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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1525)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I welcome everybody to meeting 131 of the Standing Committee on Health. We will go until about 5:10 and then go in camera for a little bit of committee business.

First of all, I want to thank our witnesses today for coming to help us with this new study.

From the Department of Heath, we have Abby Hoffman, Assistant Deputy Minister, back again after several visits.

We have from the Department for Women and Gender Equality, Lisa Smylie, Director, Research and Evaluation, Results and Delivery Unit.

From the Department of Indigenous Services Canada, we have Valerie Gideon for another return engagement. Thank you very much. She is Senior Assistant Deputy Minister, First Nations and Inuit Health Branch. We also have Dr. Tom Wong, Executive Director and Chief Medical Officer of Public Health.

We're going to have two opening statements, one by Ms. Hoffman and one by Ms. Gideon.

Ms. Hoffman, if you would like to open with a 10-minute statement, we'll start our meeting.

Ms. Abby Hoffman (Assistant Deputy Minister, Strategic Policy Branch, Department of Health): Thank you.

Good afternoon. Thank you for the opportunity to appear in front of you on this important issue.

I want to begin by acknowledging that the land we are meeting on today is the traditional and unceded territory of the Algonquin nation.

I, like everyone else, have been very concerned about the reports we've all heard of indigenous women being coerced into undergoing sterilization procedures. It is unacceptable that this could happen to any woman anywhere in Canada's health care system. Forced or coerced sterilization is a serious violation of human rights and medical ethics. It's a form of gender-based violence and evidence of a broader need to eliminate racism and discriminatory practices that may exist within our health system.

Unfortunately, there is a documented history of compulsory sterilization in Canada linked to a broader eugenics movement in the 1900s. Institutionalization, regulation of marriage and sterilization were social controls in place in some parts of the country. While these practices were codified in law in some provinces, we know that sterilization without appropriate consent occurred in other parts of the country as well. Women with intellectual disabilities and marginalized, racialized and indigenous women were often the victims. Several well-known academics, including Dr. Karen Stote and Dr. Erika Dyck, have documented this history in detail.

Recent media reports of indigenous women undergoing coerced sterilization procedures suggest that these injustices may have occurred long after laws allowing forced sterilization were repealed. The scope of the issue has not been documented comprehensively, aside from the work of now Senator Boyer and Dr. Judith Bartlett.

It's the responsibility of all players in the health system to ensure that patients have access to health services that are free from bias and discrimination. The Government of Canada takes this obligation seriously. We know that indigenous women, along with other vulnerable women impacted by poverty, mental health, addiction issues and so on, also struggle with bias and safety in the system.

Just as an example, in 2016 Women's College Hospital, following a period of study of over six years, released a report entitled “A Thousand Voices for Women's Health”. It documented how women from diverse communities feel they were treated, and expressed their expectation for services that are responsive to and respectful of individual identities, cultures, and social circumstances, and that are non-judgmental.

We know that in Canada no one level of government has exclusive jurisdiction over health care. It's a complex system of shared jurisdiction, where both the federal government and the provinces and territories have important responsibilities. The federal government, for its part, has important roles to play in ensuring the health and safety of Canadians, making financial contributions to the Canadian health care system through the CHT and setting national standards for health care through the Canada Health Act. Provincial and territorial governments have the primary responsibility, of course, for day-to-day management, organization and delivery of health care services. Each jurisdiction has created its own health care system, but based on common principles.

As part of their responsibilities to administer and deliver health care services, each province and territory has laid out, through statute, its frameworks for oversight of health care professionals by self-regulating bodies. These bodies are responsible for reviewing and responding to complaints against health care professionals under their authority, and for disciplinary action when warranted.

Provinces and territories also have the authority to regulate matters related to a patient's consent for medical treatment. The concept of informed consent has evolved over time. It's complex. The processes for making decisions on treatments that were once almost entirely the domain of providers have shifted over time to greater consideration of the views of patients. Informed consent today is about ensuring that the patient has the information and the capacity to make an informed decision based on the advice and counsel of their health practitioner.

Informed consent means that a patient has received information about the nature of the treatment that's proposed, the expected benefits, risks and side effects, alternative courses of action, and the likely consequences of not receiving treatment. But the consent also has to be valid. For the consent to be valid, the consenting individual must have the capacity to make an informed judgment and to provide their consent voluntarily.

● (1530)

Studies involving women consenting to gynecological procedures show that patients frequently describe feeling compelled to sign a consent form despite their preference not to undertake a procedure. ln a study by Hall, Prochazka and Fink, published in the Canadian Medical Association Journal in 2012, 30% of women consenting to surgery reported that they did not think they had a choice about signing the consent form, and 88% of the respondents perceived the form as strictly administrative. This suggests there are some significant shortcomings in practitioner communication with patients on matters of consent and that how and when consent is obtained from women is important.

All jurisdictions have a role in ensuring that health care services are delivered in a manner that is free from discrimination, no matter where those services are delivered, and no matter who provides the service. The federal government can and does play an important role as catalyst for health care system improvements and for supporting collaboration among multiple players and stakeholders on critical issues.

In just a minute, my colleague from lndigenous Services Canada will elaborate on a number of areas, but I want to speak briefly to our plans specific to improving cultural safety.

Our plan is consistent with the government's overall commitment to advancing reconciliation with indigenous peoples and implementing the Truth and Reconciliation Commission's calls to action. Specifically, calls to action 23 and 24 ask all orders of government to support “cultural competency training for all healthcare professionals” and the calls directed to medical and nursing schools ask them to require that all students have “training in intercultural competency, conflict resolution, human rights, and anti-racism”.

On December 11, 2018, the Minister of Health and the then minister of indigenous services wrote to provincial and territorial ministers and to health professional organizations, among others, seeking their collaboration on and participation in a federal-provincial-territorial working group. Health Canada is taking a leadership role and will partner with provinces, territories and health organizations to take actions that we hope will lead to a significant cultural shift in the Canadian health system; that is, a shift to a system that supports efforts to prevent discriminatory practices and increases access to culturally safe health services for indigenous peoples.

This March, Health Canada will convene provincial and territorial partners to begin discussing areas for collaboration on measures to increase cultural safety in the health care system. This group will work closely with indigenous partners, women and health professional organizations. We expect the federal-provincial-territorial group to build on the good work already under way across the country and to identify opportunities for action in areas such as awareness raising and training.

By way of example, in British Columbia, which is among the most advanced jurisdictions in the country, extensive cultural safety training has already been delivered to providers, administrators and policy-makers throughout the province. Health authorities, institutions, provider organizations and so on in other parts of the country have other initiatives under way as well.

We will collaborate with indigenous partners and governments at the national and regional level and with professional colleges and health organizations. Fortunately, there are opportunities to learn from the experiences of groups who've championed the objective of non-discrimination for some time, such as, for example, the First Nations Health Authority in British Columbia, which has a vision of hard-wiring the concepts of cultural safety and cultural humility into the delivery of health care services.

We know that improving health outcomes, increasing access to culturally appropriate health services and programs and addressing the social determinants of health are high priorities for indigenous leaders and communities across the country.

I believe that the work we are undertaking will increase the level of cultural safety within the health care system, lead to improvements in the quality of service and contribute to reconciliation.

I thank you for the opportunity to make these short remarks. Following my colleague's remarks, I would be pleased to attempt to answer your questions. Thank you.

● (1535)

The Chair: Thank you very much.

Now we'll go to Ms. Gideon.

Ms. Valerie Gideon (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Indigenous Services Canada): Good afternoon. Thank you for inviting me to also appear before this committee on the critical issue of forced or coerced sterilization.

I would also like to begin by acknowledging that we are on the unceded traditional territory of the Algonquin people this afternoon.

[*Translation*]

We're here today because we're all disturbed by reports of forced and coerced sterilization of indigenous women in Canada. I want to acknowledge these women and recognize their bravery. I speak as a First Nation woman, member of the Mik'maq Nation of Gesgapegiag in Quebec, and mother of two young indigenous girls, and as someone who has dedicated her entire career to advocating for the health of indigenous peoples, both outside and inside the public service.

[*English*]

Forced or coerced sterilization is a serious violation of human rights and medical ethics. All Canadians have a responsibility to ensure that these practices never happen again. As noted by my colleague, Abby Hoffman, there is evidence of the broader need to eliminate racism and discriminatory practices and to eliminate forced or coerced sterilization as a form of gender-based violence. Its practice, among others, compels us to seek to ensure there is cultural safety and humility in health systems across Canada, to improve culturally competent informed consent, and to remove barriers facing indigenous women when accessing health services. As cited by the Truth and Reconciliation Commission, addressing racism in health systems is a matter of reconciliation.

ln addition to the progress that Abby noted to advance cultural safety and humility within health systems, I would also like to highlight the work that Indigenous Services Canada has been undertaking on this issue. For the sake of time, I will outline some of the more recent actions.

ln early December of 2018, we held a teleconference with indigenous partners and national health organizations. We discussed ways to advance collaboration and to identify actions that would ensure free, prior and informed consent, along with culturally informed and safe services for indigenous women across Canada.

[*Translation*]

The Inter-American Commission on Human Rights recommended that Canada produce an information brochure for health care providers and patients on free, prior and informed consent in the context of indigenous women's health services. To make this happen, we've been in discussions with national indigenous women's organizations on how to proceed.

We're also establishing a new advisory committee on indigenous women's well-being made up of representatives from national indigenous organizations, national indigenous women’s organizations, the National Aboriginal Council of Midwives, the National Aboriginal Circle Against Family Violence, and the Society of Obstetricians and Gynaecologists of Canada. This committee will inform the department on current and emerging issues, including sexual and reproductive health. The inaugural meeting will be held on February 14, 2019.

In addition, we'll be hosting a national forum in the spring to mobilize indigenous and professional organizations to take collaborative actions on indigenous women's reproductive health, and to develop guidance on free, prior and informed consent regarding sterilization procedures.

● (1540)

[*English*]

ln addition to responding to recommendations made at the lnter-American Commission on Human Rights, lndigenous Services Canada endeavours to more broadly support indigenous women's reproductive health through its programs and policies. The first nations and Inuit health branch's maternal and child health program offers community-based home visiting services by nurses and family visitors to over 8,100 pregnant women and families with young children in over 309 first nations communities. This is not counting British Columbia, which is under the direct control of the First Nations Health Authority mentioned by Abby. Through the program, expectant mothers receive case management, screening, assessment and referral services as well as health promotion strategies to identify risks and improve maternal and child health. Budget 2017 increased the existing program funding of approximately $25 million annually by $21.1 million over five years.

ln addition, budget 2017 invested $6 million over five years for indigenous midwifery, the first-ever federal investment in this area. Midwifery care to indigenous communities has been identified as a pathway to helping improve the health and well-being of women, their children and the entire community. lndigenous midwifery is a way to bring birthing back to communities where it had previously been a longstanding traditional practice embedded with ceremony as well as traditional medical practices. Furthermore, informed choice is recognized as a central tenet of midwifery care in Canada. It could help ensure that indigenous women play a central role in their own health care and in their experience of giving birth.

[*Translation*]

Senator Yvonne Boyer and Dr. Judith Bartlett, who conducted an external review into reports of forced and coerced sterilizations in Saskatoon, found that previous custodial loss, or the threat of custodial loss, has played a role in the forced and coerced sterilization of indigenous women in Saskatchewan.

There's some evidence that midwives not only support women in their reproductive health planning, which may prevent further cases of forced or coerced sterilization, but that they also provide support to women in preventing custodial loss of their children. Further work is required in this area, and we're looking to indigenous midwives' leadership to better understand the issues. To that end, we're pleased that the National Aboriginal Council of Midwives has agreed to sit on the indigenous women's well-being advisory committee.

[*English*]

Budget 2017 also included new investments that will strengthen maternal supports by ensuring that all first nations and Inuit women are entitled to an escort when they have to leave their community for childbirth. We know that the presence of a support person offers many benefits to a labouring woman, including assisting her with making decisions and advocating for her wishes. lndigenous Services Canada's non-insured health benefits program now provides coverage for an escort for expecting mothers, regardless of their age or medical condition. This recognizes that no woman should have to birth alone.

[*Translation*]

The Government of Canada has committed to implementing the Truth and Reconciliation Commission's calls to action, including calls 22, 23 and 24, which were mentioned by my colleague. These calls pertain to using and recognizing the value of Aboriginal healing practices, retaining and increasing the number of Aboriginal health care professionals, and providing anti-racism and cultural competency training for all medical and nursing students.

[*English*]

Our department has been exploring, with the Royal College of Physicians and Surgeons of Canada and indigenous organizations, project ideas for an online knowledge hub of cultural competency learning tools. Last year, the Royal College embarked on making indigenous health and cultural safety a mandatory component of postgraduate medical education and certification.

As also mentioned by Abby, the B.C. First Nations Health Authority has done remarkable work with the province and its regional health authorities in finalizing a declaration on cultural safety and humility, as well as informing cultural safety and humility training across the provincial health system. It is presently developing the first-ever cultural safety and humility standard in partnership with the Health Standards Organization, which is affiliated with Accreditation Canada. We're hopeful that other provinces and territories will look to this work as a promising practice.

● (1545)

[*Translation*]

We can't undertake this work unilaterally. The Native Women's Association of Canada and Pauktuutit Inuit Women of Canada have been providing leadership on indigenous women's health. As our relationship with these women's organizations grows and expands to include Les Femmes Michif Otipemisiwak, or Women of the Métis Nation, we're encouraged by their good work and guidance. Their collaboration is essential to getting this right.

[*English*]

It will take the efforts of many to ensure that structural racism and the effects of colonization do not interfere with the health of indigenous women. I want to assure you that we are taking this matter very seriously and will continue to work in the spirit of collaboration and partnership towards culturally informed and safe health services for indigenous women throughout Canada.

I would now be pleased to take your questions.

The Chair: Thanks very much.

I'm just sitting here thinking that I first heard about this about two or three months ago from Alex Neve of Amnesty International. I thought, "He must be mistaken. That can't be happening in Canada." That was my first reaction. So, we appreciate your briefings and look forward to your answers to our questions, but it's an amazing subject that we have to talk about.

We're going to open with Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you all for being here and for sharing with us your experience and knowledge.

My first question is directed generally to Health Canada, but I invite everyone to answer if they wish. What training and education do health care providers receive related to obtaining valid consent for medical procedures, and are there additional considerations in obtaining consent for obstetrical procedures?

Ms. Abby Hoffman: I would say that pretty well universally in medical education there are units or modules that are a mandatory part of training on informed consent. That training covers the ethical, legal and clinical dimensions of the issue of informed and valid consent.

Beyond what happens in formal medical education settings, there are organizations like the Canadian Medical Protective Association, which obviously is the liability insurer, if you like, for the medical profession in Canada. It has a very strong interest in making sure that providers fully understand their responsibilities around informed consent legally, ethically and clinically as well. They have a lot of resources available.

In hospitals and other institutions, beyond the realm of formal undergraduate or graduate training, issues of consent are very complicated. It is the case that within hospitals on any given day hundreds of informed consent situations are encountered in the interactions between providers and patients. So in hospitals there are people whose responsibility it is to engage with providers who are in the course of making decisions informing patients about treatment options and wanting to be assured that they in fact have secured appropriate consent from patients.

I'm just recounting this, not that I'm an expert on the legal aspects of informed consent. I'm not and I don't purport to be or wish to be interpreted as such. I just want to make the point that there is both the formal training that medical students receive and also an ongoing dialogue about consent issues throughout a practitioner's career.

With respect to a particular discipline—and again I want to underscore that I'm not an expert on this—inasmuch as certain specialists are permitted to do some procedures, or to propose those procedures and to implement them in their areas of specialization, there is some consideration of how consent would apply to those particular procedures. In the obstetrics and gynecological world, because of the kinds of procedures those individual specialists are permitted to pursue, they would need to consider how they would discuss treatment or interventions and what would constitute appropriate advice and, therefore, an appropriate determination of whether or not a patient has actually given consent relative to the procedures they are authorized to pursue.

There is a specialist-specific dimension to the issue of informed consent. This all assumes that the process is working well. It assumes that due consideration is given to the circumstances of the individual patient who is discussing a treatment procedure with the provider. This is where issues around cultural safety and sensitivity and awareness of cultural difference and the circumstances of patients come into play. What may be a completely appropriate conversation with one patient may not be taken appropriately into account in the circumstances of another patient. While it may look like informed consent had been achieved, it may not have been, given the circumstances of an individual patient.

● (1550)

Mr. Ron McKinnon: I'm curious about the motivation behind coercing consent, although coerced consent is not really consent, but I ask because we're talking about it in those terms. What kind of motivation is there?

Certainly the undercurrent here is that it's a racial bias, perhaps cultural bias. I'm wondering whether this extends to non-indigenous women as well.

Do we have any information about whether non-indigenous women, perhaps for reasons of their economic situation, coerced to give consent as well?

Whoever would like to answer that, can.

Ms. Abby Hoffman: I can start, and maybe my colleagues will want to add to it. I think the history, such as has been documented, is that certain women might be more vulnerable: women of very limited economic means, women who suffer moderate to severe mental health issues, women who suffer addictions and, women who, to a provider, might seem to be in a dire situation—and in reality might indeed be so, in all objective terms. It just stands to reason that when a provider says, in the event of, let's say, an unwanted pregnancy.... You can imagine a situation where a provider might offer to an individual that he or she has a solution to deal with this kind of situation so that it won't recur, and maybe there's a conversation about contraception or sterilization, or whatever it might be.

The circumstances under which that conversation occurs might, on the one hand, not take proper consideration of the circumstances of the individual in question and how that might play into her giving what appears to be consent, but consent that's heavily influenced by her circumstances.

If you add into the situation some bias—you can imagine someone with a severe mental health condition or an addiction issue who is not really able to communicate very well, or circumstances where there is racial bias, whether it's related to indigenous status or other racialized individuals—you can kind of see how these circumstances can compound themselves. Certainly even the anecdotal as well as the better-documented history indicates that, in fact, sterilization has occurred in cases where these kinds of individuals are the subject of the situation.

Mr. Ron McKinnon: Thank you. I believe that's my time.

The Chair: Does anybody else want to respond?

Dr. Wong

Dr. Tom Wong (Executive Director and Chief Medical Officer of Public Health, Indigenous Services Canada): In addition to the excellent comment by my colleague Abby, there are ethnocultural barriers and linguistic barriers. When someone doesn't quite understand what's being explained to them, I think that's a really important aspect that one needs to consider as you optimize...to make sure that the patient understands everything that's being presented, including alternatives, risks and benefits.

The Chair: Thank you.

Mr. Ron McKinnon: I think what I'm hearing here is—

The Chair: Your time is up, sorry.

Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): I think your opening comments hit home with me. I think we all knew that there were issues back in the 1950s and 1960s, but to hear that in present-day Canada this is happening was both profoundly disturbing and concerning.

I know that both ministers sent letters to the provinces and territories. Is it fair to say that Health Canada has been designated as the overall lead for this file?

● (1555)

Ms. Valerie Gideon: From the federal-provincial-territorial relations piece, absolutely. Indigenous Services Canada, however, will lead in the partnership with indigenous women's organizations and communities.

Mrs. Cathy McLeod: Certainly when I heard about this, and with Health Canada taking the lead, what I would have anticipated.... We were hearing some stories mostly focused in Saskatchewan. Have you done an analysis of the CIHI data of tubal ligations across the country, and if so, can you table that with this committee? Were there any anomalies identified?

Ms. Abby Hoffman: I'm certainly happy to get that data and table it. I can't say that any examination of it, that I'm aware of, would have suggested from the data that there were anomalies.

I think—and I'm not saying this at all to diminish the significance of this issue—that if one looked at the total number of sterilizations across the country through a procedure as definitive as tubal ligation, the proportion of procedures that one might suspect were imposed on the patients would be very small. I don't want to prejudge what the statistics will show, but I'm not certain at this point that one will see a pattern in Saskatchewan—you referenced Saskatchewan—that would be unusual. I don't want to prejudge that situation.

The other thing I would say is that methods of contraception do vary across the country. But we will get that data for you.

Mrs. Cathy McLeod: So you don't know if any analysis has been done to date?

Ms. Abby Hoffman: I do not.

Mrs. Cathy McLeod: I think we all want to try to understand the scope of the issue. We know it's much broader than we thought, but I think understanding its scope and using the tools that we have to see if there are any outliers among the provinces could provide some opportunities.

The next piece I want to talk about—and I know that you're not legal experts—is a legal requirement for consent for medical procedures. Is the remedy for people only civil litigation? Is it a criminal offence in any province to perform a procedure without free, prior and informed consent? I don't know the answer to that question and I'm wondering if someone here knows the answer.

Ms. Abby Hoffman: I can try, but again, I'm not really in a position to speak from an expert legal standpoint.

Certainly, if someone is subjected to a procedure where, arguably, what has happened is an assault, it's a little bit unclear in the health care context whether or not that is a criminal offence or whether that is a circumstance where someone could sue for some sort of damages or liability. Whether or not in a health care setting that sort of physical assault, that is to say, some unauthorized invasion of someone's physical being through a medical procedure, would be regarded as a criminal offence, I can't tell you.

Mrs. Cathy McLeod: My next question is for Indigenous Services. There are people who have publicly come out as part of a suit. Have you offered support in any way to the people who are obviously having significant challenges from what's happened to them in their lives?

Ms. Valerie Gideon: In terms of direct outreach to the individuals who are right now in the process of the class action, we've not. We would have an interaction from counsel to counsel.

In terms of the ability of indigenous individuals to access support, we have a variety of mechanisms whereby first nations and Inuit in particular can access support through the non-insured health benefits program, which has mental health counselling available to individuals. We also have the Hope for Wellness line they can call to be referred for services. We have a variety of community-based programming that's also offered if they're living in a community.

It's something that counsel could offer to counsel. It's not something that we, as departmental representatives, would be able to to directly engage with them on.

● (1600)

Mrs. Cathy McLeod: Who's on the advisory group you talked about?

Ms. Valerie Gideon: Do you mean the indigenous women's well-being advisory group?

Mrs. Cathy McLeod: No, I thought there was an advisory group specifically for this issue.

Ms. Valerie Gideon: The federal-provincial-territorial one.

Ms. Abby Hoffman: The group is just in the process of being created. At the moment we have indications from a number of provinces—British Columbia, Saskatchewan, Ontario, one of the territories, and Newfoundland and P.E.I.—and we expect other provinces and territories to identify people.

The group will start as a group of provincial, territorial and federal officials from the ministries of health, but it's our intent to engage in that work representatives of indigenous organizations, women's organizations and health provider groups at the national level. That group is, as I say, just in the process of being created. We hope to have our first meeting in early March.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): I want to just put this into some context as I understand it.

In 2015, women in Saskatchewan reported suffering unwanted tubal ligations and told stories of being pressured by health professionals and social workers to undergo the procedure. Often, as they were in delivery, sometimes on the table as epidurals were being administered, literally under anaesthetic, the topic of whether or not tubal ligation would be appropriate came up with pressure from the physicians to undergo it then, and to have an answer then.

In 2017, an external review by the Saskatoon regional health authority highlighted the exposure of indigenous women being coerced into tubal ligations. I believe that has now been acknowledged by the Saskatoon health authority. This has happened, so we're not talking about any doubt. There is no question that coerced or forced sterilization has occurred.

In 2017, a class action representing, at that time, some 60 indigenous women was filed against the Province of Saskatchewan, regional health authorities, individual physicians, and the federal government regarding forced sterilization. We also know that as Canada is a state signatory to the UN Convention against Torture, our record on preventing and addressing torture and other forms of ill treatment was reviewed by the UN Committee Against Torture. The most recent review took place in November in Geneva. 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. They also provided Canada with a number of recommendations, and in a rare occurrence, requested that Canada provide information on the implementation of the recommendations within one year, as opposed to the typical five or six years.

Within that context, I have some questions.

First, has the federal government, to your knowledge, instructed any federal prosecutors in Canada to investigate whether criminal charges ought to be pursued? Does anyone have any information on that?

Ms. Valerie Gideon: That would be the Department of Justice, and I don't have that confirmation.

Mr. Don Davies: Does anybody have any information on that?

Ms. Abby Hoffman: I haven't either.

Mr. Don Davies: It's interesting. I'm aware of a recent case where an Ottawa doctor was charged and sentenced to seven years for surreptitiously videotaping a patient in a change room as she was naked. That was criminal, yet we have incidents that are internationally recognized as torture and that I think we all recognize as forms of assault, and as members of these committees you are not aware of even an investigation into whether or not criminal charges ought to be considered? Do I have that right?

Ms. Valerie Gideon: Again, the Saskatoon Health Region, which is under provincial jurisdiction, did the external review and would have the information around the physicians, the patients, and such. We were not directly involved in the external review process. I just want to clarify that.

Mr. Don Davies: Now, of course, we're hearing reports of that from women in British Columbia, in Manitoba, in Ontario, in Quebec, in Nunavut. Are you aware that there are reports of this happening to women outside Saskatchewan? Or is it your evidence before us today that it's only Saskatchewan that you're aware of?

● (1605)

Ms. Valerie Gideon: We're hearing reports through the press. I understand from Senator Boyer as well that she's been approached by various women. We've not had an opportunity to meet with Senator Boyer yet. We were scheduled to do so, and her schedule shifted. We are very much looking forward to that meeting to talk to her about how we may be able to support that work around women coming forward to her.

Mr. Don Davies: Now, the class action has been filed, and the federal government is a defendant. What is the federal government's official position on the class action?

Ms. Valerie Gideon: The department, through counsel, is reviewing it through the Department of Justice.

Mr. Don Davies: Okay. Will the federal government support the application by the counsel for the plaintiffs to have this certified as a class action?

Ms. Valerie Gideon: If you're interested in the specific legal proceedings, it would be better to have the Department of Justice here in order to discuss that.

Mr. Don Davies: Okay. It's my understanding that a number of applications have been made by the defendants, including the federal government. One of them was to have the class action members' names sent and publicly delivered to the defendants. That application was refused by the court. I understand that the federal government supported that application on behalf of the defendants. Do you have any knowledge of that?

Ms. Valerie Gideon: I do not, no.

Mr. Don Davies: Okay.

I guess we're calling this a working group—an FPT working group has been appointed by the federal government to oversee the development of measures. Has that FPT working group been struck yet?

Ms. Abby Hoffman: I think, Mr. Davies, that's the group I was referring to a couple of minutes ago.

Quite a few jurisdictions have indicated their intent to participate. We're hoping to hear from others soon. So, no, the individuals have not yet been appointed, nor have we met.

Mr. Don Davies: That answers my next question of who the members are, what actions have been taken, and that sort of thing. That, obviously, has not happened yet.

What support and resources, if any, has the federal government made available at this point to the victims of sterilization?

Ms. Valerie Gideon: Again, without having direct interaction with those individuals, with their not coming forward to us specifically, I would say that we do have a variety of programs and services available for indigenous women with respect to mental health supports—and I named some of them earlier.

Mr. Don Davies: Okay, that's generally, but not yet.

I also understand that under our convention obligations under a number of treaties—the Convention against Torture, UNDRIP, etc.—we know that once we are apprised of and made aware of incidents of torture in our territory, we have obligations under the treaty to take measures to protect, to provide restitution, and to ensure that perpetrators are punished.

Have any of these steps been taken so far to date, to your knowledge?

Ms. Valerie Gideon: The initiatives we're here to speak to with respect to our mandates—my mandate being prevention and promotion of health and safety of first nations and Inuit, and I won't speak on behalf of my colleague's mandate—are really to address the issues in the health care system that are allowing these instances to occur, in partnership with provinces and territories and also with the medical profession, and of course, for us, with the leadership of indigenous women's organizations, and indigenous representatives overall.

Mr. Don Davies: I understand that both the Assembly of First Nations and the UN Committee Against Torture have requested that Canada legislate specific changes to explicitly criminalize the forced sterilization in this country. Right now we just have general assault. Obviously, to my understanding, nobody has been charged. From my information, nobody is even being looked at to be charged at this point.

Do you have any information to give this committee about whether the federal government is considering specifically amending the Criminal Code to ensure that forced sterilization is a stand-alone crime under the Criminal Code?

Ms. Valerie Gideon: Go ahead, Abby.

Ms. Abby Hoffman: I'm not aware of that.

Again, I think that for useful responses to that kind of question, a representative of the Department of Justice should appear.

Mr. Don Davies: Okay.

The Chair: The time is up.

Mr. Don Davies: Thank you.

The Chair: Mr. Ouellette, you have seven minutes.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much for coming today. It's very much appreciated.

To continue along the same line of questioning as Mr. Davies, have you any knowledge of the RCMP having contacted or requested any documentation from any of your departments related to this file?

● (1610)

Ms. Valerie Gideon: I don't have any knowledge of that.

Ms. Abby Hoffman: I do not either.

Mr. Robert-Falcon Ouellette: This is a question now for the chair.

Are the RCMP or the justice department being called to be witnesses here at any point in this study?

The Chair: We're not at that point yet. They could be later, but they're not—

Mr. Robert-Falcon Ouellette: I would probably like to move a motion at some point, because I think this goes far deeper.

I've heard questions from Ms. McLeod as well as Mr. Davies that.... There is something that needs to be investigated here. Ms. Valerie Gideon said that these forced sterilizations are a serious violation of human rights. There are agencies that have a responsibility to ensure the enforcement of our laws. I've heard that both from Ms. McLeod and from Mr. Davies, on both sides. I think they should be called to account here in this committee.

The Chair: It's the will of the committee.

Mr. Robert-Falcon Ouellette: Hopefully, we'll be able to move a motion once this is over, and move forward with that.

I'd like to know who pays for the forced sterilizations in the health care system for status women.

Ms. Abby Hoffman: In most cases, any procedure of this nature, forced or otherwise, would be taking place in a hospital that is part of the provincial or territorial health system, so the cost would be paid out of a global hospital budget covered by the province or territory—but not as a discreet procedure. It would be, in most cases, part of a global financing and budgetary nature.

Mr. Robert-Falcon Ouellette: So there wouldn't be a specific request on behalf of a hospital or a health care provider to FNIHB, the first nations and Inuit health branch, to request additional funding to proceed with this.

Ms. Valerie Gideon: No, absolutely not, but we would pay for medical transportation, potentially, for the individual.

Mr. Robert-Falcon Ouellette: That's for the birth. Obviously you would request the funding for birth, and they would be transported out of the community—

Ms. Valerie Gideon: That's correct, but it would not be for the procedure itself. It's part of a provincially or a territorially insured health system.

Mr. Robert-Falcon Ouellette: Are you all aware of the case of Brian Sinclair?

Ms. Valerie Gideon: Yes.

Mr. Robert-Falcon Ouellette: For those who aren't aware, Brian Sinclair was the indigenous man who sat in an emergency ward in downtown Winnipeg in 2008 and died in the ward after 34 hours because no one looked after him.

Related to that, I was wondering whether you have had any interviews with health care professionals related to bias and how they treat indigenous people in Canada. Have you conducted any interviews related to these cases with health care professionals to find out what their train of thought is?

Ms. Valerie Gideon: I believe there was a provincial study or inquest done in that particular context.

Mr. Robert-Falcon Ouellette: That one, yes.

Ms. Valerie Gideon: It wouldn't have been done through the federal process; it would have been done through the provincial process. I would assume there would have been interviews in that context.

What we have done, though, is that we have been working with national health professional associations to advance cultural safety and humility. I referred to a few of those in my presentation, such as supporting the Royal College's work and identifying cultural safety as a mandatory requirement in post-medical education, and also working with them to develop and provide in a much more seamless way cultural safety materials for medical schools, medical professionals, both individually and across the system.

Mr. Robert-Falcon Ouellette: To return to the question about the calls to action 23 and 24, which look at health care professionals, will the working group of federal, provincial and territorial and indigenous organizations, which are hopefully part of it, include looking at the education programs for new nurses and new doctors?

Ms. Valerie Gideon: Yes, this is exactly part of the agenda.

Mr. Robert-Falcon Ouellette: Okay.

I have no more questions.

The Chair: All right.

That completes our first round of questions, and now we go to Mr. Lobb for five minutes.

Mr. Ben Lobb (Huron—Bruce, CPC): Is this issue of forced sterilization just amongst the indigenous community, or is this a wider spread issue in Canada that we may not be aware of? Perhaps it's young women who could potentially be involved in drugs, maybe have had a tough life, or whatever the circumstances. Is this isolated to the indigenous community? Is there any information on that?

Ms. Abby Hoffman: I think it's hard to say categorically, but given the circumstances under which these kinds of incidents might occur, it wouldn't be impossible to imagine, as I was saying earlier, that a woman with mental health issues or addictions or someone who, for whatever reason, is not really capable, shall we say, of holding her own in an interaction with a health care provider, might have it proposed to her that she undergo a sterilization procedure. At the end of the day, what may have seemed to the provider as consent might not in reality have been consent as one would think consent should be managed. I think, without suggesting anything about the scale of what might be going on, it's not impossible to imagine that this is not an issue confined only to indigenous women.

● (1615)

Mr. Ben Lobb: Again, forgive me for not knowing—

The Chair: Dr. Wong would like to answer that.

Dr. Tom Wong: If I may, in the past, historically, the provinces of Alberta and B.C. had legislation specifically regarding sterilization of individuals with, for example, mental illness. That was in the twenties, thirties and all the way up to the seventies. Those kinds of practices were very troubling, the fact that individuals with mental illnesses were targeted as a group to undergo tubal ligation and sterilization procedures. Those laws in those provinces have since been abolished.

Mr. Ben Lobb: Forgive me for not knowing this, but in the cases of these, I guess, mainly tubal ligations or other methods, how did this happen? Was it after one of the individuals had given birth to a child and their doctor or somebody had advised them? I'm just trying to understand how this even would have come to be. Maybe you can tell the committee a bit about what step in the process this occurred.

Ms. Valerie Gideon: The information in the external review is the information that we have. It's not by individual-by-individual circumstance. It was not a homogeneous situation, so it was at different stages. I also think there were lots of comments about how women felt there would potentially be an interaction with the child and family services system, which is why they felt coerced into sterilization. That says to me that they probably had just birthed, if they were concerned about an interaction with the child and family services system. We don't have all of the information about all of the individual circumstances, but we have some information through the external review report.

Mr. Ben Lobb: Another thing you talked about was birthing alone. Has this practice been changed now? I'm guessing that people who are having to fly or travel to a hospital now are not going by themselves. Is this true?

Ms. Valerie Gideon: Prior to budget 2017, our policy was that unless women were minors or had a medical recommendation, such as a prescription from a physician to have an escort to accompany them at birth, they would not get paid for the escort's travel. It doesn't mean that they couldn't have an escort. It's just that it wouldn't be paid directly through our program. Now that has been changed through budget 2017.

Mr. Ben Lobb: Is there a chance that these forced sterilizations are still occurring?

Ms. Valerie Gideon: There's a chance, because we don't have information about the magnitude of the problem at this stage. We are trying to raise public awareness and work with indigenous women's organizations and communities to put the information up front in communities.

We have maternal child health programs and other programs in which there are community-based workers who would be able to provide that information more proactively and discuss the possibility or the issue proactively. We have general information that is published and funded around birthing and all sorts of general public health information, but it doesn't necessarily speak specifically to coerced or forced sterilization.

Mr. Ben Lobb: I have one quick question. My time is coming to an end.

Is there now a system whereby public help, anybody who is in the advocacy area, or a doctor or a nurse can say, "Okay, I have explained this to somebody. They know now. I have proof they have consented to something." Is there an official mechanism now whereby a health practitioner can feel confident about this or a young woman could possibly feel she has been properly notified?

I'm wondering if there is a system. We know there's an issue and we know it's widespread. Is there now a way such that we can actually say that this situation is fixed and we know going forward that here's how we would demonstrate or prove that consent has been granted?

● (1620)

Ms. Abby Hoffman: I don't think we could say with absolute conviction in every single case. As I was mentioning before, in hospitals, in terms of the issues of what constitutes valid consent, what is truly voluntary consent, and when is the person giving the consent really truly capable of giving this consent, these are very complicated issues.

Where there are difficult cases, they are often the subject of discussion by a provider with authorities in a health care institution, but that's not the same thing as what you're alluding to, which is some sort of system where every problematic consent case is somehow or other logged somewhere, and somebody could look at all of those consent situations. But there is, for reasons of legal liability, a lot of interest on the part of providers in being certain that what they believe has been freely given and informed consent is in fact the circumstance.

The Chair: We have to go on to Mr. Ayoub now.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

I want to thank the witnesses for their presentations. The information provided is extremely important and also very disturbing.

Ms. Hoffman, in your opening statement, you painted a very bleak picture of what minorities, people in difficulty, and indigenous people, particularly women, are experiencing. It seems that the situation is ongoing.

You mentioned the dual responsibilities for health. The federal and provincial governments have responsibilities. An action plan was implemented a few years ago. Who was responsible for the plan at the time? Who took the lead to change the things where they were happening at the time?

[*English*]

Ms. Abby Hoffman: It will depend on what the circumstances are and what the particular issue is. In these cases or the kinds of circumstances we're talking about here, we're speaking about practices that, unfortunately, have been perpetrated by health care providers.

In hospitals, generally speaking, the behaviours and standards of practice of physicians or the providers themselves are governed by health professional bodies that are subject to provincial regulatory regimes. The oversight of those individuals—

[*Translation*]

Mr. Ramez Ayoub: Since I don't have much speaking time, I must interrupt you.

My question was mainly about who was taking the lead at the time. Things aren't quite the same now, but measures must still be taken.

I don't know whether you can answer my question, but I want to know whether you feel comfortable enough and whether you have enough evidence from across the country to make a preliminary diagnosis and, if so, to establish an action plan to fight this practice.

Ms. Valerie Gideon: We definitely need the co-operation of the provinces and territories. They have access to more detailed information on what's happening in the hospitals, which all fall under provincial and territorial jurisdiction.

Mr. Ramez Ayoub: Are the provinces and territories aware of the issue?

Ms. Valerie Gideon: Yes, definitely. That's why a working group will focus specifically on this issue.

Mr. Ramez Ayoub: Okay.

By requesting a more specific study and obtaining the facts to determine the scope of the situation, we'll be able to build on something real. Right now, we can make things up. The principle itself is completely indefensible. However, I'm bothered about the fact that we're once again faced with a tangled web of responsibilities. We're wondering what we'll do, who will take responsibility, how the action plan will be implemented and how the funds will be spent. Funds are needed to implement an action plan and solutions.

In the meantime, if the situation is real and ongoing, other women will experience what I call mutilation. There are many issues at stake. These include the legal aspect, the notion of consent, and other issues. I'm not blaming you, but you don't have the information. In my opinion, you're unable to reassure us that a plan exists and that all the provinces, clinics and doctors are moving in the same direction. Unfortunately, there's a lack of clarity.

Does this issue concern only Saskatchewan? Is the rest of Canada also affected? You've already been asked this question, but you don't really have an answer.

In addition, there has been a great deal of advocacy for women's bodies in this case. However, I'm wondering whether men have also been subjected to this practice in specific communities. Has there been any forced or voluntary sterilization of men?

● (1625)

Ms. Valerie Gideon: Good question. The statistics on what's happening in hospitals aren't the only source that will provide the answer. That data shows only how many sterilizations have taken place, and not whether the sterilizations were forced.

When the government was asked in the 1970s about the hospitals in the territories still under its responsibility, it looked at the statistics and it didn't necessarily conclude that there was an issue. This doesn't mean that Inuit women weren't affected by the issue during this period. The government then implemented measures to improve the consent process. For example, two doctors would need to recommend the procedure and the woman's spouse would also need to sign the consent form. In short, measures to address this ethical issue were implemented at the time.

A qualitative research project must be carried out, and indigenous organizations must be involved in the project. During the external review conducted in Saskatoon, a number of women stated that they wanted to participate. However, when they realized that the study had been ordered by the regional board, they withdrew from the project. They were afraid.

Mr. Ramez Ayoub: Maybe they were ashamed.

Ms. Valerie Gideon: Possibly, but they feared the repercussions. The health care system involves a power imbalance between the doctor and the patient. Most people feel this imbalance, in a way. The phenomenon is even more pronounced when it concerns an Indigenous, marginalized or vulnerable woman.

The research project will take a few months to complete. We must verify with the Indigenous organizations how the project will proceed. This process is important for the success of the project.

[*English*]

The Chair: Your time is up.

[*Translation*]

Mr. Ramez Ayoub: Thank you.

[*English*]

The Chair: Mr. Benzen.

Mr. Bob Benzen (Calgary Heritage, CPC): Thank you, Mr. Chair.

Thank you, witnesses.

I guess I want to look at it from the medical side and try to find the breakdown in this consent. The medical profession's model is “Do no harm”. I find that doctors are very, very cautious. They are very afraid of making a mistake. If you've ever had surgery, you know all of the steps you've got to go through before they actually perform a surgery. They do not want to look at losing their licence; there's insurance, there are lawsuits, there are all kinds of things. They're very concerned about doing the right thing. So consent is extremely important.

Here we have a case of a female who's pregnant for nine months. Now normally there is a relationship built up between the mother-to-be and her family doctor or a doctor of some sort. During the nine months of pregnancy, there are sonograms and testing done. There are all kinds of things that have to be done. Usually that's a period where a relationship is built, and in that relationship the pregnancy is talked about: how's it going; do we have to be careful about this; what's your nutrition? They talk about how the pregnancy is going to go. They talk about the period after the pregnancy. So there's a lot of communication going on.

I'm wondering what's going on in that process where a fair number of women are making a decision that they either feel they're forced to make or that they don't want to make, when they've had this long period of time to have these discussions to build trust with their doctor, to get informed consent, to talk it through with other people in their family. What's going on? Why isn't the consent breaking down? There seems to be enough time. This is not a rushed thing. This is not like, okay, you've just been in a car accident, you're rushed to the doctor and you've got to do this thing. You've got 10 seconds to make a decision because it's life and death. This is a long process.

Can you give us some background? When you've got all this time and all this stuff available, why are these decisions happening this way? It's not just one doctor; it seems that it's a bigger thing than this. It's happening in multiple cities. It's across Canada. Can you give us some background on why it's not happening the way we would normally think it would happen, with a good decision being made?

● (1630)

Ms. Valerie Gideon: Do you want to start that off?

Ms. Abby Hoffman: Sure. I can start it.

First of all, let's acknowledge that I think we are speaking to a degree in hypotheticals here. But I doubt that the kind of situations you are speaking of—situations where a women has had an ongoing interaction with one or several health care providers over the course of a pregnancy and has either a planned date for delivery or at least a time frame in which the birth will take place—are the cases where women are being induced into a sterilization procedure that they subsequently either deny agreeing to or feeling was the right decision.

I think the cases we're talking about are more likely instances where, if you can imagine, a person for all practical purposes is homeless, and maybe they've had an interaction with a public health professional wherever they are spending their days and nights in whatever somewhat indigent kind of living situation they have. I think it's more likely that it's that kind of person who has no established relationship with the health care system, and certainly is not dealing on any kind of equal footing with the provider. I think just speaking to these issues of consent, there's a huge difference when there's even a certain amount of cultural awareness or sensitivity to the fact that someone is of very modest economic means or really almost destitute. One can understand that.

We also need to understand that any conversation between a health care professional and a person in those circumstances is such a power imbalance that one can't take at absolute normal face value the exchange that occurs between those two people.

Again, one has to use some imagination, but you can sort of see how a circumstance could evolve in the kind of situation that I'm describing. It's further compounded by mental illness or an addiction —and I want to be clear I'm not making an accusation against health care providers, but it wouldn't be shocking to imagine that some providers without adequate training who encounter a person who's got a whole array of social and economic and psychological circumstances might well be more inclined to ask that person, if it's at the time of delivery, if they'd like to avoid this situation in future, and to have a conversation that is not adequately taking account of the real circumstances of that individual, and therefore what the exchange between the patient and the provider really means and how it should be managed properly.

The Chair: I'm sorry, but the time is up.

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, to all of the panel, for being here.

Forced sterilization of indigenous women is a serious violation of human rights, which is unacceptable.

We heard that the indigenous population speaks 60 languages, or maybe more than that. We heard that health care professionals were getting training and when there is a sterilization procedure, of course the doctors performing that procedure, the social workers or the nurses have to get consent.

What steps have been taken to reduce language and cultural barriers? For that 60 languages are they providing any translators? With 60 different languages, doctors, nurses, and maybe social workers don't know what type of language is being spoken, so are there any translators provided to them so they can understand better?

Ms. Valerie Gideon: I can speak to that from an indigenous individual's context.

There are many hospitals across Canada that do have indigenous navigators or interpreters, particularly in areas where a significant amount of the population are indigenous patients. There are also community workers that are there as health representatives who can help interpret and support women.

If women have to leave their community and travel a far distance to access hospital-based services, and if they have linguistic or cultural distinctions that are important in terms of them being able to understand the information, they will receive support, not just in terms of their own individual transportation but also for transportation of that individual to escort them. That's what we mean when we say an escort.

An escort can be for interpretive services as well, if they require those.

I don't think it is perfect yet. I think there is a lot of awareness now within provincial and territorial systems, and there has been a great increase in those services compared with what there were 10 years ago, but I think that will be part of what the group will be looking at.

Are there still hospital areas where indigenous women are accessing sterilization procedures, or other specialized procedures that carry risks, especially in terms of informed consent, where we need to invest in better interpretive services?

● (1635)

Ms. Sonia Sidhu: As Dr. Wong said, especially with mental illness, the population is going to be targeted.

Ms. Valerie Gideon: Absolutely.

Ms. Sonia Sidhu: We are giving training to the health care professionals.

Are we giving training to the indigenous population?

Ms. Valerie Gideon: This is what we are also committed to doing. It was something that even the Inter-American Commission on Human Rights recommended that Canada do, which was to provide specific public awareness materials for indigenous women with respect to forced sterilization.

We will be working with the indigenous women's organizations to develop those materials, taking into consideration the distinctions among indigenous nations so that they are very relevant to their local reality.

Ms. Sonia Sidhu: Thank you.

What other provinces have sterilization legislation? I know British Columbia and Alberta have it. Are there any other provinces working on that?

Ms. Valerie Gideon: They had it. They've repealed it because it was for individuals who had mental incapacity as it was discussed at that time.

It doesn't exist at this time.

Ms. Sonia Sidhu: Thank you.

The Chair: Mr. Davies.

Mr. Don Davies: I have to say that I'm quite concerned with what I'm hearing. I believe the testimony is well-meaning, but the description that we've been asked to imagine is that of a homeless person who is poor, with no established relationship with a medical professional, a very vulnerable woman who's coming into a hospital at the most vulnerable point in their existence: at the point of delivery. An extremely profound question is put to her at a moment where she's either pre-labour or in labour, asking her whether or not she will consent to being sterilized. I'm hearing the suggestion that this is a question of maybe a communication issue.

This situation should never arise, and I'll tell you what: If that woman were a middle-class white woman, there is no way a doctor would even put the question to her the first time while she's going into labour. There is obviously a stereotyping, racist....

I don't think there's a cultural problem here; there's no cultural issue on the side of the women. What I'm hearing is a systemic racist, post-colonial, paternalistic, sexist, classist approach in Canada's health care system as a G7 country.

I'm also going to tell you that I'm hearing a very weak and tepid response from the federal government, which has known about this for four years now. We don't know how widespread this is. We don't know what provinces it's occurring in. We don't know who it's really been affecting; we don't know who they are. There's been no attempt to reach out to the women. That's what I'm hearing.

I'm not blaming any of the officials here, by the way—I know you're here to give answers—but I have to tell you that I'm extremely concerned by what I'm hearing: a very, very weak response to something that has been internationally called torture. I can't think of a worse violation of human rights than to take away someone's reproductive choice—the choice to have a child or not—at a time when someone's in labour.

By the way, that decision should never be made at that point in time—ever. The question should never even be put. It's not a question of whether or not the person is misunderstanding the consent. I want to know the health care professional who has the gall to put that question to a woman, based on some stereotypical assumptions, at that point in time with no established relationship. That's where the problem is. It's not with anybody's culture, language or ability to understand.

I'm going to move a motion right now:

> That, pursuant to Standing Order 108(2), the Committee invite representatives from Maurice Law Barristers and Solicitors, the DisAbled Women's Network of Canada, the Native Women's Association of Canada, Amnesty International, the BC First Nations Health Authority, and the Minister of Justice, to appear before the Committee at the earliest opportunity to provide evidence with respect to the forced sterilization of women in Canada.

Colleagues, I think we're all on the same page on this. I think we all are horrified by what we've heard. I thank my colleagues for supporting my motion to have you come here today, but I think we can all understand that we don't have the right people in the room here who are placed to give us the information that we need. I would ask that all of my colleagues support this motion so that we can get to the bottom of it.

I'm going to add that we have obligations, internationally, to investigate, to put a stop to this. We've heard very honest evidence, so we don't even know if it's going on today—it could well be. We, as parliamentarians, have been apprised with knowledge that assaults are being made on the most vulnerable Canadians, whom I think we have the greatest duty to protect, assaults that constitute torture. We have a duty to investigate, to prevent this, to ensure that restitution and support are provided, and to hold those responsible accountable. I'm hearing that the witnesses before us are unable to provide any of that information, so I would ask that my colleagues support this motion.

● (1640)

The Chair: Could you clarify the parties that you're asking us to invite—

Mr. Don Davies: Sure, I....

Pass this around.

The Chair: —and explain their role? We don't have the information. You just said that we don't know how often this is happening, that we don't know where it's happening and that we don't know the circumstances. Could those witnesses provide that?

Mr. Don Davies: Yes, Mr. Chair. If I might add, I spoke today with lead counsel from Maurice Law Barristers & Solicitors, who represent the now, I think, over 100 women in Saskatchewan in the class action. However, these other groups have all played a role as well—including the Minister of Justice, who, I think it's quite obvious from comments that Mr. Ouellette made.... I think he's quite right.

The Chair: If there's a lawsuit and a class action, are they the right people to have testify?

Mr. Don Davies: Yes, I spoke to them and the counsel was fully prepared to testify. Obviously, there will be matters of confidentiality and privilege, but to generally describe the nature of what the information is and what they're hearing would be very helpful, I think—and they're willing to come.

The Chair: Okay.

Go ahead, Ms. McLeod.

Mrs. Cathy McLeod: Mr. Chair, my only comment would be that, typically, when a study is extended, there is the opportunity for other parties to add to the potential witness list. I think we would certainly appreciate wording that would allow us to perhaps submit additional witnesses, if we think there are gaps.

Mr. Don Davies: I'd be happy to amend the motion to include "and such other witnesses as my Liberal colleagues and Conservative colleagues may suggest" as well.

The Chair: I'm not a lawyer, so I just don't know. Are we going to interfere with a lawsuit that is under way? Are we going to be interfering, if we're going to have one side of the party here to testify? I don't know. Can you give us advice on that?

The Clerk of the Committee (Mr. Alexandre Jacques): No. As Mr. Davies said, the committee can decide to invite the witnesses and the witnesses can decide not to answer, and the committee can then ask them to answer. It's really the will of the committee.

The Chair: Okay.

Yes, Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub: Thank you, Mr. Chair.

I just want to make sure that we're following the procedure, so that each party can prepare properly.

I don't necessarily disagree with the motion, quite the contrary. I'm looking for the truth, and I want to make sure that we'll receive as much relevant information as possible. I want to ensure that the motion can be amended so that we can have the best possible witnesses. You said that we must also look at the legal aspect of the issue.

There's also the time frame available to our committee. There are other topics that we had planned to study. We need to look at our timetable and make sure that we have enough time to study the issue.

I'm sure that the committee members agree on the need to address this issue. Moreover, perhaps we should spend more time on the issue and do more than what Mr. Davies' motion calls for.

● (1645)

[*English*]

The Chair: Sorry, Mr. McKinnon.

Mr. Ron McKinnon: Chair, I move that the debate be now adjourned.

Mr. Don Davies: I want to clarify what we're voting on because Ms. McLeod did suggest that my motion be amended to the effect, "and such other witnesses as may be", or as the other parties may want, which I would agree to. As a friendly amendment, I'd be happy to have the motion I read out include that. I want to be clear that's what we're voting on.

The Chair: We're voting on the motion now to adjourn the debate.

Mr. Don Davies: Oh, pardon me.

The Chair: However, I really don't know the ramifications. It just doesn't seem that the committee should be inviting guests who are in the middle of a lawsuit against the government. I don't know what's right there. It strikes me that we should seek some legal advice on this to find out if it's the right thing to do.

Anyway, we have a motion to adjourn debate, which is not debatable.

Mr. Don Davies: Can I have a recorded vote?

The Chair: Yes.

The Clerk: Yeas 4, nays 4.

The Chair: I'm going to vote for the adjournment of debate, just because I think we need some legal advice on whether we're going to discuss a lawsuit in the middle of that lawsuit.

Mr. Davies.

Mr. Don Davies: While I understand and respect the substance of your position, I respectfully disagree with it.

However, to the clerk, are any conventions as to how a chair ought to vote in a situation where there's a tie, when the question is whether to adjourn debate, or is there a convention to continue debate?

The Chair: Mr. Lobb.

Mr. Ben Lobb: I have a question: How is it a tie? There are nine members sitting at this table. It's 5-4.

The Clerk: My apologies. You're right. I'm sorry.

(Motion negatived: nays 5; yeas 4)

Mr. Ben Lobb: Thanks.

The Chair: Mr. Davies, I'm not arguing. We just need more information.

Mr. Don Davies: I understand, Mr. Chair, but at the same time you've asked the clerk on the record for his advice and opinion on the very question of whether or not it's appropriate to invite a representative of the law firm when there's a case. The answer he gave was that it is appropriate to invite them. They can come, and they can choose to answer as they see fit. Not all of the questions will be appropriate, perhaps, but not all of questions won't be. There's not a blanket position on this.

The reason I want this law firm to come is that they know the most about what's actually been happening. I think they can come and describe for us in general terms, without giving names, what the evidence is that they're hearing. That doesn't mean that it's been established in a court of law, or that it's proved or anything like that, but we often hear about lawsuits and the allegations. I think all of us around this table can adjudicate that. This doesn't mean that we're making any finding about whether it's happening or not; but if we're going to try to get to the bottom of what's going on in this country, we should hear from the prime actors who actually know.

The Chair: I don't argue that. Again, I would really feel more comfortable if I had some advice, just because of the lawsuit. You're inviting the solicitors in a class action lawsuit to testify at a parliamentary committee, and I just don't know about that. I would like to get some legal advice.

Mr. Ouellette, you're up.

Mr. Robert-Falcon Ouellette: There are a few issues. One is related to the justice department. If there is a lawsuit, would they be allowed to come to testify? I'm not sure if they'd be able to answer questions. It doesn't mean you can't ask the questions, but I think there are other departments that might be more appropriate, because we're talking about an investigation. In this case, that would probably be the RCMP, because they're the ones who would probably have to conduct that investigation.

I'm not sure, but I also agree that maybe we need to take our time on this. It's good to debate it now. I think everyone is in agreement that we want to move forward in some way—I haven't heard anyone say no—but we do need to take our time to make sure that we're doing it in an appropriate way, so that we have success at the end of the day. What we've been talking about is ensuring, one, that justice is done for the women, but also that we respect the conventions and the separation of powers between the judiciary and ourselves. We have considerable powers if we wish to force people to testify, but we do have to be very careful. I think we need to take a bit more of our time.

I'm not sure if we need to specify all of the witnesses. I'm not convinced about that because there is, I believe, the subcommittee that runs the affairs of this committee that could set the witness list with everyone's suggestions. I don't think people would have their suggested witnesses denied.

I think, as well, this might be at a much higher level. I know we have some very capable assistant deputy ministers who have come to committee, but at the same time maybe someone at a more deputy minister level, even higher up in the food chain, might need to come and respond to questions. Not trying to make it overly political is also one of the issues. This goes to basic human rights in Canada, and it's something we have to deal with here.

One final thing: I know we want to move on to the next speaker, but the witnesses are sitting here. I'm not sure if we're going to get back to the witnesses to hear any more testimony. I know there was another round of questions to be asked of them. The issue is, should they continue to sit here for the next 35 minutes and listen to us? Will we get to go back to the questions, or are we done with that portion? I believe a lot of people do wish to speak and debate this issue and think out the best ways forward.

I'm just wondering if there are additional questions that people have for the witnesses. I know that the analysts have prepared a number of questions, which might also shed light on this. If they don't have it on the record.... I know it was the final round.

There are a number of questions.

● (1650)

The Chair: By the speakers list right now, we will not get back to questions today, but you're talking about the RCMP. That's a criminal issue you're suggesting. You just mentioned that we should have the RCMP, and they are for criminal matters. Is the class action suit classed as a civil action?

We have civil actions and criminal actions. I'm in over my head.

Mr. Don Davies: No, there is no criminal action yet, and by the way, the civil action that's been filed has not even been certified yet as a class action.

The Chair: We all want the answers. We all want to know more about the frequency of this, where it's happening, how it's happening. Is it just happening to indigenous people? Is it people with intellectual disabilities? Who is it?

In principle, most members want to get that information, but I need some legal advice and some parliamentary advice on where we go from here, but we'll proceed with your motion.

Who is next on the speakers list?

Ms. McLeod, you have an amendment on the table.

Mrs. Cathy McLeod: It was a friendly amendment that was supported. We all know, as a committee, know that we put motions and invite guests to attend, and sometimes it turns out that the guests choose not to attend for a variety of reasons, and we add to the witness list. However, we're at a point where we should vote on this motion to continue the study. Then obviously in your committee business, at times you have opportunities for people to talk about the additions, and you, I'm sure, will advise the committee, based on information you get, if there's something you feel should be modified.

I would suggest right now that we're at a point that we should have the vote and enjoy our last round of questioning.

The Chair: I still have some names on the list.

Mr. Longfield.

Mr. Lloyd Longfield (Guelph, Lib.): I'm a guest of the committee. The testimony we have heard so far has been excellent and I've learned a lot just hearing from the jurisdictions that are present.

Clearly there are questions on the table that aren't within their jurisdictions, but which the committee seems to want to get answered.

This committee isn't a judge and jury over the prosecution of doctors. We're trying to get some witnesses to the table.

We could have a timeline to get a witness list to the analysts if the motion is to continue the study until we are able to get some of the questions answered. That's a whole different spirit of things. We could think about witnesses and give a list to the analysts, the way we do at any other committee. The analysts could work with the House of Commons to see what is legally appropriate for the committee to be asking or studying in terms of a witness list. Getting a witness list to the analysts in a period of time so they can call further witnesses to continue the study to get to the questions...but I don't think we need to go as far as to specify the witnesses at this moment.

● (1655)

The Chair: Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub: As I said earlier, I think that we're all very concerned and that we want answers, but that we want to make sure that we do things properly.

I have a great deal of respect for my colleague, Mr. Davies. However, sometimes certain motions seem to be introduced quickly in response to presentations, as is the case today.

Until now, the Standing Committee on Health has always been very collegial. It has always worked for the best interests of Canadians and in a non-partisan manner.

In my first comment, I said that we would be able to study and improve the motion later. We mustn't make decisions on the spur of the moment. We can't say that we want to study this issue and obtain information immediately without even having a game plan.

We could go all over the place to try to obtain all kinds of information. In the end, we must avoid having the analysts base their report on something improvised. I'm calling into question this aspect. I'm not against the motion. We may adopt exactly the same motion later, once we've established a framework.

I want the committee to conduct a proper study of the issue. The study would be much more extensive than if we were simply to hear the presentations of certain people, regardless of whether the presentations are relevant.

I also think that we're wasting time. We have four witnesses before us who likely have answers. The issue isn't whether the answers are good. They could provide an overview of the current situation and tell us where the Department of Health stands on the matter.

We can continue to debate the motion or we can introduce a friendly amendment. Ultimately, I find that we don't have a plan. Our committee is reacting on the spur of the moment to a very serious situation. Three additional witnesses won't change the committee's current recommendation. Our committee is much more serious than this.

I want us to establish and approve a plan, as we've done for our other well-documented studies. We should have a list of witnesses from across the country, since all regions will be affected. Our analysts must propose a game plan that will enable us to submit a report to the minister, if necessary.

If my colleague so desires, we can always listen to two or three more witnesses. However, I would like to do more than this.

[*English*]

The Chair: Mr. McKinnon, give brief remarks if you could.

Mr. Ron McKinnon: I agree with Mr. Ayoub. I think this could be an important study, but this committee has not agreed to do such a study. We do have our work plan laid out for the next several months. Frankly, I think it's premature at this point to do a study. The testimony we've heard so far indicates that the task force, the federal-provincial task force, is just getting started. The RCMP will never be able to comment on any ongoing investigations, or even if they exist. The justice committee likewise will be fairly reticent until they have more information to go on. I think it is way too premature to launch a study of this kind and, frankly, we haven't agreed to do a study. We agreed to hold an information session.

I appreciate the witnesses being here. I apologize for the fact that they have to listen to our internal debate.

I would ask Mr. Davies to withdraw his motion and let us present it in a more orderly manner; otherwise, I'm going to have to vote against it.

● (1700)

The Chair: Mr. Ouellette.

Mr. Robert-Falcon Ouellette: Do we have copies of the motion so that I read it? I'm not a very aural person; I like to read a lot of stuff. I'd like to get a copy of the motion to be able to know what I'm actually voting on, to be honest, because it is very important to me. I'm very interested in doing this. I don't remember all of the witnesses who were potentially going to be called. I would like to make sure that we would have the provincial authorities from Saskatoon, from all of Saskatchewan, who might be involved in this or might have information to share with us. I'd also be interested in hearing from the College of Medicine.

The question we also need to debate is how large we wish to make this study. This could go on for a very long time and look at a lot of issues. I think we need a bit more time to think about this. We can debate this publicly and how many days we wish to debate this issue, whether it's another two, three, four, or eight sessions. There is a lot of information that's missing and things we don't know about, which is rather unfortunate. We have innuendo in the media. I'm interested in whether there is an investigation and what has occurred potentially in that investigation. I'm not sure what the RCMP could share, I'm not sure what the justice department could share, and I'm not sure how that relates to the civil case.

There are an awful lot of questions where, if I had a couple more days, or a week.... I don't think it's going to change the course of history if we wait just one more week to lay out a bit of a working plan for us. We could have a discussion amongst the people who really run the committee, who I'm sure are Ms. McLeod, Mr. Casey, as well as Mr. Davies, to lay out a good working plan for us. Obviously, there are the questions of where are we going to end, and how much work can we get done efficiently to ensure that we offer justice to the women?

I suspect there won't be people doing any more sterilizations in Canada in this way. There are probably people who are actually quite nervous within the health care system, I'm certain, and who are worried about lawsuits. Nonetheless, there are some potential witnesses we could call.

I'm concerned that if we set the list now.... I know there was an amendment and we could add more witnesses. How many people were on that witness list so far?

The Chair: I think Mr. Davies only had three.

Just before we go any further, what we're really talking about now is starting a study. We haven't agreed to do a study—

Mr. Don Davies: I have a point of order.

I'm waiting my turn to speak, but this conversation has gone right off the rail because the comments by Mr. McKinnon and Ayoub are actually incorrect. The motion does not call for a study.

Mr. Ramez Ayoub: I didn't say that.

Mr. Don Davies: Yes, both of you did.

Mr. Ramez Ayoub: No. I never said that.

What I said, if I may, Mr. Chair, is that I would—

Mr. Don Davies: You talked about preparing a report.

Do you remember those comments, Mr. Ayoub?

Mr. Ramez Ayoub: Yes. I was talking—

Mr. Don Davies: We don't do a report.

I'm going to read the motion again, if I may. This might help.

Mr. Ramez Ayoub: Would you let me finish. You did put some words in my mouth.

Mr. Don Davies: You misinterpreted me, Mr. Ayoub.

The Chair: It's okay.

Mr. Davies, you have the floor.

Mr. Don Davies: I'm going to read the motion again. To give the benefit of the doubt to my colleagues, this could be a result of my not passing around the motion—which, by the way, I do have in writing. It might have been easier. Listen to the motion. It reads:

> That, pursuant to Standing Order 108(2), the Committee invite representatives from Maurice Law Barristers and Solicitors, the DisAbled Women's Network of Canada, the Native Women's Association of Canada, Amnesty International, the BC First Nations Health Authority, and the Minister of Justice, to appear before the Committee at the earliest opportunity to provide evidence with respect to the forced sterilization of women in Canada.

It does not call for a study. It does not call for a report. It's no different from the motion that provided for these witnesses here. It's simply to hold another meeting with some more witnesses who could provide us with information.

What happened, then, is that as people started describing all of the difficulties of whether we should have a report and other witnesses and those sorts of things, we got off on a tangent. I was trying to be collegial to Ms. McLeod, recognizing that we could add some further witnesses to the ones I suggested, but the motion does not obligate us to do this immediately. It does not obligate us to have a report. It's not a study that we'd be undertaking; we'd just be hearing from some more witnesses.

While I have the floor, that's the most charitable interpretation of what I've heard. If I'm less charitable, I want to go on the record to note that I'm a little offended by the comments or any notion by Mr. Ayoub about this not being collegial, or of it being partisan or of it being done on a whim. I had the motion drafted in writing prior to the meeting; it was not done on a whim.

Number two, there's nothing uncollegial or partisan about this. It was based on testimony. When this issue came up, we had discussion and we put motions forward to hear from the minister. The Liberals shot that down; we can't hear from the minister. We discussed having a multi-committee panel, because this issue involves Status of Women, Indigenous Relations, and Health, as we recognize. That was shot down; the Liberals didn't want that. We proposed having a subcommittee of our Standing Committee on Health to look at this. That was shot down. Finally what we had was a briefing from ministerial officials who were hand-picked by the Liberals. These are the people here. This wasn't a decision of the committee. This was a decision by the Liberals to put these people in front of us.

Now we know from the testimony we heard today—and again, I have enormous respect for all of the people here; this is not a comment on them—that they just don't have the information we need. We're here looking at this to get a briefing, and so far I've heard Ms. Hoffman say that one could just “imagine” the situation that's there.

By the way, I received a message while we were talking. The lawyer from Maurice Law Barristers & Solicitors said she would be happy not to come, but knows dozens of women who said they would be happy to come if it were the only way to give voice to victims. I'd like to have some people come before this committee who can tell us what happened. I don't want to have to imagine a homeless person who has no.... No, I want to hear what went on.

I think it's a little disingenuous. I keep hearing that everybody wants to get to the bottom of it, but there's always a reason, from the Liberal side, for us not to get people before this committee who might actually know. If the Liberals on this committee really believe this is a serious issue that we should get to the bottom of, then let's have one more meeting, or two, and hear from some other witnesses who might be able to give us more information. That's all the motion is calling for.

● (1705)

The Chair: Mr. Lobb, you're up.

Mr. Don Davies: By the way, I just want to say that we're not calling for the RCMP either, or the justice committee, which I think I heard Mr. McKinnon mention. With respect, I realize he didn't have the motion in front of him in writing. It was just the justice minister.

The Chair: Mr. Lobb.

Mr. Ben Lobb: I'm prepared to have a vote. I like Robert quite a bit and admire him, and I think if we're going to have a vote, he should vote today because I'm pretty sure the whip's office is going to pull him off the committee after this meeting, so he may want to have the vote today while he's still on the health committee.

A voice: I don't think the whip has much control there.

Mr. Ben Lobb: He might be back on the Library of Parliament committee after today's vote.

The Chair: All right. The motion is only in English, so we need unanimous consent if we're going to accept the motion only in English. Is that right?

Mrs. Cathy McLeod: No.

The Clerk: No. If you want to pass it around.... If it's clear to everybody—

The Chair: Okay. If everybody's clear about it.... Is it clear, Robert? You asked for it in writing. Is it clear to you in English?

Mr. Robert-Falcon Ouellette: Yes.

The Chair: You are? Okay. That settles that.

We have an amendment to the motion.

[*Translation*]

Mr. Ramez Ayoub: I want to make a few comments, Mr. Chair.

I want to choose my words carefully and I'll speak in French, even though the motion is only in English.

I've stated my support from the start, as long as the debate is orderly and sensible and the committee goes beyond the simple choice of two or three witnesses. Moreover, I never said that the study requires a report at this time. I'm fully aware that the study doesn't require a report. However, I said that the motion was introduced quickly. So much the better if you say that you prepared the motion and that you didn't submit it on the spur of the moment. That said, I'll make my first comment. If the motion had been prepared, it could have been translated into French.

I'll move on to my second comment. If the motion had been prepared and we had been able to discuss it, I could have been ready to submit suggestions for additional witnesses. We're being called upon, if I may say so, to vote on a well-intentioned but hurried motion.

I've always worked well with you, Mr. Davies. I don't see why we're at this point today. We're saying the same thing and we have very similar intentions. However, we're ultimately proposing different ways to achieve the same result.

Sometimes, we want to move faster, but we end up moving slower by going too fast. In the effort to move things forward, intentions are attributed to colleagues who have absolutely no desire to stand in your way. I'm as horrified as you are to have heard what was said and to not have obtained the answers that I would have wanted. Therefore, don't attribute intentions to me and don't put words in my mouth. I'm fully aware of what I said. We can check the preliminary transcripts.

I don't want to argue with you, because we get along well. I want us to work together to find a way to do better, because we can do much better. The important thing isn't us, here at the table, but the women who are currently waiting and being mutilated or tortured, as you were saying.

Unfortunately, we have only partial answers. I want to hear from the proper witnesses. There are more than three witnesses. Rest assured that we'll need more than three or four additional witnesses to really carry out work that does credit to the current Standing Committee on Health.

I'll stop here.

● (1710)

[*English*]

The Chair: Mr. Ouellette.

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

The Chair: As quickly as you can, Mr. Ouellette.

Mr. Robert-Falcon Ouellette: Yes, of course, as quickly as I can.

I think the whip's office will be quite kind with me.

Some hon. members: Oh, oh!

The Chair: The whip's office is used to him, so don't worry.

Mr. Robert-Falcon Ouellette: They're getting used to it.

Mr. Davies, why not actually do a study and call it a study, with a report and some recommendations? If we're going to hold information sessions and are planning to put out some information, I don't understand why we wouldn't put out recommendations as well. Let's do something that might make a bit of a difference in this whole situation.

The reason I'm interested in a study is that if we look at the Truth and Reconciliation Commission, we see there haven't been a lot of charges to come from that. We had thousands of hours of testimony from thousands of witnesses, and much of it was public. Yet I haven't seen many charges come out of it. It's one of the sad things concerning how the justice system has allowed that to be swept under the rug. It reminds me of this. There are positions of power, which we have heard from testimony, and we know this in anthropology, about people's relationships and who has the power—the certificate, the degree—when people are vulnerable, as you mentioned, Mr. Davies.

I'm concerned. I really want to do this in a good way. To be honest, I'm not sure.... We're having an information session right now, a briefing, as per the agenda: “Pursuant to standing order 108 (2), briefing on Briefing on the Forced Sterilization of Women in Canada”. So it's a briefing on briefing. I'm not interested in that.

I'm interested in putting out concrete recommendations saying that if we find, after hearing witnesses...to tell the executive branch of government, whether it's in the RCMP or the Justice Department, to go out and actively hold people to account for the serious violations of human rights that have occurred in Canada. I'm not sure if a briefing on a briefing would do that. I'm not sure if we're going to have recommendations after that.

Maybe the chair can inform me.

● (1715)

The Chair: It seems to me we're all saying the same thing—except that maybe we want to do more than what Mr. Davies said. That's what it sounds like. That's what everybody over here is saying, that they want to do more than what Mr. Davies has proposed. We've always been able to sort these things out.

Mr. Davies, is there some way we can put this together and come up with a study? This side is saying that they want a study. You're saying that you want some witnesses. This side over here is saying, let's have more witnesses.

Let's have another look at this whole thing. Nobody knew that your motion was coming. Maybe that caught us by surprise. Everybody seems to want to do what you want to do, only more. Isn't there some way we could turn your motion into something more profound?

Mr. Don Davies: Perhaps.

I wouldn't call this a briefing on a briefing. We've received a briefing here, and the purpose of my motion was to extend the number of people who would give us a briefing.

The Chair: Would you consider redoing your original motion?

Mr. Don Davies: Well, what I'd like is to have a vote on this today. I look forward to having the government side, which controls this committee, come back next meeting with a proposal for a report.

Mr. Ouellette asks why I didn't do this. There are a number of tools and devices available to us. I came today prepared, on the assumption that we might want to hear from more people. I think my assumption was correct: I think we do need to hear from more.

The Chair: I think it is, too. That's what everybody over here is saying.

Mr. Don Davies: My motion was to take the least intrusive, easiest next step. Have another meeting with some more people to give us a more fulsome briefing.

I'm having trouble understanding the position of the government on this. They don't want to have one more meeting that would give us a fuller.... They seem to be opposed to that, and I suspect they'll vote against it if it gets to that, because they want to hear from many more people. They control this agenda.

Why don't we have a vote on this, on my incremental step? I look forward to and will await the next motion from the government side next meeting, or the meeting after that, to hear their proposal for a more comprehensive study that would gets before this committee the people whom we ought to hear from. I look forward to Mr. Ouellette's motion on that.

The Chair: We have three more speakers on the list now. We have 10 minutes. Could everybody keep their remarks brief?

Mr. Ayoub, what's your point?

Mr. Ramez Ayoub: Very briefly, I would like to have a two- or three-minute recess just so we can talk, if possible.

The Chair: Okay.

Mr. McKinnon.

Mr. Ron McKinnon: I was just going to comment that we are not the government. This is not a government position that we're expressing here.

Mr. Ramez Ayoub: It's a committee....

Mr. Ron McKinnon: My other point was to have a brief suspension where we can talk.

The Chair: Mr. Ouellette, briefly, please.

Mr. Robert-Falcon Ouellette: Once again, I'm interested that you mentioned hearing from women. I think this demands recommendations, because if we hear from women, we have to give them justice.

What I'm reading right now, “Pursuant to Standing Order 108(2)”, briefing on “Briefing on the Forced Sterilization of Women”, I find kind of—what's that word they have in French?—*caduc*. We pass the motion here and then we have to come up with another motion. I don't see why we can't just craft a motion that's acceptable to everyone and that would actually get us where we want to get to.

Since the UN has put out a report, I'm interested as well in understanding, for instance, the RCMP's role, to be honest, in how they move forward with—

Mr. Ramez Ayoub: Mr. Chair, I asked for two minutes. Point of order.

Mr. Robert-Falcon Ouellette: I just want to finish my—

The Chair: Mr. Ouellette is going to be very brief.

Mr. Robert-Falcon Ouellette: I'll try to be brief.

I'm interested in learning, for instance, how the RCMP carries out these investigations and what they determine when they do investigate. If the UN puts out a report saying that human rights violations have occurred within Canada, I'm interested in the RCMP —without their perhaps compromising this investigation, if there is an investigation—telling us what their exact procedure is when these allegations are made, so that we as parliamentarians and Canadians can better understand what they do, to make sure that we hold them to account in some ways, but also how they relate to the larger international bodies.

For me, that's actually quite important, because if we don't have that information, you know.... I think we do need to hold people to account. I want to see recommendations. I want to see it move forward.

Mr. Davies, you've been driving it. You have the honour of driving it.

● (1720)

The Chair: The time's up, Mr. Ouellette.

Now we're going to go to you, Ms. Sidhu, very briefly, please.

Then we're going to suspend for two minutes.

Ms. Sonia Sidhu: Mr. Davies, we produce so many reports collectively. We are united on that issue, too, because we all want to hear witnesses. My suggestion is that the analysts see what witnesses there are. In the meantime, the chair can see the RCMP report. He can get parliamentary advice. This is my suggestion.

The Chair: Okay. I'm going to suspend for two minutes.

Mr. Don Davies: Mr. Chair—

The Chair: I have the floor.

Mr. Don Davies: I'm sorry.

The Chair: I'm going suspend for two minutes.

You've had time. You had time to prepare your motion. They want to have time to talk about it. Then we'll reconvene, but in two minutes.

● (1720)

(Pause)

● (1725)

The Chair: Order. We have four minutes.

Mr. Ayoub?

Mr. Robert-Falcon Ouellette: Mr. Chair, I will start talking—

The Chair: I'm sure you will.

Mr. Robert-Falcon Ouellette: —while everyone works their way back.

We've had some interesting conversations. No one is against the motion. We do want to put forward a really good motion. Hopefully what I am going to....

Mr. Davies, I hope you can hear me as you're moving back.

Mr. Don Davies: I can.

Mr. Robert-Falcon Ouellette: I'm going to make what is hopefully a friendly amendment.

To the analysts, I'm not sure what standing order I should use. If we undertake a study, what standing order would that be? It would be pursuant to standing order X that the committee pursue a study, perhaps for another two additional sessions, determined by whomever, inviting a number of witnesses to be determined and submitted by the parties, that looks at evidence with respect to the forced sterilization of women in Canada.

The Chair: It's Ms. McLeod's, is it not? Do you care if it's your amendment or his amendment?

Mrs. Cathy McLeod: No, I don't care.

The Chair: You don't care? All right, if you'll withdraw your amendment, that will allow his to go ahead.

(Amendment withdrawn)

The Chair: It sounds like the same thing, is it not?

Mr. Lloyd Longfield: There is a time frame there that wasn't mentioned before.

The Chair: Okay, what's the time frame? I didn't hear that.

Mr. Robert-Falcon Ouellette: I was thinking two additional days.

The Chair: Okay, that is different.

Now we have a motion and we have an amendment.

Mr. Don Davies: An amendment to my motion.

The Chair: It's an amendment to your motion.

I'm going to call a vote on the amendment by Mr. Ouellette to the motion.

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

The Chair: Now we go to the motion.

Mr. Don Davies: I have one thing to say. Given your comments about how important it was that there be a report and a recommendation, I think you would have to add, as a matter of form, “that a report be issued with recommendations to the House”. You seem to want that. If that's okay, then—

Mr. Robert-Falcon Ouellette: Yes.

Mr. Don Davies: So you're amending my motion to strike out what I am saying, to have a study with a report, two meetings with witnesses to be determined by the parties with a report, with recommendations to be reported to the House. Do I understand that?

You're amending my motion, then?

Mr. Robert-Falcon Ouellette: Yes.

Mr. Ron McKinnon: Perhaps we could have what we have here read back by the analyst.

Mr. Don Davies: We have to understand that.... Is that our...?

The Chair: Can somebody read his current motion?

Mr. Ron McKinnon: The clerk, I guess.

The Chair: Okay.

Ms. Marlisa Tiedemann (Committee Researcher): I can take a crack at it, but we're trying to identify what standing order it was. I think we're waiting on the clerk for that, but it would be to the effect, pursuant to Standing Order X, that the House of Commons Standing Committee on Health pursue a study with another two additional meetings with witnesses to be determined by the parties, and that a report be issued with recommendations to the House.

Mr. Robert-Falcon Ouellette: On the forced sterilizations....

The Chair: Mr. Davies.

Mr. Don Davies: I just want to be clear. This is my motion that's been amended.

The Chair: It's your motion.

Mr. Don Davies: Okay, that's fine.

The Chair: All in favour of the amended motion? We'll have a show of hands. I'm going to get Mr. Lobb to count them.

Mr. Ben Lobb: It's nine and a half.

Voices: Oh, oh!

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

The Chair: Now we have to go in camera and we have to ask everybody to leave. We'll just be a minute. We just have one question to ask.

[*Proceedings continue in camera*]