



HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

44th PARLIAMENT, 1st SESSION

Standing Committee on the Status of Women

EVIDENCE

NUMBER 131

Monday, November 18, 2024

Chair: Mrs. Shelby Kramp-Neuman



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• (1105)

[English]

The Chair (Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC)): I call the meeting to order.

Welcome to meeting number 131 of the House of Commons Standing Committee on the Status of Women.

Before we begin, I'd like to ask all in-person participants to read the guidelines written on the updated cards on the table. These measures are in place to help prevent audio and feedback incidents and to protect the health and safety of all participants, including the interpreters. You will also notice a QR code on the card that links to a short awareness video.

To all members, again, please wait until I recognize you by name prior to speaking. I will remind you that all comments should be addressed through the chair.

[Translation]

Thank you all for your co-operation.

[English]

Pursuant to Standing Order 108(2) and the motions adopted by the committee on Tuesday, June 4, 2024, and Wednesday, September 25, 2024, the committee will resume its study of breast cancer screening for women aged 40.

I would like to welcome our witnesses. They are all appearing by video conference this morning.

As an individual, we have Dr. Nadine Caron, professor. From Ontario Health, we have Alethea Kewayosh, director, indigenous cancer care unit and indigenous health equity and coordination; and Dr. Amanda Sheppard, senior scientist. From The Olive Branch of Hope Cancer Support Services, we have Juliet Daniel, professor.

At this point, we will begin with opening remarks. Each of you has up to five minutes.

Dr. Caron, you have the floor for the first five minutes.

Thank you.

Dr. Nadine Caron (Professor, As an Individual): Thank you. *Meegweich. Merci.*

I'm joining you today from the traditional and ancestral territory of the Lheidli T'enneh peoples, Prince George, British Columbia.

I am a cancer surgeon and professor at UBC. I join you today as an indigenous woman, daughter, mother, sister, auntie, cousin and member of the Sagamok Anishnawbek First Nation.

In the field of breast cancer, I work with many hats. I strongly recommend that we move or return breast cancer screening guidelines to commence at the age of 40, as opposed to the current age of 50.

The current guidelines in B.C. state that screening mammography is available to women in their 40s and recommend that women at "average risk" start screening mammograms at the age of 50.

There is a distinct difference between a service being available and a service being recommended. These guidelines, current and previous, have never—

The Chair: I'm sorry to interrupt you. We have a question from the floor. It's from one of our members.

Ms. Leah Gazan (Winnipeg Centre, NDP): I'm so sorry.

Can you turn up the volume? I can't use my earphones. There's an echo on the floor.

The Chair: Certainly.

Ms. Leah Gazan: Thanks.

The Chair: We'll attempt to turn up the volume.

With the consent of all of you, I'll turn these television screens off to help people hear a little bit better. Is that fine?

Some hon. members: Agreed.

The Chair: Okay. We'll start that process.

In the meantime, I apologize for having to interrupt you.

Dr. Nadine Caron: That's okay.

The Chair: You can start where you left off. I'll be mindful of the time.

Dr. Nadine Caron: Okay. That's great.

Just to recap a bit, there's a difference between a service being available and a service being recommended, and these guidelines—current and previous—have never, to my knowledge, taken indigenous data or perspectives into consideration.

In recent research with the First Nations Health Authority and the BC Cancer Agency, we have found that when comparing first nations women in British Columbia to all other women in British Columbia, first nations women were diagnosed at a later stage of breast cancer.

First nations women had a lower breast cancer survival rate. Screening mammography rates were lower for first nations women, and this was very evident in the 40- to 49-year-old age group. Also, attachment to a primary care provider is lower for first nations women, which may explain the lower mammogram rates in this age group, as “discuss with your health care provider” is suggested when women consider it in this 40- to 49-year-old age group. The guidelines do indeed state to start at the age of 40 if individuals are considered at a higher risk. Currently, the age recommendation changes based on risk factors.

This is vital. These definitions of risk have limitations from an indigenous context and therefore do not seem to take indigenous realities and challenges into consideration. For example, high-risk women include those who are carriers of a pathogenic gene variant that significantly increases the risk of breast cancer. These are fancy words for DNA or genetic bases such as BRCA1 and BRCA2 and a list of others.

There are concerns regarding inequitable access to hereditary cancer testing and research, and while it has not been proven, I suspect it is similar to other documented disparities in access to genetic and genomic testing and care for indigenous people. These inequities in this health care field may limit access to screening mammography when access is based on the current guidelines. If you or your family don't get referred or tested for these genetic variants, how do you know that these recommendations to start at the age of 40 even apply to you?

The other risk factor that current guidelines use to recommend starting at the age of 40 rather than 50 is family history. Women with a family history of breast cancer are considered at higher risk, based on specifics: number of relatives with cancer, whether they're first-degree relatives and the age at which they were diagnosed.

These guidelines as they stand already recommend mammography at the age of 40 for those with a family history that matches the criteria. This is something that I just don't think we look at. What if you don't know your family history? What about factors that potentially changed your family history? What if that in itself is a barrier? What if your family history or potential family history increases your risk of developing breast cancer, but not knowing it decreases your access to the screening that can save your life?

Consider indigenous people in Canada. The legacy of the Indian residential school system includes women like my mom. These women were disconnected from their family, their culture and their community, which may have led them to not returning to or staying in their community and to losing their knowledge of their family history. Those children who never lived to leave residential school.... Caveat: I grew up in Kamloops, B.C., and the number 215 is ingrained in my soul. These children didn't grow up to be a sister with breast cancer or an aunt or a daughter with breast cancer.

The sixties scoop left individuals completely cut from their family, with many never knowing that they had a family history that would match the criteria to get a screening mammogram when they were 40. Forced relocation of indigenous communities separated families, including from the stories that could tell them their family history. The egregious differences in life expectancies and statistics between indigenous peoples in Canada and the rest of Canada include increased deaths in childhood and young adulthood, from infant mortality rates to teenage suicide, trauma and otherwise. Our family members may never have grown up to be a sister with breast cancer or an aunt with breast cancer.

So many of my patients have been robbed of their family history, of not knowing it, or of having our loved ones never grow up to be adults, yet that determines access to services to detect a common cancer that is treatable if detected early. Indigenous women should be recommended to start screening mammograms at the age of 40, given that criteria to obtain it at the age of 40 are based on a risk assessment that is a barrier in itself.

● (1110)

Screening mammograms change lives. I think we should remove limitations to accessing them.

Chi-miigwech.

The Chair: Thank you very much for your testimony.

At this point, I would like to welcome Ms. Kewayosh with Dr. Sheppard.

You have the floor for five minutes.

Ms. Alethea Kewayosh (Director, Indigenous Cancer Care Unit and Indigenous Health Equity and Coordination, Ontario Health): Thank you.

Good morning. My name is Alethea Kewayosh, and I am the director of the indigenous cancer care unit and indigenous health equity and coordination unit for Ontario Health. Joining me today is Amanda Sheppard, senior scientist, indigenous cancer care unit. Thank you for the opportunity to appear before the committee.

Ontario Health is an agency of the Government of Ontario with a mandate to integrate and transform Ontario's health care system. Ontario Health connects and coordinates the health system to make transitions into care easier for Ontarians, with a focus on driving value and ensuring equitable access to high-quality care when and where it is needed.

Indigenous people are the original inhabitants of Canada. Indigenous peoples are not a cultural group to Canada, but are distinct, constitutionally recognized peoples with aboriginal treaty rights. There are over 400,000 indigenous people in Ontario. This estimate undercounts the true number of first nations, Inuit and Métis people in Ontario.

Retrospective cohorts of females for first nations and other Ontarians were examined to assess breast cancer incidence, mortality and survival. First nations females had significantly lower incidence and mortality. However, once diagnosed with breast cancer, first nations females were significantly more likely to die, compared to other Ontarians.

In a matched cohort design comparing first nations to non-first nations women diagnosed with breast cancer in Ontario, survival was more than three times poorer for first nations women diagnosed at stage 1 than for non-first nations women. Furthermore, the risk of death after a stage 1 breast cancer diagnosis was about five times higher among first nations women with a comorbidity other than diabetes and was more than five times greater for women with diabetes than for those without a comorbidity. Therefore, having a pre-existing comorbidity was the most important factor in explaining the observed survival disparity among first nations women.

Improving care at breast cancer screening could increase their survival after early-stage breast cancer diagnosis.

There are very few cities that have examined breast screening uptake in Inuit and Métis.

The Ontario breast cancer screening program is a province-wide screening program that aims to reduce breast cancer deaths through regular screening. The program offers screening to two different groups of people who qualify for breast cancer screening. One is people aged 50 to 74 who are at average risk. OBSP recently expanded the program to people aged 40 to 49. The other group is people aged 30 to 69 at high risk.

Indigenous adults are often under-screened or never screened when it comes to cancer screening. There are many reasons for this, including intergenerational trauma and social determinants of health, and, specific to health and cancer care, stereotypes and prejudice, communication barriers and lack of translation, lack of trust for the medical system, having no family physician and poor coordination of care and jurisdictional issues.

There is no terminology for cancer in most first nations languages. In some first nations communities, cancer is a taboo subject that is surrounded in secrecy and fear, because historically, cancer was rare among first nations people.

The historical and cultural contexts have contributed to unique views and a generally pessimistic attitude toward cancer. When

asked what they thought of cancer, the response was usually, "It's a death sentence."

These views may impact the receptiveness to cancer education, prevention and delivery of care. Traditional spirituality, which is important to many indigenous people, may contribute to beliefs about cancer.

Ontario Health aims to improve cancer care for first nations, Inuit, Métis and urban indigenous people in Ontario. The indigenous cancer care unit strives to reduce inequities in care and access to cancer services to ultimately improve cancer outcomes. We do this by collaborating with regional, provincial and national indigenous and non-indigenous partners and organizations to develop and implement indigenous cancer strategies. Working together with the regional cancer programs and indigenous partners, the ICCU ensures that proposed programs and strategies are relevant and have the potential to be highly effective at the individual, family and community levels through the development of regional indigenous cancer plans.

One of the strategic priorities within the indigenous cancer strategy is cancer screening. The main objectives are to improve access and participation in cancer screening, improve coordination and integration of cancer screening services and support specific initiatives to improve organized cancer screening programs.

I would like to say I also share and appreciate the comments of the speaker prior to me.

Thank you for your time. I look forward to any questions that may come forward.

Meegwetch.

• (1115)

The Chair: Thank you very much.

To conclude, we have Professor Daniel. You have the floor for up to five minutes.

Professor Juliet Daniel (Professor, The Olive Branch of Hope Cancer Support Services): Good morning.

First I'd like to thank the Standing Committee on the Status of Women for inviting me to appear as a witness for its study of breast cancer screening for women aged 40 to 49.

I am a professor and cancer biologist at McMaster University. I'm a 15-year breast cancer survivor myself and a member of the research subcommittee of The Olive Branch of Hope Cancer Support Services, or TOBOH.

I have been partnering with TOBOH for the past decade to organize and host "Think Beyond 'Love Pink' Breast Cancer Awareness" education workshops and symposia specifically for Black and other racialized women who consider a breast cancer diagnosis to be a curse or stigma. TOBOH's mission is to tackle this stigma head-on, since knowledge is power and we know that an early diagnosis of breast cancer correlates with good survival outcomes.

Due to advancements in early detection, screening programs and treatment options, breast cancer mortality rates have actually declined almost 50% in the past four decades, from 42 deaths to 22 deaths per 100,000 people. However, epidemiological data continues to describe cancer disparities among racialized Canadian females, which contribute to overt inequities in lived experience during the cancer care continuum and in survival outcomes.

I just celebrated my 25th anniversary as a professor at McMaster. For the first decade of my career, my team was focused on characterizing a novel transcription factor that I discovered and named "Kaiso".

As it turns out, Kaiso is implicated in many aggressive human cancers, including breast, prostate, lung and pancreatic, but more importantly, we recently reported that Kaiso levels correlate with disparities in breast and prostate cancer outcomes in Black women and men respectively.

In 2008, I heard for the first time about the aggressive triple-negative breast cancer, or TNBC subtype, that was disproportionately affecting young premenopausal African-American and West African women compared to white women.

Currently, most studies and data about breast cancer and triple-negative breast cancer in Black women are based on U.S. data. As a Black Caribbean woman, I was intrigued by these studies. In 2011, during my second research leave, I began studying TNBC in Caribbean and West African women, since there was no published literature about triple-negative breast cancer in the Caribbean or Canada, and Canadian hospitals were not collecting disaggregated demographic data for cancer or any disease.

My research team is specifically interested in determining if there's an ancestral genetic predisposition or susceptibility to triple-negative breast cancer in women of African ancestry. The TNBC prevalence in West Africa ranges from 40% to 70% in Ghana and Nigeria. It ranges from 20% to 22% in the Caribbean and the U.S., but prevalence is only 10% among white women in the U.S.A., suggesting that this could be something inherited from our ancestral slaves from the transatlantic slave trade.

What is most concerning, however, about breast cancer in Black women is that despite having a lower incidence of breast cancer compared to white women, Black women have the highest mortality

rate from breast cancer. Black women under age 50 have twice the mortality rate compared to white women. This is possibly due to the fact that there are no targeted therapies for triple-negative breast cancer, which is most prevalent in Black women.

In contrast, white women tend to be diagnosed with estrogen receptor-positive breast tumours, which are effectively treated with the drug tamoxifen.

Because there are no targeted or specific therapies or drugs to treat triple-negative breast cancer, any woman—be they indigenous, Black, Latina, Asian or any other ethnicity—diagnosed with triple-negative breast cancer has a poor prognosis, because they can only be treated with radiation therapy, which targets the breast itself, and standard chemotherapy, which affects all proliferating cells in the body, such as our hair and intestinal cells.

Earlier this month, we were excited to read a published article by Wilkinson and colleagues from the University of Ottawa, which was the first study of breast cancer incidence and mortality by age, stage, molecular subtypes, race and ethnicity in Canada. They reported that compared to white women, other Canadian women had an earlier peak age of breast cancer diagnoses, and more cases were diagnosed under the age of 40. They also reported that Black women have statistically more breast cancer diagnoses at stages 3 and 4 combined, at 26%, versus 17% for white women.

● (1120)

Notably, the proportion of aggressive triple-negative breast cancers among Canadian Black women was twice that of white women, with 20% versus 9.5%. It is a statistic that is very similar to the U.S. data comparing African-American women to white American women.

Wilkinson and colleagues concluded that "Initiation of [breast cancer] screening at age 50 would likely disadvantage women who have greater proportions of BC diagnosed [before the age of 40] and may partially explain the higher proportions of advanced BC cancer diagnoses]...among many younger women of race and ethnicities other than White in this study."

One size does not fit all, and on behalf of The Olive Branch of Hope, Black Canadian and other racialized women, I urge the Canadian task force on breast cancer screening and the Standing Committee on the Status of Women to consider revising the recommendations to account for populations that are at risk for early onset and aggressive breast cancer subtypes.

I would also like to say that I concur and agree with Dr. Caron, who has pointed out that the criteria for being classified as high risk do not consider the lived experience of marginalized communities in Canada.

Thank you.

The Chair: That was excellent. Thank you all for your testimony this morning.

At this point, that does conclude all opening remarks.

I would like to move to our first round of questions.

We will begin this morning with Michelle Ferreri. You have the floor for six minutes.

Ms. Michelle Ferreri (Peterborough—Kawartha, CPC): Thanks, Chair.

Thank you to our witnesses today for attending the status of women committee as we continue our study on breast cancer and the recommendations by the national task force. Your testimony is obviously very important in this study, and you've brought up some very good points.

In the second half of today's meeting, we're going to have the chair of the task force here. I think it would be very useful to hear from you guys what you would like to ask that chair. I know you've given your recommendations.

Dr. Caron, you said something that really jumped off the page to me. In this world of Parliament, one word can make a world of difference. You said that there is a very big difference between "available" versus "recommended".

I'm going to give an opportunity, if I can, to both Dr. Caron and Professor Daniel to put on the record what you would like to ask the task force and its chair. We've heard a significant amount of testimony from breast cancer survivors and from doctors throughout this study, who weren't consulted. They're not happy with the recommendations of this task force and they'd like to see them changed. What would you like to ask her?

I'll start with you, Dr. Caron.

• (1125)

Dr. Nadine Caron: Thank you.

I really appreciate your acknowledging what I said, in terms of words. There is so much in the power of words to heal, to harm, to clarify and to confuse.

I have had so many patients over the years. As a female breast cancer surgeon, I have seen hundreds of women with breast cancer or who were along that pathway. They were confused that they were simply not recommended to have a mammogram.

Ms. Michelle Ferreri: I'm sorry to interrupt you. Could you clarify what the average age of those women would have been?

Dr. Nadine Caron: For the most part, unfortunately, I'd like to say that it was women in the 40- to 49-year-old age group who were not recommended to have it because it was simply something they could "consider", and it "could" be made available to them should they want to pursue that after a discussion with their primary care provider.

Unfortunately, in British Columbia and across the country, when it comes to accessing and discussing this with a primary care provider, that age group also includes any woman who should be considering a screening mammogram. There is the lack of understanding what a screening mammogram does and what it's for. There is the fear—and I'm speaking from the indigenous perspective of my indigenous patients and of my family members—of pursuing care in the health care system. There is the lack of cultural safety and the lack of access to a health care provider to talk to about this. All of that becomes something that then creeps into the 50-plus age group, where it is strongly recommended in the guidelines to start screening mammography.

However, most of my patients don't search the website to find out what BC Cancer is recommending or what is being recommended. They don't have the access to a primary care provider who says, "Hey, you're turning 50. I strongly recommend that you have a screening mammogram."

Ms. Michelle Ferreri: I'm sorry. I don't have much time. Go ahead and finish up what you were going to say.

Dr. Nadine Caron: When it comes to women in their forties, they're not actively recommended to have it in most cases. Therefore, it's upon them to find a primary care provider or to search for this information and have the courage to enter the health care system when it's something that is available to them but not strongly recommended.

Ms. Michelle Ferreri: Thank you for that, Dr. Caron. You brought up a very interesting point, which is access to a primary care provider. We know that is probably one of the largest issues, if not the largest issue, across this country. We still have a massive health care crisis in this country.

If I can, I'll move to Professor Daniel.

Why would a chair of a national task force have recommendations different from those of every province and every witness we've heard from? It doesn't add up. It doesn't seem to make any sense to me. I think a lot of the members on this committee feel the same way.

Can you give your two cents on what you're seeing and what you think, or what you'd like to ask her?

Prof. Juliet Daniel: Thank you.

I forgot to look up the composition of the task force, but that would be one question: What was the composition of the task force? Were there any cancer survivors or caregivers? Was there diversity representing the multicultural and multi-ethnic nature of Canada?

Also, how open-minded was the task force itself in the consultations that they conducted? As you noted, many people have complained or pointed out that they were not consulted.

Another question I would have for the chair is whether they are aware that the American Association for Cancer Research, or AACR—three or four years ago, so not that recently—added racism as a social determinant of health and a risk factor for cancer development. That means marginalized communities that experience significant levels of racism. Here in Canada, that would specifically pertain to Black and indigenous communities.

What it means is that this racism has resulted in epigenetic changes to our DNA. Those aren't mutations; they're just marks that are added to our DNA that are passed on through the intergenerational trauma from that racism. In Dr. Caron's case, for example, these epigenetic marks could have been from her ancestors and how they were treated in residential schools. In my case, they could be from how my ancestors were treated as slaves. I have inherited those epigenetic marks without even knowing it was happening—

• (1130)

The Chair: Thank you very much for that.

Prof. Juliet Daniel: I would also like to ask the chair what they would say to someone like me, who was diagnosed at the age of 45.

I found the lump because my mother passed away of ovarian cancer when I was 22. That is what inspired me to become a cancer researcher. I was very aware of what I needed to look for and what I needed to do. My family doctor and I were incredibly diligent in assessing my health on an annual basis. I had my annual physical in October 2008. Three months later, I found the lump in my breast—

The Chair: Thank you very much for sharing your story.

Prof. Juliet Daniel: It went from being a very small tumour to a very big tumour in three months. Because I'm a scientist, I was able to ask for a mammogram, etc. The average person doesn't have that scientific background and wouldn't know how to advocate for herself.

The Chair: Thank you very much for sharing your story and your expertise.

Next, I would like to give the floor to MP Damoff for six minutes.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Thank you, Chair.

Thank you to the witnesses for being here today.

I've had the privilege of visiting Dr. Daniel's lab. I hope, Dr. Caron, that I can get out to yours in Prince George as well.

I would say that you are two of the leading experts in Canada, if not in the world, on the experience of indigenous and Black women with breast cancer. I'm wondering if the task force consulted with either of you when it was determining its guidelines.

We'll start with you, Dr. Daniel.

Prof. Juliet Daniel: To be honest, I don't even remember. I've been consulted on so many things over the past two years that I actually don't remember. I don't specifically remember being consulted. I know I was on a panel with several people regarding breast cancer in general, but I cannot remember if it was the task force.

Ms. Pam Damoff: That's okay.

Dr. Caron, did they reach out to you at all?

Dr. Nadine Caron: I really appreciate your asking that. No, they did not. They did not reach out to me. I'm not aware if they reached out to my colleagues who work with me in this area either.

I just wanted to acknowledge Dr. Daniel's personal story and the overlap in terms of the peoples in this country who are missing out. I think the task force really focuses on the majority, which makes the majority of people feel safe, content and represented, but it doesn't change the harm that's being done.

I agree wholeheartedly that a social determinant of health is indeed racism, but I also want to point out what Dr. Daniel described and say that I think a social determinant of health is also access to research. The reason that screening mammography is firmly recommended at 40 or younger—really, younger—for women with genetic abnormalities that actually increase their risk of breast cancer is that the research has been done to show that there are genetic abnormalities in those populations that put them at a massive risk of breast cancer.

I would say, in regard to Dr. Daniel's population, whom she stands up so wholeheartedly for and is a voice for—a cry in the woods—overall, I think we need to start to recognize that just because there is an absence of data does not mean that there's an absence of risk. It means that there is a lot of work to do so that we can stop being what I used to refer to as “the asterisk nation”.

An example is the triple-negative data, absolutely. There was a well-known risk years ago with respect to African-American populations in the United States, but there was no data in Canada around the massive increased risk in that population. Interestingly enough, when it came to the “North American Indians”, which was the terminology used in those studies, there was no data even available. We could not even comment on it.

The absence of data, the paucity of data, is not something to rest on and say, “Whew, it doesn't seem like there's an increased risk.” I think it needs to be acknowledged and put forward, and then we need to ask ourselves what we are doing in creating guidelines when we don't even have adequate information to base these guidelines on for these populations that the Canadian government is responsible for hearing.

• (1135)

Ms. Pam Damoff: Thank you. I actually have a quick question for the chair.

I know Dr. Daniel has a manuscript she could submit as a brief, Chair. I'm wondering what the deadline is for briefs.

Maybe while you look at that—I don't want to use all my time while you look—the guidelines talk about people who are at higher risk, and you both talked about how Black women and indigenous women are at higher risk. I think, Dr. Caron, you touched on this as well.

Do they actually have any idea they're at higher risk? Even white women might have the triple X gene. How do they know unless they've been tested? Maybe they have a diligent family physician who follows the genetics of breast cancer, but is it a legitimate claim from the task force to say that people who are at higher risk can access screening at 40?

I'll start with you, Dr. Daniel. I have about a minute and a bit left.

Prof. Juliet Daniel: How do they know they're at risk? As I said—

Ms. Pam Damoff: No. Do they even know they're at risk? Would they even have any concept that they were at risk that would lead them to go to their doctor and say, “I'm high risk. I need a mammogram”?

Prof. Juliet Daniel: In partnership with The Olive Branch of Hope, this is what we've been doing now for about eight years. We've been going to Black communities across Ontario, and doing some virtual events in Nova Scotia and other places of Canada, to basically educate and inform Black women about triple-negative breast cancer.

For the record, I would like to state that when I first applied for funding in Canada to study triple-negative breast cancer in Black women—I believe that was in 2013, and I didn't get funded—one reviewer said that my study of Black women with triple-negative breast cancer was not relevant to the Canadian context. Receiving that as a Black researcher and Black breast cancer survivor and being told that studying a very aggressive breast cancer subtype in Black women in Canada was not relevant to the Canadian context was a serious affront to me and every Black person in Canada. That hurt to the core.

Part of our mission became to ensure that we educated every Black woman about her risk. We have them fill out family history charts. To Dr. Caron's point, not everyone is aware of their family history. Again, there's a stigma. Many of us were told this person died from old age. In the Caribbean, people won't even say the word “cancer”. They say, “Oh, they had the C-word.”

We have to be aware of these cultural differences and nuances. Again, that's why, as I said, the manuscript we're writing is called “one size does not fit all”, because we have to be aware of this.

The Chair: That's excellent. Thank you very much.

At this point, MP LaRouche, you have the floor for six minutes.

Ms. Pam Damoff: I'm sorry, Madam Chair. Will you give us the date for the brief?

The Chair: MP LaRouche, wait just one minute.

The date for the briefing has passed. It was October 21 for briefing documents with recommendations. If, indeed, you'd like to submit or have someone submit reference documents without recommendations, they can still be received, but the date was October 21.

Ms. Pam Damoff: Thank you.

The Chair: MP LaRouche, you have the floor for six minutes.

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): Thank you very much, Madam Chair.

I also want to thank the witnesses very much for their contribution to this important study.

During the break week, one of my activities was to attend a breakfast conference organized by the Haute-Yamaska Chamber of Commerce and Industry. It was very interesting. The conference focused on what you do when cancer strikes in a business. It was organized by the Quebec Cancer Foundation. The guest speaker was Ms. Danièle Henkel, a businesswoman who was diagnosed with breast cancer.

It was interesting, but, based on what I heard in discussions after the event, beyond the taboos that remain in business and the difficulty for women to announce this diagnosis, there is unanimous agreement that screening should begin at 40.

Since this is what I understood from their opening remarks, all the witnesses can answer the question.

I hear that there are many concerns, but if screening is extended to people from age 40 when resources are already insufficient, how will we ensure that services aren't stretched thin and that no one is penalized? How do you picture that? We're talking about screening starting at age 40, but we have to ensure that resources are also increased to provide the necessary services and that no one will feel hindered by a lack of access to resources, specifically.

Almost all of you also raised access to resources in your opening remarks.

Ms. Daniel, Ms. Sheppard, Ms. Kewayosh and others, you can answer those questions.

● (1140)

[English]

Ms. Alethea Kewayosh: I'll go first, if everyone is okay with that.

In Ontario, we have expanded the Ontario breast screening program to women age 40. We wouldn't do that unless we had the capacity to invite women age 40 and up to be screened. In terms of the challenge, it's the follow-up. Many indigenous women, especially those from remote communities in the northwest, have difficulties with follow-up care. Some have even said no to follow-up care because it means leaving communities where they are the main provider of care and nurturing at home.

I'm going to invite Amanda Sheppard to speak to that as well.

The Chair: I'm sorry to interrupt you, Dr. Sheppard.

Ms. Kewayosh, the next time you have the floor, can you be mindful to push your boom mic a little bit away from your mouth? There was a little bit of static.

Dr. Sheppard, please go ahead.

Dr. Amanda Sheppard (Senior Scientist, Ontario Health): Thanks for that.

I'll just add that there has been research in the Ontario context, and we do know that access to mammography is challenging. We know that fewer first nations women who live on reserves receive mammograms, particularly in remote communities.

I think that this is also a call for non-insured health benefits to ensure that there is funding. As we're talking about access, adequate funding is needed for flights and supports to get women to mammograms. That point hasn't been raised yet, so I want to mention it.

I also want to reiterate a point that Alethea shared earlier, which is that we know that when first nations women are diagnosed early—so, stage 1—there's poor survival. I think that's a really important call for early screening and close attention to follow-up care.

Thanks.

Dr. Nadine Caron: Madam Chair, may I please speak to that question?

The Chair: Yes.

Dr. Nadine Caron: I think it's a great question. Given time constraints to point out a few things, again, words mean a lot. There is a difference between access to screening mammography and utilization of screening mammography, and they come from very different cost expenditures, efforts, roles and responsibilities.

In British Columbia, we are trying our best to address both, increasing access not only in terms of geography but also by doing screening mammography with mobile units that go into rural, remote, indigenous and northern communities in the province. That is greatly increasing access.

Utilization means that a woman is aware of it, trusts it and chooses to use that resource. That means dealing with entities such as health literacy and cultural safety.

When it comes to cost, it becomes very challenging. It's above my pay grade to look at what a human life is worth, but we also have to remember that screening mammography not only detects cancer early but also has a preventive aspect.

Many of the patients I see who have had an abnormal mammogram are referred to a surgeon. I proceed to do the next steps. Often it is something such as DCIS, ductal carcinoma in situ. It is in situ and early, technically before stage 1. It can prevent invasive carcinoma from developing, or it can even be more up stage as ADH, LDH or LCIS.

The bottom line is that there are pathologic findings that you can find that are not invasive breast cancer but that change the risk profile of a woman so that she knows that she should get annual mammograms after that, do breast self-exams and do those annual physical checkups with her family physician to prevent breast cancer. Preventing breast cancer decreases the need for surgeries, chemotherapy, hormone therapy, radiation and all of the health care required for the complications and the care.

Finally, when it comes to women in their 40s, we have to remember that these women are caring for their children and are often caring for their parents. They are the crux of society. We must protect them.

I hope I look like I'm in my 40s; I'm not. There is no kind of self-benefit from this, apart from the fact that I do have people I love in my life whom I want to protect. I strongly, strongly think that it is worth a screening mammogram in their 40s and that screening is appropriate to the risk of this common malignancy.

● (1145)

The Chair: Thank you very much.

Leah, you have the floor for six minutes.

Ms. Leah Gazan: Thank you so much, Chair.

Dr. Daniel, you spoke about racism as a social determinant of health. Dr. Caron spoke about impacts of colonization. I would say that for indigenous populations, racism in the health care system is alive and well. The mistreatment of indigenous people in the health care system is quite pronounced, including a man, Jason Kennedy, who had the wrong leg amputated this month in the hospital. I think the real mistrust of the health care system is based on facts and based on experience.

I want to start with you, Dr. Daniel. I want you to expand on how racism becomes a social indicator of health in the current context.

Prof. Juliet Daniel: As I said, the American Association for Cancer Research, or AACR, has been one of the leading associations studying all cancers for over three to four decades. A lot of the data that many of us in Canada and around the world use is their data, because they've been collecting ethnicity-based and race-based data since 1975, which is kind of bizarre, considering what we think about American culture.

As I said, in 2020, I believe, they released their report saying that racism is now a social determinant of health. They were looking not just at historical trauma but also at current trauma, such as racial profiling. Whether it's when you go into the health care system or whether it's when you're driving your car, there's racial profiling in any scenario.

They also look at the harm within the communities of environmental racism, such as many of those communities, Black and/or indigenous, being physically located in places where there are bio-hazards, etc., as well as perhaps toxic dumps being placed near these communities. They have very little access to health care, and then they're exposed to toxic chemicals.

Ms. Leah Gazan: When you're talking about racial profiling, would you say that racial profiling also occurs in the health care system?

Prof. Juliet Daniel: Definitely. It definitely does occur.

Ms. Leah Gazan: How so?

Prof. Juliet Daniel: For example, I recently met several young Black women who felt a lump. They were under the age of 30. They were dismissed by three physicians who said they were too young, that they can't have cancer because they're too young. Their concerns about the lumps in their breasts were dismissed. In one case, the lump was dismissed for almost two years.

I also met a young indigenous woman in 2018 who first felt a lump at the age of 22. She wasn't taken seriously until she was 24, and by that point, it was advanced stage breast cancer, and she had to have a double mastectomy at the age of 24. That there is racism.

• (1150)

Ms. Leah Gazan: By just looking at research, would you say there's a double standard of care for Black people, indigenous people, people of colour and Caucasians?

Prof. Juliet Daniel: I am not a physician. I can't speak to what goes on in the hospitals. I can only speak about the women or the men who have told me of their lived experiences. We're publishing a study on that as well. There are definite differences in how they're treated by the health care system.

I think it depends on the region. I don't think it's the same in every single hospital or every single province, and we have to be aware of that. We're not saying that it's in general.

Dr. Caron is ready to respond to this, but we have to be aware that there are systemic barriers and racism that we are aware of and have experienced ourselves.

Ms. Leah Gazan: I'm going to move over to you, Dr. Sheppard, because you mentioned the first nations and Inuit health branch and providing equal access for indigenous women to get mammograms. The two-tiered health care in this country is a critical issue when there's one for indigenous people and then one for everyone else.

How is a lack of access to health care placing indigenous women more at risk for not being diagnosed at earlier stages of cancer?

Dr. Amanda Sheppard: I think the evidence is pretty clear, no matter who you are, that prognosis is better with an earlier detection. I did highlight that what we've seen in Ontario is poor survival, even with stage 1 diagnosis, so I think there are two red flags to really support early access for first nations, Inuit, Métis and urban indigenous women. I did refer to remote communities earlier, but urban indigenous women are also having barriers to access mammography and other care.

Just to add to the point earlier about racism in the health care system, with some qualitative work that we've done in the province of Ontario, repeatedly we saw comments about how women were being pushed out of the health care clinic and being told to take Tylenol when they were expressing concerns about pain and fears about different health conditions.

I'll let Alethea speak more to the issue.

The Chair: That was excellent. Thank you.

Unfortunately, MP Gazan's time is up.

At this point, that does conclude our panel. On behalf of the committee, I'd like to thank all of our witnesses for your appearances here today and for sharing your testimony.

Because we have separated it into two different panels, it's a little bit of a different structure from what we're familiar with.

Thank you very much, witnesses, for being here to share your testimony.

Prof. Juliet Daniel: *Meegwetch.*

Thank you for this opportunity.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): Madam Chair, I just have one question before they log off.

The Chair: Okay. Before you log off, I will allow one short question.

Ms. Emmanuella Lambropoulos: It's not even a question to them. It's more for you, procedure-wise.

Usually when we have two split rounds, like two rounds of panels, there's another round for the Conservatives and then another round for the Liberals. Usually it's an extra five minutes for each. I don't know if the second panel is just one panel opening up with five minutes of comments and only one witness, because that might actually allow us to—

The Chair: I welcome that, but we have taken care of that housekeeping. There was an intention to have extra rounds for both parties, but the time is not on our side and we have a full second hour. Unfortunately, that's where we're going to leave it.

At this point, we will suspend for about five minutes to transition to our—

Ms. Leah Gazan: Can I ask you for a point of order just before they leave?

The Chair: Sure.

Ms. Leah Gazan: I know the briefs were due earlier on. I'm wondering if we have agreement of the committee to send briefs if they have anything else to add, because this is the only panel that we have had with indigenous and Black women.

• (1155)

The Chair: The actual briefing deadline was October 21, which is some time back. We are still willing to accept, from the analyst's perspective, all the documents with regard to reference documents. They are still more than welcome to be submitted.

Ms. Lisa Hefner (Hamilton Mountain, Lib.): On the point of order, Chair, I would agree with Leah.

We extended the study to hear from more witnesses, so the original deadline doesn't make sense, given that we've heard from extra witnesses—

The Chair: If you'd like to put a motion forward....

Ms. Leah Gazan: Can I say a motion?

The Chair: If there's consent around the room, we can extend the deadline. I don't think we need to go to a formal vote to extend the deadline for briefs. If it's the wish of the room, we can extend that.

What date do you find reasonable? Is it another couple of days?

Ms. Lisa Hefner: I would confer with the analyst to see if maybe....

The Chair: Go ahead, MP Damoff.

Ms. Pam Damoff: Could we give them to the end of the week? I mean, they just appeared Monday, and I think it's a little bit unfair. If we could give them until the end of the week, it's still a short timeline for these very busy people to put something together for us.

The other thing is that on Emmanuella's point, we started this meeting at 11:05 and we finished it at 11:55. I had wanted to have two hours with these witnesses, and it was cut back to one hour, unfortunately. I really think we've cut them short. If anything, I would prefer to allow at least one more round of questions for them and extend the meeting by five minutes, because we've had less than an hour with these witnesses.

The Chair: From a logistical standpoint, if we go further, we'll be going far past an hour. We have a full second round.

Trust me: It was my intention to have a full second round for all parties. I recognize that this is the first time they've been here, but we're going to move into the second hour. As the comment from the gallery said, we've already spoken about this for five or six minutes, so we're already cutting into our second hour.

I understand that this is....

Ms. Pam Damoff: Chair, we have only one witness in the next hour, and there are five minutes of testimony from them, so—

The Chair: We have two, plus we have housekeeping that we need to get through.

At this point, if there are no further questions, I'd like to suspend for about five minutes while we transition into our second panel.

I do see—

Dr. Nadine Caron: May I please just make a request about the deadline?

The Chair: You have until Friday of this week. Thank you. Thank you, MP Damoff, for suggesting Friday.

Dr. Nadine Caron: May I suggest something?

What we're looking for, I'm guessing, are things that are not already available to the task force in the public space, like published papers and so on. The indigenous way of sharing knowledge is that it does need to be cleared. There is a lot of data that I think would help the task force. It is owned by the communities and it must be respected. I would need to check with the First Nations Health Authority to see what would be able to be released. That is vital data that has been ignored for decades. I cannot submit it just because I was involved in the research.

First nations individuals, based on OCAP principles, deserve at least to have their voices represented in terms of the First Nations Health Authority governance okaying it. I don't know if they're going to be able to do it by Friday. I really hope their voices aren't silenced by a deadline that was just put out without concepts being interpreted from the indigenous perspective.

The Chair: Thank you.

Go ahead, MP Sidhu.

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

I just want to say that this is why we invite the medical experts. We should extend the deadline so their voices can be in there because we want good data too.

The second thing, as my colleague Pam said, is this: Is there no way we can extend a little bit so we can maybe ask some questions?

The Chair: No. We need to move on to our second panel, and as—

Ms. Pam Damoff: Chair, I'd like to move a motion, then.

I'd like to invite these witnesses back for another hour. We've shortchanged them. These are the only experts we've heard throughout this study who have reflected Black and indigenous perspectives. I hate to do that to them, so I'd like to invite them to come back.

We didn't have very much time to even ask the folks from the Ontario Health authority questions, so I'd also like to move that we invite these witnesses back for one hour on this study as soon as possible.

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

• (1200)

The Chair: Looking at the schedule, we can make it happen on December 2.

Ms. Pam Damoff: Thank you, Chair.

The Chair: Thank you.

At this point, we'll try again to suspend for five minutes while we transition to our second panel.

Thank you very much, again, to the witnesses. I apologize for cutting you short today, but logistically, it's just where we are.

We'll suspend.

• (1200)

(Pause)

• (1205)

The Chair: I'd like to call the meeting back to order.

The committee will resume its meeting on the study of breast cancer screening for women aged 40.

I have a few additional comments before we begin.

For our new witnesses, please wait until I recognize you by name. For those participating by video conference, please click on the microphone icon to activate your mic, and please mute it when you're not speaking.

You may speak in the official language of your choice. Interpretation services are available. You have the choice of floor, English or French by using the interpretation function at the bottom of your screen. If interpretation is lost for any reason, please let me know immediately.

At this point, I would like to welcome our second panel of witnesses.

From the Canadian Task Force on Preventive Health Care, both joining by video conference, we have Dr. Guylène Thériault, physician, and Dr. Donna Reynolds, physician.

At this point, I would like to open the floor. Whoever would like to speak has the floor, or would you like to split your time?

Dr. Guylène Thériault (Physician, Canadian Task Force on Preventive Health Care): Thank you, Madam Chair and all members of Parliament present today, for your invitation to engage with the Canadian task force regarding the 2024 draft recommendations on breast cancer screening for women, specifically today for women in their forties. We look forward to any input from your committee as we work to finalize the guideline.

I am Dr. Guylène Thériault. I have worked for the past 28 years as a family physician in Quebec's urban, rural and remote areas while teaching many generations of upcoming physicians. I am the chair of the task force, as well as the chair of the breast cancer screening update working group.

Besides my degree in medicine, I have a diploma in evidence-based health care from Oxford University.

I am accompanied today by Dr. Donna Reynolds, a family physician colleague. Dr. Reynolds holds a specialty degree in public health and a master's of science in epidemiology and is also involved in teaching as well as in research. She is the interim vice-chair of the task force.

We are both volunteers on the task force. For the past eight years, we have been contributing our time to the mandate of developing preventive health care guidelines for primary care practitioners across Canada. I am aware that there have been previous sessions and witnesses on this important topic and that the task force, its members and the draft guideline have been the subject of some concerning statements.

As has been the case in previous meetings, I ask you, Madam Chair, to ensure a safe place for our discussions today.

Ms. Pam Damoff: I have a point of order, Chair.

The Chair: MP Damoff, go ahead.

Ms. Pam Damoff: I'm still hearing the translation right now in my headset. There's something wrong with the timing. I don't know if anybody else is getting that.

The Chair: Is anyone else in the room having difficulty?

Ms. Pam Damoff: I'm still hearing stuff. I don't know if she's still talking.

The Chair: At this point, it seems as though you're the only MP who is having issues. Do you want to try unplugging and plugging it back in?

Ms. Pam Damoff: Okay.

“As has been the case in previous meetings”.... This is what I'm getting.

The Chair: Ms. Thériault, if you could, please continue your testimony and see if it is getting better for MP Damoff.

Dr. Guylène Thériault: Of course, Madam Chair.

Breast cancer is an awful disease that touches too many lives. As physicians, we both have experienced the fear felt by our patients and their families. While tremendous improvements in the treatment of breast cancer over the past decades have resulted in a significant reduction in mortality, we are very conscious that there is much more yet to be accomplished. We strongly believe we can do better for Canadian women.

It is clear that many misunderstandings remain. The one I must mention now is the difference between screening and diagnosis. Individuals with symptoms that could be breast cancer, such as a lump, need to have those symptoms investigated. Even if this investigation includes a mammogram, this is not screening, and the task force guidelines do not apply here. I want to emphasize this. Anyone with a symptom should see a health care provider.

The evidence about screening is complex and nuanced and needs careful and transparent interpretation. That is why the task force undertook a comprehensive look at the evidence, including recent observational studies. From all of this evidence, we found that the decrease in breast cancer mortality from screening individuals aged 40 to 49 over a 10-year period is about one breast cancer death avoided for 1,000 women screened. This magnitude of a benefit was relatively consistent, whether we looked at older randomized clinical trials, recent observational studies or the modelling exercise we commissioned.

What about the harms of screening in this age group? The evidence we gathered showed that screening results in two individuals in 1,000 being overdiagnosed with breast cancer, and 368—more than one-third of women screened—would require additional tests, including follow-up mammograms, ultrasounds and/or biopsies, to be told they did not have cancer. Some refer to these as “false positives”. Many primary care practitioners and patients are surprised by these numbers.

To help us understand what this means to patients, we commissioned a comprehensive review of studies on patients' values and preferences. What would they choose to do, once informed about benefits and harms? The evidence showed that a majority of patients in their forties weigh the harms as greater than the benefits, but we know from the evidence that there is variability. Some want to be screened while others do not.

This is why our recommendation starts by stating that breast cancer screening is a personal choice. It specifically says that if someone is aware of the benefits and harms of screening and wants to be screened, they should have access to mammography.

The task force recommendation, therefore, is about empowering women to make informed decisions about their health. There is no right or wrong decision. The right decision for a woman is the one that aligns with her personal values at that point in time.

I now welcome your questions and comments.

• (1210)

The Chair: Thank you.

Does Dr. Reynolds have any additional comments?

Dr. Guylène Thériault: Madam Chair, we prepared for a five-minute opening statement by the task force as a whole.

The Chair: At this point, I would like to welcome MP Vien.

You have the floor for six minutes.

[*Translation*]

Mrs. Dominique Vien (Bellechasse—Les Etchemins—Lévis, CPC): Thank you very much, Madam Chair.

We were looking forward to seeing you, Ms. Thériault and Ms. Reynolds. The committee was really looking forward to hearing your perspective. I know there will be many questions about the recommendations you're about to make.

I think I'm reading the room well enough to tell you that the members here quite agree on early detection, starting at age 40.

Furthermore, Ms. Thériault, contrary to what you are telling us, there is unanimity—but it goes against your directive. Everyone who's come to meet with us here, all the witnesses, the survivors, those who've had excruciating difficulties cutting through the red tape to demand screening and who've had to fight to obtain it, all those who have come here, including the expert panel that spoke to us earlier, tell us that screening should begin at age 40.

I am a former MLA and minister in the Quebec government. At some point, things are easy to understand. On balance, there is, on the one hand, the disadvantage of having to go through repeated diagnoses and examinations, and perhaps even the issue of cost, and, on the other hand, the advantage of having a clear idea or picture of what is happening to us, if only to reassure us. It seems to me that screening starting at age 40 is the least we can do today. In addition, this week, I saw newspaper articles stating that more and more 40-year-olds are getting cancers that we didn't see in that age group before. I'm not necessarily talking about breast cancer, but all kinds of cancers.

How do you respond to that? What can you tell us this morning that will convince us that your directive not to start screening at age 40 would be the right thing to do, when everyone, including the provinces in Canada—Quebec is the only one left to join the others—is saying the opposite of what you're telling us?

• (1215)

[English]

Dr. Guylène Thériault: Madam Chair and members of Parliament, this gives me an opportunity to talk about our methods.

The task force does the recommendations on different aspects of prevention and screening. The way we approach it is that we look comprehensively at all the data. We have looked at all data, old and new. All the newer observational studies are incorporated into our thinking about these recommendations. I don't know what more to say. We did look comprehensively at all the data, including data on the values and preferences of patients. We had more than 86 studies informing the values and preferences of patients on breast cancer screening, and it was clear—

[Translation]

Mrs. Dominique Vien: Ms. Thériault, I don't have much time.

You said you didn't know what more to say. Tell us why the United States, the Canadian provinces, all the witnesses we've heard, all the parliamentarians present... Some of us have been diagnosed or have had mastectomies. What do you say to those people today? You're not convincing anyone right now.

Dr. Guylène Thériault: I'm not here to—I'm sorry.

Mrs. Dominique Vien: Please go ahead.

[English]

Dr. Guylène Thériault: Madam Chair, I'm not here to convince anyone but to explain our process and how we make our recommendations. This is through a rigorous process of looking at the evidence.

As I said, we looked at all of the different types of studies and put all that together. We looked at the studies informing on the values and preferences of patients and put that together. The decision is not made by one person but by the task force as a whole, which can look comprehensively at all that data.

What I can say to a woman diagnosed in her forties—and I have had patients diagnosed in their forties—is that this is such an awful diagnosis to have. In my opening statement, I related to you the number. I told you that when we look at women ages 40 to 49 and screen them for 10 years, we see that one out of 1,000 will not die of breast cancer because she was screened. Maybe that was her. That's a possibility.

[Translation]

Mrs. Dominique Vien: Thank you. That's fine.

[English]

The Chair: Emmanuella, you have the floor for six minutes.

Ms. Emmanuella Lambropoulos: Thank you, Madam Chair.

Thank you to both of our witnesses for being here today to answer some questions.

I think I speak for Canadians when I say that the new guidelines were very disappointing for any woman or anyone who's at risk of getting breast cancer.

I have a couple of questions.

What efforts were made to ensure that the guidelines benefit all Canadians who are at risk of getting breast cancer equally?

You've spoken about looking at the evidence. Of course, the United States made a move based on their evidence. Why was their evidence or the evidence that they used not included? Also, from what we've heard, why aren't all Canadians or women living in Canada benefiting equally?

• (1220)

Dr. Guylène Thériault: Madam Chair, I will do my best to address the question.

We looked at every kind of evidence—randomized trials and observational studies of all kinds. We also commissioned a modelling exercise to inform our recommendation. We also looked at Canadian jurisdictional data. We incorporated statistics from Statistics Canada in our evidence review. We also had a one-month opening in the summer of 2023 for anybody who wanted to submit any document. We had a knowledge exchange in September 2023 and we did open for any further comments or documentation for more than two months this summer, in 2024.

I think all of this put together explains the way we tried to gather all perspectives from any interest holders in Canada.

Ms. Emmanuella Lambropoulos: Thanks.

Women at increased risk because of family history are recommended to begin screening and doing genetic testing earlier, but we heard witnesses today who said that a lot of women don't have access to their family history. A lot of women, specifically indigenous women living in Canada, do not have access to this history very often because of colonialism and because of the different disadvantages that they've had in the last decades.

Was this taken into account or considered? What do we say to these women who don't have access to that, yet are discovering that they have later stage cancer at an earlier age?

Dr. Guylène Thériault: Madam Chair, this gives me the opportunity to clarify what the guideline is about.

The guideline is not, as I said in my opening statement, about diagnosis but about screening. It's for people who have no symptoms. That's the first thing.

The second thing is that it's not about screening women at high risk. If you read the guideline, you'll see that we incorporated women at average risk and women at moderately increased risk. We define "moderately increased risk" as a woman having one first degree or two second degree relatives diagnosed after age 50.

Anything that's more than that or different from this is not considered “moderately increased”, but probably goes into the high-risk strata, for which we don't have a recommendation because that was not our mandate.

Ms. Emmanuella Lambropoulos: I have another question.

Why is women's choice of a mammogram taken into account when mammograms save lives? Why was there a disclaimer saying that this is the choice of the woman? It makes it seem like it's not really something that could help you prevent death.

Could you could just clarify that? I don't think there's that kind of an asterisk when it comes to men's cancers, so I'm wondering if you can share why you thought that was necessary on these guidelines.

Dr. Guylène Thériault: Madam Chair, it's so interesting that I can provide some precision on this aspect.

For each of our guidelines on cancer screening, we look at the balance between benefits and harms. One of the harms would be to have what's called a “false positive”, a term that we renamed as “additional testing with no breast cancer”.

The other harm is overdiagnosis.

When you look at the numbers for women in their forties that I provided in my opening statement, and which you can find very easily on our website, on the 1,000-person diagram, you see that if you screen 1,000 women aged 40 to 49 for 10 years, you will avoid one death from breast cancer in those 1,000 women. There will be 368 who will need to have additional testing, and two will be over-diagnosed. When we present those numbers to women—and when I say “we”, I'm not saying the task force, but the more than 86 studies on choice about breast cancer screening—we found that women in their forties may weigh the harms as greater than the benefit.

We did acknowledge that there are a lot of variabilities for that. Some women may want to be screened and others may not. That's why we made the recommendation that we made.

Dr. Donna Reynolds (Physician, Canadian Task Force on Preventive Health Care): If I may add, this is why breast cancer screening is a personal choice. Women need to know what the purported benefit is and what the harms are. They need to bring that into their values and preferences. There's no wrong answer; it is what's right for the women at that time.

The benefit in family medicine is that we don't see someone just once. If someone changes their mind or if they have additional questions and want to come back, that's fantastic. It's a dialogue.

• (1225)

The Chair: Thank you so much.

At this point, MP Larouche, you have the floor for six minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you very much, Madam Chair.

Ladies, I can confirm that the committee was eager to question you.

Ms. Caron, who was on the previous panel, said that there was a difference between available services and recommended services. Those words stuck with me, especially since they are related to our study.

You are here today, but the Standing Committee on Health also conducted a study on women's health. I've had discussions with my colleague Mr. Thériault, who sits on the Standing Committee on Health. I was part of the women's health study myself, and I know that the recommendation for screening from age 40 is in the report. Other committees have looked at this. We've heard that from a number of witnesses as well.

I'd like to ask you some questions from survivors or people living with cancer. Whom did you consult? Did you make sure that women with higher cancer rates were represented? Did you make sure representation was diverse? We talked about the difference between white women, Indigenous women, racialized women and African women. Women have different backgrounds and different baggage; some of them have a family history and some don't. Have you sought out diverse views from survivors or people living with cancer?

Dr. Guylène Thériault: Madam Chair, these questions allow me to talk about how we incorporate the views of patients and, in this case, female patients.

The task force on updating breast screening conducted its study on three patients, two of whom had experienced breast cancer. What I can say is that these patients were ethnically diverse. We also have a group, which is called—

[*English*]

Now I'm speaking in French. I'm so sorry. I want to speak in English.

[*Translation*]

Ms. Andréanne Larouche: You don't have to apologize for speaking French.

[*English*]

Dr. Guylène Thériault: I just want to make sure that what I say is well understood by my colleague.

We also have a group called the TF-PAN, the Task Force Patient Advisory Network, that we consult at different moments in our guidelines. There is a diversity of individuals on that task force panel. We have met with the Black Physicians of Canada to discuss our evidence synthesis, and we have also obtained data from Statistics Canada. We are happy that a study was published very recently so that we can share the data as it was analyzed by our group.

For example, in the case of Black women, we know that in their forties there is one more death per 1,000 persons. This is something we will surely incorporate in our upcoming tools and guidelines.

Dr. Reynolds, do you have anything to add to this?

Dr. Donna Reynolds: Yes, I think this is—

[Translation]

Ms. Andr anne Larouche: Ms. Reynolds, I would ask you to be brief, because I'd like to ask another question and my speaking time is limited.

[English]

Dr. Donna Reynolds: Certainly.

In terms of the new information that we received of cancer incidence and mortality by ethnicity, we had never had that before, and we are able to see that within Canada.

It's raised such important questions, and we're hopeful that this committee will be able to influence research into that area, because it is so important. In particular for us, the question is whether screening makes a difference on these types of cancers, and we do not know that.

• (1230)

[Translation]

Ms. Andr anne Larouche: By the way, I salute the interpreters, who are doing an exceptional job. We are lucky to be able to speak French and be understood by the whole committee.

That said, how do you respond? I tried to ask you a question about the diverse representation among those consulted by your task force.

In addition, both at this committee and at the Standing Committee on Health, we heard criticism that you lacked expertise in diagnosing women with cancer. What you just said seems to confirm that. There was also criticism of the frequent rejection of contributions by certain experts. Other contributions were considered outdated; they were simply set aside. Many people tried to contact you to offer their expertise. That was heard at both committees. Some experts confirmed that their studies and expertise were set aside.

Please answer in 30 seconds.

Dr. Guyl ne Th riault: Madam Chair, I thank the member for the question. I will answer in French.

As I explained, there was cultural diversity both among the members of the Canadian Task Force on Preventive Health Care and among the patient group involved. As for expertise within our group, four experts took part in our work from start to finish. There was an oncologist, a radiation oncologist, a radiologist and a surgeon.

As I previously stated, in the summer of 2023, for one month, we allowed anyone who wanted to send us information or studies to do so. In September 2023, we shared our knowledge. Afterwards, for over two months, we were able to receive comments, references, and so on, to improve our conclusions or recommendations.

[English]

The Chair: Thank you.

MP Gazan, you have the floor for six minutes.

Ms. Leah Gazan: Thank you, Chair.

How did you pick your research subjects? Actually, let's start with how many people were part of the research study. How many subjects were there? Just a number....

Dr. Guyl ne Th riault: Madame Chair, I'm unsure of what the question is exactly. Is it, how did we pick the topic? This is an ongoing process, and Dr. Reynolds can speak to that. It is an open—

Ms. Leah Gazan: I'm sorry, but I don't have a lot of time. How did you pick the people who were involved in the study?

Dr. Guyl ne Th riault: We don't do studies. We do systematic reviews of studies. We did three systematic reviews of studies—

Ms. Leah Gazan: Yes, but how many subjects were based on that review? What was the population sample?

Dr. Guyl ne Th riault: Do you mean the population sample of the studies? Is that what you mean?

Ms. Leah Gazan: Yes.

Dr. Guyl ne Th riault: As you already know, and we know, the majority of the women in the studies we looked at were of white ethnicity, and this is something we have said in our recommendations that we have—

Ms. Leah Gazan: Okay. Thank you.

Ninety-eight per cent of the subjects you based your research on were Caucasian. I say that because you spoke today about values and preferences. We know there are higher rates of cancer diagnosis or younger diagnoses for Black, Hispanic, Asian and indigenous women.

The U.S., in fact, recommended early screening at 40. Some researchers have recommended the age of 25 for Black women. In terms of making a recommendation for screening, how did your study take into consideration more at-risk populations?

Dr. Guyl ne Th riault: Thank you for this question, Madame Chair and members of Parliament.

We did look at statistics from Statistics Canada, which were provided to us and are now published, so you can access them. What you can find in this report of Canadian statistics is that actually most women who are non-white have a lower incidence of breast cancer in Canada. Some have the same, so there's no statistical difference, but most of them have a lower incidence. The ones we see who have a higher incidence are Filipina and Arab women. Black women don't have higher incidence—

• (1235)

Ms. Leah Gazan: Can I pose a question here?

Dr. Guylène Thériault: Sure.

Ms. Leah Gazan: Part of the issue is access to screening. We've heard from several witnesses that many indigenous folks, for example, don't go to get screening or health care due to colonization and ongoing systemic racism within the health care system. Did your study take those historical factors into account when it made the observation that indigenous and Black women have lower rates of cancer? Was that part of your research, yes or no?

Dr. Guylène Thériault: Just to be clear, we don't do research. We use research to inform recommendations.

Ms. Leah Gazan: Did that research then inform your recommendations?

Dr. Guylène Thériault: Yes, it did. The research was just published by Dr. Wilkinson, which you heard about. It showed that there is a lower incidence of cancer in most racial ethnic groups except for Filipina women, Arab women and women who identified as multi-ethnic.

Ms. Leah Gazan: Yes, but did that research inform your recommendation to have a screening age of 50, yes or no?

Dr. Guylène Thériault: If we took that—

Dr. Donna Reynolds: If I may—

Dr. Guylène Thériault: Yes, go ahead.

We did have this information prior to their publication, and it did go into our deliberation.

Ms. Leah Gazan: For example, “In the U.S., it was noted that in Black, Hispanic and Asian women, breast cancer peaks at an earlier age of 40 when compared to white women. Recent Canadian analysis shows that Caucasian women are the only group whose peak incidence is greater than 50.”

That was by Dr. McKerlie. Is her information inaccurate? It conflicts with what you're sharing here today.

Dr. Guylène Thériault: I could share the data. I mean, you have to....

We have read the study, and what we find is that the median age of breast cancer diagnosis for Black women is 56, compared to 63 for white women.

Ms. Leah Gazan: She goes on to say that, “The task force was aware of this recent yet-to-be-published paper from Statistics Canada” in terms of this research, “but did not lower the screening age.”

You were aware of this research for Black, indigenous, Hispanic and Asian women. What was your reason, being aware of the research, not to lower the screening age? You were aware of it.

Dr. Guylène Thériault: Madam Chair, I will try to just repeat it. Maybe Dr. Reynolds can do a better job at this.

We were aware of this information, and as I said, most racial groups in Canada have either no significant difference in incidence of breast cancer from white women or a lower incidence, except for women who identify as multi-ethnic, Filipina and Arab, but this does not translate in increased mortality. What we know about increased mortality is that for Black women in their 40s, there is one more per 1,000 women.

As I said, we in the task force will all ensure that this information is even more prominent in our documentation. It's already there. We're going to make sure it's even more prominent in our documentation.

The Chair: Thank you.

We would like to begin the second round.

Anna, you have the floor for five minutes.

Mrs. Anna Roberts (King—Vaughan, CPC): Thank you, Madam Chair.

I'm getting a little concerned about some of the comments that we've heard here.

I want to recognize Carolyn Holland in the room, who's a survivor.

As my first question, do experts vote on the guidelines? If they don't, why not?

Dr. Guylène Thériault: Dr. Reynolds, do you want to take this?

Dr. Donna Reynolds: Certainly.

The task force follows internationally accepted standards for our methods. When we're looking at experts in their roles, the recommendations are to have them as non-voting members. The reason for that is that what they see and how they see it is very different. They see people with disease, as opposed to family physicians and primary care. We see the entire population.

Specialists or experts tend to recommend interventions at a much higher rate and more frequently than independent panels. The evidence definitely supports that.

As a result, our experts are non-voting members, as per standard guidelines—

• (1240)

Mrs. Anna Roberts: I'm sorry to interrupt; I have limited time.

I just want to say that Carolyn was diagnosed at the age of 40, I believe. She's here today because of the early diagnosis.

We heard earlier from a witness, Dr. Daniel, who said that Black and indigenous communities struggle with getting a diagnosis. There was an indigenous woman who was diagnosed. She found a lump at age 22, and was put off. She was told to go home and take some T3, because it was just pain. At age 24, she went back, and sure enough, it was breast cancer.

Here's my question. I come from a financial background, and if someone came to me for a mortgage because I was an expert in that field, I would be better equipped to diagnose and understand what their needs are.

I go to my family doctor. I recently had knee surgery, and she had to direct me to a specialist. Why do we not have specialists on this task force who understand that women's lives are vital and important to the community?

Dr. Donna Reynolds: Through you, Madam Chair, thank you.

The task force, as you know, provides recommendations for a broad array of topics, with breast cancer being one of them. In guideline development, it is recommended that those to whom the guideline is directed—for us, it's primary care—be the constituents of that panel. The experts have a perspective that differs from primary care. Theirs is completely valid in their realm of practice, and our perspectives are equally valid in our practice.

Mrs. Anna Roberts: I'm going to state something from one of our witnesses earlier. We had testimony that the Canadian task force argues that screening at 40 causes unnecessary stress that comes from callbacks. However, in the case of a life-threatening, ulterior diagnosis that affects your physical, mental and emotional health, while it was stressful waiting for the results from the biopsy, it would have been even more stressful and downright dangerous to delay screening and a possible diagnosis.

I'm sorry to disagree with you both, but I think women's lives are important and I think we need to revamp this task force to ensure that we have individuals on the task force who understand that I'm a woman and I can handle it. I can handle that news. I don't mind being called back if it means I'm going to be alive to tell my children and grandchildren that I survived breast cancer.

I'm not trying to put you guys down. I don't know where you're getting your research, but all of the evidence points to what the witnesses we've had said about how breast cancer must be diagnosed early in order to save lives.

If there's history in the family of breast cancer, why are we waiting?

Dr. Donna Reynolds: If I may....

I'm sorry. Go ahead, Dr. Thériault.

Dr. Guylène Thériault: Madam Chair, am I allowed to answer this?

The Chair: Yes.

Dr. Guylène Thériault: As I said, we're both clinicians. We have dealt with numbers of cases of different kinds of cancer, so we feel this.

The message we put forward is that breast cancer screening is a personal decision, and it is based on values and preferences. There are benefits. I will say that out of 1,000 women aged 40 to 49 who are screened for a decade, one will avoid a breast cancer death because of it, but there is also additional testing showing no cancer and there's overdiagnosing—

The Chair: Thank you very much.

Unfortunately, I have to cut you off there. Thank you very much.

Next I'd like to welcome MP Hepfner. You have the floor for five minutes.

Ms. Lisa Hepfner: Thank you, Chair.

Thank you, Doctors, for being here to answer our questions today. I know you've been under some intense scrutiny as part of your role with this task force.

I was also going to ask about the lack of subject matter expertise on the panel, because we heard from a lot of witnesses who came to us that you didn't have any experts in radiology, oncology or other areas, specifically of breast cancer, on the panel. You've answered that partially. If you have more to add, please do.

In particular, I spoke with one radiologist who specializes in breast cancer. She said she had an opportunity to review the findings of the panel, but if she was going to do so, she would have had to add her name to the document, and then she would not have been able to take her name off the document if she had disagreed with the findings. She said subject matter experts were staying away from consulting with the task force because they couldn't have a say on whether they agreed with its findings or not.

What's your response to that?

• (1245)

Dr. Guylène Thériault: Madam Chair, there's a lot to answer in that, but I've already explained that we had four experts in the working group from the beginning to the end. They were oncologists, radiation oncologists, radiologists and breast surgeons.

You can find on our website all the comments that have been made on our systematic review and our answers to them. There are not many groups that do that and are transparent like this, putting forward publicly all that we've received and all the answers we've given to these comments. We will continue to be transparent.

For the other part of the question, I don't know if Dr. Reynolds wants to comment.

Dr. Donna Reynolds: Transparency is so important. We want to have clinical experts and subject matter experts to be able to provide their input, but they also have to be transparent about it. We say putting their names on it does not mean that they agree with the recommendations, but we have to be transparent that they provided input into it. Otherwise, we would be hiding something, and we're not doing that; we're a transparent organization.

These are principles of good guideline development that are consistent with our best practice methods.

Ms. Lisa Hepfner: Thank you.

I also spoke with a group of experts in cervical cancer, and I believe there are screening guidelines coming up for them. Are you the same group? Will you change any of your task force or any of your methodology, given the history for breast cancer, when it comes to cervical cancer?

Dr. Guylène Thériault: Madam Chair, the task force does make recommendations on different screenings, and yes, cervical cancer screening is one of the topics.

It is ongoing. We have experts involved in the process. As we do all the time, we send all of our documents—such as the protocols, the systematic reviews and the guidelines—to interest holders. All of these people can participate and give comments, and we will answer these comments and make that public, yes.

Ms. Lisa Hepfner: Okay. Thank you.

Dr. Thériault, I think one of the reasons this issue got so heated early on, before you even came out with the recommendations, is that you were getting into social media fights with survivors and other experts. How is that helpful?

Dr. Guylène Thériault: You could read all my posts....

I don't know how to answer that, Madam Chair. I'm sorry I didn't address you first.

You can read all my posts. I don't think I got into any fights, but I would have put forward little things. For example, they would say that breast cancer screening in your forties would reduce breast cancer death by 50%. I would put forward that, while this is what we depicted, from two deaths out of a thousand to one out of a thousand, that's 50% less. This is the extent to which I intervened—to give some factual data that is easier to understand for patients.

Ms. Lisa Hepfner: Okay. thank you.

When you talk about breast cancer screening being a personal choice for women, do you think that's taking into account the barriers that many women face, such as not having a family doctor, not having access to your family history, not necessarily knowing or growing up with the notion that you have to check yourself?

Dr. Guylène Thériault: Madam Chair, this gives me the opportunity to talk about all that we're planning to do to ensure that our recommendations can be implemented and reach as many women as possible.

We have the guidelines. We have the 1,000-person tool that can foster discussion with a primary care provider. We had, in the past, a real, shared decision-making tool that we're looking into implementing. We are looking into creating videos and also an interactive tool online for women so that they can access the information in absolute numbers in a transparent way that applies to them and be empowered to make a decision that aligns with their values and preferences.

• (1250)

The Chair: Thank you very much.

Andréanne, you have the floor for two and a half minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

Ladies, did you receive the letter sent by the committee in July, containing four observations related to the recommendations?

The first observation is that the task force should lower the recommended age in the Canadian breast cancer screening guidelines for those at average risk for—

[*English*]

Ms. Pam Damoff: On a point of order, I'm not getting any translation, Chair.

The Chair: Okay, we'll pause your time for a minute, Andréanne.

Dr. Reynolds, I see that you're not getting any translation either.

We'll just suspend for a quick minute while we work out the translation.

• (1250)

(Pause)

• (1250)

The Chair: We will resume as before.

Andréanne, you still have two minutes left.

[*Translation*]

Ms. Andréanne Larouche: I was saying that the first observation was that the task force should lower the recommended age in the Canadian breast cancer screening guidelines—

• (1255)

[*English*]

Mrs. Anna Roberts: I'm not getting any translation.

La présidente: Is it coming across in French?

An hon. member: Yes.

The Chair: Okay.

Andréanne, could you please...?

[*Translation*]

Ms. Andréanne Larouche: Are you asking me to do a test?

I will check, but I find it peculiar that I can't finish my remarks just as I'm getting to my question.

I don't speak that quickly, but I'll keep going.

[*English*]

The Chair: Okay. That's perfect.

[*Translation*]

Ms. Andréanne Larouche: Madam Chair, I'm wasting time and I'm being penalized by having to repeat what I've already said.

May I have my two and a half minutes back, please?

The Chair: Yes.

Ms. Andréanne Larouche: Thank you.

I will therefore ask the representatives of the Canadian Task Force on Preventive Health Care whether they did indeed receive the letter that the Standing Committee on the Status of Women, or FEWO, sent them in July. It contained four observations, which I will now reread.

Observation 1

The Task Force should adjust the recommended breast cancer screening age for individuals of average risk to include 40 to 49 year olds in Canadian guidelines, to reflect the latest evidence and specialized expert opinion.

Observation 2

The Task Force should consider the testimony received during FEWO's meeting on June 11, 2024, and undertake a full review of all other recommendations contained in the Breast Cancer (Update)—Draft Recommendations (2024) to ensure that these are inclusive, informed by relevant feedback from the public comment process, by the most recent research and evidence, and reflect modern medical technology and treatment advances.

Observation 3

The Task Force should ensure that the process of public comment on the Breast Cancer (Update)—Draft Recommendations (2024) is transparent and the results of this process are made public to facilitate accountability.

Observation 4

The Task Force should amend the Breast Cancer (Update)—Draft Recommendations (2024) to ensure that women with dense breasts receive annual mammograms and are offered additional MRI or ultrasound screening.

What do you have to say about that letter and the four recommendations we sent you?

Dr. Guylène Thériault: Madam Chair, thank you.

I can tell you quickly that we responded to that letter in detail. You can find more explicit answers in it than what I can provide in a short time.

We looked at the most recent data. Our systematic review goes back to the summer of 2023. All the most recent observational data, including data from the major Canadian study you heard about, are therefore included.

Ms. Andréanne Larouche: It is true that you responded to that letter, but understand that what we've been hearing since we resumed this study is not in line with what was recommended by the experts and witnesses we heard from. That is why we sent you this letter last July.

I don't think your answer takes into account what we've been hearing since then.

[*English*]

Dr. Guylène Thériault: Madam Chair, I don't know if I should say anything to this. Is that a question?

The Chair: At this point, I'll pass the floor to MP Gazan.

You have the floor for two and a half minutes.

Ms. Leah Gazan: Thank you so much, Madam Chair.

I want to go back to what I was talking about in terms of samples, because I know you based it on other research, and all research is based on samples.

I'm going to read another quote by Dr. McKerlie. It was in the letter we sent.

She said that not only were the studies that were prioritized during the development of the draft recommendations out of date, but they also used a sample population composed of 98% white women. That means you would have known.... I would assume that if you were looking at research, you would want to know what the sample in your research was.

I want to go back to something you said about what you found with Black and indigenous women, which was that only Filipina women had higher rates. How can you state that finding, when only 2% of the sample in the data collected were non-Caucasian women?

Don't you agree with me that's too small a sample size to base an overall recommendation on for screening?

• (1300)

Dr. Guylène Thériault: There are two questions in there.

One of them is that we prioritized studies that were out of date. We had a comprehensive review. We looked at studies that were old but also very recent observations as well—

Ms. Leah Gazan: I'm asking about the sample.

Were you aware that 98% of the sample you were looking at in the research and the data collected were Caucasian women?

Dr. Guylène Thériault: Madam Chair, I think I answered that question before.

About the Filipina reference, I just want to make sure that we're well understood today. The data that I gave was not just Filipina but Arab, Filipina and multi-ethnic. It's not from the study—

Ms. Leah Gazan: How much of the sample...? I'm sorry, but I don't have a lot of time.

All the expert witnesses who have come here have indicated that 98% of your sample size were Caucasian women. That means 2% were "other" in the data collected, the sample on which you based your recommendation. This is deeply troubling—

Dr. Donna Reynolds: Maybe I can take this—

Dr. Guylène Thériault: Sure—

Ms. Leah Gazan: Sorry; I'm going to finish.

This is very troubling, because you spoke about how you were trying to reflect the values and preferences of your subjects in the recommendations, yet you don't know the sample. Is that what I'm hearing?

Dr. Donna Reynolds: What you're hearing is that there's no evidence for those people.

What we're trying to get across is that we need—

Ms. Leah Gazan: I'm going to stop you there. There's no evidence on these people, so your recommendations, then, did not take into account Black people, indigenous people and people of colour.

Dr. Guylène Thériault: I would respectfully, Madam Chair, say to just go and look at our tools. It is mentioned. We have a mention of the increased deaths in Black women. It is mentioned. It's all there. What we know is there.

The Chair: Thank you very much.

At this point, Laila, you have the floor for five minutes, please.

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

I want to thank you guys for taking the time to come here.

I think it's pretty clear at this point that Canadians don't trust what you've put out. Canadian women shouldn't trust what you've put out. In fact, most provinces have decided that your guidelines aren't worthwhile and have changed their guidelines on their own.

The biggest comparison to our country is the United States, and they've lowered it to 40. You've completely ignored anything they might have decided as to why they've done that.

Here you've been continually trying to say that the harms from breast cancer screening outweigh some women living. This is incredibly concerning. Effectively, the harms that you've been able to describe to us at this committee are anxiety. Frankly, women can handle anxiety.

I've had to live most of my life—in fact, my entire adult life—without my mom because my mom got breast cancer and died at 49 years old before cancer screening would have allowed her to potentially catch that cancer. She might be here today had she found her cancer before it was at stage 4, when virtually every option was closed to her. She lived 11 months after she was diagnosed with stage 4 breast cancer.

I will not accept that anxiety and false positives are somehow the same as women dying.

Just based on rough math, one person will die. That means 400 additional deaths. Your study is saying it's okay because only 400 women will die. I don't know if anyone around this table is okay with an extra 400 women dying because the stress and anxiety are too much.

What do you have to say to these women and the families of these women who are having to now live with that?

Dr. Guylène Thériault: Madam Chair, I will start answering that, and then Dr. Reynolds will continue.

Our recommendation doesn't say that harms outweigh the benefits or benefits outweigh the harms. Our recommendation says that women can be and should be empowered to have the information about the benefits and harms to take the decision that aligns with their values.

Dr. Reynolds, do you want to add to that?

Mrs. Laila Goodridge: Your data also says that you don't think women between the ages of 40 and 50 should get screening, because you've decided that the benefits don't outweigh the harms, and therefore this is the conversation we're having around this table. We've had the same conversation around the health committee table. We're now having it at the status of women committee table.

We're wondering how we've had witness after witness—experts—come in here and say that this is not working, and yet you are standing with this. The health minister went to extraordinary lengths and even wrote saying that he was disappointed with your findings, and you're standing here before our committee saying that

this is all okay and you stand by your findings. How do you stand by your findings?

• (1305)

Dr. Guylène Thériault: Madam Chair, our role is to look at the evidence and to put all the evidence together to come up with a recommendation. That's our first role, and that's what we have done.

Mrs. Laila Goodridge: We very clearly heard that the evidence is sorely lacking. Women's health does not get the appropriate amount of research compared to other types of health. Of course, there might not be enough evidence.

When the United States has decided that it's worth lowering cancer screening down to 40 and most provinces have decided that it's worth it, why are you so intent on standing by clearly flawed evidence, rather than potentially thinking that women's lives are worth it?

Dr. Donna Reynolds: Dr. Thériault, maybe I can step in.

Dr. Guylène Thériault: Yes, go ahead, Dr. Reynolds.

Dr. Donna Reynolds: These recommendations are conditional. They're conditional on the values and preferences of individuals.

We are not saying, "Don't. Everyone, do not." We are saying not to do systematic screening for ages 40 to 49; we are saying to inform women about the benefits and harms and let them decide.

Mrs. Laila Goodridge: You are also saying that women under 50 shouldn't get screened, which means people like my mom die. That's the reality. That is the absolute reality.

Because she was under 50, my mom was not eligible to get a mammogram until she found a lump. My mom has been dead for nearly 15 years. That's the reality. That is what we're dealing with right now.

Dr. Guylène Thériault: I hear your pain. It's obvious. I hear your pain at this moment.

If you read our recommendation—

Mrs. Laila Goodridge: It is beyond pain.

You are not taking into account anything to do with the women who have had to go through additional chemo, radiation, surgery and all the rest of it. You are not taking into account any of the additional harms that come with later-stage diagnosis.

I'm sorry. I'm not just angry about my mom; I'm angry about every single woman whose life is impacted because this screening guideline has failed. This is flawed. I'm angry because there are families who have lost loved ones because you refuse to accept that your evidence is flawed and perhaps your answer needs to change.

You came to this committee, continued down that path and doubled down. Do you know what? Everyone around this room does not like what you've said and we do not agree with what you've said.

The Chair: Thank you.

Sonia, you have the floor for five minutes.

Ms. Sonia Sidhu: Thank you, Madam Chair.

This committee heard from doctors Jean Seely and Anna Wilkinson that screening women from age 40 would save our health system over \$400 million every year. It is a big amount. It is a big burden on the health care system.

Did the task force consider these savings in its analysis of the benefits of the screening?

Dr. Guylène Thériault: The method of the task force is really to look at the benefits and harms for the individual person. We have a section in which we do look at implementation and cost-effectiveness, but it's not the basis on which we make our recommendations.

That is....

Yes, go ahead.

Ms. Sonia Sidhu: Dr. Reynolds, several witnesses have told us that your task force ignored and dismissed input from experts.

One of them, Jennie Dale, said that “experts were excluded from voting on the guidelines” and that the task force publicly “cast doubt” on those experts' integrity.

What do you have to say about this?

Dr. Donna Reynolds: Through Madam Chair, I think it came to me, Dr. Thériault. I will be pleased to pass any additional questions or issues to you.

We included experts on the working group. We included experts—a radiologist, a radiation oncologist, a medical oncologist and a breast surgeon—on the working group from start to finish. They were intimately involved with the guideline, along with our patient partners, throughout the process.

The idea that we did not include experts in this guideline is false, plain and simple. It's false.

• (1310)

Ms. Sonia Sidhu: We heard repeatedly in this committee about breast density as a risk factor of cancer, yet the task force gives women with a high breast density the same recommendation when it comes to screening as women at lower risk in their age bracket.

Why didn't the task force highlight the difference and the benefit of screening?

Dr. Guylène Thériault: Madam Chair, referring to our tools, you can see that we did highlight the potential higher benefit for women with dense breasts. It is in our tool. We said there were 1.9 deaths averted instead of one, based on one study of higher risk.

The other thing is that we looked at whether we should screen women with dense breasts differently. We looked for studies that said whether we should add ultrasound or MRI. As the U.S. found

in May 2023, there is no such study to inform patient-oriented outcomes.

Ms. Sonia Sidhu: Dr. Thériault, in our first panel, we heard from Dr. Caron earlier today that the residential school system disconnected many indigenous women from their family history. This makes it impossible for them to get the normal risk assessment for breast cancer. Doesn't this constitute a barrier to access to screening for indigenous women?

Also, my colleague raised the issue of the 98% and the 2% of the data. I'd just like an answer for that. How are you accounting for that?

Dr. Guylène Thériault: It is unfortunate for all those women who don't have this information. The answer is not easy, because they might be at high risk, and this is not covered by our guideline. They might be at a moderately increased risk, and we have the numbers to inform those women, but if they don't know, I realize it's very difficult. I understand that.

Regarding the 2% and the 98%, we did include the most recent observational studies. This has changed. I don't know the numbers by heart, but I could surely transmit them to the committee, if you want, about the most recent observational studies. That's why we asked Statistics Canada to provide any information they had about breast cancer and the diverse ethnicities in Canada.

Dr. Donna Reynolds: If I may quickly add something about the dissemination of information, it is not just the task force; we've learned that some provinces are now looking at how to provide the information on benefits and harms so that women can be informed.

There are multiple cancer agencies that we look to as well that have wonderful communication abilities to be able to get these messages out so that women can be informed and decide for themselves.

The Chair: Thank you very much.

Thank you, MP Sidhu.

From the position of chair, I would like to pose one question for, more or less, for just a yes or a no.

Is there any consideration that will be given to changing, editing or revisiting any of your guidelines?

Dr. Guylène Thériault: Madam Chair, we have a process of reviewing guidelines every year with a quick overview. Maybe I'll let Dr. Reynolds speak to that, because she knows more about that process.

The Chair: Just in the interest of time, tell me “yes”, “no” or “possibly.”

Dr. Guylène Thériault: We always review.

Dr. Donna Reynolds: Yes, always, and we look forward to the public comments from all the other sources that we're having in to make sure that it's meaningful.

The Chair: That's perfect.

This concludes our second panel.

On behalf of the committee, I would certainly like to thank both of you for your presence here today and for providing some answers to some questions. Thank you. You can excuse yourselves. I really appreciate your coming today.

For the members in the room, I mentioned that we had some housekeeping items. I know we're tight for time, because it is already a quarter after. There are just a couple of things.

The drafting instructions for breast cancer were intended to be this coming Wednesday. That's now going to be bumped until December 4 to allow for the extra meeting on December 2.

In addition to that, we have an informal meeting request from a delegation of women parliamentarians from the Ukrainian parliament. That request was shared by the clerk on November 7. The delegation is visiting Ottawa, and they've asked to meet with us for an hour in the afternoon of Wednesday, November 27. They have a jammed schedule that day, but they have a window of time of one hour available that fits during our committee meeting. Does the committee agree to have the delegation come from 4:30 to 5:30?

Okay, that's a yes.

In addition, the new study on violence targeting the 2SLGBTQI+ community was slated to begin on November 27, but now we're accommodating the Ukrainian delegation and we've added the breast cancer study, so we will be starting that a week later than we had intended. Is that fine?

It is. Okay.

Next, does the committee agree that we will defray the hospitality expenses that are related to the informal meeting? We can just go from one to the other.

Okay. Thank you for that.

To conclude, since the study of violence targeting the 2SLGBTQI+ community is beginning a little bit later, we're going to have to extend the deadline for the briefs on that. We learned earlier that we want to ensure we have enough time for the briefs, so can we delay the briefs to Wednesday, December 11? Our deadline currently is December 2.

We're just bumping things back. We will send an updated schedule to everyone. I know there have been some changes, but I wanted to make sure that we were certainly agreeable with the delegation coming, because that was the malleable piece that was going to be changing things.

Okay. That's awesome.

Is there a motion to...?

MP Damoff, go ahead.

• (1315)

Ms. Pam Damoff: You said that the Ukrainian delegation was on November 27 from 4:30 to 5:30, so is that meeting only going to be one hour?

The Chair: No, we'll do a second hour with.... I'll have to check to see what's on the schedule. There will be a full two-hour meeting, but one hour of it will be with the delegation.

Ms. Pam Damoff: I'm asking because you had said that we were supposed to start the 2SLGBTQI+ study on that day, and we couldn't. I'm wondering what we have planned for the other hour.

The Chair: Let me take a quick look. I know we bumped the breast cancer study, so....

I will circle back to you, MP Damoff and the other MPs, on whether it's the breast cancer study or additional witnesses from the other.... There are some changes because of what's happened here today, but I can confirm with everyone what the next step is.

Ms. Pam Damoff: Okay. Thank you.

The Chair: Thank you.

The meeting is adjourned.

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