

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

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For learning and unlearning with me throughout my education.

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Abstract

The historical and contemporary cases of coercive and forced sterilization of Aboriginal Women are acts of genocide rooted in colonialism and white supremacy. The legacy of coercive and forced sterilization of Aboriginal Women within the Canadian healthcare system demands a change to undergraduate medical education to prevent genocide. Through my Major Research Project, I examine the response taken by undergraduate medical programs to incorporate anti-oppressive pedagogies within the curriculum to teach Indigenous content requirements. Currently, undergraduate medical education centres around culturally based learning, which does not challenge racism and colonialism. Guided by 24th Call to Action of the Truth and Reconciliation Commission of Canada, I call upon Canadian undergraduate medical programs to implement anti-oppressive pedagogies throughout the curriculum to facilitate unlearning of colonial rhetoric amongst educators, administrators, and students. Anti-oppressive pedagogies establish learning that promotes anti-racism and anti-colonialism to Indigenize and decolonize the curriculum. Therefore, anti-oppressive pedagogies challenge genocide and white supremacy to promote the eradication of coercive and forced sterilization of Aboriginal Women.

Keywords: coercive and forced sterilization, Aboriginal Women, genocide, white supremacy, undergraduate medical education, anti-oppressive pedagogies

Dear Leo (Opa),

Much time has passed since we have spoken. Since your passing much has changed for me, I have grown and learned. You moved your family to this land to escape a genocide because this land was safe, however you never acknowledged the genocide happening here in Canada. Living on this land, our family is complacent with the genocide of Aboriginal Peoples. You and your family worked to resist oppressive regimes that swept the Netherlands but failed to stand in solidarity with Aboriginal Peoples in Canada. While I understand that you have passed and cannot change your complacency with settle colonialism in Canada, I want to do work that critiques the settler state and its genocide of Aboriginal Peoples. You raised us on stolen land, but you never told us. Perhaps, you did not know.

The oppression faced by our people, Jewish people, over the course of the Holocaust has been perpetuated onto Aboriginal Peoples for hundreds of years. As the Dutch Government encouraged Jews to marry non-Jews to breed-out Jewish traits, the Government of Canada worked to assimilate Aboriginal Peoples into Canadian society. You fought against genocide from a young, however you came to Canada and supported the settler state narrative of heroism instead of seeing the genocide taking place here. The Government of Canada has utilized many genocidal tactics to assimilate Aboriginal Peoples, and we have benefited from this process because we were able to move onto this land. I grew-up with a clear understanding of genocide that I learned from your stories as Holocaust survivors. I mad at myself for enjoying our freedom in Canada, while being complacent in the genocide of Aboriginal Peoples. We must be better.

I must say thank you. From an early age you impressed upon me that government does not have the right to award freedom, because freedom is a right, which is how I have come to relate to the research that I do. The Canadian Government operates to protect whiteness, which is synonymous with the Nazi party's protection of German Nationalism and both are rooted in white supremacy.

You are dead, so this letter may seem meaningless, but thank you for sharing what you could bare about your experiences during the Holocaust. Reading recounts of Aboriginal communities sharing their experience of coercive sterilization, I am aware of the pain imbedded in stories that discuss genocide. I live on Turtle Island; I am immensely privileged to not know oppression. I am immensely privileged to be a white Euro-Canadian, cis-female able-bodied settler; however, my privilege is violent if I remain complacent with the genocidal actions of the settler state.

Sincerely,

*Your granddaughter,
Erika Campbell*

Introduction

The coercive and forced sterilization of Aboriginal Women, within the Canadian healthcare system, is a eugenics intervention rooted in white supremacy, which perpetuates genocide of Aboriginal Peoples. Eugenics is the science of controlled breeding within humans to yield a population with desired inherited traits (Harris-Zsovan, 2010). Therefore, eugenics was employed as a tool to advance fertility amongst those deemed *fit* and prevent fertility amongst *unfit* people. Coined by Francis Galton in 1883, eugenics was built on a Eurocentric hierarchy of race that placed Northern European/ Anglo Saxon white people as most desirable and Indigenous Peoples and Black People as most inferior (Harris- Zsovan, 2010; Stote, 2015). Eugenics gave white people a scientific justification for enacting Eurocentric policies that permitted European imperialisms and colonization. Therefore, eugenics is a science based in white supremacy. Scholarship typically emphasizes white privilege, the benefits of being white on the basis of skin colour, as opposed to white supremacy, which is the production and violence of racial structures to uphold whiteness in settler societies (Bonds & Inwood, 2016). Eugenics, thus, is a product of white supremacy and not white privilege, because it functions to maintain white power through genocide; it prevents the fertility of racialized populations. My Major Research Project (MRP) will discuss the historical and contemporary involvement of Canadian physicians in the cases of coercive and forced sterilization of Aboriginal Women as an act of genocide rooted in white supremacy.

The first traces of eugenics in Canada took place in the early 1900s and was largely influenced by American eugenics models (Harris- Zsovan, 2010). Medical practitioners, charities, suffragettes, and other social reform organizations began educating the Anglo-Saxon population on eugenics. Eugenicists believed that social purity and moral reform would establish

healthy families, low crime rates, eradicate poverty, prevent alcoholism, stop child abuse, and mental illness (Dyck, 2013; Stote, 2015). Sterilization, as a eugenics intervention, was viewed as a public health measure to prevent reproduction of *feeble-minded* and non-Anglo-Saxon people, who were seen to threaten Anglo Saxon society (Stote, 2015).

Sterilization, commonly referred to in eugenics policies as sexual sterilization, is a permanent form of birth control (Reece & Barbieri, 2010). In assigned females, sterilization involves the physical occlusion of the uterine tubes through a variety of methods, such as cauterization. For eugenicists, gaining reproductive control over female fertility was essential because, “as child bearers, [women] held the ability to produce future progeny and were viewed as either helping or hindering the forward march of civilization” (Stote, 2015, p. 19). To advance this forward march in Canada, Alberta and British Columbia implemented a provincial *Sexual Sterilization Act* in 1928 and 1933, respectively. Arguably, the most well-known example of eugenics was the Holocaust. Nazi Germany adopted North American models of sterilization laws to establish the *Law for the Protection of Hereditary Health* in 1933. Sterilization laws were implemented to protect German Nationalism, which aided in the formation of the *Nuremberg Laws*. These laws provided the legal basis to kill Jews, people with disabilities, Gypsies, Queer people, Black People, People of Colour, and nonconformists until 1945 (Harris-Zsovan, 2010). As a great-granddaughter of Holocaust victims and granddaughter of a Holocaust survivor, I work to contribute to the body of literature that condemns eugenics, not just for Jews but for all peoples who have and are experiencing genocide as result of white supremacy.

After the Holocaust, eugenics was replaced with social hygiene interventions; however, this rebranding did not change the practice of coercive sterilization through sterilization policies in Canada (Dyck, 2013; Stote, 2015). For Aboriginal Peoples, the practice of coercive

sterilization was amplified in the 1960s. Earlier in the eugenics movement, the government, medical community, and other eugenics supporters were not as concerned with managing Aboriginal Peoples' reproduction because Aboriginal populations were in decline until the 1960s (Dyke, 2013). With the subsequent increase in the population of Aboriginal Peoples, public health officials increased sterilization measures taken within Aboriginal communities (2013). My MRP focuses solely on the coercive and forced sterilization of Aboriginal Women, although many Aboriginal Men were sterilized under these policies. Although, Aboriginal Peoples were the least populous racial group in Canada, Aboriginal Women were targeted for sterilization more so than another identity (Dyke, 2013; Stote, 2012). For example, in Alberta from 1969 to 1972, 3.4 percent of the population identified as Métis and First Nations, however they composed 25.7 percent of all sterilization cases that were approved by Eugenics Boards, composed of two physicians that decided, which patients were candidates for sterilization (Dyke, 2013; Harris-Zsovan, 2010). Furthermore, in the 1970s, 26 percent of Inuit Women age 30 to 50 in Igloolik, Nunavut were sterilized (Boyer & Bartlett, 2017). Physicians and the state ushered in unethical coercive and forced sterilization of Aboriginal Women as a means to reduce the Aboriginal population by preventing births.

It is worthwhile to mention that other methods of birth control were used by medical practitioners to control reproduction within Aboriginal communities at this time. Allegations of coercive abortions in Canada's North began in 1969 with the legalization of abortion (Stote, 2015). Therapeutic Abortion Committees, similar to Eugenics Boards, were comprised of medical practitioners who determined if a pregnancy was *unhealthy* and thus eligible for abortion. However, at many federally run hospitals in the North, abortions for Aboriginal Women were approved for economic reasons, even though these institutions were not accredited

to make these decisions (2015). Pressure to consent to sterilization surgeries during abortion care or as a prerequisite to obtaining an abortion also took place in these institutions (2015). While my MRP does not explore coercive abortions for Aboriginal Women, it is important to appreciate that medical practitioners retained a great deal of power over reproduction of Aboriginal Peoples. Physicians and the state exercised coercive reproductive health practices to create, what was thought to be, a moral and civilized Canadian society.

Across Canada, policies were introduced to protect surgeons, nurses, and other individuals a part of sterilization procedures who manipulated informed consent (Dyck, 2013; Stote 2015). Informed consent protocols became routine in medicine on an international basis in 1947 with the development of *the Nuremberg Code of medical ethics*. This *code* was developed to address the unethical and completely immoral medical experimentation and procedures carried out by the Nazis (Dyck, 2013). However, in Canada, when patients were deemed *mentally defective* by medical practitioners, the parameters of informed consent were waived (Stote, 2012). Consequently, more than 77 percent of Aboriginal Peoples who were sterilized were deemed to be mentally defective, therefore consent was not needed (2012). The lack of informed consent provided by patients to medical practitioners in cases of sterilization of Aboriginal Women further demonstrated the medical community's active participation in genocide.

Investigation of the complacency of physicians in genocide, white supremacy and colonialism is the central purpose of my MRP. Unfortunately, coercive sterilization of Aboriginal Women continued after the repeal of Alberta and British Columbia's *Sexual Sterilization Act* in 1972 and 1973, respectively. As such, I argue that medical practitioners continue to uphold a colonial agenda rooted in white supremacy in medicine. I argue that when medical practitioners continue to coercively sterilize Aboriginal Women, the genocide of

Aboriginal Peoples continues. Thereby, I leverage the Call to Action to decolonize healthcare proposed by Truth and Reconciliation Commission of Canada (TRC) in 2015 as a method to stop the genocide of Aboriginal Peoples through sterilization. I argue that by decolonizing and Indigenizing education in medical schools through anti-oppressive pedagogies, medical practitioners can be taught to stop coercively sterilizing Aboriginal Women and work to eradicate genocide of Aboriginal Peoples within the Canadian healthcare system.

Research Question

The continued practice of coercive and forced sterilization of Aboriginal Women by medical practitioners demonstrates a specific need in medical schools to provide training on anti-oppression to facilitate unlearning of colonial and genocidal medical practices rooted in white supremacy. How do medical practitioners in conjunction with medical policy and practice act as agents of genocide through coercive and forced sterilization of Aboriginal Women? Are Canadian medical schools working answer the Calls to Action of the TRC? Furthermore, how do anti-oppressive pedagogies in medical schools counter white supremacy?

I argue that coercive and forced sterilization of Aboriginal Women within the Canadian healthcare system demands a change to medical education, as per the 24th Call to Action of the TRC. The 24th Call to Action of the TRC states:

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. (2015, p. 3)

The call for intercultural competency, conflict resolution, human rights, and anti-racism training, will be referred to as anti-oppressive pedagogies within this paper. Anti-oppressive pedagogies are a call for acknowledging and unlearning colonialism, racism, genocide, and white supremacy within the context of the Canadian healthcare system. The 24th Call to Action proposed by Residential School survivors speaks to the broader concern of safety for Aboriginal Peoples while accessing healthcare. Within Canada, “research shows that racism against Indigenous Peoples in the healthcare system is so pervasive that people strategize around anticipated racism...” (Allan & Smylie, 2015, p. 2). Institutional oppression, including but not limited to racism, acts to make healthcare unsafe for Aboriginal Peoples.

To answer my research questions, I recount the contribution of medical practitioners in the genocide of Aboriginal Peoples through coercive and forced sterilization. I argue that as coercive and forced sterilization of Aboriginal Women continues, medical practitioners continue to participate in the genocide of Aboriginal Peoples. I examine the interlocking relationships between sterilization policy and practice as a colonial structure built by white supremacy that works to undermine Aboriginal Peoples, their kinships, and connections to the land through genocide.

Secondly, I examine the response taken by Canadian undergraduate medical programs to answer the 24th Call to Action. I want to appeal to medical school administrators and educators that anti-oppressive pedagogies are fundamental to the decolonization of healthcare. Finally, I frame the adoption of anti-oppressive pedagogies in medical schools, as method to counter narratives of white supremacy that permit the genocide of Aboriginal Peoples through coercive sterilization. Therefore, medical education rooted in anti-oppressive pedagogies can contribute to

the unlearning of healthcare practices that uphold white supremacy and make healthcare unsafe for Aboriginal Peoples. My MRP advocates with the TRC, to ensure safer healthcare in Canada.

Terminology

Language is an important aspect to this paper, so I offer an explanation for the terminology I have chosen to utilize. I am a white Euro-Canadian settler to Turtle Island. The term *settler* in this paper will be associated with people of white European descent. When white Euro-Canadians are asked to identify, we commonly pick terms that blend us with everyone else (Vowel, 2016). This is highly problematic because the experiences of Aboriginal Peoples, Black People, non-Black People of Colour, and white people are distinctly different from each other and even within these identities there are vast differences. For white people, we have white privilege born out of white supremacy that built racial hierarchies that positions us with power. This paper focuses attention on the relationships between settlers and Aboriginal Peoples, therefore I will not go into detail about other race-based relations. I reframe from capitalizing white and settler because of the violence that these identities place on Aboriginal Peoples. I do not feel that greater emphasis through capitalization needs to be placed on whiteness.

Aboriginal in recent years has become the most common term to distinguish from white people, Black People, and non-Black People of Colour in Canada (Vowel, 2016). *Aboriginal Peoples* includes First Nations, Inuit, and Métis Peoples (2016). I utilize the term *Aboriginal* in favour of *Indigenous*. The term *Indigenous*, “tends to have international connections, referring to Indigenous Peoples throughout the world rather than being country-specific” (2016, p. 10). I reframe from using *Canadian* when referencing Aboriginal Peoples because some Aboriginal Peoples do not identify as Canadian and many did not choose to be Canadian. I will use *Canadian* in reference to settler intuitions, settler healthcare, and medical policies and practices,

because settlers reinforce a national identity onto the Canadian healthcare system that is connected to the assimilation, containment, and genocide of Aboriginal Peoples for the purposes of obtaining land to build a white settler state.

Theoretical Framework

In the application of Indigenous feminist theory, I position myself as a white-settler woman who demonstrates feminist solidarity with Aboriginal Peoples. I have chosen to articulate my work through Indigenous feminist theory because it is used to educate “movements unfamiliar with issues of colonialism, racism and sexism, and builds critical political consciousness and solidarity...” (Green, 2007, p. 24). My work is a form of activism that seeks to demonstrate to the medical community the need to engage with the recommendations of TRC and to stop white supremacy and the genocide of Aboriginal Peoples by decolonizing healthcare. The healthcare system in Canada has worked to oppress Aboriginal People, therefore I employ Indigenous feminist theory “to critique oppressive traditions – and to claim and practice meaningful non-oppressive traditions” (Green, 2007, p. 27). My call for anti-oppressive pedagogies in medical schools is a call to end coercive sterilization and other medical practices rooted in white supremacy that permits genocide of Aboriginal Peoples.

I employ Indigenous feminist theory to discuss “issues of colonialism, racism and sexism, and the unpleasant synergy between these three violations of human rights” (Green, 2007, p. 20). Feminist theory and movements “are concerned with women’s flourishing – women controlling adequate resources, of all sorts, to live well,” through “respect for women’s own perspective and authority” (Frye, 2000, p. 195). While feminist theory and movements establish a foundation for an analysis of the role of women, little scholarship has centered on the experiences unique to Indigenous Women, who face colonial oppression within settler society (Green, 2007). The

ongoing cases of coercive and forced sterilization of Aboriginal Women demonstrates that colonial oppression is tied to sexism and racism and other forms of oppression that can be examined with the use of Indigenous feminist theory.

Within the context of a colonial society, racism and sexism are internalized within dominant and Indigenous political cultures to oppress Aboriginal Women (Green, 2007). Therefore, Indigenous feminism offers tools to analyze colonialism, racism, and sexism within medical policy and practice of coercive and forced sterilization of Aboriginal Women. By engaging with Indigenous feminist theory, I examine the historical and contemporary social, economic, cultural and political issues in relation to one another (Green, 2007).

The coercive and forced sterilization of Aboriginal Women by medical practitioners is a multi-dimensional ethical issue rooted in white supremacy and genocide within Canada's healthcare system (Grenier, 2020; Dyck, 2013; Stote, 2015). Therefore, Indigenous feminist theory offers a structure to articulate the ongoing impositions of colonialism on Aboriginal Women in contemporary Canadian society. When considering coercive and forced sterilization of Aboriginal Women as a call for anti-oppressive pedagogies in undergraduate medical education, Indigenous feminist theory is a lens that "interrogates power structures and practices between and among Aboriginal and dominant institutions" (Green, 2007, p. 25). Indigenous feminist theory provides a framework to understand how medical schools, as settler constructed institutions, engage in colonialism. My intention is to contribute to a body of literature that calls upon the Canadian healthcare system to take steps towards decolonization to stop the coercive and forced sterilization of Aboriginal Women. By using Indigenous feminist theory, I ground my work as a piece of activism that counters white supremacy that underpins the practice of coercive and forced sterilization of Aboriginal Women in Canada.

Research Methods

I employ decolonizing methodology to scan literature to advocate for anti-oppressive pedagogies in Canadian medical schools based on the unethical coercive and forced sterilization of Aboriginal Women entrenched in white supremacy. My analysis of literature does not involve primary research with participants and therefore does not require approval from the Research Ethics Board at Queen's University. However, as a white Euro-Canadian settler I must reflect on my privilege within Canadian society. I acknowledge the need to decolonize myself as a researcher in order to critique the genocide, white supremacy, and colonialism within the Canadian healthcare system. By basing this research within decolonizing methodologies, I work to not perpetuate 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 produced discriminatory and racist knowledge about Aboriginal Peoples. By reflecting on my privilege, I strive to decolonize myself and my work in order to complete research that shows respect, reciprocity, and responsibility to those affected by genocide (Wilson, 2008).

Decolonizing methodology, as articulated by Linda Tuhiwai Smith (2012), is concerned with the claims, values, and practices of institutions of research and power relations and provides a structure to analyze imperialism, colonization, and injustice. Decolonization proposes solutions in Indigenous discourses and brings together notions of pre-colonial time and colonized time

(2012). Decolonizing methodology is applied within my MRP to critique white supremacy as a product of colonization that amounted to the genocide of Aboriginal's Peoples through coercive and forced sterilization (Smith, 2012; Boyer, 2017). Based on the Call to Action of the TRC, anti-oppressive pedagogies in undergraduate medical education proposes an approach to counter white supremacy within the Canadian healthcare system.

In the early to mid-twentieth century, medical practitioners and the Canadian government operationalized eugenics to justify the coercive and forced sterilization of Aboriginal Women. Consequently, the coercive and force sterilization of Aboriginal Women is founded on colonial constructions of race and gender. Race, as a Western category, linked human morality to whiteness in order to justify racialization through colonialism (Smith, 2012). Gender, as defined through an imperial lens, intersects with race to constitute the roles of men and women, and establishes differences between genders to build an understanding of desired qualities of women as tied to whiteness through the roles of wifhood and motherhood (2012). Using principals of eugenics, the state and medical practitioners justified sterilization policies and practices in an attempt to fix issues of poverty and poor health that were argued to be a direct result of Aboriginal Peoples' lower racial evolution (Stote, 2012). Eurocentric constructions of gender and race was used by the settler state to target Aboriginal Women for sterilization as a eugenics intervention.

Coercive and forced sterilization were made possible through tactics of aggressive colonization, whereby Euro-Western intuitions forcibly and violently gained control of Aboriginal lands and bodies (Dyck, 2013; McCallum & Perry, 2018; Million, 2013; Smith, 2012; Stote, 2012). Such an approach aligned with settle ontologies and epistemologies, which "are under pinned by a cultural system of classification and representation, by views about human

nature, human morality and virtue, by conception of space and time, by concepts of gender and race” (Smith, 2012, p. 46). Through the application of decolonizing methodology, I challenge the culture of settler intuitions that uphold white power by following an Indigenous research agenda immersed in a sense of optimism and hope for Indigenous survival, resistances, and recovery from colonialism (Smith, 2012; Wilson, 2008). I further assert decolonizing methodologies are imperative to evaluating the commitment of medical schools to embed anti-oppressive pedagogies within curriculums to prevent the practice of coercive sterilization and by extension, the ongoing genocide of Aboriginal Peoples.

Thematic Analysis

The literature I used for research was selected via research databases. For the analysis of literature pertaining to coercive and forced sterilization of Aboriginal Women, I selected books and articles that focused on terms like “Aboriginal,” “Indigenous,” “coercive sterilization,” “Sexual Sterilization Act,” “eugenics in Canada,” “colonization,” “genocide of Aboriginal People,” and “white supremacy.” After scanning databases like the *Bibliography of Native North Americans* and *Gender Studies Database*, I found a lack of research articles on recent cases of coercive sterilization of Aboriginal Women. From there, I turned to reports, news articles, and broadcasts that highlighted the previously listed terms.

I selected literature that described the relationships between Aboriginal Peoples and Canadian healthcare systems and used terms such as “Aboriginal,” “Indigenous,” “Canada,” “healthcare,” “healthcare system,” “eugenics,” “white supremacy,” “institution,” and “hospital.” To scan literature referencing medical education and the 24th call to action of the TRC, I selected books and articles through databases by using terms like, “medical education,” “cultural safety,” “intercultural competency,” “cultural humility,” “anti-oppression,” “decolonizing education,”

and “Indigenizing education.” I also examined curriculums and course options through publicly available documents that were produced by the Association of Faculties of Medicine Canada (AFMC). I analyzed the materials provided by these organizations for implementation or plans to implement the recommendations proposed by the Calls to Action of the TRC.

Literature Review

In the scope of my research, I elected to examine the ongoing practice of coercive and forced sterilization of Aboriginal Women within the Canadian healthcare system as a means to advocate for anti-oppressive pedagogies in undergraduate medical education to eradicate medical practices rooted in colonialism and white supremacy. Historically, the practice of sterilization was a eugenics intervention positioned as a public health initiative that targeted people deemed *mentally deficient*, based on Intelligence Quotation (IQ) tests, and were therefore presumed to have a moral short coming causing poverty, poor health, and other social issues in Canada (Dyck, 2013; Harris- Zsovan, 2010; Ladd-Taylor, 2017; McLaren, 1990; Stote, 2012; Stote, 2015). Within Aboriginal communities, sterilizations as a eugenics intervention targeted Aboriginal women, separated Aboriginal Peoples from land, and reduced the Aboriginal population through genocide (Dyck, 2013; Harris- Zsovan, 2010; McLaren, 1990; Stote, 2012; Stote, 2015). Sterilization was used by the state to prevent growth within Aboriginal communities through genocide to maintain white power.

Coercive and forced sterilization took place under provincial legislation known as the *Sexual Sterilization Act* in Alberta and British Columbia from 1928 to 1972 and 1933 to 1973, respectively. Coercive and forced sterilizations were performed in Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Prince Edward Island, Nova Scotia, and Canada’s North without legislation (Dyck, 2013; Harris- Zsovan, 2010; McLaren, 1990; Stote, 2012; Stote,

2015). Sterilization of people deemed mental deficient was a national eugenics intervention carried out by physicians with the support of federal and provincial governments.

Sterilization, as a eugenics intervention, was performed on Aboriginal Women by physicians more so than any other racial, ethnic, political, or cultural identity group, even though Aboriginal Women made up the smallest percentage of the Canadian population (Dyck, 2013; Stote, 2015). Colonial rhetoric described Aboriginal Women, “as ‘savages,’ ‘depraved,’ or of ‘loose moral character’ and their sexuality was intensely policed. For those who proved unwilling to assimilate or whose sexuality was deemed difficult to control, sterilization was sometimes the result” (Stote, 2012, p.119). The legacy of settlers depicting Aboriginal Women, their sexuality, and character negatively, maintains a colonial archetype that has been imprinted onto Canadian society in present day and permitted the systemic coercive and forced sterilization of Aboriginal Women. After the repeal of Alberta and British Columbia’s *Sexual Sterilization Act* in the early 1970s, cases of coerced and forced sterilization of Aboriginal Women continued to occur by Canadian physicians.

Currently, over 100 Aboriginal Women belonging to different communities across Canada have come forward with allegations of coercive and forced sterilization (Rao, 2019; Viridi, 2018; Zingel, 2019). Coercive and forced sterilization of Aboriginal Women is an act of genocide (Stote, 2015), which must be eradicated as a healthcare practice within the Canadian healthcare system. Media reports circulated that indicated several Aboriginal Women were coerced, at University Hospital in Saskatoon, into tubal ligation, a type of sterilization surgery performed immediately after childbirth (Boyer & Bartlett, 2017; Reece & Barbieri, 2010; Soloducha, 2017). Yvonne Boyer and Judith Bartlett (2017) conducted an external review of the recent cases of coercive sterilizations of First Nations and Métis Women in the Saskatoon Health

Region (SHR), where women disclosed they felt invisible, profiled, and powerless. Many women reported that physicians and other healthcare staff provided false information about tubal ligation, with one respondent stating, “I refused the tubal so many times that they had the doctor and another person come in and say, ‘it just clamps and we can remove them.’” (Boyer & Bartlett, 2017, p.18). In interviews with healthcare professionals about Aboriginal Peoples, one interviewee reported, “one resident on labour and delivery said, I f...g hate you people more than any other race on this entire earth” (Boyer & Bartlett, 2017, p. 27). Even though Saskatchewan, like many other provinces, never fully developed sterilization legislation, a legacy of sterilization of Aboriginal Women remains within Canada’s healthcare system (Boyer & Bartlett, 2017). The historical and contemporary cases of coercive and forced sterilization of Aboriginal Women demonstrates the complacency of healthcare professionals and policy makers in colonialism.

Mohawk scholar, Audra Simpson (2014) defined colonialism as an ongoing structure built by settlers in seized spaces to continue capital accumulation to aid in the further seizure of space. As a structure, colonialism facilitates violence toward Aboriginal Peoples on the basis of their identity (McCallum & Perry, 2018). It is, thus, through colonialism that Aboriginal Peoples have been racialized through federal legal categories to create Aboriginal identities as a racial category. Assimilative policies enacted by the Canadian government, like the *Indian Act*, criminalized Aboriginal health knowledges to contain Aboriginal Peoples within settler healthcare institutions (Lux, 2016). The legacy of assimilation and containment of Aboriginal Peoples within the healthcare system affects the provision of healthcare for Aboriginal Peoples in present day. Anti-Indigenous racism is a social determinate of health that produces inequities within health and the provision healthcare for Aboriginal Peoples as it enforces a racial hierarchy that privileges white people through white supremacy (Bonds & Inwood, 2016; Grienier, 2020;

McCallum & Perry, 2018). Through these racial categories, Aboriginal Peoples face racial violence that is embedded within the settler state, therefore is present in the Canadian healthcare system.

The legacy of sterilization is rooted in a colonial legacy that aggressively sought the assimilation of Aboriginal Peoples into settler society. While literature addressed the colonial legacy of sterilization, scholarship has yet to discuss the continued practice of coercive and forced sterilization of Aboriginal Women as a Call to Action for Indigenous content requirements delivered through anti-oppressive pedagogies in Canadian undergraduate medical programs. The TRC (2015) along with the Association of Faculties of Medicine of Canada (AFMC) (2020) are demanding undergraduate medical programs to deliver education rooted in anti-racism and anti-colonialism. Racism within the healthcare system is typically suggested to be a generalized implicit bias solved through cultural safety training for healthcare providers (Grenier; 2020; McCallum & Perry, 2018). Cultural-based training, however, often fails to acknowledge the legacy of settler colonialism and white supremacy that permits anti-Indigenous racism within the healthcare system (Grenier; 2020; McCallum & Perry, 2018). Anti-oppressive pedagogies are leveraged as a means to deliver education rooted in anti-racism and anti-colonialism as anti-oppressive practices challenge systems of oppression by decentering whiteness (Carey, 2015; Gaudry & Lorenz, 2019; Grenier; 2020). To unlearn the legacy of anti-Indigenous racism in healthcare, undergraduate medical education must be provided through anti-oppressive pedagogies.

Cases of coercive and forced sterilization of Aboriginal Women have occurred as recently as 2018 (Rao, 2019; Viridi, 2018; Zingel, 2019). Allegations of coercive and forced sterilization have been reported in the Yukon, North West Territories, British Columbia, Alberta,

Saskatchewan, Manitoba, Ontario, and Quebec (Rao, 2019; Viridi, 2018; Zingel, 2019), which speaks to a need for healthcare professionals to unlearn colonialism and white supremacy. For these reasons, I advocate for the implementation of anti-oppressive pedagogies in undergraduate medical education to eradicate the practice of coercive and forced sterilization of Aboriginal Women.

Chapter 1: The Contribution of Physicians in the Genocide of Aboriginal Peoples through Coercive and Forced Sterilization

The *Royal Proclamation of 1763* built the foundation for colonial relations in Canada (Woolford, 2009). British settlers saw *the proclamation* as a device to restrict Aboriginal Peoples to reservations through treaty agreements to gain access to resources (2013). Colonizers utilized *the Royal Proclamation* to build laws that furthered the colonial agenda to gained land for the Crown and to assimilate Aboriginal Peoples. When Canada became a nation state in 1867, the newly formed Government of Canada took over established obligations and began to increase laws to control Aboriginal Peoples (Stote, 2015; Woolford, 2009). The *Indian Act of 1876* defined Aboriginal Peoples and developed the legal identity of Status Indian as an attempt to limit the number of people the federal government had obligations to through treaties (Stote, 2015; Woolford, 2009). The *Indian Act* and its amendments sought control over Aboriginal ways of life by, “undermin[ing] Aboriginal political, economic and social institutions and imposed Canadian ones” (Stote, 2015, p. 31). The *Indian Act* furthered the assimilation of Aboriginal Peoples to, “advance the government's policy of genocide through the process of enfranchisement: the removal of Indian status from an individual” (Hampton, Bourassa, McKay-McNab, 2004, p. 25). The *Indian Act* and other colonial policies were created to ensure white colonizers and settlers had access to Aboriginal land and resources.

Enfranchisement had severe consequences specifically for First Nations Women. Women lost status and rights to property within her community, if she married a non-Aboriginal man (Hampton, Bourassa, McKay-McNab, 2004). Furthermore, disenfranchisement was passed onto her children (2004). For First Nations Women, their identity and the identity of their children was dictated by their husband, however this was not the case for First Nations Men (2004). Under the *Indian Act*, Aboriginal Women were also banned from participating in Aboriginal governance systems until 1951 (Hampton, Bourassa, McKay-McNab, 2004; Stote, 2015). The *Indian Act* imposed Eurocentric legislation onto Aboriginal Peoples that was steeped in racism and sexism (Green, 2007; Hampton, Bourassa, McKay-McNab, 2004). The colonial agenda in Canada is bound to racist and sexist policies that have systemically targeted Aboriginal Women to aid in containment and assimilation of Aboriginal Peoples.

Targeting Aboriginal Women for Coercive Sterilization

Sexual sterilization as a eugenics and social hygiene intervention is a product of the colonial agenda through classism, ableism, racism, and sexism. Industrializing Canada created high rates of poverty and illness, thus eugenicists posited sterilization the most cost-effective solution to fix social problems instead of implementing better housing, sanitation, nutrition, living wages, and safer work environments (Stote, 2012). Moreover, sterilization addressed public health problems by placing blame on individuals for illness and poverty with failure to mention systemic causes (Dyck, 2013; Harris- Zsovan, 2010; McLaren, 1990; Stote, 2015). Eugenicists did not consider the implications of colonialism on Aboriginal Peoples, but instead looked to Aboriginal Peoples as possessing traits resulting in illness that made them a threat to Anglo-Saxon society. In 1904, the deputy superintendent of Indian Affairs explained that poor health on reserves and in Aboriginal communities is a product of moral failure of Aboriginal

Peoples, high birth rates, and some inherent mental, moral, or physical defect (Stote, 2015). The presumed moral shortcomings of Aboriginal Peoples resulting in poor health became a means for eugenicists to target Aboriginal Women for sterilization.

Eugenicists targeted people with *mental defectiveness* for sterilization (Dyck, 2013; Harris- Zsovan, 2010; McLaren, 1990; Stote, 2015). Mental defectiveness, also referred to as mental deficiency or feeble-mindedness, was described in legislation as, “any person in whom there is a condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury” (Harris-Zsovan, 2010, p. 77-78). The intelligence quotient (IQ) test and other psychometric examinations were deployed to determine the degree of mental defectiveness of an individual, across eugenics interventions in North America (Dyck, 2013; Harris- Zsovan, 2010; McLaren, 1990; Stote, 2015). IQ tests became the primary method to diagnosing mental defectiveness because this tool was thought to establish a 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 fashion, by physicians and the state to justify a patient’s sterilization.

Mental deficiency was commonly associated with women who were non-Anglo Saxon, particularly Aboriginal Women. Aboriginal Peoples were more often labelled as mentally deficient compared to other ethnic groups, because the IQ test privileges Eurocentric epistemologies (Harris-Zsovan, 2010; Stote, 2015). Lower scores within non-Anglo-Saxon racial and ethnic groups was a result of language and cultural barriers present within IQ tests (Harris-Zsovan, 2010). However, language and cultural biases of the IQ test was not considered by

eugenicists, physicians, and the state, therefore low IQ scores amongst Aboriginal Women backed up the prejudice about the inferiority of Aboriginal Peoples held by white settlers (2010). Furthermore, by focusing on individual moral, mental, and physical shortcomings, Karen Stote (2015) argued:

“The sterilization of Aboriginal women allows the Canadian state to deny responsibility for and avoid doing something about the deplorable conditions in which most Aboriginal communities live, conditions recognized as the direct result of the process of dispossession and colonialism” (p. 90).

The deplorable conditions experienced by Aboriginal communities can be exemplified through reserves and residential schools. In the North, studies have shown a lack of nutritious food sources amongst Inuit communities are a direct result of colonialism. Food desserts in these communities caused 75 percent of pregnant Inuit women and young children examined to have vitamin and other nutritional deficiencies (Stote, 2015). Children born with vitamin deficiencies score 20 to 40 percent lower than the average on IQ tests (2015). Therefore, the use of IQ tests to determine mental defectiveness of a patient by physicians as a justification for sterilization disproportionality targeted Aboriginal Peoples because of the conditions colonization created, which privileged settler knowledge over Aboriginal knowledge systems and forced Aboriginal Peoples to live in unethical conditions that perpetuated illness, thus lowering IQ scores.

Colonialism allowed for Aboriginal Women to be targeted by eugenics interventions. Policing of the sexual activity of Aboriginal Women began after confederation in Canada (Stote, 2015). During the early years of colonization, Aboriginal Women were exploited by settlers as sexual and political commodities (2015). Since colonization, the sexual practices of Aboriginal Women were portrayed as disrespectful to Anglo-Saxon values (2015). Aboriginal Women were

seen as sexually promiscuous therefore, “blamed for prostitution, the spread of venereal disease and alcohol problems, and were generally said to represent a threat to the public” (2015, p.40). In the late 19th and early 20th century, social reform movements enforced Eurocentric-Christian ideals onto Aboriginal communities, whereby Aboriginal Women were relegated to the private sphere to complete domestic work (McLaren, 1990; Stote, 2015). Reformist forced Aboriginal Women to conform to Christian understandings of womanhood (Stote, 2015). To combat resistance to assimilation, the state forced Aboriginal Women into prisons, reformatories, or training school to instill middle-class, settler notions of womanhood (2015). The criminalization of Aboriginal Women and their sexuality resulted in settlers labelling them as bad mothers, thus unfit for child rearing (2015). Criminalizing the sexuality of Aboriginal Women became a means of assimilation and containment of Aboriginal Peoples that worked to prevent growth of Aboriginal populations.

Within eugenics, two models of understanding the role of women emerged in the early twentieth century. There was the *mother of the race* – moral, civilized women (Stote, 2015). These women were deemed *fit* by eugenicists, meaning they were white, Anglo Saxon, abled bodied, and of socioeconomic means. The second model, *moron girl*, described women that were immoral, uncivilized and therefore posed a biological threat to advancement of the white settler state (2015). Women that were placed into the latter category were more likely to experience coercive sterilization as a means to mitigate the threat of their ability to reproduce. Maternal feminists leveraged this model of conceptualizing womanhood to gain voting rights and reproductive freedom for white women. Maternal feminism aimed to gain societal privileges for white women and protect white families by limiting contact with *unfit* and/or non-white people (2015). Women who were prostitutes, sexually active prior to marriage, had illegitimate children,

multiple sexual partners, deemed mentally deficient, and/or belonged to an Aboriginal community were seen by maternal feminist as threatening to white society through perceived promiscuity (2015). Maternal feminism was a racist form of feminism, “that excluded certain women from the specifically Anglo-Saxon work of building the nation” (2015, p.22). Aboriginal Women were excluded and targeted by racist policies lobbied for by maternal feminists. Some of Canada’s most notable feminists of the early 20th century, like Emily Murphy and Nellie McClung, worked to further the maternal feminist agenda. McClung supported imperialist expansion in Canada through the civilizing of Aboriginal Women by training them in the art of mothercraft (2015). Furthermore, McClung set up appointments for patients and their families to meet with physicians to discuss sterilization (2015). Murphy became the first female Magistrate Court Judge and presided over cases advocating for women to be sterilized as oppose to jailed for crimes committed (Dyck, 2013; Stote, 2015). Maternal feminism wanted to bring social purity to Canadian society, by ensuring a white settler state and worked with the state policy makers and physicians to accomplish this goal. Maternal feminists reinforced eugenic attitudes that women should be defined by reproductive capacity (Dyck, 2013; McLaren, 1990; Stote, 2015). Eugenics discourse became tied to feminism focused on securing rights for middle-class, Christian white women (Dyck, 2013). Therefore, maternal feminism and eugenics aligned to institute classism, racism, ableism and sexism onto societal understanding of womanhood and motherhood to further colonization in Canada.

Women, namely middle-class, white feminists, began lobbying for sterilization due to the strain that multiple pregnancies placed on families. The rhetoric of sterilization became heightened during the Depression because of the economic burden children presented on families (Dyck, 2013). Since the Catholic Church and other Christian-based religious intuitions condemned

contraception and abortions, sterilization became an option for birth control. However, members of both church and state feared that sterilization of middle-class, white women meant that, “the race...is being robbed of its future in the name of medical science” (2013, p.96). Canadian eugenics figure R.C. Wallace encourage women to:

“be brave, clean, resolute, with a firm determination with the sacred issues of life, but rather than we be mothers in the true spirit of motherhood, with the uniting zeal to fill the full measure of our being here as instruments in the hands of God in people, Christianizing and redeeming the human family” (2013, p.97).

Wallace wanted white women to reproduce to grantee a white future in Canada. Eugenics supporters hold beliefs rooted in white supremacy, as they wanted to ensure a white majority in Canada to maintain a white settler state. Thus, the state along with physician support created strict policies around the sterilization of white women who voluntarily wanted to be sterilized as a form of birth control. In the late 1960s, stigma surrounding contraception and abortion continued, sterilizations became a more common form of birth control amongst white mothers (2013). Sterilization surgeries amongst middle-class, married, white women were only preformed in the 1970s if women met one of the following criteria:

1) if a woman has five or more children at any age; 2) if a women had four or more children and was over twenty-five years of age; 3) if a women had three or more children and was over thirty years of age; 4) if a woman was over thirty-five years of age (2013, p.110).

The opposition of both church and state to the sterilization of white women in Canada is rooted in white supremacy. The coercive and forced sterilization of Aboriginal Women was of no concern for the church and state, however the consensual sterilization of middle-class white

mothers was condemned. Interestingly, the timeline of increased coercive and forced sterilizations of Aboriginal Women, matches an increase in voluntary and consensual sterilizations of white, married, middle-class women. Sterilization practices and policies demonstrated that the settler-state feared a decrease in the white population and increase in the Aboriginal population, as this jeopardized the power held by white people in Canada. Therefore, systemic coercive sterilization of Aboriginal Women was an attempt made by the government with support of white settlers and healthcare professionals to decrease the Aboriginal Population through eugenics and social hygiene interventions, by limiting growth in Aboriginal communities, which functioned to maintain white supremacy in Canada by creating policies and practices that further built a white settler state.

Physicians and the Coercive and Forced Sterilization of Aboriginal Women

Aboriginal communities have managed health and wellness of their Peoples for many generations prior to contact with colonizers. Many early-colonizers made use of medicine and healthcare provided to them by Aboriginals Peoples (Lux, 2016; RCAP, 1996; Stote, 2015). By restricting access to land and containing Aboriginal Peoples to reservations or moving communities to new spaces, the state denied Aboriginal Peoples access to medicines, thus preventing Aboriginal health practices. Amendments to the *Indian Act* in 1914 and 1952 forced Aboriginal Peoples to receive healthcare through settler institutions, while making resistance to these policies illegal (Stote, 2015). Aboriginal Peoples were forced to depend on the Canadian healthcare system for health services.

The impositions of the *Indian Act* caused poor health for many Aboriginal Women that resulted in pregnancy and postpartum complications, causing low birth rates and high infant mortality (Stote, 2015). The Government of Canada refused to acknowledge that poor health in

Aboriginal communities, such as high infant and maternal mortality, was a direct result of colonization. Instead the state increased medicalization of Aboriginal communities, which aided in colonization through assimilation and containment of Aboriginal Peoples within the Canadian healthcare system (Lux, 2016). Aboriginal Women living in the North or on reserves were evacuated to settler institutions in the South for gestational and postpartum care (Lawford & Giles, 2012; Stote, 2015). Additionally, Canadian physicians critiqued Aboriginal birth practices by blaming Aboriginal Midwives for infant and maternal death (Stote, 2015). Aboriginal health practices were seen by medical practitioners to be in direct contrast to the Euro-Canadian biomedical model, thus Aboriginal Midwifery became criminalized within health policy (2015). Through assimilation tactics, health policy in Canada aimed, “to turn Aboriginal peoples into citizens to whom the federal government no longer had obligation or responsibilities, and it was hoped that Aboriginal peoples would take fiscal responsibility for their own health care” (Stote, 2015, p. 40). However, colonization took away Aboriginal Peoples ability to manage health within their communities by assimilating and criminalizing their healthcare practices. The forced reliance of Aboriginal Peoples, specifically Aboriginal Women, on the Canadian healthcare system, through processes of medicalization initiated by the state, was monopolized within Eugenics interventions.

Medicalization and implementation of eugenics interventions within Aboriginal communities severed to maintain a white settler state. The purpose of medicalizing Aboriginal community’s health and wellness was to contain Aboriginal Peoples within healthcare institutions as a measure of protection for the settler population against the presumed threat of Aboriginal Populations (Lux, 2016; Stote, 2015). Hospitals and other settler healthcare institutions allowed for, “increased surveillance over First Nations families and borrowed the

language of modern scientific medicine to justify aggressive health interventions...” (Dyck, 2013, p. 61). The state and medical professionals viewed the Euro-Canadian biomedical model, modern medicine, as a means to bring civilization to Aboriginal communities by removing people from their lands to be treated in settler healthcare institutions (2013). Through Indian Health Services, the Government of Canada developed segregated hospitals solely for Aboriginal Peoples, namely First Nations and Inuit Peoples, with the goal to fix what settlers called the *Indian Problem* (Lux, 2016). The Indian Problem refers to settlers’ anxieties around Aboriginal Peoples as threats to national hygiene and morality. The first Indian Hospital was opened in 1946 in Alberta and soon after, Indian Hospitals were constructed from coast-to-coast-to-coast. Within these institutions, medical practitioners took on the dual role of doctor and Indian Agent (Dyck, 2013). Indian Agents, a role created under the *Indian Act*, were state officials that policed the movement and organizing of First Nations Peoples to aid assimilation (Titley, 2009; Satzewich & Mahood, 1995). Indian Agents took on the views of the state with interest in controlling First Nations lands, power, education, and other aspects of life including culture (Titley, 2009; Satzewich & Mahood, 1995). Physicians take on the role of Indian Agents in healthcare settings, like hospitals, by policing Aboriginal Peoples’ health and movement through the healthcare system in alliance with the Canadian Government. In Indian Hospitals, Aboriginal patients received unethical healthcare, which ranged from experimental surgeries, to drug and vaccine testing, and to coercive and forced sterilization (Lux, 2016). Indian Hospitals, thus, became another device employed by Canada and maintained by medical doctors to assimilate and contain Aboriginal Peoples, thus advancing the colonial agenda.

Within the Canadian healthcare system, racism informed by eugenics and other forms of Social Darwinism influenced medical practices on the basis of a patient’s race (Dyck, 2013). As

a result, medicine became a solution to fixing social problems commonly associated with racialized peoples (Dyck, 2013; Lux, 2016; McLaren, 1990; Ladd-Taylor, 2017). During the eugenics movement, but prior to official sterilization policies being enacted in Canada, “doctors managed to sway government and public health officials to turn to medical sciences for efficient methods of social management and in doing so, made themselves the authority on all things related to health” (Stote, 2015, p. 17). Since Anglo-Saxon society perceived biological and hereditary traits as the cause of social issues, physicians leveraged these racist perspectives to strengthen their position as the profession to implement eugenics interventions (McLaren, 1990). Within the early twentieth century, medical practitioners gained social and political power to become medical experts.

Many pro-sterilization physicians were able to advocate to the medical community and the state for the implementation of sterilization policies. Notable doctors with connections to the Canadian Medical Association, University of Western Ontario, University of Toronto, Toronto General Hospital, Ontario Medical Association, McGill University, Queen’s University, University of Alberta, and other institutions advocated for sterilization of *mental defective* people and racialized peoples to stop the spread of social issues within these communities. These same medical practitioners dismissed colleagues who spoke out and accused them of prejudice in their pro-sterilization agenda (McLaren, 1990). Dr. W.D. Cornwall of Ontario, for example, spoke against sterilization, claiming that “in a capitalist society generous, altruistic, socially minded traits were not valued; accordingly, the poor and weak were ground under, while the ruthless like Al Capone and Mussolini flourished” (McLaren, 1990, p. 89). Cornwall and other medical professionals who were anti-sterilization were a stark minority. The march to developing sterilization policies and other forms of eugenic interventions persisted.

While Alberta and British Columbia enacted formal sterilization policies via the *Sexual Sterilization Act* in 1928 and 1933, respectively, other provinces also carried out eugenics interventions. From 1918 to 1919, surveys completed by physician in eight provinces (Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Ontario, Prince Edward Island, and Saskatchewan), through the Canadian National Committee for Mental Hygiene (CNCMH) now known as Canadian Mental Health Association (CMHA) collected information on people diagnosed with mental deficiency (McLaren, 1990; Wong, 2016). The purpose of these surveys was to guide the measures provinces should take, “to protect itself from internal and external threat of the reproduction of feeble-minded” (McLaren, 1990, p.93). Provinces began placing people diagnosed with mental deficiency in asylums and other institutions like prisons to prevent reproduction; however, Canada looked for other means of birth control. In 1924, the Ontario Health Officials Association won the support of stakeholders to begin sterilizing people deemed mental deficient (1990). The establishment of the Eugenics Society of Canada in 1930 was mainly made up of medical practitioners that cemented national efforts to institute sterilization practices (1990). By 1937, the society claimed responsibility for arranging over 400 sterilizations in Ontario. (1990). To discredit anti-sterilization advocates, the Society discussed the success of sterilization interventions in the United States and Germany throughout the 1930s to demonstrate the benefits of such interventions as a form of birth control amongst the *unfit* (1990). The Eugenics Society of Canada applauded Nazi Germany as a model for sterilization:

Germany is seeking to purify the German people of defective inherited characteristics by widespread compulsory sterilization and over 300,000 persons have been sterilized. In our country under the democratic form of government, we believe in trusting the good

sense of our professional people and depending upon public education to achieve the same ends. (1990, p. 123)

In Ontario, other groups of doctors were working to mandate the practice of sterilization. In 1933, the Ontario Medical Association (OMA) formally endorsed the sterilization of inmates, institutionalized people, and those deemed mental deficient (1990). Doctors and municipal governments across Ontario began supporting the work of the OMA, Eugenics Society of Canada, and other like-minded organizations (1990). The municipal government in my hometown of Barrie, Ontario claimed that mentally defective peoples reproduce with carelessness, which called for their sterilization (1990). This rhetoric was not just perpetuated in Ontario, but across Canada. Ontario, Saskatchewan, and Manitoba proposed sterilization legislation similar to policies enacted in Alberta and British Columbia (Harris-Zsovan, 2010; McLaren, 1990). These bills were defeated largely because of Christian religions implications of preventing life (Harris-Zovan, 2010; McLaren, 1990). Coercive and forced sterilizations, however, still took place outside of legislation in Nova Scotia, Prince Edward Island, Ontario, Manitoba, Saskatchewan, and in Canada's North (Harris-Zovan, 2010; McLaren, 1990). Healthcare institutions outside of Alberta and British Columbia enacted practices of coercive and forced sterilization without formal policy to prevent births amongst those diagnosed by physicians as mentally deficient. The practice of coercive sterilization of people deemed mental deficient was to purify society and combat the threat of their reproduction to ensure the progress of Canada as a white settler state. Sterilization, as a eugenics intervention, used notions of purification to mask ableist, classist, sexist, and racist practices that targeted people deemed as mental deficient to aid the Government of Canada in building a white settler state.

Sterilization within Aboriginal communities upheld colonialism by undermining Aboriginal Peoples connection to their land, communities, and health practices through assimilation and containment (Stote, 2015). Sterilization, as a eugenics intervention, was a method employed to reduce the number of Aboriginal People for which the government had responsibilities based on treaty agreements and other colonial policies (2015). The federal government fell short of establishing a policy to ban coercive and forced sterilization of Aboriginal Women. The state believed that by preventing Aboriginal Women from conceiving, there would be fewer children, thus reducing problems in Aboriginal communities like poor nutrition, infant mortality, and abuse (2015). In Canada, many physicians coercively sterilized Aboriginal Women, thus instating ableist, racist, classist and sexist hierarchies in the provision of healthcare that were underpinned by colonialism and white supremacy. Whether the interventions followed positive eugenics (interventions that increased reproduction amongst white settlers) or negative eugenics (interventions that prevent reproduction among people deemed unfit), medical practitioners used their power as health experts to actively contribute to maintenance of Eurocentric racial hierarchies to ensure white power in Canada.

Physician-Assisted Genocide in Canada

Aboriginal Women were disproportionality targeted for sterilization in comparison to other identity groups. The bias of coercive and forced sterilization of Aboriginal Women through eugenics policies and practices across Canada was known to and supported by the federal government. Indian Health Services was aware that Aboriginal Women were being sterilized by physicians without proper legal channels of consent (Stote, 2015). Additionally, many Aboriginal Women were sterilized for non-medical reasons, which was illegal. In Canada, there was no policy that legalized the sterilization of Aboriginal Peoples. However, the *Indian Act* and

resulting colonial health policies that criminalized Aboriginal Midwives, denied Aboriginal Peoples access to their lands and medicines, segregated care through Indian Hospitals, and evacuated women to southern settler-run healthcare intuitions allowed physicians to target Aboriginal Women for sterilization. Furthermore, physicians diagnosed Aboriginal Women as mental defective so sterilizations could occur without consent. For example, in Alberta, “77 percent of Aboriginal patients presented to the Eugenics Board were diagnosed as a mentally defective, as compared to 46 percent of Western Europeans and 44 percent of Easter Europeans” (Stote, 2015, p. 47). The overrepresentation of Aboriginal Peoples deemed mentally defective, which ensured their sterilization, demonstrated the compliance of physicians in the colonial agenda that aimed to prevent the growth of Aboriginal communities. Furthermore, the state did not take preventative action to stop the practice of coercive and forced sterilization of Aboriginal Women by physicians, thus demonstrating complacency and support of the practice. By purposefully preventing the births in Aboriginal communities through eugenics, physicians within the support of federal and provincial governments committed an act of genocide towards Aboriginal Peoples through the coercive and forced sterilization of Aboriginal Women.

From campaigning for sterilizations policies to performing procedures coercively or without patient’s knowledge, many members of the medical community in Canada broke article II, section (d) of the United Nation *Convention of the Prevention and Punishment of the Crime of Genocide* passed in 1951. The *Convention* defines 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;
- e) Forcibly transferring children from one group to another. (Stote, 2015, p. 127)

Carrying out any of these acts towards a group of people constitutes genocide under international law, and it is obvious through the cases of coercive and forced sterilization of Aboriginal Women that Canada has committed this heinous crime. Through sterilization, physicians aided Canada in upholding the colonial agenda, which built a white settler state, through physician-assisted genocide of Aboriginal Peoples. Canada initially adopted legislation in accordance to the *Convention* that references genocide as a physical destruction of a group of people. Since Aboriginal Peoples are still here, and are increasing in numbers, Canada did not award the term *genocide* to the cases of coercive and forced sterilization of Aboriginal Women. Regardless of the country's designation of genocide, physicians and state legislation prevented births within Aboriginal communities by sterilizing Aboriginal Women more so than any other identity group in Canada as a means to maintain and grow a white settler state.

Colonial health policies that permitted eugenics interventions and hyper-surveillance of Aboriginal Women's reproductive health continues today. The returning of birth to the community through Aboriginal Midwifery is slowly growing, however many Aboriginal Women are evacuated to settler healthcare intuitions for delivery (Lawford, Giles, & Bourgeault, 2018). Furthermore, Aboriginal medicine continues to be treated as alternative medicine in Canadian society when compared the Euro-biomedical model. However, Aboriginal People's healthcare practices have existed on Turtle Island long before the professionalization of medical practitioners and the establishment of the Canadian healthcare system – the Euro-biomedical

model is the alternative health model (Abolson, 2010). As a result of the forced reliance of Aboriginal Peoples on the Canadian healthcare systems through the imposition of colonialism, the coercive and forced sterilization of Aboriginal Women continues. Therefore, the physician-assisted genocide of Aboriginal Peoples continues.

Sexual sterilization legislation was repealed in Alberta and British Columbia in 1972 and 1973, respectively. However, the practice of coercive and forced sterilization of Aboriginal Women has continued across Canada because of physicians. A proposed class-action lawsuit involving more than 100 Aboriginal Women that have been coerced into sterilization was announced in 2019 (Zingel, 2019). Cases spanning from 1985 to 2018 demonstrate that coercive sterilization of Aboriginal Women by Canadian doctors is an ongoing healthcare practice (Barrera 2019; Rao, 2019; Viridi, 2018; Zingel, 2019). Cases of sterilization have occurred in contemporary society across Canada, with 2 allegations in Quebec, 4 from Ontario, 12 from Manitoba, 64 from Saskatchewan, 10 from Alberta, 5 from British Columbia, and one from the North West Territories (Barrera, 2019; Boyer & Bartlett, 2017; Rao, 2019; Viridi, 2018; Zingel, 2019). Internationally, “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 overrepresentation and targeting of Aboriginal Women for sterilization through coercive methods by physicians is an act of genocide because the practice prevents births by Aboriginal Peoples.

In an external review on 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 that promoted sterilization as the responsible option to control births. In their work, *Tubal Ligation in the Saskatoon Health Region: The Lived*

Experience of Aboriginal Women, Boyer and Bartlett (2017), demonstrate that women were told the procedure was reversible, which is untrue. Some women actively resisted by refusing to consent to the procedure, but doctors went ahead with sterilization. Women felt powerlessness and experienced racism by physicians, nurses, and social workers, who in many cases were providing care for them during labour and delivery. The review called for education in medical schools to ensure medical practitioners understand the people they serve. This recommendation, along with the Calls to Action of the TRC demonstrates a formal request for medical practitioners to un-learn colonialism and anti-Indigenous racism during medical school and to build anti-oppressive practices to structurally change the provision of healthcare in Canada. The subsequent chapter will look to the work medical schools have done to counter the racism, sexism, ableism and classism as products of colonialism within Canada that informs medical practices, which permitted the genocide of Aboriginal Peoples through coercive and forced sterilization.

Chapter 2: Answering the Calls to Action of the Truth and Reconciliation Commission in Canadian Undergraduate Medical Education

Colonial medical practices embedded in racism, sexism, classism, and ableism must be challenged in the educational curriculum of Canadian medical schools. The coercive and forced sterilization of Aboriginal Women is a direct result of colonial policies and practices that targeted Aboriginal Peoples for genocide. The practice of coercive and forced sterilization amongst physicians continues within Canada, so too does the genocide of Aboriginal Peoples. In order to end the practice of coercive and forced sterilization of Aboriginal Women medical school educators and administrators must recognize that

racist practices are embedded in a long and nationwide history of racial segregation in hospitals, and notions of who is deserving of medical care and what that care might look like are intimately tied to political, economic, religious, technological, and cultural influences. (McCallum & Perry, 2018, p.16)

Medical schools must counter anti-Indigenous racism within healthcare institutions including undergraduate medical programs in Canada to prevent the genocide of Aboriginal Peoples, through coercive and forced sterilization of Aboriginal Women.

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, by educating students on Aboriginal health issues, Indian Residential Schools, *United Nation Declaration on the Rights of Indigenous Peoples*, Treaties, Aboriginal rights, and Indigenous teachings and practices, which will be referred to as Indigenous content requirements. I leverage the TRC Call to Action to insist on anti-oppressive pedagogies in undergraduate medical education embedded within the curriculum to ensure all students to unlearn biases they hold towards members of the communities they will serve. Anti-oppressive pedagogies acknowledge culture, race, class, religion, gender, ability, sexuality, and other factors that bias the provision of healthcare by medical doctors. Instead of focusing on one form of activism, education, and opposition, anti-oppressive practices is an umbrella term for social justice-oriented approaches like cultural safety, anti-colonial, and anti-racism, which is constantly redefined to address new tensions and social problems (Bains, 2011). Anti-oppressive practices relate both to macro- and micro-social relationships by focusing on individual interactions that are formed by social structures (2011). The implementation of anti-oppressive

pedagogies in medical schools is a strategy to promote anti-oppressive practices in healthcare. By engaging with medical students, educators, administrators, and licensed physicians to implement anti-oppressive practices in the provision of healthcare, the practice of coercive sterilization of Aboriginal Women can be unlearned.

Several stakeholder organizations have worked to implement medical education on the topic of Aboriginal health. The National Indian & Inuit Community Health Representative Organization (NIICHO) began the *Road to Competency* project in 2006 with the aim of developing Aboriginal 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 Aboriginal health centered on cultural safety (Baba 2013). These competencies outlined “the physician’s role in Aboriginal health care as a medical expert, communicator, collaborate, manger, health advocate, scholar and professional” (Baba, 2013, p.11).

In a 2013 review of undergraduate medical programs with cultural safety-related curriculums, many medical schools took steps to increase Aboriginal student representation by offering supplementary application processes and designated spots for Aboriginal students (Baba, 2013). These initiatives increased enrollment of students that self-identified as First Nations, Métis, and Inuit (2013). Furthermore, some schools offered elective courses on Aboriginal health and elective clerkships in Aboriginal communities. However, the Northern Ontario School of Medicine was the only medical school that had taken steps to embed

Aboriginal health within the curriculum for all students (2013). While increasing the number of Aboriginal students in medical schools is a promising initiative, the reality is that white-settler students are the majority of applicants (Friesen, 2019). The advantages of white-settlers is 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 (2019).

The white majority amongst medical students demonstrates the systematic advantage of 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 privilege whiteness and genocidally target Aboriginal Peoples and other racialized peoples.

Within settler institutions, like medical schools, which privileged whiteness and prioritized the healthcare of white people, cultural safety training and increasing Aboriginal student representation in medical schools is necessary to decolonize healthcare and provide healthcare to Aboriginal communities, however, there is more work to be done beyond cultural recognition of Aboriginal Peoples in settler healthcare institutions. 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 Aboriginal culture through cultural safety training, racism is not recognized in healthcare provision, “and in so doing [training programs] implicitly re-center and privilege whiteness as the normative perspective

while failing to address the myriad ways that racism deprives people of opportunity and structures their lives” (2018, p. 13). By implementing anti-oppressive pedagogies in medical education, anti-Indigenous racism can properly be challenged as whiteness is decentred. The 24th Call to Action of the TRC is a call for anti-oppressive pedagogies in medical schools to promote cultural safety, anti-Indigenous racism and other anti-oppressive practices in the Canadian healthcare system to end the physician-assisted genocide of Aboriginal Peoples through coercive and forced sterilization.

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

In 1996, the *Royal Commission on Aboriginal Peoples* (RCAP) identified healthcare practices within settler institutions as oppressive towards Aboriginal Peoples (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). Medical schools in Canada have been asked through two federal commissions, RCAP and the TRC, to educate their students on Aboriginal health to make the Canadian healthcare system acceptable to Aboriginal communities. I offer a review of the work being done to amend Canadian undergraduate medical curriculums under the guidance of the AFMC to answer the Call to Action of the TRC.

All licensed physicians educated in Canada attend medicals school 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 power to determine the requirements for accreditation for medical schools, therefore this association can influence medical schools’ implementation of anti-oppressive pedagogies. It is through this

power that I am advocating for the AFMC to require undergraduate medical education to include anti-oppressive pedagogies.

The AFMC lists *Indigenous Health* as one of the association's priorities under their social accountability mandate. Specifically, the AFMC states 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). Curriculum was one of the themes the AFMC prioritized to answer the 24th Call to Action of the TRC and 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 would be to teach about anti-Indigenous racism, cultural competency, cultural safety, and anti-colonialism.

Within the report, the AFMC acknowledges 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 demands, 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). To review the advancements made in undergraduate medical school curriculums in achieving the action statement proposed by the AFMC, and more importantly the 24th Call to Action of TRC, results from a scan of publicly available undergraduate medical school curriculums are displayed in Table 1.

Additionally, my research results include data from a 2013 study that examined cultural safety-related curriculum in undergraduate medical education. Through a scan of medical curriculums, the AFMC and other stakeholders can better understand each school’s progress in developing curriculum that meets the AFMC’s action statement and Calls to Action of the TRC.

Table 1: Anti-oppression Education in Canadian Undergraduate Medical School Curriculums

Province	School	Cultural Safety- related Curriculum (Baba, 2013)	Anti- Oppression in Curriculum (2020)
Alberta	University of Alberta – Faculty of Medicine and Dentistry	None	<p>Elective Course (University of Alberta, 2020a).</p> <ul style="list-style-type: none"> Indigenous Health – Interprofessional Practice <p>12- module course in Indigenous Health (University of Alberta, 2020b).</p> <ul style="list-style-type: none"> 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>Aboriginal Health Program</p> <ul style="list-style-type: none"> Encourages awareness of Aboriginal health and healing issues <p>Visiting Student Clerkship in Aboriginal Public Health</p> <ul style="list-style-type: none"> Work with First Nations and Inuit 	<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

		<p>Health medical officers</p> <ul style="list-style-type: none"> • Work with a family physician, home care nurse and community health staff at Siksika Reserve 	<p>pressing health concerns in Canada</p> <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	Elective Clerkship: Topics in Aboriginal Health – A community Based Elective	<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	Clinical Practicum: Aboriginal Health	Indigenous Health – Longitudinal Course (University of Manitoba, 2020).

			<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	No Data	<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	No Data	<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>Curriculum includes competency training in Social & Cultural Determinants of Health</p> <p>Elective Clerkship: Aboriginal Health Elective</p>	<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)	Curriculum “themes” include Northern & Rural Health Curriculum “threads” include Aboriginal Health	Curriculum “themes” include Northern & Rural Health and curriculum “threads” include Aboriginal Health (NOSM, 2017) <ul style="list-style-type: none"> • Learn about indigenous health in our Case Based Learning, Community Interprofessional Learning placements, and Integrated Community Experience • 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	None	<ul style="list-style-type: none"> • Elective Clerkship in Aboriginal Community (Queen’s University, 2019).
	Western University – Schulich School of Medicine and Dentistry	None	Course Theme: Diversity and Ethnicity (foundations and first application) (Schulich Medicine & Dentistry, 2020). <ul style="list-style-type: none"> • Indigenous Culture and Health (foundations and first application)
	University of Ottawa – Faculty of Medicine	Pre-Clerkship curriculum requirements include a unit on Aboriginal Health Aboriginal Community Clerkships: Akwesasne, Kitigan Zibi or Pikwakanagan Elective course for Indigenous medical students: The Impact of Traditional Healing	Indigenous Program (uOttawa, 2020). <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	No Data	Indigenous Health Elective (IHE) (University of Toronto, 2020). <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>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 	<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>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 <p>Elective Course: Aboriginal Field Course</p>	<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>Aboriginal Health Rotation – Objectives:</p> <ul style="list-style-type: none"> • Recognition of the historical context as a determining factor underlying current health inequities 	<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

		<ul style="list-style-type: none"> • Recognition of the diversity of Aboriginal populations within the country • Understanding of professional-patient power imbalance <p>Offers one course on traditional Aboriginal medicine and a second course on the historical, cultural, sociological and health perspectives of First Nations</p>	<ul style="list-style-type: none"> • 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>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 	<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>Elective course: Aboriginal Models of Mind and Mental Health</p> <p>Elective rotation: Aboriginal Health and Healing</p>	<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

			<ol style="list-style-type: none"> 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
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Results of Undergraduate Medical Curriculum Scan

Undergraduate medical education programs across Canada vary in engagement with anti-oppressive pedagogies that complies with the action statement made by the AFMC and the Call to Action of the TRC. While each medical school is implementing some degree of cultural competency and/or cultural safety programming through courses and/or clerkship opportunities, anti-Indigenous racism is not specifically addressed in undergraduate medical curriculums. Many curriculums focused 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; Sekerci & Bicer; 2019; Unver, Uslu, Kocatepe, & Kuguoglu, 2019). Education on cultural competency focuses on skill-building exercises that increases healthcare providers understanding of diverse cultures and how to ensure the needs, values, beliefs, and practices of the client is incorporated

into care (Baba, 2013; Karnick, 2016; Polster, 2018). Coined and 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 or safe for a client (Allen & Smylie, 2015; Baba, 2013). Cultural safety reaches beyond cultural sensitivity and competency to look to power imbalances, institutional discrimination, and colonization within healthcare (Baba, 2013). While cultural sensitivity, competency, and safety training offer valuable skills to healthcare professionals serving diverse clients, these trainings do not counter racism that underpins poor and unethical healthcare provided to Aboriginal Peoples.

The action statement made by the AFMC specifically stated that curriculums need to include anti-racism and anti-colonialism as the core of pedagogical framework (AFMC, 2019). Out of the 17 medical schools in Canada, anti-racism was not named in any curriculums nor was anti-colonialism, however 8 schools (University of Alberta, University of British Columbia, University of Calgary, Université Laval, McGill University, Université de Montréal, Northern Ontario School of Medicine, and Université de Sherbrooke) outlined colonialization as a course topic. Therefore, all undergraduate medical programs have to make curriculum revisions to answer the Call to Action of the TRC.

Understanding the significance of Ant-Racism and Anti-Colonialism in Undergraduate Medical Education

Practices and policies rooted in anti-racism and anti-colonialism are critical to the improvement of Aboriginal health. The relationship between race and colonization are intertwined, because white Europeans used socially constructed racial categorization to justify colonization, slavery, and other containment projects involving racialized peoples that benefited

white people (Allen & Smylie, 2015). Racism can broadly be defined as, “actions that further disadvantage the disadvantaged or further advantage the advantaged” (Paradies, Harris, & Anderson, 2008, p.4). Racism is operationalized through institutional, interpersonal, epistemic, and internalized racism. Institutional racism, which is also known as structural or systemic racism, maintains injustice across racial groups through social systems that inform societal practices, policies and progress, which remain unchallenged by those in positions of power that can reduce inequities (Paradies et al. 2008, Reading 2013; Smylie & Allen, 2015). The disproportionate coercive and forced sterilization of Aboriginal Women in settler healthcare institutions is a current example of institutional racism. Interpersonal racism occurs between people through verbal, behavioural, and/or violent slights, slurs, stereotypes, insults, microaggressions, and assaults that are hostile derogatory, and/or negative racial attacks towards an individual or group (Smylie & Allen, 2015). Epistemic racism is the positioning of knowledge, commonly Eurocentric knowledge or knowledge produced by white people as more superior than knowledge from racialized peoples (Reading, 2013; Smylie & Allen, 2015). The dominance of the Euro-Canadian biomedical model over Aboriginal health knowledge systems is an example of epistemic racism. Finally, internalized racism is the individual act of, “acceptance and internalization of negative, stereotypical beliefs, attitudes or ideologies about the inferiority of one’s racial group” (Smylie & Allen, 2015, p.5). All four components of racism contribute to discrepant health indicators and outcomes for Aboriginal Peoples.

Health disparities are caused by racism—not race. Racism enacted within the Euro-Canadian biomedical model has created a system that privileges the health and wellbeing of white people at the expense of Black people, Aboriginal Peoples, and People of Colour. The healthcare system utilizes racism to inform healthcare policy and practice. Eugenics guided by

racism permits medical interventions, like the coercive and forced sterilization of Aboriginal Women, to protect white people in Canada through physician assisted genocide of Aboriginal Peoples. Further consideration of the historical and ongoing practice of coercive and forced sterilization of Aboriginal Women must not only be understood as through racism and colonialism, but also through ableism, classism and sexism that painted Aboriginal Women as hyper-sexual beings and bad mothers with low IQs. Consequently, racism, sexism, ableism, classism and colonialism function to shape social determinates of health, health disparities, and access to care for Aboriginal Women. Therefore, undergraduate medical school curriculums must address anti-colonialism and anti-racism, as a minimum standard, because the surveillance of Aboriginal Women continues in healthcare, through the practice of forced and coercive sterilization, and policies that undermine Aboriginal midwifery, evacuate pregnant Aboriginal Peoples from their communities, and remove Aboriginal children from their mothers and communities at disproportionate rates when compared to non-Aboriginal people (Stote, 2015). I impress upon medical school administration to actively commit to the action statement made by the AFMC to make anti-racism and anti-colonialism a core component of medical education by implementing anti-oppressive pedagogies.

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 Aboriginal Peoples and non-Aboriginal people can be appreciated as a method to avoid addressing racism in healthcare and on a larger scale in Canada (Browne, 2005 Smylie & Allen, 2015). The use of culture to diffuse discussions of racism in Canada is not new (Browne, 2005; Henry, Tator, Mattis & Rees, 2006). By pinpointing culture within medical education as the social determinate of health causing health

disparities in Aboriginal communities, medical school administrators fail to acknowledge institutional and epistemic racism, racism happening at macro-levels of social interaction, within the Canadian healthcare system, which permits racism at micro-levels in the form of interpersonal and internalized racism. In other words, undergraduate medical school curriculums do not acknowledge the role of institutional and epistemic racism in shaping interactions between Aboriginal clients and healthcare providers. Medical school curriculums that are culturally-focused must analyze how culture became a way of oppressing Aboriginal Peoples. Racism and colonialization, both in historical and contemporary contexts, influence the marginalization of Aboriginal culture from white culture (Smylie & Allen, 2015). Therefore, culturally-focused curriculums must be adapted to be paired with anti-racism and anti-colonial pedagogies to properly discuss health disparities within Aboriginal Communities.

Working towards Anti-Oppressive Pedagogies in Undergraduate Medical Education

The historical and ongoing coercive and forced sterilization of Aboriginal Women demands justice in medical education to prevent medical practitioners from continuing this genocidal practice. Through Aboriginal-led and institutionally funded and supported Indigenous course requirements rooted in anti-oppressive pedagogies, medical schools can properly begin Indigenizing and decolonizing medical education to lay a foundation to combat racism, colonialism, sexism, classism, and ableism within the Canadian healthcare system.

Medical school administration and faculty have a responsibility to implement anti-oppressive pedagogies within undergraduate medical curriculums. Racism, sexism, ableism, classism, and colonialism within Canada's healthcare system enable the ongoing practice of coercive and forced sterilization of Aboriginal Women at the hands of physicians. By Indigenizing and decolonizing undergraduate medical education through anti-oppressive

pedagogies, medical education programs lay a foundation for changing healthcare. It is from this vantage point that I assert anti-oppressive pedagogies are necessary to decolonizing and Indigenizing undergraduate medical education to unlearn unethical medical practices like coercive and forced sterilization of Aboriginal Women.

Indigenous scholars and anti-racist scholars in Canada identify ignorance as an impediment to the process of decolonization (Grenier, 2020; Schaepli, Godlewska, Korteweg, Coombs, Morcom, & Rose, 2018). Within healthcare, and other institutions, ignorance permits the continuation of unjust systems that retrench inequities faced by Aboriginal Peoples (Couthard, 2014, Dion, 2009, Schefli et al., 2018). It is through “what is taught and what is omitted from curricula and textbooks, through how content is taught, and through the mindsets of teachers and teacher educators” (Schaepli et al., 2018, p. 692) that ignorance within medical education programs is maintained and passed along to every cohort of learners. I strongly insist that by answering the TRC Calls to Action and embodying the social accountability action statement regarding Indigenous Health made by the AFMC, Canadian medical schools can begin to decolonize and Indigenize undergraduate education.

A study conducted across 10 Ontario Universities involving 2,899 first year undergraduate students who graduated from an Ontario secondary school answered a questionnaire to determine knowledge surrounding Aboriginal geographies, histories, culture, governance, and current events (Schaepli et al., 2018). The questionnaire was designed in partnership with over 200 First Nations, Métis, and Inuit educators based on what students should know from the Kindergarten to Grade 12 (K-12) curriculum in the province of Ontario. The average score on the questionnaire was 24.28% ($SD = 16.06\%$, range of 0 to 86%), with Aboriginal students scoring higher than non-Aboriginal students on average, thus suggesting that

most students have had little to no exposure to question topics. The results of this study demonstrate that non-Aboriginal university students do not have an understanding of Aboriginal geographies, histories, culture, governance, and current events, therefore ignorance is prevalent amongst individual students and the education system when it comes to the lives of Aboriginal communities within Canada.

One of the most overwhelming findings of this questionnaire was that, “students seem to believe that wherever Indigenous people are, they are not *here*; not present and by implication not relevant to their daily lives” (Schaepli, 2018, p. 718). This result is not surprising because high school courses related to Aboriginal geographies, histories, culture, governance, and current events in Ontario high schools are optional. I thus extrapolate that non-Aboriginal undergraduate medical students would perform similarly on the questioner, because university level courses about Aboriginal geographies, histories, culture, governance, and current events are not mandatory prerequisites to apply to Canadian medical schools. Nevertheless, Schaepli et al. (2018) demonstrated a gap in education that creates conditions of ignorance related to Aboriginal Peoples, their geographies, their histories, their cultures, and current life experiences in Canada that can exacerbate poor and unethical healthcare in settler institutions for Aboriginal Peoples.

As medical schools respond to the Calls to Action of the TRC, there are fears amongst Aboriginal scholars that Indigenous content requirements will be a quick-fix solution or item on a check list, which will result in superficial and tokenistic changes with minimal consideration by medical institutions (Gaudry & Lorenz, 2019). Dr. Lisa Richardson, an Anishinaabekwe physician, educator, and 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 strongly assert that courses on anti-racism and anti-colonialism rooted in anti-oppressive pedagogies are important foundational tools to eradicate oppression within healthcare systems in Canada through medical education.

Medical school educators and administrators have to grapple with the issues of implementing Indigenous content requirements through anti-oppressive pedagogies. Through a survey of Aboriginal faculty, administrators, graduate students, and instructors and scan of social media of Aboriginal Peoples teaching Indigenous content in post-secondary education, Gaudry & Lorenz (2019) present themes dealing with issues of Indigenous-focused teaching and learning regarding coercive course selection, content, and pedagogical framework. The question of implementation of Indigenous content requirements in medical schools have not been 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?
(p.163)

Medical educators and administrators under the guidance of the AFMC must understand how tokenistic implementation of Indigenous content requirements can have harmful effects on Aboriginal Peoples.

Implementing mandatory courses related to Aboriginal Peoples has been largely critiqued as coercive course selection and counterproductive to building a knowledge base (Gaudry & Lorenz, 2019). Coercive course selection means that a course is required to be completed

successfully in order for the learner to complete their academic program, in this case, undergraduate medical education. The goal of Indigenous content requirements is to change attitudes of students and encourage further learning, which can be a unrealized goal if students feel coerced. Instead, they may simply go through the motions to pass the course and add it to the check-list of degree requirements. Some Aboriginal professors and instructors report facing resistance from settler students who take a course only because it is mandatory, a relationship that is harmful to Aboriginal faculty, students, and communities (Gaudry & Lorenz, 2019; Hollinsworth, 2016). Therefore, the needs and safety of Aboriginal Peoples and communities must be central to the development of Indigenous content requirements (Gaudry & Lorenz, 2019). The centering of Aboriginal Peoples and communities' needs creates the potential for relational accountability between medical schools, the students they train, and Aboriginal communities they serve. By centering relational accountability in the education of non-Aboriginal people in settler intuitions promotes learning *with* Aboriginal communities, as oppose to learning *about* Aboriginal communities (Wilson, 2008).

Medical schools must be aware that Aboriginal faculty and students are often exploited through unpaid labour and are over-worked in the creation of Indigenous content requirements. Aboriginal scholars are calling for the utilization of knowledge, experience, and expertise of Aboriginal faculty members to lead decolonization of education, which requires “greater funding for the development of Indigenous-focused courses” (Gaudry & Lorenz, 2019, p.165). To properly implement Indigenous content requirements, the initiative requires material commitments to social justice at the university level through the acceptable funding of courses and content development, and for the labour and engagement of Aboriginal Peoples and communities in decolonizing education. Aboriginal Peoples working as faculty or in other

academic positions at universities are a small labour pool who are often tasked with high administrative and academic responsibilities (2019). Aboriginal Peoples working with or at universities face greater demands than non-Aboriginal Peoples, which prompted an Aboriginal scholar surveyed to claim that

universities ‘cannot always rely on the Indigenous population to bear the burden and emotional labour of teaching and training non-Indigenous colleagues,’ while one more was troubled that most academics will only give ‘lip service... without willingness to engage deeply’ in the kind of work that Indigenous peoples are expected to carry out. (2019, p.166)

Many settler faculty members put the onus on Aboriginal faculty to solely develop Indigenous content requirements as oppose to sharing the labour (2019). Therefore, the small pool of Aboriginal faculty is overburden by the work of Indigenizing settler educational institutions without support of settler faculty members. There is a concern there are not enough Aboriginal faculty to take on the work required to bring Indigenous content requirements to post-secondary institutions. As medical schools work to answer the Calls to Action of the TRC and Aboriginal faculty are expected to do more work to lead the development of Indigenous content requirements, Gaudry and Lorenz (2019) recommend reallocation of resources at the level of the university. By increasing funding and academic resources to support the labour of Aboriginal Peoples working at or with universities, ensures the labour of Aboriginal faculty, scholars, students, and communities are sustainable as oppose to exploitative (2019). Additionally, non-Aboriginal academics, specifically white settlers, need to participate in the work of decolonizing and Indigenizing post-secondary institutions by working in collaboration with Aboriginal

scholars to reduce their burden of developing and implementing Indigenous content requirement (2019).

Lastly, rooting Indigenous content requirements in anti-oppressive pedagogies works to avoid the operationalization of racism and colonialism in the classroom, which is harmful and violent for Aboriginal Peoples and communities (Gaudry & Lorenz, 2019; Hollinsworth, 2016). In a survey of Aboriginal scholars, many respondents criticized adding onto course with Indigenous content requirements as this contributes to a check-list approach of Indigenizing and decolonizing education making content tokenistic (Gaudry & Lorenz, 2019). Instead, respondents called for either embedding Indigenous content into the curriculum or offering courses solely on Indigenous content. Aboriginal scholars and faculty members advocated for either method of bringing 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” (2019, p. 167). Pedagogically, anti-oppression must be at the core of every medical school curriculum 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). 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 an institution where Euro-biomedical knowledge continues to silence Aboriginal knowledge systems through Eurocentrism and white supremacy.

Anti-oppressive pedagogies offer a praxis to destructing Eurocentric knowledge within undergraduate medical education to allow for Indigenization and decolonization of the

curriculum. Respondents of the survey suggest that, “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” and additionally function to, “embody transformational education while also assisting in a process of unlearning” (2019, 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 teachings of Canadian history, medical students, particularly white settler students, must be willing to engage and accept the truths presented to them through these courses that counters Eurocentric rhetoric. Above all, faculty members and administration working with undergraduate medication education programs must root their work in training future practitioners in anti-oppressive pedagogies and counter Eurocentric rhetoric within their own teaching. 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 Aboriginal 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 Calls to Action of the TRC and the action statement made by the AFMC on Indigenous Health.

Chapter 3: Countering White Supremacy in Healthcare to Prevent Coercive and Forced Sterilization of Aboriginal Women

Physicians who advanced eugenics interventions through coercively sterilizing Aboriginal Women utilized racism, colonialism, sexism, classism, and ableism to benefit Canada. By decreasing the Aboriginal population through this genocidal practice, the state was

able to gain access to treaty lands, which further contained Aboriginal Peoples for the direct and long-lasting benefit of the state and white settlers. The state created systems to ensure white people had power through social, cultural, and economic capital at the expense of Aboriginal Peoples, Black People, and People of Colour. Therefore:

a desire to mould Canada into a distinctly white settler state is evident, for example, in the dispossession, removal and discipline of Indigenous people; the exclusions, segregation, and marginalization of people of colour; and the creation and repetition of pervasive national narratives about Canada that valorize white settlement and governance. (McCallum & Perry, 2018, p.16)

The maintenance of white power in Canada to create a white settler state is an act of white supremacy because colonial policies use race to develop the hierarchal organization of society to position white people as superior (Allen & Smylie, 2015; Grenier, 2020; McCallum & Perry, 2018). I assert the historical and ongoing cases of forced and coercive sterilization of Aboriginal Women are acts of white supremacy that must be unlearned as a medical practice through the implementation of Indigenous content requirements through anti-oppressive pedagogies in undergraduate medical education in Canada.

Healthcare as White Supremacy

White supremacy is produced through violence and racial structures to create and maintain a white settler state (Bonds & Inwood, 2016). Coercive and forced sterilization was but one component of national violence rooted in white supremacy. The healthcare system in Canada, thus, was developed on presumed racial superiorities and inferiorities to uphold a white settler state through the genocide of Aboriginal Peoples. Consider idolized figures, like Tommy Douglas, in Canadian and medical history that played a massive role in the eugenics movement.

Douglas, known as the “Father of Medicine,” endorsed eugenics interventions, like sterilization, in his Master’s thesis completed at McMaster University (Bronca, 2016; Shevell, 2012).

Considered by the CBC in 2004 to be on the list of “Greatest Canadians,” Douglas, during the first half of the 20th century, advocated for sterilization of *mentally deficient* and *un-moral* women (Shevell, 2012). Douglas amongst other notable and beloved Canadians, like Emily Murphy and Nellie McClung, whom also contributed to promoting eugenics interventions, are celebrated nation-wide. As Canadian settlers celebrate Douglas, Murphy, McClung, and others that worked to create a white settler state, thus advocating for white supremacy, the genocide of Aboriginal Peoples through the coercive and forced sterilization of Aboriginal Women remains a current eugenics tool. These genocidal acts are happening now and are conducted by physicians; therefore, white supremacy is still a present force that shapes the delivery of healthcare in Canada for Aboriginal Peoples.

White supremacy is entrenched within the Canadian healthcare system. Healthcare delivery through the Euro-Canadian biomedical model situates white people as the norm, therefore Aboriginal Peoples, Black People, and Peoples of Colour are racialized within the institution (Allen & Smylie, 2015; Berg, 2012; Grenier, 2020; Hole et al., 2015; McCallum & Perry, 2018; Wilkes, 2020). The normalization of whiteness has a long-standing history. In the late 19th and early 20th century, Social Darwinism theorized that Indigenous Peoples and Black People, globally, were the least evolved race and as such, they presented uncivilized behaviours that needed saving by white people (Berg, 2012, Dyck, 2013; Grenier, 2020; Harris- Zsovan, 2010; Hole et al., 2015; McLaren, 1990; Stote, 2015). Eugenics and other forms of Social Darwinism were taken up by government officials to justify colonialization and imperialism as a civilizing mission of Black People and Indigenous Peoples through tactics that include, but are

not limited to, slavery, genocide, assimilation, and containment. In fact, it is through Eurocentrism that

construction of different races, and more specifically the hierarchal organization of race to support white supremacy, was used as the basis for racist legislation such as the ‘Jim Crow’ and blood quantum laws of the United States (US), the apartheid laws of South Africa, and the Indian Act of Canada. (Allen & Smylie, 2015, p.4)

White supremacy has been upheld by the Canadian government and disseminated through the white settler state through policies and practices that maintain racial hierarchies to enforce white power. Within the Canadian healthcare system, the genocidal legacy of coercive and forced sterilization of Aboriginal Women is just one example of white supremacy.

In Canada, the *Indian Act* along and other state policies that regulated Aboriginal life in order to facilitate the genocide and assimilation of Aboriginal Peoples is directly linked to white supremacy because these policies function to build a white settler state. The *Sexual Sterilization Act* in Alberta and British Columbia along with the practice of coercive and forced sterilization of Aboriginal Women across Canada, are acts of white supremacy through genocide. The *Indian Act* forced Aboriginal Peoples to use the state’s healthcare systems and rendered the practice of Aboriginal health knowledges illegal, for example Aboriginal Midwifery was made illegal in the early 20th century (Lalonde, Butt & Bucio, 2009; Lux, 2016; Neufeld & Cidro, 2017; Stote, 2015). The criminalization of Aboriginal health knowledges is an act of assimilation to ensure Aboriginal Women would have to use healthcare that was provided by the settler state, which allowed for increased surveillance of their sexualities and reproduction. Physicians, Indian Agents, and government officials used the healthcare system to quarantine, contain, and institutionalize Aboriginal Peoples to aid the state in gaining access to land that housed

Aboriginal communities (Grenier, 2020; Lux, 2016; Neufeld & Cidro, 2017, Stote, 2015).

Through the enforced use of Canadian healthcare systems, Aboriginal Peoples were forced to engage with physicians trained through the Euro-Canadian biomedical model. A model that is connected to Eurocentrism and places white people as superior to Aboriginal Peoples (Harris-Zsovan, 2010; Stote, 2015). By forcing Aboriginal Peoples to engage with Canadian healthcare systems, the state gained control over Aboriginal bodies allowing for the practice of coercive and forced sterilization.

Within the Canadian healthcare system, physicians were able to coercively and forcibly sterilize Aboriginal Women because the settler state saw this intervention as a means to curb illness, poverty, and other social problems that were presumed to be caused by the moral shortcomings of Aboriginal Peoples. Through the implementation of Social Darwinism, eugenicists theorized that Aboriginal Peoples lacked morality compared to white people, therefore interventions like coercive and forced sterilization were a permanent solution to public health problems because Aboriginal populations decreased (Dyck, 2013; Harris-Zsovan, 2010; McLaren, 1990; Stote, 2015; Stote, 2012). To ensure the genocide of Aboriginal Peoples through the coercive sterilization of Aboriginal Women, the state enacted policies to prevent fertility of Aboriginal Women, whilst promoting the fertility of white women by banning their sterilization, unless they met strict criteria, like having five or more children (Dyck, 2013). Aboriginal Women, described as *the moron girl*, were seen as threats to the white settler state because of their ability to reproduce (Stote, 2015). Therefore, the state enacted policies to ensure that Aboriginal Women would be sterilized. The use of IQ tests by physicians, to avoid patient consent for sterilization procedures, assessed intelligence based on Eurocentric knowledge. Physicians, along with Eugenics Boards and policy makers, not only position whiteness in terms

of race as superior, but also in terms of knowledge. Placing Eurocentric knowledge systems as superior to Aboriginal knowledge systems positions white people as intellectually superior to Aboriginal Peoples. Physicians used IQ tests to label Aboriginal Peoples as *mentally defective* to forced Aboriginal Women to undergo sterilization procedures to prevent their reproduction to maintain a white settler state. Furthermore, white women, described as the *mother of the race*, were encouraged to reproduce and were not allowed to be sterilized unless they had a certain number of children to aid in building of the nation to be a white settler state (Dyck, 2010; Stote, 2015). Sterilization maintained white power through the genocide of Aboriginal Peoples by preventing reproduction and through the promotion of fertility amongst white women.

Building of a white settler state through genocide via forced and coercive sterilization mediated by the Canadian healthcare system is an act of white supremacy permitted by the state and carried out by physicians and other healthcare professionals. The ongoing practice of coercive and forced sterilization of Aboriginal Women, and genocide of Aboriginal Peoples demonstrates that the healthcare system in Canada still operationalizes white supremacy.

Eradicating White Supremacy in Undergraduate Medical Education

Considering the coercive and forced sterilization of Aboriginal Women is a contemporary healthcare practice in Canada, many physicians remain complicit in building a white settler state, and thus are engaging in white supremacy and genocide. 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 imbedded into the curriculum to lay a foundation for the eradication of white supremacy in healthcare services.

Aboriginal Women are being coerced into tubal ligation; a type of sterilization performed after childbirth. At University Hospital in Saskatoon, seven Aboriginal Women were coerced into sterilization (Boyer, 2017; Boyer & Bartlett, 2017; Soloducha, 2017). These women explained that 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 Aboriginal Women is a medical practice stemming from anti-Indigenous racism that has been a part of the Canadian healthcare system since confederation. With over 100 Aboriginal Women across Canada reporting that they too have experienced coercive and forced sterilization, undergraduate medical education must address at 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 Aboriginal Peoples was granted to non-Aboriginal physicians through the professionalization of medicine within Canada during the late 19th and early 20th century, which coincided and is connected with the eugenics movement. The Canadian government awarded governing colleges, like the Royal College of Physicians and Surgeons of Canada, the rights to oversee the licencing of physicians trained through the Euro-Canadian biomedical model. Non-Aboriginal physicians, namely white physicians, gained power to control healthcare services and provision of care through the imposition of colonization, which is underpinned by white supremacy. Settlers physicians, along with the government, built healthcare institutions to racialize, kill, and contain Aboriginal Peoples to create a white settler state. Without question, the violence of colonialism

continues to exist in Canada as there are over 100 cases, as recent as 2018, of Aboriginal Women being forced and coerced into sterilization. White supremacy is a part of healthcare in Canada.

To answer the Calls to Action of the TRC, medical schools must make a commitment to dismantling white supremacy within the healthcare in Canada. Considering the results of undergraduate medical curriculum review, displayed in table 1, medical educators and administrators must build upon culturally-based learning to incorporate anti-racism and anti-colonialism within the curriculum. By rooting undergraduate medical education in anti-racism and anti-colonialism, medical schools challenge white supremacy by Indigenizing and decolonizing the curriculum, which challenges education that establishes racial hierarchies that position whiteness as superior and justifies colonization. Education that solely focus on accepting, acknowledging, and allowing for cultural difference through cultural sensitivity, competency, and safety training does not challenge racism or white supremacy in undergraduate medical education. The Canadian government promoted multiculturalism, through culturally-based training in Canadian institutions as a method to avoiding the use of language surrounding race and ethnicity (Grenier, 2020). Within healthcare and medical education in Canada, cultural sensitivity, competency, and safety training is seen as the method to promote health equity. However, “cultural competency should be regarded not as a response to, but rather as a logical product of, institutionalised racism that functions as a tool in the reproduction of White supremacy in healthcare systems” (2020, p.3). Culturally-based training in healthcare normalizes whiteness and makes Black People, Indigenous Peoples, and People of Colour the *Other*. The presumed white physician is learning about *the Other* and perfects their skills to abilities to treat *all Others* (2020). Therefore, the white healthcare provider is pictured as the knower of *the Other* and the problem solver in the fight against oppression, whilst *the Other* is the problem that

becomes fixed (Grenier 2020; Razack 1995). Using a more self-reflexive culturally-based education, like cultural humility training, which “provides a personal evaluation of one’s own cultured positioning such that it brings about greater understanding for others’ cultures, perspective and realities” (Carey, 2015, p. 835), decenters whiteness from learning, such that whiteness is no longer normalized. Dismantling white supremacy cannot only consist of cultural humility, medical schools must go beyond the rhetoric of multiculturalism and dismantle anti-Indigenous racism.

Currently, medical education at Canadian medical school focuses solely on cultural competency, sensitivity, and safety in relation to Aboriginal Health. In order to deconstruct white supremacy within the healthcare system in Canada, education needs to de-centre whiteness, so Eurocentrism is no longer normalized within the provision of care. Anti-oppressive pedagogies enforce an educational framework that pivots from normalizing whiteness through cultural competence, by dismantling Eurocentric knowledge systems that maintain white supremacy and there by anti-Indigenous racism (Grenier 2020; Gaudry & Lorenz, 2019). To answer the Calls to Action of the TRC and implement the action statement made by the AFMC, medical school administration needs to imbed anti-oppressive pedagogies within undergraduate medical education curriculums.

Conclusion

Over 100 Aboriginal Women have bravely come forward, in recent years, 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 within the Canadian healthcare system. In the early 20th century, physicians with the support of federal and provincial governments ushered in eugenics interventions, which targeted Aboriginal communities across

Canada (Dyck, 2013; McLaren, 1990; Stote, 2012; Stote, 2015). Additionally, the Canadian government criminalized Aboriginal healthcare, such that Aboriginal midwifery and other reproductive health practices were illegal (Stote, 2015). Through the *Indian Act* and other colonial policies, Aboriginal Peoples were forced to use the Canadian healthcare system, which allowed physicians to surveil Aboriginal bodies that were contained within institutions, like Indian Hospitals (Lux, 2016). As Aboriginal Women were forced to seek healthcare by settler physicians, they became targets for eugenics interventions, such as sterilization. The goal of sterilization was to prevent births in Aboriginal communities, through genocide, to aid in assimilation of Aboriginal Peoples in order for Canada to remain a white settler state (Stote, 2015). As physicians continue the practice of coercive and forced sterilization of Aboriginal Women in present day, they also continue the genocide of Aboriginal Peoples and maintain white supremacy that was established with colonization.

I implore physicians, governing bodies of medicine and medical education, and future physicians to understand that coercive and forced sterilization of Aboriginal Women must end because it is an act of genocide. I leverage to educators and administrators of undergraduate medical education in Canada the need for proper training to unlearn anti-Indigenous racism in healthcare that permits genocide of Aboriginal Peoples. Based on the 24th Call to Action of the TRC (2015) and the action statement made by the AFMC on Indigenous health, I ask that medical schools implement Indigenous content requirements through anti-oppressive pedagogies within undergraduate medical education. In a review of undergraduate medical education curriculums, medical schools have taken steps to incorporate Indigenous content requirements through cultural sensitivity, competency, and safety training through courses and clerkships. However, education must now be root in anti-oppressive pedagogies to combat racism and

colonialism. An-overhaul of Canadian undergraduate medical education is a small price to pay for the long-standing legacy in healthcare of coercive and forced sterilization of Aboriginal Women. Thousands of Aboriginal Peoples have been 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 urge the 17 medical schools in Canada, the AFMC, the Canadian Medical Association, and Royal College of Physicians and Surgeons of Canada to act on the 24th Call to Action of the TRC to decolonize and Indigenize medical education. Reconciliation is not only accomplished by Aboriginal Peoples' resistance against colonialism, settlers need to act in solidarity with Aboriginal Peoples. We, as white settlers, have been given recommendations to facilitate reconciliation and decolonization in Canada, it is time that we act.

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