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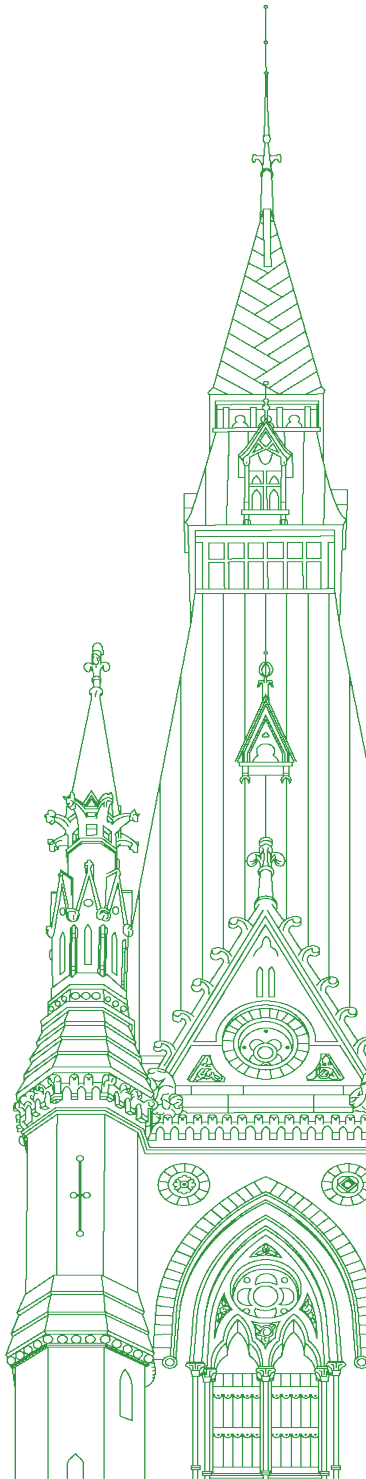

Chair: Terry Sheehan

Standing Committee on Indigenous and Northern Affairs

Thursday, March 26, 2026

● (0820)

[*English*]

The Chair (Terry Sheehan (Sault Ste. Marie—Algoma, Lib.)): Good morning, everyone. I'm going to call this meeting to order.

Welcome to meeting number 27 of the House of Commons Standing Committee on Indigenous and Northern Affairs.

We recognize that we meet on the unceded territory of the Algonquin Anishinabe people.

Pursuant to the order of the House, the committee is continuing its study of Bill S-228, an act to amend the Criminal Code on sterilization procedures.

Before we begin, I would like to remind anyone watching our proceedings that there is a helpline, the Hope for Wellness Helpline, which is available 24-7 to all indigenous people across Canada at 1-855-242-3310. If anyone is experiencing any distress during our proceedings, I encourage them to call that number.

I'd like to welcome our witnesses on the first panel.

As individuals, we have Dr. Lisa Richardson from the University of Toronto, and Professor Karen Stote, associate professor, women and gender studies, Wilfrid Laurier University. From the Association of Obstetricians and Gynecologists of Quebec, we have Liliane Brassard, vice-president. From the Collège des médecins du Québec, we welcome Dr. Mauril Gaudreault, president, by video conference, and Linda Bélanger, director of legal affairs and assistant secretary, by video conference. From the Federation of Medical Women of Canada, we have Dr. Modupe Tunde-Byass, obstetrician-gynecologist and professor, faculty of medicine, University of Toronto; and, from the National Association of Women and the Law, we have Amanda Therrien, feminist lawyer and researcher, by video conference.

After, we will proceed to questions.

To the people online, you can raise your hand, and the clerk and I will see you.

Everyone has been video tested, so I hope everything works well.

This is a reminder about interpretation. You can either keep the earpiece in the ear or place it away from the mic on those little spots on your table, and make sure your mic's off for the health of our interpreters.

Everyone will have five minutes, and we will begin with Dr. Lisa Richardson as an individual.

Please proceed.

Dr. Lisa Richardson (Professor, Temerty Faculty of Medicine, University of Toronto, As an Individual): Good morning, and thank you, Mr. Chair and honourable members of the standing committee.

My name is Dr. Lisa Richardson. I'm Anishinabe on my mother's side, a member of Wiikwemkoong Unceded Territory.

I'm an internal medicine specialist practising at Toronto General Hospital and a professor of medicine at the University of Toronto.

I have numerous roles in indigenous health, including as a founder of the National Circle for Indigenous Medical Education, the strategic lead in indigenous health at Women's College Hospital, and chair of the indigenous health committee and council member at the Royal College of Physicians and Surgeons of Canada.

Thank you for the opportunity to discuss the importance of Bill S-228 with you today.

It is, unfortunately, well documented that indigenous women, girls and two-spirit individuals have been either forced or coerced into sterilization when it is not in their best interest or choice, nor is it medically necessary. This practice has been studied extensively and exposed by the Honourable Senator Yvonne Boyer, who introduced the bill, among others.

This amendment to the Criminal Code makes clear to women that consent should always be free, prior and informed and that they can withdraw their consent at any time without coercion. Explicit criminalization of forced and coerced sterilization is an important step toward holding individuals accountable.

What is equally important, however, is access to high-quality reproductive care for indigenous women and two-spirit people. There must be expansive and culturally relevant educational materials to facilitate informed decision-making for patients and dedicated indigenous supports such as patient navigators and traditional healers.

Our health care system needs more indigenous physicians, midwives, nurses, social workers and others, who not only provide culturally safe care for indigenous peoples but who are leading health system transformation.

Hospitals must track and share reported instances of racism as quality indicators. All medical learners and practising physicians must hear the stories of survivors of forced and coerced sterilization. They must understand the numerous components of the consent process: that it is free; that consent is given voluntarily, without pressure, coercion or manipulation; that it is sought in advance of any medical intervention, allowing time for understanding and decision-making; that it is informed, in that information is provided on the nature, risks, benefits and alternatives; and that it is culturally safe, in that health care is provided in a way that respects the culture, values and beliefs of indigenous people, recognizing the necessity of non-discriminatory care.

Physicians must be reflexive and understand their own biases. They must attend to and mitigate the power dynamics that exist in the relationship between a patient and provider.

In closing, I would like to highlight the work of the Survivors Circle for Reproductive Justice in supporting survivors of forced and coerced sterilization and advocating for the changes in this bill, as well as that of Honourable Senator Yvonne Boyer.

Thank you. *Meegwetch* for the opportunity to speak today.

The Chair: Thank you, Dr. Richardson.

Now Karen Stote, associate professor, has five minutes.

Professor Karen Stote (Associate Professor, Women and Gender Studies, Wilfrid Laurier University, As an Individual): Good morning. Thank you, Mr. Chair and committee members.

I've been researching the coerced sterilization of indigenous women for about two decades. I've written two books on the subject, and I fully support the survivors of coerced sterilization and what they want and need. Bill S-228 is a tool that will help reaffirm existing consent mechanisms in a medical context and make clear that there are consequences if health professionals don't meet their obligations. I echo other voices of those who have appeared before your committee in support of the bill.

I'm here to remind this committee and government that, as some have said previously, we're talking about a colonial solution to an ongoing colonial problem. If we don't go to the source of the problem, the wound will continue to fester. If we don't address the context that leads to coerced sterilization in the first place, indigenous experiences of coercion are at risk of continuing or simply changing form.

Indigenous people were sterilized under eugenics legislation starting in the 1930s. Over 1,200 sterilizations also took place in the north and in federally operated Indian hospitals in the late 1960s and 1970s. At the time, there were problems with informed consent, as well as racism and paternalism on the part of government officials and health professionals. Also, the context was one of colonialism and the undermining of indigenous political and reproductive sovereignty. Western medicine was imposed as a tool of colonialism, and indigenous ways of health, healing and giving birth were undermined.

That context has mostly continued. After 1970, coerced sterilization continued under the banner of family planning. The practice has been a means of population control and a way to control who has access to land and how resources are distributed. Federal changes to the Criminal Code in 1969 decriminalized birth control and made sterilization more accessible, paving the way for family planning activities across Canada. This was significant for continuing coerced sterilization. The change was influenced by international discussions between western nations and corporate interests that were exploiting lands, resources and peoples for profit around the world. That's one reason indigenous experiences here are connected to others in the United States, Central America, South America, Australia, Asia, Africa and parts of Europe, where corporate interests have also been exploiting indigenous lands for profit, and where people have also been coercively sterilized.

My review of 30 years of family planning policy and practice in Saskatchewan, beginning in 1970, shows how the government's concern about poverty and births among young and single mothers at risk most often focused on indigenous women and girls. Family planning was considered by some to be a way to address poverty and reduce government budgets by reducing the birth rate among those relying on social services, without doing much to address why poverty exists in the first place. It was also one way to ensure continued access to indigenous lands for profit, because any poverty that indigenous people experience can't be separated from colonialism.

In 1978, the federal government announced that it would take a more proactive approach to family planning, and the Province of Saskatchewan identified the indigenous birth rate as the most important demographic trend over the next 25 years. That year, registered Indians began to be overrepresented among those sterilized in the province. Between 1970 and 2018, 10,654 registered Indians were sterilized in Saskatchewan. This doesn't include non-status Indians or Métis people.

Sterilization is a legitimate reproductive option when it's consensual, but the historical record is full of indigenous voices raising the possibility and reality of coercion and insisting on reproductive and political sovereignty as necessary to protect against this form of genocide.

Corporations in the Canadian political economy remain invested in exploiting indigenous lands for profit. Colonialism is ongoing. There's a connection between this and systemic racism in health care and beyond, and it's an important part of the context needed to understand why coerced sterilization keeps happening and what transformative changes are needed to stop it.

Criminalization alone won't solve things if business continues as usual in other parts of our collective relationship with indigenous peoples and their lands. I urge you as elected officials and as human beings to pass Bill S-228. Then have the courage to continue working with indigenous people to end violence against indigenous bodies and lands.

Thank you for listening.

● (0825)

The Chair: Thank you very much.

Next we have Liliane Brassard, from the Association of Obstetricians and Gynecologists of Quebec.

Please go ahead.

[*Translation*]

Liliane Brassard (Vice President, Association of Obstetricians and Gynecologists of Quebec): Good morning, Mr. Chair and members of the committee.

My name is Liliane Brassard, and I am the vice-president of the Association of Obstetricians and Gynecologists of Quebec, or AOGQ. We represent more than 500 dedicated medical specialists committed to delivering safe, accessible and, above all, quality care to women.

I want to be clear from the start: We fully recognize the serious and unacceptable injustices inflicted on indigenous women, vulnerable women and other groups of women, including forced sterilizations. There is no doubt that these practices seriously violate women's dignity, bodily integrity and fundamental rights. They must be condemned and penalized, as provided for by the law, and victims must be able to seek justice. The AOGQ fully supports the bill's intent in that regard. However—and this is the crux of our message today—we are extremely concerned about how the bill proposes to achieve that objective. Unfortunately, in its current form, Bill S-228 is likely to do the opposite of what is intended.

Why? It is crucial to point out that forced sterilization is already a crime in Canada. It is captured under the current legal framework. The problem isn't a legislative gap. The problem is actually a deficiency in the investigation and prosecution of these cases and, above all, a lack of effective supports for victims.

Instead of the government's creating a new offence, we recommend issuing clear directives to the appropriate authorities to ensure that cases are thoroughly investigated and effectively prosecuted. It is also important to strengthen training mechanisms for health professionals, supports for patients, reporting and victim supports. Furthermore, better coordination between federal and provincial authorities is needed. These are the things that will actually make a difference.

Conversely, we see three major problems with the bill.

First, it risks undermining the bodily autonomy of patients. For many patients, sterilization is a free and informed choice, one they fully consent to. However, in broadly defining sterilization as an act that wounds or maims a person, with no clear exception for procedures performed with consent, the bill will likely lead to confusion and patient stigmatization. As a result, patients who truly wish to receive such care may be reluctant to seek it.

Second, the bill risks having a deterrent effect on physicians. The bill introduces a broadly worded criminal offence, with no explicit reference to consent. The word “consent” does not appear anywhere in the new offence. In criminal law, uncertainty leads to hesitancy. In medicine, hesitancy hurts patients. Take, for example, ectopic pregnancies. An ectopic pregnancy is a pregnancy that occurs in the fallopian tube and can put the patient's life at risk. When surgical intervention is necessary, it's an emergency. The patient is experiencing severe blood loss through the fallopian tube. Currently, the recommended treatment is to remove the fallopian tube, which is completely damaged. In the absence of legal clarity, physicians could hesitate to remove the fallopian tube out of fear of being prosecuted, because the procedure is likely to result in sterilization. As a result, patients could receive less than optimal care and experience more complications.

Third, we believe the bill risks diverting attention from the real problem. The creation of a new offence may lead victims to believe that this practice wasn't previously considered a crime, which is completely false. The real problem is the inadequate enforcement of the existing law. Adding an offence without fixing the problem will make absolutely no difference on the ground.

The AOGQ fully supports the bill’s objectives of protection and justice, but protecting women also means not choosing a solution that reduces access to care, undermines patients' bodily autonomy or causes adverse effects.

The most responsible solution is the rigorous enforcement of existing provisions, along with concrete measures to ensure that perpetrators are actually prosecuted and penalized.

What these women have gone through is unacceptable. Recognizing that is crucial, but so is using the right tools to make sure it never happens again.

Thank you.

● (0830)

The Chair: Thank you.

We will now hear from Dr. Gaudreault, the president of the Collège des médecins du Québec, for five minutes.

Mauril Gaudreault (President, Collège des médecins du Québec): Mr. Chair, Mr. and Madam Vice-Chairs, and members of the Standing Committee on Indigenous and Northern Affairs, thank you for giving the Collège des médecins du Québec the opportunity to share its views on Bill S-228, which seeks to criminalize forced sterilization.

I have been the president of the Collège des médecins du Québec, or CMQ, for nearly eight years. This is my second and last term, in accordance with our statutes, and I am pleased with what the Senate is proposing. Joining me is Linda Bélanger, our director of legal affairs.

The CMQ wishes to express its full and unqualified commitment to ending this practice. Over the years, the CMQ has condemned the practice, and taken a firm stand against forced sterilization, discrimination and systemic racism. This practice undermines women's integrity, dignity and autonomy.

In the fall of 2022, when Suzy Basile, a researcher at the Université du Québec en Abitibi-Témiscamingue, released her report on the forced sterilization of first nations and Inuit women, it sent shockwaves across Quebec. The public was outraged and the medical community was shocked.

The CMQ immediately set up a working group. I headed the group and made sure to include researcher Suzy Basile; Marjolaine Siouï, executive director of the First Nations of Quebec and Labrador Health and Social Services Commission; Dr. Stanley Vollant, the first indigenous surgeon in Quebec; and two women physicians who sit on our board.

The working group's report was clear and to the point, laying out seven concrete measures: one, implement an action plan to address sterilizations and abortions forced on first nations and Inuit women; two, add a preamble to the college's code of ethics prohibiting any discrimination based on culture or identity, to ensure that every article is understood in that light; three, make training on cultural safety in health care mandatory for college inspectors and investigators; four, encourage all physicians to take this training; five, review and improve training on consent to care; six, communicate the initiatives implemented by the college to the public and physicians; and seven, work with first nations and Inuit networks to deploy reproductive health awareness tools. Most of these measures have been implemented, and we will take more if necessary.

More broadly, the CMQ co-created basic training on cultural safety in health care, with the help of experts from various marginalized populations and communities that are discriminated against in health care. The training helps physicians learn about the structural biases that give rise to health care inequities and understand how to address them. Our goal is to regain women's trust, the trust of indigenous women, in particular.

The CMQ is fully committed to combatting systems and structures that perpetuate oppression and create power inequalities with members of a population or within care teams. We are focused on making sure that none of our actions ever result in a woman being sterilized unknowingly or against her will.

While the proposed amendments specifically introduce provisions in the Criminal Code, we want to share our two expectations for their implementation.

First, consent should ideally be provided in writing, except in an emergency. We heard about cases where consent was given while the mother was giving birth, even though there was no threat to her health or the child's, under stressful conditions when the mother was highly vulnerable.

Second, communications following the bill's passage must make clear that physicians who perform an emergency sterilization procedure without consent are not criminally liable if the procedure is for the patient's welfare. Otherwise, the bill will deter physicians from performing necessary reproductive health procedures out of fear of criminal prosecution.

Researcher Suzy Basile will soon be releasing another report on sterilizations performed without consent, and early indications show that there are unfortunately more cases. The CMQ will be reviewing the report and taking appropriate action.

In the meantime, we would like to see Parliament pass Bill S-228, to criminalize forced sterilization for good. The fundamental choice to have or not have one or more children is the patient's.

The CMQ's mission is to protect the public by ensuring quality medical care, which does not include forced sterilization. We will make sure that people are protected.

Thank you. We would be happy to answer the committee's questions.

● (0835)

The Chair: Thank you.

[*English*]

Next, we'll go to the Federation of Medical Women of Canada and Dr. Modupe Tunde-Byass, obstetrician-gynecologist and professor, University of Toronto.

Please proceed.

Dr. Modupe Tunde-Byass (Obstetrician–Gynecologist and Professor, Temerty Faculty of Medicine, University of Toronto, Federation of Medical Women of Canada): Thank you, Mr. Chairman, and members of the committee for the kind invitation.

My name is Modupe Tunde-Byass. I will be speaking today in my capacity as the president of the Federation of Medical Women of Canada, as a practising OB/GYN and as a Black woman health care provider. At the heart of the Federation of Medical Women of Canada's mission is the promotion of well-being for women plus in both the medical profession and society at large. The FMWC supports and shares Bill S-228's intent to protect reproductive autonomy and ensure a safe, inclusive health care environment, particularly for women from marginalized communities, who have historically been wronged. Indigenous women were disproportionately affected by these egregious acts. The FMWC unequivocally condemns coerced or forced sterilization. I'm also further saddened and disappointed by the inaction and the lack of robust consent process that would have ensured the abolition of coerced or forced sterilization in Canada as a whole.

Upon review and consultation, the FMWC raises the concern about the unintended consequences of the impacts of Bill S-228 on obstetrics-gynecology as a profession and the associated provision of women's health services, including consensual sterilization. Politicization and criminalization of women's health will decrease access and result in a loss of bodily autonomy and reproductive rights. This is what women have fought for.

On gender equity in medicine, as of 2026, over 60% of medical school admissions are women. In 1990, 84% of practising obstetrician-gynecologists were males and in 2020, 64% were females, a fourfold increase. It is projected that over 80% of OB/GYN residents and most practising specialists are now females. This change in demographics is critical, and FMWC members are concerned with the targeted criminalization of a female profession, which is historically male-dominated and fraught with patriarchal, paternalistic and misogynistic legacy, which will cause more women harm. Women are now getting to positions of leadership and are fierce advocates for women's rights and autonomy. FMWC is further concerned that access to women's reproductive health care, which was already in crisis, will be further eroded by criminalization, which would affect current practice and deter women physicians from choosing this specialty.

I spoke to some of my trainees in OB/GYN, and one said, “We are explicitly trained in trauma-informed, non-coercive consent with clear documentation, especially in high-stakes settings like caesarean births.” Another said, “Performing two emergency hysterectomies where partners consented while patients were under general anesthesia. Both patients lived but were upset and one sued after; imagine having a criminal case opened against you in addition to dealing with [a] malpractice lawsuit!!!!!! As trainees we have never heard of this Bill. Forced sterilization is wrong”.

On emergency care risk, medical practitioners performing sterilization procedures without sufficient consent face 14 years in jail. In emergency situations, my question is, who determines sufficient consent? In some cases, consent is obtained from family members. Is this adequate? The threat of criminal prosecution may cause physicians to hesitate during critical split-second clinical decisions, leading to increased morbidity and mortality. These decisions must be made on purely clinical grounds, without the fear of criminal prosecution. Hesitating, even for a moment, can lead to lives lost, as seconds count in the face of active bleeding. Therefore, the potential for hesitation is of great concern. In the U.S., with the overturning of Roe v. Wade, criminalization and legal uncertainty have led to confusion, physician hesitancy and delayed care, and a lack of available women practitioners has led to many documented maternal deaths. We must guard against these scenarios in our country, Canada.

● (0840)

On educational and regulatory opportunity, the FMWC is disappointed that there has been no progress at the national level in developing and implementing a robust consent to prevent coerced or forced sterilization. The FMWC is advocating for the opportunity for comprehensive member education. We are seeking to collaborate with a national commission that comprises indigenous physicians, the Society of Obstetricians and Gynaecologists, regulatory bodies, medical protection associations, biomedical ethicists, midwives, etc., to come up with an urgent consent process while enhancing professional standards that will ensure robust support for health care providers. The FMWC is dedicated to ending coerced sterilization, and it supports the immediate removal of licensure of perpetrators of such acts.

With regard to unintended consequences, marginalized women often have little opportunity to speak to a provider alone and safely for reasons of language and culture, among other things. For example, a woman who—for cultural reasons—is not allowed to make a decision on her own about whether she wants more children may be negatively impacted. These women are already at the highest risk of negative outcomes, and this could further compromise their care, leading to human suffering. We see such women trusting that their provider will listen to them and help them out. While fully informed—

● (0845)

The Chair: Thank you, Dr. Tunde-Byass. We're over time. You'll be able to get out more information during the question-and-answer period, but we have to move on to the next person. Could you just close up, and then you'll get more out during the question and answer stuff?

Dr. Modupe Tunde-Byass: Okay.

In closing, FMWC recognizes the impacts of forced and coerced sterilization in indigenous, Black and marginalized populations. Criminalization will not address the structural racism and systemic discrimination that enable egregious acts to occur in the first place and to continue to impact equity-deserving populations today. With the lack of clarity and the unintended consequences that surround Bill S-228, it is advisable that extreme caution is taken in passing this bill. The FMWC favours universal education, robust consent and public awareness as more effective tools than criminalization.

Thank you so much.

The Chair: Thank you very much.

Next, we have, from the National Association of Women and the Law, Amanda Therrien, feminist lawyer and researcher.

Please proceed.

Amanda Therrien (Feminist Lawyer and Researcher, National Association of Women and the Law): Thank you, everybody. My name is Amanda Therrien. I'm a staff lawyer with the National Association of Women and the Law. For those of you who may be less familiar with NAWL's work, we are a feminist law reform organization with more than 50 years of experience in working to advance substantive equality for women through legal education and policy reform.

I'm here today to discuss Bill S-228, which seeks to address the practice of forced and coerced sterilization in Canada. We're here today to share some recommendations and potential amendments to the bill to ensure that it addresses forced and coerced sterilization without introducing unintended harms.

Our first point of concern regarding this bill is that it is not fully gender-inclusive. As drafted, the bill focuses on female reproductive anatomy: the fallopian tubes, the ovaries and the uterus. Although we recognize that forced and coerced sterilization has been largely used against indigenous women, men—particularly disabled men—intersex people and non-binary individuals have also been targeted. We are therefore recommending that this section instead refer to the reproductive organs of a "person" more broadly.

Second, the bill risks chilling access to gender-affirming care and wanted permanent contraception. This is one of our most serious concerns. A prior version of this bill captured only procedures that were for the primary purpose of preventing reproduction, but this bill goes further. It is capturing any procedure that results in the permanent prevention of reproduction. This is an issue in the context of gender-affirming care. We often see individuals, organizations and governments that are opposed to gender-affirming care describe it as mutilation, as maiming and as being coercive. One of the most common talking points is around the supposed loss of fertility. A broadly worded Criminal Code provision like this could be used or threatened in ways that create fear and hesitation among providers, which will limit access to this life-saving care.

A similar concern exists when it comes to consensual permanent contraception. As mentioned in our brief, the concern surrounding access to wanted contraception was previously raised when Bill S-250, was being studied during the last session. Dr. Diane Francoeur, CEO of the Society of Obstetricians and Gynaecologists of Canada, noted that it is still incredibly difficult for women to obtain permanent sterilization in Canada and that there's currently a three-year wait-list in Ontario for this procedure. Unfortunately, this is no longer a theoretical concern. Following the bill's passage through the Senate, a physician contacted NAWL to advise that their hospital was instructing them not to provide permanent contraception to women. We believe this change was at least in part a response to this bill.

The consequences are significant. It means fewer providers, more gatekeeping and more barriers, particularly for women who are rural and remote, as well as women navigating reproductive coercion or family violence who may need access to permanent contraception safely and discreetly.

Our solution to this is twofold. First, remove the phrase that refers to "any other procedure performed on a person that results in the permanent prevention of reproduction". It is overly broad and creates legal uncertainty far beyond what this bill was meant to capture. Second, add a clear safeguard stating that nothing in this section limits access to contraception or gender-affirming care, with the consent of the person.

Finally, if I can raise a more technical point, this bill may make forced sterilization harder to prosecute—or at least more confusing—rather than easier. Under the current state of law, without this bill, non-consensual surgical procedures, including sterilization, constitute aggravated assault. In order to prove aggravated assault, you do not have to prove that the impairment was permanent. However, if we look at the definition of sterilization procedure in Bill S-228, we see it defined as "any...procedure performed on a person that results in the permanent prevention of reproduction, regardless of whether the procedure is reversible".

This introduces a bit of uncertainty. If prosecutors want to charge someone with aggravated assault in the context of a sterilization procedure, are they now going to have to prove that the prevention of reproduction was permanent? The fact that it's not completely clear in this bill is the reason we recommend removing the definition of sterilization procedure. We want to keep the focus on the lack of consent rather than on invasive and potentially contested medical questions.

This would also bring it into alignment with the section on female genital mutilation, which is also a for-greater-certainty clause. It does not introduce a definition of FGM or require a permanent loss of function; it lists only the behaviours that constitute maiming for the purposes of aggravated assault.

● (0850)

The final version of Bill S-228 that we're proposing would be very short. It would therefore read as follows:

> 268.1(1) For greater certainty, in this section, "wounds" or "maims" includes the severing, clipping, tying, cauterizing, or removal of the reproductive organs of a person.
>
> (2) Nothing in this section shall be construed as limiting the ability of medical practitioners to provide contraception or gender affirming care with the consent of the person.

In closing, what has been missing up until now isn't a legal tool to prosecute forced and coerced sterilization. It's been the political will. This bill, as amended, will hopefully lead to more prosecutions, but the criminal law, without more, will not address systemic racism in our health care system. We need culturally safe care, indigenous-led care, indigenous language services, more accountability from medical regulatory bodies and hospitals that enshrine the duty of free, prior and informed consent in their policies.

The Criminal Code cannot deliver these changes. For this reason, Bill S-228 must be the beginning of Canada's reckoning with forced and coerced sterilization and not its end.

Thank you. I look forward to your questions.

The Chair: Thank you very much.

With that, we will move to questions.

MP Schmale, you have six minutes, please.

Jamie Schmale (Haliburton—Kawartha Lakes, CPC): Thank you very much, witnesses, for being here today and for a very interesting discussion indeed.

Thank you to Ms. Therrien for outlining not only some issues she has but also some potential suggestions. I think the committee will talk about that as well.

I'll start my questions with you, Dr. Brassard, since you're here. Unfortunately, I'll be asking questions in English. I apologize.

Believe it or not, my French is just as bad as my English—

Voices: Oh, oh!

Jamie Schmale: —so I'll stay with my first language.

When coming up to the position that your organization has taken and the concerns that you've outlined, did this also include those surveyed from areas in which indigenous populations were in the majority, where people were in community dealing with...and talking with people who may or may not have been affected by sterilization without their consent?

[*Translation*]

Liliane Brassard: Actually, it affects absolutely everywhere in Quebec. We have indigenous communities in many places.

I have to tell you that as soon as Bill S-228 was introduced, many of our members reached out to us to say they were concerned. As we've often pointed out, many women already have trouble accessing an OB/GYN, and access to reproductive health care adds another layer of difficulty. I practise full time as a gynecologist, in Drummondville. Being the vice-president of the AOGQ is not my only job. I work with women full time. As I often say, many of the services we provide in gynecology and obstetrics affect patients' reproductive organs and can lead to sterilization, even if that is not the primary objective. We are, of course, extremely worried that access to this care could decrease.

We've talked about the issue of consent numerous times. What does consent mean? Is it a signature? Is it the file? Is it the patient's understanding? It's extremely complex.

What's more, the face of medicine in the field is changing. When it comes to the new cohorts in Quebec right now, women make up 92% of obstetrics and gynecology admissions. Women are entering the profession in huge numbers.

To answer your question, I would say, yes, it affects all communities. We are worried about all women in Quebec, indigenous women included, having reduced access to this care. Some fully consenting indigenous women may wish to access sterilization treatment of their own volition, as well.

● (0855)

[*English*]

Jamie Schmale: Okay.

Obviously, I'm not a lawyer. I look too normal for that.

Voices: Oh, oh!

Jamie Schmale: I say that in a room full of lawyers and a panel full of lawyers. Of course, the sponsoring senator is also a lawyer.

Voices: Oh, oh!

Jamie Schmale: Yes. Maybe we should strike that.

Do we have unanimous consent to strike that from the record?

The Chair: Stop digging a hole.

Voices: Oh, oh!

Jamie Schmale: Oh, my goodness.

When we're talking about the liability piece, there has to be intent. There has to be intent that an action that has happened has caused an effect. Consent is defined in the Criminal Code. You have protections for emergency medical treatments. It's section 45 of the Criminal Code. All of those are protected. Somebody comes in, they're bleeding out and you make a snap decision. Unfortunately, they get sterilized as a result, but you saved their life. That's covered.

I think what we're trying to stop, and what we've heard in committee through testimony, is the fact that there are women—and, yes, men—who have been told one thing and something else happens. They wake up and find that they can't have children. That's what we're trying to stop.

There are protections in the Criminal Code in, as I said, the sterilization and ensuring intent. We're just trying to find a path forward that stops this from happening and affecting people who have full intent to have more children but from whom, unfortunately, that magic is taken.

[*Translation*]

Liliane Brassard: I, too, have to say that I'm not a lawyer, so this isn't my area of expertise. I'm much more comfortable in a delivery room or operating room.

What I can tell you, though, from my 14 years of experience, is that consent is quite a complex thing.

At the end of the day, the decision has to be made between the physician and the patient. The patient's options have to be clearly explained to her. That is understood. Even though I do my job diligently, I've seen many cases over my career where patients regretted their decisions. Sometimes, people come to regret certain choices they've made.

I'll give you a real example. I had a patient who asked me for a tubal sterilization, so I removed her fallopian tubes because she no longer wanted to have children. I had been her doctor for all three of her pregnancies. We took time to discuss it. It wasn't performed during delivery; it was done as a second procedure. However, what she had never told me was that her partner abused her and that the procedure was her way of making sure she didn't have any more children with him. She came back to see me a few years later, when she was in a new relationship, and told me that she actually wanted to have more children, but there was no way of going backwards.

We have all had cases like that in our careers, and we will continue to see those cases. Even though the patient fully consents to the procedure, she could end up regretting the decision.

Obviously, you start to wonder. Had the patient given her full consent, given that she was being abused by her partner? What tools do I have to make sure that the patient is fully consenting? That is what worries us about Bill S-228 and why we are sounding the alarm, if you will.

[*English*]

Jamie Schmale: Okay.

The Chair: Thank you very much. That's all the time we have.

Jamie Schmale: Oh, all right.

The Chair: Next we have MP Hanley, please.

Brendan Hanley (Yukon, Lib.): Thank you very much to all the witnesses for being here.

This is certainly turning into a really interesting question about the intersection between consent and criminality.

● (0900)

[*Translation*]

Dr. Brassard, I'm going to ask you my questions in English, because we're discussing something very technical, and I want to be sure I use the right words.

[*English*]

You heard the witnesses, particularly Ms. Therrien on feminist law reform, proposing some amendments that could make this more, one could say, palatable or perhaps more consistent with existing consent and practice.

I wonder whether you've had time, whether you have any reflections on some of those proposed amendments and, ultimately, whether your recommendation is that this entire bill is unnecessary or whether, with appropriate amendments, you could see a path forward.

[*Translation*]

Liliane Brassard: Thank you. I'm going to answer in French, because it's easier for me.

Of course, it's a bit hard to give you an answer on the spot. Not being a lawyer, I wouldn't want to say the wrong thing. Nevertheless, one thing I can say for sure is that if the bill is passed, the AOGQ is fully prepared to contribute and examine the concept of consent.

That being said, we are extremely concerned about the current wording of the bill. Our position is still that the real problem, the existing problem, needs to be dealt with. The law is already there. Patients do have legal recourse. What we want to know is why these cases aren't being prosecuted effectively. That is the problem. If that isn't fixed, what difference will this bill ultimately make? Probably none. That is what I come back to.

[*English*]

Brendan Hanley: You're in an interesting position because you are a practising obstetrician-gynecologist, as well as having an executive position. As we hear from witnesses, I'm reflecting that the more we hear that is closer to the front line, the more we have reservations because these are the practitioners who are actually involved in consent and procedures and often living the complexities of consent. I think you referred to hearing concerns from colleagues.

Is it your impression that you're hearing more concerns perhaps from the practising world than from the more political, academic world?

[*Translation*]

Liliane Brassard: That is absolutely the case. Many of our practising members have reached out to us to express their concerns about the bill.

I can tell you that, in the current context, it is very difficult for a young woman who does not want to have children to access voluntary sterilization. A 23- or 24-year-old woman who has decided not to have children and does not wish to use any form of contraception is going to have a heck of a time finding a gynecologist who agrees to provide that care. That is known and documented.

In my practice, I perform sterilization on young patients after meeting with them a number of times, but it's extremely tough as it is to be sure that the patient has fully understood the long-term consequences of total sterility. It's also important not to take a paternalistic medical approach. Women have the right to access this option.

Currently, gynecologists are hesitant to provide this care, but access has improved significantly in recent years. It's clear that our members have a lot of concerns. Doctors are not lawyers or legal experts. Criminalizing a specific medical procedure creates a tremendous amount of fear. It has consequences, and we've seen cases in Quebec illustrating that.

I'll give you an example. There's a surgical technique to treat patients with incontinence that involves the insertion of a vaginal sling. A certain percentage of women developed chronic pain after having the procedure, and about 5% to 6% of patients needed to have the sling removed. The situation drew intense media and political scrutiny, and as a result, so many rules around consent were introduced that, today, just about every doctor who used to perform the procedure no longer does. Obstetricians and gynecologists are primarily the only ones who still provide the service, because they care about women's health. Currently, women who suffer from incontinence no longer have access to a highly effective surgical procedure. The situation had a perverse effect.

I'm not even talking about criminal prosecution. I'm talking about legal actions.

There's no question that gynecologists in Quebec are worried. I can speak on behalf of my population, but I think the same is true in the rest of Canada. We are extremely concerned about the negative impact this could have.

● (0905)

[*English*]

The Chair: Thank you.

[*Translation*]

We now go to Mrs. Gill for six minutes.

Marilène Gill (Côte-Nord—Kawawachikamach—Nitassinan, BQ): Thank you, Mr. Chair.

Thank you to all the witnesses who are with us today. Clearly, as committee members and elected representatives, we want to do our job with as much rigour as possible, which is why we also need to address….

Sorry, Mr. Chair, but there's a conversation going on next to me, and it's distracting. I'm trying to ask my questions. I would appreciate it if those speaking would finish their conversation another time.

I'll start over, Mr. Chair.

I just want to thank all the witnesses for being with us today, knowing how difficult it is to have these discussions when there is agreement on the underlying principle of the bill. A number of witnesses, including those we've heard from today, have raised some fairly complex issues, especially around consent. I know the Collège des médecins du Québec, the Federation of Medical Women of Canada and the Association of Obstetricians and Gynecologists of Quebec have all addressed the issue.

Ms. Brassard, I'd like to hear your comments on consent issues. As you said, the bill does not define consent. There is no process either. You also talked about the fact that making a free and informed choice means understanding what is happening. Personally, I've had three Caesarean sections, planned and not. While I can't remember all the details, I did see how complex the process was.

I realize it's hard to cover everything, but could you explain consent and all its nuances? Could you also tell us whether there are solutions we can put in place? Earlier, I talked about potential flaws in the bill. How can we shine a light on this, while protecting both patients and physicians?

Liliane Brassard: In medicine, the meaning of consent is quite broad. In order to give consent, a patient must be able, at the time of the visit, to hear what they are being told. In the delivery room, when the patient is in pain, may not be the right time to obtain her consent. However, it's clear that consent doesn't mean exactly the same thing in all medical disciplines.

In gynecology and obstetrics, emergencies happen in the delivery room. Sometimes we see extremely serious complications, and we have to make very difficult decisions. Consent in emergency care is vastly different from consent in non-urgent care, where a treatment plan is decided on in the doctor's office with the patient. It's always much easier when a patient is able to give their consent with a clear mind.

Language barriers also come into play, and we don't always have the tools we need for those situations. Of course, then, improvements can be made and doctors can be given tools to strengthen consent practices. It's not unusual for my office to schedule an appointment with a unilingual patient. We aren't able to understand one another, so the appointment has to be rescheduled. We try to use tools like Google Translate, but it's difficult. There are things that need to be improved.

University faculties are already putting classes in place to improve consent practices. It's clear that consent is taken very seriously by the new cohorts of doctors. It was always taken seriously, but it's gone to a whole new level.

I would like to think that we are moving towards something better, but consent remains a very thorny issue in need of clarification.

Marilène Gill: As was mentioned, that clarification is not in the bill. Do you think that we, as lawmakers, should make that one of our objectives? I know my colleague said there was already a definition of consent, but I don't know whether it applies to this specific situation. As you said, consent differs depending on the medical specialization. What solutions are there, if any, to better deal with consent? It seems to me that the concept could even be divided.

I heard a survivor talking about the fact that she hadn't consented to having her water broken. I'm not a doctor, so I wonder about the risk of sterilization in a case like that. Sterilization is an effect, not the intended purpose. An effect and an intention are not the same. Elective abortions come to mind. In extreme cases, they can cause sterility. I say “extreme”, but that may not be the right word.

Basically, I have all kinds of questions. At what point is a person capable of giving consent? As you said, language can be a barrier. Then, of course, understanding comes into play; the patient needs to grasp everything that's going on. In addition, some situations are emergencies, which you talked about. At certain points, patients may have to be on medication, so they aren't able to give consent. I'm speaking from personal experience. I knew at the time that I wasn't able to make those kinds of decisions.

I'd like you to talk about the process. I know we don't have much time, but if we run out, you can send us all the necessary information in writing, including any amendment suggestions and recommendations for the committee, of course.

● (0910)

Liliane Brassard: When it comes to the legislative framework for consent, I don't have enough knowledge to tell you where to set the parameters. If I were to comment on that, I'd be talking through my hat, frankly.

I think that's a job for medical schools. I think that groundwork has to be laid during students' training. Just as I was taught how to perform a Caesarean section, deliver a baby and make tough decisions in the delivery room, medical schools need to incorporate consent directly into students' training. It's also necessary to partner with groups that represent indigenous populations, vulnerable women, immigrant communities and so forth. That is the way to improve consent practices.

I don't think the way forward is necessarily through a legislative framework, but I will tell you one thing: I've been practising for 14 years, and when you look at today's doctors and the doctors of 30 years ago, you see just how much the practice has changed. Nowadays, the patient is really seen as a crucial partner in the decision-making process. For instance, when I prescribe a birth control method to a patient, I always tell her that the best decision is the one that will work best for her. I may very well think that a certain method is the right one for her, but I still explain the advantages and drawbacks of each option, and in the end, she is the one who decides on the type of care.

I think it's up to medical schools and training physicians to make sure that the new generation is well equipped to obtain patients' free and informed consent.

The Chair: Thank you very much.

[*English*]

MP Morin, you have five minutes, please.

Billy Morin (Edmonton Northwest, CPC): Thank you, Chair.

In reflecting on a very serious conversation, I have an observation. Often, when it comes to free, prior and informed consent, the oxygen in our political world in Ottawa is taken up by a political discussion of major projects. It's a notable dynamic that we're now talking about it at the individual level, which is, I would say, in a lot of ways more important than some of the stuff that takes up all the oxygen. I acknowledge that, in the dynamics of the conversation today, thanking frontline staff is something to consider in this very important conversation, with the job frontline staff do and the pressures they're under.

This is for some of our guests online. I'll go to Dr. Modape Tunde-Byass from the Federation of Medical Women of Canada. Can you highlight some of the proactive education measures, the current practices of doctors in the field, the gynecologists and those who practise in this area and feel these immense pressures? I hear a consistent message that it should be a focus—I think that's pretty obvious—but where could it be improved? Arguably, this bill has been on the floor for seven years. I hear everybody say that coerced and forced sterilization is wrong. We all agree with that, it seems, naturally. Can you talk about what has changed, maybe in the last seven years, in the field to address this, even proactively beyond this legislation passing?

● (0915)

Dr. Modupe Tunde-Byass: Thank you, Mr. Chair.

I've been practising for 39 years. I have seen the new generation being taught about how to get better consent. “Consent” is describing the procedure, looking at the risks and benefits, and ensuring there is consent for refusal to have a procedure done. It's also important to give alternatives. In my work now, when I see patients, I give alternatives. I encourage them to think about the reasons and, especially around sterilization, regrets, and say, “This is extremely important. Once it's done, there is, really, no coming back.” This statement is now taught to this generation, and I see how this has changed from when I started practising. Consent is no longer signing the paper.

In an emergency situation, it's a bit different, and we continue to learn. When patients are having a Caesarean section and they're asking for sterilization at that time, it's not the best time, unless they have had a prior discussion with their health care provider and it's already documented in the charts that this is what they want. You would also ask them, “Is this what you have discussed?” If there is ambiguity, you would not carry out the consent. The emergency situation is usually where the problem is because of this: What becomes reasonable consent?

Having said this, we can still do more with education, with awareness, through both the patient's lens and that of the health care provider. We have seen that incorporating patients in helping with safety and guidelines and with being part of the committee has helped. During my lifetime, there was a time when surgeons operated on the wrong side of the body. That has almost been totally effaced because there's a patient's voice involved in that kind of consent process.

I also trained in another country, the United Kingdom, where universal education is important. I know the health care system is provincial in Canada, but for this kind of situation, I think we need to have a nationwide universal consent process that speaks to everybody across the board. In the U.K., this alone has reduced occurrences of maternal death for women, especially marginalized women, because they have a uniform education. I want to see that kind of process happen in our country so that we do not have a situation whereby one province is doing this, another province is doing that. Education and awareness are key, as is patient partnership.

The Chair: Thank you very much.

We'll now go to MP Ramsay.

Welcome to the committee.

[*Translation*]

Jacques Ramsay (La Prairie—Atateken, Lib.): Thank you, Mr. Chair.

First, I'd like to thank the witnesses.

It's a simple principle, but you helped shed light on the complexities.

First, I have a request for you, Dr. Brassard. Mr. Hanley's first question is very important. The advantage of Ms. Therrien's proposal is that it brings together all the areas where we need to exercise caution. You said it was hard for you to comment on the proposal on the spot, and I completely understand. If possible, I would like the Association of Obstetricians and Gynecologists of Quebec to send us its views on the proposal in writing.

You talked a lot about consent. You mentioned the fact that people have regrets. As a doctor, I know that regret and consent are two different things. We all know that a patient can give informed consent and still have regrets later.

You also talked about the patient as a partner. That's such an important concept. I'm an old doctor. I had bosses who were paternalistic. Then, we moved to a more corporatist approach. Dr. Gaudreault sees where I'm going with this. In other words, we did what the corporation or college asked us to do. What was right, what was allowed by the college was what we had to do. After that, a patient-centred approach emerged, but even then, we decided what was best for the patient together. Now, you spoke about the patient as a partner. That is fundamental. That is what we need to keep in mind.

Dr. Gaudreault, I commend you. You talked about the study in Abitibi. You talked about the working group that the college established. You even said that you led the group, which is surprising for someone who's the president of a physicians' college.

Nevertheless, you realize that this committee meeting is happening today because the colleges didn't do their job. Where were the colleges all those years? I'm talking about the Quebec college and those of the other provinces. Why are we here today? Did the colleges offer up any sort of mea culpa, and if so, to who?

● (0920)

Mauril Gaudreault: I'm not here to talk about past colleges and presidents.

However, as I said, we were completely shocked when Professor Suzy Basile's report was released. I believe all of this also stems from biases experienced by both patients and health care providers. I think that colleges, organizations and institutions—like the college I have the privilege of presiding over—have done their part in the past. One issue that the focus group I chaired highlighted was that patients, particularly indigenous women, did not trust our institutions, including the Collège des médecins du Québec. They didn't feel protected by it, didn't trust the various institutions representing their rights and didn't dare to file complaints. This was made very clear by Ms. Basile's study, as well as by the testimony we heard during the focus group's work.

We've also acknowledged this in territorial position statements regarding all indigenous communities: We haven't always done the work we should have done. That said, what we have codeveloped with indigenous communities and what I mentioned in my remarks is really a program designed to raise awareness among various stakeholders and health care providers about the biases we may all harbour regarding how we welcome women, particularly those from indigenous communities, and how we address them.

To answer the question, I would say yes, obviously, there is work to be done. We acknowledge, for our part, that we could have done things differently.

The Chair: Thank you, Mr. Gaudreault.

Thank you, Mr. Ramsay.

Mrs. Gill, you have the floor for two and a half minutes.

Marilène Gill: Thank you very much, Mr. Chair.

I'll ask Dr. Brassard another question, and I'd like all the witnesses, if possible, including the representatives of the Collège des médecins du Québec, to also answer my question on consent. I wanted my next question to focus on the definition, as both the Collège des médecins du Québec and the Association of Obstetricians and Gynecologists of Quebec have weighed in on the definition.

I'll turn the floor over to you, Ms. Brassard and Mr. Gaudreault. Anyway, I'll let you answer.

Liliane Brassard: To answer simply, I would say that at the AOGQ, we represent our members to ensure that patients have access to quality care, but we rely heavily on the Society of Obstetricians and Gynaecologists of Canada, which is our academic institution. There have been working committees on the definition of consent. By definition, consent, as was said earlier, is….

Actually, maybe you could clarify your question.

Marilène Gill: I was the one who made the mistake. It's true that my question could have been about the definition of consent, but I was talking more about the definition of sterilization as it appears in the bill. I'm sorry.

● (0925)

Liliane Brassard: Of course, for us, this is extremely concerning, as many of our surgical procedures result in sterilization, even if that's not the intended effect.

For example, for a patient with very abnormal bleeding, we can ablate the endometrial lining without removing her uterus. Afterward, it is not recommended that this patient become pregnant. I often say that the house has been burned down and a family can no longer be started inside it.

Therefore, many of our surgical procedures have sterilizing effects. All of this is discussed with patients and these are fully informed choices. Right now, when we need to obtain the patient's consent, I always explain that consent is being given for the surgical procedure and for sterilization. For example, if I remove a patient's uterus because of bleeding, I discuss sterilization with her, and she is fully aware that, without a uterus, she will no longer be able to have children. However, consent was given only for the surgical procedure.

In our case, the majority of our surgical procedures have the potential to cause sterilization, so we are definitely extremely concerned. This bill, as currently written, affects virtually my entire practice. That's what I would say.

Marilène Gill: Thank you.

Mr. Gaudreault, I imagine you could answer the question in writing. Thank you very much.

[*English*]

The Chair: You have 20 seconds.

[*Translation*]

Marilène Gill: Oh, really? You're very generous, Mr. Chair.

In fact, for all the other questions, as well, I would like the committee to receive answers from the Collège des médecins du Québec and from any other witness who would like to answer.

Mauril Gaudreault: You're talking specifically about free and informed consent, right?

Marilène Gill: Yes, and I was also talking about the definition of sterilization.

Mauril Gaudreault: That will obviously have to be clear in the bill.

When it comes to free and informed consent, it must be given under appropriate and optimal conditions. I will give the floor to my colleague, who is the director of legal affairs and will be able to give you a better definition of free and informed consent from the perspective of the Collège des médecins du Québec.

[*English*]

The Chair: Thank you very much, but that is the time we have.

As MP Gill mentioned, you can also send things in writing to the other witnesses you may not have had an opportunity to speak to.

[*Translation*]

Mauril Gaudreault: Okay.

[*English*]

The Chair: We still have a little more time on this important subject.

MP Schmale, go ahead for five minutes, please.

Jamie Schmale: Thank you very much, Chair.

I promise not to make lawyer jokes this round.

Dr. Brassard, maybe I can go with you because where we left off—

[*Translation*]

Mauril Gaudreault: [*Inaudible—Editor*]

[*English*]

The Chair: Dr. Gaudreault, would you turn your mic off, please?

Thank you.

Jamie Schmale: We left off talking about education. This bill was drafted because indigenous women and girls were being targeted. There was lots of documentation that they were the majority of the victims of sterilization without consent. That's the impetus of this bill. It's been around for a number of years in different forms.

Could you tell us what your organization has been doing within Québec or in the rest of the country to educate your members about forced or coerced sterilization?

[*Translation*]

Liliane Brassard: Absolutely. I repeat that non-consensual sterilization is completely unacceptable. We totally agree with that.

It's the scholarly society representing obstetricians and gynecologists that provides ongoing care training. Over the past few years, it has provided extensive training to clinicians through clinical tools that were developed and co-created in partnership with indigenous committees. There is even a committee dedicated to indigenous women's health; I couldn't say exactly how many years it has been in existence, but it's been a number of years. There's a lot of promotion around cultural safety and the need to adapt care. This is something currently being put forward by the Society of Obstetricians and Gynaecologists of Canada.

On our end, at the AOGQ, we hold an annual conference for our members in Quebec that more than half of Quebec's gynecologists attend every year. Of course, we have raised with the leadership of our professional training the concern being discussed today, which led to Bill S-228. That's something we'll want to promote to our members and encourage as part of the training of clinicians. I can assure you that we, on the ground, are always striving to be the best doctors we can be to serve our patients well.

[*English*]

Jamie Schmale: Please don't misunderstand me. I'm not saying you aren't. We just want to correct what we think is a wrong, and no one's placing blame or anything. We want to ensure going forward that this doesn't keep happening.

If I heard you correctly at the end, no deep dive into Bill S-228 has been done by the AOGQ, your organization, as of yet. You said it will be coming up at future gatherings and that you will discuss it, so a deep dive hasn't been done yet. Is that correct?

● (0930)

[*Translation*]

Liliane Brassard: I'm not quite sure what you mean by a deep dive.

[*English*]

Jamie Schmale: You said you'll be discussing it at future meetings when your members gather for their annual convention or conference. Unless I misheard you, you said you'll be discussing it in the future. Has any work been done to date?

[*Translation*]

Liliane Brassard: Actually, yes, the Society of Obstetricians and Gynaecologists of Canada has done some work on the issue. In addition, it is an issue that has already been raised at annual conferences. It's under way.

What I am telling you is that we will continue to push this message as far as possible. Ultimately, we really want to encourage members to adopt the most appropriate practices and ensure cultural safety at all levels.

To answer your question, I would say that, yes, this issue has been addressed by the Society of Obstetricians and Gynaecologists of Canada.

[*English*]

Jamie Schmale: Do you know if your organization has engaged with the Truth and Reconciliation Commission's calls to action or the National Inquiry into Missing and Murdered Indigenous Women and Girls' calls for justice?

[*Translation*]

Liliane Brassard: Currently, at the AOGQ, we do not have the expertise or capacity to work in that area, but we are always ready to collaborate when asked. We want to move forward and collaborate with all relevant authorities. It is not part of our expertise to be on the ground in this regard, but when we are called upon, we always collaborate.

[*English*]

Jamie Schmale: In your ongoing work, has your organization obtained legal advice regarding the bill's scope and application?

[*Translation*]

Liliane Brassard: Yes, certainly. We have a law firm that works with us on certain cases. We actually asked some of those lawyers to guide us, and they were the ones who helped us identify certain points and prepare our remarks today. Certainly, the main opinion comes from us, the obstetricians and gynecologists, but we did seek help to understand the bill. I must say that, as a gynecologist and obstetrician, I am far from fully understanding all the details of a bill.

[*English*]

The Chair: Thank you very much.

That brings us to the end of the questions for the first panel.

I would like to thank all the panellists for your expertise. I know you're all very busy, so thank you for sharing your testimony today.

We're going to suspend and get ready for the next panel.

● (0930)

(Pause)

● (0935)

The Chair: We're going to reconvene.

We have with us, from the Department of Justice's criminal law policy section, Nathalie Levman, senior counsel, and Morna Boyle, counsel.

The Department of Justice will have five minutes to present to us, and then we'll go right into the questions. We're going to finish up at 10:15.

Thank you.

Morna Boyle (Counsel, Criminal Law Policy Section, Department of Justice): Thank you, Mr. Chair and members of the committee, for the invitation to appear today on the unceded and unsurrendered territory of the Algonquin Anishinabe nation. We recognize that this acknowledgement must be matched by continued efforts to ensure that our work contributes meaningfully to justice and reconciliation.

We are pleased to be here today to provide a brief overview of Bill S-228, an act to amend the Criminal Code regarding sterilization procedures, and to assist the committee with any legal or technical questions it may have.

Bill S-228 proposes to amend the Criminal Code to clarify that a sterilization procedure performed without legal consent constitutes aggravated assault. Assault is the non-consensual application of force against another person. Aggravated assault is an assault that wounds, maims, disfigures or endangers the life of the victim. Aggravated assault is the Criminal Code's most serious form of assault, carrying a maximum penalty of 14 years' imprisonment.

These amendments would not alter the law of assault as it currently applies to sterilization procedures. All non-consensual surgical procedures, including sterilization procedures, already constitute aggravated assault, because surgical procedures necessarily involve wounding the person who undergoes them. The bill would clarify that a sterilization procedure constitutes a wounding or a maiming for the purposes of the Criminal Code's aggravated assault offence.

A conviction for aggravated assault requires proof—first, that an assault occurred; and second, that the assault wounded, maimed or disfigured the victim or endangered their life. This means that surgical procedures, including sterilization procedures, amount to aggravated assault only when they are non-consensual. That is because assault is defined in subsection 265(1) of the Criminal Code as the intentional application of force to another person without that person's consent. This means that the criminal law does not apply to surgical procedures, including sterilization procedures, that are performed with the patient's legally effective consent.

Both subsection 265(3) and relevant jurisprudence articulate when consent is legally effective. Specifically, legally effective consent must be freely given without fraud, duress, violence or threats. Consent must also go to the nature of the act, meaning that the person must have a sufficient foundation of knowledge about what is proposed, including its purpose and what will take place. Finally, consent must be given by a person who understands and appreciates the nature of the act. These rules are consistent with concepts of voluntariness, knowledge and capacity in provincial and territorial health law, so compliance with health law consent requirements protects from criminal liability.

Bill S-228 would not change the criminal law as it applies to medical procedures, including sterilization procedures, and therefore would not criminalize consensual sterilization procedures or in any way affect the legality of medical procedures performed with legally effective consent. That is why the bill states, “For greater certainty, a sterilization procedure is an act that wounds or maims a person” for the purposes of the aggravated assault provision. “For greater certainty” signals Parliament's intent to clarify the law, not change it.

We would also note that the bill does not alter the existing legal framework that protects individuals from criminal liability who perform surgical operations in emergency circumstances with reasonable care and skill. Those rules would continue to operate as they do now.

In sum, Bill S-228 clarifies the existing criminal law as it applies to non-consensual sterilization procedures, thereby reaffirming the importance of legally effective consent and preserving the existing criminal law framework governing non-consensual surgical procedures, including non-consensual sterilization procedures.

Thank you very much. We would be pleased to respond to the committee's questions.

● (0940)

The Chair: Thank you very much for your testimony.

We will now turn to the Conservatives for the first round of six minutes.

MP Schmale, go ahead, please.

Jamie Schmale: Thank you very much, Chair.

Thank you to a great group of lawyers in front of us today.

Voices: Oh, oh!

Jamie Schmale: I keep digging. I don't know why.

You heard the testimony we just had. You saw and heard that we were trying to dig down, narrow in and focus in to alleviate concerns if people had some. Would you care to reflect on what you observed a few moments ago?

Nathalie Levman (Senior Counsel, Criminal Law Policy Section, Department of Justice): Thank you very much for the question.

Yes, we would like to address what we view as some misunderstandings of the impact and scope of Bill S-228.

We'd like to stress that the bill would not create a new offence. The “for greater certainty” clause, as my colleague explained, merely confirms or clarifies the application of existing law.

We would also like to stress that criminal liability for non-consensual medical procedures requires both that the medical procedure took place without the person's consent and that the person who performed the procedure, or took part in it, knew that the patient was not consenting or that the person performing or taking part in it was reckless as to the lack of consent.

Situations in which a person gives valid consent and then later regrets it, after the procedure, would not be caught by the criminal law, either now or under Bill S-228, because Bill S-228 does not change the scope or application of the criminal law.

Therefore, we really want to reassure committee members and stakeholders, as criminal lawyers who are responsible for these provisions in the code from both a legal and a policy perspective, that Bill S-228 would not change the criminal law framework governing non-consensual medical procedures. This includes the fact that section 45 would continue to operate and that the consent framework, as my colleague has described it, would also continue to operate.

I'd also like to stress that the concerns we heard during the first hour were in fact taken into account in the redrafting of former Bill S-250. You'll recall that Bill S-250, as amended, is Bill S-228, the very bill you're considering. All of these concerns were taken very seriously, I believe, and factored into the current formulation of the bill.

If you'll give me permission, I would like to quote Dr. Wilson, who appeared before you on Tuesday, because we agree with what he said. He said, “As an obstetrician-gynecologist...if this bill passes, I won't be changing my practice, because there's nothing for me to change if I'm not engaging in forced and coerced sterilization.” He also said, “We don't really have anything to worry about in the way this bill is written if we're not engaging in those coercive practices.”

I stress what my colleague informed you of in her opening remarks, that complying with provincial and territorial health laws, which require the securing of informed consent prior to every single medical procedure, immunizes all medical professionals from criminal liability, both under existing criminal law and under Bill S-228, which does not change existing criminal law.

I hope this helps the committee.

Jamie Schmale: Yes, it does. Your testimony leads me to my next two questions.

How much time do I have?

The Chair: You have two minutes.

Jamie Schmale: Okay, I have two questions in two minutes.

I'll give you both of my questions because of the time. One is on the piece you were just talking about. In the previous session, we heard of the example of a doctor doing a procedure and accidentally nicking something and causing sterilization. I know you mentioned it in your words, but I want to be perfectly clear here, because I want to address the exact scenario the doctor talked about. The second is, do you think this bill needs or requires any amendments?

Thank you.

● (0945)

Nathalie Levman: For your first question, fundamental criminal law principles require criminal acts to be voluntary. Therefore, accidents are simply not criminal. This is a function of standard fundamental criminal law principles. Thus, accidents cannot be captured by existing criminal law—or under Bill S-228.

Because Bill S-228 is a “for greater certainty” clause and doesn't change the existing scope of criminal liability for medical procedures, including sterilization procedures, it's our view that no further amendments are necessary.

The Chair: Thank you very much.

Your two questions are done? Okay.

Next is Dr. Hanley for six minutes, please.

Brendan Hanley: Thank you very much to both of you for being here.

I want to clarify what you said about the text of Bill S-228 versus Bill S-250 in the previous Parliament.

Did you say that the text is a mirror of the final amended version of Bill S-250? To be clear, has any word changed from the final amended version of Bill S-250?

Nathalie Levman: No. Bill S-228 reflects Bill S-250 as amended by the Senate committee on legal and constitutional affairs.

Brendan Hanley: I'm going to build a bit off what Mr. Morin brought up in the previous hour on the concept of free, prior and informed consent as applied to individual medical procedures.

I wonder if you can comment on what the understanding is and what the definition is within medical jurisprudence.

Nathalie Levman: That's an excellent question.

We have two legal frameworks that apply to medical professionals. The first is provincial and territorial health law. For example, the Health Care Consent Act of Ontario provides a regulatory framework that doctors must follow to comply with informed consent rules. They more or less mirror what we see in section 265, which I have open here. It says that you have to consent to every touching. That's a fundamental aspect of our law, as confirmed by the Supreme Court of Canada in its Morgentaler decision. They were very clear that any kind of medical procedure performed without complying with the criminal law's consent rules, which are articulated in section 265 and in the jurisprudence, is an assault. We know that. This is fundamental, in our society, to protecting bodily autonomy and integrity.

What we see in the criminal law is exactly as my colleague has described it. You cannot induce consent through fraud, threats, violence or an exercise of authority. Most importantly, if no consent is given at all because the person, let's say, isn't informed—they go in for one procedure they've consented to and the result is that they end up sterilized, which they have not consented to—then no consent is given. This is both for the purposes of a statute such as the Health Care Consent Act or equivalent statutes in other jurisdictions and for the purposes of the criminal law.

We have overlapping legal frameworks—one criminal and one regulatory. One is at the federal level, and one is at the provincial-territorial level.

I hope this helps.

Brendan Hanley: Are you aware of other areas of medical practice in which there is, outside of normal consent laws and the laws to which you refer, additional legislation at the federal level that applies to other areas of consent in medical practice?

● (0950)

Nathalie Levman: The other provision was already noted. It's the female genital mutilation provision.

I want to stress that female genital mutilation and sterilization are not analogous procedures. Female genital mutilation is a form of violence against women. It is never medically indicated. That's why subsection 268(4) clearly says that no consent to female genital mutilation is valid unless it falls within some narrow exceptions. Because female genital mutilation is defined in part as an excision—excision means cutting and, therefore, removing something like a cancerous growth or fixing the damage caused by female genital mutilation; that requires cutting—the law will recognize consent in those limited situations in which a particular procedure on female genitalia is legitimate and medically indicated.

I want to stress that Bill S-228 has no similar provision. You see nothing in Bill S-228 that says no consent is valid, which is because consent is valid in this context.

Medical procedures that have social utility.... This is from the Supreme Court of Canada in Jobidon in 1991. The law clearly allows people to consent to medical procedures that could be highly invasive but have social benefit and benefit to the patient who's undergoing them.

That's why Bill S-228 fits very nicely within the current framework addressing medical procedures that are non-consensual. All it says is that if a sterilization procedure is non-consensual—meaning it doesn't comply with the criminal law's rules on consent as my colleague has described them—then it will be a criminal act and somebody could be held liable, but only if they have the requisite knowledge or recklessness with respect to the lack of consent of the patient.

That's what Bill S-228 does. It's different from the FGM provision because it's a different practice. FGM is not legitimate. Sterilization procedures that are consensual are legitimate, but FGM is never legitimate.

I wanted to explain the differences between these two provisions.

The Chair: Thank you very much.

[*Translation*]

Mrs. Gill, you have the floor for six minutes.

Marilène Gill: Thank you, Mr. Chair.

I thank the witnesses for joining us to enlighten us through their professional expertise.

The Collège des médecins du Québec has informed the committee of a number of concerns. You assumed that the Collège des médecins du Québec, the Association of Obstetricians and Gynecologists of Quebec and the Society of Obstetricians and Gynaecologists of Canada may not have understood the content and scope of Bill S-228.

The representatives of these organizations had a few questions and provided us with information about the harmonization of the bill, which I will present to you last. One of those questions was about the scope of section 45 of the Criminal Code. In their view, that should be clarified. The section states, in particular:

> (a) the operation is performed with reasonable care and skill; and
>
> (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

In short, this concerns emergency situations. That is the concern these people have raised. They think that clarification in this regard would help protect both the patient and the practising physicians, of course.

So that's one of their proposals. I'd like to hear your comments on this first proposal. Then I'll have others.

[*English*]

Nathalie Levman: Nothing in Bill S-228 impacts section 45. My colleague reviewed this in her opening remarks, and I've restated it. The existing legal framework continues to protect from criminal liability in appropriate situations, including emergency situations.

Section 45 applies now. I understand that it's operating now to ensure that physicians can save lives. I want to stress that this is a very significant, socially important role to play. You need to be able to save lives in emergencies with uterine ruptures or whatnot. The existing criminal law does this, and nothing in Bill S-228 changes it.

I would really like to reassure the medical community and this committee that Bill S-228 won't change the existing framework that already protects medical professionals who save people's lives and have to forgo the consent process because of the emergency.

● (0955)

[*Translation*]

Marilène Gill: I wasn't planning to ask you the question, but it occurred to me while you were speaking. We've heard from several doctors among today's witnesses. Were doctors involved in the drafting or the reflection that went into Bill S-228, or even into Bill S-250? It's a yes or no question. I'm just asking you in passing. I have other questions, as well.

[*English*]

Nathalie Levman: I want to point out that this is a private member's bill, not a government bill. I can refer to what I know, what I understand to have been the process.

Bill S-250, as introduced, started with a very broad offence that would have criminalized all sterilization procedures, subject to very limited exceptions. My understanding is that the medical community came to the Senate committee on legal and constitutional affairs and expressed their support for the intent but also their extreme concern with it. The concerns were taken into account by Senator Boyer, as I understand it, and others who supported her in developing the amendments that were ultimately accepted by legal and constitutional, during their clause-by-clause review of Bill S-250. Those are the amendments you're reviewing today.

[*Translation*]

Marilène Gill: Actually, my question applies whether it is a government bill—in which case you could have answered—or a bill introduced by a member of Parliament. For us legislators, regardless of the type of bill, this raises questions about how we should proceed to reassure people beforehand rather than afterward.

I have another question for you from the Collège des médecins du Québec. I think you've answered it, to some extent. Those people drew a parallel between cases of mutilation and consent. For the Collège des médecins du Québec, verbal consent would not be enough. They would prefer that it be handled differently. As I mentioned earlier, the goal is to strengthen the protection of patients and physicians.

I have one last question, which I'll ask you right away because, if I let you answer the previous question first, I'll run out of time for this one. It's about the definition. You alluded to it a few moments ago. According to the people from the Collège des médecins du Québec, there is something of an inconsistency. When comparing the French and English versions, we see that the English version is missing an element. I can send it to you. The members of the Collège des médecins du Québec would like “occluding” to be used in the English version, in addition to “clipping”, a term that doesn't really encompass the terms used in the French version. So it's a matter of harmonization.

Please answer my question about the analogy between mutilation and sterilization, in which case verbal consent would not be enough.

[*English*]

Nathalie Levman: As I said before, there are two legal frameworks. Some of the comments made about consent and informed consent really belong more in the context of PT health law in terms of what steps are necessary administratively to ensure that you’re getting proper informed consent. That's why both my colleague and I have stressed that complying with PT health laws completely immunizes a medical professional from criminal liability, because those rules are very strict. They often require written consent—barring emergency situations, which we've already talked about. That's what I'd have to say. We need to try to keep the legal frameworks separate: One's criminal, and one's regulatory; one's federal, and one's provincial and territorial.

Regarding the text of Bill S-228, I'd like to say—and it is on the record—that Justice officials assisted, through our minister's office, which is the only correct way of doing it, with the amendments to former Bill S-250. In doing this, we had numerous officials, including legislative drafters. We don't draft in one language and then translate; we draft in both languages at the same time. Even if they don't look exactly the same, and they don't look like an exact translation, I can assure the committee that they reach the same objective, which is what we seek to achieve in drafting rooms.

● (1000)

The Chair: Thank you very much.

This brings us to Dr. Ramsay for five minutes, please.

[*Translation*]

Jacques Ramsay: Good morning.

This is all very informative and very reassuring from a legal standpoint.

You were here during the first hour and you heard Amanda Therrien propose an amendment. Among other things, she was concerned about the use of the word “permanent” and the fact that sterilization procedures had also been performed on men.

Did you find this proposal relevant? What are your comments on that?

[*English*]

Nathalie Levman: I would like to point the committee to proposed subsection 268.1(2) of Bill S-228, which says, “or any other procedure performed on a person that results in the permanent prevention of reproduction”. We call that a basket clause in law. It means that all procedures that result in permanent prevention of reproduction, or sterilization, would be caught by the definition. This would include a non-consensual vasectomy as well.

In relation to her other concerns, I would say that the clause in which NAWL has suggested a limitation isn't necessary precisely because of what we've shared with you today. Bill S-228 doesn't alter the existing criminal law. We don't see provisions like this in the criminal law now, because we know that all medical procedures that are consented to are not criminal. They're not criminal now, and they wouldn't be criminal under Bill S-228. It's our view, then, that the provision would not be necessary.

[*Translation*]

Jacques Ramsay: When I listen to you, Attorney Levman—I imagine that's your title because, from the way you speak, I'm sure you're a lawyer—I get the impression that Bill S-228 is not necessary at all.

[*English*]

Nathalie Levman: Perhaps I will answer with respect to some of the testimony you've heard before this committee.

Many stakeholders have told you that clarifying the law in this regard is very important to them, given the history you have heard. We've heard it from impacted people and from the sponsor of the bill. We've also heard it from certain members of the medical community who also feel that clarifying the law would assist with raising awareness and with facilitating the development of very important educational measures that are required to prevent this from happening in the future.

[*Translation*]

Jacques Ramsay: I follow you, but when you tell us that certain things are not necessary, we could say the same thing about vasectomies in the case of other people. I'm thinking of people with Down's syndrome who may have had vasectomies. We could also say, for clarification purposes, that there are people who have been mistreated in this regard, as well. In my opinion, this might warrant the same openness as that required for Bill S-228.

[*English*]

Nathalie Levman: Bill S-228 would clarify that.

● (1005)

[*Translation*]

Jacques Ramsay: Okay, I appreciate that. It clarifies things, but I just wanted—

[*English*]

Nathalie Levman: It doesn't change anything. A non-consensual vasectomy is already an assault.

[*Translation*]

Jacques Ramsay: Okay.

I have a question that is perhaps more important. There's been a lot of concern here about the availability of family planning services for everyone. We heard from Dr. Brassard that it was a struggle to get a younger woman sterilized.

I understand that this is a Senate public bill and that it does not fall under the Department of Justice, but beyond the legal implications, have there been any concerns about the social implications of this bill?

[*English*]

Nathalie Levman: My view is that fundamental criminal law principles protect people from non-culpable behaviour, behaviour that serves a social function.

Any medical professional who is providing a procedure consensually to a patient is not at risk. They're not at risk now. They would not be at risk under Bill S-228 either. In light of your first question, in contrast, it would—as I understand it—help certain stakeholders feel that their rights are recognized in the law.

[*Translation*]

Jacques Ramsay: Absolutely.

We've also heard many times that, sometimes, decisions on procedures must be made in a few seconds. So there is no time for doubt and second-guessing; action must be taken quickly.

Could Bill S-228 have an impact on that? I am well aware that it is covered; I understood that. However, the word “consent” is not specifically used in Bill C-228, and you're referring to another provision, which I believe is section 265 of the Criminal Code.

To clarify matters, shouldn't we first use the word “consent” in Bill C-228, given that that health care professionals may have to act quickly and don't have the luxury of reflecting to determine whether the actions they're about to take will comply with Bill C-228?

[*English*]

The Chair: Please provide a very brief answer. You can also submit something in writing afterwards, if you feel that you don't have the time.

Nathalie Levman: Thank you.

That is the current state of the law. The current state of the law protects medical professionals who have to make difficult decisions in emergency situations for the benefit of their patients. Nothing in Bill S-228 changes that.

I want to stress that fundamental principles of criminal law foist criminal liability on to people who not only do a wrong—meaning they perform a non-consensual surgery—but who also know or who are reckless as to whether the person has consented. Just because there might be a misunderstanding about consent doesn't mean criminal liability will flow. You have to make out both of those elements beyond a reasonable doubt to establish criminal liability. The existing criminal law protects medical professionals right now in the same way that it would protect medical professionals under Bill S-228.

The Chair: Thank you very much.

That brings us to the end.

Does anybody else have anything pressing they would like to say right now? Nope. I'm seeing nothing.

When we're back after the two constituency weeks, we'll pick up where we left off. As a reminder, we will be getting at Bill S-2 when we're done this. Friday is the deadline to get your witnesses' names in.

Go ahead, MP Morin.

Billy Morin: I have a quick question, Chair.

There were comments before the meeting started. Kashechewan, as per the motion, would request an hour on the 14th when we get back. I don't know the process to acknowledge whether that can happen.

The Chair: I recognize that. We will take it up with the ministry, if the minister is available on such a date. We recognize the motion you had put forward, and the date.

Thank you.

Billy Morin: Thank you.

The Chair: Is there anybody else?

[*Translation*]

Mrs. Gill, you have the floor.

Marilène Gill: Thank you, Mr. Chair.

To make our work easier, would it be possible to get a schedule of meetings until the end of spring? Even if it's not complete, it will at least give us an idea of what's coming.

● (1010)

[*English*]

The Chair: Perfect.

The clerk has work to do over the next couple of weeks as well. We will get it to you. I'll also consult with the vice-chairs as we develop the calendar.

Go ahead.

Jamie Schmale: Thank you, Chair.

This is to confirm that the week we come back is the week of April 13. Is that correct?

The Chair: That's correct.

Jamie Schmale: As my colleague mentioned, the minister would talk about Kashechewan on the 14th, if that's possible.

The Chair: That's correct.

Jamie Schmale: Let's say that happens. Would April 16 potentially be another meeting on Bill C-228?

The Chair: That's correct.

Jamie Schmale: Okay.

Are we hoping to do line-by-line in the second hour on that one?

The Chair: That's all possible. It's up to you guys.

Jamie Schmale: We're good with it.

Potentially, then, we could be finished Bill S-228 on April 16—

The Chair: That week, yes.

Jamie Schmale: —leading to Bill S-2, maybe, or something else on the 21st.

The Chair: That's correct. I'll consult with the vice-chairs to make sure the calendar makes sense, because we have the Bloc Québécois study, which also needs to come to a conclusion. We have to put it into the form of line-by-line.

[*Translation*]

Marilène Gill: Thank you.

[*English*]

The Chair: Go ahead, Deputy Gill.

[*Translation*]

Marilène Gill: There may be a mission to the UN coming up. I don't know yet when it's scheduled, but we'll have to talk about it, because it starts on April 20, which means the committee may not be meeting. I would like to know if the committee will not be meeting, as the deadline for Bill S-2 is April 30.

[*English*]

The Chair: That is correct. We will have to get permission from the House to see if we get to go to the UN.

Jamie Schmale: Now, if this is the case....

We have the committee—we're still working on that part—but if the House doesn't allow the committee to go.... I think there was also talk about some members using their own means of getting there and staying for the week.

I guess we'll have to discuss that, because it will push the next chat to the 28th.

[*Translation*]

Marilène Gill: That was my question.

[*English*]

The Chair: We can chat about this during the constituency weeks. Maybe I'll set up a call with the vice-chairs to do that.

[*Translation*]

Marilène Gill: Thank you very much.

[*English*]

The Chair: Thank you again to the Department of Justice for the very informed testimony.

We're done.