HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

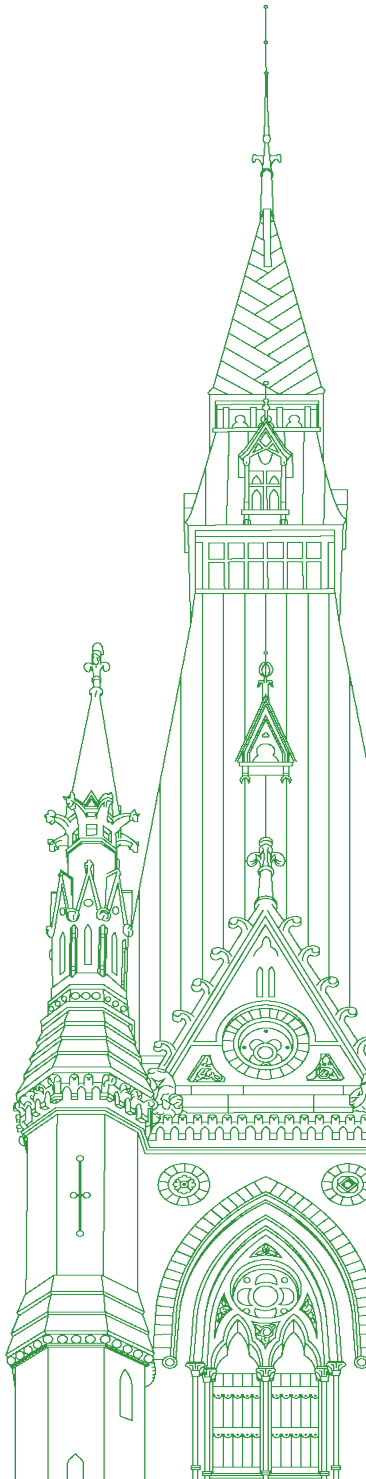
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 123

Thursday, June 13, 2024



Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, June 13, 2024

● (1100)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 123 of the House of Commons Standing Committee on Health.

Before we begin, I'd like to ask all members and other in-person participants to consult the cards on the table for guidelines to prevent audio feedback incidents.

Please take note of the following preventative measures in place to protect the health and safety of all participants, including the interpreters. Use only the approved black earpiece. The former grey earpieces must no longer be used. Please keep your earpiece away from all microphones at all times.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): On a point of order, Chair.

[*English*]

The Chair: Go ahead.

[*Translation*]

Mr. Luc Thériault: I cannot hear a single thing.

First, I would like you to call for decorum. Next, through you, Mr. Chair, I would like to say to the interpreters that if we want everything to go smoothly today, then they will have to get as close to their microphones as possible. I know that they have a tough job to do, but I can barely hear anything and the volume on my headset is almost at 10, which is dangerous to me.

The Chair: Is it the same technical problem as the other times, which is unrelated to the noise in the room?

Mr. Luc Thériault: Last week I chose to follow the meeting nonetheless, but the situation is not resolved.

The Chair: Okay. We will suspend the meeting to try to resolve the technical problem.

Meeting suspended.

● (1100)

_____(Pause)_____

● (1105)

[*English*]

The Chair: I call the meeting back to order.

Mr. Thériault, does it appear to be resolved for the moment?

[*Translation*]

Mr. Luc Thériault: The volume is now set to 8 out of 10 and I can hear properly. I will need to pay attention when a new interpreter enters the booth because at this volume, the sound can be damaging. I will keep going like this because I can hear now. The sound in the room will also have to be adjusted according to the witnesses appearing via video conference.

The Chair: Okay, thank you.

I will carry on.

[*English*]

When you're not using the earpiece, place it face down on the sticker placed on the table for this purpose. Thank you for your cooperation.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted on April 11, 2024, the committee is continuing its study of breast cancer screening guidelines.

I would like to welcome our panel of witnesses.

Colleagues, you will notice from the notice of meeting that we've arranged the witnesses in two two-person panels. This was done to accommodate the schedule of the witnesses and to ensure the maximum amount of time to question each one.

From 11 to 12 today, we have, appearing by video conference, Dr. Jean Seely, professor of radiology, faculty of medicine, University of Ottawa. With us in the room, from the Canadian Cancer Society, are Kelly Wilson Cull, director of advocacy, and Ciana Van Dusen, advocacy manager of prevention and early detection.

We'll begin with Dr. Seely online for her opening statement of up to five minutes.

Welcome to the committee, Dr. Seely. You have the floor.

Dr. Jean Seely (Professor of Radiology, Faculty of Medicine, University of Ottawa, As an Individual): Thank you very much, Mr. Casey and members of the committee, for the opportunity to comment on the draft Canadian task force breast cancer screening guidelines.

As a breast imaging specialist, I diagnose women along their entire cancer journey. I detect breast cancers through screening or diagnose them after a woman presents with a symptom of a palpable lump. I perform biopsies and I localize breast cancers for the surgeons. I interpret the imaging of women diagnosed with late-stage or recurrent breast cancer. I speak to women at all stages of breast cancer. A screen-detected cancer found before symptoms occur is a very different diagnosis from one found because of symptoms at stages 2 or 3, or when it's incurable, at stage 4.

The task force falsely equates an additional imaging test as a harm comparable to a delayed diagnosis of late-stage breast cancer. My patients attest that the severity of the harm of a delayed diagnosis vastly exceeds any stress associated with any additional imaging test. Equating these harms is a false equivalency.

The recent draft guidelines released by the task force for breast cancer screening have sparked significant concern within the medical community. As an expert included on the evidence review panel, I find their recommendations profoundly disappointing. These guidelines ignore robust and recent evidence supporting the initiation of screening at age 40, a standard now adopted in the United States and numerous other countries.

The task force recommendations are anchored in studies dating back 40 to 60 years, utilizing obsolete technologies like film-screen mammography. As experts, we recommended against including these outdated data, which overlook monumental advances in breast cancer treatment, including hormone receptor-positive treatments like tamoxifen, less invasive surgical options like lumpectomy and sentinel lymph node biopsy, and modern immunological and chemotherapeutic agents that have revolutionized breast cancer management. The task force working group interfered with our expert recommendations and insisted on using these studies.

The task force approach diminished the importance of recent observational studies, involving millions of women, comparing screening to no screening with updated diagnosis and treatment. These studies include one Canadian study of over 2.7 million women screened over 20 years, which demonstrated a 44% reduction in breast cancer mortality in women who began screening in their forties. Similar studies in Sweden show even greater benefits, with reductions in mortality of 50% to 60% in women aged 40 years and older.

Furthermore, the task force used the old trials to evaluate cancer stage at detection and therefore missed the benefits of early-stage detection with up-to-date screening technology. The improvements in screening technology in the past 15 years have improved breast cancer detection by 20% to 40%.

Breast cancer is a devastating diagnosis, but the harms are mostly preventable when it is detected early. The survival rates are starkly different across stages—a nearly 100% five-year survival rate for stage 1 detected through screening as compared with only a 22% five-year survival rate at stage 4, when the disease has become incurable. Furthermore, the treatment is much less intensive and costly when treated early. Stage 1 cancer costs an average of $30,000 Canadian to treat, as compared with up to $500,000 for stage 4. Systematic screening programs in Canada find that 87% of breast cancers are stage 1 at diagnosis.

The task force disregarded data that showed women of a race or ethnicity other than white are more likely to be diagnosed with breast cancer in their forties. A one-size-fits-all approach to recommending screening only starting at 50 discriminates against these women and contributes to their twice-higher rates of advanced breast cancer due to delays in screening, access to screening and delays in diagnosis.

The task force acknowledged that women with dense breasts were twice as likely to develop breast cancer as women with non-dense breasts. However, it failed to recognize the reduced sensitivity of mammography in these women, which drops from 90% in women with non-dense breasts to 60% in those with the densest breasts. The task force ignored high-quality randomized studies that showed adding screening with MRI reduced interval cancers—cancers diagnosed by symptoms after a normal mammogram—by 80% and by 50% in women screened with supplemental breast ultrasound. These have been shown to be evidence-based acceptable surrogates for breast cancer mortality, but the task force did not consider them despite an expert recommendation.

● (1110)

We must demand that our health policies be reflective of the latest scientific evidence and best practices in medicine.

Thank you very much for your attention.

The Chair: Thank you, Dr. Seely.

Next we have the Canadian Cancer Society, with Ms. Wilson Cull or Ms. Van Dusen, or a combination of the two.

You have five minutes. Welcome to the committee. You have the floor.

Ms. Kelly Wilson Cull (Director, Advocacy, Canadian Cancer Society): Good morning.

My name is Kelly Wilson Cull, and I'm the director of advocacy. With me today is Ciana Van Dusen, who's the advocacy manager of prevention and early detection.

The Canadian Cancer Society is the voice for people who care about cancer in Canada. As a part of our commitment to improving and saving lives, we are pleased to provide recommendations on breast cancer screening.

Cancer is the leading cause of death in Canada. It is predicted that two out of five people will be diagnosed with cancer in their lifetime, and approximately one in four will die of the disease. In Canada, an estimated one in eight women is expected to be diagnosed with breast cancer during their lifetime. Breast cancer is the most common cancer among women in Canada, and despite fewer women being diagnosed with breast cancer under the age of 50, it remains the leading cause of cancer death for people in Canada aged 30 to 49.

While data from a new study shows that breast cancer incidence rates for women in Canada in their forties have increased over the last 55 years, overall, breast cancer incidence and death rates in Canada are trending downwards as early detection, treatment and care continue to improve. However, we must acknowledge that international data indicates that more Black, Asian and Hispanic women with breast cancer are diagnosed before the age of 50 and are more often diagnosed with a later-stage disease compared with other women. This means that waiting to start screening at age 50 could result in missed opportunities for early detection among women in these communities.

Evidence from trials, modelling studies and real-world data has shown benefits from regular breast cancer screening starting at age 40. Timely access to breast cancer screening is critical to finding breast cancer early, when treatment is most likely to be successful. We continue to hear from people living with breast cancer that they do not feel represented by the current guidelines because they do not reflect their lived experiences. Furthermore, according to a national survey, most respondents support expanding systematic access to breast cancer screening to include women aged 40 to 49.

CCS supports expanding access to breast cancer screening for women and trans, non-binary and gender-diverse people aged 40 to 49 at average risk of developing breast cancer. We also need to ensure that there is clear guidance for people who have an elevated or high risk of developing breast cancer, such as people with certain genetic mutations, a family history or dense breasts.

I will turn the remarks over to Ciana.

● (1115)

[*Translation*]

Ms. Ciana Van Dusen (Advocacy Manager, Prevention and Early Detection, Canadian Cancer Society): Thank you, Ms. Wilson Cull.

A growing number of provinces in Canada have started offering cancer screening services starting at the age of 40 or have made announcements about expanding access to these services. While the provinces and territories are looking at the new national guidelines, the Canadian Cancer Society, or the CCS, is asking remaining administrations to include women 40 to 49 at an average risk for breast cancer in their breast cancer screening program. This change also reflects the new evidence that was released between the last update of the Canadian guidelines in 2018, and those that were presented a few weeks ago.

The data on participation in breast cancer screening programs in Canada will soon be updated by Canadian Partnership Against Cancer. For now, our data goes back to before the pandemic and the breast cancer screening programs do not meet the national objective of 70% participation. It is important to increase capacity to meet people's needs in Canada, while taking into account the needs of underserved populations, specifically individuals who are part of racialized or indigenous communities, as well as low-income individuals or those living in a rural or remote region, and adapting the services accordingly.

What is more, the CCS recommends that the federal government invest more in research in order to expand knowledge on screening and the risks associated with cancer. It is also important to fill the gaps in data in order to have a better understanding of the incidence of cancer in Canada. The Pan-Canadian Cancer Data Strategy and the Pan-Canadian Health Data Charter describe interesting possibilities for improving the data in the country.

Governments need to invest in breast cancer prevention, early detection and treatment and in reducing the effects of the labour shortage. These investments include many investments in human resources, in integrating new technologies, in digital infrastructure and in modernizing care trajectories to meet Canadians' current and future needs.

Thank you for taking the time to listen to our recommendations. We look forward to continuing to work together to better support people affected by cancer because it takes society as a whole to tackle cancer.

Thank you.

The Chair: Thank you.

We will begin the round of questions with the Conservatives.

Mr. Ellis, you have the floor.

[*English*]

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair.

Thank you to our witnesses for being here for this very important topic.

What we've heard very clearly is that in spite of what the task force has said, the science is perhaps changing very rapidly. It's a dynamic environment. Some science is not being taken into account, which is very discouraging.

Dr. Seely, I know you don't have a crystal ball—or if you do, I'd be happy to borrow it now and again—but the task force has put out its draft guidelines. Do you think there's a way, with the voice of this particular committee and your voices added, that the draft guidelines from the task force can be changed to be more reflective of current science?

● (1120)

Dr. Jean Seely: The problem with the task force recommendations is that they dictated what evidence could be used. They insisted on including the randomized controlled trials that were 40 to 60 years old. Because of that, the evidence generated for these recommendations does not reflect the most up-to-date evidence. My concern is that these draft recommendations will not change despite the feedback.

Our recommendations are to not adhere to any of these recommendations and to start again with the evidence that experts recommend should be used.

Mr. Stephen Ellis: Going down that line, there's a concern that I think we should all share. It's certainly one of my concerns. We don't want women in Canada getting mixed messages. That creates a difficulty. If we believe—and I believe what you're saying is true—that the draft guidelines will become guidelines, how can we amplify the voice saying, on behalf of women, that they should be able to access screening for breast cancer at age 40?

I live in Nova Scotia. That is a reality there. Women can access screening, as you well know, at age 40. Would it behoove this committee to write to every provincial minister of health after the final report of this committee to ensure they hear that message loud and clear? Is that another path we could possibly go down to ensure the message is heard clearly?

Dr. Jean Seely: That certainly would help. What we know is that all the provinces and territories have now updated their screening guidelines. The only two that remain are Quebec, which is looking at the evidence, and Manitoba. The problem is that these task force guidelines are adhered to by many family physicians in the country. We know that when the task force changed its recommendations in 2011, British Columbia—which, like Nova Scotia, allowed women to be screened in their forties—saw a marked decrease in the participation of women in their forties. It dropped from 50% participation to 25%.

We must have even better messaging to not adopt these guidelines, as they are adhered to by many family physicians who don't have time to follow the most up-to-date evidence.

Mr. Stephen Ellis: Do you think there's an opportunity, then, to target The College of Family Physicians of Canada so that family physicians can hear this message very clearly? Obviously, the science exists, but most of this is a communications exercise, as you mentioned very clearly, to family physicians and to women in Canada. I realize you're not a marketing expert, but what I'm asking is how we get that message out there so that it's loud and clear without, sadly, the task force changing its guidelines.

Dr. Jean Seely: For sure a message from the government and this committee would be very helpful. It would probably be very useful to target it to the family physicians, who have a more limited knowledge about this, and to amplify it at the level of the screening programs.

I would encourage Quebec and Manitoba to have a systematic approach. The programs that have been delivering screening are excellent, and we would recommend that all of that screening be done within a screening program and by self-referrals starting at age 40 and older.

Mr. Stephen Ellis: Thank you very much.

Ms. Cull, is that approach something the Canadian Cancer Society believes would help amplify the message as well? I realize I'm putting you on the spot, but that's what we're here to do, so thank you for that.

Ms. Kelly Wilson Cull: Certainly, yes. The Canadian Cancer Society is very actively engaged with all provincial governments across Canada on this issue. We recognize that many provincial programs—

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): On a point of order, I'm showing English, but I'm getting French interpretation right now.

The Chair: We'll get you to repeat your answer once we check what the technical problem is.

I believe the problem is resolved. When this happened, Mr. Ellis still had about a minute left on the clock, but you were in the middle of your answer, so please go ahead and complete your answer.

● (1125)

Ms. Kelly Wilson Cull: Thank you very much.

I think you used the term “mixed messages”, and that's part of the challenge we're experiencing as a result of these guidelines. We have provinces and territories across Canada with different approaches to breast cancer screening. What that has inadvertently created is inequity: Where you live dictates what your breast cancer screening access looks like.

From the Canadian Cancer Society's point of view, we are urging all provincial governments to reduce access to systematic screening starting at age 40. We recognize that some provinces—I'm from Nova Scotia—have access to self-referral, for example, and have for some time, whereas provinces like Ontario have committed to rolling this out but aren't quite there yet.

Where you live shouldn't dictate your access to breast cancer screening in Canada. We want to ensure that there's an equitable approach. At this point, we know that provinces are taking their cues from the task force, so we need leadership and a strong infrastructure to ensure the provinces are getting the most accurate, up-to-date, comprehensive guidelines. Then they can make the right decisions for their constituents.

The Chair: Thank you.

Next we have Mr. Naqvi for six minutes, please.

Mr. Yasir Naqvi (Ottawa Centre, Lib.): Thank you very much, Chair. I'll be sharing my time with Dr. Powlowski, if that's okay with you.

I want to thank all of the witnesses for being here, particularly Dr. Seely, whom I had the opportunity to meet a little over a year ago on precisely this issue. I'm thankful to her for the guidance that she gave me on the task force work.

Since that time, the issue of breast cancer and screening has become personal to me, as my mother was diagnosed with breast cancer. Although she's an older woman, it was screening that caught her cancer in its very early stages, and she's on an incredible journey of recovery and living her full life.

I must say that I feel very frustrated by the draft guidelines the task force has issued and I am thankful that this committee is doing the important work and listening to witnesses.

Dr. Seely, when we met, you spoke about a study you had done, I believe in 2023, that looked at how screening of women aged 40 to 49 impacted net survival. Would you be able to elaborate for us on some of the key findings and why you believe the screening age should be lowered to 40?

Dr. Jean Seely: Thank you very much, Mr. Naqvi. I'm sorry your mother was diagnosed, but I'm very grateful that she was screen-detected, because it's a very different diagnosis.

As noted, there is a geographic difference in screening programs in the country. Some women who live in the provinces of British Columbia and Nova Scotia are able to participate in screening programs, and others are not. We were able to look at over 55,000 women diagnosed with breast cancer in Canada over a 10-year period. What we could see is that the women who lived in a province where there was a screening program offered for women in their forties had a significant increase in the 10-year net survival of their breast cancer, which was on par with some of the chemotherapeutic agents we use for every woman diagnosed with a hormone receptor-positive cancer.

We found there was a significant decrease in breast cancer mortality for women living in the provinces that had screening programs. What we didn't know is how many women in those provinces were screen-detected, because that's not something we currently track. However, we could see a marked improvement. It correlated with a study we had done previously that showed the stage at which breast cancer was diagnosed was significantly lower—stage 1—if they lived in those provinces, compared to the ones that did not screen. It also had a benefit for women who were older, in their fifties, and increased improvement in their stage and overall survival.

● (1130)

Mr. Yasir Naqvi: Very quickly, before I pass it on to Mr. Powlowski, I'll note that one of the cautions we hear is about false positives: If you lower the age, it may increase that particular incidence. Can you comment on that? Is that a misguided fear in this instance?

Dr. Jean Seely: The task force has called them false positives, which is not a correct term. We're not telling a woman when she's recalled from screening that she has cancer; we're simply telling her she needs some more imaging to identify if there's an abnormality. Over 94% or 95% of those turn out to be overlapping tissue. We're looking at a three-dimensional structure and showing it in 2-D, and it's something we can use to reassure a woman at that time.

We need to do biopsies, and about 1% or less are benign. This is a very well-tolerated procedure. I do biopsies all the time, and women tell me they would much rather have this kind of abnormal imaging test than have a delayed diagnosis of breast cancer. The women who have a delayed late-stage diagnosis are angry that they lost the opportunity to be screen-detected.

Mr. Yasir Naqvi: Thank you.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Seely, it seems like the task force ignored the advice of their own experts, which is, to me, very troubling. Could you start off by clarifying for us who is on the task force? What is their level of expertise?

Dr. Jean Seely: The working group of the task force was carefully selected to have no expertise in breast cancer imaging, diagnosis or treatment. I was invited to be an expert to the evidence review panel, which is the group that looks at the evidence and provides it to the working group to inform their recommendation.

Mr. Marcus Powlowski: Can I interrupt you? Are you just supposed to compile the evidence, or are you supposed to be evaluating the evidence?

Dr. Jean Seely: For my job as expert adviser to the evidence review panel, we recommended the evidence. We put it into context. These are people who don't understand imaging. We gave a lot of recommendations and included the fact that the technology in those old trials was no longer used, but the working group overrode our recommendations and insisted to the evidence review panel that they must include those studies.

Mr. Marcus Powlowski: Who is on the evidence review panel?

Dr. Jean Seely: On the evidence review panel are three different groups across the country. The one in Ottawa consisted of methodologists and epidemiologists whose methodology expertise is to analyze the evidence. That's who we were helping to advise.

The working group is separate, and we never directly interacted with them, but we could see their comments and their responses to the evidence review, which dictated the evidence that could be used.

The Chair: Thank you, Dr. Seely.

Thank you, Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

I also want to thank the witnesses for their informative testimonies.

Dr. Seely, the working group recommends not proceeding with systematic mammography screening for women 40 to 49. This group emphasizes the informed choice of the patient, which involves an equally informed discussion between the patient and her doctor on the pros and cons of screening.

A study published in 2022 mentions that the obstacles to an individualized breast cancer risk assessment included knowledge of the risk factors and risk assessment tools. It also mentioned that doctors were having a hard time identifying breast cancer risk factors outside of family history, such as reproductive factors, ethnic origin or breast density. The study shows that some doctors lacked the skills to calculate the overall risk of breast cancer.

Do you not think that the doctors' lack of knowledge of risk factors and assessment tools can influence the informed decision that the patient should be making?

Dr. Jean Seely: Thank you for your question, Mr. Thériault

● (1135)

[*English*]

There are three factors to that answer.

One is that 80% of women in their forties who get breast cancer have no risk factors. This is why we don't recommend a risk-based approach to screening. We recommend systematic screening starting at age 40. We would miss too many cancers otherwise.

There is a second point, which is that there's a tremendous lack of family physicians. In Ontario, over two million people do not have a family physician. This poses a very big obstacle to getting access to screening and to having a discussion to allow them in.

Third, you mentioned a very good point. There is a lack of awareness of the risk factors. Even women who should be in high-risk screening are not advocated for to have screening earlier than age 40, when they should be in a high-risk screening program.

These are obstacles that the task force is placing with these recommendations, and they are going to accentuate the confusion and disparities we see, particularly among some of the racial groups and ethnicities I mentioned. It's a very important point.

[*Translation*]

Mr. Luc Thériault: I will ask a question that has not been asked yet during our meetings.

Every specialist and expert who comes to see us, including the representatives from the Canadian Cancer Society, tell us that there needs to be systematic screening between 40 and 49.

Why did the working group decide to set aside this advice? Is there a financial aspect, for better or worse, tied to that, even though I hear that this could save us a lot of money? What do you think? Why are these people insisting on this?

[*English*]

Dr. Jean Seely: It's a very difficult question to answer. We know there is a very strong anti-screening bias among the working group members.

Before the task force even began its work on this guideline, the co-chair publicly stated that she didn't believe there was any new evidence and didn't think the recommendations would change. Many of the other working group members are very strongly anti-screening, and they have already publicly published or commented on this.

I think it's about a lack of knowledge or lack of informed patient care. I am not sure if there are any other factors, but it's a good question.

[*Translation*]

Mr. Luc Thériault: That seriously catches my attention. Do you believe that the bias we talk about and that the working group talks about is very serious and harmful to women 40 to 49? What are we talking about when we talk about bias? This term comes up often during the study.

[*English*]

Dr. Jean Seely: I'm so sorry. I didn't really understand the question. If you're asking about the prejudice—

[*Translation*]

Mr. Luc Thériault: What is the bias? People say there is a bias associated with the screening. What is so biased? What is the nature of these biases when it comes to saving lives?

[*English*]

Dr. Jean Seely: The bias we see is the belief that treatment will resolve all breast cancers and is not dependent on stage. We've heard anecdotes that a patient at stage 3 might benefit from breast cancer treatment and do better than at stage 1. We have data that shows that is absolutely not the case. This comes from a belief based on a lack of awareness of all the data and a strong belief that treatment can solve anything. I see too many women dying within a year of their diagnosis of breast cancer.

That is exactly not our experience. It's an incorrect belief that chemotherapy will resolve and solve all the problems.

● (1140)

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

Next is Ms. Zarrillo, please, for six minutes.

Ms. Bonita Zarrillo (Port Moody—Coquitlam, NDP): Thank you, Chair.

Thank you, Dr. Seely, for all your testimony today.

We've definitely seen a reaction from the community. We've seen a reaction from women, who have a hard time being believed on many things but certainly on their health. I hear your comments about going back to the drawing board. It seems like this study is perhaps antiquated and needs to be modernized.

Dr. Seely, I'm going to ask you about what special considerations you would want if this task force goes back to the drawing board, but before I do, I want to share my personal story.

I was diagnosed with breast cancer in my forties, and I think people forget that we have children. Most women who are diagnosed with breast cancer in their forties have children. My youngest was in grade 6 at the time, and I think some of the visceral response we've seen from the community is due to the fact that the task force didn't seem to consider what impact breast cancer has on the people who experience it.

It took me two years for my doctor to get me screened. You mentioned the supplementary screening. I have dense breasts, and in the end, the cancer was close to my pectoral muscle and needed an ultrasound to be found. It was lobular, not ductal, so it grew in sheets and could not be felt as a lump. I chose to have a double mastectomy because of the stress of not being believed for two years and then being at stage 2 before they found it. Having to tell my children was very difficult.

Terry Fox is from the Tri-Cities, where I am in Port Coquitlam. Their run is in Coquitlam, and every year the students of SD 43, our school district, do a Terry Fox run. To see your sixth-grader put your name after “I'm running for” is something I wouldn't want any woman to see.

I'm sorry; I'm upset today. I didn't think I would get upset.

I wonder if you could let us know what the new technologies are. What is the task force missing? What are the special considerations they need to remember when the government sends this back for reconsideration?

Dr. Jean Seely: Thank you so much, Ms. Zarrillo. I'm so sorry about your experience.

I hear this and see this almost every week, and you are not alone. There are many women like you, and we're here today to do a better job for women in their forties, when they are in the prime of their lives and are productive members of society and parents.

Breast cancer doesn't just affect a woman; it affects the whole family. It affects grandparents, spouses and children, and this is why we are working to change these guidelines.

These guidelines cause tremendous confusion, and unfortunately, even using the estimated number of one per thousand lives saved by screening but lost if you don't screen women in their forties in Canada, we estimate this translates into 400 to 600 women's lives lost per year. This has a huge impact on Canadian society.

The technology has improved dramatically. I mentioned the 20% to 40%. This is based on digital mammography, which we now use and is particularly better for women with dense breast tissue. We also need digital breast tomosynthesis, which is another technology shown to increase cancer detection rates by up to 40%. It is being used in multiple centres in the United States and is slowly being used in Canada.

Reducing cancer and diagnosing it at stage 1 are possible. We now know from randomized trials that we can screen women with dense breasts with an MRI and reduce their interval cancers by 80%. They are diagnosed at stage 1.

This is all the technology we can use to inform up-to-date evidence.

Ms. Bonita Zarrillo: In my experience, what worries me the most is non-white women, women of colour and women who are more likely in their forties and fifties.... Knowing how hard I had to fight, I'm wondering how we are disadvantaging non-white women with this antiquated task force study.

● (1145)

Dr. Jean Seely: The women who are more likely to present with advanced breast cancer are women of all races and ethnicities other than white. This is because the peak age at which they are diagnosed with breast cancer is their forties. They are not able to access screening programs in many parts of the country based on these guidelines and based on a lack of access to a family physician. This is, unfortunately, similar to what we see in some of the developing world, with advanced breast cancers presenting in these women at a 2.5 times higher rate than white women in Canada.

These guidelines are very harmful. That's why I would recommend that we reject them and start again.

The Chair: Thank you, Ms. Zarrillo.

Mrs. Goodridge, you have five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I want to thank MP Zarrillo for sharing. That touched me. There aren't a lot of topics that get me really teary. I'm generally a very strong person who can hide a lot of emotion, but on this subject, I don't hide a lot of emotion.

My mom would have been one of the 400 to 600 women who would still be alive today had more screening been available. My mom passed away at 49 years old. She was diagnosed with breast cancer when she was 48 years old. She left behind four little kids. I was the oldest, and I had to take on a lot of extra responsibility through her chemo, through her radiation, through her palliative stage and then, eventually, after her passing. This isn't something that I wish on anybody. This isn't something that I hope another person ever has to struggle with.

I am angry. I'm angry with the task force. I think these guidelines fail to recognize the value of the lives of women and their families and the fear they have created by saying that additional screening is somehow not valid.

I want to open it up to you, Dr. Seely. I really appreciated your piece. You talked about the fact that you're seeing more women pass away within one year of diagnosis. What do you think we could do, beyond what the guidelines have put forward, to make things better for the outcomes of women?

Dr. Jean Seely: I'm so sorry for your loss. Probably every one of us has a member of our family...but it's even more potent when it's your mother.

As to recommendations, women should have a risk assessment for breast cancer, with informed and up-to-date tools to recommend what their next step should be, starting between the ages of 25 and 30. This is in alignment with the European guidelines and the American guidelines, which suggest that we should be thinking about breast cancer as early as 25 to 30. We should be recommending systematic screening starting at age 40. We should be allowing self-referral to a screening program. We have extremely good-quality screening programs in Canada.

This is what we would recommend. It is a woman's decision whether she wants to be screened or not. We know that participation rates are about 60%. They could be better, but we know that women in their forties are begging to be allowed a screening, to be allowed into the screening programs and to benefit from early detection. They want to live a healthy life and to be there for their children for many years.

Those are the major recommendations for young women. For women who are 74 years and older, life expectancy has changed and improved dramatically. We would recommend continuing to screen women older than 74 as long as they have a life expectancy of seven to 10 years, which is the majority of women in their seventies.

These recommendations align with international standards, and they are the ones we would recommend for Canadian guidelines.

● (1150)

Mrs. Laila Goodridge: Thank you. I really appreciate that. I've had a number of women in their seventies bring up their concerns about screening stopping at 74 for exactly the points you raised, so I think this is an important piece to make sure we involve.

I'm going to open this up to the Canadian Cancer Society.

What recommendation would you put forward, very succinctly? Do you think we should have a reversal of the guidelines that were just put forward by the task force?

Ms. Ciana Van Dusen: It's a difficult question, but we have heard it all today. We need access for women in their forties, from 40 to 49. It's about working with them in the capacity that they have today to get there. There is a public consultation, and we are encouraging our community to be very much a part of it in hopes that it might make a bit of a difference. We've also requested that a report be published after to understand what has been heard from the public.

A concern is that we have been consulted in the past and our thoughts, considerations and the research that has been provided haven't always come through. We're hoping this will be different, but we're also cautious. We'll see.

The Chair: Thank you, Ms. Van Dusen.

Ms. Kelly Wilson Cull: If I could....

The Chair: Please go ahead, very briefly.

Ms. Kelly Wilson Cull: It's just to add that we requested the task force to consider high-risk and elevated-risk guidelines in the current review. That's something else we would be looking to see. It's important to know that these screening programs are for average-risk populations. We need separate guidance for those at elevated and high risk.

The Chair: Thank you.

Ms. Sidhu, go ahead, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Thank you to all the witnesses for being with us.

My question goes to Dr. Seely.

Dr. Seely, I would like to start where we left off in the last meeting. We've briefly spoken about outreach to women across provinces. We heard shocking testimony that in some cases, women are left to their own resources. Sometimes they hear about the need to get screened from women's magazines, not from physicians.

What recommendation can you give to this committee about raising awareness among women about screening?

Dr. Jean Seely: This is exactly the experience. We see a lot of barriers. For the reasons I mentioned earlier, The College of Family Physicians, which sees a lot of women in the more rural or remote communities, very much adheres to the Canadian task force guidelines. They have extremely busy practices. They're seeing all aspects of medical problems and they don't have the time to get informed, so they rely very heavily on the Canadian task force guidelines.

This is a recurrent theme. We have thousands of people across the country who tell us their family physician refused them screening in their forties, even though the task force does acknowledge that it should be an informed decision. They are simply following the final guideline to not recommend routine screening for these women. The biggest reason these guidelines are so harmful is that they will pose a barrier.

Once the guidelines recommend that a woman can self-refer—when she's 40 to 49—there are outreach programs occurring across the country in different screening programs. We have some programs with mobile vans or coaches that go to different underserved communities. We have screening programs in the Northwest Territories and in Yukon. We're trying to establish this now in Nunavut.

It is feasible, but the message of not recommending routine screening is the most harmful. That is really where we have to focus, to start.

Ms. Sonia Sidhu: Thank you.

My next question is about the American guidelines that were published on April 30. Could you talk to the committee about the methodology and the justification for using the recommendation for screening at the age of 40? I know you said it saves almost 2,600 lives, which is a lot of lives. Then we heard the testimony.

Dr. Seely, you mentioned a study done in Sweden on breast cancer imaging. Could you expand on the results and, overall, on the current European guidelines too?

● (1155)

Dr. Jean Seely: Let me start with the American recommendations.

The U.S. preventive services task force, for their recommendations released earlier this year, started their methodology with the principle that they knew screening mammography was effective at reducing breast cancer mortality. They did not re-evaluate the old randomized controlled trials, recognizing that it had already been proven effective. They only looked at data from 2016 onward, and they included some of the up-to-date evidence showing the benefit of early-stage diagnosis with screening and the increased incidence of breast cancer in women in their forties. That was the basis.

They also looked at the evidence of the disparities among races and ethnicities that showed they were not able to access screening. That was one of the big reasons to change the guidelines to include women in their forties.

You had a question about Sweden, about the more recent observational trial. They were able to compare no screening...and then the trial initiated screening and compared the mortality from breast cancer. Once they initiated screening, they compared the women who did not participate in screening with the women who did participate. What they found was a 60% reduction in breast cancer mortality by comparing women who did not choose to participate in screening with those who did participate. It was a huge benefit in lowering mortality. This accommodated all the recent advances in treatment, and it showed that even for the same treatment of breast cancer, screen detection was associated with a marked improvement in breast cancer mortality.

The Chair: Thank you, Dr. Seely and Ms. Sidhu.

Next is Mr. Thériault.

[*Translation*]

You have two and a half minutes.

Mr. Luc Thériault: Thank you.

In an article in *Le Devoir* from May 30, 2024, the chair of the Canadian working group explains the difference between the recommendations of her group and those of her American counterpart, including the fact that the Canadian working group reviewed 82 studies on patient values and preferences.

To quote Dr. Thériault: “The majority of women in their 40s in these studies, when presented a scenario in line with our numbers (deaths prevented, the number of additional scans, etc.), do not want to be screened”. I find that rather surprising.

Do you think it is normal for value and preference studies to prevail when women's lives are at stake?

[*English*]

Ms. Ciana Van Dusen: That doesn't align with what we're hearing in our community, as our cancer community is quite strongly advocating for access. It's also important to remember that the opportunity to screen is a choice, and women can decide not to be screened if it is not their preference and does not align with their values, especially knowing the risks and benefits.

It is fair to consider that in this very holistic approach, we're looking at mortality, we're looking at costs and we're looking at quality of life, which is also an important factor. There's a lot to look at here, but in developing our own recommendations, we took quite a holistic approach.

[*Translation*]

Mr. Luc Thériault: Thank you.

Dr. Seely, according to the working group that made the recommendations, the risks of excessive screening far outweigh the benefits. Risks include increased anxiety, unnecessary tests tied to overdiagnosis, such as biopsies.

Do you think that the overdiagnosis referred to in the studies we used is overblown?

[*English*]

Dr. Jean Seely: Those are a couple of great questions.

The abnormal recalls—what they've called false positives—are vastly exaggerated, and our patients tell us they are so grateful when they get screened and are happy to return to screening. The majority of studies show this.

Overdiagnosis—the case of diagnosing a cancer that is not going to lead to death in a woman because she might die of another cause—is a small, acknowledged risk of screening. It is much less likely in a woman in her forties who has another 40 to 50 years ahead of her than a woman in, say, her eighties who might die of other causes. Saying this is a harm to prevent a woman from benefiting from early diagnosis is an exaggeration.

● (1200)

The Chair: Thank you, Dr. Seely.

The last person to pose questions to this panel is Ms. Zarrillo. You have two and a half minutes.

Ms. Bonita Zarrillo: Thank you.

Dr. Seely, I'm concerned about the reality of discrimination in medicine. I'm wondering if a modernized, back-to-the-drawing-board approach to this task force would offset some of that discrimination.

Dr. Jean Seely: There are international guidelines that include experts and methodology expertise to produce guidelines. I know we're speaking about breast cancer, but we have colleagues who are outraged by the task force recommendations for prostate screening, lung cancer screening, cervical screening and a whole host of others.

The expertise is there. You must include people who understand the disease and who are aware of the up-to-date evidence in order to produce guidelines that will save lives and make a difference. We need to go back to the drawing board.

Ms. Bonita Zarrillo: I'll finish by asking Ms. Wilson Cull about those at elevated and high risk. Could inclusion of the recognition of elevated and high-risk parameters have an impact on breast cancer survival or breast cancer diagnoses in people? What impact would it have?

Ms. Kelly Wilson Cull: As I said, we see the importance of distinguishing between what population-based screening programs do and a differentiated pathway for people who have an elevated and high risk. We hear from patients, and we've done a lot of work surveying patient groups. People are showing up at their family doctors with signs and symptoms and are being refused screening access within this group. If you have, for example, a family history, your risk pathway needs to look different from that of someone who is asymptomatic or not presenting signs and symptoms.

To go back to the mixed messaging point, we see different provinces and territories with different approaches to high-risk guidelines. Again, that creates an inequity of access from province to province. We need leadership in this country to ensure that all Canadians, whether of average risk, high risk or elevated risk, are getting a consistent approach to screening, regardless of where they live in Canada.

The Chair: Thank you very much.

That concludes the time we have available for this panel.

I want to thank you so much for being with us. I don't think there can be any greater statement on the importance of your work than the level of emotion and personal attachment to these issues that you've seen demonstrated by parliamentarians posing questions today. Thank you for what you do and for being with us.

We'll suspend for about three minutes to allow our witnesses to take their leave and get the others set up and tested.

Thanks, everyone.

● (1200)

_____(Pause)_____

● (1205)

The Chair: I call the meeting back to order.

I would like to welcome our witnesses for the second hour of today's meeting and thank them for being with us. Appearing as an individual, we have Dr. Martin J. Yaffe, a senior scientist at Sunnybrook Research Institute, University of Toronto. Appearing by video conference on behalf of the Canadian Society of Breast Imaging, we have Dr. Supriya Kulkarni, president.

Welcome to both of you. We will start with your opening statements of up to five minutes each.

Dr. Yaffe, you have the floor.

Dr. Martin Yaffe (Senior Scientist, Sunnybrook Research Institute, University of Toronto, As an Individual): Thank you very much, Mr. Chairman.

I'd like to thank the committee for this opportunity to discuss this very important issue.

The decision to participate in breast cancer screening or not should be up to individuals, but to inform that decision, they need accurate, unbiased and accessible information regarding the benefits, limitations and potential harms associated with screening. The Canadian Task Force on Preventive Health Care provides advice to primary care physicians and the public, but disturbingly, the information it provides has been distorted to discourage participation in breast cancer screening. This may be responsible in part for the low participation rates mentioned earlier by Ms. Van Dusen.

I am a senior breast cancer research scientist who leads a group of 20 researchers at the Sunnybrook Research Institute in Toronto. I also co-lead the imaging research program at the Ontario Institute for Cancer Research. Much of my work over the past 44 years has focused on breast cancer screening, and my group has helped develop and validate the technique of digital mammography that is now used worldwide. We established breast density as a risk factor for breast cancer. Also, in 2015, I helped write the World Health Organization's IARC handbook on breast cancer screening.

I've been at odds scientifically with the task force since 2011.

Dr. Seely already mentioned the randomized trials conducted in the 1990s that proved earlier detection of breast cancer by mammography screening can help reduce breast cancer deaths. With the modern developments in both screening and breast cancer therapy, more recent large studies, including the one done in Canada that was mentioned earlier, show a 44% reduction in breast cancer deaths in women from the age of 40 onward participating in mammography screening. They have shown definitively that breast cancer screening of younger women saves lives. Certainly, this is a much larger benefit than was seen in earlier randomized trials conducted 40 to 60 years ago. In addition, screening detection of breast cancers in younger women can, in some cases, give them back 20 additional years of life to be with their families, in the workplace and interacting with society.

A decision on screening involves weighing the benefits of averting premature death against the limitations and possible harms. The task force has not done this. Instead, it's made blanket statements about harms, suggesting without evidence that they may approach or outweigh the benefits for younger women.

The task force commissioned a project to model screening outcomes. A table in its guidelines suggested very low benefits from screening younger women. However, we have not had the opportunity to see the details of how it did that work.

I published modelling results in 2015 and 2022, some using the same model as the Canadian task force, and the U.S. preventive services task force commissioned modelling to inform its 2024 guidelines update. Results coming from five NCI-funded models in the U.S. agree well with those from my lab. They show continuously increasing absolute and relative benefits of breast cancer mortality reduction when the starting age for screening is reduced to 40, the stopping age is increased to 79—in other words above 74, as we've been discussing—and screening is performed annually rather than every two years. The worst results are obtained when screening is done at three years, which is a strategy suggested by the Canadian task force with no evidence at all to support it.

Modelling allows us to weigh the benefits versus the possible harms of breast cancer screening, and it has shown that the net improvement in quality-adjusted years of life—I can talk about that later if you want—gained by screening increases when screening starts earlier, ends later and is annual. The benefits consistently dwarf the harms.

As an expert invited to the Ottawa evidence review and synthesis centre, I had the same experience as Dr. Seely of interference by the task force. Against the advice of invited experts, they focused on the older, now obsolete randomized controlled trial data, set arbitrary thresholds to assess the data and used too short an observation time to allow the full impact of the benefits to be measured.

The task force takes a “less is more” position toward screening, and this comes at the cost of thousands of lost lives, accompanied by increased morbidity due to later treatment of disease. Of course, the task force also insists on specifying outcomes only in absolute quantities, which minimizes the perceived level of benefit, especially for lay people. Two lives saved per thousand seems like a small benefit, but that represents a 40% mortality reduction and 470 or more deaths avoided each year in Canada.

● (1210)

It's apparent that the task force has a strong bias against screening or preventive medicine of any kind. Of course, nobody should be coerced into being screened. It's a personal decision, but impediments to access must be removed to provide equity in saving lives. No woman should ever be put in a position of having to debate with her doctor, who has been misinformed by the task force, that she should be able to access screening.

Thank you.

The Chair: Thank you, Dr. Yaffe.

Next, from the Canadian Society of Breast Imaging, we have Dr. Kulkarni.

Welcome to the committee. You have the floor.

Dr. Supriya Kulkarni (President, Canadian Society of Breast Imaging): Thank you.

Honourable health committee members, I am grateful to have this opportunity today to talk to you all about breast cancer screening, a topic that is very close to my heart.

I am an academic breast imaging radiologist working at the Princess Margaret Cancer Centre in Toronto and am currently serving as the president of the Canadian Society of Breast Imaging. I am greatly invested in improving patient care and experience through the health care system.

The recently issued Canadian task force recommendations, which excluded screening of eligible women between 40 and 49 years of age, came as a huge disappointment. The recommendations conflict with those of other reputable organizations, leading to confusion among health care providers and patients.

Canada's evolving ethno-racial landscape has been systematically excluded by task force recommendations, which are still predominantly based on older studies involving white women. The data is not fully representative of our population, leading to recommendations that might not be applicable, beneficial or safe for everyone. For example, Black women experience poor breast cancer survival rates, are more likely to be diagnosed with advanced-stage breast cancer and have biologically aggressive tumours, all of which occur at an earlier age than in white women.

Canadian data shows significantly higher proportions of stages 2, 3 and 4 breast cancers occurring in women in Canadian jurisdictions that do not include women in their forties in screening programs as opposed to those that do. Lower stage means less aggressive treatment, fewer side effects and increased disease-free survival. Stage matters. Modelling has shown that by not screening women in the 40 to 49 age group, we would see an additional 470-plus avoidable deaths every year. This is equivalent to allowing a passenger jet full of young Canadian women to crash every year because we refuse to screen them at the right time. This is the chilling reality of the situation.

Mammography is a compression technique. Tissues overlap, and up to 16% of women who come for their first mammogram are likely to be recalled for additional pictures or an ultrasound and sometimes end up with a biopsy with benign diagnosis. This percentage drops over subsequent years. Recalls are not harms. These are like sending your bag through airport screening. Most of the time, it goes through. However, sometimes it gets pulled out, opened, checked and given back, and occasionally a forgotten nail clipper gets thrown out. Most women are grateful that they went through the one extra step for safety.

The task force recommends shared decision-making to allow women to discuss with their primary care providers the age at which they should have a mammogram. In a country that is grappling with a severe shortage of family doctors, this is a distant dream. The power differential between the physicians following the task force guidelines and the patient is a barrier to shared decision-making.

The current tools provided by the task force are biased towards not having a mammogram. Among other recommendations, the task force recommended against supplemental screening for women with dense breasts. We know that dense breast tissue precludes finding breast cancers at an earlier stage, akin to finding a snowball in a snowstorm. This often leads to delayed diagnosis, greater stage and spread of cancer and more extensive and expensive drugs, which may lack funding. These drugs can have a devastating side effect that significantly diminishes quality of life and function.

The task force has stated that there was insufficient evidence to support supplementary screening, and they selectively chose to follow the U.S. task force on their dense breast recommendations. Meanwhile, there are decades of data that demonstrate the benefit of supplementary screening. More recently, Ontario conducted a health technology assessment and drafted a recommendation to publicly fund supplemental screening.

To conclude, we want guidelines based on new and inclusive science that are aligned with other international guidelines and that consider the changing landscape of diversity and ethnicity in Canada. Early detection with normal, personalized therapies is the best we can give women in their cancer journey.

No woman should be denied a mammogram. Self-referral should be allowed, and for those women who prefer not to have a mammogram, they should be free to opt out.

Thank you so much.

● (1215)

The Chair: Thank you, Dr. Kulkarni.

We'll begin now with our rounds of questions, starting with Mrs. Vecchio for six minutes.

Mrs. Karen Vecchio: Thank you very much. It is absolutely wonderful to have both of you here today.

I want to start off with Dr. Martin Yaffe. Thank you very much for the information you provided.

I want to go back to the task force and the task force members: who, what, where and why? Can you start by telling me how these members are appointed to the task force? How are they chosen to represent Canadians on the task force?

Dr. Martin Yaffe: That's a very good question. I am not exactly sure how they're all appointed, but some of them are appointed through The College of Family Physicians. There were other bodies as well, I think, that recommended individuals.

What I've noticed, though, is that there tends to be over time—how can I put it?—a concentration of people who are like-minded. The like-mindedness tends to be an attitude that less is more and that somehow, when a woman finds a cancer, treatment alone is adequate, even if the cancer is found at a relatively advanced point.

There's a mindset that has accumulated and has been concentrated within the membership of the task force that tends to be like-minded on the subject and demonstrates a fairly clear bias against screening.

● (1220)

Mrs. Karen Vecchio: I'll go back to you. We're talking about screening, and we have heard, like many of you who have come to this committee to share with us, that it should be lowered to age 40. Those 40 to 49 should be included, up to 74, and we may see that expanded as well.

You're not part of the task force, but did you have a role to play in reviewing the information and providing your own recommendations? What type of information did you get as feedback?

Dr. Martin Yaffe: As I mentioned, I've been at odds scientifically with the various task forces since 2011. I've found that they've been very resistant to receiving information from experts like me, Dr. Kulkarni, Dr. Seely and others who are aware of and very familiar with the scientific literature in the area. Instead, they've focused narrowly on the old studies because they're randomized trials. That's a great way of doing a study, but they're so old that they're not relevant.

I may have drifted a bit from your question. If you don't mind, just repeat the last part of it. I want to make sure I answer you.

Mrs. Karen Vecchio: Actually, you answered it. That's where I wanted to go. I just wanted to know whether or not you had the opportunity to review some of these things. As you said, you have not been in agreement since 2011.

If we could just put it on the record, would you like to see all the recommendations that have come from the task force reversed?

Dr. Martin Yaffe: Absolutely. I agree with the other witnesses. They have recommended strongly, based on science, that women should have unfettered access to screening as of age 40. There should be a strong consideration for continuing screening beyond age 74 as long as women are otherwise in good health.

That's all backed by the modelling that I mentioned. There is at least the capability or the possibility of saving a thousand additional lives in Canada every year if we do these things—screening women in their forties, extending screening beyond age 74 and doing supplemental screening for women with dense breasts, for whom mammography does not work all that well.

Mrs. Karen Vecchio: I want to switch over, because I have a quick question for Dr. Kulkarni.

Thank you so much for talking about this. I really liked your analogy that compared this to airline screening. I always wonder if I've left a water bottle. You get anxiety, but the anxiety sure is a lot better than what else could happen.

That's what we have to see for women. When they're talking about the harm being anxiety, we can deal with it when we have solutions. Having early detection for women is really important.

We are talking about the ages 40 to 74. I want to get your opinion on those 75 and older and what that should look like. My mother-in-law is in phenomenally great shape. I expect to have her around until she is about 120. What do we do for women over the age of 74 who are in exceptional health?

Dr. Supriya Kulkarni: We see that all the time. There are people who come for screening and a very common comment is "These people are healthier than me". As long as a woman is healthy and active and has at least a seven-plus-year life expectancy, they should continue to screen.

That's what we are all recommending as part of our organizations. That is the recommendation—they should continue screening. The program should allow these women into the screening program.

Mrs. Karen Vecchio: Do I still have time?

The Chair: You have 45 seconds.

Mrs. Karen Vecchio: Great.

I'm going to go back to you, then. We've talked about recognizing dense breasts and recognizing that makeup and ethnicity may have an impact on the composition of one's breasts. I heard someone talk about ages 25 to 40. What should we be doing for women who are 25 to 40 prior to having a physical screening?

Dr. Supriya Kulkarni: At the current time, there is a lot of discussion about risk assessment. It's been generally recommended, even by the NCCN guidelines, that women between 25 and 30 years of age can get a basic risk assessment profile. They are not yet at the age where systematic screening is offered, but they should at least get a risk assessment performed so that, in case there's a flag that they're high risk, appropriate steps can be taken. High-risk women generally get screened much earlier than average-risk women. That's what we want to offer to all these young women.

● (1225)

The Chair: Thank you, Dr. Kulkarni.

Dr. Martin Yaffe: May I add something to that?

The Chair: Please be very brief.

Dr. Martin Yaffe: We have a program in at least one province—Ontario—for women who have been identified as high risk. Those women are eligible as of age 30 to receive an MRI and ultrasound, which are more accurate for women at high risk.

The Chair: Thank you both.

Next we have Dr. Hanley, please, for six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much to all the panellists.

I want to acknowledge the courage of my fellow panellists for speaking up. I don't think we hear enough in general from people with lived experience, and hearing testimony from panel members themselves is extremely powerful.

Dr. Yaffe, I'll go to you, but I'd appreciate brief answers, with full respect. I'd love to spend hours on this, but I only have three minutes. I'm going to share some time with my colleague Dr. Powlowski.

Regarding randomized trials versus observational trials, what I'm taking away is that we can no longer do the randomized trials that were done in the fifties and sixties because it would be unfeasible to do a control and test group, let alone with the evolving technology. In other words, we can't really replicate previous gold-standard trials.

Do you favour the U.S. approach, which is to understand the basic concepts and then move on and use only modern trials from 2016 onward, even though most of them are observational? Could you quickly comment on the merit of that approach?

Dr. Martin Yaffe: Absolutely. Randomized trials can prove and have proven the principle, but the technology used is no longer representative of current practice. Observational trials allow us to be more quantitative and to use modern data to show what the possibility of mortality reduction is. Modelling will allow us to go beyond that and extrapolate from what we've learned in the randomized and observational studies.

Mr. Brendan Hanley: That's a good segue. Based on the premise that all models are wrong but some are more useful than others, could you defend your modelling practice? I think you alluded to its compatibility with other modelling exercises, particularly in the United States.

Dr. Martin Yaffe: It's not my model. It was developed by Statistics Canada in partnership with the Canadian Partnership Against Cancer. It's a wonderful model, and it is available for multiple cancers. It's been validated against empirical data, against actual measurements in the public. We compare it to the U.S. models, of which there are five. Actually, one of the models is from the Netherlands. We always cross-compare models, and they tend to agree with each other, which is great. That gives us more confidence in their validity.

Mr. Brendan Hanley: Thank you very much.

Dr. Kulkarni, I have so many questions for you, but I'm going to limit myself to one. I believe the European recommendations are for age 45 onward.

Dr. Supriya Kulkarni: That's correct.

Mr. Brendan Hanley: Can you comment on that versus the U.S.? Is there a difference in the methodology or the basis for conclusions in Europe?

Dr. Supriya Kulkarni: Different organizations tend to have a bit of variation as to whether to start at 40 or 45. Even some organizations in the U.S., such as the ACS, recommend age 45. We have some provinces in Canada that recommend 45 and above too, so there's a bit of variation. However, overall, if you look at all the evidence that is currently available, it is a best practice to start screening at 40, and that's what we are pushing for.

Mr. Brendan Hanley: Thank you.

I'm going to hand it over to Dr. Powlowski.

Mr. Marcus Powlowski: Dr. Yaffe, were you a subject matter expert adviser to the task force?

Dr. Martin Yaffe: No, I wasn't. I was invited by the Ottawa evidence review and synthesis centre to advise them. However, as Dr. Seely and I mentioned, we both worked with them. There was interference by the task force on what that group was allowed to do.

Mr. Marcus Powlowski: Am I right that anyone who dealt with the task force had to sign a confidentiality agreement as part of working with it?

● (1230)

Dr. Martin Yaffe: That's correct, and that's one of the reasons I wasn't willing to work with them directly. I wanted to be able to speak freely.

Mr. Marcus Powlowski: To your knowledge of the people who worked with them directly, did the task force follow the advice of their own experts? We've already had Dr. Seely say they didn't, but I know she can't speak for the other experts and neither can you. To your knowledge, did they follow the advice of their own experts?

Dr. Martin Yaffe: I really don't know. I did speak with one of them, who informed me that he felt his interaction with them was minimal. He didn't understand much of the decision-making process and didn't feel that he had much influence on the process.

Mr. Marcus Powlowski: Is it troubling to you that for a matter so important, advisers were forced to sign a confidentiality agreement and therefore can't really make public what they told the task force?

Dr. Martin Yaffe: Sometimes confidentiality agreements are limited in time, and there are sometimes reasons for that. However, I did feel that the restriction, especially when I found the whole process very difficult to understand and agree with, was very problematic. Why should we be looking at studies that were done 60 years ago that are completely unrepresentative? That makes no sense at all.

Mr. Marcus Powlowski: Lastly, the reason given for putting non-subject matter experts on the task force making the decision is that they didn't have any personal financial interest in the outcome. I know that some taking the other side are going to say that of course radiologists want to do more mammograms, because they make a fair bit of money on mammograms.

Do you want to formally reply to that, Dr. Yaffe or Dr. Kulkarni?

The Chair: Give a brief response, please.

Dr. Martin Yaffe: I'll just say that I am a Ph.D. and I get a salary for doing research, so the amount of screening that takes place doesn't affect my personal life.

The Chair: Thank you, Dr. Yaffe.

[*Translation*]

Mr. Thériault, you have six minutes.

Mr. Luc Thériault: Thank you very much, Mr. Chair.

I have a question for Mr. Yaffe.

Jacques Simard, vice-dean of research and higher education at the faculty of medicine at Laval University, suggested that instead of changing the screening age for everyone, women should obtain personalized care according to their level of risk, which would be assessed taking into account family history, breast density and age. He suggests that those who represent a so-called normal risk continue to have a mammogram every two years between 50 and 69, while those who represent an intermediate risk begin having an annual mammogram in addition to an MRI.

What do you do think about this recommendation?

[*English*]

Dr. Martin Yaffe: It's a very interesting recommendation, and I respect Dr. Simard's work very much, but I don't think at this point we have validation that it would work. In other words, to screen people less frequently, we have to know that the risk of developing cancer is so low that they're not going to have cancers missed because of that policy. That has not at this point been validated.

Most individuals don't express risk factors for breast cancer other than being female and getting older. It is a great idea, and I think in the future it may be something we do, but we're not ready for it at the present time.

[*Translation*]

Mr. Luc Thériault: Thank you.

At a press conference, the chair of the working group said this about the updated recommendations: “Just because we are seeing more cancer does not mean we need more screening. We need to be asking why there is more cancer.”

What do you think?

[*English*]

Dr. Martin Yaffe: Was that for me or for Dr. Kulkarni?

[*Translation*]

Mr. Luc Thériault: The question is for you.

[*English*]

Dr. Martin Yaffe: Thank you.

It is important for us to understand the causes of cancer and to continue to look for the means to prevent cancer. We know there are some issues around alcohol consumption. There are lifestyle issues, such as obesity. However, at the same time, prevention and early detection and treatment are not competing with each other. While we're learning how to prevent cancer, we should be doing what we can to prevent women from dying of breast cancer.

Screening is often referred to as secondary prevention. We're preventing advanced disease. If we find it earlier, it's treated much more successfully. It's better for the patient. It's also better for the health care system. Research that's about to be published shows that costs go down as you do more screening, because you have fewer advanced-stage cancers that need to be treated.

● (1235)

[*Translation*]

Mr. Luc Thériault: Thank you very much.

The Chair: You still have two minutes, if you like.

Mr. Luc Thériault: I thought I had two and a half minutes.

I am happy to keep going.

The Chair: No, you had six minutes.

Mr. Luc Thériault: Okay, thank you.

Many experts are critical of "false positives" during screenings and support this phenomenon to not recommend systematic prevention in women 40 to 49.

What do you think? Can you provide more details on this?

[*English*]

Dr. Martin Yaffe: I'm sorry. I missed the first part of your question. I thought I heard "false positive". Is that what you're talking about?

[*Translation*]

Mr. Luc Thériault: Yes, many experts are critical about the adverse effects of false positives.

I am listening.

[*English*]

Dr. Martin Yaffe: First of all, we need to get away from the term "false positive". It's completely a misnomer. A false positive implies that someone has said somebody has cancer when they don't. What the term really refers to, as I think Dr. Kulkarni mentioned earlier, is when women are asked to come back for additional imaging to make sure there's no cancer. The first screening exam is not absolutely clearly negative, and they want to make sure they don't miss a cancer.

If it takes a while before the answer to that additional imaging comes out, there will be some anxiety, but much of the research shows that the anxiety is transient. As Dr. Seely mentioned, patients are generally much happier to accept that anxiety as opposed to the chance of a missed diagnosis of cancer and the need to treat advanced disease. The task force is really off base in considering that as a harm. We should try to reduce anxiety, not reduce the detection of cancer.

[*Translation*]

Mr. Luc Thériault: Thank you.

According to the working group that made the recommendations, the risks of excessive screening would far outweigh the benefits. Increased anxiety, unnecessary tests and overdiagnosis such as biopsies are apparently some of the inconveniences caused.

Do you think that the overdiagnosis referred to in the studies that were used is generally overblown?

[*English*]

Dr. Martin Yaffe: I co-authored with medical oncologist Dr. Kathleen Pritchard, one of Canada's outstanding medical oncologists in breast cancer, a paper called "Overdiagnosing Overdiagnosis". The point is that some cancers will grow slowly. For some people, if they didn't know they had cancer, that cancer may not have bothered them before they died of some other cause. The reality is that the fraction of those cancers—these are real cancers, but they're cancers that perhaps grow slowly—is relatively small. It's generally under 10%, and perhaps is in the order of 5%.

The idea is to avoid overtreating those individuals. Once a cancer is diagnosed, try to determine if it's going to be one of the aggressive ones or the less aggressive ones and make therapy suitable for the characteristics of the cancer. I think that's the right approach, rather than not finding the cancer and playing Russian roulette with letting a dangerous cancer continue to grow.

The Chair: Thank you, Dr. Yaffe.

Dr. Supriya Kulkarni: May I add to that?

The Chair: Be very brief, please.

Dr. Supriya Kulkarni: I want to echo Martin's sentiments that overdiagnosis is a word that is very difficult to understand. The role of screening is to find the cancer. How to treat the cancer is a different aspect of the cancer. To determine which cancer will be biologically aggressive and will grow and kill the woman versus which cancer will not grow but will allow the woman to die of some other cause.... That's something we cannot tell based on imaging.

It's not really overdiagnosis. We have to figure out which cancer needs treatment and which doesn't. That's not part of the screening process.

● (1240)

The Chair: Thank you.

Next is Ms. Zarrillo, please, for six minutes.

Ms. Bonita Zarrillo: Thank you.

I really appreciate the comments by Dr. Kulkarni because in modernized cancer treatments, there are many more options.

It was a year ago exactly that Minister Duclos announced up to $500,000 in additional funding for the task force to help expedite the update of the breast cancer screening guidelines. He's quoted as saying, "having breast cancer screening guidelines that are based on the latest science is essential."

Dr. Yaffe, I wonder if you think this task force's new guidelines are based on the latest science.

Dr. Martin Yaffe: I think they would say they have looked at the latest science—at least some of the latest science—but because they have continued to focus so much on these 40- to 60-year-old studies, that raises concerns.

The more modern data shows mortality reductions in the range of 40% to perhaps even as high as 60% for women who participate in screening—emphasis on the word "participate"—and that the stage at which the cancer is found is earlier, which means it can be treated more successfully with better outcomes, less morbidity and at lower cost. I don't see that in anything the task force has put in its literature. I've read its reports. There's nothing that clarifies that it has taken the more modern data seriously.

As mentioned earlier today, there's nothing on breast density. There's nothing on women who are racialized, whose breast cancers tend to occur earlier and be more aggressive in some cases and whose outcomes, we know, are worse. They do much worse. There's an inequity there.

Ms. Bonita Zarrillo: Thank you, Doctor. That inequity is something I'm really concerned about. I want to ask a question about that later.

I just want to follow up on one thing, Dr. Yaffe. Do you have any information on the parameters that the government gave this task force? Specifically, is there a cost-saving requirement? Was there an ROI that this task force was asked to do in relation to women's health and breast cancer?

Dr. Martin Yaffe: I don't know the answer to that question. I suspect there is an underlying sentiment among task force members that spending less money on breast cancer screening will free up money to do things they may be more interested in, but I don't know that for a fact. As I mentioned, what we've learned is there's a potential cost reduction associated with screening.

Ms. Bonita Zarrillo: I'm going to ask Dr. Kulkarni the same question. Do you have any information on the parameters the government gave the task force and anything that might be related to that?

Dr. Supriya Kulkarni: No, I don't think this information is available to any of us from the outside. I don't have any information.

I'll just address another thing that was brought up, which is that mammographies don't pay that well. It is a misconception that reading more mammograms is an easy job. For example, a mammography would pay 10 times less than what a CT scan would pay. Anything related to women's health is not that well reimbursed, so you can see there's another problem there. It's not being prioritized.

No, there's no information.

Ms. Bonita Zarrillo: I appreciate that. The work of women is not compensated properly in the medical industry.

Dr. Kulkarni, what expertise do you believe needs to be included in the task force with the back-to-the-drawing-board recommendation that could come from this committee?

Dr. Supriya Kulkarni: They invited some advisers—we heard from two of them today—for the evidence review. Other advisers were working directly with the task force. All of these people need to be talked with.

Find out if the decisions that were made—the draft recommendations—were a unanimous decision. Were there any people within the team who felt this was not okay to do? That's one thing.

The second thing, as we saw, is that these recommendations cannot go forward as they are. They need to be reversed or they need to be at least temporarily stopped until the investigation is fully over. All family physicians should be encouraged to follow provincial guidelines for the time being until this is resolved. Rolling them out the way they are will be detrimental to the country.

Ms. Bonita Zarrillo: With that, Mr. Chair, I would like this committee to ask the Public Health Agency of Canada and the government to supply to this committee the parameters that were given to the task force for their updated study.

I have another question, Dr. Kulkarni. Dr. Yaffe noted the debate with the doctor. That was certainly my experience as a woman with dense breasts. I had to have a debate with my doctor for two years. I worry about non-white people. Dr. Seely mentioned earlier how much they have to debate and fight against prejudice and bias.

I'm wondering, if you wouldn't mind sharing, how we overcome bias at the doctor's office.

● (1245)

Dr. Supriya Kulkarni: First of all, public education is very important. We are not spending enough dollars on informing people. We have a huge population now that is very diverse and we are not addressing that.

The most important thing is the guidelines. The guidelines have to endorse that we need to do this.

That is followed by capacity. The wait times in our country are horrendous right now. They do not allow us to open up our doors to more ultrasound screenings. It's a huge capacity issue.

A lot of work needs to be done so that screenings can be equally available to everybody without having to fight for them.

Ms. Bonita Zarrillo: I don't remember seeing that in the task force—

The Chair: Thank you, Ms. Zarrillo and Dr. Kulkarni. That's your time.

We'll go to Mrs. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Thank you to the witnesses for being here. It's refreshing to hear common-sense solutions being brought forward. I've done so much research on this over the course of this brief study, and so many different organizations have very quickly come out as opposed to these guidelines.

Dr. Kulkarni, would you like to see a reversal of the task force guidelines? Would that be your recommendation?

Dr. Supriya Kulkarni: Yes.

Mrs. Laila Goodridge: Thanks. I appreciate that.

To me, it is apparent and obvious that there are very serious issues with the task force guidelines. This week, as we've heard, evidence on that has piled up from a variety of experts. I think that's important, so I'm looking for unanimous consent to move the following motion:

That, given that the federally created Canadian Task Force on Preventive Health Care decided not to lower the breast cancer screening age guidelines, and that, Breast Cancer Canada said it was "deeply concerned" by the task force's guidelines, the committee report to the House that the decision by the Canadian Task Force on Preventive Health Care should be immediately reversed and breast cancer screening should be extended to women in their 40s, as this will help save lives.

The Chair: Unanimous consent is not required to present the motion because it touches on the subject matter at hand.

The motion is properly before the committee and is in order. The debate is now on the motion.

Dr. Hanley.

Mr. Brendan Hanley: I thought I saw Dr. Ellis's hand first.

The Chair: I saw yours first.

Mrs. Laila Goodridge: Sorry, Mr. Chair, I asked for unanimous consent and I—

The Chair: You asked for unanimous consent to move the motion and you didn't need it.

Mrs. Laila Goodridge: It was to pass the motion.

The Chair: That's not what you said.

Mrs. Laila Goodridge: I'm sorry.

The Chair: Okay, you're looking for unanimous consent on the motion.

Does Mrs. Goodridge have unanimous consent to adopt the motion as presented?

Some hon. members: No.

The Chair: You do not have—

Mrs. Laila Goodridge: Mr. Chair, let me get this straight. We've heard from countless—

The Chair: You don't have unanimous consent. It appears that there's a willingness to debate the motion.

Is it your intention to withdraw the motion or are we going to have a debate on it?

Some hon. members: Debate.

The Chair: All right, we'll go to Dr. Hanley, Dr. Ellis and Mrs. Goodridge.

Mr. Brendan Hanley: I accept the motion. I just don't feel comfortable with the recommendation. Although I think that ultimately we need to get to a place where we have a uniform recommendation on screening, I'm not sure that we can direct an independent task force as to what to conclude. We have to find a way to advocate for guidelines and advocate for family physician education.

My interest is in getting to the same place. I'm not sure that this is the correct process to do so.

● (1250)

The Chair: Dr. Ellis.

Mr. Stephen Ellis: Thanks very much.

I respect Dr. Hanley's comments on this. I think the difficulty is that we've heard overwhelming evidence at this committee and it's piling up by the minute. We have one of the world's foremost experts here, Dr. Yaffe, who has worked on this around the world for 44 years, as he said himself. We know very clearly that the evidence suggests women should be offered screening for breast cancer between the ages of 40 and 79. That means women would have access without receiving mixed messages. It would be an incredibly strong message from this committee to tell the task force that what they have concluded is incorrect.

I realize that many of us sitting around this table may not be scientific experts, and I realize we're not on the task force. The difficulty, as we have heard very clearly, is that continuing to allow the task force to operate in a manner that is disrespectful of science, is anti-screening and anti-prevention—those words are not too strong; we've heard them repeatedly here—is reckless, especially when we have heard that 1,000 women will die based on the reckless nature of Canada's preventive health care task force.

Perhaps many would argue that this is not in the purview of this committee or the federal government. However, the important fact we need to remember is that this committee can have an incredibly loud voice out there on behalf of Canadian women, a number of whom will die when they shouldn't because of the inaction, inability or perhaps ignorance of a task force that does not want to consider science, which is dynamic and changing. I was a family doctor for 26 years. Realizing that science changes is an important aspect of providing excellent, quality health care.

The other important thing to note is that for the Canadian Task Force on Preventive Health Care to have a bias, as Dr. Yaffe and other witnesses have suggested, against screening and prevention is a non-starter. It's illogical to think that a task force based on preventive health care would have a bias against screening. That is nonsensical.

To not allow women to make well-informed decisions based on a discussion they could have with their health care provider is incredibly misogynistic, in my opinion. As I said, I'm a male former health care provider. To not allow women to have an opportunity to have a discussion is problematic for me. To not allow that to exist is going to result in the deaths of more women, and that is absolutely intolerable.

I will state for folks that this is an incredibly personal thing for me. My wife had breast cancer diagnosed at age 48. Thankfully, she made it past her five-year mark and has made a fantastic recovery.

That being said, it is not just science. It's personal. We look at the potential years of life lost for young women who are not able to access screening. As our colleague from the NDP mentioned, women from marginalized, racialized and often remote and rural communities do not have access.

Do you know what really struck me with our NDP colleague's testimony? It was that she was a 48-year-old white woman who had to fight for herself. I can only imagine, from my perspective, what it would be like to be from a racialized community and attempting to advocate for yourself when the Canadian Task Force on Preventive Health Care has said that you are not able, at age 40 plus, to access screening for breast cancer. I can't imagine how much of a daunting task that would be. In fact, I would suggest that it becomes an impossibility to advocate for yourself against a system in which the cards and the deck are already stacked against you.

● (1255)

Perhaps, as my colleague Dr. Hanley suggests, this isn't quite the way it should be, but if we do not come forward with an incredibly loud voice, as I suggested to the last panel, the likelihood of the task force succumbing to anybody else.... My goodness, we have someone like Dr. Yaffe suggesting that this needs to be changed, and the likelihood of the task force changing course and agreeing with him is probably slim to none. If we do not make incredible amounts of noise about this on behalf of Canadian women, I think we are doing it a disservice.

The other thing to consider, when you look at the amount of press playing into this, is that it's incredibly important for the media to understand the decision being made and how important it is that the task force is going against new evidence. Our neighbours to the south in the U.S. preventive services task force have agreed that the evidence is there for screenings, perhaps not, as Dr. Yaffe suggested, to age 79, but certainly between ages 40 and 74, with the option for women over 74 to have screenings, as Dr. Kulkarni said, based on their overall level of health. That makes perfect sense.

For us not to make a loud noise about this, when we have had an overwhelming amount of evidence to the contrary, does Canadian women a disservice. I don't want to be a part of doing Canadian women a disservice, and I would urge my colleagues, in spite of their belief that this is not the appropriate table to make this call, to reverse their decision and support my colleague's motion unanimously. I think science is against you, I think public opinion is against you, and I think history will stand against you and say that the decisions you have chosen to make here are inappropriate.

I want to be clear. I like my colleague Dr. Hanley. I respect his decision. That being said, if we do not make a loud noise about this, the difficulty that will persist is that we will continue to send mixed messages to provinces and to Canadian women. Canadian women are going to die because of that and that's not right. It may not be exactly in our purview, but it is certainly within our purview to say that we categorically do not agree with the decisions that have been made, that the decision should immediately be reversed and that breast cancer screening should be extended to women in their forties.

I've asked other panellists here today how best they think we could make a loud noise with respect to that because I believe that is exactly what needs to happen. This needs to be a loud noise. It needs to be definitive. We need to call out a task force that is not respecting science, that refuses to respect science. We know that other task forces in the United States and Europe have chosen not to require randomized controlled trials. We believe this part of the science has been settled. We need to move forward and understand that we have new methods of diagnosis and new methods of treatment for breast cancer and that those new and best methods need to be respectful of Canadian women.

I don't think I can state it any stronger than that. I urge my colleagues to accept unanimously this motion put forward by my colleague from Fort McMurray—Cold Lake on behalf of Canadian women, who are dying senselessly because of the inaction and ineptitude of the Canadian Task Force on Preventive Health Care.

Thank you, Chair.

● (1300)

The Chair: Thank you, Dr. Ellis.

Mrs. Goodridge.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

I hope we can get to a quick vote on this motion and get back to committee business. It is very troubling that members, particularly Dr. Hanley, who is a medical doctor, won't vote in favour of it after all the testimony we've heard here, but I'm hoping we can get to a quick vote.

The Chair: Dr. Powlowski.

Mr. Marcus Powlowski: Generally speaking, I'm in favour of this issue and I have been involved with it a long time. Dr. Yaffe and I spoke about it a number of years ago. Don Davies from the NDP—let me give a shout-out to him—has also been very involved in trying to get this issue addressed.

I have some concerns, as Brendan does, with a parliamentary panel of admittedly non-experts trying to overturn the decision of a body—albeit a seemingly flawed body—like the task force. In my life, I separate the medical—I still practise medicine—from the parliamentary. I think that's important. We're not experts.

I'm just throwing this out there because we haven't had time to fully consider the whole thing. I wonder if there's an appetite for amending the motion. I haven't even cleared this with my own party, but I'm suggesting there might be an appetite for this wording:

> That, given that the federally created Canadian Task Force on Preventive Health Care decided not to lower the breast cancer screening age guidelines, and that, Breast Cancer Canada said it was “deeply concerned” by the task force's guidelines, the committee report to the House that the decision by the Canadian Task Force on Preventive Health Care should be immediately reconsidered and that consideration be given to extending breast cancer screening to women in their 40s....

That would perhaps strike a better balance between the two concerns about a parliamentary committee making an attempt to go where perhaps it shouldn't.

Having said that, I agree that we have heard some compelling evidence on this. Certainly, there's enough expertise here that suggests the decision ought to be reconsidered.

This would be a better balance. I don't know if I have to make that a formal motion to amend. Perhaps we need to pause for five minutes for parties to consider it.

Mrs. Laila Goodridge: Mr. Chair, I will accept that.

The Chair: It would be best if you formally move the amendment. It appears that the Conservatives have already made up their minds about it, or at least one of them has.

I'm going to take that to mean the motion is being amended. The amendment is to change the word “reversed” to “reconsidered”, and after that, the wording would be “that consideration be given to extending breast cancer screening” and so on. I think that's the essence of what you have suggested.

Mr. Marcus Powlowski: After the wording at the end—“and that consideration be given to extending breast cancer screening to women in their 40s”—I would put “as this will, in the committee's opinion, help save lives”.

There's an interpretation of the evidence there and we're not experts in it, so I would either drop “as this will help save lives” or put “in the opinion of the committee, this will help save lives”.

The Chair: The amendment is in order, so the debate is now on the amendment.

We did have a speaking order on the main motion, but the speaking order resets, so if you want back in, put your hand up.

Dr. Ellis is next.

Mr. Stephen Ellis: Thanks very much, Chair.

I thank Dr. Powlowski for that.

With the change, the wording is somewhat watered down, but it's incredibly important that we move on this sooner rather than later. I would hope that my colleagues support the wording change. I know that here on this side, we are supportive of it because we can't move fast enough to make this happen.

The task force committee has been a dilly-dally committee that has known this evidence for some time now. I don't think that in 2024, this is a sudden thing. I think the inaction and the inability to hold the Canadian task force to task have allowed this to continue and have allowed thousands of Canadian women to die every year needlessly.

Time is of the essence, folks. Let's show our colours and support this motion.

● (1305)

The Chair: Ms. Zarrillo.

Ms. Bonita Zarrillo: Can I see the amendment in writing, please?

Mr. Marcus Powlowski: Sean, can someone do that? I have to type on my little screen and you're probably much quicker than I am.

The Chair: We're going to require a suspension to get the wording and get it translated, so what I'd like to do is dismiss the witnesses and get the amendment circulated.

Mr. Marcus Powlowski: Sean, can the witnesses stay if they're interested?

The Chair: Absolutely. This is one of these scenarios where you're welcome to stay but you're free to go.

To each of our witnesses, thank you.

Yes, Mr. Hanley.

Mr. Brendan Hanley: I'm sorry, but I have a point of order before you suspend.

I want a chance to float the wording I had, which is very similar to Marcus', before we get a written—

Mrs. Laila Goodridge: That's not a point of order.

The Chair: You can do a subamendment or you can defeat his amendment and then propose a new one. Those are your two options. That could perhaps be discussed during the suspension.

Mr. Brendan Hanley: Since it isn't in writing yet and Marcus isn't sure of his own wording, I have a refinement to make. I'm happy to do it as a subamendment. I want to get us to a place where we can all—

The Chair: You and Dr. Powlowski should talk.

To our witnesses, we will not get back to you today. You are welcome to stay but you are free to leave. We greatly appreciate you being here. You can see that you've sparked a spirited debate, a debate that needs to be had. We thank you for your work and for your presence.

We're going to suspend to get the amendment in both languages and in writing to the committee.

The committee stands suspended.

● (1305)

_____(Pause)_____

● (1335)

The Chair: I call the meeting back to order.

We do not have the amendment available for distribution in both languages, but during the suspension it was agreed that we're ready to recommence.

Where we left off, the debate was on the amendment proposed by Dr. Powlowski. The amendment is to delete all the words after the word “immediately” in the motion and to replace them with the following: “reconsidered and that consideration be given to extending breast cancer screening to women in their 40s, as this will, in the committee's opinion, help save lives.”

Where we left off, Dr. Ellis had the floor, so I recognize Dr. Ellis on the amendment.

● (1340)

Mr. Stephen Ellis: Thanks very much, Chair.

The concern I have is that it's a somewhat watered-down version. I think we should move to a vote on it as quickly as possible.

[*Translation*]

The Chair: Mr. Thériault, you have the floor.

Mr. Luc Thériault: Chair, I will try to be brief because we are running out of time.

I agree with the substance of the motion. Usually the committee meets, reports back and makes recommendations, but given the urgency, we will make a recommendation to the House today. That does not mean that we will not draft a detailed report to express the full argument around this recommendation.

I have no qualms about not being an expert. If we had to wait to be an expert before making recommendations, not one committee would do it. In that sense, I agree with moving forward. It is rare to see all the witnesses have such a clear view. I asked my questions and I got very clear, unambiguous answers. I agree with the initiative, even though it is a bit unusual. I think the seriousness of the matter calls for the committee to urgently indicate to the House what it wants, as this session ends. I see no problem in the wording that I have before me.

A voice: [*Inaudible—Editor*]

[*English*]

The Chair: Dr. Hanley—

[*Translation*]

Mr. Luc Thériault: Sorry to interrupt, Mr. Chair.

I do want to talk about Mr. Powlowski's motion.

I would go back to the original motion. For the reasons I just gave, I feel perfectly comfortable making recommendations even though I'm not an expert. It's clear that it's the committee making these recommendations. We're obviously not the ones who will be making the decision. The government will.

[*English*]

The Chair: Dr. Hanley, please go ahead.

Mr. Brendan Hanley: I support the amendment, and I agree in principle with what Mr. Thériault is saying. I want to make it clear, again, for the record, that I would love for us all to get a consensus to make this unanimous so we can express the urgency. I have no problem making noise. I have no problem with the urgency of this, but I think we have to respect the proper process.

The minister doesn't direct the task force, and neither do we direct guidelines. As politicians, we are not responsible for issuing guidelines, but we can ask the task force to consider an urgent review, with a view to arriving at a recommendation to screen women aged 40 plus.

I think the goal is to get there in an expeditious way. Hopefully, we can all agree on that by following due process.

The Chair: Thank you, Dr. Hanley.

Ms. Zarrillo, please go ahead.

Ms. Bonita Zarrillo: We're going to a vote. I was on the list for the motion, so we'll go to the vote and then we can talk about that.

The Chair: Mrs. Roberts left. She was next. After Mrs. Roberts is Mr. Naqvi.

Mr. Yasir Naqvi: Thank you very much, Chair.

This is a very important topic. It impacts a lot of women in this country. The mark of this committee has been to do thoughtful work and thoughtful analysis.

I'm sure that we all agree on the recommendation we will be making through the work this committee has been doing. What saddens me is that at this moment, with the original motion and the amended motion, which I support, we're basically writing the report. We're really missing the opportunity to capture the pretty much unanimous analysis that we received from some incredible witnesses. The value of capturing and documenting the witnesses' testimony is being missed by using the process we're using. We're not getting a more substantive document in front of the task force in their 60-day review period, which has been extended, as the minister has asked them to do, by basically having a five- or six-line set of recommendations.

That's my concern. I think that's what Mr. Hanley was referring to as well—shortchanging the process. I don't believe in being loud for the sake of it when being loud is not substantiated by a rational thought process. Being loud is far more effective when you can justify why you're being loud, and I think we're missing the opportunity to write a report that analysts would have captured by hearing the testimony.

In any case, I support the amendments that have been put forward so we can help ensure we are moving forward with protecting the lives of women, especially, as we heard, those who are racialized. I come from that background. I've talked about the experience I went through with my mother, who's an educated woman—all of us are—and the kind of anxiety that we faced as we worked through that process.

We should do this in a way that is befitting of this parliamentary committee.

● (1345)

The Chair: Mrs. Vecchio, please go ahead.

Mrs. Karen Vecchio: I saw Sonia put up her hand.

The Chair: Ms. Sidhu, please go ahead.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

I agree with the proposed amendment. We heard Ms. Zarrillo's testimony.

Thank you, Mrs. Goodridge, for your work. We all agree. My mom is also fighting cancer.

Members are in agreement with the amendments, but we also heard testimony. This is not how we write reports. I would like to remind members opposite that we are writing other reports. We are also discussing this in FEWO. We were going to listen to even more witnesses, to come up with a more exclusive report. This is something I urge the committee to do. If everyone agrees and we have the same views, why can't we listen to more witnesses?

The Chair: The speakers list is now exhausted, so we're ready for the question.

The question is on the amendment proposed by Mr. Powlowski.

(Amendment negatived [*See Minutes of Proceedings*])

The Chair: We're now on to the main motion as presented by Mrs. Goodridge.

We'll go to Ms. Zarrillo.

Ms. Bonita Zarrillo: Thank you, Mr. Chair.

I really appreciate the opportunity to have this discussion today, and I appreciate the motion put forward in relation to fast-tracking this.

Some of the discussion we've had reminds me that for two years I had to fight my own health care provider to get heard and seen. I feel a sense that some of the underlying messages the Liberal Party is trying to send—asking for women's health to be prioritized and asking for women's health to be seen in the House of Commons—are not rational, and I fundamentally object to them.

I have an amendment that I would like to move today, and I hope it can be passed unanimously. I know the health minister has already put forward directives on the draft recommendations from the task force. The health minister has a lot of power to ensure that women are seen, and I hope we can move quickly on this and finally be at a point where women are seen in the health care system and by this government.

One part of my amendment is guidance, as a follow-up to what my Bloc colleague had to say about how many witnesses spoke today about their concerns.

After the wording "'deeply concerned' by the task force's guidelines", I would like to add a comma and then "and so were the majority of witnesses". Then after the wording "help save lives", I'd like to add "that the Minister of Health direct the task force to go back to the drawing board and revisit the guidelines based on the latest science; and that the Public Health Agency of Canada table to this committee the parameters given to the task force to update breast cancer screening guidelines."

I will remind the committee that the health minister did say that with the additional $500,000 given to this task force, his expectation was that the report would be based on current science.

Thank you, Mr. Chair.

● (1350)

The Chair: I just want to make sure we have your amendment. From what I heard, it appears that your amendment is in order. Just give us a minute to distribute it.

I have Dr. Powlowski and Mrs. Goodridge to speak to it.

Mr. Marcus Powlowski: I would like to see the amendment before I speak to it.

The Chair: I think we all would. That's happening as we speak.

Mrs. Laila Goodridge: Mr. Chair, on a point of order, I'm ready to speak to it.

The Chair: Dr. Powlowski is next, and he has asked to see it, so we're going to respect that. It's not going to take much longer.

Mrs. Laila Goodridge: On a point of order, Mr. Chair, I appreciate that he is next. We have provided it to the clerk, and I have a printed copy for all those in the room. We have very limited time. I believe a very common-sense, reasonable proposal has been put forward by Ms. Zarrillo. It's clear that some members are looking to filibuster, but frankly, women's lives are on the line.

I'm asking that we move to a vote so we can move forward on this very important topic for women and all Canadians.

The Chair: We won't be moving to a vote until the speakers list is exhausted.

Dr. Powlowski, you should have the amendment now. Please go ahead.

Mr. Marcus Powlowski: I suggest going to Laila first while I read it.

The Chair: Okay.

Mrs. Goodridge, go ahead.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

I believe this is the result of working across party lines.

I want to thank MP Zarrillo for working with both me and Mr. Thériault.

[*Translation*]

This helped us come up with a motion and an amendment that really meet Canadians' needs.

[*English*]

I do not believe we need to talk out the clock on this. We have a handful of minutes left, and I'm pleading with committee members to allow us to get to a vote.

The Chair: We actually have resources until 2:30. A motion to adjourn can be presented at any time before 2:30, but if there isn't one, that's when we'll cut off the meeting.

I have Mr. Naqvi, Dr. Powlowski and then Dr. Hanley.

Mr. Yasir Naqvi: Thank you very much, Chair.

The challenge I have with the amendment that's been presented is that it asks the minister to do something the minister does not have the power to do. Again, I'm challenged about approving a motion that is outside the scope of a minister's authority. In particular, it's the part that says, "that the Minister of Health direct the task force to go back to the drawing board and revisit the guidelines based on the latest science". The minister does not have the authority to do that.

I want to highlight for the committee that the minister has taken some very important steps to address this issue, and he did so the day the draft guidelines were issued by the task force. Among the steps he's taken, he has highlighted his serious concerns about the task force's findings. He has encouraged all leading experts on breast cancer to carefully review the draft guidelines and to provide their feedback to the task force during their consultation period. He has also called for an extension of the public consultation period from six weeks to a minimum of 60 days so there is ample time for that to happen.

He has asked the chief public health officer to convene a meeting of senior provincial and territorial officials and key experts to review the guidelines in order to share their best practices as well. That is an important step because, as we know, the delivery of health care takes place at the provincial and territorial levels. Furthermore, the minister has noted that the task force has identified some important research gaps and uncertainties. He has outlined steps to meet those gaps.

Last of all, the minister has asked that the Public Health Agency of Canada accelerate the launch of the external expert review that will examine the processes of the Canadian Task Force on Preventive Health Care and provide recommendations to improve the process of the task force so we don't run into similar issues in the future. That's a really important step the minister has taken. PHAC funds the task force but doesn't direct the task force, nor does the minister direct the task force. We need to make sure that if there are some systemic challenges to the manner in which this task force operates, which I think we are all seeing in this process, we don't run into them moving forward.

To me, the challenging part is that right now we are debating a motion asking the minister to do something that he does not have the capacity to do. I think we all want to move forward with this. We want to make sure that, if it is the will of the committee that we move by way of a simple motion, we do so in a responsible way, in a way that is within how the process works.

● (1355)

I suggest that instead of using the word “direct” in the motion, which says, “that the Minister of Health direct the task force”, we use “urge”. That change will allow the minister to do something he is able to do and that he has already spoken to, as opposed to asking him to do something he does not have the authority to do.

This is a really important issue. This issue is personal to so many Canadians. It's personal to members of this committee, including me. This is not a political or partisan issue. We need to make sure we move in a way that befits this committee so that, as has been said—and I agree with members—Canadian women know we are doing our work in a thoughtful and responsible way by making sure their health is front and centre.

Thank you.

● (1400)

The Chair: We have a subamendment to substitute the word “urge” with the word “direct”, as contained in the amendment. The subamendment is in order.

The debate is on the subamendment, and the speakers list resets.

Dr. Ellis, go ahead.

Mr. Stephen Ellis: I think it's a bad idea. Let's get to the vote.

The Chair: Dr. Powlowski has his hand up.

Go ahead, Dr. Powlowski. You have the floor.

Mr. Marcus Powlowski: I'm speaking to the subamendment of the original motion, but I have to say that I am unhappy that my initial amendments weren't accepted. I think they presented a good compromise.

This motion as it currently stands is basically an attempt by a committee of parliamentarians to overturn the decision of a medical task force, albeit, as I see it, a very flawed medical task force that I agree came to the wrong decision. I don't think it's the place of a bunch of elected parliamentarians to try to overturn the decision of an expert task force, just as it wouldn't be appropriate for us to tell farmers what kinds of seeds to plant in the fields, to tell roofers what kinds of tiles to put on their roof or to tell airplane pilots how they should be flying their planes.

We ought to recognize that there is a degree of expertise here that we do not have. We're coming off as though we're telling them how they should be doing things, ordering them to basically go back to the starting point and review the basic evidence. We are not better than they are at evaluating the evidence, so I don't like the way this is twisted. I don't think it's appropriate that we're trying to dictate to a group of experts what they should and shouldn't be doing. This just ends up looking like a political exercise.

We all disagree with their conclusion, but the right way to do it would be to strongly recommend that they reconsider. Hopefully, they will. We've already put in process other measures to review this. My understanding is that we've also looked at reviewing the way the panel is formed and the way decisions are made by the task force. The minister has already said he's going to do that.

We would have been a lot better off leaving the original amendment. I think this goes too far. Nowadays everybody is an expert in everything, and everybody is an expert on the evidence. We all have to realize that we as parliamentarians are not experts in everything in life, and I think this has gone too far.

The Chair: Thank you, Dr. Powlowski.

Are there any further submissions with respect to the subamendment?

Seeing none, are we ready for the question on the subamendment? The subamendment is simply to delete the word “direct” in the amendment and to substitute for it the word “urge”.

All those in favour of the subamendment, please raise your hand. All those opposed?

Only one Liberal voted.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, some members weren't here for the vote.

[*English*]

The Chair: I don't have a clear sense of things. It doesn't appear that people are paying attention.

We will conduct a recorded division on the subamendment.

● (1405)

It is a tie, five-five. The chair votes in favour of the subamendment.

(Subamendment agreed to: yeas 6; nays 5 [*See Minutes of Proceedings*])

The Chair: We're on the amendment as amended. This is Ms. Zarrillo's amendment with the word “urge” instead of “direct”.

Is there any debate on the amendment as amended? If not, are we ready for the question?

An hon. member: Call the question.

The Chair: We'll have a recorded vote, please, on the amendment as amended.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, there seems to be some confusion about the English and French versions. We agree on the word “exhorter” in French, but we don't agree on the word “exhort” in English. I'm not sure I understand. You're saying we're going to replace the word… Which word are we replacing?

Mrs. Laila Goodridge: The word “exhort” exists in English too, and it has the same definition as in French.

Mr. Luc Thériault: Okay.

[*English*]

Mrs. Laila Goodridge: Mr. Chair, I would like—

[*Translation*]

Mr. Luc Thériault: Because we voted against the word “exhort” in English.

Mrs. Laila Goodridge: The word “urge” doesn't have the same definition as the word “exhort.”

Mr. Luc Thériault: Okay.

There are some problems with… I just want to make sure I'm voting on the right thing.

The Chair: Okay.

So you want to change your vote?

Mr. Luc Thériault: I don't want to change my vote. I think the word “exhorter,” as you said it and as it was translated, is the most effective word for this context. But my understanding is that there's no equivalent word in English so there's a problem.

Mrs. Laila Goodridge: The word “exhort” in English means exactly the same thing as the word “exhorter” in French.

Mr. Luc Thériault: Okay.

[*English*]

The Chair: Regardless of the reason, for Mr. Thériault to change his vote requires the unanimous consent of the committee.

Does Mr. Thériault have the unanimous consent of the committee to change—

[*Translation*]

Mr. Luc Thériault: I wasn't asking to change my vote, Mr. Chair. You're calling another vote, but before we vote, I just wanted an explanation and some clarification.

● (1410)

The Chair: Okay.

I apologize, Mr. Thériault, I misunderstood your intervention. What I understand is that the translated version of the subamendment doesn't used the word “exhorter” but a different word. Do I have that right?

Mr. Luc Thériault: No, that wasn't it, but you can keep going, Mr. Chair. I'll figure it out.

When you called the vote, you said “exhorter.”

[*English*]

The Chair: Okay.

[*Translation*]

What would be the best word? “Diriger?”

Mr. Luc Thériault: Mr. Chair, I'm not trying to find the best word, I'm just saying that the word “exhorter” in French matched up with what I wanted.

The Chair: Okay.

Mr. Luc Thériault: Now you've called another vote, and I just want to make sure I understand what I'm voting on. I'm not changing my vote, but you just called another vote, so I want to clear up which word is being used in English and which word is being used in French.

The Chair: The word “urge” is being translated as “exhorter.” Are you okay with that?

Mr. Luc Thériault: Yes.

[*English*]

The Chair: We are now going ahead with a recorded division on the amendment as amended.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, could you at least read out the amendment again before we vote?

The Chair: Here's the amendment as subamended:

[*English*]

She moved that the motion be amended by adding the words "and so were the majority of witnesses" after the words "by the task force's guidelines" and by adding after the words "help save lives" the following: "that the Minister of Health direct the task force to go back to the drawing board and revisit the guidelines based on the latest science; and that the Public Health Agency of Canada table to this committee the parameters given to the task force to update breast cancer screening guidelines".

Are we clear on what we are voting on? That is the amendment as subamended.

(Amendment as amended agreed to: yeas 10; nays 0)

The Chair: We're now on the main motion as amended. Is there any debate on the motion?

Are we ready for the question? Do you think we can do this by a show of hands?

(Motion as amended agreed to [*See Minutes of Proceedings*])

The Chair: Dr. Ellis has a motion that I think will be uncontroversial.

Dr. Ellis, go ahead.

● (1415)

Mr. Stephen Ellis: I move a motion to adjourn.

(Motion agreed to)

The Chair: The meeting is adjourned.