Q. Okay. I want to ask you to turn your mind to a patient by the name of [redacted] Do you recall that's the patient from Alberta who was diagnosed with pancreatic cancer and was palliative?

A. Yes.

Q. Okay. And so, I'm going to ask you to look at your report, Exhibit 30, again. And, in your note at page 8, can you just look with me at the second paragraph, where it says, "There was no pathology"?

A. Yes.

Q. Okay. It says:

> "There was no pathology or notes from a referring physician. Only chest x-rays and ultrasounds were ordered. The ultrasound comments of thickening of the pancreas and evidence of cirrhosis of the liver. It is not clear that the patient ever had metastatic pancreatic cancer given no pathology, confirmatory imaging or an elevation in CA19.9." (as read)

Do you see where you've ---

A. Yes.

the Fort McMurray Cancer Centre."

(as read)

And then they go on to talk about the FOLFIRINOX regimen that he would like to take; right?

A. Yes.

Q. And so, if I can ask you now to turn with me to page -- same tab, page 76 and 77, you see that consultation note and that diagnosis is repeated in the file?

A. Yes.

Q. Okay. Can I ask you to turn with me again, in the same tab, to page 107 and 108? The same note is there?

A. Yes.

Q. Okay. And, can I ask you to look at Tab 8 of that book, and look at page 104 and 105?

A. Yes.

Q. All right. And, the same report is there as well?

A. Yes.

Q. Okay. So, when you say in your report that it is not clear that the patient ever had metastatic pancreatic cancer given no pathology, confirmatory imaging or an evaluation in CA19.9, that was quite simply wrong?

A. Correct.

Q. All right. And, in fact, we've gone through it, there are numerous documents and the reports are reported over and over of the very clear diagnosis, first of all, of metastatic pancreatic cancer. And, secondly, a fairly extensive discussion of the conventional therapies that are available; right?

A. Yes.

Q. All right. So, this patient was informed, based on these documents, of the availability of conventional palliative care and the types of options that he had?

A. Yes.

Q. Okay. Now, in your report at Exhibit 30, page 8, you say that -- your indulgence, please. That there was no evidence that Dr. Khan discussed these potential options with the patient. And, let me just begin, you say:

"This is an incurable malignancy with evidence of improved survival, quality of life with FOLFIRINOX chemotherapy and improved quality of life with gemcitabine. He appears to not have received either

received information on a port-a-cath. We will arrange for him to have a port-a-cath to be inserted within two weeks. As well, I will ask for a staging CT chest, abdomen and pelvis within two weeks time. I will check his chart next week to see when his CT scan and port-a-cath insertion is scheduled for, to arrange for a recall, and start his first cycle of FOLFIRINOX chemotherapy." (as read)

A. Yes.

Q. So, as of this note in October of 2013, this patient not only is fully informed, but is now going to start the palliative FOLFIRINOX treatment; right?

A. Yes.

Q. Okay. And, you say in your note that there is no evidence that Dr. Khan discussed these potential options of conventional therapy with the patient. We just reviewed that; right?

A. Yes.

Q. Okay. Can you take a look, please, at Exhibit 44, Tab 5? This is the treatment plan that

the imaging that was in the records that you were asked to review, that Dr. Khan did order. So, can you please look with me at Exhibit 44, Tab 9? So, that's an abdominal ultrasound dated October 30th, 2013?

A. Yes.

Q. Okay. And, can I ask you to look with me at -- your indulgence, please. The next page, which is I guess page 7, which is January 13th, 2014. Do you see there that it is an abdominal ultrasound that is ordered and measuring the pancreatic mass?

A. Yes.

Q. Okay. And, just the page before it, Dr. Tozer, if you could flip back, that is October 30th, 2013, a chest PA is ordered ---

A. Yes.

Q. --- by Dr. Khan? And, can I ask you to also turn up the very last page in that tab, again Dr. Khan ordering imaging dated February 24th, 2014, which is the abdominal ultrasound?

A. Yes.

Q. Okay. Now, you're aware that Mr. [redacted] ultimately opted to try the SEF chemo, which is the carboplatin and mesna as a --

A. Yes.

Q. --- palliative treatment? And, I

take it, if it is offered -- chemotherapy is offered as a palliative treatment, the code is palliative care?

A. It's not the treatment, it's the visit.

Q. Ah. It's the visit, okay. And, if a patient is palliative and you were talking to them about their medical condition ---

A. Yes.

Q. --- what would the visit be characterized as?

A. Sorry, you're going to have to be more specific.

Q. Sure. Patient comes to you, says, "I have metastatic pancreatic cancer, I'd like to know what I can do. What are my options? I've been told I'm palliative." And, you discuss various options with the patient. How do you code that?

A. I don't bill palliative care.

Q. So, you don't know?

A. I don't bill it.

Q. So, what would you bill that visit for?

A. I would just bill it as a partial assessment.

Q. Okay.

A. The reason I don't bill it is because most of my patients are being seen either by their family physicians and palliative care physicians, so I would not want to negate those billings.

Q. I see. Okay. So, that's your choice that ---

A. That's my choice.

Q. That's your choice. But, someone else who sees that patient, like if it's a family physician, they can bill it as a palliative care visit?

A. Yes.

Q. Okay. Thank you for clarifying.

A. But, if you're asking me what would -- but you're still asking me what would happen at a visit like that?

Q. No. I'm just asking you how you would code it, because you talked about the coding that Dr. Khan did which was ---

A. Right.

Q. --- a palliative care code. You said you would not ---

A. I don't.

Q. --- use that code, and you've now explained to us why not.

A. Right. But, my other colleagues do.

Q. Right. Okay. Thank you. So, I just want to go through just briefly what appeared to have happened when Mr. [redacted] chooses to take the palliative treatment. And, just so we can be reminded a little bit, in your expert opinion -- as I recall your evidence, Dr. Tozer, you had indicated that the diagnosis for this patient, Mr. [redacted], was a poor prognosis and the typical lifespan was short?

A. Correct.

Q. Okay. And, he, in fact, dies March 28th, 2014. He is diagnosed in 2013, November -- sorry, in 2013 and he takes SEF chemo for a four-month period. So, I just want to show you what appears to be occurring when he's starting the SEF chemo during this period of his treatment.

So, can you take a look with me at Tab 3 of Exhibit 52? And, can you turn up page 62 for me, please? And, this is the linear endoscopic ultrasound taken September 20th, 2013. So, this is before he commences any SEF chemo. Do you see there in the sixth line, it says that the CT scan revealed a 6 by 4

**MS. HENEIN:** Okay.

**THE CHAIRPERSON:** Yes. I think probably -- if we're ---

**MS. HENEIN:** Great.

**THE CHAIRPERSON:** --- moving to a new area ---

**MS. HENEIN:** Yes, a new patient.

**THE CHAIRPERSON:** --- then we would -- yes.

**MS. HENEIN:** Thank you.

**THE CHAIRPERSON:** So, I have 10:13. Let's break till 10:30.

--- Whereupon the hearing was in recess from 10:15 a.m. to 10:35 a.m.

**THE CHAIRPERSON:** Please be seated. Please proceed, Ms. Henein.

**MS. HENEIN:** Thank you very much.

BY MS. HENEIN:

Q. Dr. Tozer, we were moving to [redacted]. And, just to, again, prompt your memory, she was a pancreatic cancer patient? Yes?

A. Mm-hmm. Yes.

Q. Sorry. It's just the court reporter has to have a "yes" or a "no" ---

A. I know, I heard.

Q. Patient was palliative; right?

A. Yes.

Q. And, she had had a fairly extensive conventional treatment; right?

A. Yes.

Q. Okay. And then she ultimately, after conventional treatment, appears to have her cancer returned, do you recall, October 2013?

A. Yes.

Q. Okay. So, let me just walk you through a little bit of that history as to where she is before she comes to Dr. Khan and where she is after, okay? Do you recall, and I can take you to the documents if you need it, she's diagnosed with pancreatic cancer in 2012?

A. Okay. Yes.

Q. Okay. And, if you recall, she has surgery -- what's called Whipple surgery in August 2012?

A. Yes.

Q. And, you described to us what Whipple surgery was, but can you just refresh our

A. Yes.

Q. --- gemcitabine? And so, she has gone through the conventional therapy?

A. For localized pancreatic cancer, yes.

Q. Yes. And, she's now in the palliative stage?

A. Yes. So, this is different.

Q. This is different. And, it is at the time that she is seeing Dr. Khan, she's continuing to be followed by her conventional physicians?

A. We assume so.

Q. Yes. And, can I ask you to look at Exhibit 44, Tab 3? Oh, I'm sorry. Exhibit 33. Does the panel have that? So, if you look at Exhibit 33.

**THE CHAIRPERSON:** Did you say Tab 3?

**MS. HENEIN:** Tab 3. Yes, Dr. King.

BY MS. HENEIN:

Q. Do you see there that in Dr. Khan's notes on October 11th, 2012, it says, "Started gemcitabine". Do you see that at about six lines down?

A. Yes.

Q. What is the next sentence or the

A. We won't know.

Q. No, we don't know. And, number 4, it says, "SEF chemo as a backup ---

A. Yes.

Q. --- if DCA fails", right?

A. Yes.

Q. And so, we're dealing again here with a patient that has extensive experience and extensive treatment with conventional oncologists; right?

A. Yes.

Q. And, she's taken not only the conventional treatment for the cancer, but she's taken the conventional palliative treatment; right?

A. Yes.

Q. And, she's done palliative treatment that is conventional while she's seeing Dr. Khan; right?

A. Yes.

Q. And, one year later, there is a notation that she's finished with it, she doesn't want to do any more conventional palliative treatment?

A. Yes.

Q. Okay. In your evidence, you said that there wasn't any imaging that followed her

in this. The patient has started SEF chemo, she is in a palliative state; right?

A. Yes.

Q. Okay. And, she has completed her cycle of gemcitabine, she's declined any further standard chemo palliatively, so she's now switching to SEF chemo. And so, we know that March 6, 2014, the ultrasound shows there is metastatic disease in the liver. So, looking at Exhibit 34, it appears, if you can look with me, on April 23rd, 2014, while she's on SEF chemo, the report is -- just looking towards the bottom there. It says, "Flow was not identified on doppler in any of these four lesions on the" ---

A. Yes.

Q. Okay. And then further down, it says, "Possible necrotic tissue laterally with no flow"?

A. Yes.

Q. Okay. And then on the last page, it says, "The four in the right lobe of the liver would appear necrotic and no flow identified."

A. Right.

Q. And, my recollection of your evidence about that, suggesting that there had been some improvement, was that you don't know if this was

conventional doctors; right?

A. Maybe, yes.

Q. And, you recall that October 2013, when her cancer returns, is when she discusses trying SEF chemo ---

A. Yes.

Q. --- right? And, she is then under the treatment of Dr. Khan palliatively, because you said her prognosis is that she's going to die ---

A. Yes.

Q. --- right? And, it appears that, and I appreciate you have a different interpretation, but that for some period of time, according to some of the MRIs, that some of the tumours are necrotic and there seems to be some stabilization of the disease, and then there's some advancement -- a new ---

A. Yes.

Q. --- metastasis? Okay. So, that's, sort of, what is happening while she's on the SEF chemo, there is a bit of stabilization, there's also a new small lymph node. And, throughout this ---

A. No. There's a new small lesion on the liver.

Q. Thank you. Yes, small lesion on the liver. And, as he is dealing with her, he is also

referring her not only for MRIs and assessments, but he's also referring her for consultations with conventional doctors?

A. Yes.

Q. Okay. All right. Let me go to the next patient, which is [redacted]. And, for that, we will -- I'm going to ask you to pull up Exhibit 37. I'm going to take these away, okay?

A. Okay.

Q. Do you have your report here, Dr. Tozer?

A. Yes.

Q. Where is that one -- okay. And, I think Exhibit 38 as well, which is (indiscernible). All right. Just so we are, again, reminded of your evidence about Ms. [redacted] this also was a palliative patient?

A. Yes.

Q. Okay. And, she had recurrent metastatic colon cancer and conventional treatment had been tried, but failed?

A. Yes.

Q. Okay. And, in this case, this patient had undergone conventional treatment that involved surgery, and radiation and chemotherapy?

A. Yes.

Q. Right. And, you'll recall then, after all of that, she then decided in her palliative state, when she had metastatic colon cancer, to try SEF chemo?

A. Yes.

Q. Okay. So, let me just go through that with you. Do you recall that this patient, before she went to see Dr. Khan, had a history of using naturopathic treatments?

A. Yes.

**MS. HENEIN:** Okay. So, if I can ask you to look with me at her -- at the consultation note from Dr. Trinkaus. If that could be marked as the next exhibit?

**THE CHAIRPERSON:** Okay. So, this gets us to Exhibit 96, which is a consultation note from Dr. Trinkaus, that's T-R-I-N-K-A-U-S, from Markham Stouffville Hospital, and it's dated 16th of March, 2012.

--- EXHIBIT NO. 96: Consultation note from Dr. Mateya Trinkaus from Markham Stouffville Hospital, dated March 16, 2012

very aggressive treatment with curative intent. So, she had a port-a-cath implanted for her -- for the chemotherapy. They probably -- so the pre-operative portal vein embolization is basically when they cut off the blood flow to one of the metastases to make it smaller and therefore more easily to be removed. She underwent a cholecystectomy, right hepatectomy to remove the -- all the metastatic disease that they could see. She had a diverting loop ileostomy, so she has a colostomy in place. She had an anterior resection in her colon. She's undergone hysterectomy. She's had both her ovaries and fallopian tubes removed, and has had a partial removal of her vagina.

Q. Okay. So, it is a very aggressive surgical intervention, to try to stop ---

A. Cure.

Q. --- the disease -- to cure the disease?

A. Yes, to cure.

Q. And, I'm going to come through the dates. But, by the time she gets to Dr. Khan, she's in palliative care?

A. Yes.

Q. Okay. And, can I just ask you to look at the next page of that questionnaire? And,

conventional palliative chemotherapy?

A. Yes.

Q. And, she wanted a naturopathic approach?

A. Yes.

Q. And, was seeing both Dr. Khan and Dr. Tina Konstantinou?

A. Yes.

Q. All right. And, she indicates that she's had further deterioration?

A. Yes.

Q. Okay. And, do you see there on the third page, Dr. Trinkaus extensively discusses going back on conventional chemotherapy?

A. Yes.

Q. And, once again, the patient declines?

A. Yes.

Q. Okay. Now, you know, I take it, that the patient decides to go back, and the palliative option she chooses in March of 2014 is to go and try DCA?

A. Yes.

**MS. HENEIN:** Okay. And, I just want to take you to the letter that is sent to Ms. [redacted]

--- Whereupon the hearing was in recess from 11:55 a.m. to 1:04 p.m.

**THE CHAIRPERSON:** Please be seated.

**MS. HENEIN:** Panel members, I'm moving to the patient, [redacted] And so, you will need books 49 and 54.

**UNIDENTIFIED SPEAKER:** Sorry, which books did you say?

**MS. HENEIN:** Fifty-four and 49.

**UNIDENTIFIED SPEAKER:** Fifty-four and 49.

**MS. HENEIN:** Thank you.

BY MS. HENEIN:

Q. Dr. Tozer, [redacted] which we've discussed in terms of all the documents you did not review, had lung cancer with mets in the brain, the bone and the liver; right?

A. Yes.

Q. And so, she was palliative?

A. Yes.

Q. And, just looking at your report at Exhibit 30, you find that, one, she could have developed intracranial pressure and was being

that, "You should follow along what the conventional doctors are telling you to do, and they're assessing you and testing you," ---

A. Yes.

Q. --- right? And, he also says to her, "Ask them if it's okay to even continue with the chemo to help improve your breathing"?

A. Yes.

Q. All right. Now, can I just ask you a question about what it means to take palliative chemotherapy? Am I right that the purpose of palliative care is to improve the symptoms of the patient?

A. To potentially improve symptoms that potentially prolong life.

Q. Right. It's not curative, though?

A. No.

Q. All right. So, one of the things you're looking at is whether or not the patient in receiving a palliative treatment to -- is reporting that their symptoms are improving; right?

A. Yes.

Q. All right. So, can you look, please, at Tab 7, page 26? These are Dr. Khan's notes. And, do you see there at the top, on November

A. Yes.

Q. Okay. So, I'm going to suggest to you that the patient appears to be reporting some improvement in symptoms and sometimes there is a bit of a decline with her breathing ---

A. Yes.

Q. --- a shortness of breath which he's monitoring and ultimately sends her to the hospital to assess. Okay.

Now, do you accept, having reviewed the communications of this patient, that she repeatedly requests, while she's in this palliative stage, towards the end, the last two, three months, she is requesting the chemotherapy ---

A. Yes.

Q. --- that is being offered? And, she is reporting that her -- some of her symptoms seem to be improving?

A. Yes.

Q. All right. And so, that would be, I'm going to suggest to you, consistent with the objectives of -- one of the objectives of palliative care. You talked about the prolonging of life, which is one, but the other one is to try to ameliorate symptoms.

symptoms or it may be also designed to prolong life?

A. Yes.

Q. Okay. And, it doesn't necessarily do both?

A. Correct.

Q. Okay.

A. And, we gave an example of that last time.

Q. Right. And, in this case, it appears that Ms. [redacted] reports some alleviation of her symptoms when she is on the SEF chemo?

A. Yes.

Q. Okay. Can we go to Michel LeBlanc? And, Michel LeBlanc, you will need Exhibit 45. You don't have Exhibit 45 there. Let me get it for you.

**MS. HENEIN:** So, just so we -- sorry, I'll just wait. Do you have it, Dr. Yanivker? Yes. Okay. Thank you.

BY MS. HENEIN:

Q. So, Michel LeBlanc was diagnosed and is also a palliative patient; right?

A. Yes.

Q. And, he is the patient who is diagnosed with esophageal carcinoma and liver mets?

to be worse than the last time I saw it in November. This was stented today hoping to give him some palliation." (as read)

A. Correct.

Q. Okay. So, Dr. Khan, in managing this patient, is dealing with the risk of obstruction and is doing it, I'm going to suggest to you, appropriately by referring him to doctors who can assist and who are experts in the area.

A. Yes.

Q. And, it appears, at least based on Dr. Schweiger's review of this particular patient, that between November 22nd and January 2014, the obstruction doesn't seem to have advanced. It seems to be static at this point anyway?

A. It's only -- right. It's only a two-month interval.

Q. Right. And so, I take it you agree with me that your report was incorrect?

A. On that aspect, yes.

Q. Okay. Thank you.

I would like to move to the next patient, and this is [redacted], and that is Exhibit 51. So, [redacted], and your assessment of her is

at page 5 of your report, is a triple-negative breast cancer patient. And, just to quote you on your evidence, "This was a very terrible situation, and the only treatment for her would be palliative chemotherapy," am I right?

A. Yes.

**THE CHAIRPERSON:** Just pause for a moment, please.

BY MS. HENEIN:

Q. So, I would like you to take a look at this patient because I'm going to suggest to you that Ms. [redacted] was being seen by an interdisciplinary team of doctors; okay? So, let's just take a look at who she was seeing at the time.

**MS. HENEIN:** Can the medical questionnaire for [redacted] be marked as the next exhibit, please?

**THE CHAIRPERSON:** Okay. So, Exhibit 107 ---

**MS. HENEIN:** Thank you.

**THE CHAIRPERSON:** --- is the medical questionnaire of [redacted]

alkylating agent.

Q. Okay. So, that's one type of chemotherapy, and then cisplatin-gemcitabine is a different type of ---

A. Yes.

Q. --- chemotherapy? All right. So, it appears, at least according to this note, that in fact she has been treated with two rounds of ---

A. She had one round in the adjuvant setting ---

Q. Yes.

A. --- and one round in the metastatic setting.

Q. Okay. Which is palliative?

A. Which is palliative. So, the first one was adjuvant ---

Q. Yes.

A. --- the second one was palliative.

Q. Okay. So, there is some information about the treatment she was receiving?

A. Yes.

Q. Okay. Now, did you, before you wrote your report, contact her oncologist to get a more detailed or accurate assessment of what she had received?

would have been to try to be curative; right?

A. Yes.

Q. Exactly. And then it was failed ---

A. Yes.

Q. --- then it's palliative?

A. Yes.

Q. Okay. Now, you indicated that tumour markers are helpful to assess a patient?

A. Yes.

Q. And, would you do tumour markers when a patient is in a palliative state?

A. Yes.

Q. Okay. And, are you aware that Dr. Khan did request such tests in February of 2013 and February of 2014?

A. No.

Q. Okay. So, let me just show you those documents. So, one is from 2013, Dr. Tozer, and this one is from 2014.

**MS. HENEIN:** Can I ask that the 2013 result be marked as the next exhibit, and then the 2014 result be marked as the following exhibit as well?

**THE CHAIRPERSON:** Yes. The 2013 result

be entertained with palliative intent"?

A. Yes.

Q. "She was clearly dying"?

A. Yes.

Q. All right. And so, if you were a doctor treating her, I gather you can bill her treatments as palliative?

A. No.

Q. Why not? Not you because you personally don't do it, but other doctors could do that?

A. You can bill a visit as palliative.

Q. Yes. I apologize.

A. Not a treatment.

Q. Right, the visit as palliative.

A. Yes.

Q. Okay. Now, this patient who had only, according to you, a few months to live, wanted to continue alternative therapy. She had no interest in conventional palliative treatment?

A. Yes.

Q. Okay. And, that's reflected in the notes of Dr. Khan dated August 13th, 2012.

**MS. HENEIN:** If the August 13th, 2012 note relating to [redacted] could be marked as the