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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order.

Ladies and gentlemen, this is meeting 154 of the Standing Committee on Health and our last meeting for this Parliament.

We have a jammed schedule here today. Actually, we have a vote. We understand the bells will ring at 5:30. I'm seeking unanimous consent to go to 5:45.

Some hon. members: Agreed.

The Chair: Thank you very much. We'll go to 5:45.

Our first witness is Commissioner Brenda Lucki, commissioner of the RCMP. We have her here for half an hour.

Thanks very much for coming on short notice. We appreciate it very much.

Commissioner Brenda Lucki (Commissioner, Royal Canadian Mounted Police): Thanks.

The Chair: It's a short round so we're going to have one question from each party. We're going to start with....

Sorry, Ms. Lucki, you have an opening statement of 10 minutes. Go ahead.

Commr Brenda Lucki: Thank you, Mr. Chair.

Good afternoon, Mr. Chair and members of this committee.

Ladies and gentlemen, thanks for inviting me here to speak today.

I want to start by saying the RCMP takes all reported allegations of criminal activity and incidents very seriously and we are committed to continuing to provide services that are focused on the safety of our communities.

[*Translation*]

Such allegations could include the forced or coerced sterilization of women.

[*English*]

Following a consultation of the RCMP's contract divisions through their respective commanding officers, to date, we have no allegations on file for forced sterilization that were found to be reported to the RCMP directly. I've also taken the steps to reach out to the president of the Canadian Association of Chiefs of Police for assistance in raising the awareness among all the other police agencies. A bulletin was disseminated by the CACP to its member agencies and a report is expected in the near future. There are quite a few of them so they're still waiting for results.

It's important to note that the investigation of any allegations of forced or coerced sterilization would fall under the mandate of the police of jurisdiction. Therefore, any evidence of criminal activity should be reported to the local police of jurisdiction where offences are alleged to have taken place so that they can be properly investigated.

[*Translation*]

The RCMP proactively works with communities to identify, prioritize and solve problems, as well as to build trust and faith in the RCMP as a police service.

[*English*]

This collaborative approach is based on the philosophy that prevention is a core responsibility of policing, where decisions are evidence-based and responses should be community-led, police-supported, sustainable and flexible. The RCMP has been part of these efforts in many communities across Canada and will continue to reach out with professionalism and compassion to enhance trust with the communities we serve.

I have to add that compassion is one of our core values, but honestly, as part of our modernization, I don't think compassion is good enough. I think we need to bump it up to empathy. It falls in line not just with reconciliation but.... If we can all learn—when I say “we” I'm talking about my organization—to walk a mile in somebody's shoes, I think we would have a better understanding of others' circumstances and they would be treated differently if we had that understanding. Part of this is teaching people from the day they get into the organization and reteaching everybody along the way. In some effects, we've introduced at the training academy, for example, the Kairos blanket exercise, which is one way of teaching more empathy and more history.

In addition to contributing to a safer and healthier indigenous community, it's one of the key priorities of the RCMP. Protecting all Canadians from criminal activity is of the utmost importance. We're committed to protecting our communities and to achieving reconciliation with indigenous communities and partners through a renewed relationship built on the recognition of rights, respect, mutual trust, co-operation and partnership.

[*Translation*]

I would be happy to answer your questions.

[*English*]

The Chair: Thank you very much.

That's the shortest 10-minute opening statement we've ever had.

We'll go right to our questions with Mr. Ouellette.

You have seven minutes.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much, Commissioner, for coming here today. I really appreciate the opportunity to be able to question you on these very serious allegations concerning forced sterilization of women, especially indigenous women, in Canada.

Obviously, you said that no complaint has ever been made to the RCMP.

● (1535)

Commr Brenda Lucki: Perhaps I should be more specific. When we go back into our records, we can go back only so far. Certain things are purged along the way, according to our archived records management system, so the looking back is looking at anything in the electronic world. We tried various keywords in that system to try to find anything that we could, but we didn't find anything.

Mr. Robert-Falcon Ouellette: Is there a statute of limitations on the sterilization of women? If someone came forward and said they had a complaint, would you be able to say, "That happened 20 years ago, five years ago, 10 years ago", or another number, and say, "We can't investigate"?

Commr Brenda Lucki: It depends on the circumstances, of course. We don't have, in the Criminal Code, anything that deals directly with forced sterilization. The law that we use is aggravated assault, or there are other kinds of criminality, depending on what the victim brings forward in their statement or the review of the events. For an aggravated assault, no, there isn't a statute.

Mr. Robert-Falcon Ouellette: Obviously this has been in the media for a number of years now. It's been out there. If the allegations that are being debated in society are false, I believe that deserves to be investigated. If those allegations are true, that deserves to be investigated. One, if they're false, obviously it's in the media. This undermines and destroys people's reputations: doctors, nurses and social workers. If it's true, these are very serious allegations.

If at one point someone has already raised it in the media, at what point would the RCMP, our national police force, start investigating? What would be the trigger, the moment you would say that this is something serious enough for us to take a deep look at and send an investigator to have a conversation, at least, with a lawyer?

Commr Brenda Lucki: It's difficult to answer that question. When it was brought to my attention as the commissioner, of course we did all the searches and we also reviewed the report from the Saskatoon regional health authority.

There's more work to be done, though. I notice that at one point—I think it was in some of the minutes—there was mention of several victims, with names of defendants. That has never come to our attention, so we have to go looking for that. Of course, we might deal with privacy issues when we deal with health care, getting information through the health care system. Of course, it's encouraging people to come forward. For anything, a crime against a person, the rules always seem to be a bit more difficult in the sense that it's a very personal type of crime. It's not so easy for people to want to come forward, but we definitely need to look into it to see if we can get names of victims and see their willingness.

I noticed, in the minutes that I looked through, I think it was Ms. Francyne Joe who talked about informed choice. Informed choice also works with victims of crime, in the sense that not everybody wants to come forward when it comes to such a personalized crime. That's why it's probably been unreported.

I'll be honest. There's also—and it's mentioned again in the report—the trust level with police and coming forward for such a personalized crime. Some people might not even realize that they thought it was a crime, depending on the circumstances in how that situation evolved. Now we have to look at it and say, "Okay, is there a list of victims we can talk to, reach out to, to see if they want to come forward to give statements?"

Mr. Robert-Falcon Ouellette: What is the level of trust right now between indigenous peoples and the RCMP in Canada? Have you been keeping statistics on that and understanding surveys about that? Obviously that's a very important consideration. If someone's not willing to make a complaint, why are they not willing?

Commr Brenda Lucki: I think it varies and it varies in all agencies. That's the reason we have a big focus on reconciliation. Of course, there are various reports that have come out. We always look at things that we can do better. It depends on the community. If you go to certain communities, trust levels are a lot higher, and in other communities, not so much. I guess it depends on the personal experiences of the people in those communities.

● (1540)

Mr. Robert-Falcon Ouellette: You obviously are trying to build a relationship with indigenous communities, but the history of the RCMP was one also of suppression of indigenous peoples.

Commr Brenda Lucki: Yes, in the early days it was also protection.

Mr. Robert-Falcon Ouellette: That's a point of view.

Genocide is one of the things that has come up in the last little bit and this is a very serious accusation. Obviously you have a very important role in the maintenance of law and order and the protection of human rights.

Do you believe the RCMP should be taking more of an active role in investigating and ensuring that if crimes have been committed against women in this country, they are afforded the full protection of the state against those who continue to perpetrate those crimes?

We even heard from a witness that these crimes are still ongoing, or at least there are allegations that they are still ongoing.

Commr Brenda Lucki: Any crime against any person needs to be investigated. Whenever we get complaints, we take it to the full extent, even if we are looking at third party complaints for certain crimes with domestic violence and crimes against the person, because it's not so easy for people to come forward.

Mr. Robert-Falcon Ouellette: If someone who is a third party made a complaint, would you accept that as a way of moving an investigation forward?

Commr Brenda Lucki: In terms of moving the investigation forward, where it goes from there is dependent on the willingness—

Mr. Robert-Falcon Ouellette: For instance, if this committee asked you to investigate this in a more in-depth way, would you then start investigating or would we wait for someone else to come forward?

Commr Brenda Lucki: We are starting to look into trying to get, for instance, names of victims, because obviously there are names of victims in the civil proceedings.

Mr. Robert-Falcon Ouellette: Yes.

Commr Brenda Lucki: In a letter that I received from MP Davies, I noticed that he made mention of names of victims and defendants. With privacy issues, I'm not sure whether we're even allowed to have those lists, but of course, if we were allowed to have them, that would definitely be a starting point.

Mr. Robert-Falcon Ouellette: Thank you very much.

The Chair: Thank you.

Now we'll go to Ms. Gladu.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Mr. Chair, thank you very much, and thank you, Commissioner, for coming today.

First of all, in your mind, with the definitions that we have today, is it illegal for somebody to perform a forced sterilization upon someone who has given consent during labour?

Commr Brenda Lucki: The only law we have to rely on is aggravated assault. With aggravated assault, the Criminal Code says, “Every one commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant.”

Each situation would depend on the circumstances.

Ms. Marilyn Gladu: Okay.

Do you think it would be helpful to introduce a law that specifically called out forced sterilization and gave a definition of what is “informed consent”?

Commr Brenda Lucki: On the way here, I honestly thought about whether I even had an opinion about that. I'm not sure I do. I just think, right now, with the RCMP, we work within the laws of the Criminal Code that we have.

Ms. Marilyn Gladu: Okay.

We heard testimony that there may be as many as a thousand or more Canadian women who have experienced forced sterilization.

Is it your view that it would be the responsibility of local police to investigate those instances, and where we don't have local police and the RCMP is serving that function, it would then be the RCMP's responsibility?

Commr Brenda Lucki: It's not a question of local police or RCMP. It's a question of police of jurisdiction. It's always where the event took place.

If an event took place in, for instance, as we have spoken about, a Saskatoon hospital, the Saskatoon city police would be the police of jurisdiction. If it took place outside of Saskatoon and not in Regina, anywhere else in Saskatchewan, it would be the RCMP.

Ms. Marilyn Gladu: I'm sure that when you heard you were coming to the committee, you looked into the situation. You said there weren't any cases.

Was there other information that you uncovered, and would you have recommendations for the committee on what we should do to try to prevent this from happening to other women?

Commr Brenda Lucki: We actually looked into it a few months ago when I received a letter from MP Don Davies. We solicited the assistance of the Canadian Association of Chiefs of Police as well. Definitely, as I said, we went back and we don't have any cases that came forward that weren't investigated. There were none that came forward in our system, so it's about getting the victims to come forward.

I am feeling confident because, if the victims have come forward civilly, maybe there is a potential that they want to come forward criminally. However, everybody has to make an informed choice.

● (1545)

Ms. Marilyn Gladu: Thank you.

The Chair: Okay.

Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Chair.

Commissioner, thank you for being here.

As a state party to the UN convention against torture, Canada's record on preventing and addressing torture and other forms of treatment is periodically reviewed by the UN Committee Against Torture. Canada's most recent review took place last November in Geneva, and in its final report, the committee officially recognized that the “extensive forced or coerced sterilization of indigenous women” in Canada is a form of torture.

The UN committee provided Canada with a number of recommendations, including that the Government of Canada ensure that all allegations of forced or coerced sterilization are impartially investigated.

In your view, which institution in Canada should bear primary responsibility for ensuring that all allegations of forced sterilization are impartially investigated in Canada?

Commr Brenda Lucki: I would have to go back to the place of jurisdiction where the event took place, because that's the way the law works.

Mr. Don Davies: Do you have reason to believe that some of these forced sterilizations could have taken place in areas of jurisdiction under which the RCMP had control?

Commr Brenda Lucki: Possibly, yes.

Mr. Don Davies: Okay. As you pointed out, I wrote to you back in February and pointed out to you that a class action lawsuit had been filed, at that time naming some 60 women as complainants and naming the federal government, regional health authorities and individual physicians over incidents of forced or coerced sterilization. I understand that class action has since gone to over 100 women.

With that information, you have a potential source of named victims and a potential source of named defendants. Presumably with a source gathering when and what happened, would that not constitute some evidence that would give you a basis for contacting those people and commencing an investigation starting there?

Commr Brenda Lucki: We would have to get the source and get the names, and so far we're following up on that. We're not sure how successful we'll be, because in health, if you've ever dealt with health, it's very hard to get names or anything under privacy, so unless—

Mr. Don Davies: Could you get a warrant?

Commr Brenda Lucki: It would depend on the circumstances, but normally when we go for a warrant it's very specific information. It's not like a blanket kind of exercise where we ask for "any or all names related to", but I'd have to look into that further.

Mr. Don Davies: Fair enough.

Commissioner Lucki, is it your position that the RCMP does not have the authority to proactively investigate suspected criminal activity in the absence of a complaint?

Commr Brenda Lucki: Normally we always work off a complaint of some form, whether it's a suspicion of a complaint. We're following a name, a victim, a defendant, and going from that trail, but without the names and respecting privacy, because there may be some victims who may want to go civilly but would not want to go through anything criminally....

Mr. Don Davies: That could come up through the investigation. This is where I have trouble. If we went outside today and came across a vehicle with its engine running and a broken windshield, and there was blood all over the seats and trailing away from the scene, would you say that there was nothing to investigate until a complaint was received?

Commr Brenda Lucki: No.

Mr. Don Davies: There is potential evidence of some sort of foul play. Isn't that correct?

Commr Brenda Lucki: But that's right in front of us. It's right there, as opposed to most of this historic.... When I say "historic", 2018 isn't historic, but I would say that it's something that has already occurred. It's not in the process of occurring. It's a different set of circumstances.

Mr. Don Davies: Then let me be more focused on this. I'm going to operate from the assumption that, as former justice minister Jody Wilson-Raybould said, she was content that the current Criminal Code is sufficient to cover this and that performing a surgical procedure on someone against their will or without their consent does constitute a crime. In fact, that was the reason the government gave to the UN Committee Against Torture for why it won't change the Criminal Code to have a specific crime for it.

I'm operating from the assumption that if you operate on someone without their consent, you're committing the crime of aggravated assault as it currently is, so when we know that there are dozens and dozens of women who have said that this has occurred, and we know when it occurred, where it occurred and in some cases who did it, I'm puzzled by why the RCMP would say, "We're just going to sit back and not do anything, even though there seems to be potential evidence of a crime, until someone comes forward." We would never investigate the Mafia if that were the case.

Commr Brenda Lucki: We're not really saying that we're sitting back and doing nothing. We're following up to try to get some of the names or all of the names of potential victims and potential defendants so that we can follow up and have a trail to follow up.

Mr. Don Davies: Have you contacted the lawyer for the defendants?

Commr Brenda Lucki: Not to my knowledge, but I know they've have done some work on.... I'm not sure who they've contacted, but I don't think so.

Mr. Don Davies: Have you checked with the records filed in the courthouse for the class action?

● (1550)

Commr Brenda Lucki: I know that there is a whole bunch of people following up on things. I don't have the specifics, but I know they're trying to follow the trail to see if we can get names and also they are working with the other police agencies to see what they have.

Mr. Don Davies: Okay.

Now, if a survivor of forced sterilization had previously come forward to the RCMP but was then referred to a medical regulatory authority, would such an interaction be recorded as a complaint, or in any way, with your records?

Commr Brenda Lucki: It should be recorded as at least a contact, but depending on when it was, it may not show up in our records. It could have been already disposed of if it was far in the past.

Mr. Don Davies: Okay. I'm going to repeat a question that Ms. Gladu asked you. I know you've answered it, but I want to push it a bit.

In terms of a Criminal Code amendment that made performing a surgical procedure on someone without their consent or against their will a specific Criminal Code offence, would you find that helpful in giving the officers under your command greater guidance and maybe a potential source of investigation, or do you feel that the Criminal Code is fine the way it is right now?

Commr Brenda Lucki: I just think that we enforce the applicable laws in accordance with the specific circumstances—the laws that are there. I think the Department of Justice would be in a better position to respond to such a question.

Mr. Don Davies: For my last question, I'm going to go back to the complaint thing. If it came to the police's attention that there was, say, a child who was being sexually abused in a household and you had some sort of information that it might have occurred but no complaint had come forward, would you wait until a complaint was filed before you did anything?

Commr Brenda Lucki: No, but if they said, for instance, that something happened in Canada, which is right now what we have, or it happened in a town, unless we get more information to narrow down who that child is, we would follow up as far as we could follow up and try to figure out who that was.

Mr. Don Davies: In this case—

The Chair: No, you're done.

Mr. Don Davies: I'm sorry.

The Chair: Thanks very much.

Now we're going to go back to that side. Is there anyone...? I know that Mr. Ouellette wants a question.

Mr. McKinnon, go ahead, please.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

We've heard that it's sometimes difficult for women to approach police to lodge a complaint or to register that an incident has occurred. I'm wondering if there are alternatives to that. It comes to mind that information can be sworn to a justice of the peace, I believe, to initiate a criminal action. Is that correct?

Commr Brenda Lucki: Yes, I believe.

Mr. Ron McKinnon: People could approach a justice of the peace and say, “This has been going on and I'd like to lodge a complaint.” That would be passed on to the appropriate police of jurisdiction.

Commr Brenda Lucki: They couldn't necessarily lay a charge. They could bring the information forward, but we'd still have to investigate it before anything further criminally could happen. We could encourage them also.... We do have victim services units that we use to make victims more at ease. We are doing a lot of extra training now, trauma centre-type of training, in the RCMP. We have a bunch of different courses, because we need to be, and we want to be, that police agency that not only do people feel comfortable with and trust us, but when they do come forward, we treat them with the dignity and respect they deserve as a victim.

Mr. Ron McKinnon: I respect that. However, I guess I was looking for an alternative other than going through police services and whether a justice of the peace could serve that function.

Commr Brenda Lucki: In some ways.... They could bring the complaint forward, but the police would still come and need to take a statement.

Mr. Ron McKinnon: That's okay. It can be initiated outside of the police forces. Is that right?

● (1555)

Commr Brenda Lucki: Yes.

Mr. Ron McKinnon: Okay.

My other question, if I have time, is about warrants. Medical records typically are privileged. In order to access them, you'd probably need specific incidents to get a warrant about. If you had a complainant who was a victim, you could presumably get a warrant for that person's medical records much more easily to follow up on that specific complaint.

Commr Brenda Lucki: Yes. Normally, though, when we do have a victim, it's basically consent. The victim can provide consent and we can get access to the records.

Mr. Ron McKinnon: Okay. Great.

Those were my questions.

The Chair: Did you have a question Mr. Ayoub?

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Yes, I would like to ask a question if we have a bit of time left.

I will continue in the same vein as Mr. Davies, who asked you why you do not investigate until you receive complaints or names are submitted to you.

In that specific case, what do you think organizations defending those who have been wronged should do? There are about 100 such organizations. According to those people, a crime has taken place. What do you suggest they do so that you can do your job?

[*English*]

Commr Brenda Lucki: For the lawyers who have the 100 names, if they were to speak with those victims and provide them the option of coming to the police, we would absolutely sit down with each and every victim they have, to look at it from a criminal point of view. That's one thing they could do.

Obviously they're not going to release the names without their consent as well, but if they were to, and if we could have those conversations and possibly could convince victims to come forward through the lawyers, that would be one avenue we could explore.

The Chair: Mr. Ouellette.

Mr. Robert-Falcon Ouellette: I was just wondering how the RCMP would balance this out between criminal investigations and the professional obligations of professional bodies, such as the college of physicians, which also has to conduct investigations and regulate its members. Is there a difference? How do they balance out?

Commr Brenda Lucki: They have their own processes, their regulatory processes that we don't get involved in. We go through the Criminal Code, and so it's criminal.... When it comes to regulatory, it's no different from how in our organization we have internal investigations. Maybe it's not against the Criminal Code, so we do our internal investigation, just as any—

Mr. Robert-Falcon Ouellette: Meaning that a doctor could have not taken the necessary precautions to ensure that someone truly wanted to have sterilization or a tubal ligation yet proceeded with the procedure anyway and the college could determine they had broken its code of ethics, but it might not be a criminal matter.

Commr Brenda Lucki: It depends. If they feel it was criminal they should be bringing it forward to the police. It's no different from it is when we do an internal investigation. If we get enough reason to believe—reasonable and probable grounds—that a criminal matter has occurred, then we would go that route.

Mr. Robert-Falcon Ouellette: I have another short question. If someone wanted to make a complaint to the police—indigenous people often don't do this—how would they go about doing that? Is there a number for the RCMP that you can call?

Commr Brenda Lucki: If it's urgent, you can call 911, obviously. Each town has its own local number, which—

Mr. Robert-Falcon Ouellette: We're talking about Saskatchewan, where we say there's a very great problem and a great gulf between police services and indigenous peoples. If I don't trust the police in Saskatchewan, how am I going to call them? Who am I going to call?

Commr Brenda Lucki: You could present your complaint to another police agency and they would take it to the police of jurisdiction. If you wanted to, if you trusted the police in Alberta, you could go over to Alberta and make your complaint, but the complaint would come back to Saskatchewan, the police of jurisdiction.

Mr. Robert-Falcon Ouellette: Is there a 1-800 number for the RCMP?

Commr Brenda Lucki: There's 911.

Voices: Oh, oh!

Mr. Robert-Falcon Ouellette: Okay.

I have one final question. In Canadian history, has anyone ever been charged under the Criminal Code with aggravated assault in relation to forced sterilization, as far as you're aware?

Commr Brenda Lucki: Not to my knowledge, but I'm not 100% sure.

Mr. Robert-Falcon Ouellette: I believe that's it.

The Chair: Thank you very much. That brings us to exactly four o'clock.

I want to thank you again for coming on such short notice.

Commr Brenda Lucki: Thank you.

The Chair: I believe that's the shortest notice we've ever given anybody, and I know you're very busy so I wanted to thank you.

Now we're going to take a break for a couple of minutes and change panels.

Thank you very much.

● (1600)

(Pause)

● (1605)

The Chair: We'll reconvene our meeting number 154.

Welcome, guests. We appreciate your taking the time to come to provide us with testimony. We are going to go to 5:10.

I'll introduce our guests. Dr. Judith Bartlett is a retired professor from the faculty of medicine, University of Manitoba. From the DisAbled Women's Network of Canada, we have Sonia Alimi, research coordinator, and Jihan Abbas, researcher. From the Royal College of Physicians and Surgeons, we have Dr. Lisa Richardson, chair, indigenous health committee. From the Society of Obstetricians and Gynaecologists of Canada, we have Dr. Jennifer Blake, chief executive officer.

Thank you very much for coming.

We're going to ask each of you for an opening statement and then we'll go to questions. We'll start with Dr. Bartlett.

Dr. Judith Bartlett (Retired professor, Faculty of Medicine, University of Manitoba, As an Individual): Thank you for the invitation. I have lots of red marks on my paper because I realize I'm going to have to cut it down a lot.

I am going to talk about the Saskatoon Health Region lived experience of aboriginal women feeling coerced into tubal ligation. I and Dr. Yvonne Boyer were the co-studiers on that.

I won't go into the media reports. You've heard about those. We started this project—were asked to—in the fall of 2016. The Saskatoon Health Region had attempted before that to have a review, but they had an individual whom the community just wasn't going to trust, so no women came forward.

We proceeded with a community-based approach that involved pre-meetings with both the aboriginal and the health communities ahead of time, to get them to participate in the design of the study as well as to get their agreement to participate in the analysis of the data once we had it. It's a specific collective approach that I use in research.

We did literature searches, of course, looking at all the international tools, and reviewed all of the corporate documents and laws. At one point we realized we had to actually examine the child welfare law as well, because it did have an impact.

Eighteen aboriginal women called our confidential phone line. We interviewed seven of these—six in person and one by phone. Seven others made appointments, but for various reasons they were not able to attend. Some of them made a couple of tries, but they just weren't ready.

We did nine interviews with health care personnel and an interview with a couple of social workers, as well, from child welfare.

The interviews with the aboriginal women revealed that all clearly felt stressed and under much duress from being coerced, while they were in labour, into having a tubal ligation, and this added extra stress to the usual stress of childbirth. The review outlines the depth of the women's experience of being coerced. Themes arising reveal that aboriginal women were living, often, overwhelming and complex lives when this coercion was taking place. This complexity was intricately interwoven with the negative historical context of colonialism.

The overarching themes for the women were that aboriginal women felt invisible, profiled and powerless. They experienced the coercion. I don't have the time to talk about the details of that, but those are in the report. They talked about the impacts on their self-image, their relationships and their access to health care at a later time.

Such experiences as these keep aboriginal women from accessing health care. They're aware that the risk is higher to them, but they just cannot make themselves go, and that has implications for their children as well, and for the rest of their family.

Considering the distress they had and the angst they had about attending, the fact that they actually got there and told their stories to strangers was quite amazing.

The health providers were really concerned to hear that aboriginal women experienced coercion. Their overriding themes were in and around policy and team challenges. They realized there were negative attitudes toward aboriginal women and how this whole issue impacted internal and external care.

● (1610)

Data analysis revealed that health providers work in large, complex and ever-changing hospital systems and environments. Most felt that in recent years positive policy and practice had happened, but they did think that aboriginal women were still falling between the cracks. One thing they brought up, as did the women, was the issue of child and family services. On top of the coercion of having a tubal ligation, they were also often faced with their child being apprehended within a couple of days of birth. That was a major issue. They all came up with suggestions. You'll see them in the report and you'll see the details of the study in the report.

We came up with recommendations. In terms of the data, one thing we could not find was data on medical charts. We were able to get three medical charts, but the rest of them were destroyed at 10 years. That answers the question about litigation for some of these women. When their history goes back 20 years, there's no way to find that.

Saskatchewan, like all the provinces at that time, was in the midst of a lot of health care changes. We felt that their knee-jerk reaction to immediately stop tubal ligations post-delivery, unless you had a pre-discussion with a family doctor or an obstetrician, was going to be a real problem. The health providers and the women also thought that was going to be a real problem in the future. We suggested that the first thing they needed to do was to look at this policy. We also felt that they needed to utilize the resources they have. They have an aboriginal health council, they have a Métis and first nations health service, and they had, at the time, some sort of steering group that was working with changing their provincial policies. In these recommendations, we reminded them that there were requirements in Canadian law; that the implementation of an indigenous health engagement strategy, we felt, needed to be in place; and that there were requirements in Canadian law for consultation and accommodation.

Regarding cultural training, we recommended that they have mandatory cultural training looking at indigenous peoples and their cultures and at human rights cultures. There needs to be a clear addressing of the false stereotypes about aboriginal women being unable to look after their own children, where decisions are made for them.

In education, we recommended that there needed to be cultural competency in nursing, medical and all health professions. This is beyond cultural training. It means that there needs to be introspection by the learner to understand their own level of privilege in society. There are lots of papers on that. That can be learned.

● (1615)

They were talking about restructuring in Saskatchewan. We feel that the change has to be substantive, not simply an indigenization of health. That will not be enough. They need to begin extraordinary measures. It's been probably 20 or 25 years—I can't remember how long now—that we've had an Aboriginal Health and Wellness Centre in Winnipeg. Saskatoon has a large aboriginal population and they don't have that yet.

The Chair: I have to ask you to wind up, if you would. Thanks.

Dr. Judith Bartlett: Okay.

We thought they needed an advisory council to help the women who experienced this go through whatever process they selected to go through in order to go through a healing process. We expected that they needed to partner with expert groups—indigenous nursing, indigenous physicians and others—and that there be actual resources put on the table to ensure that those groups could participate.

Then, in terms of the issue of women who are at high risk, we recommended a reproductive centre of some type that would be supportive of women. One health provider stated that there were at least 30 high-risk pregnant women in her practice. There are examples. For instance, health providers talked about Sanctum House, which provides wraparound services for people living with or affected by HIV or AIDS, and Infinity House for mothers and children with transition—

The Chair: Dr. Bartlett, I'm sorry. We have to go to the DisAbled Women's Network of Canada now. Thank you.

[*Translation*]

Ms. Sonia Alimi (Research Coordinator, DisAbled Women's Network of Canada): Good afternoon.

Before we focus on the points we are discussing today, on behalf of the DisAbled Women's Network of Canada, we want to remind you that we are meeting on unceeded Algonquin territory and highlight the period of truth and reconciliation we are now going through. So let's take this opportunity to focus more specifically on the needs of our aboriginal sisters and on how we can repair the harm caused to improve the lives of current and future generations.

We thank the Standing Committee on Health for inviting our organization to testify and we recognize the other witnesses here today.

We will make our presentation in both official languages.

At the DisAbled Women's Network of Canada, we are committed to denouncing oppressions intersectionally. So we address oppressions stemming from ableism, a system that infringes on the rights and freedoms of people whose abilities do not meet the standards, as well as racism, colonialism, sexism and other systems of oppression.

When it comes to forced sterilizations, we think they are a direct consequence of an ableist society. In that sense, they have specific repercussions on girls and women with disabilities. Jihan Abbas will highlight that painful observation.

Let's not forget that forced sterilization is closely related to a eugenic vision to determine and hierarchize individuals and their possibilities of existence. It is based on the logic of ableist oppression, which has established notions of deviation, by targeting what is missing, what is against nature and what can be oppressed and limited. As a result, we consider that forced sterilization, being a concrete expression of the ableist system, opens the door to racist, colonialist and sexist practices, among other things.

We know that racism and ableism are tightly interwoven. It is very useful to remind you that the eugenics movement, both in the United States and in Canada, had to do with the white supremacist ideas focusing on the degeneration of the white race. An overwhelming number of black women have been subjected to and are still being subjected to non-consensual sterilizations.

Researcher Shatema Threadcarft, in her 2016 work on intimate justice and the bodies of black women in the United States, shows the prevalence of those practices.

Canada is no exception in that respect. Before the Standing Senate Committee on Human Rights, university professor Josephine Etowa revealed that, during a study on the health condition of black women in Nova Scotia, it was noted that hysterectomy was being practised in a worrisome proportion. Here is what Ms. Etowa said, and I quote:

> They started telling us their personal stories of how women in their community, especially those with dark skin colour, every time they went to the doctor, even in their early twenties, hysterectomy was one of the answers to whatever problem they went to see the doctor for.

So we understand how racism and ableism are expressed, and we see that this is an important issue in the forced sterilization file.

It is also a problem experienced by trans and intersex individuals.

Alexandre Baril, assistant professor at the University of Ottawa, states in his 2013 thesis that the Canadian government requires trans individuals who want to acquire a marital status to undergo changes to their genital organs involving a suppression of the ability to reproduce “naturally”.

Canadian sociologist and anthropologist Morgan Holmes, who represents the Egale Canada group, also reports on the concrete effects of cisgenderism leading to the forced sterilization of intersex individuals, especially children. She also appeared before the Standing Committee on Human Rights, on May 15, 2019. During her presentation, she denounced the paradox of subsection 268(3) of the Criminal Code, which, while prohibiting female genital mutilation, authorizes surgical procedures on intersex children, whose reproductive capabilities are removed with impunity and without consent.

On another note, which still continues to shed light on the situation intersectionally, the issue of sterilization also affects women in prison in large numbers. A U.S. study from 2016 talks about the pressures on incarcerated women to undergo surgeries to remove their reproductive capabilities. That same study confirms that those injunctions always seek to respond to a eugenic and ableist system.

The facts I am sharing here with you are only the tip of the iceberg. It is important to know that many other women at the intersection of multiple oppressions are subjected to forced sterilization. That is why we feel it is important, in the context of our presentation, to insist on the intersectional dimension of this problem and to show that solutions cannot be found outside such an analysis.

● (1620)

I will now yield the floor to Ms. Abbas.

[*English*]

Ms. Jihan Abbas (Researcher, DisAbled Women's Network of Canada): In Canada, women with disabilities have historically been targeted for coercion and forced sterilization, and they remain vulnerable to these practices even today.

Canada was of course influenced by the eugenics movement throughout the 20th century. In fact, both Alberta and British Columbia had legislation enabling sterilization for anyone diagnosed as “mentally ill” or “deficient”. Data from the Alberta Eugenics Board case files indicate 1,154 women with disabilities were sterilized under these practices. Close to 40% of these were sterilized after 1955.

Sterilization laws in Alberta were not repealed until 1972. Unfortunately, in the case of British Columbia, records of these practices have been lost or destroyed. While other provinces may not have had official sterilization laws, countless women with disabilities were likely sterilized, as these procedures were often performed on young women with disabilities through parental consent. As well, sterilization practices in Canada have also been sexist, racist and imperialist and have disproportionately targeted indigenous women.

There are two examples of case law that show the vulnerability of women with disabilities to forced sterilization, as well as the possibility for legal protection. In 1995, Leilani Muir, a woman with an intellectual disability, successfully sued the Alberta government over the practice of forced sterilization. Muir, who had been admitted to the Provincial Training School for Mental Defectives in 1955, had been sterilized at age 14. Her advocacy led to an official apology from the Alberta government and compensation for hundreds of others.

There was also the 1986 Supreme Court of Canada decision known as the Eve decision. The case involved a 24-year-old woman with an intellectual disability. The mother had argued that, as her daughter's substitute decision-maker, she wanted to be authorized to have her daughter undergo tubal ligation. The Supreme Court ruled against the mother, saying that the procedure was “non-therapeutic”.

This landmark decision was a critical turning point in the struggle for recognition of the rights of persons with intellectual disabilities. It ended the long-standing practice of non-therapeutic sterilization of people with intellectual disabilities and other mental disabilities and affirmed that, regardless of cognitive ability, all persons have a fundamental right that cannot be overridden.

Despite these cases, parental influence continues to be a factor for young women with disabilities, as parents still wield power and control that can influence access to and decisions around reproductive health.

In our own research, the recently released “More Than a Footnote” report, we spoke to one woman who shared that her parents had made reproductive health choices on her behalf without her consent and against her will. Much of the existing research here deals with women with intellectual disabilities, as they appear particularly vulnerable to this. They have inadequate access to education and they're more likely to experience poor reproductive health outcomes.

We also want to note that in terms of reproductive coercion young women and girls with disabilities may be subject to problematic forms of power and control over their reproductive health because of the role of adult decision-makers in their lives. Of course, here is the intersection of paternalism and ableism.

One recent Canadian study framed these ongoing forms of coercion as violence enacted upon young women with disabilities and drew attention to some of the most prevalent forms. These include birth control sabotage, pregnancy coercion and controlling the outcomes of a pregnancy.

For young women with disabilities, there are unique dynamics that require our attention. On this note, the continued use of Depo-Provera as a contemporary practice is something to which we must pay attention. Depo-Provera remains controversial, and its side effects can be serious and are not well understood. There is evidence that this was prescribed to women with disabilities before it was approved in Canada as a contraception. As well, one Canadian study found that young women with intellectual disabilities were commonly prescribed this in response to family and caregiver concerns about pregnancy and menstrual hygiene.

One of the most disturbing things we've come across is the practice of applying invasive growth attenuation treatments, commonly referred to as the Ashley treatment, to children with complex disabilities and medical conditions. It's aimed at keeping them small, presumably to make it easier for their caregivers to provide care. Procedures can include things such as high doses of estrogen, hysterectomies and breast bud removal. While this practice seems more prevalent in the U.S., it has spread to other countries and it's difficult to gauge what is happening here in Canada. There is a need for a dedicated space to explore these things.

Finally, in DAWN Canada's research, it has also been illustrated how widespread reproductive coercion is for women with disabilities. Women with disabilities share that while they may not be the victims of forced sterilization, as they would have been historically, they continue to be actively pressured against motherhood. There are continued reminders from family, friends and medical professionals that shape their decision-making.

Of course, there are several factors that increase vulnerability among this group. These include limited contraception options and a lack of knowledge among health care providers about disability.

● (1625)

We have recommendations to reduce this vulnerability. These include supporting self-advocacy so women and girls with disabilities become partners in their own care, teaching health care providers about disability to avoid ignorance and ableism, and conducting more research and policy analysis to examine the many insidious ways in which women with disabilities and their bodies are controlled by caregivers, parents and support workers.

Finally, in terms of broader action, DAWN Canada points to the promise offered through the Nairobi principles, which seek to affirm sexual and reproductive rights through an intersectional lens that is inclusive of both a gender analysis and the very real impacts of ableism on the lived experiences of women and girls with disabilities. These principles move us collectively to a place that affirms both the need for access to safe abortion and the need to consider the ways ableism shapes autonomy and access to reproductive health.

Thank you.

The Chair: Thanks very much.

Now we go to Dr. Richardson.

Dr. Lisa Richardson (Chair, Indigenous Health Committee, Royal College of Physicians and Surgeons of Canada): Thank you for having me here on behalf of the Royal College. I'm the chair of the indigenous health committee there and one of the few indigenous physicians at the University of Toronto. I practice general internal medicine. I'm very actively involved in indigenous medical education and I really want to focus my opening on the role of education and where we should go following these terrible and very upsetting activities. Particularly since I am a health practitioner and an indigenous woman, that intersection makes this topic area extremely personal and difficult to talk about, quite frankly.

I want to provide some context and background for how we think about the experiences of indigenous peoples overall in the health care system. We have ongoing evidence of the mistreatment of our peoples within health care. They experience racism and this most egregious manner of mistreatment in the form of forced sterilization. We have ample evidence around that: the Health Council of Canada reports, our health council report, and the “First Peoples, Second Class Treatment” report, as well as all of the anecdotal evidence that we experience every day as indigenous health advocates.

For example, I received a phone call from my colleague in emergency saying, “You need to come down and deal with this. I have a patient who's just had a large acute myocardial infarction and did not have any lifesaving treatment for six hours because there was a thought that this person was inebriated.” This is the reality of our peoples within the health care system.

Second, there is the intersection of this with being an indigenous woman. For these women who've experienced the forced and coerced sterilization this is, of course, another layer of intersection. I appreciate my colleague's approach to intersectionality, because we know that the vulnerability of an indigenous person in the health care system is extreme. Add to that the experience of being an indigenous woman and everything that we know from the MMIWG report and the embodiment of colonial violence is actually compounded when one enters the health care system. That is the context in which we need to consider how we move forward on this.

One of our major recommendations is that there be a large commitment to and investment in cultural safety education for our health care providers. This is what we are actively committed to at the Royal College. In fact, we passed a motion in our council in 2017 to make indigenous cultural safety and anti-racism education a mandatory component of every subspecialty training program across the country, as well as a part of accreditation. That needs to extend to people in practice. There needs to be an understanding not only of the specific needs and how to have important conversations in a culturally safe way with all practitioners but also of colonial and historical practices and how they continue to play out in that patient-provider interaction.

Working with a wonderful team at the Royal College, we're really trying to pull together information and push this out, but that leads to recommendation two, which is that we need to have accountability measures in place. We need data. I'm a physician. I'm a scientist. We need data, but I would argue that we need to think about what counts as data, because we don't need a randomized controlled trial to elucidate the fact that there is a problem here. We have stories from people coming forward. What we need to do is to facilitate that coming forward for those people, the women who've experienced this or who are concerned about an interaction, in a way that is safe and that lets them know that they will be listened to and that their experience as an indigenous person is actually recognized and valued.

What are some mechanisms through which one might do that? I want to draw upon what I think are different layers as to how one might think about this kind of work. I'm very familiar with some of the mechanisms in Ontario. One could leverage some of the quality metrics and quality standards that exist at the provincial and regional health authority level, such as the Excellent Care for All Act in Ontario, under which we're asked to have quality improvement plans, patient safety questionnaires, etc.

How can we build on these experiences of indigenous patients and indigenous women and, in particular, have an understanding of what policies and procedures exist around sterilization practices? How can that be embedded within existing structures?

● (1630)

At a larger level, how can PHAC, for example, build on the amazing work that's been done with the opioid crisis to collect, gather data, and then report on it? What I love about PHAC and the opioid response is that you can go on the website and actually see what the data is and what the numbers are. That level of transparency is very important when you're working with our communities.

The third piece I want to speak about is that in our practice at the Royal College we recognize that we are a colonial institution. We're working very hard to decolonize, but we recognize that tension. We have amazing indigenous practitioners who are working there, but our practice is always one of self-determination and allyship. Even though I'm an indigenous person working at the Royal College, I'm still working within a non-indigenous institution. We support our colleagues and national indigenous organizations in their calls around the criminalization of this behaviour and of this practice.

I actually believe, and in hearing the earlier testimony, that the current system is not working. How can we look at changing the Criminal Code in order to make sure that these cases are being appropriately investigated and followed? Thank you.

● (1635)

The Chair: Thank you.

Now we go to Dr. Blake.

Dr. Jennifer Blake (Chief Executive Officer, Society of Obstetricians and Gynaecologists of Canada): Thank you very much.

I'm the chief executive officer of the Society of Obstetricians and Gynaecologists of Canada, commonly known as SOGC. I am an obstetrician-gynecologist. I'm also adjunct professor of obstetrics and gynecology at both the University of Ottawa and the University of Toronto. In the past I've served as chief of obstetrics and gynecology and head of women's health at Sunnybrook Health Sciences Centre, chief of pediatric gynecology at the Hospital for Sick Children, and undergraduate dean of McMaster University's medical school. I'm bringing a lot of years with me.

Let me begin by saying that when I was first contacted about forced sterilization, I assumed we were talking about a deep historical practice. I was shocked to hear that we were talking about something that's current. It is my hope that, as of today, it is indeed history.

I also need to say that I'll be referring to women using “she”, “her” and “hers”. This is not because we are not mindful of the needs of all persons, but because the fundamental mission of the SOGC is the advancement of the health of women. As I think we've heard amply today, that work is not yet done.

The SOGC is a professional society that draws its membership from obstetricians, gynecologists, family doctors, nurses and midwives—many professionals. It advocates on behalf of women to receive quality care throughout their sexual and reproductive lives, including, always, the right to safe, respectful and culturally appropriate care. There are more than 380,000 childbirths in Canada each year. In each case, we believe that the caregivers are extraordinarily caring and professional and are mindful of the particular vulnerabilities we have when we are pregnant and when we are in labour; we can talk about what those are. We also guide women through a lifetime of intimate gynecologic needs. These needs must always be met with uncompromising professionalism and respect.

The SOGC advances health care through education, advocacy, leadership and collaboration. We have no examining, licensing or regulatory authority over any health care provider. We do provide clinical practice guidelines—10 to 17 each year—that are carefully researched and are interprofessional in their development. I would draw your attention to the 2013 guideline on cultural competence, which was developed by our indigenous women's health committee in consultation with many indigenous women's groups.

This is part of our significant educational role, providing professional development to licensed members, all based on a philosophy that respects sexual and reproductive health as a human right. These rights have been well described by the United Nations. The right to decide freely and responsibly the number, spacing and timing of an individual's children, and to have the means and information to do so, is a fundamental human right. We also seek to recognize and remedy the inequities of access and outcomes faced by indigenous women and vulnerable women in Canada and around the world. This is also in call to action 19 of the TRC report.

I'm here today to speak about the experiences of sterilization brought forward by indigenous women and described in the Boyer and Bartlett report. I need to say that coercion has no place in any surgical procedure. As physicians, we fully understand the ethical primacy of autonomy, and therefore, of freely given and fully informed consent, but consent is influenced by context. I need to address some of those contexts and considerations.

First, the bar for informed consent is much higher for vulnerable persons and for elective procedures than it is for life-threatening situations in an emergency room, for example, and particularly so for irreversible ones. For such an important choice as permanent sterilization, it is preferred to have these discussions long before delivery, for reasons that I can explain. It's always more challenging to obtain a fully informed consent when a person is in pain, or in crisis, or far away from her home and community. The process of obtaining consent is far more complex than just obtaining a signature. It's a thoughtful discussion of the procedure's risks and benefits but also the alternatives. For example, a hormonal IUD provides far better contraception than sterilization and is reversible, and a vasectomy carries much less surgical risk than a tubal sterilization.

There may be circumstances that lead to a late request. Dr. Bartlett alluded to the fact that a moratorium can also be harmful. However, we need to be aware that for some of these, such as a life-threatening complication that would arise in a subsequent pregnancy, you might not know it until the time of delivery, and therefore, that's the time when this discussion is happening. That is a problem, and you have to be extremely careful. It can result in a strong recommendation against subsequent pregnancies. Communication is critical, but it is always the woman's informed choice to make. It is her decision whether she wishes to have or to not have a sterilization, and to understand the risks that go along with either of those choices. There are risks, in that case, with either.

● (1640)

For no other procedure do we worry as much about the risk of regret as we do with tubal sterilization. We always have to worry about the woman not having reason for subsequent regret. The ability to bear a child is so fundamental. Tubal sterilization we always consider permanent and an irrevocable choice. There are different methods, and some of them are potentially reversible, but those reversals carry a risk of tubal pregnancy, which can be a life-threatening complication, especially if you live in a remote community.

Consent is fundamentally based on a therapeutic alliance between the patient and her health care provider. If that therapeutic relationship is not present, it's far more difficult to be sure that you do indeed have consent. Circumstances that erode trust are a perceived power imbalance and the experience of racism and isolation. All of these intersectional stresses that we've discussed can make it very difficult to be sure that consent has been freely given. The assent may be there, the signature may be there, but there is no true test of consent. That is one of the complexities.

As a physician, you are not aware of what's gone on before. You don't know whether conversations have gone on that might have influenced the decision. You don't know about prior traumas that may have led to an impaired consent. If a woman is incarcerated, does she have children in care? Has she been threatened with loss of her children? Are there other pressures at play that she might not disclose? Is she struggling with addictions? Is she a victim of human trafficking? All of these things make us vulnerable. The crucial context might not be disclosed due to fear or a sense of powerlessness or hopelessness. They can be difficult to determine in the best of circumstances, but when you're in a crisis or an acute situation, you really don't know.

Cultural safety and literacy are important competencies that we hope will lead to improved therapeutic relationships. We are well aware that how we communicate is culturally bound. It's not just about the language. A thousand other cultural influences bind our ability to communicate and to reach understanding with one another.

We support the recommendations of TRC calls to action 23 and 24. Those in fact were why we published our guideline in 2013. We believe this is crucial. We believe the currently available cultural safety training does not specifically or adequately deal with issues with respect to women's health. There are specific needs that this issue brings up that have to be brought forward. They are far more complex and just add layers of nuance to what needs to be taught.

Decisions with respect to fertility or sterilization are far more complex than a relatively simple technical procedure. I've seen women refuse cancer-curing treatments in order to not risk the potential that they might have a child, and they died knowing they'd made the right decision even though they had in fact never been able to conceive. Fertility is something that is deeply important to people.

While the cases that have come to light focus on indigenous women, we at the SOGC believe these considerations apply to all people, regardless of their identity. Trust, communication and understanding are paramount in any relationship. No physician wants to learn that a patient they treated in good faith gave their consent under coercion. We will work with all involved parties—we welcome this hearing—to ensure that a process is in place to protect the freedom of reproductive choice that all women should enjoy.

We support the recommendations of TRC calls to action 23 and 24 for cultural competency training, but we specifically call for additional modules dealing with the issues around women's health. We think all contraceptive options need to be fully available to all Canadians, free of barriers. We know that cost is a barrier for many. That ranges from education to cost-free access. We know that long-acting reversible contraception is the superior method of contraception, but we don't have implants yet in Canada that are easily inserted, easily removed and provide effective contraception. They are available in just about every other country. Not every woman wants an intrauterine device.

● (1645)

Finally, healthy pregnancy and childbirth lie at the heart of a healthy community. The most important thing that any of us has is our family. We know that a multitude of transgenerational harms can be transmitted in pregnancy and, conversely, can be mitigated by a healthy pregnancy, and there is so much evidence on this. That means good nutrition, clean air and water, and appropriate health care in a supportive and caring community. We ask the Government of Canada to really help ensure that every Canadian has the best start in life.

Thank you.

The Chair: I just have to say that you're all amazing. I think we're so lucky to have access to your experience, your knowledge and your thoughts.

As you did, Dr. Blake, I thought we were talking about something historical when this first came up.

Dr. Jennifer Blake: Yes.

The Chair: For a lot of us here, we're just scratching the surface in learning about this.

We will now go to questions. We're going to start with Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Chair.

Thank you all for coming.

Dr. Abbas, you hit the nail on the head. During the testimony, one of the words that came to mind from my medical training was the word “paternalism”. As a medical student, I would overhear these conversations at other tables among more senior practitioners: “This 23-year-old is on her eighth pregnancy. I'm going to do a caesarean.” “Why don't you just ask her if she wants a tubal when you do that?” More often than not they would be indigenous, but basically they would be people who were poor. Again, indigenous people are overrepresented among those in poverty.

I think I know the answer to this question, but if someone is in this situation and she's about to go in for a caesarean and the doctor says, “We're going in. Since I'm in there anyway, and you already have eight kids, do you want a tubal ligation?” would you call that being coerced?

Dr. Bartlett, I see you nodding your head.

Dr. Judith Bartlett: I would call that being coerced. That woman is in no condition emotionally to make that kind of decision. In fact, that happens—you're correct—more often than it should happen. Any time you're being asked to make a decision when you're not in a state of mind to weigh out the pros and cons, then it's coercion.

Mr. Doug Eyolfson: Thank you.

Would we say there's general agreement to that around the table?

Go ahead, please.

Dr. Jennifer Blake: Can I just say that there is general agreement, but you don't know the circumstances. You've painted a picture in such a way that someone, in kind of a cavalier way, is saying, "While we're in there", but you don't just "while we're in there" get to a caesarean section. Is this her eighth caesarean section, for example? Where does she live? I think in any case, you can talk about generalities—

Mr. Doug Eyolfson: Absolutely.

Dr. Jennifer Blake: —but you have to really understand that there are specifics in each situation that need to be really thoughtfully considered.

Mr. Doug Eyolfson: I agree. I meant if they were doing it, because as we know.... Again, I don't like to admit this on behalf of my profession, but there are those who do make cavalier decisions sometimes, and tragically enough they think their intentions are good even when you realize that ultimately there are very disastrous results.

Dr. Jennifer Blake: We can agree that cavalier decision-making is not good decision-making and is inappropriate.

Mr. Doug Eyolfson: Absolutely.

This is a question for all the people across the board here with medical backgrounds. If you find that a sterilization was performed and, in fact, the woman did not give consent, what sanctions or actions is a regulatory body like a licensing authority—for example, the provincial college of physicians and surgeons—able to take?

● (1650)

Dr. Jennifer Blake: Depending on the circumstances, you can lose your licence to practise. There are a range of issues, but if in fact there is coercion, which is operating without consent, that is actually something that would result in disciplinary action and there are a range of actions that the college can impose right through to permanently barring someone from practising.

Mr. Doug Eyolfson: Thank you.

Dr. Richardson, you talked about the culturally relevant education. I agree. We had much of this in residency. I'm a rural college graduate from the EM program.

We find that for such fundamental issues this needs to be done more or less before residency. Has there been dialogue with the medical schools to get such culturally appropriate and culturally sensitive training at a very early stage, before people are heading out to the wards to actually see patients?

Dr. Lisa Richardson: Thank you for the question. It's actually great timing, because our major national organization, the Association of Faculties of Medicine of Canada, which is for undergraduate medical education, the Royal College and the College of Family Physicians of Canada are meeting next Sunday, because our deans have approved the creation of a national consortium in order to make sure that we are sharing and doing this work.

I'm going to speak as an educator. It's a spiral, so that you start before you enter medical school. We're now having conversations about having as a requirement for entry into medical school cultural safety education, so that once our students arrive, we're not having to teach what one of my elders calls "Indigenous 101", but are actually able to delve into this. How does one practice trauma-informed care? How does one have these complex conversations where there's historical trauma?

We are all committed to that. It's happening. In fact, it's been happening in the medical schools for much longer, and now we're extending this into residency training.

Mr. Doug Eyolfson: Thank you. I had some other questions, but they more or less got answered during the testimony so I'll stop a little prematurely.

Thanks very much to all of you.

The Chair: Now we have Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair, and thank you to all the witnesses.

I'm going to start with you, Dr. Blake. Is it only obstetricians and gynecologists in Canada who can perform a tubal ligation?

Dr. Jennifer Blake: No. Depending on where you are, family physicians may well be the ones who are able to perform a tubal.

Ms. Marilyn Gladu: Is there a complaint process such that if somebody felt they had a procedure without their informed consent they could complain about an OB/GYN?

Dr. Jennifer Blake: Yes. It starts at the local hospital level. I think almost every hospital now has an ombudsperson or someone in a quality office you would be able to speak to. Beyond that, there is the college in your province or territory. Also, at any time, you could speak with a lawyer, if you felt that it was for your lawyer. There's also your own care provider. You could go to your family doctor, who could help you push a complaint forward.

Ms. Marilyn Gladu: The reason I'm asking you this is that we've heard testimony that people could be charged today under existing law—so I'm not sure another law will help—but we've heard that people are too intimidated to speak to police or to even go through that whole criminal process.

I'm trying to figure out how we eliminate these forced sterilizations. If there was a complaint brought forward professionally, what would the SOGC do if somebody received one or multiple complaints that they were doing sterilizations without consent?

Dr. Jennifer Blake: The SOGC does not have any regulatory authority, so we would refer that to the local provincial college, and it would be up to the college. You'd really need to talk to the college about how they handle complaints that have a criminal element to them, but a forced sterilization would be illegal under current Canadian law.

● (1655)

Ms. Marilyn Gladu: Let's talk to the college.

Dr. Richardson, what do you think the college would do if it received complaints like that?

Dr. Lisa Richardson: You're speaking about the regulatory authority and the provincial colleges, which I'm not a part of, but I actually did speak to the chief medical officer of our college, the CPSO, about this.

As soon as they do a very thorough investigation, and as soon as there's any possibility that it is falling into the criminal realm, then it gets moved along. We have, unfortunately, many cases of that with regard to sexual assaults and sexual violence, so there is a precedent there and they are quite experienced. What she did say is that she wants to hear about all of this, and they're not hearing any of this.

You're speaking about the reporting, and it is a major issue because patients in general don't want to report. The literature suggests that only 20% of patient safety incidents that lead to mortality, increase morbidity or increase hospital stays get reported.

That's heightened completely for indigenous patients. When we speak to our people, they're worried about reporting. They're worried about the repercussions. If they make an anonymous report, the institution will not act because it's anonymous. If they make a report and they attach their name to it, they're suddenly the whistle-blower in a hostile environment, etc.

I think the crux of one of the things that needs to be worked on is what reporting that is safe looks like. Maybe it's to a third party who doesn't have to disclose the full background and identity and ideally is someone who is indigenous or understands the indigenous experience. Then, do a more robust investigation. I think that reporting piece is critical when we look at the way.... We have a lot of experience in the patient safety world and in our health care institutions.

Ms. Marilyn Gladu: Perfect.

I have a question now for you, Dr. Abbas. We're talking about people who are disabled. There are some disabled people who wouldn't be mentally competent to give consent and may be under parental care. I was listening to your comments about the parents taking the decision for them.

What is the right thing to do in a circumstance where someone is not mentally competent to decide whether or not to have a procedure and they have people who maybe have their power of attorney or are their parents or their caregivers? What do you recommend should be done in that circumstance?

Ms. Jihan Abbas: I think that's a big question. There are procedures around guardianship and things like that. I think one of the concerns, as we're hearing anecdotally from people, is that those formal things that would give somebody power of attorney or whatnot oftentimes aren't happening. It's happening informally with parents and caregivers. That's a real concern there as well, especially with women with disabilities.

I don't know, Sonia, if you want to add to that.

[*Translation*]

Ms. Sonia Alimi: Yes. I want to clarify what we also mean when we talk about individuals not giving their informed consent.

For example, people with intellectual disabilities who are members of the People First movement consider that they can provide their informed consent.

Who can decide what individuals can or cannot give their informed consent? That is a more social question and the answer is very broad, but I think that we should focus more on that aspect.

[*English*]

Ms. Marilyn Gladu: Also, Ms. Alimi, you talked about intersex people and the number of times they're being sterilized. How many intersex people are there in total in Canada?

[*Translation*]

Ms. Sonia Alimi: I don't have the exact number. In my presentation, I mentioned the statements of Morgan Holmes, who represents the Egale Canada group. I don't have the exact figure; I cannot answer that question.

[*English*]

Ms. Marilyn Gladu: Okay.

I want to talk a bit more about the cultural safety training.

Dr. Richardson, I think you were talking about the training that's needed and what should be put in place. Does the federal government have a role to support that?

Dr. Lisa Richardson: It's great that you're asking.

We've worked with the Métis National Council, the AFN and ITK. I'm a member of the Indigenous Physicians Association of Canada and the Canadian Indigenous Nurses Association. We've actually put together a request for the creation of a large online knowledge hub for cultural safety material, so that one can go to this online hub at any point and learn and expand one's knowledge. We've put that forward to Health Canada, and we're waiting to hear back from Dr. Gideon.

● (1700)

The Chair: I'm sorry. We're done.

Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

Dr. Blake, the Inter-American Court of Human Rights and the European Court of Human Rights have both recognized that informed consent can never be given during and immediately after labour and delivery. Is that the position of the society?

Dr. Jennifer Blake: We avoid, at all costs, trying to obtain consent at the time of labour and delivery. There are many reasons for that. That is the hardest time, so you always try to make sure that the request and the intention to seek sterilization have been expressed previously.

Mr. Don Davies: You don't have a hard and fast rule that's as clear as that.

Dr. Jennifer Blake: We don't have a hard and fast rule on that, but I can tell you there is a universal understanding that this is not the time to be obtaining consent.

Mr. Don Davies: The International Federation of Gynecology and Obstetrics has emphasized that "sterilisation for prevention of future pregnancy cannot be ethically justified on grounds of medical emergency.... [She] must be given the time and support she needs to consider her choice." Is that also consistent with your society's understanding?

Dr. Jennifer Blake: Yes.

Mr. Don Davies: Of course, at this committee's last meeting we learned that tubal ligations are being performed on indigenous women in Canada. We heard a story as recently as December 2018. These are being performed while women are in labour or immediately postpartum, when these women are physically and emotionally exhausted, often still under the influence of anaesthetic and unable to give informed consent.

Given that it seems to be well established within your profession that it's not possible to give informed consent for tubal ligation immediately before, during or after labour, why do you think health professionals continue to seek it from indigenous women?

Dr. Jennifer Blake: I can't answer that, because, as I say, I had thought that this was a historical practice. You're asking me to speculate about something that....

Mr. Don Davies: I guess you'd agree that it shouldn't be happening.

Dr. Jennifer Blake: It's even more than what you've described. There's also the whole hormonal milieu in pregnancy. You're flooded with oxytocin. It's called the cuddle hormone. You don't have your natural safeguards working for you when you're full of oxytocin. It's an altered state of brain. It is clear that this is the time to avoid, and it's not necessary. You have alternatives if someone really doesn't want to consent.

Mr. Don Davies: I understand that.

We had some testimony before, and I want to clarify something. Is the physician who's performing the tubal ligation or the procedure ultimately responsible for ensuring that informed consent has been given?

Dr. Jennifer Blake: Yes.

Mr. Don Davies: If these in fact have happened, these tubal ligations, then it is the person who's performing.... In all cases it would be a physician, I imagine, of some type. You mentioned that it could be a family physician or an—

Dr. Jennifer Blake: You are responsible. If you're the operating surgeon, you are responsible.

Mr. Don Davies: Okay. Thank you.

Dr. Bartlett, I don't know if you were in the room when we heard the testimony of the commissioner of the RCMP who seems to have, up to now, found it difficult to determine the name of a single woman who has had this happen. How difficult is it—you've done some research—to find out the identities or names of women who have reported forced or coerced sterilization in Canada?

Dr. Judith Bartlett: Even from our study, it's difficult. We have assured them that this is confidential, so, in fact, their names are destroyed.

Mr. Don Davies: Do you know who some of them are?

Dr. Judith Bartlett: I know who they are, but I can't—

Mr. Don Davies: You can't say who they are, but you've discovered who they are.

Dr. Judith Bartlett: I've interviewed them, but I don't have their names anymore.

Mr. Don Davies: I understand, but you found them.

Dr. Judith Bartlett: We found them. They found us through our posters and our reaching out. We had to reach out through the appropriate channels and take the appropriate process.

● (1705)

Mr. Don Davies: Right.

Dr. Judith Bartlett: You can't just go out and say "report it." The Saskatoon Health Region has a great in-ward reporting system for anything that goes wrong. The problem is that these women aren't even in a position to feel safe enough to do that.

Mr. Don Davies: Right, and I'm going to get to that if I can.

The Saskatchewan Health Authority is currently investigating the case of a 30-year-old woman, a Nakota woman, who says she was the victim of coerced sterilization at a Moose Jaw, Saskatchewan, hospital on December 13, 2018. Does the Saskatchewan Health Authority know who that is?

Dr. Judith Bartlett: I couldn't tell you.

Mr. Don Davies: Okay.

A November 2018 article from APTN news quotes Senator Boyer as saying the following with respect to the report you co-authored: "The report that Dr. Bartlett and I did was just a mere glimpse into the problem." We heard, of course, about the 100 allegations. Do you believe we currently understand the full scope of this problem in Canada?

Dr. Judith Bartlett: No, I don't think so. I think a lot more research has to be done. I think something has to be done to make sure this doesn't happen.

In terms of how all the women will come forward and deal with this, even the women who came to us said that when they left, they felt so much better just from having talked about it, just from having said it. There has to be something put in place where women can actually go and talk about this. They may not want to go to court or they may not want to talk to the health authority, but they need to express this harm.

Mr. Don Davies: Right.

I was struck by your use of the words “extraordinary measures”. We heard Commissioner Lucki talk about the need to build trust in police. Last month there was some pretty disturbing video of a Kelowna RCMP officer interrogating an underage indigenous woman, a teen, for more than two hours after she reported a sexual assault while in the care of the B.C. child welfare system. She was barraged with such denigrating questions as to whether or not she was at all turned on by it. A statement of claim was filed in March by that youth, who claimed that she felt punished for reporting a sexual assault. She also alleged that no meaningful investigations were carried out surrounding the circumstances of the sexual assault.

This is the context in which indigenous women are experiencing interactions with the police, yet we just heard the commissioner of the RCMP say they're going to wait until indigenous women come to them. We just had the report of the murdered and missing women inquiry, which dealt with this issue in the context of genocide. Do you think it's reasonable for the Government of Canada to refuse to direct the RCMP or for the RCMP to refuse to undertake proactive investigations, to reach out to indigenous women, given that context of the experience of indigenous women with police in Canada?

Dr. Judith Bartlett: I think they can reach out, but reaching out has to be done differently. A whole process has to be undertaken in order to reach out. I don't think women will come forward to the RCMP. There's no safety there for them. I don't think they will. I'm not sure I can answer your question....

Mr. Don Davies: I'm probably out of time, so if anybody else has any comment—

The Chair: We're over time.

Mr. Don Davies: Okay. Thank you.

The Chair: Mr. McKinnon, we have two minutes left.

Mr. Ron McKinnon: Okay.

It seems to me, from what we've heard in the various panels, that one of the fundamental problems, among a number of fundamental problems, is that victims are not reporting. If they don't report to the police, then the police will never investigate. If they don't report to the hospital or the college of surgeons, those bodies will never investigate.

Dr. Richardson, you mentioned that all forced and coerced sterilization allegations in Canada must be thoroughly and impartially investigated, but if they're not made, how can we do that? How can we go forward and make it possible or easy for these incidents to be properly reported?

Dr. Lisa Richardson: When we look at the MMIWG framework and the recommendation that there be an indigenous ombudsperson and an indigenous and human rights tribunal, at arm's length from all of these organizations, that may be one sort of mechanism. I do think, as Dr. Bartlett said, that given the institutional history and the ongoing racism that exists within these colonial institutions, we will have to look at a different approach. I think my venerable colleagues who wrote the MMIWG report explored that extensively and came up with the recommendation that there be an independent process.

● (1710)

Mr. Ron McKinnon: Okay.

The Chair: I'm sorry. The time is up.

Mr. Ron McKinnon: Thank you.

The Chair: To the panel, thank you so much for your contribution. I hope we can do justice to your testimony. I know we'll try. We probably won't turn this around overnight, but we'll give it our best shot. Thanks very much, on behalf of the entire committee, for your testimony.

We'll take a little break and then go in camera. We have two important things to do.

Thank you very much.

[*Proceedings continue in camera*]