. - year and next two years?

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. And there are currently two or three vacancies?

DR. LAING:

A. Well, if you look at the number of physicians that we have approved through the salaried physician advisory committee, it's seven, maybe eight, depending on how you look at it, because many years ago, there was actually a medical oncologist in Corner Brook, and when

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that position became vacant, it sort of came back into the pool of medical oncologists, if you will, so could say that there is eight. If you look at our FTEs, we really only have six. So we have two vacancies, for sure. We have done human resource planning extensively with Dr. Howell and have submitted that to government. So we're hoping as the next couple of years go by that we will have increased positions to actually recruit even more people than the two that we have.

CHAYTOR, Q.C.:

Q. So you're hoping to get beyond eight and perhaps have as much as ten?

DR. LAING:

A. Yeah, and we're also very active in our recruiting in radiation oncology. So we're short two radiation oncologists, but we have a new radiation oncologist starting just in the next few weeks. We have another slated to start in 2009, and hopefully someone else to come, and we've just hired someone on a locum basis. So we've been doing well, in terms of our recruitment in the last couple of years.

CHAYTOR, Q.C.:

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Q. And would you look to try and recruit people for other areas, geographical areas within the province?
DR. LAING:
A. To be stand-alone medical oncologists outside of here, no.
CHAYTOR, Q.C.:
Q. That's not part of the plan?
DR. LAING:
A. That's not part of the plan. We will, however, continue to--with our increased capacity, continue to be able to really, you know, ensure that our peripheral clinics are fully functional and we'll continue to operate those as we are.
CHAYTOR, Q.C.:
Q. Okay. And so the current situation, in terms of you have really six FTEs and you could have as many as eight, how does that compare to when you first arrived in 1999? Was there a problem at that time with turnover of oncologists?
DR. LAING:
A. There was a very big problem at that time. So when I started in August of 1999, in the two

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months before I came back, three medical oncologists resigned their positions within the NCTRF. So that when I came back, instead of being the sixth medical oncologist, I was the third, and then subsequent to that time, we continued to have quite a lot of turnover. In fact, at one point, we estimated that perhaps there were 20 something, both medical and radiation oncologists who had come and gone from the NCTRF from the mid 1990s to 2002. Dr. Siddiqui came shortly after I did, and Dr. McCarthy and Dr. Rorke came that year, and we, you know, continued to build the team with Dr. Ahmad, Dr. Zulfiqar and Dr. Zaidi, and really the only person that's left since 2002 was Dr. Zaidi, and that was for family reasons, to return to practice in Pakistan.
CHAYTOR, Q.C.:
Q. So even though you only started in 1999, I don't mean "only", but you're the senior member?
DR. LAING:
A. I am.
CHAYTOR, Q.C.:
Q. Yes, okay.

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DR. LAING:
A. But I'm not the oldest.
CHAYTOR, Q.C.:
Q. Fair enough, and so what happened then to stabilize things, what happened in 2003, that time period? What happened to make things a little more stable for you?
DR. LAING:
A. I think that -- I think we had a good group of people that really, you know, came together and we work extremely well together. You know, I think that if you have turnover and people are chronically understaffed, that it doesn't take a whole lot for you to give up and to move on, and I think once we got a good group of people who worked well together, and we built that early group of the four of us and then added on with excellent, very competent, and wonderful physicians, that, you know, this became a place where people wanted to come and practise. So I really think that, you know, that was the turning point in about 2002/2003, once we built the group of the seven of us.
CHAYTOR, Q.C.:

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Q. And was there anything else -- other than the people and the personalities around you, was there anything else that happened to improve the situation?
DR. LAING:
A. I think that our -- there were some issues with the previous Director of Medical Oncology, and I think when he left, it made a big difference, to be quite honest with you, and then I think that in -- I can't remember what year, maybe it was in 2003 when we had a change in our compensation package, that that helped, and -- but I think that the biggest driving force was really to have that -- get rid of that swinging door policy and really have a group of people that were committed to staying and working together and, you know, having removal of somebody who caused a lot of stress and anxiety for people and made it difficult to come to work, obviously, makes things better, and then, you know, to have a competitive package to be able to recruit and to retain physicians helps as well.
CHAYTOR, Q.C.:
Q. And when did that package increase, when did

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your -- we've heard about an oncology stipend, for example.

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. When was that introduced for oncologists?

DR. LAING:

A. The physician job action would have been in 2002, and then we would have had a new memorandum of understanding in 2003, so it would have been then.

CHAYTOR, Q.C.:

Q. Okay, and so -- and that increase then, your oncology stipend was how much per annum at that point?

DR. LAING:

A. It would have been $50,000.00 for step one, $55,000.00 for step two, and $60,000.00 for step three, and it still remains that.

CHAYTOR, Q.C.:

Q. Okay. So by the of that, the end of 2002/2003, whenever you received the oncology stipend, how did your remuneration compare to your counterparts in the rest of the country?

DR. LAING:

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A. It's still lower, still significantly lower than other people, but the gap was narrowed.

CHAYTOR, Q.C.:

Q. So that assisted in your ability to be able to recruit people and keep people?

DR. LAING:

A. And keep the people that were here, yes.

CHAYTOR, Q.C.:

Q. So the gap was narrowed, but it was still --

DR. LAING:

A. Significant.

CHAYTOR, Q.C.:

Q. Significantly lower, okay, and how does that compare to today? We've heard, of course, that there has been additional compensation for pathologists and medical and radiation oncologists?

DR. LAING:

A. That's correct.

CHAYTOR, Q.C.:

Q. So how in terms of competitive is your package now today?

DR. LAING:

A. Now I would say that we have probably the best competitive salary that we have had. It

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really was modelled after the current salary in Ontario, and Ontario, British Columbia, and Nova Scotia, really have been the ones that we've been watching and keeping our eye on over the last few years. So when we had discussions with government, we had as part of that, prepared and found out what our counterparts were getting across the country, because, of course, when you're looking at recruitment, you really have to have a competitive salary, and that was probably never more important than in this last year or two in terms of attracting oncologists and pathologists.

CHAYTOR, Q.C.:

Q. Okay. So you've been involved yourself, in particularly, I would take it, as Clinical Chief in those discussions with government around that?

DR. LAING:

A. Yes. There's a Canadian Association of Medical Oncologists, which you may have heard us talk about before. They having a Human Resource Planning Committee that's really looking at things like what's going to happen

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when -- there's going to be a large number of medical oncologists retire within, I would say, the next five to ten years. Medical oncology has only been a subspecialty since the mid 1980s. Prior to that, medical oncologists were hematologists that turned to treating solid tumours, and so there's quite a number of late 50 and early 60 year olds who were sort of grandfathered over from hematologists to medical oncologists, and there's a lot of concern about what's going to happen because there's going to be a large void in the workforce for that. We liaise often with our colleagues across the country. The medical oncology community in Canada is quite small, so there's always people saying, you know, can you send us along information about your retention or your payment package and those sorts of things. So there's -- we keep all that together within CAMO, and CAMO sets the standard, if you will, for how many medical oncologists are needed and over the years have looked at the number of new patients, although there's some thought now to look at not only the number of new patients,

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but the number of follow-up patients that an oncologist should be seeing to define workload and to plan the human resources planning, recruitment, those sorts of things.

CHAYTOR, Q.C.:

Q. Okay, and when you talk about competition or competitive salary, there's also an alternative payment plan for oncologists within Newfoundland?

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. So in terms of having your salary competitive, does that include the alternative payment plan?

DR. LAING:

A. That's what makes it competitive.

CHAYTOR, Q.C.:

Q. That's what makes it competitive?

DR. LAING:

A. That's what makes it competitive.

CHAYTOR, Q.C.:

Q. Okay, and when was the alternative payment plan introduced for oncologists?

DR. LAING:

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A. I would say 2005. Yes, 2005.

CHAYTOR, Q.C.:

Q. And there's been some recent changes, though, I take it, to that in this past few months?

DR. LAING:

A. So when we had a change, there was two options. One was to have an increase in the a additional workload for case funding, and one was to take an increase in the base salary. So those were the options that were given to the oncologists and they could choose whichever one of those seemed to be more appropriate and viable for them.

CHAYTOR, Q.C.:

Q. Okay, and so then it's an individual choice as to which --

DR. LAING:

A. That's right.

CHAYTOR, Q.C.:

Q. People would prefer, okay, and then that makes -- that's the current package which was offered makes your total package among the best within the country?

DR. LAING:

A. Yes, because many of us derive income from

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various different sources.

CHAYTOR, Q.C.:

Q. And in 2005, though, the alternative payment that you were receiving then --

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. How did that bring your salaries in terms of comparison within the rest of the country?

DR. LAING:

A. It varied because, of course, you have to realize that how the alternate payment plan works is that in order to generate the extra income, you need to see more patients than is recommended by either the Canadian Association of Medical Oncology, or the radiation oncology, which is the Canadian Association of Radiation Oncology. So the threshold over which physicians receive payment is based on those numbers. So in medical oncology, it's 140, and in radiation oncology now it's around 190. So although our physicians were able to generate this extra income, in order to do that they had to work twice as hard, if you will, than a oncologist who was getting a

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straight salary of that amount of money, for example, in Ontario.

CHAYTOR, Q.C.:

Q. Mr. Ritter testified that you were involved, of course, in the meetings and the discussions, and also with respect to the pathologist's remuneration and the recent increases?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And he also said that you had individual meetings or visit to your office by Minister Wiseman?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Was that in relation to the salaries for oncologists?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And what was the purpose of -- I take it, it would be unusual to have such a visit.

DR. LAING:

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A. It was.
CHAYTOR, Q.C.:
Q. And perhaps you could tell us then about that and what was discussed, and whether anything else relevant to the ER/PR issue was discussed in that meeting?
DR. LAING:
A. So prior to that meeting, we had requested an opportunity for the oncologists and the pathologists to sit down with the Premier. So that would have happened -- whenever that was. I think it was a Thursday. So that a week or so before. Subsequent to that -- in fact, I should clarify that at that meeting with the Premier, we discussed several issues that we felt were very important, which included pharmacy services, remuneration package, information technology support, and -- amongst other things. Subsequent to that, I had a meeting with Louise Jones because she wanted to know what exactly I had presented because I was the one who, on behalf of the oncologists, presented to the Premier.
CHAYTOR, Q.C.:
Q. She wasn't in attendance, I take it, at the

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meeting?
DR. LAING:
A. No, no. So I provided her with a copy of my PowerPoint presentation and went over the various things that we discussed at that meeting, and later that afternoon, she showed up at my office door and said I'm really glad we have this meeting because guess who's here, and that's when Minister Wiseman was there. So he came in with a member of his staff, and one of the -- I guess, several of the discussion points that we had around our compensation package was related to the fact that for some true alternate funding packages, what happens is you -- the group of physicians are given a lump sum of money and then they decide how to divide that up. That, for example, was done in Ontario and it took quite some time, in the order of about two years for them to sort out things like medical coverage and those sorts of things. So we felt, as a group, that we had to be very careful because the salaried physicians had medical coverage and a pensions plan and all those sorts of issues. As a university person, I had those -- you know,

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medical coverage and all those sorts of things through the university. So we really were trying to think about how we might have some time to sort things out. When Minister Wiseman came to see me that day, he indicated that they were prepared to offer an increase in the salary to the pathologists. That was something that we were told was not an option because, of course, all of us, the medical oncologists, radiation oncologists, pathologists, and several other specialists in this province, are paid on a salaried physician's scale. So when he said that they were going to make that available for pathologists and what did I think of that, I asked him if he had thought about making that an option for oncologists as well, and he said, well, they hadn't really thought that through and then he left. Almost as quickly as he showed up, he left, and it wasn't until maybe a week or so later we all got individual letters outlining this offer for the increase in the base salary versus an increase in the per case funding for the additional workload. We then went to the Newfoundland and Labrador

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Medical Association and had meetings with them to try and decide how we were going to -- you know, how this was going to play itself out, and then subsequently each individual physician chose which compensation package they wanted, and we communicated that back to government.
CHAYTOR, Q.C.:
Q. Okay, and if we could look at, please, P-1286, and this is a -- not what I was expecting, but it might be in here. No, I think I have the wrong exhibit number. That's okay. It was a letter -- what I was trying to --
DR. LAING:
A. It's attached to this, I believe.
CHAYTOR, Q.C.:
Q. Is it attached to this? Okay, maybe I didn't go far enough. It's a letter that you and Dr. Ganguly--yes, here it is.
DR. LAING:
A. There it is.
CHAYTOR, Q.C.:
Q. There is it, yes, okay. Thank you. It's July 19th, 2005. And it's actually page 11 of the exhibit, that you wrote to Dr. Williams?

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DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Signed by you and Dr. Ganguly and you're the director of medical oncology, of course, at that point in time?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And it's in support of the pathologists of this province?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And you write that, "The quality of oncology treatment is entirely dependent on the quality of the pathology report. As technology progresses in both the diagnosis and treatment of many malignancies it is becoming more and more challenging to deliver an expert high quality pathological diagnosis. This has resulted in the development of tumour-specific multidisciplinary teams to manage various malignancies. This has already occurred in many areas of the country and is now occurring

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in Newfoundland and Labrador, as well. Specialized pathologists sit on these tumour boards and routinely review cases specific to that tumour site. We believe it is imperative that remuneration offered to pathologists in this province be competitive with the rest of the country. We need to maintain and build our current mix of experienced pathologists to keep pace with the rest of Canada in terms of the overall quality of oncology care." So, Dr. Laing, what was the purpose of you and Dr. Ganguly in July of 2005 in writing this letter to Dr. Williams?
DR. LAING:
A. So we wrote this letter in support of our pathology colleagues. At that time we had started our tumour board rounds and the expertise of the pathologists being there was obviously quite important. And they really came to us and said that they were trying to build as much support within the medical community for them to be recognized as subspecialists, as important physicians, so that people could see their role. Often they were looked upon as the people that were, you

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know, working in the lab and, you know, in the basement of the hospital and not integral to patient care. The pathologist is not the one who's necessarily going to be sitting in the room with the cancer patient, but what they tell us determines so importantly right from the diagnosis, what the prognosis of the cancer is and in many instances now and becoming increasingly important in terms of predictive markers. So really, this was the start of our support. This was in 2005, but this was after, you know, discussions long before this with the pathologists. Subsequent to this I did go and meet with the pathologists, with Treasury Board, and really, you know, worked with them and lobbied with them for better compensation. And the end result of this is that they did eventually receive the oncology bonus as part of their remuneration, which made their salary more competitive.
CHAYTOR, Q.C.:
Q. So you were involved in that lobby effort back in mid 2005 onwards, you've been involved -
DR. LAING:

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A. Or even, you know, even before that.
CHAYTOR, Q.C.:
Q. Even before?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. Doctor, the reference to the tumour-specific multidisciplinary teams, I take it that's referring to tumour board rounds?
DR. LAING:
A. That's right.
CHAYTOR, Q.C.:
Q. Okay. And it says, "This has already occurred in many areas of the country and is now occurring in Newfoundland and Labrador, as well." What's your recollection as to when those tumour board rounds began here in the province?
DR. LAING:
A. We started a very preliminary tumour board round for breast oncology in 2001. That was shelved by the then director of medical oncology. And in towards the end of 2001 we had an external review done by Dr. Susan O'Reilly from the BC Cancer Agency and part of

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that review recommended reinstatement or the establishment, if you will, of multidisciplinary tumour rounds, so it would have been in about 2002 that we started that. We used to do breast and something on one week and GI on the other and it was sort of back and forth. Since then it's grown. We continue to do a weekly tumour board round on Wednesday mornings from eight to nine, which is attended by medical oncologists, radiation oncologists, surgeons, radiologists and pathologists.

CHAYTOR, Q.C.:

Q. And when did it become weekly?

DR. LAING:

A. It's been weekly since the beginning.

CHAYTOR, Q.C.:

Q. Okay.

DR. LAING:

A. And there's also a separate tumour board round for GU, for genitourinary malignancies that meets once a month. There's a tumour board round for hematology that meets once a week. There's tumour board round for lung cancer that's had a little bit of a hiatus but is

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planning to get back up and active. And we've just started a new GI specific tumour board round which will likely start now within probably early October. And I think that's all of them, so -

CHAYTOR, Q.C.:

Q. And what happened in 2001? So you had initiated a tumour board round specific for breast -

DR. LAING:

A. We started, what we had started was almost like a breast triage.

CHAYTOR, Q.C.:

Q. And who was responsible for initiating that, who took the initiative?

DR. LAING:

A. We had concerns about the timeliness of seeing patients with breast cancer because they have to be, for patients who receive adjuvant treatment, it's imperative that are seen and started on their therapy within 12 weeks of their definitive surgery. And it really started as a way to look at the referrals and sort of see who needed to come, you know, sooner or later. We did it in combination

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with our new patient referral system. We called it a tumour board round but it really was, I guess, the beginning of that and we spent a lot of time reviewing patients and saying, okay, this person had their surgery then and need to come whenever. But it was stopped. And it wasn't until after the then director, Dr. Tang, left that we were able to reestablish those, and that would have been in 2002.

CHAYTOR, Q.C.:

Q. And why was it stopped at the time?

DR. LAING:

A. I'm not certain.

CHAYTOR, Q.C.:

Q. Okay. You used the word, I think initially in telling about that, you said it was "shelved". So was there some conscious decision not to continue with those rounds?

DR. LAING:

A. I went on maternity leave and when I came back, they weren't doing them any more and, yeah, so.

CHAYTOR, Q.C.:

Q. Okay. So maybe someone else who was still

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there during your leave might know what happened?

DR. LAING:

A. Sure, yeah.

CHAYTOR, Q.C.:

Q. Yes, okay. And you said there was a review done by Dr. Susan O'Reilly from BC Cancer back in 2002?

DR. LAING:

A. Yeah. And a radiation oncologist from the Cross Cancer Institute who, I'm sorry, I cannot remember his name right now.

CHAYTOR, Q.C.:

Q. Okay. And one of the things they recommended was to reinstitute tumour board rounds?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. And was there anything else, any other recommendations that came out of that review that were advantageous?

DR. LAING:

A. There were several recommendations. When we got the report, many of them were optimate with those same things that we had started to

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act upon. One of her recommendations was that remuneration for oncologists be made competitive in order to be able to recruit and retain people. And tumour board rounds was another recommendation. A provincial drug budget so that--because prior to that each of the smaller health regions, and recall in those days there were several health regions, had a very individual drug budget, so if somebody, for example, in Labrador, needed to have Herceptin for metastatic disease, you could spend all of the Labrador budget, you know, in three lumps. So that was one of her recommendations, that we have a provincial systemic therapy program, which we did. She recommended that we look at guideline development, that we increase our participation in clinical trials, those sorts of things, as well.

CHAYTOR, Q.C.:

Q. Okay, and guideline development around what in particular, what kind of guidelines was she talking about?

DR. LAING:

A. For tumour disease sites, so in terms of

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treatment guidelines.

CHAYTOR, Q.C.:

Q. And has that since happened, have those guidelines been developed?

DR. LAING:

A. We are--we have done some guideline development and continue to do so, yeah. We have a breast disease site group, which I think you may be aware of.

CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

A. And we've also had meetings where, you know, the lung people and the GI people and that have gotten together and we've all been given a task to sort of go and look at a particular area and we've made some recommendations. We don't have the necessary support, if you will, to have all those guidelines finalized and published. We're now working with Eastern Health to try and find out how they want us to post and to disseminated the guidelines that we have done so far in breast cancer.

CHAYTOR, Q.C.:

Q. Okay, and I will refer you to some of those

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guidelines a little later on when I ask you about the current situation.

DR. LAING:

A. Sure.

CHAYTOR, Q.C.:

Q. Doctor, I'd like to just turn now then to ER/PR and your knowledge and background in ER/PR testing. At the time -

THE COMMISSIONER:

Q. Ms. Chaytor, it's about 5:00. Do want to start on ER/PR route for the next five minutes or would you rather start in the morning?

CHAYTOR, Q.C.:

Q. Actually, two quick questions, perhaps.

THE COMMISSIONER:

Q. Sure.

CHAYTOR, Q.C.:

Q. And then tomorrow morning perhaps we'll start with your PowerPoint presentation.

THE COMMISSIONER:

Q. Okay.

DR. LAING:

A. That would be fine, yes.

CHAYTOR, Q.C.:

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Q. So at the time that you did your residency training what method was being used then to carry out ER and PR testing?

DR. LAING:

A. So I started my training in 1996 and so initially when I was training, we had the older method, so the--we would get a quantitative report from the Ligand Binding assay. And then during my time in BC is when there was the switch over to immunohistochemistry.

CHAYTOR, Q.C.:

Q. Okay. So you learned in terms of reading the reports, you learned both methods?

DR. LAING:

A. So when we would get the reports in at the BC Cancer Agency, we would get a number and then there would be, under that there would be a range, so you would have a negative, an equivocal and a positive test for both ER and PR. And that's how I learned in the beginning.

CHAYTOR, Q.C.:

Q. And then when the switch over to the IHC and you're still at the BC Cancer Agency at that

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point, what was used at that point for cutoff for positivity?

DR. LAING:

A. I'm not certain. We would just simply get a result, in those days it said, once we went to the immunohistochemical method, if it was positive or negative. You know, that would be the -

CHAYTOR, Q.C.:

Q. So no percentages were given?

DR. LAING:

A. No, I don't recall having percentages at that time.

CHAYTOR, Q.C.:

Q. Okay. And we've seen here that in the late '90s when the switch happened in Newfoundland, that there was a 30 percent given.

DR. LAING:

A. That's right.

CHAYTOR, Q.C.:

Q. Which was thought to correlate or correspond with the old method?

DR. LAING:

A. With the old positive, yes.

CHAYTOR, Q.C.:

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Q. Yes, the old biomedical assay method. Was there any such comparison, do you know, done in BC at the time or was there anything indicated on the pathology reports that you would receive to make such a correlation?

DR. LAING:

A. Not that I recall, no, no.

CHAYTOR, Q.C.:

Q. And you weren't given anything in the way of percentage, it would come, the pathology report would come at that time would come and say either negative or positive?

DR. LAING:

A. That's what I remember. Now you have to understand, too, in those days I was a fellow, so I would always be seeing these patients alongside an attending oncologist, so--but we would get positive or negative results. And prior to that, a I said, you would actually get a number, you know, 275, I can't even remember what the unit was, I believe it was picomoles per litre and nanomoles per litre, it's been so long since I've seen. And even, you know, in my practice when I took over, some of my patients who had metastatic disease

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would have had their initial ER/PR determination on their primary tumour done by the old quantitative method.

CHAYTOR, Q.C.:

Q. Yes, when you started here in St. John's?

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay.

DR. LAING:

A. But our new patients coming through then would have had immunohistochemistry testing done.

CHAYTOR, Q.C.:

Q. Okay. Thank you. Okay, thank you, Commissioner.

THE COMMISSIONER:

Q. All right, then, we'll meet in the morning at 9:30. Thank you.

Upon conclusion.

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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 8th day of September, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 8th day of September, A.D., 2008

Judy Moss

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