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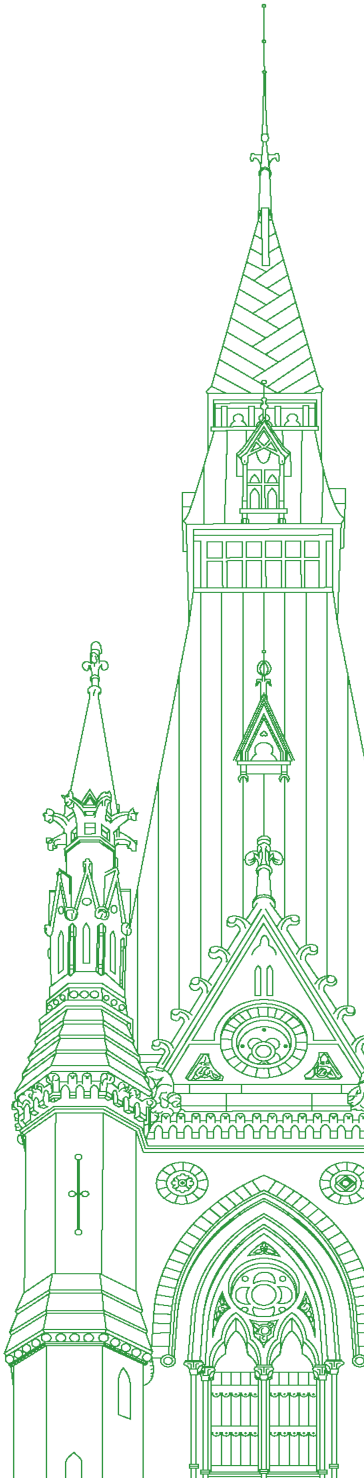

Chair: Mrs. Shelby Kramp-Neuman

Standing Committee on the Status of Women

Monday, October 21, 2024

● (1105)

[*English*]

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

[*Translation*]

Welcome to meeting number 125 of the House of Commons Standing Committee on the Status of Women.

[*English*]

I remind all members of the following points: Please wait until I recognize you by name before speaking, and all comments should be addressed through the chair.

[*Translation*]

Thank you 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 continue its study of breast cancer screening.

Before we begin, I 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.

Welcome to our witnesses.

Appearing as individuals we have Dr. Anna Wilkinson, medical doctor; Julie McIntyre, by video conference; Dr. Paula Gordon, clinical professor of radiology, by video conference; and Dr. Shiela Appavoo, radiologist, by video conference.

From Breast Cancer Canada we have Kim MacDonald, patient advocate. From Breast Cancer Action Quebec we have Jennifer Beeman, research and advocacy adviser, by video conference; and Milena Gioia, coordinator, programs and advocacy, by video conference. From the Quebec Breast Cancer Foundation we have Karine-Iseult Ippersiel, president and chief executive officer.

We begin with opening statements.

Dr. Wilkinson, you have the floor for up to five minutes.

Dr. Anna Wilkinson (Medical Doctor, As an Individual): Thank you.

I'm a family doctor and a GP-oncologist. I work with Statistics Canada and the Canadian Cancer Registry to look at real-life cancer outcomes. I have a unique vantage point to understand the impacts of breast cancer screening recommendations across our entire health care system.

My research with Statistics Canada has focused on breast cancer in women in their forties. We found the incidence of breast cancer in these women has increased almost 10% in recent years and that women with access to organized breast screening programs have an earlier stage at diagnosis and significantly increased survival. We've also found that women in their forties have more aggressive subtypes of breast cancer, where the survival for cancers diagnosed beyond stage 1 drops off dramatically.

We've shown that the peak age for breast cancer diagnosis among white women is 65, but for women of other races and ethnic groups, it's typically before 50. These same women have significantly more advanced stage cancers at diagnosis. This work has been done in spite of the fact that our national cancer data has significant gaps that limit our analytical abilities.

We've established that the costs of breast cancer treatment rise exponentially with later stages of diagnosis. Our cost-effectiveness analysis has shown that screening at age 40 saves lives and saves our health system half a billion dollars annually, as it's so much more expensive to treat advanced cancers than it is to do screening.

I was an invited expert on the evidence review for the 2024 breast cancer screening guidelines, an experience that highlighted critical flaws in the process. The task force ignored our expert recommendations, with the end result being that the benefit of screening was minimized. The task force dictated the terms of the evidence review, mandated the use of old studies and insisted on too short a time frame to show the full benefits of screening. It determined the benefit of screening in women 40 to 49 by extrapolating the benefit from older women, even though trials looking specifically at women 40 to 49 showed higher benefits, in the range of 44% to 57% mortality reduction. It did the same with dense breasts and family history; it merely extrapolated the benefits observed in average-risk women. The task force had access to race and ethnicity data from StatsCan but did not act on the age of earlier diagnosis in all women other than white. We experts voiced our concerns in a limitations document, which was ignored.

Even if we use the task force bias and minimize mortality benefits of only one death averted per 1,000 women screened over 10 years, this amounts to over 2,500 deaths of 40-year-old women. This number somehow did not reach their threshold of significance, a threshold that seemed inconsistent between guidelines. The real number of deaths, based on modelling, is threefold or fourfold higher.

Concerningly, the 2018 task force 1,000-person tool, which Canadian family doctors used for six years to counsel their patients, contains serious errors. The 2018 tool notes that there were seven cancers per 1,000 women, while the 2024 tool now states that there are 19 cancers per 1,000 women. The 2018 number was incorrect. The 2018 tool used an overdiagnosis rate of 48%, while the 2024 review found this number to be 3%. These incorrect numbers caused the 2018 tool to show a minimal benefit of screening. The task force misinformed Canadian family physicians and their patients for years with the very tools designed to facilitate shared decision-making and with no apparent explanation.

The task force is a venerable institution, and busy family physicians use its guidelines to inform discussions with patients. Despite provincial practices, the task force recommendations matter. They cause family physicians to dissuade patients from screening or to not even broach the topic. They create confusion, as their recommendations are often different from specialist guidelines. They create an unconscious bias that younger women don't get breast cancer. The task force drives inequities as provinces institute different programs based on their own interpretations of the evidence.

Disturbingly, the issues we face with breast cancer guidelines are just the tip of the iceberg. We hear about breast cancer, as there are passionate advocates placing these issues front and centre. Similar outdated and nonsensical recommendations exist for lung and cervical cancers and in many other realms, broadly impacting women's health.

We must have a transparent guideline process that is nimble and responsive and reflects current evidence. Our national guidelines should be unifying and effectively incorporate Canadian subject matter expertise. We should strive for guidelines that remove barriers to accessing care, embrace an individual's autonomy to make decisions about their own health, and support equitable access to life-saving cancer screenings.

● (1110)

Thank you.

The Chair: Thank you for your testimony.

At this point, I would like to welcome Ms. McIntyre.

You have up to five minutes.

Ms. Julie McIntyre (As an Individual): Good morning.

Thank you, members of the committee, for your efforts to protect women's health and save lives, and for the opportunity to share my story.

A year ago today, I had just finished my eighth and final chemotherapy treatment and was a few days away from my 50th birthday—ironically, the age at which I would be eligible for a screening mammogram as per the task force guidelines. I am only one of the many Canadian women who have a more advanced stage of breast cancer because of the outdated and flawed task force breast cancer screening guidelines.

My name is Julie McIntyre. I am a mom, a wife, a daughter, a sister, an aunt and a high school teacher, and in February 2023 I became one of the one in eight women diagnosed with breast cancer. I was 49 and thought I was in good health. I ate well, exercised, was rarely sick and had no direct family history.

In January 2023, I found a lump in my breast. I periodically examined my breasts—nothing formal, just enough to know my normal. I cannot imagine if I had followed the task force guidelines, which advise against self-examination, because I would not have recognized the change. I soon went to see my doctor, who sent me for both a mammogram and an ultrasound. I learned that I have category D dense breast tissue, which increased my risk for breast cancer.

I had never heard of breast density and its associated risk until my diagnosis, because my first mammogram took place after finding my lump at 49. The task force recommends breast screening starting at 50, and since breast density can be determined only by a mammogram read by a radiologist, many women in their forties, like me, are unaware of their breast density, the increased risk it can carry for breast cancer and the importance of additional screening. I am very grateful to have had an ultrasound along with my mammogram, because it identified an area of concern that was later biopsied. Two weeks after the biopsy, we were given the devastating news that I had breast cancer: invasive lobular carcinoma.

The first step in my treatment was surgery—a mastectomy—in April 2023. What was expected to be a two-centimetre tumour from pre-surgery imaging turned out to be six centimetres in size. It was three times larger, along with a second much smaller tumour. This larger-sized tumour placed me at a more advanced stage, and my treatment plan would require chemotherapy.

I was angry and upset in thinking about how much further advanced my cancer would have been if I hadn't self-examined, if I hadn't been able to get to my doctor and if I hadn't had both a mammogram and an ultrasound, but also about the fact that if I had entered a screening program at the age of 40, had been informed of my breast density and had been regularly screened, my cancer might have been caught earlier, and I would have been spared some of the harsh side effects of aggressive treatment. Most importantly to my family and me, I would have had an overall better prognosis. The evidence shows that early detection leads to a better prognosis and survival outcomes. After surgery came eight rounds of chemotherapy, 15 rounds of radiation, and hormone therapy, which I will be on for five to 10 years—perhaps longer.

The Canadian task force argues that screening at 40 causes unnecessary stress that comes with callbacks. As someone who has lived through breast cancer, there is no comparison to the stress and anxiety that accompany a cancer diagnosis: the deep heartache and gut-wrenching pain that come with telling your children their mom has cancer and telling your spouse and your parents; cancer treatment in the form of surgery, chemotherapy, radiation, medication and all of their side effects; losing your hair and parts of your body; side effects from medications to prevent recurrence; and living with the fear of recurrence and metastasis and wondering if every new pain is a sign that the cancer has spread.

It is a life-altering diagnosis that affects your physical, mental and emotional health, and while it was stressful waiting for the results from the biopsy, it would be even more stressful and downright dangerous to delay screening and a possible diagnosis.

I am so grateful that many provinces allow women to self-refer for mammograms starting at age 40 or 45—this will save lives—but I remain deeply concerned about the task force screening guidelines, which contribute to more advanced diagnoses and lost lives.

● (1115)

It is critical that the screening guidelines reflect current science and evidence around screening at 40, racial disparities in breast cancer, and breast density and other risks. It's also equally important that communication to the public and to family physicians is consistent and clear to avoid confusion and roadblocks that may prevent many women from getting the screening and care they need.

Screening starting at 40 is critical for early detection of breast cancer. It is time to listen to the science and to give Canadian women the best opportunity for early detection.

Thank you very much.

The Chair: Thank you, Ms. McIntyre, for sharing your story.

Next, I would welcome Dr. Gordon.

You have up to five minutes.

Dr. Paula Gordon (Clinical Professor of Radiology, University of British Columbia, As an Individual): Thank you for the opportunity to testify on this critical issue.

I'm a breast radiologist in Vancouver, and I've been in practice for over 40 years. I watched the previous session, in which you heard compelling testimony from women harmed by the task force, and just now with Ms. McIntyre, with some needing both breasts to be removed, having hair loss from chemo, having to take time off work or worse, having to work through treatment.

Cancers in younger women grow and spread faster, so it's especially important that we find them earlier. The years of life saved by screening are greater for women in their forties than in any other decade, yet the task force still recommends that screening start at age 50, perpetuating avoidable deaths and suffering. Women in provinces that start screening at 40 are more likely to be diagnosed at an early stage. They're less likely to need chemotherapy, and they can have less aggressive surgery. That's why all women should be offered screening starting at 40.

Canadian data showed that since the task force first recommended not screening women in their forties back in 2011, the stage of breast cancers has increased, and the number of women whose cancer has spread has gone up by 10%. The task force ignored this research when making its current guidelines.

Currently, 9 out of 12 jurisdictions have lowered the screening age to 40 or have pledged to lower it. Alberta and Northwest Territories screen at 45. We are waiting for action only from Quebec, and that review is due in December. Even with all this progress, many women are still unaware that they can self-refer. Family doctors who trust the task force are not telling women about screening, and if they do, it's often to discourage it. That comes back to a power imbalance.

Dr. Michelle Nadler testified to HESA that “the task force doesn't mind” if women screen “as long as [they're] informed”. There's a strong emphasis that women must speak to their family doctor before self-referring, but the decision aid tool, which you heard about from Dr. Wilkinson, that the task force sends to family doctors is a one-size-fits-all. It does not allow for individual variation like ethnicity, family history and breast density. The only benefit it shows is averted deaths. It doesn't include the potential to avoid harsh therapy. It overstates the risks of mammograms to doctors, and it wants women to decline screening as a result.

Both women and health care professionals need education. When I lecture to health practitioners, they're shocked to hear that the task force members are mostly family doctors and that content experts are deliberately excluded. Canadians assume guidelines are made by experts. This is a breach of public trust.

All women should have a risk assessment by age 30. The task force guidelines are intended for women who are not at increased risk. However, women with a first-degree relative with breast cancer are at increased risk, as are women with dense breasts and women who've had cancer. The task force guidelines do not apply to those groups, but family doctors don't know that, and some use those guidelines for these women as well.

That said, I'd like to emphasize that 85% of women who get breast cancer have no increased risk, no family history. That's why we need to screen all average-risk women, starting at age 40. Women with additional risk factors may need to start younger or to be screened more often or to be offered supplemental tests like ultrasound or MRI, but average-risk women need to be screened. Women should receive an invitation letter on their fortieth birthday, informing them that they can now have screening mammograms. Currently, only Alberta sends invitations at age 45. Women in their forties are the sandwich generation. They're caring for young children at home and for aging parents, and they're working and contributing to the economy. They are not acceptable losses. All women in Canada deserve the opportunity for early detection.

The task force should be disbanded. We cannot wait for an expert and external review in the spring in the hopes that action will one day be taken for a newer, better, accountable task force. Women are dying needlessly now. We need the guidelines suspended now. In the interim, provincial guidelines can be used. Ontario began self-referral at 40 on October 8, and it has predicted that 845 additional cancers will be found this year. Those cancers would have been found eventually, but now they can be found at an earlier stage. A new model for the task force should incorporate experts and patients. There's no time to wait. We need to act now.

Thank you.

● (1120)

The Chair: Thank you very much for your testimony, Dr. Gordon.

At this point, Dr. Appavoo, you have up to five minutes.

Dr. Shiela Appavoo (Radiologist, As an Individual): Honourable members of the Standing Committee on the Status of Women, thank you for reconvening this important study.

I'm Dr. Shiela Appavoo, a general radiologist with an interest in breast imaging and three decades of experience in breast cancer screening and diagnosis. I also chair the Coalition for Responsible Healthcare Guidelines.

Today I want to focus on breast screening guidelines, as well as other guidelines that affect women, specifically those from the Canadian task force on preventive health care, operating under the Public Health Agency of Canada. You have heard and will hear a lot about breast cancer science and patient experience, but I would like to talk about the guidelines and the guideline development process itself, as well as the Public Health Agency's current external expert review of the Canadian task force on preventive health care.

As you've heard, there is strong criticism of the current Canadian task force breast cancer screening draft, which again recommends against screening women aged 40 to 49 and thus falls behind recommendations from the U.S. task force, the Canadian Cancer Society and almost all the provinces.

The problem with the Canadian task force is fundamental and extends beyond breast cancer screening. Content experts have raised issues with task force guidelines in areas that affect women, such as lung cancer, cervical cancer, colorectal cancer, perinatal mental health such as postpartum depression, vision screening and pediatric developmental delay. Aside from the breast cancer guideline, none of these guidelines have been updated dating back to 2013; thus they pose risks for Canadian women and their families. This risks avoidable late-stage diagnosis of significant and life-altering diseases.

Among other issues you will likely hear today, the task force demonstrated bias in its predetermination of the results of the breast screening guideline revision. The working group chair stated in May 2023 that they didn't believe changes to the guidelines were needed from the 2018 guideline. This was weeks before the evidence review was even initiated.

The task force also biases and manipulates knowledge translation. For example, it allows information to be expressed to patients and primary care providers only on its own terms. In its communications and in the way evidence is considered, the task force consistently underestimates screening benefits while amplifying its portrayal of harms.

As an example, its “1,000-women” chart, which is offered as a decision tool, underestimates the benefits of screening and fails to address crucial questions such as the reduction of morbidity or non-death harms when a woman screens versus not screening, as Dr. Gordon mentioned. Modern studies and computer modelling estimate a very meaningful value of around a 40% mortality benefit from screening, which the task force has arbitrarily chosen not to communicate. What the task force provides is not knowledge translation, but knowledge restriction.

Although the task force supposedly operates at arm's length from the Public Health Agency of Canada, it is funded and supported by the Public Health Agency. There's considerable interactivity between the agency and the task force, yet the Public Health Agency has been given the task of carrying out an external expert review, which is now under way.

While the panel members are distinguished and appropriately include representation from primary care and population medicine, they lack disease-specific specialists. This is exactly the approach for which specialists have criticized the task force. When I asked the Public Health Agency to include representation from specialists who look after patients with the actual disease processes, I was told they had made a deliberate choice in their panel composition. This suggests that the exclusion of topic experts was fully intentional.

The so-called external review of the task force is being led by the same body that funds it. Part of the evaluation is being performed at the University of Calgary, which houses the task force.

How can these bodies, whose reputations are tied to the task force, be truly objective? This is not an unbiased or external review at all. I urge the committee to recognize the fundamental flaws, bias and lack of accountability in both the task force and the Public Health Agency of Canada's review of the task force.

The breast cancer screening guidelines, as you've heard, are deeply problematic, as are multiple other guidelines. It's essential to address these broader guideline issues affecting women and their families across multiple health topics. A good start would be to put a moratorium on the current review of the task force and to place the review in the hands of a truly external and objective body and university. We must advocate for an honest and external review of the task force and the dismantling and rebuilding of the task force to ensure a proper structure and oversight. In this way, we can arrive at safe, appropriate and modern guidelines in many fields that affect women and their families.

Thank you.

● (1125)

The Chair: Thank you very much.

Ms. MacDonald, you have the floor for up to five minutes.

Ms. Kim MacDonald (Patient Advocate, Breast Cancer Canada): Thank you.

I almost feel compelled to applaud everyone who is speaking today.

Thank you for the privilege to speak on a topic so important to me as a survivor and to so many Canadians impacted by breast cancer.

I first want to say how shocked and disappointed I was in the task force recommendation of keeping the breast cancer screening age at 50 and how heartened I am by provinces like Ontario for lowering the age of self-referral to 40.

My story is a little different. I was being screened every six months starting at age 45 because I was considered “high risk”, but since nothing other than cysts were found, I was unilaterally dismissed from my specialist roster after two and a half years. In the end, I was the one who noticed the lump. I was the one who saw the alarming changes to my right breast as the unchecked tumour grew. I called the specialist, thinking I could get in, but I was told that I couldn't come back until I got another referral from my GP. My breast cancer could have been caught months earlier if I had continued to be screened, but it wasn't diagnosed until I had a tumour the size of a baseball—10 centimetres.

I was stage 2B, ER-negative and HER2-positive. My cancer was aggressive, and so was my treatment: eight rounds of chemotherapy over 16 weeks, a double mastectomy, 25 rounds of radiation, two surgeries to put a port-a-cath under my skin and take it out again, 18 Herceptin infusions and 64 needles in my stomach. I had to leave my job for 10 months and collect disability at the peak of my career.

This treatment saved me, and I am seven and a half years in remission and extremely grateful for that. I'm not here to gain your sympathy but rather to say that by the time women discover a lump themselves, the cancer has grown and perhaps has spread, and treatment can be traumatizing. Mammograms, MRIs and ultrasounds can discover breast cancer in its earliest stages, resulting in far less invasive treatment, ultimately saving lives and money.

I feel compelled to tell you about a friend who fought so hard to bring awareness to others on this subject. In 2017, Nadine Parsons had a sore lower back. She had X-rays done and went to two chiropractors, and still the pain worsened—for months. On January 1, 2018, she woke up and could not move. Her husband took her to emergency and, after several tests, it was discovered that not only did she have breast cancer, but it had spread to her lymph nodes and then to her bones, which is why she was in so much pain.

For the next year and a half of living with metastatic breast cancer, Nadine Parsons was an advocate, telling younger women about the signs she had breast cancer that she had missed, but because she was so young, nobody had ever suggested that she have breast screening. When I ran into her at a fundraiser and she told me her story, she was filled with such positivity and optimism that I was sure that she was going to survive, but on July 24, 2019, Nadine Parsons succumbed to breast cancer. She was one of 5,000 Canadian women that year who died from it. She was 37 years old.

Tragically, this story is not unique. Screening saves lives. It needs to be accessible. The difference between stage 1 and stage 4 is timing. I'm one of the lucky ones. I lived, and that's why I'm here today.

Dr. Jean Seely, the head of breast imaging at the Ottawa Hospital and professor at the University of Ottawa, was quoted in a report released in April of this year. She said, “Breast cancer in younger women tends to be diagnosed at later stages and is often more aggressive.” She went on, “It's alarming to see rising rates among women in their Twenties and Thirties because they are not regularly screened for breast cancer.”

There are over 50 kinds of breast cancer, and Breast Cancer Canada is investing in targeted therapies. Not every woman needs to go through what I did. Some may need a lumpectomy and a small amount of radiation. If it's caught early, they may avoid chemotherapy altogether. Research is making that happen.

When a woman gets breast cancer, it affects her entire community. The earlier it is caught, the less invasive the treatment, the less of a burden on the health care system and the less likely it is that she will die. Early screening can help save a life—like mine.

Thank you.

● (1130)

The Chair: Thank you very much for your powerful testimony.

At this point, I would like to welcome Jennifer Beeman.

You have up to five minutes.

Ms. Jennifer Beeman (Research and Advocacy Advisor, Breast Cancer Action Quebec): It's my colleague, Milena, who will be giving the presentation.

Thank you.

The Chair: Welcome, Milena.

Milena Gioia: Hello, everyone.

We thank committee members for the invitation to be part of this important discussion.

We're coming to you from Tiohtià:ke, part of the unceded indigenous lands of the Kanien’kehá:ka Nation.

It's important for us to use gender-inclusive language in our work, as breast cancer affects people based on their physiology and not their gender. We use the term “women and AFAB people”. AFAB is an acronym for “assigned female at birth”, which includes non-binary and transmasculine people who have the same risk of breast cancer as cis women do, and for us, “women” also includes transwomen, who can also be at an increased risk with gender-affirming hormone therapy.

Breast Cancer Action Quebec is an intersectional feminist organization that has been working for breast cancer prevention for over 30 years, providing education programs and fighting for better chemical regulations to reduce toxic substances in our environment and in the products that increase breast cancer risk.

Among our many different programs, we give breast cancer education workshops with women from communities often not reached by public health campaigns. We are committed to working with marginalized communities to listen to them and to empower them with the tools to take their health in hand.

Marginalized populations have very different needs and experiences regarding breast cancer, which include barriers to the existing screening program. This should be a central issue when considering expanding the breast cancer screening program to start at 40. These groups are not well served by the current screening program, and in most cases this is a reflection of the deep inequities in our health care system, which will not be solved by simply extending the program to younger populations.

Health care funding is severely limited. Shouldn't we be putting money into increasing breast cancer education and participation in the current program first, especially considering that the 50 to 74 age bracket is at the highest risk? If the program is widened to the general population, starting at 40, won't these populations face the same exclusions and barriers to participation?

Specifically, women and AFAB people with disabilities, particularly regarding mobility, have major problems with the most basic physical access to mammography screening machines and even to clinics. Disability groups have organized major campaigns to change this, with little success. This injustice has been an issue for over 30 years.

Gender-diverse people face a lack of information on basic questions of breast cancer risk, for example, how hormone therapy raises breast cancer risk for transwomen and how it may reduce it for transmen. Fully respectful health care practices are also far too rare.

Indigenous women and AFAB people are facing increasing rates of breast cancer along with all of the issues they face regarding the lack of equitable, respectful and culturally sensitive treatment in the health care system.

Black women and AFAB people are facing very specific problems regarding breast cancer, with many people being diagnosed at younger ages with more aggressive forms of the disease that are often less responsive to treatment. Also, they may participate less in existing screening programs. Lowering the screening age will not address racial disparities. In addition, Black women are facing very similar trends regarding uterine cancer, so far more work from the ground up needs to be done.

In Canada, we don’t collect race-based health data, which is a major problem and the source of many injustices. Much of the research on Black women and breast cancer has come from the U.S and the U.K., but this body of research has shown that the category of “women” cannot be treated as if they all experience breast cancer in the same way, which tends to mean the same way as white, cis, well-educated women. Gender differentiated data could also help us better serve the gender-diverse population.

The problems that all of these groups face regarding screening raises vital questions. As we all know, health care funding is severely limited. Breast cancer risk, diagnosis and treatments play out differently for different populations, so responses need to be tailored depending on these realities.

In addition, we'd like to call your attention to the lack of diversity in these two FEWO sessions among survivors, groups and experts, including the specialties and the populations they study and work with. Surely we all agree that Canadians deserve the whole picture on this important issue.

● (1135)

Thank you again for the opportunity for us to share our questions with you.

The Chair: Thank you very much, Milena Gioia.

Next, we have Madame Ippersiel.

[*Translation*]

Ms. Ippersiel, you now have the floor for five minutes.

Ms. Karine-Iseult Ippersiel (President and Chief Executive Officer, Quebec Breast Cancer Foundation): Thank you, Madam Chair.

Committee members, thank you for having me here.

For 30 years, the Quebec Breast Cancer Foundation has been advocating for the interests and promoting the well-being of breast cancer patients. The foundation makes a particularly significant contribution to medical and scientific advances, with investments in innovation and cutting-edge research and in support, prevention and healing programs.

Every year, breast cancer accounts for around 1,380 deaths in Quebec. It remains the most common cancer in women. It's not only one of the most common cancers, it too often strikes the youngest people. Some 18% of diagnoses are made in women aged 50 and under. The increased number of cases in this age group has been documented.

It's widely acknowledged that screening plays a key role in reducing the mortality risk by 41%, for example.

As a result, we believe that it's vital to focus on the need for early detection in order to save even more lives.

Today, the committee is looking at screening age. The Quebec breast cancer screening program encourages women aged 50 to 74 to undergo screening mammography every two years. In recent months, the health minister has tasked the Institut national d'excellence en santé et en services sociaux with looking at the potential to expand the screening program to include people as young as 40. This is a welcome initiative.

However, it should be noted that the screening program focuses on a single risk factor, which is age. A program based solely on age assumes that all women in the same age category face the same level of risk. This isn't in line with the information available to science.

We now know that 12% of the population has more than a 10% risk of developing breast cancer before the age of 70. Approximately 50% of all breast cancers are diagnosed in women belonging to this sub-population. In contrast, 50% of the population faces a breast cancer risk of 3% or less. In other words, breast cancer is concentrated in a relatively small portion of the female population.

Evidence suggests that other risk factors must be considered when determining each woman's risk profile. These factors include age, family history of cancer, DNA, breast density, Ashkenazi Jewish descent, hormone exposure, alcohol consumption, height and body mass index. This shows the need to move towards more preventive and personalized medicine.

As a result, the foundation would like to see governments transition from an age-based to a risk-based approach to screening.

With this in mind, the foundation was the first to provide funding for PERSPECTIVE, an innovative project that assessed a new screening strategy based on each individual's unique risk profile. The project led to the development of a saliva test that, combined with a questionnaire, calculates a woman's risk of breast cancer. This makes it possible to carry out customized screening and promotes early detection of the disease. The integration of this innovative approach would modernize breast cancer screening and would have many social and economic benefits.

There would be multiple benefits for patients. These benefits include earlier detection, which significantly affects the choice of treatment; higher survival rates; improved quality of life; better patient experiences; less stress from excessive screening; and a lower psychosocial impact.

The benefits for the health care system are just as significant. These benefits include more effective use of human and technical resources; improved clinical performance; better quality of care; and lower health care and social costs.

We also know that the socio-economic burden of breast cancer is significant in Quebec and the rest of Canada. In specific terms, the average cost of care required for breast cancer treatment varies according to the stage. The earlier the cancer is detected, the lower the health care costs. In Ontario, the treatment for a cancer *in situ* costs around $14,000, while the treatment for stage 4 cancer costs around $370,000. This amounts to a difference of almost $350,000. Early detection is important. It could both save lives and lower costs.

Now that the PERSPECTIVE project has come to fruition, the foundation wants to help modernize breast cancer screening methods by integrating this innovation into standard health care practices.

● (1140)

We want governments to get on board with this new perspective, which aligns with science and which would have a major impact. Let's do this for women, for survivors, for daughters, for spouses and for mothers, too many of whom are still living with cancer.

[*English*]

The Chair: Thank you all for your opening remarks.

At this point, we will go to our first round of questions.

I'd like to begin with Michelle Ferreri, for six minutes.

Ms. Michelle Ferreri (Peterborough—Kawartha, CPC): Thank you, Chair, and thank you so much to all of the witnesses here.

This is powerful and emotional testimony as we continue the study on the task force recommendations on breast cancer. There are many survivors who've come courageously here to the status of women committee to speak about their experiences, along with many physicians as well.

Dr. Wilkinson, you said something pretty pointed. As people have been watching this, and I've been watching the feedback online, people are saying, “Well, the provincial guidelines already say 40, or you can self-refer, so what does it matter what the task force says?”

Can you comment on that?

Dr. Anna Wilkinson: Certainly, I spoke to that a bit in my speech, but it really does matter.

Even though, on the ground, it seems like there is access, when the task force says, “Don't screen,” that is what family physicians take as what they should be recommending to their patients. It creates a bias, so when patients go for shared decision-making to their family physician, the family physician is already predisposed to say, “You know what, the risks probably outweigh the benefits.”

It impacts the counselling that patients get. It impacts the ability to access across our country, because some provinces do screen, some provinces don't, and some are at age 40. It also has far-reaching impacts in terms of the way that women see it. They get mixed messages. They're not sure what to do, because they hear they shouldn't screen and their province says they should screen.

Even though there are provincial guidelines that say we can screen, it's really critical that we have strong national guidance for our patients, for our doctors and for our provinces.

● (1145)

Ms. Michelle Ferreri: Thank you for that clarity.

We had witnesses who testified about who the experts were, who was actually sitting on this task force, and who was actually giving this recommendation. A lot of feedback was that people who weren't in the position to give professional recommendation were doing that on the task force.

Is this task force delving into the technology and advancements we've seen in breast cancer screening and technology, for example, AI and thermolability through heat? Has that been brought up?

I would open it to anybody who wants, but I'm looking at you, Dr. Wilkinson, as a physician.

Are they looking at these new age...? Mammography and mammograms are also a deterrent for many women. It's uncomfortable. There are many amazing emerging technologies.

Is the task force willing to look at that, as well as at what's in our food?

Dr. Anna Wilkinson: There are a few questions there.

First, regarding the expert involvement, the actual task force and working group for this had no breast cancer experts on it. They did have experts working with them. Dr. Michelle Nadler was one of them, but she was a non-voting member.

In terms of our evidence review group, we had three experts. However, again, we didn't have a vote, and the evidence that the review panel could pull was dictated by the working group. Even though we said, “This doesn't make sense. You were looking at the side effects of treatment, yet you were measuring the numbers of mastectomies, which, actually, in the error you were looking at, was a treatment for breast cancer, not a side effect of therapy”.... There are really basic misunderstandings in terms of the way breast cancer treatment works, and they skew the results.

In terms of looking at modern data, that is very difficult, because the way the evidence is acceptable is primarily through randomized controlled trials. Those randomized controlled trials take a long time and are very expensive to complete. For example, we did not fully look for dense breasts, the supplemental screening. Those randomized controlled trials were not included—the dense trials—because at the time there was only one round of screening, even though there was a second round published in 2021 that was not included. It's this need for completed randomized controlled trials that means we're always behind the eight ball, trying to catch up.

Ms. Michelle Ferreri: Thank you. I see that a lot in medicine. We're always in reaction mode instead of preventative or offensive.

Ms. MacDonald, thank you for your powerful testimony. It's great to see you here. Your testimony around Nadine was really powerful. Thank you for speaking on her behalf. I'm sure her family is very grateful for that.

You said something that I'd like to have on the record again. You talked about the timing of screening being directly tied to survival, which was your experience. I would like you to elaborate a little on why timing matters in the survival of breast cancer.

Ms. Kim MacDonald: Sure. Right now, at stage 0 or stage 1, if it's found that early, as it often is in screening, you have about a 99% survival rate. By the time it gets to stage 4, we're talking about a 31% survival rate. Although that number is getting better with research and the medicine that we have now, and people with metastatic breast cancer are living longer, they cannot be cured. If you are at an early stage, you can be cured with the medicine that we have today.

That's the difference between going in, getting screened and finding out you're at stages 0, 1 or 2, versus it being too late when you're at stage 3 and it's in the lymph nodes, or you're at stage 4, when it's in your liver, bones or lungs. The timing is the difference.

The Chair: Excellent. Thank you for that.

I welcome Emmanuella to go next.

You have up to six minutes. Thank you.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): Thank you, Madam Chair.

I apologize for the darkness of my screen. I've tried to fix it, but it's not really working.

I want to thank all the witnesses for being here today to share their testimony and their expertise with us.

Milena, you spoke about the fact that Canada doesn't collect race-based data. On this issue of breast cancer and ensuring that all women get the help they need when they need it, what type of data would you suggest should begin to be collected? What exactly should we be looking for in that?

● (1150)

Ms. Jennifer Beeman: I can take that question, as we're working together.

One of the big issues is how differently breast cancer plays out for different populations. It was interesting to hear the presentation from the Quebec Breast Cancer Foundation towards a more targeted approach, because that's where our understanding is going as well, specifically because different ethnic backgrounds play into breast cancer risk. It was already known that it was the case for Ashkenazi Jewish women. Now there's such a big, urgent health care “crisis”, I'd call it, regarding Black women and breast cancer. They really need to be around this table.

There are Black women breast cancer researchers who are calling it urgent that we get race-based data and to better understand it. Black women have historically been marginalized in many different ways, including with clinical trials. The percentage of Black women who've been part of clinical trials has been less than 1%. Researchers theorize that it's one of the reasons that it's becoming very clear that certain therapies don't work for them the way they work for white women.

There are layers to this issue. Breast cancer is a harrowing disease. We know that as well as anyone else here. It's wretched. Seeing anyone die from this is terrible. Overdiagnosis, where we turn healthy women into breast cancer patients, is an equally important problem that needs to be taken very seriously. No one who's been through breast cancer would want that. We need to start targeting.

As we said, race is a question that we need data on. It's the same thing for indigenous women. We need a lot more data on what's happening for indigenous women as well. Research out of Alberta indicates that their breast cancer incidence is going up. Do they respond to therapies late? Obviously, there are diagnoses at later stages. Do they respond to the same therapies? Then there are the historical problems in terms of how they are treated within the health care system.

There are layers to the problem and they require many perspectives. They require these women, and groups that work with them, to be around the table as well.

Thank you.

Ms. Emmanuella Lambropoulos: Thank you very much for that response.

Dr. Gordon, you said that the majority of provinces at this point are lowering the age to 40. Quebec is the only province that we're still waiting on. They are still at 50. I'm wondering if you know what their argument is for staying there for so long. I don't know if the task force's guidelines have anything to do with that. Generally, the way Quebec tends to go is not necessarily based on federal guidelines.

I'm wondering if you can give any insight there.

Dr. Paula Gordon: With Quebec, the previous speaker, Ms. Beeman, brought up the issue of overdiagnosis. Let me explain to the attendees what that really is.

Overdiagnosis is the theoretical possibility that somebody could be diagnosed with breast cancer, a real breast cancer, and treated for it, but that they would die of something else before the breast cancer would have surfaced, so they never really needed to find out that they had breast cancer. The extreme example is a woman who has breast cancer and finishes her treatment, and six months later, she has a massive heart attack and dies. Another example is that she's diagnosed with another cancer that's very aggressive. Let's say she gets a pancreatic cancer, and she dies even before her breast cancer would have killed her. Overdiagnosis is real, but at the time a woman is diagnosed with breast cancer, if you don't have a crystal ball, you don't know what's happening to that woman six months or a year later, except overdiagnosis is vanishingly rare in younger women. Women in their forties are much less likely to have significant heart disease. They're less likely to develop other cancers, so overdiagnosis is not a reason to not offer breast cancer screening to women in their forties.

The task force is using it the wrong way, and perhaps Quebec is as well. Depending on what evidence committees are willing to look at, like the task force, they can choose to exaggerate the harms and understate the benefits. We have Canadian data showing that women in their forties who have mammograms are 44% less likely to die of breast cancer than women who don't.

If I can just take a moment to address another comment from Ms. Beeman and her colleague, who brought up the issue of representation among the experts, the other panellists might not be aware that in your previous session, Dr. Ify McKerlie, who is a Black physician and a breast cancer specialist, did give testimony. I'm sorry that there are no other non-white experts.... Well, Dr. Appavoo, do you count as non-white? I don't see colour anymore—

● (1155)

Ms. Emmanuella Lambropoulos: Thank you so much.

I appreciate your comments.

The Chair: Thank you very much.

Unfortunately, Emmanuella, your time is exhausted.

Next, I would like to welcome Andréanne Larouche.

You have six minutes.

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): Thank you for your virtual and in-person testimony this evening.

I took many notes. I fail to understand why governments haven't recognized the value of prevention, rather than waiting and needing to provide care later.

Screening doesn't start at the age of 40. Is this because of concerns about lacking the resources, given the costs involved? The figures provided vividly demonstrate how much prevention, by treating cancers at much earlier stages, affects both women's lives and the economy.

Can you hear me, Ms. Wilkinson?

[*English*]

The Chair: To whom are you asking the question?

[*Translation*]

Ms. Andréanne Larouche: Can you hear me now in French?

[*English*]

The Chair: Do you have the interpretation on, Dr. Wilkinson? Are you able to hear?

Dr. Anna Wilkinson: We're not able to hear the interpretation.

[*Translation*]

Ms. Andréanne Larouche: May I start again, Madam Chair?

[*English*]

The Chair: The clerk will help you.

We'll suspend for a minute while this is being sorted out.

● (1155)

_____________________(Pause)_____________________

● (1155)

The Chair: Andréanne, we are ready to go. Please go ahead.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

As I was saying, I want to thank the witnesses participating in the meeting in person or online for their important testimony.

I'm particularly struck by how this issue sometimes seems to come down to economics. Is the idea of not screening for breast cancer before the age of 50 driven by a fear of lacking the financial, material and human resources needed to detect the cancer? Is it really a matter of cost?

In this study, the figures show just how much a cancer detected later or at a much more advanced stage leads to higher costs and, above all, more serious consequences for the person living with the diagnosis. The person must undergo much more extensive treatment. This affects both their personal and economic lives. I think that this is a terrible shame. At the same time, I hope that there will be more talk of prevention and detection. I hope that we can also focus on this area as part of our study.

I'll turn to you first, Ms. Ippersiel.

You talked about the PERSPECTIVE project. I think that it's worth looking beyond age. There's the age 40 factor. We've heard evidence confirming the benefits of cancer detection before the age of 50 and the need to change screening guidelines to include women in their 40s. That's my understanding of your remarks. However, we must also take into account the improvements in research technology to focus even more on much higher-risk groups, with a view to developing more appropriate and personalized treatments. Cancer research is increasingly moving towards more personalized diagnoses and treatments to better reflect each individual's reality, experiences, disease stage, time of disease detection and prognosis.

I want to hear your comments on the PERSPECTIVE research project that you talked about.

As part of this study of the PERSPECTIVE project, I want to know what aspects we should keep in mind. This project mustn't be forgotten in our report.

● (1200)

Ms. Karine-Iseult Ippersiel: The PERSPECTIVE project has been running for 10 years. The project involves researchers—including professor Jacques Simard from Laval University in Quebec City—at the Centre hospitalier de l'Université Laval, or CHUL, in Quebec City.

Basically, they combined a saliva test with a questionnaire on all the risk factors that I spoke about earlier. The result is a risk score based on the polygenic breast cancer risk score unique to each individual. After screening, based on this risk score, a filter could be created to prioritize the people who face the highest risk of breast cancer in society. This would help avoid discrimination and the decision to focus on people in their 40s or 50s. It could cover everyone aged 30 to 74.

They surveyed people who participated in clinical research. Of these people, 89% said that, if they knew that they had a higher risk score, they would pursue a more stringent and frequent screening program based on their risk level. In contrast, a person who doesn't have as high a risk level could wait until they reach the risk level of the general public before entering the system. Knowing this risk would make it possible to really prioritize high-risk individuals and make better use of resources that, as you say, are minimal in the field.

Ms. Andréanne Larouche: Ms. Beeman, on that note, you said that it's also necessary to take a closer look at racial disparities. Why are there so many differences among various communities? What steps can be taken to ensure that screening incorporates these factors?

I would like to hear your thoughts regarding Ms. Ippersiel's comments on the PERSPECTIVE project and on the need to focus on other risk factors.

Ms. Jennifer Beeman: Our approach to ethnic origin or race really falls along the same lines. We're seeing this in women of African descent. Researchers are beginning to identify a genetic predisposition to breast cancer, as is the case for women of Ashkenazi Jewish descent. This could be a risk factor. As Ms. Ippersiel explained, there really is a movement to take much more targeted approaches to breast cancer screening. Breast cancer has a whole range of risk factors. This could mean starting screening earlier. A number of specialists are coming to a useful consensus.

I also encourage you to look at the analysis of the Toronto-based Rethink Breast Cancer. This group works with women and people under the age of 50 who have breast cancer, people who have metastatic cancer and marginalized groups. Its position is extremely sound. This organization isn't in favour of screening for breast cancer starting at age 40. Instead, it advocates for a more targeted approach to screening, based on a range of risk factors.

The perspectives are somewhat limited in the information sessions. A wider range of people are asking perfectly legitimate questions about the benefits of expanding breast cancer screening to include women aged 40 to 49, in comparison with other approaches. It's challenging. We aren't experts. However, we should listen to a range of experts on this topic.

Ethnic origin—for example in the case of first nations women, black women and perhaps other groups—may involve specific risk factors for these women.

● (1205)

[*English*]

The Chair: Thank you very much for that.

Leah, you have six minutes.

Ms. Leah Gazan (Winnipeg Centre, NDP): Thank you, Chair.

My first question is for Milena Gioia.

I really appreciated your testimony talking about the importance of inclusive care. You spoke specifically to the AFAB community. Why is it important to provide gender-affirming care in the treatment of breast cancer?

Milena Gioia: Thank you so much for the question.

It's really about ensuring that everybody is included in our measures to challenge and to prevent breast cancer, to detect it. If we don't include.... What's happening right now is that gender-diverse people, so non-binary and transpeople, aren't targeted by the current awareness campaigns. All this pink stuff around breast cancer is not very.... Transmen don't feel called to participate in this whole aspect of it. They don't necessarily know that they are at risk for breast cancer even after having top surgery, like gender-affirming double mastectomy, let's say.

Ms. Leah Gazan: I have limited time. I ask that question for a very specific reason. There has been push-back provincially to get rid of gender-affirming care. My concern is if we continue to push back against gender-affirming care in certain provinces, how is that going to impact the safety of the trans community, particularly around breast cancers?

Milena Gioia: Are you talking about gender-affirming care in general?

Ms. Leah Gazan: I'm talking about gender-affirming care, but in this specific instance, it is related to breast cancers.

Milena Gioia: It would affect mental health. Suicide rates would go up. I think that maybe matters. I'm not sure if I understand the question about how gender-affirming care would affect—

Ms. Leah Gazan: Let me clarify the question.

If it's difficult to access gender-affirming care.... My assumption is that people would be less likely to get medical help, particularly around breast cancers, if they don't feel they can get health care that respects gender diversity.

Milena Gioia: Absolutely. That's already the case in accessing any kind of medical care. Gender-diverse people don't use their pronouns, or pronouns are not asked for, so of course, that would add another level of complication for people in trying to access, for example, mammography.

Ms. Leah Gazan: You brought up the point that this study hasn't been very inclusive, and I'll accept that, especially because of what we've heard around certain groups, for example, Black women, being at a higher risk of getting breast cancer. If either you or Jennifer Beeman would like to answer, you spoke more specifically about Black women and indigenous women.

I'm also concerned about the fact that the current technologies are not accessible to the disability community. Can you expand on that and on how it places the disability community at risk? I'm concerned about it because if we're not being inclusive in the study, then we're missing really critical points in the research to bring thoughtful and well-informed recommendations forward.

Could either one of you answer that?

● (1210)

Milena Gioia: You can go ahead, Jennifer, if you like.

Ms. Jennifer Beeman: In the case of accessibility for women and AFAB people with disabilities, particularly mobility disabilities, I've known about this for 30 years. We were approached by a very important disability group in Quebec to join a campaign to mobilize groups to get support, because the question of accessibility hadn't changed. Anyone who has had a mammogram knows you have to stand up. Presumably, there are other ways to do this. There was a big mobilization, and we couldn't get a meeting with the health minister to take this on. I don't know how this plays out in other provinces, but these voices need to be heard, because already there are problems of access for many people.

Thank you for the question.

Ms. Leah Gazan: Thank you.

I'm concerned because, first of all, we have a task force, it seems, that has no experts on it in the area. It's not diverse. In most of the research that has been done, I think over 90% were Caucasian women. We're making decisions about breast cancer based on this information, and then it seems like we're doing a similar thing in this study. I'm a bit concerned now. I just want to say that I appreciate this, and I feel that we need more information about it.

The Chair: Thank you, Leah.

At this point, we will begin our second round.

Dominique, you have five minutes.

[*Translation*]

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

I thank the witnesses for making themselves available today to further enlighten us about breast cancer and early detection.

Ms. Ippersiel, thank you for being with us. That's very kind.

I'm interested in the studies you mentioned involving the saliva test. My understanding is that it's currently under development at the Centre hospitalier de l'Université Laval or CHUL. A doctor is leading that study.

What's the reaction to this scientific breakthrough?

I know we want to screen women for cancer when they're younger, based on factors other than age. If we could convince those in charge to start screening people between the ages of 40 to 50, that would be a good start.

What's the reaction from the scientific community, the government or INESSS, which is the Institut national d'excellence en santé et en services sociaux for Quebec?

Ms. Karine-Iseult Ippersiel: I can tell you that the foundation looked at several health authorities, including INESSS and the ministry of health. We know that they're aware of the study and that they're following it closely, because it's coming to an end shortly, with conclusive results and data. They will be published in the near future.

Health authorities are also waiting for the results so they can make their decisions and determine next steps. Obviously, the foundation is working very hard to turn this into clinical field research, so that we can administer the saliva test and questionnaire to a specific population, as part of a pilot project, to see the effect outside of clinical research and more broadly, down here on earth, so to speak.

Certainly, everyone knows about it and it's on their radar.

Mrs. Dominique Vien: It's true that Quebec is usually at the forefront of social issues. Having been a member of the Quebec government for quite some time, I can attest to that. In this case, we're closer to the back of the pack.

We're hopeful that the Institut national d'excellence en santé et en services sociaux, or INESSS, will move forward; however, for you, at the Quebec Breast Cancer Foundation, have you been in contact with the Quebec government or the Quebec minister of health, Christian Dubé? What steps have you taken, and how were you received?

Ms. Karine-Iseult Ippersiel: I'm not at INESSS, so I don't know when they'll release their report. I do know that they follow the Canadian Task Force on Preventive Health Care when making their own decisions.

Then, of course, there are resource issues in Quebec. It can take anywhere from 10 to 33 weeks or even 38 weeks to get a mammogram, depending on where you live. The Foundation has been very vocal on this issue for years. We spoke to Minister Dubé's office about it, and the message was well received, as well as by the Centre intégré de cancérologie and all the organizations with which we met.

As I said, this study is concluding shortly, so the results should be published soon. We're waiting for them all. I hope we'll be able to run a pilot project in the field.

● (1215)

Mrs. Dominique Vien: Ms. Ippersiel, what does the foundation think about the task force that examined the guidelines? There doesn't seem to be many fans among the witnesses we've met. Dr. Appavoo made a heartfelt appeal to us earlier, when she asked that the task force be abolished and the guidelines suspended.

What's your opinion of the task force? Should we shelve it and review its mandate, or get rid of it? What's your position?

Ms. Karine-Iseult Ippersiel: Obviously, it's not up to the Quebec Breast Cancer Foundation to set up working groups. Rather, that's up to the government. We're watching what these working groups are doing, we're waiting for the answers and we're trying to see—

Mrs. Dominique Vien: Based on your observations, what's your assessment of them?

Ms. Karine-Iseult Ippersiel: Obviously, we find that science and innovation evolve rapidly, and that working groups don't necessarily move at the same pace. In our opinion, it's important to take into account cutting-edge work and all the research being done. Things are moving much faster these days, so we find it somewhat unfortunate that we're always looking to the past rather than keeping up with what's being done now.

Since we know that there are several types of breast cancer, and that breast cancer affects different communities, different age groups and women with different realities, it would be important for specialists from all the relevant fields to sit on these committees. They should be much more inclusive and forward-looking.

Mrs. Dominique Vien: Dr. Appavoo, I heard your comments about the task force loud and clear. You're saying that things aren't moving in the right direction and that you're watching.

Can you remind us how many women sit on that task force?

[*English*]

The Chair: You can answer that quickly.

[*Translation*]

Mrs. Dominique Vien: Perhaps our analysts can provide us with those numbers; however, since I had 15 seconds remaining, I wanted to ask the question. Thank you.

[*English*]

The Chair: If you could send along a response, that would be ideal. You could submit it to the committee.

Dr. Shiela Appavoo: Are you asking me?

The Chair: Yes, if that's possible. If you have any questions, you can follow up with the committee afterwards.

Dr. Shiela Appavoo: Was I being asked how many women were on the task force? Okay. Yes, I can look that up and tell you.

The working group for the breast cancer screening guideline was chaired by a woman.

The Chair: Okay. Thank you very much.

Only because of the shortness of time, we will move on to our next member of Parliament to pose questions.

You have five minutes, Marc.

[*Translation*]

Mr. Marc Serré (Nickel Belt, Lib.): Thank you, Madam Chair.

I want to thank all the witnesses, who presented us with some excellent recommendations on breast cancer screening. For example, they told us that screening should start at age 40, and earlier for women at risk. We also heard recommendations for women of colour, indigenous women and women with special needs. Some never even get the chance to have a mammogram.

Then, we were told that more data is needed. Dr. Gordon said that data already exists, but that the Task Force on Preventive Health Care wasn't even consulting that data. I hope, then, that the task force and the Public Health Agency will listen to today's testimony and recommendations.

[*English*]

I think it's appalling, what the task force has done.

Dr. Gordon, you mentioned completely dismantling the task force, so my first question will be for you.

Dr. Appavoo, you mentioned a moratorium on the task force guidelines and recommendations, so I would like to hear from both of you. If that happens, what is a replacement? What are the next steps if we dismantle the task force or put in place a moratorium?

I'll have Dr. Gordon answer first and then Dr. Appavoo, please.

Dr. Paula Gordon: I would like to point out to the committee that the task force was disbanded by the Liberal government in 2005 and reinstituted in 2010 but with no oversight, so, yes, it can be suspended. In the meantime, there are provincial guidelines that can be followed, but they need to be publicized, and women need to know that they can self-refer.

● (1220)

Mr. Marc Serré: Shiela.

Dr. Shiela Appavoo: As Dr. Gordon said, this has been done before. It can be done again. I think there are better ways to do these guidelines. As we've seen, the U.S. task force's model recommended screening women aged 40 to 49.

There are other guidelines. There are the National Comprehensive Cancer Network guideline and the provincial screening guidelines. Almost every other guideline you could throw a stick at recommends screening at 40. It's just the Canadian task force that is entrenched in this idea that women 40 to 49 shouldn't be screened, and I think that is a symptom of the more fundamental problems with the task force.

Mr. Marc Serré: Dr. Wilkinson, you mentioned the task force ignoring all the recommendations from the experts, but you also mentioned that they almost did this intentionally, because now there are provincial interpretations, and the guidelines are not clear.

Can you expand a bit on the recommendations to us as a federal committee here, and what to do next?

Dr. Anna Wilkinson: I would love to just quickly mention data, because lots of people have been referring to data. There are data in terms of evidence, but there are also data that we collect within our Canadian Cancer Registry. I think a part of the guidelines is the ability to have some quality assessment after the fact to determine what happened with these guidelines. Currently, there are significant issues with our Cancer Registry data that prevent us from assessing what's going on. A very basic outcome of this committee could be to say....

We have no data from Quebec since 2010, so I cannot tell you what's going on in the country with breast cancer, because I don't have data for a significant portion of our population. We don't have data from Nova Scotia from 2021-22. Our incidence data right now dates to 2019, and our mortality data dates to 2021.

If, for each cancer case, we collected data on the race and ethnicity of that person, on the density of their breast, on whether or not it was screen-detected and on whether or not it was a recurrence, that would allow us to properly assess what's going on.

We just finished a big study on race and ethnicity in breast cancer that will be published within the next week or so, and we had a very complex linkage of census data with registry data to try to put together what is going on in our country, when it could be so simple just to flag who gets what.

Mr. Marc Serré: Thank you for that.

I have 20 seconds left before the chair cuts me off, but, Dr. Gordon, Dr. Wilkinson and all members of the committee here, can you send over...? There are issues with wait times that we haven't really addressed in the committee right now. Is there a possibility of sending some recommendations along on how to address the problem, the length of time...and the wait times right now across the country?

Dr. Anna Wilkinson: We have a one- to two-week wait time for mammograms in Ottawa right now, in our region. We do not have a wait-time issue for mammograms, and we have accessible mammogram units for people who are in wheelchairs.

Mr. Marc Serré: It's not the case across the country, though.

Dr. Anna Wilkinson: It's not the case across the country, for sure, but I'm saying that it's a very heterogeneous problem, I think.

Mr. Marc Serré: Wow.

The Chair: That's interesting. Thank you.

Andréanne, you have two and a half minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

Ms. Wilkinson, what you just said about the availability of resources is interesting, so I'll continue in that vein. You seem to be saying that resources are available in the Ottawa region, and that they're even adapted to the needs of people with disabilities.

Ms. Ippersiel, I did some research on Mr. Dubé's announcement last week about a study commissioned by the Institut national d'excellence en santé et services sociaux, or INESSS, on the potential expansion of breast cancer screening starting at age 40. I've seen a lot of headlines that seem to question whether Quebec has the necessary resources. Isn't that approaching the problem from the back end? Shouldn't we make sure we have the resources first?

This affects the federal health transfers the ministry of health is calling for. When we don't get those transfers upfront, we don't get the critical and necessary investment in our health care system.

There should be no question of economic cuts or austerity. These transfers need to be made.

Ms. Karine-Iseult Ippersiel: Definitely. In Ottawa, Ontario, the wait is one to two weeks, if at all. Across the river, on the other hand, the wait is 26 to 33 weeks, sometimes 38.

The problem is manifold. First, there has been a shortage of 500 to 700 medical imaging technologists in Quebec since 2021. Second, since technologists earn less in the Outaouais region of Quebec than on the Ontario side, those working in Gatineau eventually go to work on the other side of the river. Early last summer, Minister Dubé responded to the situation by increasing a bonus for medical imaging technologists in the Outaouais region.

Training is another problem. If you're not able to specialize in mammography in the Outaouais region, you have to go to Montreal, a difficult situation for a mother with children. As we know, more and more medical imaging technologists are women. The situation is more complex. So it's not just about the money: It's also about the people who are going to do the work.

Yes, offering screening to women aged 40 to 50 is an excellent idea too, but unfortunately we have to ask ourselves whether we have the resources to do that, given that, for a simple mammogram, the wait for women aged 50 to 74 is 15 to 33 weeks.

● (1225)

[*English*]

The Chair: Thank you.

Leah, you have two and a half minutes.

Ms. Leah Gazan: Thank you so much.

I was wondering, Dr. Wilkinson, if you could send the committee a brief on the recommendations that are coming out of your latest report. That would be really helpful—and maybe some other recommendations that are coming out.

Dr. Anna Wilkinson: Sure.

Ms. Leah Gazan: Unfortunately, I have limited time.

I wanted to ask this to Madam MacDonald and Madam McIntyre. We often talk about the physical parts of cancer, but we don't talk about cancer in terms of the emotional and financial parts of it. I think that's something that has come out in the study. That is one reason that I put forward a bill for a guaranteed livable basic income, because you just never know what's going to happen in life. People need to live with dignity, including those experiencing life-changing health incidents.

I'm wondering if both of you could very briefly just give maybe one suggestion on where the system is lacking in terms of financial or socio-emotional supports for people struggling with cancer.

We'll start with you, Madam MacDonald, and then go to you, Madam McIntyre.

Ms. Kim MacDonald: I'll speak to the mental health aspect of it.

I want to say that mental health is as important and impacted as much as physical health when it comes to breast cancer. I think if I were to make a recommendation, it would be that women, or anyone who's going through breast cancer, be assigned a therapist. Have it be part of the treatment, because I think it's just as important as all the doctors and specialists we see. I think it would benefit patients greatly to have a social worker or a therapist as part of the treatment.

Ms. Leah Gazan: Madam McIntyre.

Ms. Julie McIntyre: I was fortunate enough to be able to take a leave from work, but I know not everybody is able to do so. The financial losses can be significant. I do think that's important to consider—and that there are supports in place for people that they don't necessarily have to seek out.

When you're going through a cancer diagnosis, you are dealing with so much. For me, mentally, I was in survivor mode, looking at each treatment one step at a time, one day at a time, dealing with side effects, etc. What I've noticed is that I put the emotional aspect on hold—subconsciously, to be honest. Now that I have finished my active treatment, I'm trying to deal with lots of the emotions that will continue to affect me.

Social workers and therapists are very important. Again, we can't expect everyone to have to seek out those people. As Ms. MacDonald said, that should be available. It is available in the hospitals, but you do have to make an appointment or try to navigate the system. Some kind of health care coordinator who could help patients with that would be very helpful.

The Chair: Thank you very much for that.

Next I'd like to welcome Michelle Rempel Garner. You have five minutes.

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): Thank you, Chair.

I know this topic has been studied at the health committee. I'd like to direct my questions more around a gender lens or a gender approach to some of these recommendations.

I know that the task force suggested that self-referral for women under 50 was something that could be an option. At the same time, I think it's a well-established fact that women have to advocate differently from men for their own care. Then you start getting into different issues based on different ethnicities, demographics and locations in the country.

Given that, did the task force consider the difficulties or the barriers faced by women in self-advocacy, even women in privileged positions, in making that recommendation? If not, what would you recommend to this committee as it pertains to self-referral?

I'll start with you, Dr. Appavoo.

● (1230)

Dr. Shiela Appavoo: I think the guidelines themselves are separate from provincial guidelines and rules around self-referral. For example, in some provinces, even dating years back, women were allowed to self-refer at 40. In my own province, until October 2022, women were allowed to self-refer at 50 only. In October it moved down to 45.

Those provincial clinical practice guidelines and rules are affected by the task force recommendations. I would say that there's indirectly a strong influence on provincial clinical practice guidelines and thus patient access.

I'm not sure if that answers your question.

Hon. Michelle Rempel Garner: More clearly, or more directly, I am a woman in a position of privilege. I have never been accused of not being able to speak my mind or advocate for anything. I don't have a primary care physician. Once a month, I have to eat an entire bottle of Aleve to deal with my menstrual cramps. When I go to a doctor, they just tell me, well, maybe you're anxious. I tell them I'm incapacitated: Don't you think there's something wrong? They tell me that it could just be that I'm getting older.

This is me. I was a federal cabinet minister. If I'm being gaslit, I can't imagine how it is for somebody who does not have my experience in self-advocacy. I guess what I'm asking is whether the aspect of medical gaslighting, or that bias in taking women's health seriously, particularly in the family physician's office as the first point of referral, was taken seriously by the task force. How can we self-refer if we already have that bias that we're dealing with? What should this committee be recommending to address that gap?

Go ahead, Dr. Wilkinson.

Dr. Anna Wilkinson: When we did our race and ethnicity study, we gave that information to the task force. That study, which is coming out shortly, found that all races and ethnicities other than white have a much earlier peak onset. That means that 41% of cases of breast cancer in Korean women are diagnosed before the age of 50. A third of breast cancer cases are diagnosed before the age of 50 in Arab women and Black women and first nations women—you name it.

If we're talking about restricting access, if you have a task force guideline that says you have to go and have a discussion with someone, you need to have the resources to know that, first of all, and to then seek someone out and advocate for yourself. If that physician has been told that, actually, no, they shouldn't do that, then you're completely skewing this away from people who actually need access the most.

Hon. Michelle Rempel Garner: I agree. In a different life, I did a lot of work with primary care networks in Alberta.

Would one of the recommendations that you would give to the committee be to consider that medical bias, which is quantifiably present for women? Would you recommend that this be taken into consideration when thinking about any sort of guideline that could relate to self-referral?

Dr. Anna Wilkinson: Absolutely.

Hon. Michelle Rempel Garner: Thank you.

The Chair: Thank you, Michelle.

Next we have Sonia for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Madam Chair. I'll be sharing my time with Pam.

Thank you to all the witnesses for being here and for your knowledgeable testimony.

Dr. Gordon, we heard last time from Ms. Jennie Dale, the co-founder of Dense Breasts Canada, that family doctors are often not educated on breast density and the associated risks. Do doctors need more education? If they do, what kind of education would it be? What guidelines should be there?

● (1235)

Dr. Paula Gordon: Family doctors and the public absolutely need more education on dense breasts.

You heard from one of the presenters today that she found out only after she already had her cancer diagnosis. Women with dense breasts are at a greater risk of getting breast cancer, and they're at risk of their cancer not being seen even if they do have a mammogram.

Family doctors definitely need to be educated. It should be part of the curriculum in medical school and in the residency for family practitioners. The task force is in denial over the risks associated with dense breasts, but, as I said, they're mainly family doctors, so they need to be educated as well. They need to listen to the experts. They need to let the experts vote on their panels so that women won't fall through the cracks.

Ms. Sonia Sidhu: I'll hand it over to Pam.

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

Thanks to all of our witnesses for being here today. I've met with many of you previously.

I'm not a regular member of this committee, but I would suggest that the committee think about adding another meeting to hear from those who specialize in the treatment and research of Black women, indigenous women and those with a disability.

I tried submitting Dr. Juliet Daniel as a witness, and I was told that you weren't accepting any more witnesses. I did ask her to submit a brief, but it was on pretty short notice.

One of the things we're tasked with is coming up with recommendations.

Dr. Wilkinson, I know you've spoken about HPV screening and lung cancer screening. In Ontario we started vaccinating for HPV in 2008. The guidelines were put in place in 2013. I would expect that research has come a long way since 2013. Do you think that any task force should be shortening the timeline when they look at these guidelines? It seems like waiting 10 years or more to update them is too long.

Dr. Anna Wilkinson: Yes, I think we should be updating guidelines every five years or so. It's becoming more and more complicated, because, traditionally, we've relied on these randomized controlled trials to dictate what we're doing, and we're more and more in an era where those may not be available for some of the basic questions, so we have to think about when to stale-date trials.

We asked for a pause in this breast cancer screening guideline process to have only trials after 2000 considered. We had the pause, but there was no change, so these guidelines that you see still have evidence from 1963, from the 1970s and from the 1980s. Everything about breast cancer has changed since then, like the imaging we use and the fact that we didn't know about molecular subtypes. We didn't even have tamoxifen or lumpectomy until the mid-eighties, so these trials were done before those basic things. We really need to think about the validity of the evidence we're using if it's older.

Ms. Pam Damoff: We're also seeing more younger women getting breast cancer now than we did in the 1960s, when it was much more in older women. We're just finding it more.

The other thing I wanted to ask you about is the Canadian Cancer Society having withdrawn its support for many of the guidelines that the task force has put out. You talked about subject matter experts being consulted but not being voting members. If the task force stayed in place, what could we recommend in terms of people who have expertise providing input and perhaps voting? How do you see that working?

Dr. Anna Wilkinson: As a family physician, one of the major difficulties I find is that there are multiple guidelines on each topic. The Canadian Association of Radiologists has a breast screening guideline that's different from the task force guideline, and that's so across all subject matters. It's confusing for family physicians. Which guideline do you follow?

We should, as a nation, be bringing those people into the fold. It shouldn't be the specialist versus primary care. Let's have a collaborative guideline so that, for the issue of breast cancer screening in Canada, we pull in all of the expertise from all of these specialists, and we have one way forward.

● (1240)

The Chair: Thank you very much.

Thank you, Pam.

Thank you, Sonia.

Laila, you have five minutes.

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

I want to thank everyone for this study here today. It's wonderful to have breast cancer be prominently studied here in the month of October.

We did study this at the health committee, and we had some amazing testimony, but I want to go further on this.

Dr. Paula Gordon, can you tell us how you would advise a woman who might be on the fence about whether they should talk to their doctor? What advice would you give a woman today?

Dr. Paula Gordon: That's a really good question, because we know that family doctors are provided with a decision tool that understates the benefits and exaggerates the harms. It's almost designed to discourage women from having screening.

My advice would be to go have your mammogram at age 40. Yes, it's going to be a little uncomfortable. Don't book the test for when you're premenstrual, because that's when breasts are the most tender. Let's make it the best we can for your first time. Maybe even take a Tylenol an hour before the test. That'll give you some very important information right off the bat. You'll find out whether you have dense breasts, and hopefully you'll get an all-clear.

Another important piece of advice I would give women is that when you get that report and it tells you your breast density, if you're category C or D, which means you have dense breasts, you should, at the very least, do breast self-examination, because we know mammograms can miss cancers and we want women to find them as early as possible. If at all possible, try to get a supplemental test like ultrasound if you're at average risk. If you're at very high risk, have an MRI. Go online and look at the IBIS risk assessment tool. It's just a few questions, and it will tell you what your lifetime risk and risk over the next 10 years are of getting breast cancer. If you have higher than a 20% or 25% lifetime risk, you're at high risk, and you should be talking to your doctor about getting referred to a high-risk screening program.

All women should have a risk assessment by about age 30, and women should be encouraged to do breast self-examination so they get to know what their normal is and have a better chance of finding cancer as early as possible.

Thank you.

Mrs. Laila Goodridge: Thank you.

Yes, we do know that early detection does truly save lives.

I'm going to open this up to Dr. Appavoo.

What advice do you have for women? We know that this task force has failed women, so what advice could you give to women today who are possibly on the fence?

Dr. Shiela Appavoo: Do you mean regarding breast cancer screening?

Mrs. Laila Goodridge: I mean regarding breast cancer screening. Right now we can skip past them. We have a captive audience.

What advice do you want women to have?

Dr. Shiela Appavoo: Do that risk assessment between the ages of 25 and 30 so that you know before it's too late if you are at a higher likelihood of getting cancer, even in your thirties. As we've heard today, there are a significant number of women who do get breast cancer in their thirties, so find out your risk before you find out the wrong way.

As Dr. Gordon says, women 40 to 49, or basically in premenopausal women after 40, should be screening every year, because in those years the hormones are at a higher level. Breast cancer is sort of fed by the hormones in a lot of cases and grows faster and more aggressively. We know from studies that there's a lower chance of getting a late-stage cancer if you screen every year instead of every other year.

The other thing is—I'm going to wander slightly off topic—women aged 74 and above are a bit ignored. As Dr. Wilkinson said, with those studies in the 1960s to the 1980s, the lifespan for women was about 76 years in 1970, and the studies stopped at age 74. Well, lifespan for women now is around 83 years, so stopping at 74 makes sense if you only look at these ancient studies. It doesn't make sense in 2024.

Mrs. Laila Goodridge: Dr. Wilkinson, the last minute goes to you.

What advice would you give to Canadian women here today?

Dr. Anna Wilkinson: Screening is a very personal decision. You can make your own decision as a woman about whether that's something you want to do or not.

I agree. Know your risk and know it early. When you're 40, that's when you can start thinking about mammograms. The rates of cancer are not really high enough in the twenties and thirties to think about broadly screening, but if we had clear guidance from the task force, we'd probably have high-risk programs across the country. Right now we have them only in Ontario and Nova Scotia, so there's very limited access to that for women who realize they're high risk.

● (1245)

The Chair: Thank you.

Lisa, you have five minutes.

Ms. Lisa Hepfner (Hamilton Mountain, Lib.): Thank you, Chair.

I want to echo my colleagues and thank all of you for being here. This has been really valuable testimony today.

I want to start with Ms. Kim MacDonald and a different type of screening that affects women who have experienced breast cancer. We were talking about it this morning. It's airport screening.

Even just today, you've had experiences as a breast cancer survivor in the airport. As we're coming up with recommendations, I'm hoping you can add this to the conversation.

Ms. Kim MacDonald: Yes, I would love this to be added to the conversation. This is something that breast cancer survivors talk about with each other. When you go through airport security, if you have prosthetic breasts or a bra that has some kind of light prosthetics in it, you are stopped. You are screened. You are patted down. You are treated like a criminal. This happens to me often, or I'll just go flat because it's easier and I know that I won't be patted down.

It's like you're being humiliated every time you travel. Also, you're telling a perfect stranger that you had breast cancer and you had a mastectomy. I told this woman at the airport that this is why I was being flagged. She said, “Okay, but I still need to do everything. Do you want to go to a room?” I said, “No, I don't have time to go to a room. Just pat me down right now. I'm not doing anything illegal.”

Time and again, women who have had breast cancer and mastectomies are stopped and treated as if they're smuggling something in, just because they're wearing prosthetic breasts. My suggestion would be that we have a card or something that gets us out of the humiliation, like people who may have an artificial limb or a plate when they get stopped. It's very personal. It's very embarrassing, and it happens all the time. It happens to me almost every time if I wear anything underneath my shirt.

Ms. Lisa Hepfner: Thank you for sharing that.

Ms. Kim MacDonald: Thank you for asking.

Ms. Lisa Hepfner: My next question was going to be about any potential solutions. You kind of touched on that. Do you know of any other sorts of examples, such as cards, that we could put forward?

Ms. Kim MacDonald: I don't know specifically. I just know that other people who have issues because of health who go through airport security can get a pass without being patted down. I think a card might be the best solution to get women who've had breast cancer past that.

Ms. Lisa Hepfner: To reiterate, it's not just you. You've spoken about this with other breast cancer survivors.

Ms. Kim MacDonald: Yes, many. I was given a card when I had radiation. If I had to cross the border, there was something I could show in case the radiation went off at the border. I know it sounds insane, but it's true. I had a lot of radiation. I didn't travel during that time in my treatment, so I didn't have that problem, but I was given a card by my doctor in case I had an issue because of radiation.

I don't know why this is not already a thing, because it happens all the time to women, not just in Canada.

Ms. Lisa Hepfner: Thank you, Kim.

I'll turn to Dr. Appavoo.

In your opening statement, I think we all agree that we were shocked by the findings of the task force. The health minister ordered a review of that task force, but I think you raised some concerns about the review of the task force. Can you reiterate those and maybe give us some more to work on moving forward?

Dr. Shiela Appavoo: Sure. You know, it's called an external experts review, and the experts are external, but the review isn't external. The body that funds the task force is running the review. There's a massive conflict of interest there. I mean, who wants to look bad?

The Public Health Agency of Canada did an audit of the task force in 2022, and it didn't address fundamental problems like the lack of experts. It really was not satisfactory. We can see they've chosen deliberately to exclude any representation from the specialists who are involved in actual treatment of these diseases.

The university evaluation is from the University of Calgary, which houses the task force. Again, the university is not going to want to look bad. They should have an external university doing the review.

Somebody like the chief science adviser should be supervising this, overseeing it, or perhaps, although it may be out of their purview, someone like or analogous to the Integrity Commissioner. This should really be an external review. This is putting the fox in charge of the chickens.

● (1250)

Ms. Lisa Hepfner: Thank you.

Dr. Gordon, you also raised this. You said content experts are being deliberately excluded. I'm getting that you think they should be included in any task force.

Dr. Paula Gordon: Yes. Thank you.

The Chair: Excellent. Thank you, Lisa.

Next, Andréanne, you have two and a half minutes.

[*Translation*]

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

Ms. Gioia, there's one aspect that hasn't been addressed here today. In fact, it's been touched upon, because we all know women, in our circles, affected by increasingly aggressive cancers at young ages. I'd like you to talk to us about environmental factors, because that's what your group is focusing on.

How might we explain some of the observations made about these more virulent cases affecting young women?

Milena Gioia: Thank you for the question. I'll let Ms. Beeman respond.

Ms. Jennifer Beeman: For Action cancer du sein du Québec, exposure to endocrine disruptors that mimic hormones, especially estrogen, is a major problem. It's a broad field of research. Numerous researchers in various fields have demonstrated that it's linked to an increased risk among young women and black women. In fact, the products made for them contain more toxic substances.

Increased risk is an issue that really needs to be rigorously addressed. We wonder why there is this increase in breast cancer, but also other types of cancer, such as uterine cancer, in very young women. It's still quite rare, but the increase is striking nonetheless. So it's important.

Thank you for the question.

Ms. Andréanne Larouche: Thank you.

I have about 30 seconds remaining.

To conclude today's debate, at least for me, I'll turn to Dr. Appavoo.

You said that lowering the screening age was a step in the right direction, but that it still wasn't low enough. You'd like screening to start at the age of 40.

Can you explain why you've drawn that conclusion?

[*English*]

Dr. Shiela Appavoo: Screening should be initiated at age 40. It should be annual from 40-50, and preferably during the premenopausal years, while the hormone levels are higher. That is for women at average risk. For women at an elevated risk of getting it—especially if they have a young relative, particularly a first degree relative, like a mother or sister, who had breast cancer in the premenopausal years—they should start screening about 10 years earlier than the age of diagnosis of their first degree relative. If their mother had breast cancer at age 45, they should actually be getting into screening at age 35. Again, for those over the age of 74, it depends on the health of the woman, but 70 is the new 50. We're still young in our seventies, so as long as you're young, that's good.

The Chair: Thank you.

Lastly, we have Leah Gazan, for two and a half minutes.

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

As we've gone through the study, I just find everything shocking and horrifying. All the information around the task force is so disturbing. I wish I had more time.

My last question is for you, Dr. Appavoo.

I know your group is calling for an accountability structure to oversee the task force. That seems really necessary, especially with everything we're learning. You're talking about ensuring the folks who oversee it are experts in the field, so they can oversee the guidelines that are being put in place.

Who would be on it? Who would make that choice about who would oversee it?

● (1255)

Dr. Shiela Appavoo: I think the panels themselves should include and potentially be chaired or co-chaired by content experts. That's actually probably an assumption most people have until they learn otherwise. Most people assume the panel of experts writing the guidelines includes experts in the sciences that are specific to the topics. For example, a breast screening guideline should be chaired by somebody who has breast cancer expertise as well as family medicine, and should include methodologies and statistics.

Overall, right now, there's no accountability for the task force or its guidelines. For example, the cervix guideline that was done in 2013 was very regressive. Gynecologists already knew HPV screening was the way of the future. They recommended against it. There is absolutely no way to change that guideline. That guideline still stands. It was outdated in 2013, when it was published.

It's 2024, and it's still there. Why? There's nobody to say, “This needs to go”, “This needs to be revised now”, or, “Let's replace it with a different guideline, perhaps from a different jurisdiction, such as a province or a different country.” There's just nothing. We're just stymied when it comes to trying to fix or change any of the task force guidelines. That is directly due to a lack of accountability. That's why I say, “This task force needs to be replaced.” Maybe I'm wrong, but I don't see a way forward to getting accountability unless the entire structure is changed.

The Chair: Thank you, Leah.

You had five seconds, so I stole it. Oh, oh!

Ms. Leah Gazan: It's rare that I don't talk longer.

Some hon. members: Oh, oh!

The Chair: On behalf of the committee, I would certainly like to thank all of the witnesses for their testimony today.

Is the committee in agreement to adjourn the meeting?

Some hon. members: Agreed.

The Chair: Thank you.

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