

Exhibit P-137

Fighting for a hand to hold: confronting medical colonialism against indigenous children in Canada

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Chapter 9

Cruel Treatment: Indian Hospitals, Sanatoria, and Skin Grafting

Of all the forms of inequality, injustice in health is the most shocking and the most inhumane.

– Martin Luther King Jr, in Harriett A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*

The five acts outlined in the Genocide Convention may overlap. That is, many examples categorized in the other acts also fall within the act of “causing serious bodily or mental harm to members of the group” (UN 1951) discussed in this chapter. As such, even though the examples in the pages that follow focus more specifically on bodily and mental harm suffered by Indigenous children, the themes from the last two chapters – experimentation, imposed poverty, malnutrition, and starvation resulting in illness and death – continue here.

Indian Hospitals: A Segregated System to Break the Child and to Break Up the Family

Aboriginal Peoples Television Network journalist Holly Moore’s award-winning investigative report, “The Cure Was Worse,” explores the “Indian hospitals” that spread across Canada for most of the twentieth century. The only thing “Indian” about these hospitals was the patients; they were anchored in the dominant biomedical model, staffed by white physicians, and run by the colonial government (Lux 2017). As medical historian Maureen Lux explains in *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s*, “ra-

cially segregated institutions reassured [white Canadian] citizens that their access to modern hospitals need not be shared with Aboriginal patients” (Lux 2016, 4). At its peak in the early 1960s, this part of the segregated Canadian health care system had a total capacity of over two thousand beds in more than twenty Indian hospital institutions throughout the country (3).

Marilyn Buffalo, whose grandmother was first a patient and then worked as a ward aide and caregiver at one of these hospitals, makes a direct link between the residential school system and the Indian hospitals: “One system fed into the other, but I learned very early in life that it’s just one system, one policy. And that was to break the child, to break up the family” (Moore 2017). Joan Morris, whose mother was hospitalized for almost two decades, states that “the Indian Hospitals didn’t operate on their own. They always worked with the residential schools. To me, the hospitals were a hundred percent worse” (Moore 2017).

One of the many parallels and direct links with the residential schools was the pervasiveness of tuberculosis (TB), a major reason for the number of Indigenous Peoples institutionalized in these Indian hospitals and also in some non-segregated (or mixed) hospitals. Residential school children diagnosed with TB could be transferred to an Indian hospital. However, residential schools were not the only point of entry. As will be discussed further in Chapter 11, many Indigenous Peoples across the country were forcibly removed from their communities to be hospitalized, oftentimes hundreds, if not thousands, of kilometres away. Some were prevented from leaving once hospitalized. An Indigenous nurse who worked at one of the hospitals compared it to being “like a jail. The patients couldn’t leave” (Meijer Drees 2013, 175). The prison analogy is apt. In 1951, Dr Percy E. Moore, who played a major role in the development and administration of this segregated hospital system as director of Indian Health Service (IHS), recommended that amendments be made to Section 72 of the Indian Act to include “compulsory hospitalization and treatment of infectious diseases among Indians” (Lux 2016, 116). The 1953 Indian Health Regulations subsequently made it possible to fine, detain, and/or incarcerate Indigenous Peoples deemed a danger to the health of the (white) public (116–17). Police forces were called upon to enforce such policies (Lux 2016, 116–17; Meijer Drees 2013, 174). Many Indigenous Peoples would spend years in these institutions, including much of their childhood.

Indeed, hospitalization for TB treatment felt like an eternity. One Inuk woman from Nunavik has shared how the protracted and strict bed rest enforced as part of her treatment (despite, in her case, not feeling sick) contributed to losing track of time: “I really don’t remember if I was gone for two or three years” (Olofsson et al. 2008, 135). Thamasie Simarapik, also from Nunavik, recounts how all the Inuit – children and adults – who underwent treatment at the time were marked by the bed rest routine “that would continue even once antibiotic drugs became standard treatment” (136).

A Cruel Existence: Aggressive Treatments, Experimentation, and Abuse

Dr William Barclay, one of the doctors who practised at the Charles Camsell Indian Hospital in Edmonton, explained that “rigorously enforced” bed rest was a “cornerstone of therapy.” Forced immobilization by applying plaster casts, strict bed rest, and iatrogenic pneumothoraces (surgically collapsing the lung by injecting air into the chest) were all part of their “therapeutic armamentarium” (Grygier 1994, 109). Surgical procedures, including thoracoplasty (removal of portions of the ribs), described as “a painful and deforming procedure,” were performed under only local anesthesia (109).

Despite the advent of antituberculosis medications in the 1940s and even more effective antibiotics in the 1950s, thoracic surgery was simply “made more daring and heroic” and “did not easily give way to the new chemotherapy regime, particularly for Aboriginal patients” (Lux 2016, 65). Dr A.L. Paine, the medical superintendent at the Manitoba Sanatorium, “undertook what he called ‘salvage surgery,’ or lung resections to reduce the perceived risk of relapse once Aboriginal patients returned home” (Lux 2016, 66). In 1958, Paine explained the double-standard: “More white patients with residual minimal lesions are being treated conservatively, though resection is still favoured to prevent relapse in those of Indian blood” (66).

In 1959, British specialist Dr P.E. Baldry visited several Canadian sanatoria. He was disturbed by the number of surgeries performed there and was surprised that lung resections were still being used for even small foci of infection, despite effective oral antibiotics being widely available (Lux 2016, 66). Surgical interventions seemed to be favoured for all Canadian patients with tuberculosis, compared to the United States and England, but “Aboriginal

patients underwent chest surgery to a greater extent than other Canadians,” and were subjected to “more aggressive treatment” (66–7). Baldry also noted that physicians working in Canadian sanatoria had “little faith in their patients and ... separate[d] them from their homes for rather long periods” (66). His visit occurred at a time when Indigenous Peoples made up increasing proportions of the patients hospitalized for tuberculosis treatment. For example, Inuit patients made up over 50 per cent of hospitalizations at the Mountain Sanatorium in Hamilton, Ontario, in 1956; the following year, “there were only Aboriginal patients in the institution” (66). Whether knowingly or not, Baldry was likely alluding to the IHS* policy not to treat Indigenous tuberculosis patients “on an out-patient basis in view of the fact that we cannot supervise their activities very closely while they are at home and in the majority of cases their medication would not be taken regularly” because they did “not have the educational background for home therapy of active tuberculosis” (Lux 2016, 67). So, not only did Indigenous Peoples not benefit from effective antituberculosis medications and the shift to out-patient treatment that it afforded primarily to non-Indigenous (i.e., overwhelmingly white) patients (Grygier 1994, 12; Lux 2016, 67, 118), but overly aggressive surgical interventions continued unabated. Perhaps this explains (at least in part) why, as late as 1965, the Saskatchewan Anti-TB League reported that “the average length of treatment for non-Aboriginal patients decreased from the previous year, from 10.11 months to 8.63 months” while the average for Indigenous patients increased from 14.41 months to 17.93 months (Lux 2016, 67).

All Indigenous patients could be subjected to these treatments, but there were particularities to the children’s experiences. Medical and surgical procedures, done without the child’s parents, must have been terrifying. Doreen Callihoo, an Indigenous woman from Villeneuve, Alberta, was a young child when she was admitted for TB treatment at the Charles Camsell Indian Hospital, where she ended up spending the bulk of her childhood. As a child, she she received streptomycin injections and pneumothorax treatments twice a week. In adolescence, “she had two separate thoracoplasties ... performed under local anesthetic,” and a few years later, one of her lungs was surgically

* Indian Health Service (IHS) was renamed Indian and Northern Health Services in 1954 (Bonesteel 2006, 73) or 1955 (Grygier 1994, 81)

removed because of a chronic lung infection (Lux 2016 3, 13). Barclay recounted how the “most heartbreaking chore” practising at the hospital was streptomycin rounds for children with suspected tuberculosis meningitis. The medication was given by intramuscular injection, and also “through a spinal tap to the children who dread the whole procedure.” This was often done in vain, as the medical teams “saved very few of those early cases” before other medications were developed (Grygier 1994, 110). Barclay stated that they used “these treatments more on blind faith and trust than on any scientific evidence that they were effective.” For Indigenous Peoples who were “hospitalized far away from home and friends, it was a cruel existence” (109).

The harshness of aggressive medical and surgical treatments for tuberculosis (and other illnesses), and the fact that loved ones would far too often not return home, raised the suspicion among many Indigenous Peoples that they were being used as “guinea pigs” in hospitals across the country (Lux 2001, 180; Lux 2016, 110–13). Some were “positive that there was experimentation” going on (Meijer Drees 2013, 182; see also Lux 2016, 102; Selway 2016, 170). Joanasie Salomonie, an Inuk evacuated aboard the *C.D. Howe* ship in 1954, was hospitalized at the Parc Savard Indian Hospital in Quebec City for two years. He was sure that the doctors were conducting “a medicine experiment using different things on us” and “practising on us” (Grygier 1994, 115; see also Lux 2016, 112). Kathleen Steinhauer, from the Saddle Lake reserve in northeastern Alberta, worked as a nurse at the Charles Camsell Indian Hospital for a couple of years after graduating in 1954, and then returned there toward the end of her career in the 1970s. In a 2004 interview, Steinhauer recalled that both patients and staff felt that new tuberculosis treatments “were pioneered on patients in the Indian Hospital system.” Even when patients were being informed about the treatment, she believed that “they often did not fully understand what was being asked of them” (Meijer Drees 2013, 168–75).

A 1976 hospital policy review submission suggests that the IHS actually boasted about being “one of the first hospitals to experiment with the use of streptomycin and to achieve a breakthrough in tuberculosis treatment” in the late 1940s (Lux 2016, 112). In 1956, it undertook a trial using different forms of the common antituberculosis drug para-aminosalicylic acid (PAS) on Indigenous patients. Extensive blood work was taken from dozens of Inuit patients for this and other studies, including tests conducted for the

Defence Research Board, as well as American researchers (112). Such research, conducted without proper consent, was clearly done with the full knowledge of IHS director Moore, for whom hospital staff using the hospital laboratory to perform such studies could be considered a legitimate expense of public funds (113).

More recently, the CBC broke the story of Florence Genaille. In 1953, the Ojibway girl from Rolling River First Nation was being treated for tuberculosis at the Brandon Sanatorium in Manitoba, where “doctors bound her to a gurney, pumped her body with electric currents and then took notes as her fingers curled, her arms shook and her neck strained backwards.” Genaille was at a loss to explain why the medical team would have performed such tests but recalled that her “fingers were beginning to twist sideways, it was so incredibly painful” (Carreiro 2017).

Such treatment would not be surprising given that the abuse of Indigenous children occurred, to some extent, in most health care institutions across the country at the time. Some hospitals and sanatoria may have been better or worse than others, but all shared in the foundational violence inflicted on Indigenous children: the removal from their families and the transfer to the colonial-run medical system without a parent or guardian.

At the Charles Camsell Indian Hospital, Barclay recalled how “children resented being immobilized and did their best to prevent us from applying a cast from which they couldn’t subsequently wiggle free” (Grygier 1994, 110). Staying in bed for indefinite periods would not be easy for most people, but it was especially “difficult for many of the Inuit who were used to an active life outdoors to be confined to bed – particularly the children” (Olofsson et al. 2008, 136). This was exacerbated by the fact that many of them “did not feel particularly sick, hated being in bed all the time, and did not understand that it was essential” (Grygier 1994, 110). Children “were often physically restrained to teach the discipline of bed rest” (Lux 2016, 105). Some would be placed in plaster casts. In fact, hospital staff would joke about “a condition they called ‘cantstayinbeditis,’ for which the treatment was ‘castitis’: immobilization by applying plaster casts on both legs with a bar connecting the casts” (Lux 2016, 105; see also Grygier 1994, 110). Children who managed to free themselves of the leg casts were fitted with body casts that extended all the way up to their chest (Lux 2016, 105). Titus Allooloo, an Inuk who had been evacuated to Quebec City and then transferred to the Mountain Sanatorium

in Hamilton when he was six years old, was physically restrained with a harness and received a strapping if he was caught without it (Grygier 1994, 110). Markoosie Patsauq, an Inuk from Nunavik, was hospitalized at the Clearwater Lake Indian Hospital in The Pas (Manitoba). During his time there, children would be punished for not staying flat in bed during rest periods, including the strapping of the hands with a ruler for sitting up, a straight-jacket for a day if caught with “even just one foot, not both” on the floor, and spanking and a straightjacket for four days for having played with another child (Olofsson et al. 2008, 136).

William Tagoona was five years old when he was hospitalized in the same institution, where he stayed for eighteen months in the mid-1950s. In a 1998 interview conducted when he was living in Kuujjuaq, Nunavik, he shared an experience that scarred him for life. After throwing up macaroni, food he’d never tasted before, onto his plate, he recalled that the “nurse got really angry and mixed up the macaroni and vomit and force fed it to me.” Tagoona remembered how most of the children were constantly afraid because nurses would beat them with thick, leather belts for stepping out of line, like looking away from the nurse’s face when being read bedtime stories or turning away from the nurse at the time of the goodnight kiss (McKinley 1998; see also Lux 2016, 102). Other Nunavimmiut who were hospitalized for tuberculosis treatment at different southern institutions as children also remembered that some “nurses would patrol the wards with a ruler or a yardstick to hit any misbehaving children” (Olofsson et al. 2008, 137).

Over the last few years, reports of sexual assault have also come to public attention. Ann Hardy was a child living in Fort Smith, Northwest Territories, when she was diagnosed with tuberculosis and transferred to the Charles Camsell Indian Hospital, more than 700 kilometres away. Hardy asserts that she and other children were sexually abused and assaulted by the staff there, and she is now the representative plaintiff in a \$1.1 billion class-action lawsuit filed on behalf of “Indian hospital” patients against the federal government. The statement of claim asserts that “systemic failures created a toxic environment in which physical and sexual abuse was rampant” (Pelley 2018). A lawyer described the treatment at the twenty-nine segregated hospitals across Canada that are listed in the claim as “horrific” (Pelley 2018). Such legal actions seeking redress are important but rarely succeed in forcing governments to deal justly with Indigenous Peoples by putting an end to

colonial practices and policies. However, such class actions do push for some accountability, even if it is much too late. Joan Morris, whose mother was hospitalized at the Nanaimo Indian Hospital for seventeen years, focuses on the medical establishment in saying, “We can’t let these people, the medical profession, get away with what’s been done to our people” (Moore 2017).

The treatments, experiments, and abuses suffered by Indigenous Peoples, including children, in the segregated Indian hospital system have contributed to a deep-seated sense of mistrust of health care providers and the medical establishment. According to Lux, such patient narratives from Indigenous patients also point “to a wider suspicion of the intentions of the colonizing state’s myriad policies and its institutions [that are] intended to eliminate their languages and cultures” (Lux 2016, 113).

Skin Grafting in Igloolik: The Scars Don’t Go Away

Another example of physicians conducting experiments on Indigenous Peoples with government and academic institutional support made headlines in June 2019, when the Canadian Press reported that several Inuit had filed a multimillion-dollar lawsuit against the federal government for biological and medical experiments performed on them between 1967 and 1973 (CP 2019b).

These experiments are not well known, even though they occurred as part of an extensive collaboration through the International Biological Program. Discussions were initiated almost a decade prior, in 1959, with over 150 participants from scientific academies worldwide who were involved in planning meetings; subcommittees were struck in 1965 for seven program areas. One of them was “Human Adaptability” (NAS n.d.).

As Nancy Wachowich details, at least part of the Human Adaptability Project took place in Igloolik and Sanirajak (Hall Beach), at the northern end of Foxe Basin in the Qikiqtaaluk region of Nunavut, where North American researchers and scientists arrived in large numbers to perform extensive tests on the Inuit population, which was estimated to be over 750 in 1969 (Wachowich 1999, 288n4). Personal histories were obtained, including through psychosocial interviews, and IQ testing was performed on many. Medical examinations were done, with many undergoing dental evaluations. Pictures were taken and various body parts were measured. Blood, hair, and

urine samples were obtained. Several hundred Nunavummiut underwent radiological imaging studies of various areas of the body, including the chest and skull. Selected subjects underwent exercise testing, cold tolerance experiments, and skin grafting (Wachowich 1999, 175, 288n4).

The five Nunavummiut who are suing the Canadian government underwent skin grafting, among other abuses. It is unclear how old they were at the time, but it is likely that at least some of them were minors given that the lawsuit is seeking aggravated damages for “young age” and “vulnerability” (Uttak et al. 2019, point 25). Rhoda Kaukjak Katsak is not part of the lawsuit, but she was in her early teens when she underwent skin graft experiments in Igloodik (Wachowich 1999, 174). In the 1990s, Katsak shared her recollection of what happened when the researchers arrived. She underwent various exercise tests, a physical exam including blood pressure, and had blood samples taken. While Katsak couldn’t remember all the testing she underwent, she was never able to forget the skin grafting. She recalls that after making the “whole skin area numb ... they took this very long, thin cylinder, like a stick, sharp on one end, and they kind of drilled it into my arm to cut the skin ... They did that twice.” She was with Jake and Oopah, two of her older siblings. Jake was two years older than she was and, therefore, also a minor at the time (162). They underwent the same procedure that she did and she received one skin graft from each of them (i.e., each sibling received grafts from the other two). She mentioned that it didn’t hurt at the time because of the anesthetic, but that it did hurt later (174–5).

Eminent physician and researcher Dr John B. Dossetor details the skin graft experiments in his 2005 memoir. He explains that the goals of his research team were, first, to study the human leukocyte antigen (HLA) system in the Inuit and, second, to apply this knowledge to test theories about the impacts on skin grafts at a time when the field of organ transplants – including transplant rejection – was still being actively studied (Dossetor 2005, 118–19, 121). The HLA system plays a major role in regulating the immune system and, therefore, in the success or failure of organ and tissue transplants. The researchers needed to find individuals who shared specific HLA factors. They felt that this would be more likely among siblings in “relatively in-bred populations” who were geographically isolated, and so the Inuit were selected because of their “relatively contained gene pool” (Dossetor 2005, 115, 117–18).

Dossetor's initial trip, in July 1971, was to Inuvik and Tuktoyaktuk (Inuit Lands in the northwest region of the current Northwest Territories, near the Beaufort Sea) to obtain ordinary tissue typing of Inuit families. Dossetor and his research team of twenty anthropologists, physicians, and physiologists then went to Igloolik in January 1972 to draw blood samples from the population to determine HLA typing, and in June 1972, the research team performed skin grafts on selected individuals (Dossetor 2005, 118–19). Although Dossetor's book doesn't mention how many people were part of the skin grafting experiments, the lawyer who filed the lawsuit on behalf of the five Inuit is aware of at least thirty people (CP 2019b).

The skin grafting procedures were conducted by Edmonton-based plastic surgeon Dr Mac Alton. Dossetor explains that the two of them exchanged skin grafts and used grafts of their own skin onto themselves (or auto grafts) as controls. Their purpose in doing this was to show the Nunavummiut what a persistent "take" and a rejected graft looked like while demonstrating that they were not harmed by the procedure (Dossetor 2005, 121).

Dossetor (2005, 119) explains that the "expeditions were greatly facilitated by Dr Otto Schaeffer, who had practised medicine in the North for ten years or so, could speak several dialects, and was known and trusted by the Inuit." The research team relied on Schaeffer to obtain consent, which "was mainly 'community consent,' although we also asked for individual consent." Dossetor recalls that Schaeffer obtained "community consent after meeting with the community elders in various ceremonies and explaining why we wanted their help" (Dossetor 2005, 119). HIV had not been identified yet, but Dossetor admits in retrospect that they did not discuss the possibility of hepatitis B and hepatitis C transmission, even though the risks for these infectious illnesses were known at the time. Dossetor acknowledges that his research would have been "disastrous" if these viral infections were more "prevalent in the North at that time" (121).

Dossetor (2005, 121) considered the experiments "successful" insofar as they showed "that skin grafts lasted longer in the Inuit than in Caucasians and that the system could be used to predict long-term survivors from the short." However, upon learning of Katsak's account years after the experiments took place (the *Globe and Mail* published an excerpt of her account from Wachowich's book in February 2000), he was "disturbed to read that

one's research was so poorly understood, and that the subjects could not recall receiving adequate information or giving informed consent" (121).

He seemed surprised that the skin graft experiments were "not willingly undertaken by cheerful confident subjects, as we thought" (Dossetor 2005, 121–4). As a pediatrician, I can confirm that, after years of working with children and over a decade in pediatric emergency medicine where I've seen thousands of children over the years, I have yet to meet a child who would cheerfully subject themselves to getting poked for blood tests.

Limited Understandings of Consent

In his book, Dossetor (2005, 123) recognizes that "community consent" was not enough and that his team "should have found a way of explaining it in detail to each graft recipient, and making sure they not only understood what it was about, but also gave individual consent." The conclusion he draws is that "relying on the elders was not enough" (Dossetor 2015, 123). However, this didn't compel him to "reach out or apologize to those he experimented on" (Oudshoorn 2019). He seems to resent and even blame the Elders, by implying that they broke "their promise to explain to the community what they had agreed to," despite Dossetor and his team meeting with them "in their own community meetings, in their own language" (Dossetor 2005, 124). He expresses dismay that Katsak (whom, it is worth noting, he refers to by her first name only, Rhoda) didn't mention the fact that he and Alton had exchanged skin grafts and that the grafting on all subjects was done by "one of Canada's leading plastic surgeons." According to Dossetor, there was "only minimal risk involved and that diminishes, but by no means abolishes, the need for fully informed consent" (124).

Of course, precisely because so little was known about tissue transplantation at the time, that Dossetor and Alton exchanged skin grafts, and the fact that the grafts were performed by an ostensibly expert plastic surgeon are quite irrelevant when it comes to free and informed consent. Neither consideration would have had any bearing on limiting the potential spread of hepatitis B or hepatitis C if either (or any other blood-borne infection) was endemic in the community. The fundamental tenet of free and informed consent is the prospective study subject deciding for themselves whether they want to participate or not, with the option of ceasing their

participation at any time; whether researchers are willing to do part of the experiment on themselves or a surgical procedure is carried out by an expert surgeon is inconsequential.

More importantly, a bioethicist with an international reputation justifying, in 2005, that the minimal risk involved in an experiment diminishes the need for fully informed consent is disturbing. It makes one wonder whether other liberties were taken with research ethics when these experiments were conducted in 1971 and 1972. This occurred at a time when a framework for ethical requirements for human participation in research didn't yet exist in Canada; the Medical Research Council of Canada put together its first such framework in 1978 (Oudshoorn 2019). However, research ethics principles for human experimentation were outlined in the Nuremberg Code, over twenty years prior, and prominent scientists have written from as early as the mid-1800s that “the principle of medical and surgical morality consists in never performing on man an experiment which might be harmful to him to any extent, even though the result might be highly advantageous to science, i.e., to the health of others” (Goodman et al. 2003, 8).

Katsak's recollection of the experiments is particularly illuminating on the issue of consent. Her understanding was that the researchers were trying to figure out if a burn victim “could get a graft from [a] sibling's skin” (Wachowich 1999, 177). Her mother was likely present, but as Katsak reflects: “I don't think it was a matter of her consenting. I don't think she thought of it that way” (175).

In speaking about her mother, Katsak mentions that it “would never have even occurred to her that she could say no to the Qallunaat”^{*} (Wachowich 1999, 177). Katsak goes on to explain how researchers often came to study the Inuit in Igloodik when she was growing up, commenting how it “was like they couldn't get enough!” (176). They would basically do what they wanted and didn't explain what they were doing very well. She found it odd that community members complained to each other, but that they would nonetheless participate. She described this tendency as stemming from politeness, for lack of a better word. But she also provides a significant insight: “I guess what it comes down to is that the Qallunaat have always been the

^{*} The term *qallunaat* “is subject to debate, but it is used variously to refer to ‘Southerners,’ ‘white people,’ or even ‘English speakers’” (Aodla Freeman 2015, xiii).

people with the authority. I learned that in school. Even my parents always treated them that way. It was normal for Qallunaat to ask us to come over and do things for them, even things like giving them our skin ... We just did whatever they told us to do. They were the ones who ran the town” (176).

In the section of his book about the skin graft experiments, Dossetor doesn't explore the impacts of colonialism and racism, nor of how institutionalized relationships of domination impact on medical research. Indeed, as the editors of *Useful Bodies* point out, “the overwhelming concentration on the issue of informed consent, with its focus on the relationship between doctors and patients, has ... obscured the important question of the relationship among medical researchers, doctors, and the state as well as between state and society” (Goodman et al. 2003, 5; see also Simpson 2014, 15). The focus on a limited understanding of consent has “diverted attention away from the issue of experiments per se,” allowing “humans to be used in the name of science ... provided that they are willing scientific objects” despite the fact that “individual or collective decision to participate in an experiment might be founded on misinformation, misplaced trust in the profession, or pecuniary circumstances” (13). Importantly, “human experimentation, even when informed consent has been obtained, may still violate the patient’s autonomy” (4). These are precisely the themes Katsak was referring to; her vantage point meant that she had perspectives on medical ethics that differed markedly from those of an “expert” like Dossetor.

Katsak is certainly not alone in her views. When this story made headlines in May 2019, Lazarie Uttak, who underwent the skin graft experiments with her sister, said: “I feel like we were being used” (Oudshoorn 2019). Paul Quassa, former Nunavut premier, said he never gave his consent to be experimented on for skin graft testing and was skeptical about the details that were allegedly shared with community members in Inuktitut. Importantly, he categorically dismissed the idea that “community consent” could be unilaterally granted by Elders for invasive medical procedures. Quassa echoed Katsak’s sentiment of Inuit being very trusting back then and simply doing what they were told (Oudshoorn 2019). The lawsuit filed against the Canadian government (both Uttak and Quassa are named as plaintiffs) addresses this point by providing historical background to the experiments conducted in Igloodik. It explains how the government of Canada asserted its authority over the region of Nunavut and the Inuit who lived there by “controlling all

aspects of their life.” It did so by establishing the presence – whether occasional or permanent – of police forces, courts, and judges, Department of Indian Affairs representatives, and various regulatory enforcement personnel (e.g., Fisheries and Wildlife Officers), as well as social workers and health care professionals. In so doing, the Nunavummiut were forced “to perceive Canada, which was largely represented by Qablunaq (non Inuit), and anyone associated with Canada as powerful, superior and influential” (Uttak et al. 2019, points 5 and 6). Those conducting the experiments “did not appear to be Inuk or Nunavummiut, but rather were Qablunaq, and apparently representing Canada” which compelled the individuals filing the claim to “believe that they had no choice but to submit to the Experiments” (point 12).

The biological and medical experiments for which compensation is being sought included skin grafting but also involved exposing the subjects to extreme cold conditions, assaulting subjects with sharp objects to assess pain responses, and inserting “objects into body cavities” (Uttak et al. 2019, point 13). As reported by the *Canadian Press*, the statement of claim “alleges the plaintiffs suffered irreparable psychological harm, along with other severe impairments and disabilities, including mistrust of people in positions of power, humiliation and betrayal, and avoidance of medical practitioners” (CP 2019b). The lawsuit names the University of Alberta, the University of Manitoba, McGill University, and the International Biological Program because of various researchers’ affiliations (Uttak et al. 2019, point 16). However, it asserts that Canada had an obligation “not to allow the Nunavummiut to be subjected to experimental procedures without their informed and meaningful consent” (point 8). Whether the Canadian government was actively involved or not, it had a “proactive duty to prevent the Experiments” (point 11) or “terminate” them (point 21). According to the Nunavummiut filing the claim, Canada “breached fiduciary duties and obligations” by, among other things, allowing Inuit “to be subject to Experiments which were demeaning and disregarded their inherent value as human beings and having the right to be treated with dignity” (point 19).

Quassa, who characterized the details revealed in Dossetor’s memoir as “sickening,” made it a point to mention that “We are not monkeys, we are not animals, we are another human being that deserves respect.” He lamented the researchers’ approach because the Nunavummiut “never got any information from them about why this was happening and the reason

why they did it. I never found out” (Oudshoorn 2019). As is often the case with such research rooted in epistemic racism, there was “no medical or cosmetic reason or benefit” to the Inuit who were experimented on (Uttak et al. 2019, point 14). In Kutsak’s account, she certainly didn’t talk about any benefit, but she does confirm that she’s had the scars ever since: “They don’t go away” (Wachowich 1999, 177).

Chapter 10

Gendered Violence: Forced Sterilization and Coercive Contraception

La mémoire se transmet par le sang. Mémoire écorchée, démembrée, violée.
Mémoire effacée de la conscience du peuple. Un grand vide se creuse d'une
génération à l'autre. Lorsque le récit n'est pas raconté il y a privation.
– Natasha Kanapé Fontaine, *Nanimissuat – Île-tonnere*

Physicians and other health care providers in Canada used Indigenous children for their professional interests (and career advancement) under the veneer of scientific knowledge in processes that were firmly rooted in epistemic racism. This was done with little concern for the health, well-being, or dignity of those being experimented on. The medical establishment also carried out pharmacological and surgical interventions on Indigenous women and girls that had little to do with advancing scientific knowledge – and certainly had nothing to do with providing dignified health care. Rather, they served to advance the mission for Canada to remain a “white man’s country.” These interventions were rooted in the eugenics movement that had gained force in the country in the first half of the twentieth century, which saw the deployment of willfully imposed measures intended to prevent the birth of Indigenous children in various settings.

Eugenic Practices in Canada

In her landmark book, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women*, women and gender studies professor Karen Stote addresses head-on the fourth act of the Genocide Convention: imposing measures intended to prevent births within the group (UN 1951). Stote states unequivocally that the “sterilization of Aboriginal women did take place in

Canada and was often coupled with other policies or practices relating to the control of births, including coercive abortions and the indiscriminate prescription of contraceptives, and always within the larger historical and material context of colonialism and assimilation” (Stote 2015, 92). She explains how compulsory sterilization for specific segments of the population (e.g., people living in poverty, individuals deemed to be less intelligent based on IQ testing, etc.) was legislated through the Sexual Sterilization Act in Alberta (1928–72) and British Columbia (1933–73) and was propelled by eugenic ideologies. Although the records of sterilizations performed under this Act in British Columbia are thought to be lost or destroyed, it is estimated that at least a few hundred sterilizations were performed. In Alberta, records indicate that over 2,800 sterilization procedures were performed under its Act (Stote 2015, 46–50). Other Canadian jurisdictions (e.g., Ontario, Northwest Territories) did not succeed in implementing such legislation despite the attempts of eugenic movements to do so, but hundreds to thousands of Indigenous women were nonetheless coercively sterilized up until the 1970s outside of Alberta and British Columbia (53–9, 79). In these situations, the federal government wasn’t able to enact legislation openly facilitating the sterilization of Indigenous Peoples. However, as Stote points out, “through its refusal to condemn the practice, by enacting policies and legislation affecting other aspects of Indigenous life that made sterilizations more likely and through its financial support, it allowed sterilizations to be carried out more effectively” (58). Part of the financial support she refers to is government payment for sterilization procedures billed by physicians (57–8).

Leilani O’Malley was one of the women who courageously fought to hold governments accountable for the violence they inflicted. Her highly publicized lawsuit (filed under her married name, Leilani Muir) against the Alberta government blew the lid on eugenics practices that had continued in Canada until the 1970s. She was awarded over \$700,000 in 1996 in litigation that paved the way for other Survivors to fight for compensation as well (Ha 2016).

Lawsuits and settlements in the 1990s made this chapter of Canadian history known to the general public. However, what is less commonly known is that children were often impacted. For example, O’Malley, who was not Indigenous, had been admitted to Alberta’s Provincial Training School (PTS) for Mental Defectives in Red Deer by her abusive family just prior to

turning eleven years old in the 1950s. When she was only fourteen years old, the medical team there told her that she had to have her appendix removed. Years later, unable to conceive a child, she found out that “an appendectomy was indeed performed on her, but her fallopian tubes were also removed” (Ha 2016).

Targeting the Young: “I was just a child”

O’Malley was not the only person who was a minor at the time of forced sterilization. Using archival records, sociology professor Jana Grekul and her colleagues explain, in “Sterilizing the ‘Feeble-Minded’: Eugenics in Alberta, Canada, 1929–1972,” that “women, teenagers and young adults, and Aborigines were particularly targeted by the Alberta Eugenics Board” that was created by the Sexual Sterilization Act (Grekul et al. 2004, 358).

A handful of “feeder” institutions presented individuals to the Eugenics Board for sterilization: Alberta Hospital in Ponoka, Alberta Hospital in Edmonton, Deerhome in Red Deer, and P.T.S. (Grekul et al. 2004, 366, 369, 381n12). Based on estimates, teenagers (defined as being between the ages of fifteen and nineteen) represented less than a tenth of the provincial population at the time but made up well over a quarter of the cases presented to the Eugenics Board for sterilization (Grekul et al. 2004, 374). Because consent was often unnecessary for minors, and because it was known that obtaining consent often delayed sterilization procedures, teenagers consequently accounted for 40 per cent of all Albertans who were sterilized (374). Based on “race and ethnicity,” Indigenous Peoples were “the most prominent victims of the Board’s attention” because they were “noticeably over-represented” of all individuals presented to the Eugenics Board for sterilization. They were also more likely to be diagnosed as “mentally defective” and consequently deemed to be not competent to provide consent and, therefore, couldn’t refuse the procedure. As such, almost 75 per cent of all Indigenous Peoples who were presented to the Board were eventually sterilized, which was a gross overrepresentation when compared to the 60 per cent of all patients who were presented to the Board and underwent the same fate (375). Finally, a gender-based analysis confirmed that there was a two-stage bias when it came to women: they were more likely to be presented to the Eugenics Board and were more likely to be sterilized once presented (373). Based on these

conclusions, it follows that Indigenous teenaged girls and young women were disproportionately targeted by the sterilization legislation that was in place in Alberta for over four decades.

In terms of absolute numbers, the Eugenics Board considered a total of 4,875 cases and “passed” (i.e., recommended sterilization for) 99 per cent of those. Even the remaining 1 per cent weren’t refused but, rather, were deferred. Essentially, the Eugenics Board simply “never said ‘no’” (Grekul et al. 2004, 367). As mentioned earlier, approximately 60 per cent of those who were “passed” were sterilized. The remaining 40 per cent were never sterilized only because of consent requirements that may have delayed the operation indefinitely; an example would be an instance where consent was withheld by the person or the next of kin (367).

Physicians and other health care professionals were making all of these decisions. The provincial government relied heavily on a few very powerful physicians who were able to exert their influence on the province’s mental health institutions for a long period of time. Dr W.W. Cross was the minister of health from 1935 until 1956, while Dr Malcolm Bow served as deputy minister of health from 1932 until 1952. Dr R. MacLean led the Mental Hygiene / Guidance Clinics beginning in the 1930s and was the medical superintendent at Alberta Hospital in Ponoka, where he acted as the director of the Mental Health Division from 1948 until 1965 (Grekul et al. 2004, 379). The Sexual Sterilization Act stipulated that the Eugenics Board would have a total of four members. Notably, two members were to be physicians. For over forty years, there were only two chairs (one of whom was a physician, Dr R.K. Thompson), which meant that no more than nineteen other individuals served as members for the three remaining positions, with most being professionals, including medical doctors, psychiatrists, and social workers (366). The minimal turnover of members, with a legislated preponderance of physicians (predominantly white men), ensured that an elite and cohesive group wielded almost total control over the fate of those brought before the provincial Eugenics Board for decades.

At the institutional level, physicians were usually responsible for “presenting” individuals from the different “feeder” establishments in front of the Eugenics Board to undergo sterilization (Grekul et al. 2004, 366). For example, Dr Leonard Jan Le Vann, the medical superintendent of P.T.S., was a particularly zealous and unscrupulous proponent of eugenic sterilization. He

identified himself as a psychiatrist but had reportedly never been fully accredited (Ha 2016). The overwhelming majority of individuals who were presented to the Eugenics Board from the P.T.S. (where Leilani O'Malley had been admitted) were diagnosed as “mentally defective” under his leadership. This meant that neither the individual being presented for sterilization nor a relative had to provide consent for the sterilization procedure, which virtually eliminated any chance that the procedure could be delayed (Grekul et al. 2004, 370). It is worth noting that Le Vann published research articles after using institutionalized children “as guinea pigs for experiments with powerful antipsychotic drugs ... without obtaining consent from parents or guardians” (Wahlsten 2003, 329). It should, therefore, come as no surprise that the minutes from a Eugenics Board meeting in February 1951 noted that Le Vann went so far as to propose that even young children should be presented for sterilization. The Eugenics Board, which we'll recall never said no, stayed true to form and ruled that P.T.S. could present these children for sterilization, but only when they reached adolescence (Grekul et al. 2004, 370). In 1955, records indicate that the Eugenics Board discussed a new admission form developed by P.T.S. that asked parents to provide consent for sterilization upon admission, even if their child didn't fall under the jurisdiction of the Sexual Sterilization Act (370). Given that Le Vann remained in his position for the better part of a quarter of a century, hundreds of children were impacted by his practices, disproportionately so in the case of Indigenous girls and young women.

Archived material allows for a more in-depth exploration of the situation in Alberta, but Indigenous children underwent sterilization procedures in other parts of Canada as well. For example, in British Columbia, sterilizations were performed on minors institutionalized at Woodlands, a facility whose mandate was to house disabled children, those abandoned at birth, and wards of the state, including Indigenous children (Stote 2015, 53, 103). Emboldened by the sterilization legislation that was successfully passed in Alberta and in many American states, campaigns in favour of sterilization began to gain ground in Ontario in the late 1920s (McConnachie 1987, 214). The full extent to which Indigenous Peoples were impacted by sterilization is unknown. However, we can surmise that Indigenous children, girls in particular, were targeted much like they were in Alberta. In Ontario, as early as 1928, when being classified as “mentally unfit” was often a prerequisite to

sterilization, researchers suggested that “Indian children suffered from a greater level of retardation than whites and that IQ seemed to rise with the admixture of white blood” (Stote 2015, 55). The Simcoe County Council passed a resolution “calling for all children in provincial institutions for the mentally handicapped to be sterilized, then discharged” (McConnachie 1987, 214). A subcommittee of the 1936 annual Convention of Ontario Mayors endorsed a resolution calling for “the compulsory predischarge sterilization of all feeble-minded in institutions” (McConnachie 1987, 214–15; see also Stote 2015, 54). As historian Kathleen McConnachie explained in her 1987 doctoral dissertation, even though the Convention ultimately rejected the resolution, “the degree to which it entered public debate, indicated its growing acceptance as the economic burdens of the Depression grew worse” (McConnachie 1987, 215). Meanwhile, across the country, Indigenous children may have been sterilized while they were institutionalized in residential schools (Stote 2015, 78). The TRC has confirmed that cases of coerced and forced sterilization were brought to its attention, generally in situations where child welfare caseworkers or social workers were involved (Kirkup 2018c).

Modern-Day Forced Sterilization and Coercive Contraception

Even though there was no longer any Canadian jurisdiction that had sterilization legislation by the early 1970s, this didn’t mean that sterilizations weren’t occurring. In April 1973, a CBC public affairs program reported that “Inuit women were sterilized without their consent in the North and while at the Charles Camsell Hospital, and it discussed the linguistic barriers and climate of paternalism that led women to be sterilized ‘for their own good.’” Perhaps for the first time, it “also featured charges that some Inuit children were separated from their families, sometimes never to be seen again after being sent to southern hospitals for medical treatment” (Stote 2015, 71). A few years later, Catholic missionary Robert Lechat charged that Inuit women (and men) in current-day Nunavut were being pressured to undergo sterilization procedures. In Igloolik (where the skin graft experiments occurred around the same time), over a quarter of the women of child-bearing age had been sterilized (Lechat 1976, 5). Inuit women publicly declared that “if we had known exactly what the operation we were made to undergo meant, we would never have accepted it,” prompting Lechat to term such cases “an

extorted consent” (6). Although the Canadian government repeatedly denied any official directive, Lechat demanded to know the “reasoning behind the Canadian government’s intensification of its sterilization policy among the Inuit” (5). Information about these procedures was revealed in a formal parliamentary inquiry stemming from Lechat’s demands and a similar request from the National Indian Brotherhood (Stote 2015, 80). It became clear that even if openly eugenicist ideology no longer framed the public debate as it did in the interwar period, coerced and forced sterilizations had continued through to the late 1960s and early 1970s. From 1971 to 1974, “at least 580 sterilizations were performed at Indian Health Services hospitals” spread across the country, including the Charles Camsell Indian Hospital and Inuvik General Hospital; Indigenous women made up 95 per cent of those sterilized (Stote 2015, 80). Although there was suspicion that numbers were being underreported by health and government authorities, the information obtained, nonetheless, suggested that almost 350 Indigenous (mostly Inuit) women had been sterilized in “Northern Zones” between 1970 and 1975 (83–7). The initial CBC story suggested that “there was a calculated attempt to reduce the birth rate of Indian peoples in northern Canada” (Stote 2015, 71). Lechat suspected that the federal government’s motivation was its interest in keeping a low Inuit birth rate given the risk a larger population would pose to its finances and its access to the natural resources on those lands (Lechat 1976, 7). Of course, the government maintained throughout that there was no formal sterilization policy. However, as Stote asks, when “do we begin to consider consistent and longstanding practices not as isolated instances of abuse but as policy, whether explicitly and openly stated or not?” (Stote 2015, 91).

When eugenically motivated invasive surgical procedures done *en masse* without proper consent had started falling out of favour, recently developed pharmacological options became more viable to produce the same effect of preventing Indigenous births. As early as 1964, oral contraceptives (Enovid and Ortho-Novum) were distributed in large numbers by both nurses and physicians at various clinics, dispensaries, nursing stations, and hospitals that were mandated to provide care to Indigenous communities. Soon thereafter, the distribution of oral contraceptive pills would be carried out by physicians only (Stote 2015, 63). However, the use of contraceptives for birth control purposes was illegal in Canada until 1969 (65, 67).

Attempts to get the federal government to intervene to end such practices were unsuccessful. For example, Kahn-Tineta Horn, from the Kanien'kehá:ka community of Kahnawà:ke (near Montreal), was informed that one of the physicians mandated to serve her community had been told "to issue birth control pills, contraceptives and other means of birth control to Indians that he takes care of, but not to the Roman Catholic French Canadians who are in his practice." She conveyed this in a letter sent to the director of the Indian Affairs Branch of Indian and Northern Affairs in January 1966, asking whether the doctors providing care to her community are treating them "the same or differently from their other [non-Indigenous] patients" (Stote 2015, 64). Dr Harry A. Proctor, who had served as long-time assistant to Dr Percy E. Moore and had succeeded him in the role of director of IHS* (Lux 2016, 245n25), responded by pleading ignorance about any such practice and denied any governmental responsibility (Stote 2015, 64–5).

However, just a few months prior, in August 1965, Proctor had solicited the input of his zone superintendents from across Canada to determine "whether the size of the required prototype [Indian] home could be reduced if birth control techniques were actively advocated among the Indian population" (Stote 2015, 60). According to Stote (2015), the responses made it "clear that prior to the legalization of birth control for contraceptive purposes, it was considered viable to promote their use in Indigenous communities and these were prescribed with the express intent of limiting the number of births within the group" (60). For instance, the zone superintendent from the Atlantic Zone initially cautioned about the routine use of oral contraceptives because they had not yet proven safe for birth control purposes. However, he went on to write how children could be targeted: "Obviously, with the high illegitimacy rate amongst our Indians, to exert sufficient control over the sizes of families, it would be necessary to feed the pills to a very large percentage of the single females, even those in the 14 and 15 year old category" (60–1).

Despite knowing that coercive prescribing was occurring, which had possibly even been encouraged through communication initiatives like Proctor's,

* In 1962, the IHS, which had become Indian and Northern Health Services in the mid-1950s (Grygier 1994, 81), merged with other federal programs to become the Medical Services Branch. It was renamed the First Nations and Inuit Health Branch in 2000 (Bonesteel 2006, 73).

the federal government denied that prescribing birth control to Indigenous communities was an official policy (Stote 2015, 66–7). Yet, a memorandum written by John Munro, minister of National Health and Welfare, months before the legalization of birth control in Canada openly recognized that “our policy for our lay dispensers now is that they will try to prescribe and persuade, but that they don’t encourage any public education or information campaigns” (68). Munro’s memo to his deputy minister, Dr J.N. Crawford, begins by referring to the “genocide question,” intimating that a formal policy openly targeting Indigenous communities would be risky. The issue was obviously on their radar. His solution was to unduly influence Indigenous women, once contraceptives for birth control became legal, through public education campaigns that were ostensibly directed at the general Canadian population. As Stote clarifies, once legalized, “the sale and advertisement of contraceptives would increase the effectiveness of efforts to reduce the size of the Indian population while allowing government to avoid criticisms that federal policy was genocidal in its application” (68).

In September 1970, the year following the legalization of contraception for birth control in Canada, the federal government announced a formal program framed around “the right of Canadians to exercise free individual choice in the practice of family planning” (Stote 2015, 68). Women’s control over contraceptive methods was an important demand for some feminist movements at the time. However, it is worth noting that the mainstream feminist movement of the early twentieth century had “created a space for itself as a colonial agent by reinforcing sexist and racist notions of womanhood” through its participation in capitalism and “in the colonization of Aboriginal peoples and their lands in ways that also made the sterilization of Aboriginal women more likely to occur” (27). As such, “family planning” for Indigenous communities was a de-historicized and de-politicized euphemism for governmental birth control initiatives that targeted Indigenous women. In October 1971, Dr J.H. Wiebe, director of the Medical Services Branch, sent a letter to regional directors advising them that birth control initiatives would be expanded in Indigenous communities where “abnormally high birth rates” were deemed to be an issue (69). Some of the goals of these initiatives included reducing the incidence of “unwanted children,” “child neglect and abuse,” and “child abandonment or desertion” (69–70).

In correspondence with Dr Maurice Leclair, the deputy minister of National Health and Welfare, Wiebe had written that he was “acutely aware” of the charges of genocide levied by Indigenous Peoples. This awareness may have been informed by Harold Cardinal, of the Sucker Creek Cree First Nation, who famously described Canada’s 1969 White Paper as a “thinly disguised programme of extermination through assimilation,” which offered “nothing better than cultural genocide” (Cardinal 1999, 1). Contraceptive devices and drugs were, therefore, framed as being relegated to the individual doctor-patient relationship (Stote 2015, 69). As Stote points out, the new government program not only “now made it more difficult to intervene in coercive practices in Aboriginal communities,” but it “also allowed the federal government to avoid responsibility for these [practices] by hiding behind the rhetoric of individual choice and non-interference due to doctor-patient privilege” (69).

This is instructive because it recognizes how genocidal practices can be carried out without official governmental policies. When such practices have been in place for decades, the ambient culture within the medical establishment can continue to perpetuate them without government endorsement, whether official or implicit. Wiebe’s 1971 letter to regional directors sheds light on this culture. He acknowledged that the matter of “family planning” had been “included in the curricula of departmentally directed courses of instruction, such as those for the indoctrination of health workers” even prior to the legalization of contraception for birth control purposes, but that the Medical Services Branch had had to remain “aloof from active advocacy of family planning in the practice of public health on Indian reserves” at the time due to “provisions of the criminal code and other legislation” (Stote 2015, 69).

In other words, at a time when the government was not able to launch public education and information campaigns about contraceptives for birth control purposes in the general population because such use was illegal, its own Indigenous health care department was promoting the indoctrination of physicians and other health care providers on this matter through curricula that it had developed. For generations of physicians dealing with Indigenous Peoples, it is reasonable to speculate that even long after such courses of instruction had ceased, the hidden curriculum would continue

to ensure the transmission of ideologies that sought to justify the coerced and forced sterilization in Indigenous communities, particularly of girls and women. Indeed, far from being a relic of a bygone era, echoes of this practice continue to be heard to the present day.

In 2015, news broke of several courageous Indigenous women who spoke out about having been coerced or forced to undergo tubal ligation surgery immediately after childbirth in Saskatoon since the 1970s. Other women have subsequently come forward, including some who had been forcibly sterilized as minors. Storyteller, social activist, and author Morningstar Mercredi, originally from Fort Chipewyan (in Alberta), was inspired by these women to go public about her own experience. In the 1970s, Mercredi slipped on ice in Saskatoon while pregnant and had some bleeding. She went to the hospital and was told that she required surgery. When she woke up, the doctors had performed an abortion and she was informed that her chances of becoming pregnant were now less than that of most women. “How in God’s name could that be when I was just a child?” Mercredi questioned in an interview. She was fourteen years old at the time. Mercredi would later learn that she had undergone surgery to remove an ovary and a fallopian tube. She has stated how only now, when she is well into her adulthood, does she feel strong enough to fight for her childhood self who had to go through such a traumatizing experience all alone (Kirkup 2018b). She is certainly not the only teenager who has had to deal with being coercively or forcibly sterilized in recent decades.

In 2017, an external review conducted by two Métis women – Yvonne Boyer (a lawyer with a background in nursing) and Dr Judith Bartlett (a physician and researcher) – highlighted the experiences of seven women who underwent such procedures in public health care institutions in Saskatchewan. Overarching themes outlined in the report included that women felt profiled, coerced, and powerless (Boyer and Bartlett 2017, 17–21). Intimating cultural factors within the medical establishment, Dr Alike Lafontaine, former president of the Indigenous Physicians Association of Canada, aptly observed around this time that “these forced tubal ligations would have never happened if these individuals had been treated like people instead of caricatures” (Kirkup 2017). The release of the report by Boyer and Bartlett, which also addressed the presence of anti-Indigenous systemic racism,

prompted the Saskatoon Health Region (since amalgamated into the Saskatchewan Health Authority) to issue an apology (Hamilton and Quenneville, 2017).

That same year, a class-action lawsuit was filed by two Indigenous women against physicians, health authorities, the government of Saskatchewan, and the government of Canada for coerced and forced sterilizations in 2001 and 2008 (Kassam 2017). In an interview from 2018, Boyer commented that if “it’s happened in Saskatoon, it has happened in Regina, it’s happened in Winnipeg, it’s happened where there’s a high population of Indigenous women” (Moran 2018). Indeed, in a May 2019 letter to the UN Special Rapporteur on Violence against Women, Alisa Lombard, a lawyer leading the lawsuit, confirmed that her firm had been contacted by dozens of Indigenous women across Canada, bringing the total for claims of unwanted sterilization procedures to over a hundred, including one woman who reported being forcibly sterilized as recently as December 2018 (Lombard 2019, 2).

In late 2018, along with Amnesty International Canada, the Maurice Law firm raised the issue with the UN Committee Against Torture, highlighting how the “modern-day forced sterilization of Indigenous women” was occurring in “publicly funded and administered hospitals in Canada” (Kirkup 2018a). The Committee recognized that “forced or coerced sterilization of Indigenous women *and girls* dating back to the 1970s and including recent cases” is a form of torture (UN CAT 2018, 12; emphasis added). In January 2019, the Inter-American Commission on Human Rights (IACHR) issued a press release confirming that it had “received, in a consistent and systematic manner, reports from indigenous women, girls and adolescents who claim to have been subjected to sterilizations without their full, free and informed consent in Canada.” In the release, the president of the IACHR and Rapporteur on the Rights of Women stated in no uncertain terms that deciding if or when “to have children is a fundamental right that was taken away from them without their consent, as a result of misogynistic and racist stereotypes. This form of gender-based violence must immediately stop and the State must take all of the necessary measures for doing so.” Importantly, the IACHR also called for “adequate reparations” (IACHR 2019).

Government Responses and Legislated Violence Against Indigenous Women

Niki Ashton, member of parliament for the federal electoral district of Churchill-Keewatinook Aski (Manitoba), raised the issue of forced sterilizations of Indigenous women in the House of Commons (Kirkup 2018c). She affirmed that “this is what genocide looks like,” and reminded the government that the United National Committee Against Torture “also demanded an explanation for the lack of reparations and sanctions” (Ashton 2018). In his response, Prime Minister Justin Trudeau didn’t address the issue that such practice is genocidal, but did recognize that Indigenous Peoples “can face systemic barriers in accessing services, including discrimination and racism” and committed to working “with partners to ensure [that] all indigenous peoples have access to culturally safe health services, no matter where they live in Canada” (Trudeau 2018).

The federal government subsequently invited all provinces and territories to form a working group that would examine the issue of Indigenous women being sterilized against their will across the country. In February 2019, the Coalition Avenir Québec government dismissed the invitation to the working group. It claimed that health is a provincial issue and that it was already having talks with various Indigenous communities in Quebec about the matter (CP 2019a). However, this narrative was disputed in an open letter drafted by Suzy Basile of the Atikamekw Nation and professor at the School of Indigenous Studies at Université du Québec en Abitibi-Témiscamingue; the letter was signed by several Indigenous activists and leaders, including Ellen Gabriel (past president of Quebec Native Women), Viviane Michel (current president of Quebec Native Women), and Marjolaine Sioui (executive director of the First Nations of Quebec and Labrador Health and Social Services Commission). The letter clarified that Indigenous health still falls under federal jurisdiction and exposed that the provincial government had “not yet initiated any formal dialogue on the subject.” They denounced the provincial government’s refusal to participate in the working group as perpetuating a “colonial attitude” that further entrenches “the silence and denial it has shown on all too many First Nations and Inuit issues in Quebec.” At the time that they wrote the letter, they could not “determine with certainty whether or not there have been forced sterilizations of First Nations

and Inuit women in Quebec,” but they went on to clarify that the information available to them suggested that such practices had very likely occurred at different times in Quebec history (Basile et al. 2019). Media articles in 2019 seem to confirm this (Hoye 2019). It’s only a matter of time before the public learns about such instances of coerced and forced sterilizations in Quebec targeting Indigenous women and girls, the circumstances in which they occurred, and how pervasive they were. Similar to the rest of Canada, the question is not whether such practices have occurred, but to what extent they continue.

Beverly Jacobs, a Kanien’kehá:ka lawyer and professor from Six Nations, argues that the reality of violence against Indigenous women must be placed “in the larger context of Canada’s colonial relationship to Indigenous peoples” (Jacobs 2017, 49). She explains that foundational violence occurred when Canada’s colonial government “violated peace and friendship treaties, which were based on nation-to-nation relationships, by unilaterally establishing its government through legislation in which it had control over ‘Indians and lands reserved for Indians’ (section 91(24) of *British North America Act*, 1867).” This legislation then gave the government “authority to establish the most racist and sexist piece of legislation called the *Indian Act*” (Jacobs 2017, 49–50). The patriarchal Indian Act had far-reaching consequences on Indigenous women’s identity, belonging, and roles in the family and traditional governance structures (50).

This context of hostility and violence against Indigenous women is important as it has allowed the persistence of a medical culture that treats Indigenous women and their bodies with contempt (MMIWG 2019c, 102–3; Vang et al. 2018, 1867–8). This explains, at least in part, why the issue of coerced and forced sterilization targeting Indigenous women and girls has continued years after formal eugenic legislation was ended.