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TRANSCRIPT OF THE MINUTES

of the

COMMITTEE ON WOMEN'S ISSUES
COMMITTEE ON HEALTH

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HELD AT: Hearing Room
250 Broadway, 16th Floor

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DARLENE MEALY
Chairperson

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CHAIRPERSON MEALY: Good afternoon. We're going to start our joint hearing with the Health Committee and Women's Issues Committee. We're opening up this committee in regards to health.

I want to say good afternoon. I'd like to thank everyone for coming out today to this important hearing. My name is Council Member Darlene Mealy. I'm the Chair of the Women's Issues Committee.

Today we are holding a joint hearing with the Health Committee, chaired by our Majority Leader Joel Rivera, evaluating new recommendations in breast cancer screening. The recent mammogram recommendation announced by the Federal Task Force has caused a big stir in the medical community and a lot of confusion for women.

After many years of advocacy and education telling women to get an annual mammogram when they are 40, most women over 40 adopted this practice as part of their regular health routine, and most health insurance includes mammograms as part of coverage for annual prevention checkups.

Now this is all in question.

Also, for years, women have heard their physicians, along with many cancer advocacy groups beating the drum about breast self-exams and mammograms saving lives. For years, women's health advocates have argued for these screenings to be covered by insurance.

The recent recommendations have brought up many questions and today both committees will hear testimony from medical and research experts and women's health and cancer advocates. Hopefully, we can make sure women have clear instructions on the best way to proceed with our health.

So I'm going to let our first panel begin. Can you introduce yourself and give us your name?

DR. ROSS WILSON: Sure. Good afternoon Chairperson Mealy and members of the Committees on Health and Women's Issues. I'm Dr. Ross Wilson, acting Senior Vice President and Deputy Chief Medical Officer for the New York City Health and Hospital Corporation. I'm joined here with Dr. Lynn Silver, the Assistant Commissioner

for the Bureau of Chronic Disease Prevention and Control of the New York City Department of Health and Mental Hygiene.

We thank you for the opportunity to discuss recent announcements that have been made regarding breast cancer screening. I'd like to begin by saying that HHC continues to extensively promote the early detection and treatment of breast cancer as the primary tool for reducing the burden of disease.

Our policy has not changed. HHC's clinicians screen for breast cancer through providing clinical breast examinations and mammograms for women aged 40 years and older, regardless of their ability to pay. Last year, HHC's 16 hospitals and diagnostic and treatment centers provided more than 72,000 mammograms.

HHC facilities use state of the art digital mammography systems that produce digital breast images through computerization rather than traditional x-ray film, substantially increasing image resolution and reducing delays in generating results. I would like to thank members of the Council for providing funding for some of these

digital mammography systems in prior city budgets.

The impact of breast cancer in New York City is significant. According to the Health Department, nearly 5,000 women are diagnosed with breast cancer each year and more than 1,100 women died of breast cancer in 2007.

Approximately three-quarters of new cases of breast cancer between 2002 and 2006 and 86% of breast cancer deaths occur in women aged 50 and older. But 18% of cases and 10% of deaths occurred in women ages 40 to 39.

Mammography screening rates for breast cancer are higher across the city at 78% in 2008. Rates of screening are similar or slightly higher in black and Latino women compared to white women, but lower in Asian women. In 2008, uninsured women were significantly less likely to be screened, 62% in contrast to 80-82% for the insured. Screening rates are slightly lower in women aged 40 to 49. While black women in New York are screened at the highest rate, they die more than any other group of women.

Breast cancer screening is effective at reducing mortality but mammography is

a less effective screening test than some other cancer screens. Even if all women over 40 are screened annually, mammography alone will not prevent fewer than one-sixth to one-third of deaths and so should not be our only strategy for reducing breast cancer deaths. Promoting mammography can and should remain a critical part of our efforts to reduce the burden of breast cancer in New York women.

Around the city the main barriers to screening are lack of insurance and co-pays or deductibles. However, at HHC, we provide mammograms regardless of ability to pay. HHC and the city support key provisions of federal health care reform that would eliminate co-pays and deductibles for preventive care like breast cancer screening.

HHC monitors the availability of mammogram services and utilization of such services in women who are at the most risk from breast cancer. We believe that we can only achieve optimum quality of care through rigorous self-monitoring and by resolving issues that may impede the proper delivery of health care services

to the population that we serve.

Of the 72,000 mammograms provided last year, many of these were for women who did not have health insurance or the ability to pay for such procedures. Any woman who does not have a primary care provider or medical home can go to an HHC facility, register to become a patient and receive her annual mammography and any other services she needs, including clinical breast examination.

HHC is committed to ensuring that a woman's lack of insurance coverage does not pose a barrier to accessing mammograms and needed care. HHC staff help patients obtain public health insurance for which their eligible. We also offer services at little or no cost through the HHC Options fee scale program.

The prevention of breast cancer continued to be challenging as the specific causes for breast cancer remain elusive. Furthermore, except for smoking, obesity and lack of exercise, most of the risk factors associated with breast cancer cannot be easily controlled or prevented. Those risk factors include age, more common among

women aged over 50. Race, breast cancer is more common among Caucasian women, although mortality is higher amongst African American women. Family history of breast cancer, it's more common among those who have close blood relatives with breast cancer. The early onset of menstruation, it's more common among women who had onset of menstruation at age 12. No children or late onset of pregnancy. Breast cancer is more common among women who have no children or had first pregnancy over the age of 30 and did not breast feed. Women who breast fed for a longer duration seem to have a lesser risk for breast cancer.

In light of recent opinions and recommendations that have been published on the value of screening, it's critical to emphasize public education on the need to have a mammogram and the importance of the doctor/patient relationship.

HHC has traditionally conducted extensive public awareness and outreach efforts but we specifically focus on breast cancer screenings in May when we sponsor our annual Mother's Day mammogram campaign. The Mother's Day

mammogram campaign is designed primarily to reach underserved women. The campaign stresses the importance of having a mammogram, an important and potentially lifesaving procedure.

This multimedia effort has featured both radio and newspaper advertisements with wide circulations in minority and new immigrant communities. Materials are provided in multiple languages to community-based organizations, many of whom serve non-English speaking communities. We also link them to a primary care provider if they need one.

In addition to conducting public awareness campaigns, we recognize the importance of patient/provider relationship and encourage our providers to promote breast cancer screening to their patients. The provider's advice to the patient on the need for a mammogram is invaluable.

We also recognize how important it is for our providers to keep up to date on evidence based practices so they can provide the highest quality and advice to their patients. We conduct periodic education programs for our providers on breast cancer screening and the

effective management of breast cancer.

The decision to undergo a mammogram is taken by a patient in conjunction with their physician. Their physicians are familiar with the evolving scientific evidence and will make a recommendation for screening which reflects that evidence and the individual patient's particular clinical situation.

In addition to mammography, there is also a need to focus efforts on reducing the number of New Yorkers at risk for breast cancer. An important part of the prevention equation is promoting changes to lifestyles that contribute to the breast cancer burden. Studies suggest that as many as 35% of breast cancer cases can be attributed to obesity, lack of physical activity, lack of breast feeding and alcohol consumption.

The Health Department promotes risk reduction through two major initiatives. Firstly, a broad multidimensional plan to prevent obesity by increasing access to healthy foods, decreasing consumption of unhealthy foods and getting New Yorkers moving. As you know, much of this work is being done in partnership with the City Council.

And secondly, targeted efforts for low-income, first-time mothers and their infants to encourage breast feeding through the Newborn Home Visiting Program/Nurse Family partnership and other programs.

This concludes my testimony and I look forward to answering any questions that you may have.

CHAIRPERSON MEALY: Please introduce yourself. You're not? I just want to thank my colleagues that are here in attendance, Council Member Rosie Mendez, Council Member Helen Sears, Council Member Foster and Council Member Al Vann that just left. I want to let you know that Councilman James Sanders sent in a letter. He will be excused for today.

I'd just like to ask a couple of questions and then I'll let my colleagues speak afterwards.

Are you concerned that the new recommendations may have caused confusion among women about what to do about breast cancer screening?

DR. ROSS WILSON: I think that the

way that the information was released has the potential to cause confusion. I think there is no question about that. I think the task force itself recognizes it. I think they used the word "clumsy" with regard to the communication. I think that's regrettable and I think the task force regrets it, as much as we all regret it, as much as the community regrets it.

Anecdotally, within the community we serve, we've not noticed any reduction in people presenting for mammography, nor have our providers provided information to us that suggests that at the patient level there has been much confusion. People who have previously had mammograms want to continue to have mammograms and they're continuing to present and we are continuing to provide mammograms to those patients even if they happen not to be in the age group that's changed, particularly the contentious age group of 40 to 49.

CHAIRPERSON MEALY: Could there have been a better effect to telling the community in regards to this?

DR. ROSS WILSON: I think it would

be presumptuous of me to provide advice to the task force. But I think--

CHAIRPERSON MEALY: [interposing] No, I know it would be presumptuous, but could there have been a better way to inform the community first?

DR. ROSS WILSON: I think there has to be a better way but I'm not sure how it is. That is a very difficult task for a group such as that that was constituted to do this. They have a scientific task to do. They have been asked to take all of the science and come up with a recommendation even when the science is inexact or is changing. That's a very difficult task. So they came out with recommendations that are about the science.

What didn’t happen was the next step which was how do we translate that knowledge into both information that the community would understand and secondly, how we would translate that into a plan and what we would do differently if we were to follow that.

Currently there are a minimum of three different sets of guidelines available for

our providers. There are probably many more than that. They all agree on the major parts, which is that clinical breast examination and mammography are both useful tools. They all agree on the fact that mammography is an imperfect tool and even if everybody had a mammogram every time they're supposed to have one, we would not be able to eliminate breast cancer just with those alone because the tool is not good enough. They disagree on which particular age groups have come up on.

I guess the key thing that this new task force has introduced into the discussion for the patients aged 40 to 49 where breast cancer is less common and then hence, as a result of screening, there are often more false positive tests. If a woman has a false positive mammogram, this is a cause of a lot of anxiety. It's also the cause of further testing.

They were trying to make a balance between the risks to a person of having a false positive test, someone who actually doesn’t have cancer but having an abnormal test versus not doing it. That's what they were trying to

address.

They're technically correct about the science. The science is not really clear here. I think the word "clumsy" is the right way to translate that into a practice which has been entrenched for some time and which from a public health point of view we have supported.

CHAIRPERSON MEALY: I have another question. You had said in your testimony that the Asian ethnic is very low. Should there be a different screening recommendation be made by ethnic groups?

DR. ROSS WILSON: I'll ask my colleague to comment, but I don’t think this data would support a different screening guideline. It may support a different approach to communication with the community. Dr. Silver?

DR. LYNN SILVER: I would concur. In general we have found lower screening rates in the Asian community.

CHAIRPERSON MEALY: For the record, could you say your name?

DR. LYNN SILVER: Dr. Lynn Silver, Assistant Commissioner of Department of Health.

We have found lower screening rates for a number of cancers in the Asian community which has led us to do more targeted outreach in education in that community to increase screening rates. Not necessarily changing the actual recommendations, just working harder to get people from those groups screened.

We've had some success with colon cancer. We still need to make more progress on both colon and breast cancer screening.

CHAIRPERSON MEALY: Thank you. One of my colleagues would like to ask some questions. I believe being women we have a lot of questions to ask. Council Member Sears has a question.

COUNCIL MEMBER SEARS: I don’t have a lot, just a very few. I happen to agree with Dr. Wilson. I thought that it was cumbersome and really distributing in the fact that in its confusion it created doubt. That I think was the most offensive of the way they handled that.

What approximately is the estimated age for the duration of technology? I ask that for very specific reasons. So the equipment to take the mammography, how long do they

approximately last?

DR. ROSS WILSON: Can I ask you just to ask that question again?

COUNCIL MEMBER SEARS: Sure. The technology for mammography what is the estimated of the age for doing what it does? What is the length of time for the use of that equipment?

DR. ROSS WILSON: How long would the equipment last?

COUNCIL MEMBER SEARS: Yes. To be effective in what it does.

DR. ROSS WILSON: There are two answers to that question. One is that the technology itself is changing.

COUNCIL MEMBER SEARS: That's why I asked that question. It moves all the time.

DR. ROSS WILSON: It does. We've historically used what's been called analog radiological techniques based on film. There has been a major push to move onto what's called digital techniques where images are looked at on a screen but they can be stored and transmitted more easily and they have higher resolution.

Our experience, and not just ours

but everyone's experience is that the digital techniques are superior and we've got those in place across our sites.

COUNCIL MEMBER SEARS: HHC uses that now.

DR. ROSS WILSON: They do and they do with support from the Council in helping us get there. So we're very appreciative of that support.

In the future there are some real challenges with the technology. NMR scanning, MRI scanning is being regarded by many as moving from a diagnostic to a screening role. That's very difficult, very complex. There is the use of more sophisticated forms of ultrasound. Over the next ten years we'll see changes in technology. As we see changes in technology, we hope to see better effectiveness, the ability to have earlier detection of breast cancer and less false positives.

So I think we're in a phase at the moment where five years from now we'll be having a different conversation, and ten years from now we'll be having quite a different conversation

about the technology involved in terms of detection.

COUNCIL MEMBER SEARS: The reason I ask that is because the advancement of technology is so fast and understanding the cost of it. But aside from perhaps lack of insurance, I also think women are very reluctant to take their mammography when they're younger. Now there is introduced two different machines, one for smaller breasts and those for larger breasts. A mammography is uncomfortable. The new machines are really fine.

So I think one of the things that could be very helpful in having women screened when they should, particularly within the different ethnic groups is that I think it would help to somehow communicate.

I think Council offices are very effective for doing that. Is that the equipment is available for women who need one or the other of that equipment and that they should because I really have heard feedback in my office that they are reluctant because it is extremely uncomfortable. Of course that shouldn’t stop them, but it is. I think they need to know that

there is another one that's available to them. The HHC is very good because they really have advanced technology and it's very costly to really keep up with.

DR. ROSS WILSON: I agree. I think we're fortunate to be in a position now where we can offer mammography at 16 sites, which should not be unduly painful or uncomfortable.

COUNCIL MEMBER SEARS: The new equipment is excellent, it really is.

DR. ROSS WILSON: Correct.

COUNCIL MEMBER SEARS: I know, because I've used it. I get all my care at Elmhurst because I think HHC is great. I think that we need to do a better job, I think with HHC and 51 Council Members, on how we can communicate to the women in our districts as to what is available and how effective new technology has been.

I think perhaps, and I don’t know if HHC has a little piece of literature just addressing the technology.

DR. ROSS WILSON: I'm not sure that we do as a specific activity.

COUNCIL MEMBER SEARS: I don’t either.

DR. ROSS WILSON: It is part of a broader education piece.

COUNCIL MEMBER SEARS: I just wanted to know that because I feel that that’s one of the big issues keeping women away from having a mammography. Thank you.

DR. ROSS WILSON: Thank you.

CHAIRPERSON MEALY: We have Council Member Mendez.

COUNCIL MEMBER MENDEZ: Good afternoon. Just for the record, I get my health care at Gouverneur and I get my mammograms there. So you have two Council Members going to HHC.

My first question, and just to let everyone know, in February I'll be 47 and next year will be 30 years that I have been getting mammograms. I found a lump at the age of 17. So I'm certainly aware of procedures from 17 until now. I've been them with more frequency and now I'm getting them year, except for last year when I missed my appointment. It took four months to get one and then we were in election time so I

couldn’t do that.

My first question will be to DOH. Can I ask you what your recommendations are for preventative services?

DR. LYNN SILVER: At present, the Department of Health's recommendations are based on the 2003 U.S. Preventive Service Task Force recommendations which were that women 40 and older have a mammogram every one to two years. For now those are our recommendations. We have not made any changes. We are carefully studying the issue and speaking to researchers and epidemiologists with a variety of understandings on the issues but we are being cautious and basically looking carefully at the data.

COUNCIL MEMBER MENDEZ: Thank you. As my colleague mentioned about getting the word out, now DOH is very great and has done all these wonderful commercials on smoking. Does DOH have any plans to do any type of public service announcements for women and breast cancer preventative services once you make your determination of how often women should get checked? Is that in DOH's plans?

DR. LYNN SILVER: DOH has a wide range of activities for getting the word out on breast cancer and trying to encourage women to get breast cancer screening. Cancer screening, for example, has been a major part of our electronic health records initiative so that we make sure that every woman who goes to a site that has one of those, their cancer screening is verified and they get referred if they haven't been screened for example, which is reaching now thousands of providers across the city.

We have not been able to do mass media campaigns basically due to lack of funding at this point. So we have not had television ads or major media campaigns on this issue. We've worked with HHC over the past years around the Mother's Day campaign, which is a great campaign. I would love to have funds available to do mass media work on this issue. Unfortunately, in the current financial context it's been very difficult.

COUNCIL MEMBER MENDEZ: I'll pay attention when we get to executive budget. My recollection was in last year's budget there was a

lot of money for public service announcements. Maybe it's just being steered in one area as opposed to another. But we'll be getting to preliminary budget hearings very soon before you know it.

My question is to either HHC or DOH regarding ethnic and socioeconomic groups. You spoke briefly about Asian Americans and the lower rate among Asian American women, but what about other groups and what kind of targeting. Just my own experience among Latinas and the stigma attached and women not wanting to get tested. What have you observed and what are you doing with other groups?

DR. LYNN SILVER: The screening rates in Latina women are not lower. In fact, they're slightly higher, and have been for some time. So we're happy about that. We're not having disparities in screening rates. Really what we're seeing is very significant disparities in mortality, particularly for black women but also for others.

For that we have actually created a working group on reducing disparities in breast

cancer in the city. We've been working with a number of organizations and providers, including HHC to try and devise strategies to reduce that huge gap in mortality, which is very significant for minority women.

So not only are we trying to maintain the push to keep women getting their screening in mammography and further increase the levels of screening which are good but could still be better. We still have 20% of women not getting screened. But we also want to make sure that women who do have lesions detected are getting care in a timely fashion and getting high quality care so that we're not seeing these disparities in deaths which is of great concern.

COUNCIL MEMBER MENDEZ: Again, for either one of the panelists, what are the wait times now to get a mammogram?

DR. LYNN SILVER: We've done two consecutive studies on that. The first study was 2007 where we basically called all of the registered mammography facilities in the city as essentially simulated patients to verify the wait time. What we found was that the median wait time

was actually quite acceptable. It was below two weeks in facilities across the city. We did have a few facilities that had very long wait times, but most facilities were reasonable and women in each borough had good options with short times.

We're in the process of finalizing a repeat of that study now. The preliminary data I have looks like it's still below two weeks and possibly slightly shorter than the previous survey. So long wait times, although a few facilities have them, don’t appear to be the explanation or the key barrier to women being screened. It's probably more a combination of insurance, cultural issues, acceptance and so forth.

COUNCIL MEMBER MENDEZ: Thank you very much.

CHAIRPERSON MEALY: I would just like to ask a question. Could DOH answer this? When cancer is caught in a later stage, what is the likelihood of survival for these women?

DR. LYNN SILVER: As with other cancers, the basic principle is that the earlier you catch it, the more likely you are to survive.

If you catch it in its earlier stages, I don’t have all the survival statistics with me, but I believe it's over 90%. When you get into Stage 4 cancers or cancers that had already disseminated at diagnosis, it's much lower. It's a small minority of women.

CHAIRPERSON MEALY: So let's be clear. You tell women to start get tested at about 40 years of age. Now they're saying we should not get tested from 40 to 49. Is that correct? That's what they're stating now?

DR. LYNN SILVER: Not entirely, no. The recommendation actually said that women should be routinely screened above age 50 and that women 40 to 49 should discuss the pros and cons of screening with their physician.

I believe part of the intention of that was that most women are unaware why mammography definitely saves lives in that age group. It reduces mortality by about 15% in that age group of the very high incidence of other diagnosis. So they didn’t recommend against it but that was part of the confusion.

CHAIRPERSON MEALY: So what did

they recommend? I would like to be very clear. What I read it said that you do not have to get tested every year. Now you should at least get tested after your 50.

DR. LYNN SILVER: It shifted the routine testing recommendation to above 50. And it recommended that women discuss the pros and cons of screening with their provider between 40 and 49. It down rated the evidence rating from what's called a B to a C. In other words, it made a poorer assessment of the evidence for screening between ages 40 and 49 than the previous U.S. Preventive Service Task Force had in 2003. That's not the Department of Health's position. I'm just citing what the task force position was

DR. ROSS WILSON: But it also added that if you were a person or a patient who has a particular risk factor that you would be addressed at a younger age. If you have a family member with cancer, you have a blood relative with breast cancer, you've detected a lump at an earlier stage in your life or there have been other factors in your particular medical history, then you might be having mammography as we've heard at this table at

the age of 20.

So the guidelines as they're written do not preclude mammography being performed. They really emphasize the importance of the consultation with your primary care provider to take a history and make sure that examination is undertaken with attention to this being one of the aspects of women's health that should be considered.

So the guidelines as they're written done preclude that from happening, it just says the routine nature of it, if you are a low-risk patient, they've taken away that recommendation for 40 to 49.

CHAIRPERSON MEALY: Thank you for clearing that up.

DR. LYNN SILVER: It does not recommend against it.

CHAIRPERSON MEALY: Thank you. Are there any other questions? Well we want to thank you for sharing information.

DR. ROSS WILSON: Thank you for the opportunity to speak to you and to be able to discuss a very important topic. Thank you very

much.

CHAIRPERSON MEALY: You will be hearing from me more.

DR. LYNN SILVER: Thank you. We very much appreciate the Council's concern and close monitoring of cancer issues for the city. Your support has been fundamental to making progress.

CHAIRPERSON MEALY: Thank you.

FEMALE VOICE: The next panel is Claire Bradley from the American Cancer Society and Dara Richardson-Heron from Susan G. Komen for the Cure.

CHAIRPERSON MEALY: Before we start we want to acknowledge we've been joined by Council Member Inez Dickens and Council Member Julissa Ferreras. You can start. Introduce yourself.

DR. CLAIRE BRADLEY: Good afternoon distinguished members of both the Health and Women's Issues Committees. I am Dr. Claire Bradley. I'm the Chief Medical Officer for the Eastern Division of the American Cancer Society. That includes the states of both New York and New

Jersey.

On behalf of the 11 million cancer patients and survivors in America today, the Society thanks you for your leadership in the fight against cancer and your commitment to helping women gain access to life-saving early detection of breast cancer.

I appreciate the opportunity to testimony today about the important role mammography plays in combating breast cancer deaths.

As I am sure you all know, breast cancer is the leading cause of cancer among women in New York and the entire nation, excluding skin cancers. In fact, as many New York women will be diagnosed this year with breast cancer as men and women together are diagnosed with lung cancer. That amount is 13,500 individuals. And yet lung cancer will claims three and a half times as many lives as will breast cancer.

So you want to ask, well why is this? The primary answer to that question underlies the importance of your hearing today. Because screening and early detection, thanks to

mammography, is a major reason the breast cancer death rates continued to decline in the United States. It is not the only reason, but a major one.

The American Cancer Society in recent weeks has publicly disagreed with the recommendation of the United States Preventative Services Task Force with respect to mammography. The scientific evidence supporting the value of mammography in effectively reducing deaths from breast cancer is strong.

And in looking at the evidence, the Society, along with other medical groups, believes that screening mammography offers an identifiable and important survival benefit to women in the 40 to 50 age group. In fact, about 17% of women who die from breast cancer are diagnosed within their 40s, from 40 to 50.

More specifically, the Society believes that the reduction in mortality and less invasive treatments associated with early detection of breast cancer using mammography continues to justify a recommendation of annual screening in women beginning at age 40.

It is important to acknowledge that beginning in 1990 breast cancer deaths declined 2.3% annually for all women and 3.3% per year for women age 40 to 50 years of age. They may not seem like much from year to year, but when you consider the total over 19 years, the impact translates to a 20% drop in mortality for women less than 50.

This is particularly significant when taking into consideration that the death rate was absolutely stable for the preceding six decades. And hopefully that decline will continue into the future.

There is no dispute that screening mammograms and better treatments are responsible for that success. Actually it looks like it's about 50/50. The improvements in mortality are probably 50% due to better early detection and 50% due to better treatments. But they're not separate issues and they're closely linked. So if you use mammography to identify cancer earlier, obviously the treatments are going to be more effective. But it looks like it's about 50/50.

Based on the review of the

Preventive Task Force guidelines and their analysis, we see no reason to change what has been proven effective in reducing the death rates for breast cancer in all recommended age groups, including those women age 40 to 50.

The data and literature examined by the U.S. Preventive Services Task Force in the lead up to its November announcement on mammography is essentially the same data reviewed by an expert panel of breast cancer researchers and clinicians convened by the American Cancer Society in 2003.

However, in that earlier review, the Society's panel considered additional findings of a population-based study of modern mammography which showed much stronger benefits from screening compared with the more limited data examined by the task force.

In addition, since that time, a number of advances are increasing the effectiveness of mammograms in the 40 to 49 population. Those things are improved quality standards for mammography, digital mammography as well as MRI for high-risk women.

The American Cancer Society does not pretend that mammography screening is a perfect test. We know it has its limitations. In fact, we are among the institutions funding research that is aimed at finding even better tools for detecting and treating breast cancer. We need to identify which cancers are likely to grow and become lethal and those that will not. Unfortunately, at this point we are not there with the science.

But the essential fact remains, mammogram screening saves lives. We must refrain from doing things that undermine confidence in that test. Rejecting a test because it is not perfect would be an incredible betrayal of women in our society and a step backwards. We've come a long way in trying to get women to undergo mammography.

Unfortunately, the confusion being created by these new recommendations leads many women to wonder whether they should get an annual checkup, adding to the many other factors that discourage screening. We've heard today some of those barriers such as not having insurance,

having a co-pay with your insurance. There have been studies that showed for women who are in similar type insurance plans; those plans that require a co-pay for the mammography, those women have lower rates of mammography than those plans that don't have a co-pay. There are many social issues and many issues.

This is potentially going to be just another barrier as potentially providers may not refer the way they had in the past. And if a woman has just one more thing that says well maybe I don't need to schedule that mammography today, that would be a terrible thing.

It is sad and unacceptable that today nearly 40% of American women age 40 and up do not get a regular mammography. The most recent data from 2008 for New York State indicate that 64% of women over 40 get a regular mammography every two years. For many of the women who don't, it is often a matter of now having access to these tests, which is a major failure of our health care system.

As a result, too many women are at risk of being diagnosed at later stages of the

disease after the cancer has spread. That leads to more invasive and arduous treatments and more expensive treatments, poorer prognosis and poorer patient outcomes.

We know we can do better and we greatly appreciate the efforts that you have made to identify barriers and help overcome them. Unfortunately we are facing a turbulent time in health care. Here in New York the state budget deficit is forcing cutbacks in cancer screening for the uninsured. We expect that fewer than one-half of the 24,000 women over 40 who were screened in the metropolitan area will be served through these programs this year.

Congress is wrestling with major changes and the ACS is pushing hard for universal access to quality coverage that includes cancer screenings with no co-pays to stand in the way. A number of private insurance plans don’t require a co-payment for mammography and we are working here in the city as well as the state to make that practice uniform if the federal government does not do so.

Americans need access to consistent

and understandable health information that allows them to make meaningful decisions with their doctors about preventive services. New York and 48 other states currently have laws requiring insurance companies to cover mammography for women beginning at age 40. Public officials, from the United States Health and Human Services Secretary Kathleen Sebelius to Governor Patterson have reaffirmed the importance of this coverage.

We have made a great deal of progress in cancer prevention, detection, treatment and cancer care over the last few decades. Let us work together to continue this progress. Thank you and I welcome your questions.

Let me just provide a number and a hotline number. We talked about women and if they have questions where can they go. The American Cancer Society has a 24 hour 7 day a week hotline that women can call. It's a 1-800 number. 227-2345 and also the American Cancer Society has a website cancer.org where women, men, anyone can go and get information. If they don’t have the number, they could actually get the number off of the website. Thank you.

CHAIRPERSON MEALY: Thank you.

DR. DARA RICHARDSON-HERON: Hello and good afternoon. My name is Dr. Dara Richardson-Heron and I'm the Chief Executive Officer of Susan G. Komen for the Cure, the greater New York City affiliate.

I think we all know that a lot has been said about the report from the United States Preventative Services Task Force recommendations which were released in early November.

I really just first would like to very clearly state that Susan G. Komen for the Cure continued to recommend annual mammography beginning at age 40 for women at average risk and earlier for women who have known risk for breast cancer, such as a family history.

Furthermore, we continue to recommend breast self-awareness and physician examination. Many breast cancers are diagnosed and treated in a timely fashion because women feel lumps or find other abnormalities which lead them to seek medical evaluation and attention. In our large nation of diverse cultures, ethnicities and levels of education, it's very important that we

continue to information women about and help to demystify the issues around breast health.

It's also important to emphasize that the new guidelines are not intended for women who have already been diagnosed with breast cancer. Women with a family history of breast cancer or other significant risk factors should continue to have regular screening. This was not highlighted enough in any of the media reports on the recommendations.

It's been said earlier, but the messaging and release of the task force recommendations to the public was more than clumsy. In my opinion it was irresponsible. It certainly should have been handled differently and it could have been handled different to ensure that the correct message was relayed. The report presents statistical analysis which does not take into account clinical realities. Saving 1 life in 1,900 is significant, particularly if that life is your own, your mother's life or the life of another family member or colleague or friend.

Despite what was contained in the report and relayed by the media, most people have

not read the full guidelines. The lay public has not read the guidelines, so what they heard was "I don’t need a mammogram if I'm under 50".

I am a physician myself. I am also a 12-year breast cancer survivor and the recommendations were confusing to me. So I find it irresponsible and unconscionable that the recommendations were relayed to the public in the way that they were.

You asked earlier could it have been done better, yes. How? It should have been a private discussion amongst physicians, advocates, politicians and others; a decision made on how best to present this information to the public and then rolled out so that the public would get the message that needed to be heard.

The one message that should have been said is while there is disagreement about exactly when mammography should start, and when they should begin and on what schedule, but everyone agrees, including the task force that mammograms save lives, both in women age 40 to 49 and women over 50. Also, it should have said that women over 75 count too because we all hope to get

there.

Another thing, 75% to 90% of women have no risk factors or family history for breast cancer. The goal of routine screening is to identify breast cancer when it is in its early stage and much more responsive to treatment.

And again we cannot lose sight of the critically important fact that fully one-third or more of women in the world who actually qualify for screening under today's guidelines are not being screened due to a lack of access, education or awareness. That issue needs to be continually focused on. Because if we can make progress in those groups, in those vulnerable populations, we can make more progress in the fight against breast cancer.

Additionally, I'd like to just point out some very interesting and important considerations that appear not to have been taken into account when the original guidelines and analysis was done and the resulting recommendations were made.

One, it appears that no practicing clinicians were involved in the development of the

recommendations. Two, breast cancer advocates were not involved in the process. Three, the task force acknowledges that with their recommendations, 20% of cancers that would have been found in our current recommendations would be missed under the current guidelines.

Women who are not screened for early detection will present with more locally advanced or even metastasic disease. The cost of treating more advanced cancer is dramatically higher than curing the most early screened detected cancer in every measurable way.

Living with cancer is not better than not having cancer. It's costly in dollars and cents, medications, physician and ancillary costs, diagnostic tests, not to mention the cost to the quality of life for women and their families, days missed from work, and need for additional help at home.

I was diagnosed with breast cancer at age 34. If I had waited until age 50, I would not be speaking to you today.

The end point used in the task force analysis was lives saved and mortality,

which is really the wrong end point for breast cancer.

Thanks to research and improvements in treatments, we all know that many women may live long and productive lives with locally advanced or metastatic breast cancer due to some of the cancers being slow growing as well as better therapies.

Recommending against breast self-examination or breast self-awareness is clearly the wrong message. While it is technically correct that there was a rigorous clinical trial comparing monthly exam to non-monthly exam in a subset of women and it did not change the mortality, it's not a good reason to send a message to women not to practice breast self-awareness. The purpose of breast self-awareness is so that you can identify an abnormality and present it to your doctor for evaluation.

For many women, particularly those who have no other entry end point into the medical system, the annual mammogram and the Pap smear which was attacked two days after this recommend, are the only time that women come to medical

attention.

It provides an opportunity for more than just a mammogram or a Pap smear, but it also provides an opportunity for other problems to be identified. If we remove this access, we're doing a major disservice to women and women's health. This really is unconscionable.

The recommendation that each woman should have a conversation with her doctor; many of the women served by our organizations don’t have a doctor. So who are they going to be talking to? How will they have the conversation?

There are different levels of risk for different populations and we know that these different populations may need different screening. Some, like the African American community, may require earlier screening. But in any case, reverting to no screening in the absence of a better tool is clearly not the answer.

Finally, the recommendations ignore the unique disproportionate and detrimental impact that the recommendations may have on women who are already under served, uninsured and have less access to preventive screening. This is

particularly true for women of color, women from restrictive cultural backgrounds and non-English speaking women.

At Susan G. Komen for the Cure, we certainly understand that mammograms are not perfect, but they are currently our best tool for early detection and risk assessment. We agree and fully support more research to identify screening tools that will be more effective, sensitive and specific than mammography.

We also understand that it is possible that one day, hopefully in the very near future, guidelines for screening will be tailored to the individual. However, until a better screening methodology is developed and proved to be safe and have beneficial results, we must rely on our best screening tool which has been prove to save lives and that is mammography.

Susan G. Komen strongly urges women to continue breast self-awareness, regular physical examination, regular physician examination and screening mammography.

We also strongly support city, state and federal funding and political advocacy

for additional research and development of a better tool for early detection and hopefully a cure for breast cancer, the most common cancer among women in the United States other than skin cancer and the second leading cause of cancer death in women after lung cancer. Thank you.

CHAIRPERSON MEALY: I want to thank both of you. We do have questions, but I want to thank you so much for answering that question. I knew it could be a better way. I really appreciate your testimony. How do you think these federal recommendations will affect the insurance coverage of mammograms?

DR. CLAIRE BRADLEY: Actually, it's interesting, I think the biggest concern that we had because it was a federal body was that for Medicare that the coverage was going to change. Very soon after the guidelines were publicly released, the head of HHS, Kathleen Sebelius, came out and said don’t worry, we are not changing our guidelines.

Now, my concern is going to be that at the state level, where states are struggling financially that there might be some changes in

particular for the Medicaid population. So I think we have to be very vigilant that there are no changes.

DR. DARA RICHARDSON-HERON: I'd like to add to that. I agree with what she said as well, but I'm a little bit more cynical. I think that insurance companies are looking for ways to make changes to the recommendations under the guise that it might be cost saving. But I think it's a wrong message and it's short-sighted on their part because you will spend significantly more money trying to treat a late stage cancer.

The other more positive thing that I would say is there was a recent Senate meeting I believe where new recommendations were made for health care reform and it was preventive services for women which included mammography and I believe that was passed just recently.

What that would do is basically make these guidelines from the Preventative Services Task Force obsolete because it would require insurance companies to include a package of preventive health services for women which would include mammography. But again, we're a

long way before we have that whole thing passed.

CHAIRPERSON MEALY: Thank you. What do you think about private insurance, how would that be affected?

DR. DARA RICHARDSON-HERON: I unfortunately tend to believe that most insurance companies are looking for cost-saving measures. So if the task force and others maintain that women should not have these tests, then I think they'll figure out a way to make you either have a higher co-pay or pay for it.

DR. CLAIRE BRADLEY: I mean it's possible. That's why the laws I think, although I don’t like to have a law for this and a law for that, unfortunately in this area I think it's helpful, which we currently have.

CHAIRPERSON MEALY: Thank you so much. We have been joined by Council Member Kendall Stewart and Council Member Mathieu Eugene. We have a question from Council Member Julissa Ferreras.

COUNCIL MEMBER FERRERAS: Thank you so much. I really did enjoy greatly your testimonies. My question is more on the end of

the women that were receiving this information. I'm someone who wakes up and the news is on. I got to bed and the news is on. I'm cooking and the news is on.

What I received was every time that I watched the news it was the same information but it was given to me however the reporter felt that he or she wanted to report it. So the Latino press was saying one thing. New York One was saying something else. CNN was saying something else.

For the women that I'm assisting in my office it was very, very confusing. So as an advocate, in your opinion what is the most responsible message that we need to be getting out there? I worked really closely with our local hospitals to fund a mammography unit and if we listen to what these experts are saying, they're kind of saying the mammography unit isn't open to everyone anymore. I would think that as a Council Member I should be responsible enough to continue to fund the mammography unit. But how do I convince my women to go there, especially the ones that are in the 40 to 50 age range?

DR. DARA RICHARDSON-HERON: For me I could answer it very simply. Mammography saves lives.

For women of color, particularly, and really all women, you should have a mammogram beginning at age 40 or earlier if you have a family history. You should talk to your healthcare provider, find someone who you can talk to about when you should start and what tests might be best for you. But bottom line, simplistically, mammography saves lives. Go and have your test at minimum beginning at age 40.

DR. CLAIRE BRADLEY: In many areas of health care there are conflicting guidelines. It could be how to treat a particular cancer; it could be how to treat high blood pressure or how to do this. So I think it's very easy to say, especially for cancer that you can look to, and you may want to say your own organization, but look to the American Cancer Society. They have guidelines on how to detect and in some areas, for colorectal cancer, how to prevent cancer. As she said, we know that mammography in women over 40 saves lives.

It's interesting, if you look at some of the narrative from the task force, they basically said that for women over 50 you have to screen about 1,300 women to identify a breast cancer, but for women 40 to 50 you have to screen 1,900 women. So somewhere between that 1,300 and 1,900 someone said that's too many to save a life or to detect a cancer early. So I think that we have the evidence that mammography decreases mortality for breast cancer in women not only greater than 50 but from 40 to 50.

COUNCIL MEMBER FERRERAS: This happened recently in my office with one of my constituents. Someone came in. She had gone to her doctor. Her doctor was someone who believed the study that just came out and he told her she didn’t have to screen. So what about all these women that are facing these decisions?

My recommendation was get a second opinion because that's kind of what we do. But we always think second advice when we get bad news, right? So you get the bad news and you seek a second opinion. However they don’t even have the news yet and it seems like the approach is a

little different. Is there a certain school of medicine that's going with the study as opposed to another school of medicine that isn't?

DR. CLAIRE BRADLEY: I think from what I'm hearing, at the end of the day, after the new recommendations came out and there was some public debate about whether this was a good change or a bad change, my sense is that there were more people in favor of saying no, we need to continue screening at 40. But our worst concern is that there are going to be people that are going to say no, you don’t need it.

I don’t think that it's only when you get bad news that you need a second opinion. I think one of the keys to improving outcomes for individuals is to tell patients or potential patients as much information as you can so that they can be empowered to be the decider in their own health care.

Clearly it's a partnership between a patient and a provider. But if it were my loved one or someone that was asking me I'd say, no, you need to go look at the Cancer Society, you need to go look at this organization, but don’t just take

that. It's not the only decision; it's not the best decision maybe for you.

DR. DARA RICHARDSON-HERON: I would agree with that. I mean you have to advocate for your own health. When I found the lump in my breast at age 34, my own doctor said, don’t worry, it's very unlikely for a woman to be diagnosed with breast cancer at such a young age. Don’t worry, it's nothing. But because I was a physician I basically demanded a mammography. Quite frankly, this was before any of these recommendations changed. So you're going to get information from various different physicians. I would say she needs to find another physician.

COUNCIL MEMBER FERRERAS: Thank you.

CHAIRPERSON MEALY: Councilwoman Dickens has a question.

COUNCIL MEMBER DICKENS: Thank you, Madame Chair. Good afternoon and thank you both for your testimony. Actually, the chair, Darlene Mealy had really asked my question which was concerning the insurance.

I agree with you, Dr. Richardson-

Heron. Health is a big business and I think the insurance companies will look for a way to go along with the new recommendations in order not to pay. I remember there was a time when finally breast cancer was coming to the forefront. It was difficult in the beginning to sometimes get private insurance companies to even pay for the mammograms. So I have a fear about that.

I also have a fear about Medicaid not paying and using the recommendations as their guidelines for not paying. And in addition to that, I am glad that the American College disagrees with the recommendations. Is that correct? Do they disagree with some of the recommendations?

DR. CLAIRE BRADLEY: The American Cancer Society?

DR. DARA RICHARDSON-HERON: The American Cancer Society does.

DR. CLAIRE BRADLEY: Yes, the American Cancer Society does.

COUNCIL MEMBER DICKENS: All right. But not the American College, they agree with these recommendations? The American College of

Obstetricians and Gynecologists, do they agree?

DR. DARA RICHARDSON-HERON: I don’t believe they've come out with a statement on it. But two days after this was released, they came out with a statement asking that Pap smear guidelines be somewhat lessened. So I have not heard a statement from them about the mammography guidelines. I'm not aware of it.

COUNCIL MEMBER DICKENS: In the case of a patient that is on Medicaid, or even now with private insurance you've got HMOs and with some you've got doctors that you're assigned. If the doctor you're assigned to says I'm going along with these guidelines, it's difficult for you to change. Like in HIP for instance, just to call out the name. I'm concerned because so many people have HIP. How do we combat that?

How would a patient, other than taking a year to write letters, because that's what you do. When you disagree with the findings of your insurance company, you wind up writing letters and making calls and calling everybody and sometimes it takes you as much as six months to a year to get them to reverse their original

decision. In that time, the growth of the cells is progressing.

DR. CLAIRE BRADLEY: There's an important point and I think I mentioned it and maybe I wasn’t clear enough. There are 48 states in this country that require that insurance cover mammography beginning at 40. So right now it's a law.

Not that you're not going to have providers who may say you don’t need it, but if that woman went to her insurance and said, no, I want this, they would have to provide it for her. They are legally required. They sometimes skirt around laws, that's true. But right now we have laws that protect coverage for mammography beginning at 40. We have to make sure that those laws stay on the books.

The worst thing that could happen is that these guidelines would change those laws.

COUNCIL MEMBER DICKENS: That's the key. Because my colleague mentioning one of her constituents having this same issue, it means that other women are having the same issue. I have some very severe fears about what's going to occur

down the line, maybe not today, but based upon these guidelines. It's fearful.

DR. DARA RICHARDSON-HERON: I think you're very right to be afraid because insurers do look to these guidelines for guidance in making their recommendations. They absolutely do. But, as she said, they're a law now. The only time that that could be a real problem is if these provisions become law.

COUNCIL MEMBER DICKENS: So then that means we have to be a watchdog on that.

DR. DARA RICHARDSON-HERON: Yes.

COUNCIL MEMBER DICKENS: Thank you.

CHAIRPERSON MEALY: Thank you, Council Member. Councilman Mathieu Eugene has a question.

COUNCIL MEMBER EUGENE: Thank you very much, Madame Chair. Let me thank you and congratulate both of you for your presentation. Myself, I do believe that the best medicine is preventive medicine being a physician myself.

When I was doing my community service I created a not-for-profit organization in the community and I've been doing everything to

provide access to quality health care to the people in the community. I know how important the screening is regarding disease.

I want to commend and congratulate the American Cancer Society for the wonderful job that you are doing. I have many, many times had the opportunity to work together with you, using your van for screening.

I think other Council Members asked the question already, but maybe not. In case the recommendations are adopted, do you have in mind or in place what you should do? I know that you have been in the forefront of the fight against cancer. In case the recommendations get adopted, do you have in place or in mind what we are going to do to continue to motivate the people to give the awareness to the women that the screening is important and prevention is important?

DR. CLAIRE BRADLEY: There are a couple of levels that we're working in. One is at the federal government, especially now that they're talking about health care reform and we're talking about the importance of coverage for all preventive screenings. But because it's so

timely, the importance of mammography beginning at 40. So any federal plans or any laws, we want to make sure that that coverage begins at 40. We're also doing the same thing at the state level and we're glad that Governor Patterson has supported screening beginning at 40.

The other thing is we work with providers. So those providers that say start at 50, hopefully our message is getting through that no, we need to start at 40 and this is the reason, because it saves lives.

Then we also work directly with women about why it's important for them to get mammography. Women often put themselves last in terms of what they have to do. So they take care of their parents and they take care of their kids, especially in the age of 40 to 50 because many of them don’t go to the doctors for themselves. They're done having their children and they haven’t really started seeing someone because of chronic conditions.

So the recommendation that you need to speak to your provider, well these women may not go to see a provider for 10, 15 years. So to

them we're giving the message why it's important for women to begin regular mammography screening beginning at 40. So there are a lot of different levels we're working at and this is a difficult time because of the new task for change and also because of the economy. So we know that people are looking to save money at the federal level and at the state level. So we need to be particularly vigilant.

COUNCIL MEMBER EUGENE: Thank you.

CHAIRPERSON MEALY: Thank you so much for your testimony, it's been very informative and to the point.

DR. CLAIRE BRADLEY: Thank you.

DR. DARA RICHARDSON-HERON: Thank you.

CHAIRPERSON MEALY: Thank you. We will call up the next panel.

FEMALE VOICE: The next panel is Loretta Lawrence from the New York State Radiological Society and Gail Schwartz from SHARE Cancer Support.

CHAIRPERSON MEALY: You can start. All conversations could be outside. Thank you

very much. Could you state your name for the record please?

DR. LORETTA LAWRENCE: Sure. I'm Dr. Loretta Lawrence. I'm a Fellow of the American College of Radiology. I'm the current President for the New York State Radiological Society which is a chapter of the American College of Radiology. I am the Director of Breast Imaging for the North Shore LIJ Health System. I do want to thank you for inviting me here today.

There seems to be a little confusion about what the task force actually recommended. I wasn’t going to go into this because I sort of had this idea that we all know. So I just wanted to say what they actually said and then I'll go on with what I plan to say.

The task force recommended against routine mammography in women aged 40 to 49, stating that patient should sit down with their physician and discuss the risks and make a decision about what they should do.

They recommended a mammogram in women aged 50 to 74, not every year but every other year, which is a change as well. And in

women over age 74, they said there was no benefit to justify screening mammography. So they said a little bit more than just this discussion about people between 40 and 50 which is very important.

I am strongly opposed to the breast cancer screening recommendations released by the United States Preventative Services Task Force on November 16th, 2009. I am a radiologist who has specialized in breast imaging for the past 22 years.

The task force is comprised of government-appointed health experts that review published research and make recommendation regarding preventative health care. The panel of 16 experts responsible for the recent recommendations did not include a single expert in breast cancer field. None were from breast imaging, radiation oncology, medical oncology or breast surgery.

The American College of Radiology response regarding benefits versus concerns of annual screening mammography starting at age 40 included the following. It is well known that mammography has reduced the breast cancer death

rate in the United States by 30% since 1990, which is hardly a small benefit. Based on the performance of screening mammography as it is currently practiced in the United States, one invasive breast cancer is found in every 556 mammograms performed in women in their 40s. Mammography performed only every other year, which is what the task force recommended, in women aged 50 to 74 would miss 19% to 33% of cancers that could be detected by annual screening.

Of all abnormal mammograms, 85% require only additional images to clarify whether a cancer may or may not be present. Only 2% of women who receive screening mammograms eventually require a biopsy. The task force data show that the rate of biopsy is actually lower among younger women.

The task force agrees that screening mammography decreases mortality from breast cancer in women in their 40s by 15%, but this is a very low number. The task force relied on studies with methodology flaws that underestimated the benefits of mammography. 20% of women whose deaths are from breast cancer are

in the 40 to 49 age group. Many individual trials show the benefit of screening with the following percent breast cancer mortality reduction in women aged 40 to 49, including HIP, which was 25%, Gothenburg 44%, Malmo 36%, Sweden a whopping 48%, and British Columbia 39%.

The task force recommends screening based on risk in the 40 to 49 age group. Only 10% to 25% of breast cancers occur in high risk women in that age group. Not screening the others would miss 75% to 90% of cancers in that group.

I personally asked someone to review for me all the breast core biopsies done in our Long Island Jewish database for the past year and it revealed that we did a total of 2,040 core needle biopsies which are minimally invasive procedures, in which we found 657 cancers. In the group between 40 and 50 alone, 642 biopsies were performed and 138 cancers were found. That's a positive predictive value of 20%. What I want you to know is that 93 of these cancers were invasive. It is unconscionable to ignore these patients.

Regarding the question of how often women should be screened, even the task for agrees

that with increased screening, decreased mortality is achieved. Breast cancers grow at variable rates and in order to catch early and fast growing cancers, we must screen every year. This is especially true in the 40 to 49 age group who have denser breasts and their tumors are known to grow faster.

I strongly support the American Cancer Society guidelines which continue to recommend annual routine mammography screening for all healthy women age 40 and older. A major concern is that the task force recommendations will be used by the possible health plans being considered in Congress which could lead insurance companies to stop covering annual breast cancer screenings beginning at age 40. Thank you.

CHAIRPERSON MEALY: Thank you.

GAIL SCHWARTZ: Thank you. I welcome the opportunity to speak to the members of these two distinguished committees. My name is Gail Garfield Schwartz and I'm Advocacy Manager at SHARE Cancer Support for women with breast and ovarian cancer.

SHARE is a 33 year old not-for-

profit organization that provides peer support, education, information and resources to women and men affected by breast or ovarian cancer. Our primary goal is to empower those affected to make informed decisions for themselves about diagnostic procedures, treatment and post-treatment issues.

So we have hotlines and we speak to women on those hotlines and we have support groups and we speak to women in them who were diagnosed through a screening mammogram and others who felt a lump in their breast but had no sign of anything when they had a mammogram.

I myself had mammograms from the age of 50 when my mother was diagnosed with breast cancer to the age of 70 when a mammogram discovered a very small lump the day after my physician had given me a clinical examination and found nothing. So I would never be a person to say that mammograms are not effective.

We've known for a long time that mammography is the best technology that we have for screening. But I think we also know that it's not without risks. One of the things that we're concerned about is that the risks being measured

against the benefits to the individual undergoing the mammogram and also the costs have to be weighed against the benefits. I'll discuss that a little bit later.

We all have our stories to tell and we've heard plenty of stories on our SHARE website from women who were outraged by these recommendations, such as the kind of thing that we've heard people talking about today; I discovered it, I was 34, I was 41, so on and so forth. My doctor didn’t discover it. What would I have done without mammography?

But we have to bear in mind that screening mammography is different from diagnostic mammography. Screening mammography is the entire population which has no symptoms. Therefore, some of the things that I'm about to say are going to be different from what you've already heard. It doesn’t mean that we take a radical viewpoint about these new guidelines but it does mean that we ask some questions about the received wisdom that we've heard today.

Of course, we recognize that the screening tests that take place for people who may

be at high risk for breast cancer are not in the basket of things that we're discussing today. Those people need to have screening at an earlier age and probably earlier than 40.

But the goal of all screening is to decrease mortality. There wouldn’t be any reason to screen unless it was believed, based on evidence, that screening detects the cancer earlier than not screening and also that this early detection allows earlier treatment and also that the earlier treatment will allow the screened individual to live longer than they would live if their cancers were discovered later in their lives. I think that there should be evidence that screening itself does not entail health risks when the other three conditions are also met.

What we currently know from published research cited by the U.S. Preventive Services Task Force is there really isn't any compelling evidence that this is the case for general screening mammograms for women under 50. Research to this effect has actually been accumulating for many years and we have many participants at SHARE who go to the annual medical

breast cancer conferences. For many years these data have been presented at these conferences.

The research shows, as we've heard before, that to prevent one breast cancer death among women under 50, 1,904 screen mammograms must be performed every year over the course of ten years, whereas to prevent one death from breast cancer among women 60 or older, only 377 screenings have to be performed over the course of ten years. So clearly there is a very great difference in the power of mammography to detect early and its power to detect late.

That’s why the U.S. Preventative Services Task Force which is a reputable and well respected government-appointed panel of experts that systematically review evidence and develop recommendations for clinical preventative services released its new guidelines. We've heard what they say and I'm not going to repeat that because I think it would be more important to have Q&A and discussion than to repeat what Dr. Lawrence has said.

I don't know if she said that they supported screening mammograms every two years

starting at age 50 because based on the research, the benefits of yearly screening are no greater than the benefits of screening every two years.

So as a grassroots organization, a support group who serve people who have already been diagnosed, we have to figure out a way to sort this out. The question is how do we give credibility to the research results that support the need to review and modify clinical practice guidelines? How do we help our practitioners use evidence based medicine in their practices?

Our understanding of the biology of breast cancer and the process of breast cancer has changed since the original screening guidelines were developed. So it's our responsibility, how do we help to translate this to women and their providers?

One of the ways to do this is to encourage women and their health care providers if they have one, and just as an aside I think that one of the most important things we all have to do is to find ways to make sure that every woman does have a health care provider because that’s the crux of the matter that we face.

Women need to engage in the conversation with their provider on whether screening is right for them and whether the benefits, reduced chance of dying from breast cancer, outweigh the harms of false positives, unnecessary biopsies and excessive radiation, as well as the limitations that may exist for women their age.

Dense breasts, which Dr. Lawrence mentioned, are known to interfere with a diagnosis through mammography. Many cancers may be detected and treated even though they might never develop into dangerous malignancies.

So we feel that there are important challenges to government and to us the nonprofit community to make these facts understood by the public.

I mention the comments to the SHARE blogs and basically most of them boil down to like hell will I follow these guidelines. So now we can envision a scenario in which health care providers follow the new guidelines and patients are outraged and frightened.

We in government and the not-for-

profit sector have a responsibility to provide a forum for the exchange of information and the articulation of concerns from the public as well as from health care providers. This is more labor-intensive to be sure than simply mouthing the simple but inaccurate message that mammography saves lives. But we believe it's far more valuable.

To use a phrase that you may remember from the 60s, if you're old enough, it's a teach them to fish approach rather than a give them a fish approach. True public awareness about screening mammography must be based on a complete understanding of the evidence.

I'd like to make a final point about costs, notwithstanding popular sentiment, cost is important and value added health care expenditures are essential, especially in these times. The costs of health care are pooled in our society. Almost every process offered any individual is paid for in part by the community, either through insurance premiums or through taxes. Thus, a $300 screening mammogram that does an individual no good, multiplied by tens of

thousands of individuals is a highly questionable use of resources.

There was an article in the New England Journal of Medicine on November 25th, 2009 in response to these task force guidelines. I'll just quote a little bit from that. "A recent cost benefit analysis showed that adherence to the current guidelines that is the pre-task force guidelines, from the American Cancer Society costs more than $680,000 per quality adjusted life year gained."

Statistician Donald Berry, also a doctor, also quoted in this article, calculated that for a woman in her 40s a decade's worth of mammograms would increase her life span by an average of five days. Clearly there are more worthy expenditures.

One more worth expenditure would be to find better tools than the current ones, such as tools that will tell us not only that a malignancy is present but also how lethal it is. We need to encourage scientists to develop an understanding of exactly which types of cancers whenever they are detected are killers and which

are not. New screening tools based on biology could be a far more valuable expenditure of scarce health resources than doing screening mammograms on tens of thousands of young women unnecessarily.

Before I close, I'd just like to briefly address the new guidelines on breast self-examination to dispel a misunderstanding. As I understand it, the guidelines recommended not doing the highly formalized breast self-examination that has been recommended for many years. That is once a month at the same time in the same place in the same way. Since this procedure did not have any impact on mortality from the disease.

But of course that doesn’t mean that women should not know their breasts, what they look like, what they feel like, whether something looks or feels different and should be dealt with. So in some sense, the hullabaloo about this is unnecessary because it's just a misunderstanding of what was meant. That is, of course, how many women find their breast cancers, and should be considered. They don’t find them through rituals that we were made to believe save

our lives but don’t really add anything.

So I thank you again for the opportunity to present a SHARE breast cancer advocate's perspective on this issue.

CHAIRPERSON MEALY: Thank you so much. There's so much that was just said. How would you recommend incorporating new information without discouraging women from having mammograms who need it? Anyone can answer really.

GAIL GARFIELD SCHWARTZ: Well since you looked at me, I'll answer you first. SHARE feels that this is a very important responsibility for us and we are already starting to fulfill our responsibility by having a blog on our website.

I think that government and the Council and other government agencies should either participate in or create themselves forums in the community where the issues are discussed and where the questions are discussed in a kind of either/or fashion. Why should you choose this? What would be the consequences if you chose this? Why should you choose that? What would be the consequences if you choose that? Rather than in an oppositional way that says those are the bad

guys and we're the good guys, because there are some good guys on both sides of this issue.

You have all asked questions that reflect the kind of terror that's going through all women today because they feel that they are doomed to die if they don’t get a mammogram and that's certainly not true. I don’t think any of the doctors who have supported early mammography would say they're doomed to die if they don’t get them.

DR. LORETTA LAWRENCE: I just can't say enough that I think women at 40 and above need to have a yearly mammogram. Breast cancer is an extremely heterogeneous disease. And although it's one of the harms that the task force talks about, a diagnosis of DCIS, that may not kill women but there are some cases of DCIS which will recur as invasive cancers.

The problem is how do we know and how will one predict which woman is going to get the more biologically aggressive tumor? And until we can do that, which you know, with the help of God we will down the line, until now if you don’t screen women every year, including those between

50 and 74, you will miss interval cancers. If she gets an aggressive tumor that starts developing right around the time she has her mammogram we're going to wait two years to find it as opposed to one and that tumor will be bigger.

CHAIRPERSON MEALY: Thank you so much. Just for the record, I hope women get it every year. And we still should continue touching ourselves and finding out exactly what feels different. I read the end of your statement. I don’t know if they really meant that, not through the rituals. Rituals I feel that women still should continue touching their breasts to make sure that they do not feel anything that feels abnormal and they should get tested. If it's not a year, it should be six months. So I just want to thank you.

I would like to thank everyone for this hearing. We will be gaveling out. Thank you so much on this important issue.

DR. LORETTA LAWRENCE: Thank you.

GAIL GARFIELD SCHWARTZ: Thank you.

[Pause]

CHAIRPERSON MEALY: Can you

introduce yourself?

ADDIE BACKLAND: Good afternoon. I'm Addie Backland. I'm the Executive Director of the American Italian Cancer Foundation. I'm also a 19-month breast cancer survivor.

I've listened to all of the testimony today. I will go through some of what I have prepared, but I want to talk on a couple of levels, as a survivor myself and as probably all of you know is that we run the largest mobile mammography program in the five boroughs, courtesy of in large part funding from they New York City Council.

The women that we serve are economically disadvantaged and medically under served, which means a lot of them are immigrants, including a large number of Asians. We've seen that population grow tremendously in this last year. Those that have cultural barriers, some cultures, they don’t want to know anything bad or they don’t want to learn. So this upfront piece that we perform to get the women working with the community sites in under served areas of the boroughs to actually schedule their mammogram.

It's very upsetting to us to hear this new report because these women don’t want to get their mammograms anyway. It's hard enough to convince them that they need to do it. And then now we have this to deal with and I am quite certain it's going to cause confusion. However, I have to say our numbers are skyrocketing.

We have scrambled together to put additional funds together to serve the uninsured in spite of the New York State Cancer Services Program cutbacks which are practically nothing. They're not serving the women. We're paying. No out of pocket costs. Now we went from 47% uninsured last year to 53% uninsured.

It's my fear that with these new guidelines, these are the people that are going to suffer. A lot of them don’t have medical providers. In fact, some of the immigrants don’t even speak English. It's very difficult and it's a challenge.

I'll back up now and read my remarks. It was already stated that each year about 5,000 women in New York City are diagnosed with breast cancer and 1,200 will die of the

disease. There is no known way to prevent breast cancer at this point in time, so early detection is the real tool we have. It's the best tool we have in reducing the number of deaths.

I was fortunate myself to have breast cancer diagnosed in stage one, the earliest stage. It's very easily treated and the five year survival rate is typically nearly 100%. I can actually use the word cure. There is a slight chance, there's about a 5% chance I will develop cancer in the next five years, but that's very small.

But I just want to say in my case I had HER2 positive breast cancer. I had a mammogram, and then I had a biopsy and a sonogram which discovered the cancer. But if you have a very aggressive cancer like HER2, if I had waited and if I had not gone through all of the testing, it would have been a whole other story for me.

Too many women are diagnosed at a late stage because they don’t receive the screening on a regular basis. Late stage breast cancer is far more expensive to treat. This has been mentioned. And the five year survival rate

is only 20%.

We look at each of the boroughs specifically. In New York City, 17.6% of all breast cancer diagnosis occurs in women age 40 to 49 and in Staten Island that percentage is 19.2%.

The recent report from the United States Preventive Services Task Force has recommend against annual mammography screenings for women age 40 to 49 due to the potential harms associated with false positives and the corresponding anxiety women may experience.

However, I am quite certain that women in New York City who have been diagnosed with breast cancer at age 40 through 49 will attest to the fact that these potential harms are almost meaningless in comparison to the harms of a breast cancer diagnosis at an advanced stage. To these women, early detection is the difference between life and death.

Every time a woman gets a mammogram it's a personal choice and we certainly do encourage mammograms. We believe it's a personal choice, but we believe that insurance coverage for mammography services should not change. Women who

choose to get a mammogram should be secure in knowing that this service will be covered by their health insurance or government program.

The American Italian Cancer Foundation's mobile mammography program will continue to cover annual screenings for women age 40 and older as long as our funders continue to support us and various cancer advocacy organizations continue to recommend screening for that age group. Thank you very much. I trust that you will continue your support of breast cancer screening programs for the women of New York City with emphasis on those age 40 and over, economically disadvantaged and medically under served.

CHAIRPERSON MEALY: Thank you so much. Councilwoman Dickens has a question.

COUNCIL MEMBER DICKENS: Not a question actually. I want to thank the American Italian Cancer Foundation for that mobile mammography because you have come into my district several times over the last four years. So I want to thank you because it has been a great service.

ADDIE BACKLAND: Thank you. It's

really important and I feel very strongly that we don’t miss anybody, regardless of what the guidelines say. So thank you so much.

CHAIRPERSON MEALY: Do you think many women are unaware of their family history with breast cancer? Do they know they're at risk because of their family history?

ADDIE BACKLAND: I think for the populations we serve, I think the figures, and I may be a little off, but 65% of the women we serve have an average income of $25,000 a year and 20% have annual incomes of $5,000 or less. So these are not people that are talking to their medical providers or even aware. They're immigrants. It's very difficult.

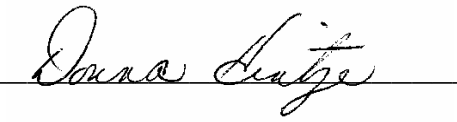
CHAIRPERSON MEALY: Thank you. I can understand. So I'm going to make sure you come to my district.

ADDIE BACKLAND: Please, we'd love to.

CHAIRPERSON MEALY: Thank you so much. Thank you for your testimony and we will call this meeting adjourned.

C E R T I F I C A T E

I, Donna Hintze certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

Signature 

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