

Combating Physician-Assisted Genocide and White Supremacy in Healthcare through Anti-Oppressive Pedagogies in Canadian Medical Schools to Prevent the Coercive and Forced Sterilization of Indigenous Women

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Abstract: Coercive and forced sterilization of Indigenous Peoples are acts of genocide that are rooted in colonialism and white supremacy and require fundamental changes to undergraduate medical education. I (Erika Campbell) draw upon the Truth and Reconciliation Commission of Canada’s 24th Call to Action, which calls for “skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism” in medical schools. Additionally, I draw upon Call for Justice 7.6 from the Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girl, which calls upon institutions and health service providers be educated in areas including, but not limited to: the history of colonialism in the oppression and genocide of Inuit, Métis, and First Nations Peoples; anti-bias and anti-racism; local language and culture; and local health and healing practice. I analyzed the responses of all 17 undergraduate medical programs in Canada to determine how they incorporated anti-racism within their medical education to meet the Calls to Action and Justice. All undergraduate medical programs include some form of cultural learning, which I argue does not directly challenge racism and colonialism. As such, I advocate for the implementation of anti-oppressive pedagogies within curricula to facilitate the unlearning of colonial rhetoric. I further argue the implementation of anti-oppressive pedagogies within education will contribute to the eradication of the ongoing genocide of Indigenous Peoples and white supremacy within our healthcare systems.

Key words: Coercive and Forced Sterilization, Indigenous Women, Undergraduate Medical Education, Anti-Oppressive Pedagogies, Genocide

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Introduction

The coercive and forced sterilization of Indigenous Women by those working within the Canadian healthcare system was a eugenics intervention rooted in white supremacy, which perpetuated the ongoing genocide of Indigenous Peoples. Eugenics was developed as the science of controlled breeding within humans to yield a population with desired inherited traits (Harris-Zsovan, 2010). As a tool of selective breeding, eugenics was employed to advance fertility amongst those deemed *fit* and prevent fertility amongst *unfit* people. Coined by Francis Galton in 1883, the science of eugenics was built on a Eurocentric hierarchy of race that positioned Northern European/Anglo Saxon white people as most desirable and Indigenous Peoples and Black People as most inferior (Harris-Zsovan, 2010; Stote, 2015). Eugenics was further leverage by white people as scientific justification for enacting Eurocentric policies that permitted European imperialisms and colonization to build a white settler state in Canada and other colonial states. Therefore, eugenics was based in white supremacy, which was produced and enacted through targeted violence of racialized structures to uphold whiteness in settler societies (Bonds & Inwood, 2016). Eugenics was a construct of white supremacy because it functioned to maintain white power by promoting fertility amongst white people while preventing the fertility of racialized populations, a process that is recognized as genocide.

Below, I (Erika Campbell) have outlined the historical and contemporary involvement of Canadian physicians in genocide through the coercive and forced sterilization of Indigenous Women. I advocated for the implementation of Indigenous content through anti-oppressive pedagogies within undergraduate medical education as a means to combat the ongoing genocide of Indigenous Peoples by those physicians trained and licensed in Canada.

***Note:** This research project was a collaboration between Erika Campbell, a white settler scholar, and Dr. Karen Lawford, an Indigenous scholar from Lac Seul First Nation. The research presented in this article was compiled from the project Erika undertook during her master's degree in Gender Studies at Queen's University

while under the supervision of Karen. The article is written in the first person to foreground the important scholarly contributions of graduate students.

Literature Review

Indigenous Women were disproportionality targeted for sterilization in comparison to other identity groups (Stote, 2015). The bias of coercive and forced sterilization of Indigenous Women through eugenics policies and practices across Canada was known to and supported by the federal government (Stote, 2015). Sterilization took place in provinces like Alberta and British Columbia, which had each established a *Sexual Sterilization Act*, and in provinces like Saskatchewan, Manitoba, Ontario, and Quebec, which were without sterilization legislation. In fact, the federal department, Indian Health Services, was aware that Indigenous Women were being sterilized by physicians without proper legal channels of consent (Harris- Zsovan, 2010; McLaren, 1990; Stote, 2015). This awareness, however, did not result in any change to the practice.

In Canada, there was no policy that legalized the specific sterilization of Indigenous Peoples; however, *the Indian Act* and resulting colonial health policies that criminalized Indigenous Midwives in the late 1800s with additional legislation barring their practices in 1914 (Stote, 2015). As well as, the Indian Act denied Indigenous Peoples access to their lands and medicines, segregated care through Indian Hospitals, and evacuated Indigenous women to southern settler-run healthcare intuitions, which further allowed physicians to target Indigenous Women for sterilization (Lux, 2016; Stote, 2015). Physicians diagnosed Indigenous Women as *mentally defective* based on low Intelligent Quotient (IQ) scores and other psychometric evaluations that we developed and thus favoured European epistemologies, so that sterilizations could occur without consent (Stote, 2015). In fact, IQ tests became the primary method to diagnosing mental defectiveness because this tool was thought to establish a required level of scientific merit to the diagnosis (Stote, 2015).

Under the *Sexual Sterilization Act*, "records indicate that patients whom the [Eugenics] Board wished to sterilize were often subject to more than one test in hopes that their score would fall within the criteria for mental

deficiency” (Stote, 2015, p. 47). The designation of mental deficiency was used in an ableist, racist fashion by physicians and the state to justify a patient’s sterilization. Lower scores within non-Anglo-Saxon racial and ethnic groups were a result of language and cultural barriers present within IQ tests (Harris-Zsovan, 2010). However, language and cultural biases of the IQ test were not considered by eugenicists, physicians, and the state, therefore low IQ scores amongst Indigenous Women supported the racist prejudices about the inferiority of Indigenous Peoples held by white settlers (Harris-Zsovan, 2010). For example, in Alberta, “77 percent of Indigenous patients presented to the Eugenics Board were diagnosed as a mentally defective, as compared to 46 percent of Western Europeans and 44 percent of Eastern Europeans” (Stote, 2015, p. 47). The overrepresentation of Indigenous Peoples deemed mentally defective, which ensured their sterilization, demonstrated the active engagement of physicians in the colonial agenda to prevent the growth of Indigenous communities.

Despite knowing of the coercive and forced sterilization of Indigenous Women by physicians, the Government of Canada and many provincial governments did not take preventative action to stop the practice, thus demonstrating their complicity and support. By purposefully preventing the births of Indigenous Peoples through the application of eugenics, physicians along with the support of federal and provincial governments committed an act of genocide towards Indigenous Peoples.

Physician assisted genocide through the coercive and forced sterilization of Indigenous Women was in violation of an international convention. From campaigning for sterilization policies to performing procedures coercively or without patient’s knowledge, many members of the Canadian medical community broke article II, section (d) of the United Nations (UN) *Convention of the Prevention and Punishment of the Crime of Genocide* passed enacted in 1951 (Stote, 2015). The *Convention* defined genocide in relation to the following acts committed to destroy part or whole national, ethnic, racial, or religious groups:

- a) Killing members of the group;
- b) Causing serious bodily or mental harm to members of the group;
- c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
- d) Imposing measures to prevent birth within the group; and
- e) Forcibly transferring children from one group to another (UN General Assembly, 1951).

Under international law, carrying out any of these acts towards a group of people constitutes genocide. It is obvious through the cases of coercive and forced sterilization of Indigenous Women that Canada has indeed committed this heinous crime. Through sterilization, physicians aided Canada in upholding a colonial agenda and contributed to the building of a white settler state. However, it is important to note that section (d) was not the only violation of the *Convention* within Canada: the Sixties Scoop and the Indian Residential School System violated section (e). Indian Hospitals violated sections (b) and (c) and the ongoing cases of missing and murdered Indigenous Women, Girls, and 2SLGBTQQA+ (MMIWG2S+) violates section (a). Genocide of Indigenous Peoples has a long history within Canada that continues to be a reality in present-day society (Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019).

Canada has adopted legislation in accordance with the *Convention* that references genocide as the physical destruction of a group of people. Canada, however, chose to not apply the term genocide to the cases of coercive and forced sterilization of Indigenous Women (Stote, 2015). According to the Federal Government rationale, the fact that Indigenous Peoples are still here and are increasing in numbers, genocide could not have been committed. Regardless, physicians and state legislation purposefully prevented births within Indigenous communities by sterilizing Indigenous Women more so than any other identity group in Canada to maintain and grow a white settler state. It is vital to

make note that at the international level, “coercive sterilization is a mark of settler colonialism and is recognized by the UN as a human rights violation, a form of discrimination, and violence against women” (Viridi, 2018). The continued over-representation and targeting of Indigenous Women for sterilization through coercive methods by physicians thus demonstrated an act of genocide because the practice prevents the births of Indigenous Peoples.

Unfortunately, Canada’s eugenics history is not that distant. The *Sexual Sterilization Act* was enacted in 1928 in Alberta and 1933 in British Columbia and were repealed in 1972 and 1973, respectively. The practice of coercive and forced sterilization of Indigenous Women has continued across Canada because of physician practice despite the Acts being repealed. A proposed class-action lawsuit involving more than 100 Indigenous Women who have been coerced into sterilization was announced in 2019 (Zingel, 2019). Cases that spanned from 1985 to 2018 demonstrated that coercive sterilization of Indigenous Women by Canadian doctors demonstrated an ongoing healthcare practice (Barrera 2019; Rao, 2019; Viridi, 2018; Zingel, 2019). Coerced and forced sterilization have occurred across Canada, with 2 allegations in Quebec, 4 from Ontario, 12 from Manitoba, 64 from Saskatchewan, 10 from Alberta, 5 from British Columbia, and 1 from the North West Territories (Barrera, 2019; Boyer & Bartlett, 2017; Rao, 2019; Virid, 2018; Zingel, 2019).

In an external review of the cases of coercive sterilization in Saskatoon Health Region, Boyer and Bartlett (2017) reported that First Nations and Métis Women were profiled and discriminated against by healthcare professionals who promoted sterilization as the responsible option to control births. In their work, *Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Indigenous Women*, Boyer and Bartlett (2017) recounted how women were told the procedure was reversible, which was untrue. Some women actively resisted sterilization by refusing to consent to the procedure, but physicians went ahead with the sterilization. Indigenous Women felt powerlessness and experienced racism and targeted genocide from physicians, nurses, and social workers, who in many

cases were providing care for them during labour and delivery.

The Boyer and Bartlett (2017) review called for education in medical schools to ensure medical practitioners understood the people they serve. Their recommendation, along with the 24th Call to Action of the *Truth and Reconciliation Commission of Canada* (TRC, 2015) demonstrated a formal request for physicians to un-learn colonialism and anti-Indigenous racism during their medical training. The 24th Call to Action of the TRC (2015) stated:

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Indigenous health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Indigenous rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (p. 3).

To further support the Calls to Action of the TRC, Call to Justice 7.6 of the *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (2019), stated:

We call upon institutions and health service providers to ensure that all persons involved in the provision of health services to Indigenous Peoples receive ongoing training, education, and awareness in areas including, but not limited to:

- the history of colonialism in the oppression and genocide of Inuit, Métis, and First Nations Peoples;
- anti-bias and anti-racism;
- local language and culture; and
- local health and healing practices (p. 75).

The recommendations made within the *Report* (2019) on Missing and Murdered Indigenous Women and Girls explicitly examined state violence towards Indigenous Women, Girls and 2SLGBTQQIA+ Peoples and recognized that forced and coerced sterilization not only contributed the dehumanization of Indigenous Women, Girls and 2SLGBTQQIA+ peoples, but was an act of genocide. The Calls to Justice from the *Report* contained

an explicit connection to the coercive and forced sterilization of Indigenous Peoples. To understand how to interrupt the contemporary practice of coercive and forced sterilization of Indigenous Peoples, my research analyzed the curriculums of all Canada's 17 medical schools that aimed to counter racism as a product of colonialism within Canada that informs medical practices, which contributed to the ongoing genocide of Indigenous Peoples through coercive and forced sterilization. Based on the TRC Calls to Action, I have advocated for the implementation of anti-oppressive pedagogies in undergraduate medical education as a meaningful approach to counter white supremacy within the Canadian healthcare system.

Background
Situating Anti-oppressive Pedagogies in Undergraduate Medical Education

The TRC (2015) demands that medical schools incorporate courses to build intercultural competency, conflict-resolutions, human rights, and anti-racism, which can be understood as anti-oppressive pedagogies through the education of students on Indigenous health issues, Indian Residential Schools, the *United Nation Declaration on the Rights of Indigenous Peoples*, Treaties, Indigenous rights, and Indigenous teachings and practices, which will be referred to as Indigenous content requirements in the remainder of the manuscript. Additionally, the Calls to Justice of the *Reclaiming Power and Place* (2019) require education on colonization, oppression and genocide of Inuit, Métis, and First Nations Peoples, anti-bias, anti-racism, language and culture, and health and health practices. I leveraged the Calls to Action and Justice to insist on anti-oppressive pedagogies in undergraduate medical education, because this pedagogical approach encapsulated the core elements of the recommendations raised by the TRC and *Reclaiming Power and Place* to prevent forced sterilization of Indigenous Women by physicians.

Anti-oppressive pedagogies have acknowledged culture, race, class, religion, gender, ability, sexuality, and other factors that contribute to bias (Gaudry & Lorenz, 2019). Anti-oppressive pedagogies can be understood as a praxis of anti-oppression theory (Baines, 2011). Anti-

oppressive theory was developed based on the work of Paulo Freire (2018) in *Pedagogy of the Oppressed*, wherein he argued that people must not see the reality of oppression as fixed, but as one that can be altered to achieve liberation. Freire (2018) explained that one of greatest obstacles to combating oppression and achieving liberation was the lack of recognition of oppression. The consciousness of the oppressor or oppressed was described as being submerged within oppression, meaning that oppression was combatted by raising the consciousness—that is, the existence—of oppression to inspire action and reflection aimed at combating oppression for the achievement of liberation (2018). Anti-oppression theory thus was examined alongside the intersecting and multiplicity of oppressions with the intention to combat oppression (Moosa-Mitha, 2015). Instead of focusing on one form of activism, education, and opposition, anti-oppressive praxis was designed as an umbrella term for social justice-oriented approaches like cultural safety, anti-colonialism, and anti-racism (Baines, 2011). Anti-oppressive praxis, as explained by Baines (2011), must undergo a constant process of redefinition and refinement to address emerging tensions and social problems. Anti-oppressive practices, thus, relate both to macro- and micro-social relationships by focusing on individual interactions that are formed by, with, and alongside social structures.

Anti-oppressive pedagogies have also been recommended by Métis scholar, Adam Gaudry and white settler scholar, Danielle E. Lorenz, to implement Indigenous content requirements into post-secondary education because “when courses are rooted in anti-oppressive theory, they examine the ways that oppression manifests while also working to transform curricula, pedagogies, and politics to produce change” (2019, p. 167). By engaging with medical students, educators, and licensed physicians through anti-oppressive pedagogies to implement Indigenous content requirements, the ending of coercive sterilization of Indigenous Women can be realized. By identifying the mechanisms of oppression and transformation, health practices can be transformed.

Several stakeholder organizations have worked to implement medical education on the topic of Indigenous health and other Indigenous content requirements. The

National Indian & Inuit Community Health Representative Organization (NIICHO) began the *Road to Competency* project in 2006 with the aim of developing Indigenous cultural and cultural safety competencies for healthcare providers and healthcare professional students (Baba, 2013). In 2008, the National Aboriginal Health Organization (NAHO) published a guide on culturally safe healthcare with recommendations to improve cultural safety in education programs (Baba, 2013). The Association of Faculties of Medicine of Canada (AFMC) and the Indigenous Physicians Association of Canada (IPAC) collaborated in 2009 to develop core competencies for undergraduate medical education in Indigenous health centered on cultural safety (Baba 2013). These competencies outlined “the physician’s role in Indigenous health care as a medical expert, communicator, collaborator, manager, health advocate, scholar and professional” (Baba, 2013, p.11).

Four years later, a 2013 review of undergraduate medical programs with cultural safety-related curriculums was conducted. It was found that many medical schools took steps to increase Indigenous student representation by offering supplementary application processes and designated spots for Aboriginal students (Baba, 2013). These initiatives increased enrollment of students who self-identified as First Nations, Métis, and Inuit (2013). Furthermore, some schools offered elective courses on Indigenous health and elective clerkships in Indigenous communities; However, the Northern Ontario School of Medicine was the only medical school that took steps to embed Indigenous health within the curriculum for all students (2013). While increasing the number of Indigenous students in medical schools was a promising initiative, most of the applicants were white-settler students (Friesen, 2019). The advantages of white settler students was noted by the University of Manitoba, which revealed a pattern in their admissions process:

wealthy white students from big cities were more likely to be interviewed and more likely to get in, partly because of built-in advantages. As undergrads they don’t have to work part-time to pay for school, they’re able to pay for MCAT prep courses and, in interviews, they can cite an

impressive range of travel and volunteer experiences (Friesen, 2019).

The white majority amongst medical student applicants demonstrated the systematic advantage embedded within the Euro-Canadian biomedical model that privileges white people as medical practitioners. Additionally, Eurocentric policies and practices that have constructed the Euro-Canadian biomedical model privileged whiteness while simultaneously targeting Indigenous Peoples and other racialized peoples via genocidal healthcare practices.

Within settler institutions, like medical schools, that privileged whiteness and prioritized the healthcare of white people, cultural safety training and increasing Indigenous student representation in medical schools was named as a necessary to decolonize healthcare and provide healthcare to Indigenous communities, but this has proven to be an insufficient strategy. Within the medical community, “work that identifies racism in health care tends to recommend generalized implicit bias and cultural safety training—primarily for health professionals, and most commonly physicians” (McCallum & Perry, 2018, p.13). By focusing solely on Indigenous cultures through cultural safety training, racism was not recognized in healthcare provision, “and in so doing [training programs] implicitly re-center[ed] and privilege[d] whiteness as the normative perspective while failing to address the myriad ways that racism deprives people of opportunity and structures their lives” (McCallum & Perry, 2018, p. 13). By implementing anti-oppressive pedagogies in medical education, anti-Indigenous racism could be properly challenged when whiteness is decentred. The 24th Call to Action of the TRC and Call to Justice 7.6 called for anti-oppressive pedagogies in medical schools to promote cultural safety, anti-Indigenous racism, and other anti-oppressive education through the inclusion of Indigenous content requirements.

Methods

I employed decolonizing methodology to scan literature that advocated for anti-oppressive pedagogies in Canadian medical schools based on the unethical coercive and forced sterilization of Indigenous Women,

a healthcare practice that is entrenched in white supremacy. My research does not include primary research with participants and therefore did not require approval from the Research Ethics Board at Queen's University. However, as a white settler, I reflected on my privilege within Canadian society and the need to continue the process of decolonizing myself as a researcher in order to critique genocide, white supremacy, and colonialism within Canadian healthcare systems.

By basing my research within decolonizing methodologies, I committed to not perpetuating an imperial lens within my research. Research conducted through an imperial lens has sought to:

- (1) allow [settlers] to characterize and *classify* societies into categories,
- (2) condense complex images of other societies through a *system of representation*,
- (3) provide a standard *model of comparison*, and
- (4) provide *criteria of evaluation* against which other societies can be ranked (Smith, 2012, p. 45).

Through imperial research practices, settlers have produced discriminatory and racist knowledge about Indigenous Peoples. In contrast to imperial research practices, I am dedicated to a path of decolonization in order to complete research that shows respect, reciprocity, and responsibility to those affected by genocide (Wilson, 2008).

I employed decolonizing methodology as articulated by Linda Tuhiwai Smith (2012), which was described as being concerned with the claims, values, and practices of institutions of research to provide a structure to analyze imperialism, colonization, and injustice. Decolonization can be used to propose solutions in Indigenous discourses and bring together notions of pre-colonial and colonized times for envisioning Indigenous futures. Thus, I applied decolonizing methodology to draw attention to and critique of white supremacy and colonization within medical education training, which amounted to the genocide of Indigenous Peoples through coercive and forced sterilization (Boyer, 2017; Smith, 2012; Stote, 2015). Decolonizing methodologies

were imperative to my evaluation of the commitment of medical schools to embed anti-oppressive pedagogies within their curriculums to prevent the practice of coercive sterilization and by extension, the ongoing genocide of Indigenous Peoples within Canada's healthcare systems.

Documentary Analysis

I selected literature that described the relationships between Indigenous Peoples and Canadian healthcare systems, and used the search terms: Aboriginal, Indigenous, Canada, healthcare, health system, eugenics, white supremacy, institution, and hospital. To scan literature referencing medical education and the Call to Actions and Justice, outlined above, I selected books and articles through databases using the terms: medical education, cultural safety, intercultural competency, cultural humility, anti-oppression, decolonizing education, and Indigenizing education. I also examined curriculums and course/clerkship options through publicly available documents returned through searches of websites connected to the Association of Faculties of Medicine Canada (AFMC) and the 17 medical schools in Canada. I analyzed the materials provided by these institutions including the 17 medical schools which described implementation or plans to implement the recommendations proposed by Call to Action and Calls to Justice. This literature review was conducted in June of 2020.

Findings

Answering the Call to Action: Curriculum Review of Canadian Undergraduate Medical Education

Healthcare practices within settler institutions were identified as oppressive towards Aboriginal Peoples in the 1996 the *Royal Commission on Aboriginal Peoples* (RCAP) (Jull & Giles, 2012). RCAP advocated for an increase in Aboriginal healthcare providers, and cultural competency and safety training for all healthcare professionals (Butler, Exner-Piro, & Berry, 2018). Two federal commissions, RCAP and the TRC, tasked medical schools in Canada to educate their students on Aboriginal health to make the Canadian healthcare system acceptable to Aboriginal communities.

All licensed physicians educated in Canada attend medical schools accredited by the AFMC in conjunction with the Canadian Medical Association (CMA) through the Committee on Accreditation of Canadian Medical Schools (CACMS) (Baba, 2013). The AFMC has the authority to determine the requirements for accreditation for medical schools, therefore this association has the ability to influence medical schools' implementation of anti-oppressive pedagogies.

The AFMC listed *Indigenous Health* as one of the association's priorities under their social accountability mandate. Specifically, the AFMC stated it works to ensure, "Canadian medical schools respond to the Calls to Action of the Truth and Reconciliation Commission, by training more Indigenous health professionals and by committing to develop safe working and learning environments for Indigenous learners, faculty and staff" (AFMC, 2020). To uphold their social accountability mandate for Indigenous Health, the AFMC released *The Report on Indigenous Health Activities* in April 2017, detailing the work to put "the education and training about Indigenous person's health needs in Canada front and center" (Verma, 2017, p. 1). In 2019, the AFMC released the *Joint Commitment to Action on Indigenous Health* to guide, "Canadian medical schools to respond to the TRC Calls to Action and fulfill their social accountability mandate with respect to Indigenous health" (AFMC, 2020, para. 2). Curriculum was one of the themes the AFMC prioritized to answer the 24th Call to Action of the TRC and it identified that "in order to meet this call, Canadian medical schools are faced with a number of challenges, from developing curricula that address both national and regional Indigenous health issues, to mobilizing resources and overcoming barriers to implement this curricular change" (Anderson et al., 2019, p. 11). The goal of the curriculum outlined by the AFMC was to educate learners about anti-Indigenous racism, cultural competency, cultural safety, and anti-colonialism.

Within the report, the AFMC acknowledged that currently, "concepts that form the core of anti-racist/ anti-colonial pedagogy, such as privilege, systemic power dynamics, Whiteness, settler, and oppression, are not present in the framework" (Anderson et al., 2019, p. 13). The AFMC demanded, through an action statement,

that "medical schools commit to the development and implementation of a longitudinal Indigenous health curriculum with anti-racism/ anti-colonialism as the core pedagogical approaches" (2019, p. 14). With the action statement of AFMC, coupled with Calls to Action and Justice of the TRC and the *Inquiry*, anti-racism, and anti-colonialism, along with culturally focused education must be taught within Canadian medical schools.

Results of Undergraduate Medical Curriculum Scan

My research topic aligned with an action statement made by the AFMC on Indigenous health, which specifically stated that curriculums need to include anti-racism and anti-colonialism as the core of pedagogical framework (Anderson et al., 2019). Out of the 17 medical schools in Canada, anti-racism was not named in any curriculums nor was anti-colonialism, however nine schools (University of Alberta, University of British Columbia, University of Calgary, Université Laval, McGill University, Université de Montréal, Northern Ontario School of Medicine, Université de Sherbrooke, and Dalhousie University) outlined colonialization as a course topic. Therefore, all undergraduate medical programs have demonstrated a need to make curriculum revisions in order to answer the Calls to Action of the TRC. As of June 2019, there was no medical school in Canada that specifically identified anti-racism within their training. A summary of my findings is demonstrated in Table 1.

Table 1. Results of Undergraduate Medical Curriculum Scan

Province	School	Anti- Oppression in Curriculum (2020)
Alberta	University of Alberta – Faculty of Medicine and Dentistry	<p>Elective Course (University of Alberta, 2020a).</p> <ul style="list-style-type: none"> Indigenous Health – Interprofessional Practice: 12- module course in Indigenous Health (University of Alberta, 2020b). Course addresses the history and legacy of Residential School, UNDRIP, Indigenous teachings and practices, and impacts of colonization
	University of Calgary – Cumming School of Medicine	<p>Indigenous Health Dialogue (IHD) (Cumming School of Medicine, 2020).</p> <ul style="list-style-type: none"> Established to enhance existing initiatives, create new opportunities for programming and respond to the TRC’s Calls to Action Oversees sever service, research and educational initiative that will help address some of the most pressing health concerns in Canada <p>Indigenous Health in Medical Education (Cumming School of Medicine, 2020).</p> <ul style="list-style-type: none"> Curriculum reinforces the importance of Indigenous Health Students are taught how to develop care approaches that take a patient’s background experiences, impacts of colonization and personal resilience into account
British Columbia	University of British Columbia – Faculty of Medicine	<p>Indigenous Public Health Training (University of British Columbia, 2020).</p> <ul style="list-style-type: none"> Optional one-week intensive course that equips Indigenous community members and scholars with necessary skills to address public health issues in Indigenous Communities
		<p>UBC 23 24 Indigenous Cultural Safety (University of British Columbia, 2020).</p> <ul style="list-style-type: none"> Required component of 13 UBC health professional programs (including Faculty of Medicine) Students engage in this foundational Indigenous cultural safety learning experience that covers topic of Indigenous perspectives of history, the legacy of colonialism in Canada, Indigenous peoples’ health and Canada’s healthcare system Two online modules and two in-person workshops for a total of 12.5 hours of learning
Manitoba	University of Manitoba – Max Rady College of Medicine	<p>Indigenous Health – Longitudinal Course (University of Manitoba, 2020).</p> <ul style="list-style-type: none"> Spans four years Trains physician who will contribute to the improvements of health outcomes for Manitoba’s First Nations, Métis and Inuit Teaching methods incorporate facilitated dialogue, community engagement and critical self-reflection Undergraduate medical students are guided through content and issues of increasing complexity in the realm of Indigenous health
Newfoundland and Labrador	Memorial University of Newfoundland – Faculty of Medicine	<p>Aboriginal Health Initiative (Memorial University, 2020a).</p> <ul style="list-style-type: none"> Heighted cultural sensitivity of both Aboriginal and non-Aboriginal students on issues of Aboriginal health and health care services <p>Indigenous Health – Phase 1 Course (Memorial University, 2020b).</p> <ul style="list-style-type: none"> 5 hours course on Indigenous Health
Nova Scotia	Dalhousie University – Faculty of Medicine	<p>Indigenous Health Interest Group</p> <ul style="list-style-type: none"> Working group of Indigenous and non-Indigenous students that assists in the development of culturally competent health practitioners and researchers, and helps to fulfill the TRC’s Calls to Action
Ontario	McMaster University – Michael G. DeGroote School of Medicine	<p>Pre-Clinical – Professional Competencies (McMaster University, 2020a).</p> <ul style="list-style-type: none"> Social, cultural and humanistic dimensions of health <p>Elective Clerkship (McMaster University, 2020b).</p> <ul style="list-style-type: none"> Aboriginal Health Elective
	Lakehead University and Laurentian University – Northern Ontario School of Medicine (NOSM)	<p>Curriculum “themes” include Northern & Rural Health and curriculum “threads” include Aboriginal Health (NOSM, 2017)</p> <ul style="list-style-type: none"> Learn about indigenous health in our Case Based Learning, Community Interprofessional Learning placements, and Integrated Community Experience

		<ul style="list-style-type: none"> • Integrated Community Experience: students spend 4 weeks living in Indigenous communities to learn about indigenous culture and history, and to understand some of the health issues facing Indigenous peoples
	Queen's University – School of Medicine	<ul style="list-style-type: none"> • Elective Clerkship in Aboriginal Community (Queen's University, 2019).
	Western University – Schulich School of Medicine and Dentistry	<p>Course Theme: Diversity and Ethnicity (foundations and first application) (Schulich Medicine & Dentistry, 2020).</p> <ul style="list-style-type: none"> • Indigenous Culture and Health (foundations and first application)
	University of Ottawa – Faculty of Medicine	<p>Indigenous Program (uOttawa, 2020).</p> <ul style="list-style-type: none"> • Program strives to increase awareness of Indigenous cultures, health, social issues and traditional knowledge within the MD curriculum. This focus ensures that medical students will practice culturally safe care in serving Indigenous populations
	University of Toronto – Faculty of Medicine	<p>Indigenous Health Elective (IHE) (University of Toronto, 2020).</p> <ul style="list-style-type: none"> • Provides an opportunity for first- and second-year medical students to engage with leaders in the Indigenous community, learn about the health and social challenges faced by Indigenous peoples in Canada, and gain a deeper understanding of Indigenous culture.
Québec	Université Laval – Faculté de Médecine	<p>Quebec First Nations, and Inuit Faculty of Medicines Program: Aboriginal Health Rotation – Objectives:</p> <ul style="list-style-type: none"> • Recognition of the historical context as a determining factor underlying current health inequities • Recognition of the diversity of Aboriginal populations within the country • Understanding of professional-patient power imbalance
	McGill University – Faculty of Medicine	<p>Quebec First Nations, and Inuit Faculty of Medicines Program: Aboriginal Health Rotation – Objectives (QFNIFMP, 2020).</p> <ul style="list-style-type: none"> • Recognition of the historical context as a determining factor underlying current health inequities • Recognition of the diversity of Aboriginal populations within the country • Understanding of professional-patient power imbalance
	Université de Montréal – Faculté de Médecine	<p>Quebec First Nations, and Inuit Faculty of Medicines Program: Aboriginal Health Rotation – Objectives (QFNIFMP, 2020).</p> <ul style="list-style-type: none"> • Recognition of the historical context as a determining factor underlying current health inequities • Recognition of the diversity of Aboriginal populations within the country • Understanding of professional-patient power imbalance
	Université de Sherbrooke – Faculté de Médecine et des Sciences de la Santé	<p>Quebec First Nations, and Inuit Faculty of Medicines Program: Aboriginal Health Rotation – Objectives (QFNIFMP, 2020).</p> <ul style="list-style-type: none"> • Recognition of the historical context as a determining factor underlying current health inequities • Recognition of the diversity of Aboriginal populations within the country • Understanding of professional-patient power imbalance
Saskatchewan	University of Saskatchewan – College of Medicine	<p>Making the Links (University of Saskatchewan, 2020).</p> <ul style="list-style-type: none"> • Making the Links started in 2005 as a unique service-learning experience offered by the College of Medicine. Selected undergraduate medical students experience community health and development in three contexts: <ol style="list-style-type: none"> 1. Urban underserved community at SWITCH (the Student Wellness Initiative Towards Community Health) in Saskatoon 2. Remote communities in northern Saskatchewan (Île-à-la-Crosse, Dillon, Kawacatoose, and Pine House) 3. International communities globally. <p>Indigenous Health Committee (University of Saskatchewan, 2020).</p> <ul style="list-style-type: none"> • The Indigenous Health Committee is comprised of faculty, staff, and community members who are dedicated to Indigenous health. The IHC exists to strengthen culturally-based linkages between Indigenous world views and the medical community. • The committee offers many services to the College of Medicine

Limitations of Results

As of June 2019, medical schools across Canada do not explicitly state anti-racism as theme within the curriculum. I acknowledge that discussion of anti-racism may still take place within these programs. However, to respond to the action statements made by the AFMC, the Calls to Action and Justice, medical schools must outline anti-racism education within curriculums.

Discussion

All undergraduate medical programs across Canada vary in their engagement with anti-racism and anti-colonial education, which can be collectively understood as anti-oppressive pedagogies. While each medical school is implementing some degree of culturally-based programming through courses and/or clerkship opportunities, anti-racism is not specifically addressed in any undergraduate medical curriculum. Instead, many curriculums focus on cultural sensitivity, competency, and safety. Cultural sensitivity can be understood as awareness about ethnic and cultural preferences of an individual in order to explain attitudes and responses of the individual to their environment (Baba, 2013; Carey, 2015; Sekerci & Bicer, 2019; Unver, Uslu, Kocatepe, & Kuguoglu, 2019). Education focusing on cultural competency provides skill-building exercises to increase healthcare providers' understanding of diverse cultures. It also aims to incorporate the needs, values, beliefs, and practices of the client (Baba, 2013; Karnick, 2016; Polster, 2018).

Developed by Māori midwives and nurses in the 1980s, cultural safety addresses power relations between the client and healthcare provider to hold the provider responsible for addressing professional and institution powers that make an environment unsafe for a client (Allan & Smylie, 2015; Baba, 2013). Thus, cultural safety reaches beyond cultural sensitivity and competency to examine power imbalances, institutional discrimination, and colonization within healthcare (Baba, 2013). I must note that while cultural sensitivity, competency, and safety training offer valuable skills to healthcare professionals serving diverse clients, these trainings do not counter the racism and white supremacy that

underpin the systemically embedded poor and unethical healthcare that is provided to Indigenous Peoples that has resulted in the coercive and forced sterilization of Indigenous women.

The Significance of Ant-Racism and Anti-Colonialism in Undergraduate Medical Education

Health disparities are caused by racism and other forms of systemic exclusions and marginalizations, not race. Racism is enacted within the Euro-Canadian biomedical model and creates as a system to privilege the health and wellbeing of white people at the expense of Black People, Indigenous Peoples, and People of Colour. Healthcare systems in Canada utilize racism to inform healthcare policy, practice, and resource allocations.

The coercive and forced sterilization of Indigenous Women enacts eugenics and is guided by racism to continue the building of a settler state in Canada. To be clear, physician assisted genocide of Indigenous Peoples is not something of the past, it is in our present reality of Canada. I further argue the historical and ongoing practice of coercive and forced sterilization of Indigenous Women must be understood not only through a lens of racism and colonialism, but also through ableism, classism, and sexism which falsely positions Indigenous Women as hyper-sexual beings and bad mothers with low IQs (Stote, 2015). These colonial, white supremacist logics and ideologies are fueling each justification of coercive and forced sterilization. Consequently, racism, sexism, ableism, classism, and colonialism function together and shape social determinates of health, health disparities, and access to care for Indigenous Peoples.

I implore undergraduate medical school curriculums to teach anti-colonialism and anti-racism as a minimum standard within the medical pedagogical framework. To begin to answer the TRC Calls to Action and Calls to Justice of the *Inquiry*, I impress upon Canadian medical school administration to commit to combating genocide, racism, and white supremacy actively and meaningfully by developing a mandatory stand-alone anti-oppressive course and/or embedding anti-oppressive pedagogies in every course to deliver Indigenous content, so physicians trained in this country are global leaders in change. It is not my intention to attenuate the urgent need for radical

change within Canada’s healthcare systems so that Indigenous Peoples can thrive. Rather, I draw upon the Calls to Justice and Action to frame the desperate need to change the content of medical education in Canada so that the ongoing genocide of Indigenous Peoples by healthcare providers is immediately ended.

By opting to teach cultural sensitivity, competency, and safety in medical schools, educators and administrators of these intuitions risk conflating culture and race. The focus on cultural differences in medical curriculums between Indigenous Peoples and non-Indigenous people is leveraged as a way to avoid addressing the systemic racism in our healthcare systems and on a larger scale, in Canada (Browne, 2005; Allan & Smylie, 2015). Unfortunately, the use of culture to diffuse discussions of racism in Canada is not new (Browne, 2005; Grenier, 2020; Henry, Tator, Mattis, & Rees, 2006). By pinpointing culture within medical education as a social determinate of health causing health disparities in Indigenous communities, medical schools fail to acknowledge institutional and epistemic racism, racism that happens at macro-levels of social interaction and within all Canadian healthcare systems. Macro-levels of racism cause racism at micro-levels in the form of interpersonal and internalized racism. In other words, undergraduate medical schools have yet to acknowledge their role in teaching and advancing institutional and epistemic racism, which shape interactions between Indigenous clients and healthcare providers. Medical school curriculums using culturally focused teaching must assess—and re-assess—how culture has become a tool of oppressing Indigenous Peoples. I strongly assert culturally focused curriculums must be adapted and paired with anti-racism and anti-colonial pedagogies to properly address the health disparities of Indigenous Peoples.

Working towards Anti-Oppressive Pedagogies in Undergraduate Medical Education

As Canadian medical schools respond to the TRC Calls to Action, there are fears amongst Indigenous scholars that Indigenous content requirements will be a quick-fix solution or a check list item that will result in superficial and tokenistic changes with minimal consideration by medical institutions (Gaudry & Lorenz, 2019). Dr. Lisa

Richardson, an Anishinaabekwe physician, educator, and the strategic lead in Indigenous Health at University of Toronto Tweeted: “learning to be an anti-racist is not an ‘attend a lecture, tick-a-box/task complete’ process. It is a commitment to deep listening, reading, awakening, reflecting, seeing, intervening, dismantling, reimagining, rebuilding...over the course of one’s entire lifetime” (Richardson, 2020). I argue anti-racism, anti-colonialism, and cultural safety/competency courses rooted in anti-oppressive pedagogies can be important foundational tools within medical education programs to combat oppression within healthcare systems in Canada.

At the same time, I caution an overzealous response of implementing mandatory courses. The question of implementing mandatory Indigenous content requirements in medical schools has yet to be fully addressed, leaving important questions unanswered:

Will mandatory courses be an end to themselves? Is their objective merely to ensure a disengaged multicultural appreciation of ‘the other’ and the colonial containment...? Or will complex and demanding issues such as settler colonialism, land rights, dispossession, state violence, heteropatriarchy, racism and sexism form the core of the curriculum? (Gaudry & Lorenz, 2019, p. 163)

Medical educators and administrators, under the guidance of the AFMC, must give careful attention to the potential tokenistic implementation of Indigenous content requirements, which can reproduce stereotypes and oppressions.

Rooting Indigenous content requirements in anti-oppressive pedagogies avoids the operationalization of racism and colonialism in the classroom, which are harmful and violent for Indigenous Peoples and communities (Gaudry & Lorenz, 2019; Hollinsworth, 2016). In a survey of Indigenous scholars, many respondents criticize the adding of Indigenous content requirements into courses to meet the requirement of the TRC Calls to Action because it contributes to a checklist, tokenistic approach of Indigenizing and decolonizing education (Gaudry & Lorenz, 2019). Instead, survey respondents call for either embedding Indigenous content into the curriculum or offering courses solely on Indigenous content. Indigenous scholars and faculty members advocate for either

method to bring Indigenous content requirements into Canadian medical education programs. The inclusion, however, must be done through Indigenous ontologies and epistemologies by considering “scope of courses including their design, implementation, assignments, marking, goals, and delivery” (Gaudry & Lorenz, 2019, p. 167). Pedagogically, anti-oppression must be at the core of every medical school curriculum because when courses are taught and constructed from this perspective, the complex ways oppression arises are a part of learning, but so too are the ideals of transforming systems and structures to produce change. Therefore, the use of pedagogies rooted in anti-oppressive theory to create and teach Indigenous content requirements allows for Indigenous ontologies and epistemologies to be taught at institutions and counters the Euro-biomedical knowledge that continues to silence Indigenous knowledge systems through Eurocentrism and white supremacy.

Further, anti-oppressive pedagogies offer a praxis to deconstruct Eurocentric knowledge within undergraduate medical education and allow for Indigenization and decolonization of the curriculum. The Gaudry and Lorenz (2019) survey results suggest “anti-oppressive pedagogical practice works to transform power relations in the classroom, clear space, and recognize place-based histories as well as to amplify the ongoing resistance of local Indigenous peoples,” which additionally function to “embody transformational education while also assisting in a process of unlearning” (p. 167). While the recommendation to root Indigenous content requirements in anti-oppressive theory as a means to facilitate unlearning of pop culture, K-12 education, and common mis-teachings of Canadian history, medical students and in particular white settler students, must be willing to engage and accept the truths presented to them through these courses that counter Eurocentric rhetoric. Above all, faculty members and administration working with undergraduate medical education programs must root their own teaching and administrative work in anti-oppressive pedagogical framework to counter and unlearn their own Eurocentric bias. Faculty and administration, particularly white academics, must commit to decolonizing themselves and implement anti-oppressive practices.

Regardless of the subject they teach, educators must stop relaying racist and colonial rhetoric about Indigenous Peoples, communities, and their knowledges, particularly knowledge surrounding health and experiences in settler healthcare systems, to their students. I call upon all medical education programs to implement anti-oppressive pedagogies in solidarity with the TRC Calls to Action.

Combating White Supremacy in Undergraduate Medical Education through Anti-Oppressive Pedagogies

Considering the coercive and forced sterilization of Indigenous Women continues to be a healthcare practice in Canada, many physicians remain complicit in building a white settler state, and thus are engaging in white supremacy and genocide. Indeed, healthcare in Canada is complicit in keeping “anti-Indigenous colonial relations alive through the continued oppression and exploitation of Indigenous individuals” (Grenier, 2020, p. 4). To challenge anti-Indigenous racism in the Canadian healthcare system, white supremacy must be unlearned. Anti-oppressive pedagogies in undergraduate medical education programs must be embedded into the curriculum to lay a foundation for the eradication of white supremacy in healthcare services.

Indigenous Women are being coerced into tubal ligation, a type of sterilization performed after childbirth. At University Hospital in Saskatoon, for example, seven Indigenous Women report being coerced into sterilization (Boyer, 2017; Boyer & Bartlett, 2017; Soloducha, 2017). These women explain they were pressured by physicians, nurses, and social workers either during labour or immediately following delivery to undergo tubal ligation (Boyer, 2017; Boyer & Bartlett, 2017; Soloducha, 2017). The coercive sterilization of Indigenous Women is a medical practice stemming from anti-Indigenous racism that has been a part of the Canadian healthcare system since Confederation in 1867. With over 100 Indigenous Women across Canada reporting that they too have experienced coercive and forced sterilization, undergraduate medical education must address the systemic anti-Indigenous racism fueled by white supremacy.

To this day, “substantial power imbalances still exists between non-Indigenous health care providers and

Indigenous peoples, which underpins many of their unacceptable experiences in the health care system” (Boyer, 2017, p. E1409). The power to assimilate and contain Indigenous Peoples was granted to non-Indigenous physicians through the professionalization of medicine within Canada during the late 19th and early 20th century, which coincides and is connected to the eugenics movement. White physicians, gained control over healthcare services and provision of care through the imposition and implementation of colonization, which is underpinned by white supremacy. Settler physicians, along with the Federal Government, built healthcare institutions to racialize, kill, and contain Indigenous Peoples to create a white settler state. Without question, the violence of colonialism continues to exist in Canada since there are over 100 cases, as recent as 2018, of Indigenous Women being forced and coerced into sterilization. White supremacy is a part of healthcare in Canada. It is through the authority and influence held by physicians that I am advocating for the AFMC to make it a requirement that undergraduate medical education must include anti-oppressive pedagogies.

Currently, medical education at Canadian medical school focuses solely on cultural competency, sensitivity, and safety in relation to Indigenous Health. In order to dismantle white supremacy within the healthcare systems in Canada, education must de-centre whiteness, so Eurocentrism is no longer normalized within the provision of care. By including anti-oppressive pedagogies, the medical education framework will pivot from normalizing whiteness through cultural competence, to dismantling Eurocentric knowledge systems that maintain white supremacy and thereby anti-Indigenous racism (Gaudry & Lorenz, 2019; Grenier 2020). To answer the Calls to Action and Justice, medical schools must embed anti-oppressive pedagogies within undergraduate medical education curriculums.

Conclusion

In recent years, over 100 Indigenous Women have bravely come forward to voice their experience of coerced and forced sterilization by Canadian physicians. The experiences of these women are a part of a legacy of colonialism, genocide, and white supremacy, which

remain foundational within Canadian healthcare systems. In the early 20th century, physicians with the support of federal and provincial governments ushered in eugenics interventions, which targeted Indigenous communities across Canada (McLaren, 1990; Stote, 2015). Additionally, the Canadian government criminalized Indigenous healthcare, such that Indigenous midwifery and other reproductive health practices became illegal. Through the *Indian Act* and colonial policies, Indigenous Peoples were forced to use the Canadian healthcare system, which allowed physicians to surveil Indigenous bodies that were contained within institutions, like Indian Hospitals (Lux, 2016). As Indigenous Women were forced to seek healthcare by settler physicians, they became targets for eugenics interventions, such as sterilization. The goal of sterilization is to prevent births in Indigenous communities through genocide, which aids in assimilation of Indigenous Peoples in order for Canada to remain a white settler state (Stote, 2015). Since physicians continue the practice of coercive and forced sterilization of Indigenous Women in present day, they also continue the genocide of Indigenous Peoples and they maintain the white supremacy that underpins colonization.

I implore physicians, governing bodies of medicine and medical education, and future physicians to understand that coercive and forced sterilization of Indigenous Women must end because it is an act of genocide. I further beseech educators and administrators of undergraduate medical education in Canada the need for proper training to unlearn anti-Indigenous racism in healthcare, which permits and even facilitates the ongoing genocide of Indigenous Peoples. Anti-Indigenous racism impacts healthcare for Indigenous Peoples beyond the forced sterilization of Indigenous Women. Racism is so pervasive in the health system that many Indigenous Peoples strategize around anticipated racism or avoid access healthcare (Allan & Smylie, 2015). On September 28, 2020, Joyce Echaquan, an Atikamekw woman, and mother of seven, died at Centre hospitalier régional de Lanaudière in Joliette, Quebec after hospital staff berated Echaquan with racist, misogynistic insults, which Echaquan recorded through a live stream moments before her death (Page, 2021). When asked by

a reporter if Echaquan would be alive if she were white in October 2021, the coroner, Géhane Kamel, assigned to investigate Echaquan's death, said, 'I think so' (Nerestant, 2021). Based on the 24th Call to Action of the TRC and Call to Justice 7.6 of the *National Inquiry into Missing and Murdered Indigenous Women and Girls*, I insist medical schools implement Indigenous content requirements through anti-oppressive pedagogies within undergraduate medical education.

Canadian medical schools have taken steps to incorporate Indigenous content requirements through cultural sensitivity, competency, and safety training through courses and clerkships in Indigenous communities; however, education must now be rooted in anti-oppressive pedagogies to combat racism, white supremacy, and colonialism. An overhaul of Canadian undergraduate medical education is a small step for the long-standing legacy in healthcare of coercive and forced sterilization of Indigenous Women that has resulted in thousands of Indigenous Peoples being sterilized within the past 100 years. Unlearning anti-Indigenous racism, colonialism, and white supremacy is no longer an option, it must be a requirement to be able to work as a physician in Canada.

I strongly urge all 17 medical schools in Canada, the AFMC, the Canadian Medical Association, and Royal College of Physicians and Surgeons of Canada to act on the TRC 24th Call to Action to decolonize and Indigenize medical education. Reconciliation is not only accomplished by Indigenous Peoples' resistance against colonialism, settlers must act in solidarity with Indigenous Peoples. As white settlers, we have been given recommendations to facilitate reconciliation and decolonization in Canada. It is time we act.

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