with private education loans but also create jobs following college. The proposal allows college graduates to swap a portion of their private student loan debt for a federally subsidized loan with a lower interest rate. As a result of the conversion, the federal government would earn $9 billion for school construction, improvements for primary and secondary education facilities and institutions of higher education.

We must provide financial support for students to complete trade certifications or college degrees. Education is the only way to end the cycle of poverty.

We must encourage innovation in lending so small business and those in minority communities have access to capital.

We must aggressively advocate for loan modifications to reduce foreclosures and keep Americans in their homes.

In short, we need a concerted effort from the Federal government to expand access to the critical services and resources for minority communities. The exaggerated rate of Black unemployment is problematic for the entire Nation. These families, and those in disproportionately affected regions, need a solid pathway out of poverty.

By re-training workers in expanding industries, instead of those that are shrinking we can move people out of poverty.

Targeted assistance to Americans disproportionately suffering from the recession is crucial to reducing the unemployment rate for all.

PREVENTIVE SERVICES TASK FORCE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentlewoman from Ohio (Mrs. SCHMIDT) is recognized for 60 minutes as the designee of the minority leader.

Mrs. SCHMIDT. Mr. Speaker, I rise tonight to speak about a very important issue, it's about breast cancer and my expressed disappointment and disagreement with the recent set of recommendations issued by the United States Preventive Services Task Force, this simple little 12-page study that, quite frankly, has angered millions of women across the United States. I highly recommend people to take the 15 minutes that it will take to read this report and see just how flawed it really is.

As most Americans know, especially women, breast cancer represents a major health threat both in this country and across the world. Breast cancer is one of the most frequently diagnosed forms of cancer for women, and it ranks second only to lung cancer in terms of cancer-related deaths.

In 2008, an estimated 250,000 cases of breast cancer were diagnosed in the United States, and 40,000 women lost their lives to this terrible disease. These 40,000 deaths represent, however, a significant reduction in mortalities compared to 20 years ago. In fact, since 1990, the mortality rate for breast cancer has decreased approximately 30 percent. Medical experts attribute this dramatic decrease to both improved treatment methods and to the widespread and regular use of early detection techniques such as mammograms.

Despite these positive gains and despite the thousands of lives that breast cancer screening has saved during the past two decades, the United States Preventive Services Task Force recently issued new recommendations advocating, get this, against routine mammograms for women younger than 50, biannual mammograms for women 50 to 75, no mammograms at all for women older than 75, and actually recommended against teaching women the proper and important method of self breast examinations; they don't want medical experts to show them how to do a self breast exam.

In coming to these conclusions, the Task Force—which, by the way, did not include a single expert in mammography or oncology—reasoned that the physical and psychological harms associated with breast cancer screening outweigh the benefits for women younger than 50 years of age. The task force then explained that the harms it was concerned about included unnecessary tests and biopsies, and the general inconvenience, stress, and—get this—anxiety caused by potentially false positive screening results.

Personally, I was appalled and shocked to think that we might have a little bit of anxiety thinking that we might have felt something in a self breast cancer exam or that a mammography might have showed a shadow that was a little inconclusive and that we might need follow up, that we might have anxiety with that. And since for most of us it will be a false positive, we really don't need to have that anxiety. I was appalled because, yeah, you have a little anxiety, but think of the joy that you have realizing it was a false positive. And think about the relief that you have knowing that you now have the ability to fight a disease when you find it at its earliest and most preventable stage.

My concern is what these recommendations will do for women who should be receiving annual breast exams both now and in the future. Because what the government report is essentially telling women is that they should forgo proven methods of detecting breast cancer because in the aggregate screening methods don't save enough lives to outweigh the discomfort, inconvenience, and yes, the report talks about the cost.

Quite frankly, this is not just bad advice, this is awful advice. And I believe it will result in countless unnecessary and preventable deaths for women who do not avail themselves of screening techniques that could and would detect breast cancer at its earliest and most treatable stages and, yes, save lives.

For example, the task force downplayed the importance of self breast examinations. In doing so, the task force reasons that having a medical professional demonstrate the proper method of self-examination is insignificant to the cancer detection, and that too many women would suffer, again, anxiety from false positive results. But the report ignored a very important question; how many women have had their lives saved because of a simple self breast exam?

Perhaps the anxiety for those who don't understand what they have uncovered is less important than the one person who actually finds something and saves his or her own life because, yes, men also get breast cancer.

I also oppose the task force's recommendations because they represent an unfortunate and dangerous step back in the fight for health care equality for women. I was in the State legislature in Ohio for 4 years, and I uncovered this. It was through my insistence that insurance companies in Ohio pay the true cost for mammograms for women in Ohio. Recommendations like this task force's will serve to weaken State mandates like Ohio's, and they will ultimately lead to a rationing of preventative care across the country.

For example, according to language in the health care bill just passed by the House, the task force's recommendations could give the Secretary of Health and Human Services the power to exclude mammograms and other breast cancer screening techniques from any government-run health care plan or exchange. If you read pages 1317 and 1318 of the bill, you will see that the language in there suggests a slippery slope where this could occur.

Now, yes, it talks about testing and demonstration projects, but it says, the Secretary of Health and Human Services shall ensure that a subsidy or reward is provided only if a government task force recommendation is rated as A or B. Well, this task force only graded breast cancer screening for women 40 to 49, as a C, so this bill may not require the Federal Government to cover the cost of preventative care.

The Federal Government may not be required to cover annual screenings for women 50 and older. And the task force recommends that screening should be done biannually for this age group, and not for women over 75 at all. But the Senate bill is even more alarming. Comparable provisions were also included in the Senate proposed health care bill until an amendment was adopted last week.

For example, 2713 of the bill requires that private insurers cover only preventative services that receive a rating of A or B from the task force. Section 4105 of the bill granted the Secretary of Health and Human Services the ability to modify any government coverage of preventative services if consistent with recommendations of the task force. In fact, there were more than a dozen occasions in the Senate bill when recommendations from the task force would influence the availability of health care.

□ 2115

Now, not surprisingly, the Obama administration and the Secretary of

Health and Human Services have attempted to deflect the public outroar about this task force's recommendations, stating that the task force does not set Federal policy, that it does not determine what services are covered by the Federal Government. They also have claimed that the Federal Government's policy concerning breast cancer screening coverage will not change as a result of the task force's recommendations. Insurance companies have made similar promises, assuring their customers that they will continue to pay for annual mammograms as well, but it begs the question:

For how long?

The language contained in the House and the Senate bill speaks for itself, and it speaks loud and clear. There is simply no guarantee that the administration, that the Secretary of Health and Human Services, and that the insurance companies won't change their positions in the future, and there is no guarantee that mammograms will continue to be covered.

Fortunately, the task force's recommendations have been strongly rejected by a litany of respected medical organizations, including, notably, the American Cancer Society and the American College of Radiology. The recommendations also run contrary to positions taken by the American Medical Association, the American College of Obstetrics and Gynecology, and the National Cancer Institute. I have some of these publications here, and in a little while, I will read from them.

Right now, I am really hopeful that women ignore this task force's recommendation. It is for their health and for their safety, and it is also for the health and the safety of their families. I would also hope that, as we debate this health care bill, that we ensure that we do not look at cost and then look at treatment and decide that cost outweighs treatment. Yes, there is a limited amount of money out there, but nobody's health should be put on the line because of the dollars that are involved.

So I hope that women tonight will listen to their doctors—not to the government, not to the insurance companies, and certainly not to this task force—and will make the right decisions for all of their health care. There simply is no room for a government bureaucrat in a woman's decision to screen for breast cancer.

Right now, I have my good friend from Pennsylvania's Fifth Congressional District, Congressman GLENN THOMPSON, who wants to weigh in on this.

Mr. THOMPSON of Pennsylvania. I thank the gentlelady from Ohio for yielding and for hosting this Special Order this evening on what is truly such an important topic. I don't think there is anyone here in this Chamber or anyone across the United States who, through family or friends, has not been touched by breast cancer in their families or within their networks of friends.

I came here in January. Prior to that, I had worked in health care for 28 years, in rehabilitation services. I was a rehabilitation professional, working, actually, as a rehab services manager for most of that time. During that time, I had my staff. They were wonderful, caring, compassionate individuals who were true professionals. I worked with just a tremendous number of women who were breast cancer survivors postmastectomy. I was developing innovative rehabilitation techniques and exercises, and I really tried to touch the lives of people who were facing this devastating disease.

You had talked about these recommendations that were put out, and I'm sure you're going to go into detail on this, but I pulled a document, and it was one of those that you referenced.

Truly, when I think of cancer, I think of an organization such as the American Cancer Society, which just offers their expertise. Their researchers do just a tremendous job on awareness and on prevention and on treatment all across the board. In their 2009 Cancer Prevention and Early Detection Facts and Figures, just go to page 35. It talks about what their recommendations are. It is very specifically that mammographies begin at age 40, and it's annually. Those are not dated recommendations. Those are not dated screening guidelines. Those are 2009.

You know, breast cancer, as the gentlelady mentioned, is the second leading cause of death in American women. In 2008, there were over 40,000 deaths in this country. Certainly, breast cancer also touches the lives of men in much smaller numbers, but it does have a presence. In the United States, women get breast cancer more than any other type of cancer except for skin cancer. Breast cancer is only second to lung cancer as the cause of death in women. Breast cancer does occur in men, but as I said before, the numbers of cases are certainly small.

Now, age and health history certainly can have an effect on the risk of developing breast cancer. Anything increases your chance of getting a disease. It's called a ''risk factor.'' Having a risk factor does not mean that you will get the cancer, but not having risk factors does not mean that you will not get the cancer.

People who think they may be at risk certainly need to talk to their doctors as the relationship between the patient and the physician is just so important. We've talked about that relationship so many times in this health care debate. One of my biggest fears isn't the cost of health care. Really, my biggest fear is when the government or a bureaucrat becomes a wedge between the decisionmaking relationship of the patient and the physician. Certainly, when it comes to risk factors, touching base and communicating with one's physician is so important. People who think they may be at risk should discuss this with their doctors, and they should discuss all of the risk factors that are present.

Cancer prevention is certainly very important. Cancer prevention is an action taken to lower the chance of getting cancer. By preventing cancer, the number of new cases of cancer in a group or in a population is lowered. Hopefully, this will lower the number of deaths caused by cancer. To prevent new cancers from starting, scientists look at risk factors and protective factors. That's where the value of these regular screenings comes in. Anything that increases your chance of developing cancer is called a ''cancer risk factor,'' and anything that decreases your chance of developing cancer is called a ''cancer protective factor.''

Now, some factors for cancer can be avoided, but many cannot. For example, smoking and inheriting certain genes are risk factors for certain types of cancer, but only smoking can be avoided. As for regular exercise and a healthy diet, neither of those really fit well into the lifestyle one has while working in Congress. I've found, since January, neither a healthy diet nor exercise, but both of those can be protective factors for some types of cancers. Avoiding risk factors and increasing protective factors may lower your risk, but it does not mean that you will not get cancer. Different ways to prevent cancer are being studied, including changing one's lifestyle, eating habits, avoiding things known to cause cancer, taking medication to treat a precancerous condition or to keep cancer from starting.

Certainly, breast cancer screenings have been shown to reduce breast cancer mortality. In the United States, death rates from breast cancer in women have been declining since 1990. I think that's a track record we can be very proud of, and it's a trend line that is just so important. Most of that has been due, in large part, to early detection by mammography screening and by improvements in treatment.

When you look at those trends, I find appalling the recommendations we've recently seen come out to not just move up the age of when mammographies would begin but the fact that they would go to every 2 years versus an annual basis. Currently, 61 percent of breast cancers are diagnosed at a localized stage for which the 5-year survival rate is 98 percent. Again, within the United States, I think that's a statistic we can be very proud of. Further reductions in breast cancer deaths are possible by not spreading out but, rather, increasing mammography screening rates and by providing timely access to high-quality follow-ups and treatment.

Despite the relatively high prevalence of mammography screenings in the United States and within the document I made reference to previously—this is from 2006—I think that we've seen actual improvements in terms of access to screenings. Nationwide, for women 40 years of age and older, 61.2 percent have had mammography and clinical breast exams. Ages 40 to 64 is

59.7 percent; 65 years of age and older is 64.6 percent. These are good numbers. They could be better. We could improve upon them. I don't think we can improve upon them by following those recommendations that were just recently put out.

Recent studies suggest that many women are initiating mammographies later than recommended or are not having mammographies at all or are not having them at the recommended intervals or are not receiving appropriate and timely follow-ups of positive screening results. These indicators of inadequate screenings are associated with a more advanced tumor size and stage at diagnosis.

In accordance with the American Cancer Society screening guidelines, it is important for women aged 40 and older to receive mammography screenings on an annual basis at an accredited mammography screening facility. For women with increased risks of breast cancer, the society recommends annual screenings using MRIs, or magnetic resonance imaging, in addition to the mammograms.

I am very appreciative of my good friend from Ohio for, once again, taking the leadership on this very important topic and for allowing me to join in with you tonight.

I yield back.

Mrs. SCHMIDT. I thank you very much. This whole report concerns me on a multitude of levels.

A few weeks ago, I and a group of women got together, and we held a press conference. At the press conference, when it was my turn to speak, I actually had a reporter who questioned what we were saying because we were not ''professionals'' in the field.

I held up the report, and I said, Have you read it?

Well, he hadn't read it. So I handed it to him and suggested that he read it; but you know, I'm not a professional. I don't have a medical background. I'm just a woman, and I'm a woman concerned about my friends who have had to undergo the fear of having breast cancer. With treatment and especially with early diagnosis, they are living very, very normal lives. I could go on and on.

I have a friend who was 41. She missed her first mammography at the age of 40. She went, and she had a very, very small tumor, and she had it out. That was 4 years ago. She has a little girl. She's going to live to be a ripe old age. Thank God she was able to have that mammography, because there is no breast cancer in her family. So, according to this report, she shouldn't have had it until age 50 because she's not at risk, but ah, indeed, 75 percent of people who get breast cancer do not have risk factors for cancer. Only 25 percent do.

I want to read right now the report from the American College of Radiology. It's dated November 24, 2009. I want to read it because they're the scientists; they're the professionals—I'm not. I think that what you will see in this is an unraveling of the inconsistencies of this report.

It says that several sections of the Senate health care reform legislation contain language stipulating that insurance entities, such as private insurers, Medicare and Medicaid, would only be required to cover services receiving a specific rate from the United States preventative service task force. Presently, this would exclude mammography services for the majority of women 40 to 49. It would only require coverage of biannual—that's every other year—coverage for women 50 to 74, and it would exclude coverage for those women 74 years of age and older. While the USPSTF recommendations may result in cost savings, a great many women will die unnecessarily from breast cancer as a result.

These are not my words. These are the words of the American College of Radiology.

It goes on to read that this is not a political argument. It is a matter of life and death. Congress needs to act to specifically protect annual mammography coverage for women ages 40 and older and for high-risk women under 40 as recommended by their physician, said James T. Thrall, M.D., FACR, Chair of the American College of Radiology Board of Chancellors.

If the cost-cutting USPSTF mammography recommendations are not excluded from health care reform legislation, the government or private insurers would be permitted to refuse women coverage for this lifesaving exam, turning back the clock on two decades of advances against the Nation's second leading cancer killer.

These aren't my words. This is the American College of Radiology. They go on.

The federally funded and staffed task force includes representatives from major health insurers, but it does not include a single radiologist, oncologist, breast surgeon or any other clinician with demonstrative expertise in breast cancer diagnosis or treatment.

□ 2130

Despite demonstrations by their own analysis that screening annually beginning at age 40 saves most lives and most years of life, the task force recommended against mammography screening for women 40 to 49 years of age, annual mammograms for women between 50 and 74—in favor of only every other year—and all breast cancer screening in women over 74. These recommendations run counter to even the task forces own data and are out of touch with the long-proven policies of the American Cancer Society, the ACR, and other experts in the field.

I have to digress for a moment because my very, very dear friend, her mother is 90. Her mother did a self-breast exam and noticed a lump, had a mammography. They did a lumpectomy. That was a few months ago.

My very dear friend lost her father a couple of years ago. All she has is her mother and her brothers and sisters. She is delighted to know that her mother has a long life ahead of her and at least isn't at risk for this disease. But, again, according to what these recommendations are, she wouldn't have gotten a mammography and wouldn't have gotten a lumpectomy.

I will go back to the American College of Radiology's report that strongly urges those in Congress to exclude the USPSTF guidelines from health care legislation and make changes to the task force membership, an operating process that will guard against such unacceptable recommendations moving forward without any input from experts in breast cancer diagnosis and treatment, said W. Phil Evans MD, FACR, president of the Society of Breast Imaging, SBI.

This states that since the onset of regular mammography screening in 1990, the mortality rate from breast cancer, which has been unchanged for the preceding 50 years, has decreased by 30 percent. Ignoring direct scientific evidence from large clinical trials, the task force based their recommendations to reduce breast cancer screening on conflicting computer models—conflicting computer models—and the unsupported and discredited idea that the parameters of mammography screening change abruptly at the age of 50.

In truth, there are no data to support this premise.

Let me continue, that allowing a small number of people with no demonstrative expertise in the subject matter to make recommendations regarding diagnosis of a disease which kills more than 40,000 women a year makes no scientific sense and is a mistake that many women will pay for with their lives—these are not my words. This is the American College of Radiology's words—and that lawmakers need to require that the task force includes experts from the field on which they are making recommendations and that its recommendations be submitted for comment and review to outside stakeholders in similar fashion to rules enacted by the Centers for Medicare and Medicaid Services, said Thrall.

Before I continue with this, I just want to say that if we are going to base health care on any task force's grading system of an ''A'' or a ''B,'' my fear is what kind of experts are going to be doing the grading and what kinds of outcomes are going to be there, because clearly, according to the American College of Radiology, this report is not true science.

Let me continue, that it is well known that mammography has reduced the breast cancer death rate in the United States by 30 percent since 1990, hardly a small benefit. Based on data on the performance of screening mammography as it is currently practiced in the United States, one invasive cancer is found for every 556 mammograms performed in women in their forties.

I want to repeat that, because, you know, this report says that for women under the age of 50 they are going to have anxiety and fear—''Oh, my gosh, I might have breast cancer''—so why put them through it. Well, for 556 people that's true, but that one in 556 does have breast cancer. That one in 556 has the right to know it, know it in its earliest stages and get treated appropriately.

Let me continue, that mammography only every other year in women 50 to 74 would miss 19 to 33 percent of cancers that could be detected by annual screening.

Let me digress, that's my age group. I am in my fifties. So I am not supposed to have this every year, this mammography? I am supposed to have it every other year? But that means my chances for finding early detection and living a long time would be decreased instead of helped.

Then it continues that starting at age 50 would sacrifice 3 years of life per 1,000 women screened that could have been saved had screening started at the age of 40.

Okay. I don't want to be that one life in 1,000 and neither does any other woman in America, but let me continue.

Eighty-five percent of all abnormal mammograms would require only additional images to clarify whether cancer may be present or not. Only 2 percent of women who receive screening mammograms eventually require a biopsy, but the task force data showed that the rate of biopsy is actually lower among younger women.

The issue of overdiagnosis is controversial. By the task force's own admission, it is difficult to quantify and is less of a factor among younger women who have had many years of life expectancy.

Weighing the significance, documented benefits of annual mammography screening against possible anxiety and the need for additional imaging or biopsy, it is difficult to understand how the task force reached its recommendations.

Again, these aren't my words. These are the American College of Radiology, that these new recommendations have created a great deal of confusion among women, a situation that might have been avoided by consulting those of us in the field who actually care for women who are seeking detection, diagnosis, and treatment of breast cancer. The unfortunate result may be decreased utilization of this lifesaving tool.

I urge insurers and Congress not to compound the problem by allowing the possibility of denying coverage to women who seek routine annual mammography starting at the age of 40 and continue for as long as they are in good health, said Carol H. Lee, MD, Chair of the ACR Breast Imaging Commission. The task force is a panel funded and staffed by the Health and Human Services Agency for Health Care Research and Quality.

The Medicare Improvement for Patients and Providers Act of 2008 gave the U.S. Department of Health and Human Services the authority to consider the USPSTF recommendations in Medicare coverage determinations. Private insurers may also incorporate the task force recommendations as a cost-saving measure.

I want to repeat that, because I think that's the most chilling revelation that I have uncovered in this whole breast cancer debate. The Medicare Improvement for Patients and Providers Act of 2008 gave the U.S. Department of Health and Human Services the authority to consider this task force's recommendation in Medicare coverage determinations. Private insurers may also incorporate the USPSTF recommendations as a cost-saving measure.

I am quite alarmed, and I think most Americans are as well.

I have been joined by my colleague from Wyoming, Ms. CYNTHIA LUMMIS.

Mrs. LUMMIS. I would like to thank the gentlewoman from Ohio for bringing this issue to our attention once again this evening. You know, many of us have anecdotal information about friends, relatives, colleagues who have experienced the diagnosis of breast cancer in their forties simply because they went in to receive a routine mammogram.

That was certainly the case with my sister-in-law who, in her forties, went in for a routine mammogram, had none of the genetic or typical markers that reveal the need to have mammograms, but, of course, since they were regularly recommended for women in their thirties and forties, she went in for her annual mammogram and was diagnosed with a very aggressive form of breast cancer. She was diagnosed, had her mastectomy, and began her chemotherapy all within the period of 30 days.

Without that routine mammogram, that aggressive breast cancer would have had an opportunity to spread in a way that would have caused or exacerbated the chance that that cancer would not have been treatable and would not have saved her life.

In fact, we learned during the health care debate in the House that in the United States both men and women have better rates of survivability for cancer in the United States than they do in Canada or in Europe. That is because cancer is routinely screened for and it is rapidly addressed following diagnosis. In fact, the opportunity in the United States to receive treatment quickly following diagnosis is directly related to the current health care system in the United States.

As the gentlewoman from Ohio indicated, there are opportunities, due to the findings of this panel, for insurers to use it as a basis to decide not to provide covered health care insurance for breast cancer mammography screening for women in their forties.

I believe that that is an indicator of how serious this issue is, and I want to particularly thank the gentlewoman from Ohio for calling it to our attention this evening.

Mrs. SCHMIDT. Thank you so much, and I hope that your sister is doing well.

Mrs. LUMMIS. She is doing very well. She is cancer free. And I would indicate, also, that it is, of course, just another example. But I am from Wyoming. One of our Senator's wives, Bobbi Barrasso, was also diagnosed with breast cancer in her forties as a result of a mammogram and is also doing well.

You look at our tiny little congressional delegation that consists of one Member of the House and two Senators, and of those three people, two have examples of breast cancer within their own families that was diagnosed in women in their forties due to a routine mammogram. That gives, even though anecdotal, a couple of examples that are repeated all over the country by people who may be tuning in tonight on C–SPAN. Many of you know women who have been diagnosed and successfully treated for breast cancer in the United States.

Part of the reason the prognosis has improved so dramatically in the United States for this very serious and, unfortunately, very common form of cancer is the fact that following routine screening, we have the opportunity to receive aggressive treatment in a health care system that, while in need of reform, is not in need of the kind of reform that would increase the period of time between when we are diagnosed and when we are treated.

We know, from around the world, from systems of government in Europe and in Canada that have the form of health care that was being advocated in this body by the majority party and a form which, in fact, passed this body and is now being debated in the Senate, that, indeed, when you add more government to the health care system, you do add time lags between diagnosis and treatment. And that is something that we should be trying to encourage our colleagues to prevent and prevent especially because of the United States' superior record when compared to other nations around the world with regard to breast cancer.

Mrs. SCHMIDT. Thank you so much.

I want to continue to show that while I am not a medical professional and my dear colleague from Wyoming is not a medical professional, we are not just speaking from the heart and from our soul. We are also speaking from an intelligent position.

The Washington Post had an article by Otis W. Brawley. Who is Otis W. Brawley? Well, he is the writer, is the chief medical officer of the American Cancer Society.

Now I am not going to read this whole article that was in The Washington Post on November 19, but let me read some of the things from it.

□ 2145

Studying cancer deaths among women in their forties reveals some

important trends. Death rates were dropping slightly in the 1970s, thanks to better awareness and better treatment. In 1983, the American Cancer Society began recommending that all women get screened beginning at the age of 40. By 1990, death rates began a steep decline that continues today. While some of that drop is due to improvements in treatment, conservative estimates are that about half is due to mammography. Without mammography, many women would not be candidates for breast-conserving therapy. You cannot treat a tumor until you find it, and we know that mammography has led to finding tumors when they're smaller and far more treatable.

We think the task force may underestimate mammography's lifesaving value.

It goes on.

In the end he wraps up by saying, In the meantime the American Cancer Society continues to recommend annual screening using mammography and clinical breast examination for all women beginning at the age of 40. The test is far from perfect, but it's the best way we have to find tumors early. How many lives are enough to make routine screening worth it? How many mothers, sisters, aunts, grandmothers, daughters and friends are we willing to lose to breast cancer while the debate goes on about the limitations of mammography? Turning back the clock will add up to too many lives lost, and too many women finding their tumors later, when treatment options are limited. Our medical staff and volunteers overwhelmingly believe the benefits of screening women ages 40 to 49 outweighs its limitations. Let's not behave as though we lack a tool with proven benefits to women.

Again, these are not my words; these are the words a medical professional has written in the Washington Post. I could go on, because the American Medical News, I pulled this off line. I just want to read some of the things that it says in here.

It says, Taking its concern a step further, the American College of Radiology asked that the recommendations be rescinded to prevent the possibility of the new guidelines influencing policymakers as they shape health system reform legislation.

This was printed on November 30. This article goes on to say:

Washington, D.C. radiologist Rachel Brem dismissed the potential harm when compared to the value of detecting cancer. ''Virtually all my patients would prefer the small anxiety of a false-positive with the possibility to diagnose an early breast cancer.''

Oh, yes, Mr. Speaker, we women would prefer to have a little anxiety and find it early, find it, treat it appropriately, and live to a ripe old age.

It goes on to say, Researchers of one study found that annual mammography screening for women ages 50 to 79 resulted in an 8 percent median increase in breast cancer mortality reduction. For screening every 2 years, it was 7 percent. So we lose a percent if we wait every 2 years. For screening that begins at age 40 and continues to age 69, researchers found a 3 percent median breast cancer mortality reduction with either annual or biennial screening. Researchers concluded that greater mortality reductions could be achieved by stopping screening at an older age than by initiating screening at an earlier age. No recommendations were made for women 75 and older because, the task force said, there is insufficient evidence to assess the additional benefits and harms. But early detection is partially credited for the steadily falling breast cancer rate among women younger than 50, according to the American Cancer Society.

It goes on to say that they, too, debunk the findings of this study.

I also went through and looked at some of what was being said in my own hometown. On the editorial page on November 18, Krista Ramsey, I want to read this because it really has the sentiment of my heart:

Tell us why we shouldn't feel betrayed.

After decades of memorizing breast cancer's warning signs, training ourselves to do monthly self-exams, and guilting ourselves into annual mammograms, we women are now being told the exams are useless and mammograms unreliable.

A Federal task force has reversed a decades-long campaign that trained women to make screenings a cornerstone of their self-care. It now recommends against routine mammograms for women in their forties, longer intervals between them for older women, and ditching the self-exams.

Intended or not, yanking away the tools we relied on to keep ourselves safe from this disease shakes the confidence that we can keep ourselves safe. And fear and confusion have always been breast cancer's best friend.

Now we are left to reconcile two utterly conflicting messages—the task force cautioning against the test the American Cancer Society still calls lifesaving.

As so often happens with debates over medical care, women can't help but feel like pawns. Experts told us to get smart about this disease and we did our homework. They told us to face it straight on—have the tests, entertain the thought it could happen to us—and we didn't flinch.

For decades, we have walked against breast cancer, run against it, shopped and marched against it. We devoted a whole month to raising our awareness, nagging other females we loved to schedule mammograms. We pinned on looped ribbons, we donned hot pink—and nobody looks good in hot pink.

Now it seems the message is sit back, don't worry and wait. The millions we raised for research on prevention went for this?

The dueling medical experts are going to be the ones to feel the pinch if they think they can, just like that, back women off of mammograms. And they should be very careful about warning against screenings because the results could make us worry our pretty little heads.

It's not that we shouldn't be disabused of reassuring but faulty medical advice. It's not that women have had a long history of being talked down to, and all around, when it comes to matters of their health. Still, our skepticism can kill us.

It's well known that we women take better care of others than ourselves. It doesn't take much for us to rationalize resetting our priorities—I'll get that tooth fixed after we pay off some bills, I'll schedule that test after we finish soccer season.

Leaving work for a mammogram has always been a hassle. Now we can justify waiting another year. And then, as our busy lives barrel on, that 1 year becomes 5. For many women, that 5-year gamble will do no harm. For some, it's a fatal bet. And nobody can say which one of us can afford to wait and which cannot.

How much less painful this would be if we all couldn't name women who needed a mammogram earlier than she got it. How many children wish their mom could have been diagnosed in time so she could see them graduate from high school? Do we suspect this whole debacle is more about saving on health care costs than sparing us anxiety? You bet we do.

Are we concerned that tightening the recommendations will, down the road, mean limiting our care? We're not stupid.

We're sophisticated enough to understand cancer is a wily opponent that doesn't follow anybody's rules. But we're savvy enough to know that when it comes to our health, we only get the care we demand.

Tell us the truth. Tell us what you don't know. Put our lives before cost savings. Bring us fully into this discussion. And imagine that women who will be undiagnosed or wrongly diagnosed by your miscalculations is your daughter, your mother or your wife.

I have now been joined by my very good friend, Dr. BURGESS from Texas, and yield you as much time as you need.

Mr. BURGESS. I thank the gentlelady for yielding. I thank you so much for taking the initiative to do this hour tonight. I think it is extremely important and extremely timely. Last month when the United States preventive service task force came out up with their guidelines, I went home from Congress to my desk and there was a copy of OB–GYN News that had just been delivered the week before these task force guidelines came out. This was the current state of the art, the current state of thinking just prior to these task force recommendations being made.

In the article, and I am quoting here, the most effective method for women

to avoid death from breast cancer is to have regular mammographic screening, said Dr. Blake Cady at a breast cancer symposium sponsored by the American Society of Clinical Oncology. Interestingly, in their article they cite some statistics, and I'll be honest, these are statistics that I knew but I had forgotten. The rates of cancer deaths in the current study, 25 percent of them occurred in women who had regular screenings. Seventy-five percent occurred in women who did not. That's a 3-to-1 risk ratio of dying from breast cancer between those who were screened and those who were unscreened. In fact, they go on to say that amongst women who were unscreened, the 56 percent mortality is the same overall mortality we used to see in breast cancer up until 1970 prior to the onset of widespread mammographic screening.

Another piece of information I wanted to share tonight is from the American College of Obstetrics and Gynecology from their president, Gerald F. Joseph, who wrote to me December 4 of this year:

As you know, the American College of OB–GYN expressed concern about the new breast cancer screening guidelines in a letter to the United States preventive service task force in May where we raised concerns that the C recommendation against routine screening mammography in women ages 40 to 49 would be misunderstood by clinicians, by patients, misunderstood by policymakers and insurers and ultimately this could prevent women in that age group from receiving important services. Immediately following the release of the new guidelines, the American College of OB–GYN instructed fellows of the college that it would continue to recommend routine screening for women in this age group.

Here is probably the most critical point of Dr. Joseph's letter. In his last paragraph, This is especially critical right now as we caution Congress against giving the United States preventive service task force authority over women's health in health care reform.

Today, these guidelines are simply that, they are just guidelines. Any doctor or patient is free to take them or disregard them, however it is their wish. Once this bill, as the gentlelady correctly pointed out, becomes law, no longer will that be an optional exercise. Those will be the mandated screening guidelines that will be established in law. And I will tell you as a physician, if an insurance company decides they're not going to cover something, the patient isn't going to get it done. It is just as simple as that. This is a step backward, as Dr. Cady pointed out. It is going back prior to 1970 when we had that 56 percent mortality prior to the institution of regular screenings. We don't need to do that. We don't need to do that as a country. We have the information, we need to act on the information, we need to keep patients involved in their own health care. I cannot tell you the number of people who came to me ultimately who had a diagnosis of breast cancer who found the cancer themselves. I didn't find it on a clinical exam. They found it on a breast self-exam. It wasn't detected on a mammogram. It may have occurred in that 2-year period between screens, but the patient found it herself. The earlier diagnosis was made possible by the patient's involvement in her own care. And to say that we are unnecessarily alarming patients by teaching them to be involved in their own care I think does women a great disservice.

So I thank the gentlelady for bringing this to the floor of the Congress tonight. I am going to submit the letter from the American College of OB–GYN president for the CONGRESSIONAL RECORD, and I thank you for providing this very valuable service for women tonight on the House floor.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
Ponchatoula, LA, December 4, 2009.

Hon. MICHAEL BURGESS, M.D.FACOG,
Cannon House Office Building,
Washington, DC.

DEAR DR. BURGESS: On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing over 53,000 physicians and partners in women's health, thank you for your remarks at the December 2nd Breast Cancer Screening Recommendations hearing held by the Energy and Commerce Subcommittee on Health. Your opening statement and questions to the United States Preventive Services Task Force (USPSTF) panel highlighted both the importance of the doctor-patient relationship in making medical decisions, and the flaws in the USPSTF recommendations process.

Once again, your medical knowledge and expertise are proving invaluable to Congress' development of good health policy.

As you know, ACOG expressed concern about the new breast cancer screening guidelines in a letter to the USPSTF in May, where we raised concerns that the C recommendation against routine screening mammography in women ages 40–49 would be misunderstood by clinicians, patients, policymakers, and insurers and that ultimately, this could prevent women in that age group from receiving important mammography services. Immediately following the release of the new guidelines, ACOG instructed its Fellows that the College would continue to recommend routine screening for women in this age group.

Your questions to the panel effectively highlighted the flaws in the process by which the USPSTF makes recommendations. Lack of transparency and public input are part of the problem; there is no formal mechanism for the public to comment on proposed guidelines, and comments that the Task Force receives from experts are not often taken seriously. We also appreciate your comment that the USPSTF is comprised mostly of primary care doctors and includes only a limited number of ob/gyns and other specialists. This point is especially critical right now, as we caution Congress against giving the USPSTF authority over women's health in health care reform.

Thank you again for your remarks and for always standing up for women's health.

Sincerely,

GERALD F. JOSEPH, M.D.,
President, ACOG.

Mrs. SCHMIDT. Thank you so much because you are the medical expert in the field and I'm so glad that you came here to share your testimony this evening, my good friend from Texas. Because as we continue with this health care debate, the one underlying theme that I think the American public has is, will this interfere with their health. And I think what we're seeing from this task force's recommendations is that when the government takes over the health care, it has the potential ability to do just that—interfere with our health. This task force had a flawed document, it was driven to say that the risks for women were anxiety, but it also said in the report that costs outweighed, were looked at in looking at when you should have the mammographies and when you shouldn't have the mammographies. This report clearly was driven by the fact that it costs money to have good health care, no matter where you are.

□ 2200

And so it showed if you eliminate mammography for women under the age of 50, you eliminate a whole lot of cost. And for 556 women, that is okay. But that unlucky one that's after 556, she's the one that is going to be missed.

And so as we debate health care in this country, we should never put a price on it, and we should never allow government to interfere with our lives, especially when it comes to the care of our health and our family.

So I hope that we take what's out there in the bills in the House, in the Senate, and we delete them and we start over with a commonsense approach to solving the problems with health care in this country because quite frankly, we have the best health care in the world. It needs tweaking, but what we're doing right now potentially would change it and change it in a fashion that I don't think any American wants.

My good friend from Texas, if you don't have anything more to say, I think we will yield back our time.

I yield back our time, Mr. Speaker.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes as the designee of the minority leader.

Mr. KING of Iowa. Thank you, Mr. Speaker. It's my privilege to be recognized and address you here on the floor of the House and pick up—I think, transition from the discussion that has taken place in the previous hour by the gentlelady from Ohio—and I appreciate the presentation that's been made here—and to fit the breast cancer issue in with the larger health care debate is what I will seek to do, Mr. Speaker.

And that is this: that the question about how breast cancer is treated and how it's tested fits back into the broader question of what happens if we end