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CMA APOLOGY TO INDIGENOUS PEOPLES: HISTORICAL AND ETHICAL REVIEW REPORT

September 2024



TRIGGER WARNING

The content uncovered by the Canadian Medical Association's (CMA's) research is triggering; for example, outdated and racist terms are used, and the disrespect and disregard that are fundamental to systemic racism are exhibited.

Please take your time and consider self-care and mental health supports when reviewing this content.

Below is a list of culturally appropriate supports:

THE INDIAN RESIDENTIAL SCHOOL CRISIS LINE: 1-866-925-4419

The crisis line is available 24 hours a day for anyone experiencing pain or distress as a result of a residential school experience.

HOPE FOR WELLNESS HELPLINE: 1-855-242-3310, OR CHAT ONLINE AT [HOPEFORWELLNESS.CA](https://www.hopeforwellness.ca)

The Hope for Wellness Helpline offers immediate help to all Indigenous Peoples across Canada in the following languages: Ojibway, Cree, Inuktitut, English and French. They provide 24/7 culturally grounded assessment, referrals, counselling and support in times of crisis, including suicide intervention.

SUICIDE CRISIS HELPLINE: CALL OR TEXT 9-8-8 (TOLL-FREE)

The Suicide Crisis Helpline provides a safe space to talk, 24 hours a day, every day of the year. This service is available in English and French.


The methodology supporting this report was guided by various Indigenous experts; however it was deemed important that non-Indigenous CMA staff take on the significant work of reviewing the material discovered during this process to uncover the truth first-hand. What is presented in this document pertains to historical information largely voiced from a settler perspective and has been written by settlers. Within our action plan moving forward we intend to address these gaps in concrete ways in partnership and allyship with Indigenous leaders.

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EXECUTIVE SUMMARY

This report is organized into four sections: 

SECTION 1: REVIEW OF CMA ARCHIVES AND SOCIAL MEDIA ACCOUNTS

SECTION 2: HISTORICAL REVIEW OF PARLIAMENTARY RECORDS

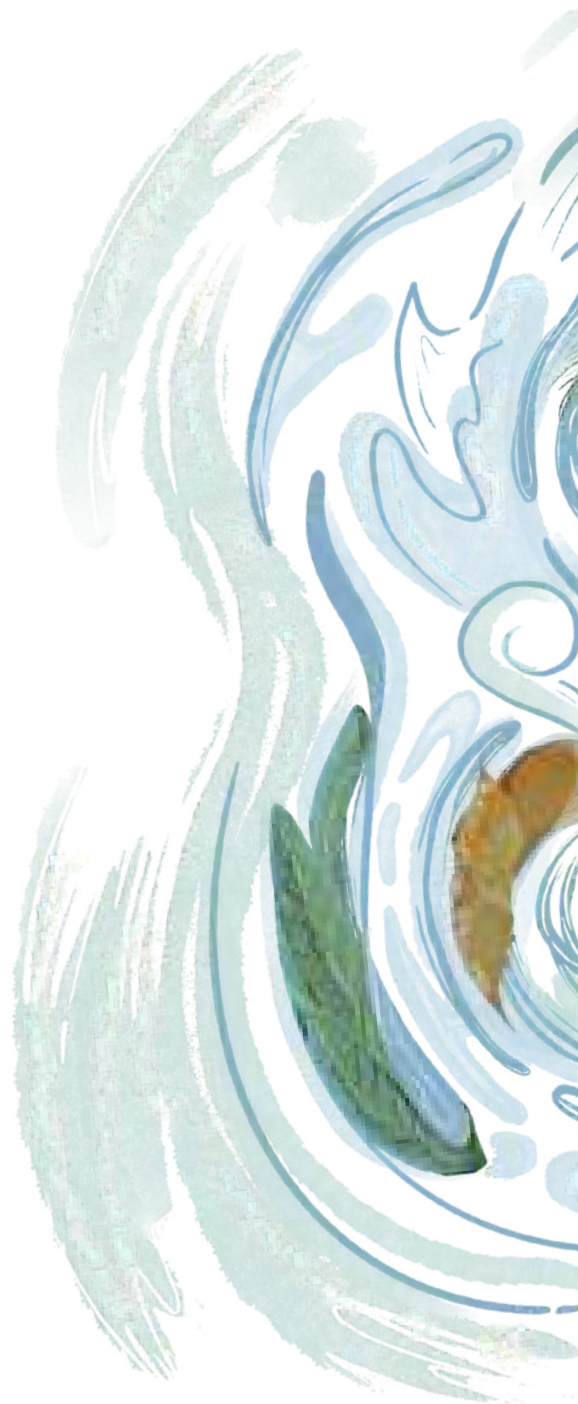
SECTION 3: ETHICS REVIEW OF CMA ARCHIVES AND PARLIAMENTARY RECORDS

SECTION 4: REVIEW OF THE CMA'S LEADERSHIP SELECTION PROCESS

In June 2023, the Canadian Medical Association (CMA) announced its commitment to a formal apology for the harms caused to Indigenous Peoples by the CMA as the national voice representing physicians across Canada. As part of that process, the CMA embarked on a historical review of its archives and social media accounts, as well as a review of material published in the *Canadian Medical Association Journal (CMAJ)*. This report contains the findings of the historical review of the CMA archives and social media. A separate review of *CMAJ* is currently underway (results will be shared in 2025); however some references to *CMAJ* articles that were uncovered during the search of the CMA archives are referenced in this report to provide context.

To facilitate the historical review, CMA staff took an inventory of all information types available in the archives and their location. With the guidance of a majority Indigenous-owned consulting firm, select members of the CMA's original Indigenous Guiding Circle, the CMA Board of Directors and CMA staff, 44 significant events were highlighted for review. During the course of this search additional materials were discovered that fell outside of these specific events but were still deemed relevant and included in the analysis. For more detailed information on the events searched and how the research was conducted, please see the research methodology section of this report.

The results of the historical review of the CMA archives and social media accounts were grouped into the following categories: Indigenous-specific racism and inequity in the health system; forced or coerced sterilization of Indigenous Peoples; medical experimentation on Indigenous children and adults; and forced relocation and residential schools. For background purposes, additional research was conducted beyond what is contained in the CMA archives (e.g., the death of Brian Sinclair, the Canada Food Guide, the relocation of Inuit to the high Arctic).



For many of the events and dates chosen for review, there was very little found in the CMA archives or on its social media accounts (a significant portion of these events pre-date social media platforms). While concerns regarding inequity in health outcomes of Indigenous Peoples were being raised by some as far back as the early 1900s, from a review of the archives it appears these concerns were largely unaddressed by the CMA and the medical community as a whole. For example, the efforts of Dr. Peter Bryce to draw attention to the deplorable conditions in residential schools were not acknowledged by the CMA from when he published his first report in 1907 to his death in 1932. There was also no mention of Dr. Bryce's endeavours to raise awareness of the maltreatment and abuse Indigenous children experienced in residential schools in his obituary published in *CMAJ* the year of his death.

From the review of the documents found during the targeted search of the CMA archives from this period, it would seem the greatest area of concern when it came to Indigenous patients was remuneration. The CMA raised the issue of inadequate remuneration of physicians for the treatment of Indigenous patients with the federal government on

numerous occasions well into the 1960s. However, it was also in the mid-1960s that the CMA began to raise serious concerns regarding the care of Indigenous patients, particularly in the area of maternal welfare. At the 1968 meeting of the CMA General Council a motion was passed to severely censure the federal government for its move to require Indigenous patients to pay for their medical care and transportation to medical facilities in the interest of saving money, noting that such measures would "result in a deterioration of maternal and child health care amongst the Indians and Eskimos."

References to issues such as forced or coerced sterilization, medical experimentation and the forced relocation of Inuit were

also largely absent from the records searched. For instance, there are no specific references to the forced sterilization of Indigenous women in Canada in the CMA archives until an article in the August 2017 edition of *CMAJ*. A review of the CMA's social media posts from this time period using keywords such as "forced sterilization", "coerced sterilization," "tubal ligation," and "Indigenous women" produced very few results. As well, Prime Minister Justin Trudeau's formal apology in 2019 for the mistreatment of Inuit with tuberculosis, including any public comments by the CMA on its social channels, yielded no search results. This silence is noteworthy given the gravity and scope of the harms caused to Inuit by Canada's tuberculosis policies.

It is only in very recent years that the CMA has acknowledged anti-Indigenous racism in the health system, with the release of the Truth and Reconciliation Commission of Canada's report in 2015 marking a turning point for the CMA.



From this point onward, there has been a marked increase in the CMA's work in Indigenous health, although as the previous paragraph demonstrates, there is room for improvement.



In addition to the review of the CMA's archives and social media accounts, a review of publicly available parliamentary records, primarily committee hearings and parliamentary debates from 1871 to the end of 2023 that reference the CMA was conducted. The records were then assessed to identify those that refer to the CMA's advocacy on topics related to Indigenous health. An analysis of those records revealed several instances where the CMA either failed to advocate on behalf of Indigenous patients (including failing to specifically call to attention the disproportionate impact of certain issues on

Indigenous Peoples) or made statements that displayed racist, colonial and paternalistic attitudes toward Indigenous patients. For example, in one instance a CMA spokesperson supported a system where Indigenous Peoples should pay a portion of the cost of health services to "introduce them to citizenship in this country, which is our main objective." This was in 1961, before the federal government passing the Medical Care Act in 1966.

The review also demonstrated instances where the CMA did advocate for policies that might have benefited Indigenous Peoples or helped support Indigenous health, such as advocacy in support of Indigenous self-determination and the identification of self-determination as a determinant of health for Indigenous Peoples, and more recently, calls for more supports to increase the number of Indigenous health workers.

The parliamentary records, as well as the archival and social media records uncovered during the historical search process, were also examined utilizing the ethics assessment framework developed for the apology project (more information on the framework and the application of medical ethics can be found in section 3 of this report). The analysis revealed that the CMA may have fallen short of ethical norms with regard to adequately or specifically addressing the needs of Indigenous patients and populations. This includes not following through on commitments made to Indigenous Peoples and communities, not advocating on issues affecting Indigenous Peoples in a sufficient or timely matter (e.g., being slow to endorse Jordan's Principle and the Truth and Reconciliation Commission of Canada's Calls to Action) and not acknowledging the harms Indigenous Peoples experienced within the residential school system even after those



harms were being reported (see the Dr. Bryce example above). It is also reasonable to conclude that some physicians have been complicit in the systemic discrimination of Indigenous patients, through either direct or indirect action, and have breached ethical norms (e.g., participating in medical experiments on Indigenous patients).

A review demonstrated that for most of the time the CMA has been selecting leaders, the process has been heavily influenced by the provincial and territorial medical associations and the pathway to leadership has been very narrow. It is likely that highly qualified members were overlooked for CMA leadership positions because they were not involved in medical politics at a provincial or territorial level. There was also no specific effort to ensure Indigenous representation.

In recent years, changes have been made to the leadership selection process to make it more open and inclusive. Changes made in 2022 enable members to apply directly for leadership positions, resulting in double the number of applicants for open positions compared with before the changes were instituted. Applicants are also encouraged to self-identify across a range of attributes including age, gender,

sexual identity, ethnicity, race, Indigeneity and disability. The CMA Nominations Committee considers these attributes alongside a candidate's skills and experience. In addition to these changes, Nominations Committee members must undergo unconscious bias training and CMA board members are required to complete mandatory Indigenous cultural awareness training.

It is clear from this review that although the CMA has made strides in recent years on the path toward reconciliation, much work remains. The issuing of a formal apology to Indigenous Peoples is an important step in the right direction, and the creation of an Indigenous health goal in allyship with First Nations, Inuit and Métis Peoples will continue to guide the CMA forward on its reconciliation journey.



INTRODUCTION

BACKGROUND

The Canadian Medical Association (CMA) is committed to advancing reconciliation in health care, with Indigenous voices leading the way. First Nations, Inuit and Métis Peoples in Canada continue to experience unacceptable health disparities because of the legacy of colonization and systemic racism. These issues were highlighted in the 2015 report

of the Truth and Reconciliation Commission of Canada on the devastating legacy of Canada's residential schools. Eight of the 94 Calls to Action in that report are for wide-ranging transformative changes to health care.¹

In 2020, as part of the CMA's work to determine the organization's focus for the next 20 years, a commitment was

made to developing an impactful strategic goal statement focused on Indigenous health, in allyship with Indigenous Peoples. To accomplish this goal, in June 2022, the CMA convened an Indigenous Guiding Circle (IGC) with 16 First Nations, Inuit and Métis Elders, leaders and Knowledge Keepers. Together, they identified a long-term goal to serve as the North Star for the CMA's work in Indigenous health.

The CMA's Indigenous health goal

Indigenous Peoples achieve measurable, on-going improvements in health and wellness, supported by a transformed health system that:

- *is free of racism and discrimination;*
- *upholds Indigenous Peoples' right to self-determination;*
- *values, respects and holds safe space for Indigenous worldviews, medicine and healing practices; and*
- *provides equitable access to culturally safe, trauma-informed care for all First Nations, Inuit and Métis.*

¹ National Centre for Truth and Reconciliation. *Truth and Reconciliation Commission Reports* [Internet]. Winnipeg: University of Manitoba; 2024. Available: <https://nctr.ca/records/reports/#trc-reports> (accessed 2024 Aug 27).



This goal recognizes that respecting the agency and knowledge of Indigenous Peoples and their right to self-determination is of paramount importance and central to any meaningful positive change within the health system. As former CMA President Dr. Alika Lafontaine said:



“This goal is a bridge between where we are and where we want to be in the future. Indigenous Peoples — patients, their families and their communities — have had their voices devalued and dismissed in regard to our own health care. The Indigenous Guiding Circle is part of changing that.”

To guide this work moving forward, a new IGC has been struck with a renewed mandate to identify initiatives to help the CMA meet the aspirations outlined in the Indigenous health goal established by the original IGC and provide an important Indigenous lens on the CMA's efforts to advocate for a more accessible and equitable health system.

EVOLUTION OF THE APOLOGY PROJECT

During the process of creating the CMA's Indigenous health goal, members of the IGC made it clear that if the CMA was serious about working to advance Indigenous health in allyship with First Nations, Inuit and Métis Peoples, the organization would need to start by taking a long, hard look in the mirror to discover its truth and its role in the harm caused to Indigenous Peoples and to apologize for those harms.

To that end, in June 2023, the CMA announced its commitment to a formal apology for the harms caused to Indigenous Peoples by the CMA and as the national voice representing physicians across Canada.² To fully understand and appreciate what the CMA is apologizing for, the association committed to a historical review of its archives, as well as a review of the *Canadian Medical Association Journal (CMAJ)*.

The IGC also recommended that an apology must consider the role of physicians in the mistreatment of Indigenous Peoples, including the devastating impacts of Indian hospitals, forced medical experimentation and sterilization, and the role of systemic racism, neglect and abuse within the health care system. Over time the scope of the research broadened to include a review of the CMA's governance structures, as well as a social media review. This report contains the findings from those reviews (the *CMAJ* review is being conducted separately and those findings will be forthcoming). The apology project has been guided and informed by the current IGC, and key collaborators include the CMA Committee on Ethics and Indigenous advisors including CMA board members and staff.

It is hoped that by completing this work the CMA can take an important step toward truth and reconciliation with First Nations, Inuit and Métis Peoples, and in the process build meaningful relationships with Indigenous Peoples and Indigenous-led organizations.

² Canadian Medical Association (CMA). *CMA announces the beginning of an apology process for harms to Indigenous Peoples in health care, part of its commitment to walking the path to reconciliation* [media release]. Ottawa: The Association; 2023 Jun 13. Available: <https://www.cma.ca/about-us/what-we-do/press-room/cma-announces-beginning-apology-process-harms-indigenous-peoples-health-care-part-its-commitment> (accessed 2024 Aug 27).

RESEARCH METHODOLOGY

As part of the CMA apology project, CMA Library and Archives staff were tasked with searching the CMA archives to find information documenting the organization's relationship with Indigenous Peoples in Canada. As a first step in outlining the scope of the historical review, staff took an inventory of all types of information available in the archives and their locations.



There were over 60 different types of documents noted within the archives. Not all types were deemed to be "in scope" for the apology. As well, a search of the CMA's social media accounts led by CMA Communications staff was conducted in the fall of 2023, and those results are included in this report. A scholarly review of CMAJ's content is also underway in partnership with the National Collaborating Centre for Indigenous Health; the results will be available in 2025.

A list of key Indigenous and health care historical events and people since the CMA's inception in 1867 was compiled in a document

entitled *Apology Historical Review Approach* dated June 29, 2023. Over 80 events and people were identified. With the guidance of a majority Indigenous-owned consulting firm, CMA staff and select members of the original IGC and CMA Board of Directors, 44 specific events were highlighted as a starting point, representing the following categories or themes: residential schools, forced sterilization, tuberculosis, medical experimentation and forced relocation.

During the search, additional themes were identified, including under-representation of First Nations, Inuit and Métis physicians, poor-quality health care for Indigenous Peoples, anti-Indigenous racism in the health system, and human rights (United Nations Declaration on the Rights of Indigenous Peoples).

A subset of eight historical events was selected for a pilot search.

The intent of the pilot was to test the search methods outlined in the workplan and determine if the search results were easy for readers to navigate. Staff developed two lists of keywords to be used when searching (the choice of keywords depended on the date of the historical event and the language used at that time):

- A short list of keywords was developed for use when hand searching print resources or for searching digital tools that did not allow for complex search strings.
- A detailed list of keywords was developed for use when searching digital tools that allowed for complex search strings. This list included place names, languages and groups and was extracted from a validated and peer-reviewed search filter developed by information specialists at CADTH.³

The CMA archives were searched for each of the eight historical events in the pilot, and a checklist was used to document what was searched for, what was found and what was not found. Scans of search results such as minutes, programs and briefs were saved with the checklist.

³ Canadian Agency for Drugs and Technologies in Health (CADTH). Indigenous Peoples - Canada - MEDLINE. In: *CADTH Search Filters Database*. Ottawa: CADTH; 2024. Available: <https://searchfilters.cadth.ca/link/10>. (accessed 2024 Aug 21).

As needed, “for context” documents were saved with the search results for each event. The intent was to provide context for a reader unfamiliar with the details of the event or for a searcher who needed additional history about the event to conduct the search. This information was saved in the checklist or in the folder for the related event.

While the search was being conducted, resources were found that fell outside of the historical events and dates being searched but were still deemed to contain important information. This information was saved in a separate folder on the assumption

the content would give the reader a broad sense of the information held in the CMA archives that is related to Indigenous Peoples.

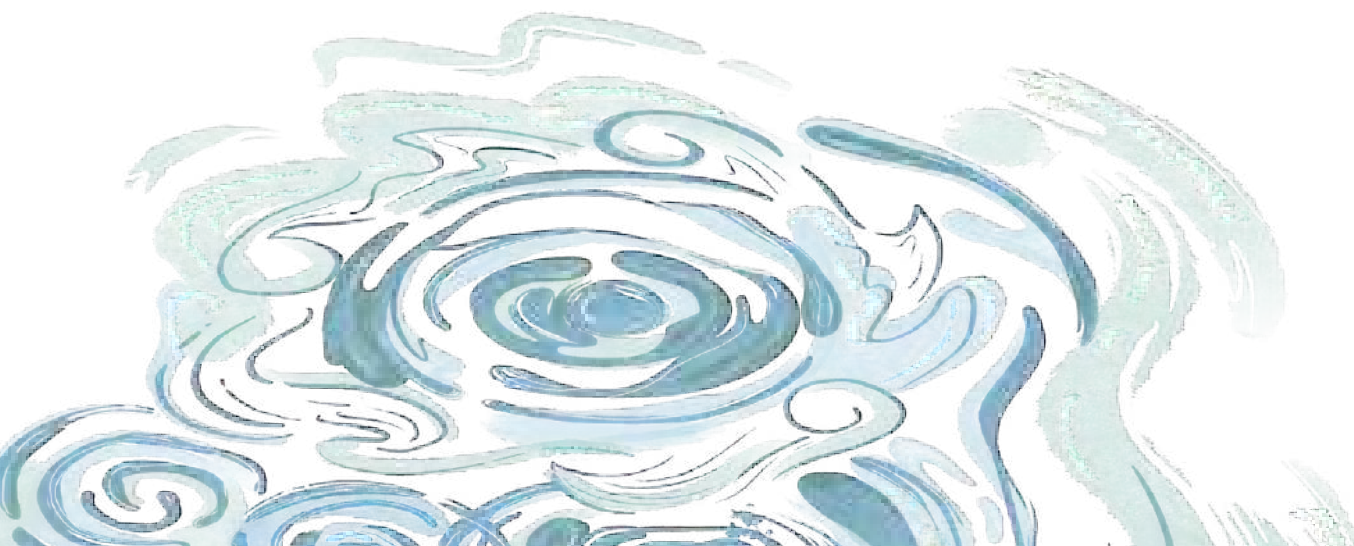
The pilot search was completed on Aug. 4, 2023. The search for the remaining historical events was finished in November 2023.



The final phase included a peer review to ensure that the search methods and the reporting of results were consistent across all events, as much as possible.

Information for each of the key events consisted of a folder including a completed checklist (to document what resources were searched), search results (documents where mention of the event was found) and “context” documents to provide more detailed information about the event (information not necessarily found in the CMA archives). The folder entitled *Events or resources found outside of the targeted search* contains 92 documents.

In addition to the archival review, a search was conducted of publicly available parliamentary records, primarily committee hearings and parliamentary debates, from 1871 to the end of 2023 that reference the CMA. The records were then reviewed to identify those that refer to the CMA’s advocacy on topics related to Indigenous health. The archival, social media and parliamentary records found during the search process form the basis of this report.



SECTION 1: REVIEW OF CMA ARCHIVES AND SOCIAL MEDIA ACCOUNTS

INTRODUCTION

As outlined in the methodology, a targeted search of the CMA archives and social media was completed over the summer and fall of 2023. The results of that search were then reviewed, analyzed and summarized according to topic area. Information from material outside of the CMA archives and the CMA's social media accounts is included in this section of the report where necessary for context.

It should be noted that social media platforms are still a relatively new means of communication, and they did not yet exist at the time of many of the key dates searched for this report. The CMA began to post on X (formerly Twitter) in 2009, on Facebook in 2014 and on Instagram in 2015. Initially the posts on X consisted of live tweeting from events, such as CMA General Council and the Annual General Meeting (AGM). Over time the CMA's use of social media platforms and tools continued to expand to support various advocacy, communications, research and educational activities. This increased use of social media mirrored the increasing use of social media by the population at large.

INDIGENOUS-SPECIFIC RACISM AND INEQUITY IN THE HEALTH SYSTEM

On Sept. 28, 2020, a 37-year-old Atikamekw woman named Joyce Echaquan died in a hospital just outside of Montreal after live-streaming her abusive treatment at the hands of hospital staff. The mother of seven went to the hospital two days before her death complaining of stomach pains. She had a history of health issues, including diabetes and cardiomyopathy, yet the gastroenterologist who saw her the day before her death believed she was suffering from drug withdrawal, despite there being no evidence to support this opinion.⁴

She was restrained and given morphine instead of tests, and her pleas for help were ignored. As Ms. Echaquan was groaning in pain and begging for assistance, a hospital staff member was recorded asking her if she "was done acting stupid."⁴

A coroner's inquest into Ms. Echaquan's death determined the "racism and prejudice Ms. Echaquan faced" contributed to her death.⁴ She may have officially died from an excess of fluid in her lungs, but there can be no question that her treatment at the hands of hospital staff was a factor in her passing. The top recommendation from the report was for the province to acknowledge that systemic racism exists and "make the commitment to contribute to its elimination."⁴



⁴ Nerestant A. Racism, prejudice contributed to Joyce Echaquan's death in hospital, Quebec coroner's inquiry concludes. *CBC News* 2021 Oct 1. Available: <https://www.cbc.ca/news/canada/montreal/joyce-echaquan-systemic-racism-quebec-government-1.6196038> (accessed 2024 Apr 19).

The case of Joyce Echaquan is far from the only example of Indigenous-specific racism in health care. However, acknowledging the impact of systemic racism, or even that it exists, continues to be a challenge. Consequently, inequities in the health system are widespread, from lack of access to health services to disproportionately poor health outcomes among

First Nations, Inuit and Métis communities in Canada.

The CMA archives and social media accounts were searched for key events related to Indigenous-specific racism in health care, such as the coroner's inquest into Ms. Echaquan's death and the death of Brian Sinclair (discussed later in this report). Materials published in defined time periods coinciding with the release of

reports that included references to Indigenous health were also reviewed. As well, while the CMA archives were being searched for key events and time periods, additional materials were found that do not specifically relate to the categories being searched but that nevertheless shed light on the history of Indigenous health at the CMA and within the medical profession.

In a 1922 CMAJ article entitled “A Report of a Medical Survey in the Wabaska District,” Dr. W.W. Bell stated:

Of the fifty-nine children attending the Roman Catholic Schools at Stony Point, fourteen were half-breed, and forty-five were Indian; we found in twelve of these signs of hereditary syphilis, nineteen had symptoms of tuberculosis. The chief trouble with the people throughout all this district is laziness. The children are allowed to do what they like at all times. There is no discipline: only girls are made to do any work. The result is that when the boys reach manhood they refuse to work except under compulsion and live with their parents, often when they marry bringing their wives back to their parents' small tepee to crowd it still more. Another cause of trouble is a propensity for gambling, and an absolute inability to value money. Added to this is a love for any kind of spirituous liquor, many forms of which they make for themselves by using prunes, raisins, potatoes and sometimes flour and wheat.⁵

⁵ Bell WW. A report of a medical survey in the Wabaska District. *CMAJ* 1922 Oct;12(10):726-7. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1706797/pdf/canmedaj00421-0064.pdf> (accessed 2024 Apr 19).

If this represents the view of Indigenous Peoples by the medical establishment at that time, it is not hard to imagine how these beliefs could have negatively impacted their care and health.

From the review of documents in the CMA archives from this period, it would appear that the greatest area of concern when it came to Indigenous patients was remuneration. At the Dec. 18, 1924, Executive Committee meeting in Ottawa, the following motion was passed:

Be it resolved that the Secretary of the CMA be advised that the Department of Indian Affairs is not adequately remunerating the profession of Manitoba for services given to Indian patients.⁶

This issue continued to be raised at annual and Executive Committee meetings well into the 1950s and 1960s, with the association expressing its concern on behalf of physicians from various jurisdictions across the country to the federal government. Disparities in remuneration also went beyond the care of Indigenous patients, as reported by the Committee on Economics to the 1968 meeting of General Council:

Great variations persist in fees paid by various federal departments – D.V.A., Indian Affairs, Mariners, Eskimos, etc. This has been a chronic problem discussed at General Council many times without satisfactory resolution.⁷

Lack of proper funding is but one example of inequity in the health system. A search of the archives for examples of poor health outcomes among Indigenous Peoples did reveal that concerns were being raised by some physicians; however, they were often ignored. For example, at the Apr. 22, 1933, Executive Committee meeting, the general secretary drew attention to a letter received from Dr. F.G. Banting of Toronto expressing his concern over reports indicating high rates of trachoma and tuberculosis within the Indigenous population in Canada, and urged the CMA to “take some steps to persuade the government to do something in the way of health measures for these people.”⁸ A motion was passed instructing the CMA to contact the Deputy Superintendent General of Indian Affairs for further information, which was carried out by the organization. At the annual meeting that same year, it was reported that the CMA had heard back from the deputy superintendent general and had been informed that the reports were “exaggerated” and that “further reports indicate the situation is not serious and is well in hand.”⁹ From the archival review it would appear this response was accepted, and no further action was taken.

⁶ Canadian Medical Association (CMA). *CMA Executive Committee, Minutes, December 18, 1924*. Ottawa: The Association; 1924. p. 12.

⁷ Canadian Medical Association (CMA). Report of the Committee on Economics. *Reports for the General Council at the One Hundred and First Annual Meeting of the Canadian Medical Association, Regina, June 17, 18, 19, 1968*. Ottawa: The Association; 1968. p. 43.

⁸ Canadian Medical Association (CMA). Medical care of Indians in Canada. *CMA Executive Committee, Minutes, April 22, 1933*. Ottawa: The Association; 1933.

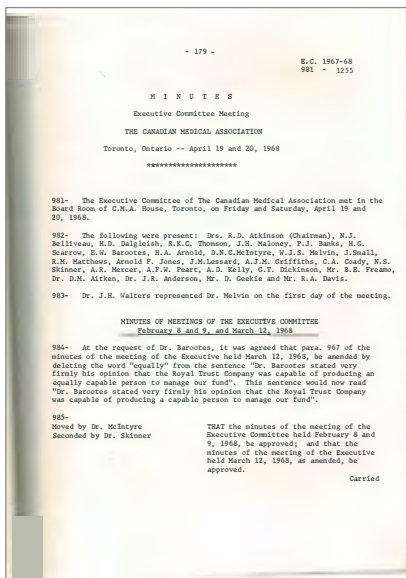
⁹ Canadian Medical Association (CMA). Medical care of Indians. Business Arising out of the Minutes of the Annual General Meeting, Saint John, New Brunswick, June 19-23, 1933. *CMA Executive Committee, Minutes, June 19, 1933*. Ottawa: The Association; 1933. p. 62.

By the mid to late 1960s, the CMA was starting to raise serious concerns regarding the care of Indigenous patients. An area of particular concern during this period was maternal welfare. At the 1968 General Council meeting, the issue of high rates of maternal morbidity and mortality among “Indians and Eskimos” was discussed, with specific reference to the fact that “the vast majority of these people suffer from lack of income, with subsequent poor nutrition and housing, and from isolation from medical centres.”¹⁰

It was also noted that “many public health measures necessary to remedy these problems remain undone.”¹⁰ It was noted the federal government had announced its intention to require Indigenous patients to pay for their medical care and transportation to medical facilities in the interest of saving money. This was met with harsh criticism, and a resolution was passed to severely censure the federal government and advise them that such measures would “result in a deterioration of

maternal and child health care amongst the Indians and Eskimos.”¹⁰ It was also noted that the Executive Committee had initiated a study on the provision of medical services to Indigenous Peoples.

Further criticism of the federal government was raised at the 1968 annual meeting of the Ontario Medical Association (OMA) by the then-president of the CMA, Dr. Normand J. Belliveau, and was reported in *The Globe and Mail*:



“We find it strange, for example, that they should institute a program aimed at providing comprehensive medical insurance for everyone in the country – indicating the financing of this may be a small problem, but certainly not insurmountable – and at the same time announcing that they must cut back on the medical services provided to Indian and Eskimo populations, because we cannot afford it.”¹¹

¹⁰ Canadian Medical Association (CMA). Indian Health Services. Business referred from General Council. *Meeting of Incoming Executive Committee, Minutes, June 20, 1968*. Ottawa: The Association; 1968. p. 18.

¹¹ Confused by statements. *The Globe and Mail* 1968 May 7. p. 13.

From this point onward, the CMA began to take a greater interest in the disparity between Indigenous and non-Indigenous patients. At the 1970 annual meeting in Winnipeg, the following resolution was passed as an act of recognition:



The Council recommends that the CMA officially recognize that while there are health care delivery problems in isolated communities in Canada that the major cause of ill health and high premature death rates among Canada's native population are primarily related to socio-economic and basic public health problems. Major efforts to correct high morbidity and mortality rates should be directed at the true basic factors – the very low standard of living, low incomes, low educational levels, inadequate housing, poor sanitation and inadequate public health programmes et cetera. Efforts to improve personal health care while desirable, should be recognized to be of secondary importance when dealing with the total problem.¹²

At the 1990 annual meeting in Regina, the theme for one afternoon was "Evolving Issues in Native Health," with topics such as "determinants of Native health" and "evolving issues in Native mental health" discussed. Dr. Ruth Wilson, who was an assistant professor at Queen's University and coordinator of Queen's Weeneebayko, provided those in attendance with some stark facts, including that Indigenous men and women lived around nine and seven years less than

non-Indigenous men and women, respectively.¹³ Around this time the CMA formed a Working Group on Aboriginal Health to "develop an awareness and understanding of Aboriginal health problems, barriers and solutions, specifically to provide background material, information and support for the CMA to encourage the Royal Commission on Aboriginal Peoples (RCAP) to address relevant health issues."¹⁴ The Working Group completed its mandate in 1993, with the development

of a comprehensive and detailed submission to the commission. As part of this endeavour, the working group convened a workshop of Indigenous groups "soliciting their input into what CMA could do to help them improve their health."¹⁴ The Working Group consisted of CMA board members, CMA staff and representatives of Indigenous medical organizations, such as Dr. Vincent Tookenay, president of the Native Physicians' Association in Canada.

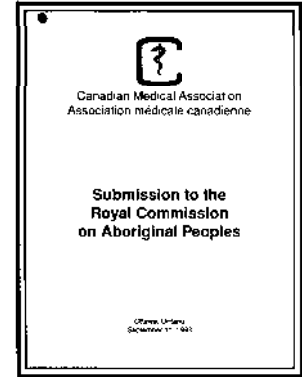
¹² Canadian Medical Association (CMA). Recommendation review. Recommendation XIII. *Reports for the General Council at the 103rd Annual Meeting, The Canadian Medical Association, Winnipeg - June 15, 16, and 17, 1970*. Ottawa: The Association; 1970. p. 43-4.

¹³ Canadian Medical Association (CMA). *Evolving issues in Native health care. 1990 Annual Meeting Bulletin*. Ottawa: The Association; 1990 Oct. p. 7.

¹⁴ Canadian Medical Association (CMA). Briefing note: Aboriginal health. *1993 CMA Annual Meeting "Hot Spots" Briefing Notes and Related Spokespersons*. Ottawa: The Association; 1993.

In the introduction to the submission, it was stated:

Physicians have another role as advocates for Aboriginal peoples seeking to improve their health and social conditions. Aboriginal peoples seek support and partnerships in solving the social problems they face – problems that dramatically affect their health. The CMA recognizes the importance of physicians and other health care professionals and organizations collaborating with Aboriginal peoples to advocate changes that will improve their health.¹⁵



Included in the report is an accounting of the CMA's activities in Indigenous health, including the introduction of a special bursary program for undergraduate Aboriginal medical students. This program was implemented in 1992–93 because of "the CMA's concerns that Aboriginal students are often financially disadvantaged and find it difficult to pursue prolonged post-secondary education."¹⁶ Through donations to the Canadian Medical Foundation, undergraduate medical students of Indigenous ancestry were eligible for up to \$4000 (\$25,000 total was available per year), and successful applicants also received membership in the CMA, the relevant provincial or territorial

medical association and the Native Physicians' Association in Canada. In its first year 11 bursaries were dispersed, ranging in amounts from \$1000 to \$4000 per student.¹⁷ The program was sunsetted in 2016 when the CMA ended its annual grant to the Canadian Medical Foundation and giving was focused through the CMA Foundation.

The submission also contained numerous recommendations, including recommending that the government acknowledge "that the degree of ill health in the Aboriginal population is unacceptable" and that it "increase culturally relevant, holistic, and community delivered

health care and health promotion, also recognizing mental health as a fundamental component."¹⁸

In his inaugural address as CMA president in 2001, Dr. Henry Haddad stated that the health status of Indigenous Peoples was one of Canada's major unresolved challenges.¹⁹ Stemming from these concerns and ongoing work at the CMA related to Indigenous health, a letter of intent between the CMA and the National Aboriginal Health Organization was signed in 2002 to foster collaboration and identify areas of mutual interest to develop an effective working relationship (the National Aboriginal Health Organization's funding was eliminated as part of the

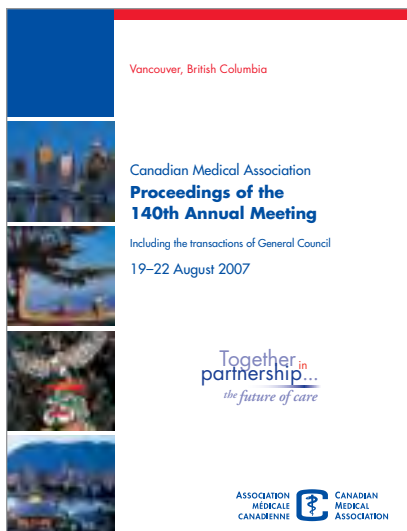
¹⁵ Canadian Medical Association (CMA). *Submission to the Royal Commission on Aboriginal Peoples. September 1, 1993.* Ottawa: The Association; 1993. p.1.

¹⁶ Canadian Medical Association (CMA). *Submission to the Royal Commission on Aboriginal Peoples. September 1, 1993.* Ottawa: The Association; 1993. p. 2.

¹⁷ Canadian Medical Association (CMA). *Submission to the Royal Commission on Aboriginal Peoples. September 1, 1993.* Ottawa: The Association; 1993. p. 3.

¹⁸ Canadian Medical Association (CMA). *Submission to the Royal Commission on Aboriginal Peoples. September 1, 1993.* Ottawa: The Association; 1993. p. 12.

¹⁹ Office for Public Health. Canadian Medical Association (CMA). *Proceedings of Special Session on Aboriginal Health. April 5-6, 2002.* Ottawa: The Association; 2002.



2012 Canadian federal budget, and the organization ceased operations in June of that year²⁰). It would appear from the documents reviewed in the archives that much of the focus in the 2000s

was on public health measures — clean drinking water,²¹ safe and nutritious food for children in northern communities affected by “disruptions in traditional food acquisition methods and a shift to a more processed low-nutrient diet”²² and the effects of climate change on Indigenous populations in remote northern regions,²³ to name a few. There were also calls for medical schools to develop courses to educate physicians on Indigenous history and culture and to develop courses on communication skills to enhance the care of Indigenous patients,²⁴ and for the federal government to address the lower health status of Indigenous children.²⁵

Various initiatives and advocacy continued throughout the 2000s and 2010s; however, the concept of systemic discrimination within the health system and its role in the poor health outcomes of Indigenous Peoples did not emerge in the work of the CMA until more recently. In 2010, the CMA commissioned a discussion paper, with the assistance of CMA staff, entitled *The Health of Aboriginal Peoples in Canada: Opportunities for the Canadian Medical Association*.²⁶ The discussion paper grew from a resolution passed at General Council in 2009:

Resolution passed at General Council in 2009

*The Canadian Medical Association, in collaboration with provincial/territorial medical associations, will work with national Aboriginal organizations and governments to set specific goals for Aboriginal and First Nations health over a generation and will monitor and publish the collective progress annually.*²⁷

²⁰ National Aboriginal Health Organization's funding cut: Organization to close at the end of June. *CBC News* 2012 Apr 9. Available: <https://www.cbc.ca/news/canada/north/national-aboriginal-health-organization-s-funding-cut-1.1194520> (accessed 2024 Feb 9).

²¹ Canadian Medical Association (CMA). GC Resolution DM 5-14 and 5-18. *BD2008-023A. Section 1: Disposition of Resolutions adopted by 2007 General Council*. Ottawa: The Association; 2007. p. 15.

²² Canadian Medical Association (CMA). GC Resolution DM 5-67. *BD2008-023A. Section 1: Disposition of Resolutions adopted by 2007 General Council*. Ottawa: The Association; 2007. p. 15.

²³ Canadian Medical Association (CMA). Health and the Environment. GC Resolution 07-82. *Canadian Medical Association Proceedings of the 140th Annual Meeting including the transactions of the General Council 19-22 August 2007 Vancouver, British Columbia*. Ottawa: The Association; 2007. p. 53.

²⁴ Canadian Medical Association (CMA). Delegates' motions – medical education. GC Resolution 06-82. *Canadian Medical Association Reports to General Council 140th Annual Meeting 19-22 August 2007, Vancouver, British Columbia*. Ottawa: The Association; 2007. p. 280.

²⁵ Canadian Medical Association (CMA). Child Health. GC Resolution 06-11. *Canadian Medical Association Reports to General Council 140th Annual Meeting 19-22 August 2007, Vancouver, British Columbia*. Ottawa: The Association; 2007. p. 270.

²⁶ Canadian Medical Association (CMA). *The health of Aboriginal Peoples in Canada: Opportunities for the Canadian Medical Association, 2010 - a discussion paper*. Ottawa: The Association; 2010 Oct 20.

²⁷ Canadian Medical Association (CMA). GC Resolution 09-93. *Canadian Medical Association Proceedings of the 142nd Annual Meeting including transactions of General Council, 16-19 August 2009, Saskatoon, Saskatchewan*. Ottawa: The Association; 2009. p. 56.

The paper drew attention to the negative effects of colonization on First Nations, Inuit and Métis communities in Canada over multiple generations and stated, "colonization was destructive to the physical and social fiber of all Aboriginal Peoples and remains a contributing factor to their current health status."²⁸ It highlighted the efforts of Indigenous and other national organizations that worked on advancing Indigenous health, and the critical importance of forming partnerships with Indigenous-led organizations and groups, as policies and programs for Indigenous Peoples must also be designed by Indigenous Peoples.

Of note, the paper also stated that in the past decade, the CMA had initiated a comprehensive, multi-year action plan to address Indigenous health but failed to live up to promises made. As the report made clear, "CMA's reputation was damaged and a loss of credibility within the physician and aboriginal community resulted."²⁹ The report contained a list of "lessons learned" that included engaging with Indigenous communities early on, setting achievable expectations and focusing on projects that draw on the CMA's core strengths such as

advocacy and policy development. Unfortunately, it would appear that shortly after this document was written, the CMA's work in Indigenous health declined once again, owing to resourcing issues, program reviews and subsequent streamlining.

The report also referred to the lingering trauma from residential schools and forced assimilation but did not reference anti-Indigenous racism in the health system or how stereotypes and beliefs may affect the treatment and care an Indigenous patient receives. The issue of discrimination affecting the care of Indigenous patients perhaps first started to gain serious attention with the case of Jordan River Anderson, a First Nations child born with a rare neuromuscular disorder on the Norway House Cree Nation Reserve in northern Manitoba in 1999.³⁰ Jordan spent the better part of his short life in a hospital, where he eventually died at the age of five, while the province and federal government bickered over who should pay for his at-home care. This care would have been paid for automatically if he had not been First Nations. From this tragic event Jordan's

Principle was born, which was passed with unanimous support in the House of Commons on Dec. 12, 2007, and is supposed to ensure First Nations children receive the care they need, when and where they need it.³⁰ It should be noted that there have been numerous challenges to the government's implementation of Jordan's Principle, and in 2016, the Canadian Human Rights Tribunal ruled that Canada's definition of Jordan's Principle was discriminatory.³⁰ In 2023, the federal government settled a \$23 billion compensation agreement for First Nations children and their families who were harmed by the government's discriminatory approach to their care and failure to follow Jordan's Principle.³⁰

The CMA did not formally endorse Jordan's Principle until it passed a motion of support at General Council in August 2008.³¹ By that time, CMAJ had publicly endorsed the principle, as had hundreds of organizations such as the Assembly of First Nations and the Canadian Paediatric Society. There is no explanation to be found in the CMA archives as to why it took the CMA so long to formally support the principle.

²⁸ Canadian Medical Association (CMA). *The health of Aboriginal Peoples in Canada: Opportunities for the Canadian Medical Association, 2010 - a discussion paper*. Ottawa: The Association; 2010 Oct 20. p. 4.

²⁹ Canadian Medical Association (CMA). *The health of Aboriginal Peoples in Canada: Opportunities for the Canadian Medical Association, 2010 - a discussion paper*. Ottawa: The Association; 2010 Oct 20. p. 16.

³⁰ First Nations Child and Caring Society of Canada. *Jordan's Principle* [Internet]. Ottawa: First Nations Child and Caring Society of Canada; 2024. Available: <https://fncaringsociety.com/jordans-principle> (accessed 2024 Apr 22).

³¹ Canadian Medical Association (CMA). Delegates' motions. GC Resolution 08-68. *Canadian Medical Association Proceedings of the 141st Annual Meeting including the transactions of General Council 17-20 August 2008, Montreal, Quebec*. Ottawa: The Association; 2008. p. 50.

There is nothing in the CMA archives from 2008 regarding the death of Brian Sinclair; however, the incident was all but ignored at the time it occurred, much as Mr. Sinclair, an Indigenous man living with a double amputation and medical issues, was ignored as he languished in a Winnipeg emergency department for 34 hours and ultimately died from a completely treatable bladder infection owing to a blocked catheter.³² Eventually his death would gain considerable attention and an inquest would be initiated. There is also nothing in the CMA archives from 2014 when the final report of the inquest into Mr. Sinclair's death was released. *CMAJ* did publish several pieces on, or related to, Mr. Sinclair's death from as early as 2009. The term "systemic discrimination" was used in an article from 2013 that reported on the progress of the inquest into Mr. Sinclair's death. It stated that "systemic racism, a chronic shortage of nursing resources and a culture of indifference among some health professionals" were among the factors being examined in the death of Mr. Sinclair.³³

The issues of systemic racism and anti-Indigenous racism in health care would continue to be reported in *CMAJ*; however, from the search of key events in the CMA archives it seems these subjects were not gaining widespread attention at the CMA during this time period. For example, a search was conducted of the year 2007 when the Indian Residential Schools Settlement Agreement was implemented using key words such as Aboriginal, First Nation, Indigenous, Inuit, Métis,

residential, school, Indian and settlement, and nothing related to the agreement was found. Perhaps the turning point was the release of the Truth and Reconciliation Commission of Canada's report in 2015, which included 94 Calls to Action.³⁴ The report laid bare the horrible legacy of the residential school system and its devastating impact on Indigenous Peoples. At the May 2015 CMA board meeting, the following motion was passed:

*The Canadian Medical Association acknowledges the completion of the important work of the Truth and Reconciliation Commission of Canada and the importance of recognizing and not forgetting the terrible impact that the residential school system has had and, as a consequence of ongoing intergenerational trauma, continues to have on the health of many First Nations, Inuit and Métis People of Canada.*³⁵

³² Geary A. Ignored to death: Brian Sinclair's death caused by racism, inquest inadequate, group says: Brian Sinclair, 45, was found dead in Health Sciences Centre ER 34 hours after arriving without being treated. *CBC News* 2017 Sep 18. Available: <https://www.cbc.ca/news/canada/manitoba/winnipeg-brian-sinclair-report-1.4295996>. (accessed 2024 Feb 12).

³³ Lett D. Emergency department problems raised at Sinclair inquest. *CMAJ* 2013 Nov 19;185(17):1483. Available: <https://www.cmaj.ca/content/cmaj/185/17/1483.full.pdf> (accessed 2024 Apr 23).

³⁴ Truth and Reconciliation Commission of Canada. *Truth and Reconciliation Commission of Canada: Calls to Action*. Winnipeg: The Commission; 2015. Available: https://publications.gc.ca/collections/collection_2015/trc/IR4-8-2015-eng.pdf (accessed 2024 Apr 25).

³⁵ Canadian Medical Association (CMA). Board Resolution BD 15-06-232. *CMA Board of Directors, Minutes, May 28–30, 2015*. Ottawa: The Association; 2015. p. 180.

At General Council that year, four resolutions were passed that were pertinent to the health-related Calls to Action, including that the CMA would “promote practical advocacy strategies to support the



health and well-being of First Nations, Métis and Inuit communities in Canada.”³⁶ In follow-up to the resolution the CMA committed to consulting with the Royal College of Physicians and Surgeons of Canada (Royal College) on their Indigenous health initiative. For a period of time, the CMA was invited to meetings of their Indigenous Health Committee as a guest; however, since the COVID-19 pandemic, the CMA has not attended any meetings. In 2016, an education session on Indigenous health was held before the start of General Council, in partnership with the Royal College, the College of Family Physicians of Canada and the Indigenous Physicians Association of Canada. The session focused on how to strengthen the role of physicians in improving and supporting wellness among Indigenous Peoples and featured several speakers including Marie Wilson, Truth and Reconciliation Commission of Canada commissioner; Dr. Karen Hill, representing the Indigenous Physicians Association of Canada; Dr. Evan Adams, representing the First Nations Health Authority; and Dr. Alika Lafontaine, who was participating as a member of the Royal College’s Indigenous Health Advisory Committee.

In 2020, a report on Indigenous-specific racism and discrimination in British Columbia’s health system was released entitled *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*.³⁷ Over 600 people shared their experiences with the reviewers, and the report found widespread examples of racism faced by First Nations, Inuit and Métis Peoples. On the day the report was released, the CMA issued a statement and spoke out on X acknowledging the importance of the report and thanking those who bravely shared their stories.³⁸ The statement pointed to the report as “yet another reminder that tangible actions to address anti-Indigenous racism in Canada’s health care system are long overdue” and further declared:

*At the Canadian Medical Association, we acknowledge that systemic racism exists, and that colonialism has influenced and continues to influence the experiences of Indigenous peoples in Canada’s health care system. Just as systems are designed and upheld by people, we can also change and improve them.*³⁹

³⁶ Canadian Medical Association (CMA). GC Resolution 15-77. *CMA 2015 Halifax, Proceedings of the 148th Annual Meeting including transactions of General Council, August 23–26, 2015*. Ottawa: The Association; 2015. p. 42.

³⁷ Turpel-Lafond (Aki-Kwe) ME. *In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. health care*. Victoria (BC): British Columbia Ministry of Health; 2020 Nov 30. Available: <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf> (accessed 2024 Apr 23).

³⁸ @CMA Docs [X social media account]. *Today’s Turpel-Lafond report is another reminder that tangible actions to address anti-Indigenous racism in Canada’s health care system are long overdue* [X]. Ottawa: Canadian Medical Association (CMA); 2020 Nov 30. Available: https://x.com/CMA_Docs/status/1333560834455445507 (accessed 2024 Aug 21).

³⁹ Canadian Medical Association (CMA). *CMA president statement on Turpel-Lafond report* [media release]. Ottawa: The Association; 2020 Nov 30. Available: <https://www.cma.ca/about-us/what-we-do/press-room/cma-president-statement-turpel-lafond-report> (accessed 2024 Apr 23).

Just two months before this report was released, the death of Joyce Echaquan in a Quebec hospital gained widespread attention, sparking outrage that led to calls for sweeping changes including the adoption of Joyce's Principle, a call to action in memory of Ms. Echaquan that seeks to "guarantee all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional

and spiritual health."⁴⁰ While the principle has been adopted by the federal government and many unions and universities, the Quebec government has refused to adopt it, arguing that systemic discrimination does not exist within the health system in Quebec.⁴¹

In response to Ms. Echaquan's death, on Oct. 27, 2020, the CMA published an open letter to her family, the community of Manawan, Atikamekw Nation and Indigenous Peoples. The letter

followed a meeting held on Oct. 16 that then-President Dr. Ann Collins attended with Ms. Echaquan's family, various levels of government and Indigenous and non-Indigenous health leaders. The meeting paid tribute to Ms. Echaquan's memory, and participants discussed the issue of anti-Indigenous racism in health care and systemic discrimination in Canada. In the letter, Dr. Collins stated that systemic racism must be acknowledged and addressed. She also stated:

There's no question we have an incredibly long way to go to create a culturally safe, equitable and accessible health care system for all First Nations, Inuit and Métis Peoples. But there's also no question that we must absolutely make it happen, and urgently.⁴²

⁴⁰ Council of the Atikamekw of Manawan (CDAM) and the Atikamekw Nation Council (CNA). *Joyce's Principle: Brief presented by the Council of the Atikamekw of Manawan and the Council de la Nation Atikamekw*. QC: Justice for Joyce; 2020 Nov. Available: https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief_Eng.pdf (accessed 2024 Apr 23).

⁴¹ The Canadian Press. Bill prompts call for Quebec to recognize systemic racism in health system: Proposed law aims at instituting a 'cultural safety approach' toward Indigenous patients. *CBC News* 2023 Sep 13. Available: <https://www.cbc.ca/news/canada/montreal/bill-quebec-recognize-systemic-racism-in-health-system-1.6965025#:~:text=He%20said%20systemic%20racism%20is,the%20word%2C%22%20said%20Gaudreault> (accessed 2024 Apr 23).

⁴² Canadian Medical Association (CMA). *An open letter to Joyce Echaquan's family, community of Manawan, Atikamekw Nation and Indigenous Peoples* [media release]. Ottawa: The Association; 2020 Oct 27. Available: <https://www.cma.ca/latest-stories/open-letter-joyce-echaquans-family-community-manawan-atikamekw-nation-and-indigenous-peoples> (accessed 2024 Apr 23).

When the coroner's report on Ms. Echaquan's death was released on Oct. 1, 2021, the CMA responded on X by praising the work of the coroner and stating that "systemic racism exists, and it cannot be tolerated. CMA is committed to working with First Nations, Métis & Inuit communities to co-design a new path forward — one that is equitable & free of racism."⁴³

As Dr. Lafontaine put it during the 2023 Fireside Chats on Indigenous Health, the case of Joyce Echaquan "broke through the noise" and made people realize that even though we have been talking about anti-Indigenous racism and discrimination in the health system for some time, we still have a lot of work to do to tackle these problems.⁴⁴ In recent years, the CMA has increasingly spoken out on social media regarding these issues, from supporting an accelerated response to the Calls to Action,⁴⁵ to stating on Facebook in 2023 that "the road to reconciliation in healthcare must start with



acknowledging systemic racism – only then can we ensure better health outcomes for Indigenous Peoples."⁴⁶ The creation of an Indigenous health goal and IGC will continue to guide the CMA in the right direction to address anti-Indigenous racism and systemic discrimination in the health system, now and in the future.



⁴³ @CMA Docs [X social media account]. *Clear & welcomed call to action from Quebec coroner Géhane Kamel* [X]. Ottawa: Canadian Medical Association (CMA); 2021 Oct 1. Available: https://twitter.com/CMA_Docs/status/1444014799952695299 (accessed 2024 Apr 23).

⁴⁴ Canadian Medical Association (CMA). *Fireside Chats on Indigenous health: The CMA's journey of reconciliation* [news—latest stories]. Ottawa: The Association; 2023. Available: <https://www.cma.ca/latest-stories/fireside-chats-indigenous-health-cmas-journey-reconciliation> (accessed 2024 Jul 5).

⁴⁵ @CMA Docs [X social media account]. *Systemic racism continues to plague our society and our institutions* [X]. Ottawa: Canadian Medical Association (CMA); 2021 Jun 3. Available: https://x.com/CMA_Docs/status/1400508995660562454 (accessed 2024 Aug 21).

⁴⁶ Canadian Medical Association (CMA). *Unlearning and undoing systemic white supremacy and systemic anti-Indigenous-specific racism* [Facebook]. *CMA Health Summit; 2023 Aug 18; Ottawa*. Ottawa: The Association; 2023 Aug 9. Available: <https://www.facebook.com/CanadianMedicalAssociation/videos/the-road-to-reconciliation-in-healthcare-must-start-with-acknowledging-systemic-/1427682321350171/> (accessed 2024 Apr 24).

FORCED OR COERCED STERILIZATION OF INDIGENOUS PEOPLES

Throughout much of the 20th century, Indigenous Peoples were forced to undergo sterilization and subjected to medical experiments without their informed consent. Beginning in the 1930s and continuing into the 1970s, Indigenous patients at Indian hospitals and students at residential schools were subjected to inappropriate medical procedures and experiments including nutritional experiments, receipt of experimental tuberculosis vaccines, and treatments for ailments that were vastly different and more invasive than the treatments non-Indigenous patients received (e.g., the removal of a lung to treat tuberculosis long after antibiotics became the standard course of treatment).⁴⁷ As well, thousands of Indigenous women, and some men, were subjected to forced sterilization for decades after sexual sterilization acts were repealed in the 1970s. As recently as May 2023, a physician in the Northwest Territories was issued

a series of punishments for forcing an Indigenous woman to undergo sterilization without her consent in 2019.⁴⁸ The appalling nature of these acts contributed to a deep-seeded distrust of the health system among Indigenous Peoples.

There is little in the CMA archives or social media accounts regarding forced or coerced sterilization. In the proceedings of the 1971 meeting of General Council in Halifax, there is mention of a policy resolution regarding sterilization. The policy outlines under which circumstances sterilization is acceptable and includes the following wording:

*C) and if performed with the written permission of the patient, and after the patient has signed a statement to the effect that he or she understands that the sterility will in all likelihood be permanent; similar consent of the spouse, or guardian if applicable, should be obtained whenever possible.*⁴⁹



⁴⁷ Dangerfield K. Canada subjected Indigenous people to 'cruel' medical experiments, lawsuit claims. *Global News* 2018 May 11. Available: <https://globalnews.ca/news/4202373/indigenous-people-medical-experiments-canada-class-action-lawsuit/> (accessed 2023 Nov 20).

⁴⁸ Cheng M. Canada's Indigenous women forcibly sterilized decades after other rich countries stopped. *CTV News* 2023 Jul 12. Available: <https://www.ctvnews.ca/health/canada-s-indigenous-women-forcibly-sterilized-decades-after-other-rich-countries-stopped-1.6476708> (accessed 2023 Nov 20).

⁴⁹ Canadian Medical Association (CMA). Sterilization. *Reports to the General Council at the 104th annual meeting, The Canadian Medical Association, Halifax, June 7, 8, 9, 1971*. Ottawa: The Association; 1971. p. 11.

This policy is not specifically related to forced sterilization, but rather to sexual sterilization in general. There were several articles in *CMAJ* during the 1970s regarding voluntary sterilization, consent and how attitudes toward such procedures had changed over time. For example, an article published on Mar. 4, 1978, entitled "Consent and Sterilization" states that in 1948 the secretary of the Canadian Medical Protective Association (CMPA) said that any request from a healthy woman or man for sterilization "must be refused, promptly and finally."⁵⁰ It goes on to say that attitudes toward voluntary sterilization have changed over time, and it would appear that by the 1970s the concern was more with physician liability regarding ensuring the patient was properly informed of the finality of sterilization to make an informed decision and whether or not a physician was legally bound to inform the spouse (the consensus was that they were not legally bound, although "many authors advise that an approval be obtained from the spouse").

There is also reference in the archives to the sterilization of mentally disabled people following a Supreme Court decision in 1987 that effectively outlawed their "contraceptive sterilization."⁵¹

There are no specific references to the forced sterilization of Indigenous women in Canada in the CMA archives until an article in the August 2017 edition of *CMAJ* regarding accounts of coerced sterilization. The story concerns a report entitled "Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women," which states that while coerced sterilization of Indigenous women was supposed to have ended in Canada in the early 1970s, there were current reports from Saskatoon hospitals of women being coerced by health professionals into having tubal ligations.⁵² In response to the report, Arthur Schafer, director of the Centre for Professional and Applied Ethics at the University of Manitoba, asked the question: "Is the lack of respect and compassion for Indigenous women, which

the report describes, occurring at other Canadian hospitals? If so, how common is such abuse?"⁵² After this report came out, the issue of continued forced sterilization of Indigenous women received greater attention and several lawsuits were launched against provincial governments, with some still ongoing. A December 2018 *National Post* article quoted then-CMA President Dr. Gigi Osler as saying, "for me, to read these stories, it reinforces my desire and commitment for change to make sure...we are looking after our vulnerable groups and in this case, Indigenous women."⁵³ A review of social media posts from this time period using key words such as "forced sterilization" or "coerced sterilization," "tubal ligation" and "Indigenous women" produced very few results.

In July 2022, the CMA issued a statement in response to a Standing Senate Committee on Human Rights report entitled *The Scars that We Carry: Forced and Coerced Sterilization of Persons in Canada – Part II*.⁵⁴ The report

⁵⁰ Sharpe G. Consent and sterilization. *CMAJ* 1978 Mar 4;118(5):591-3. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1817980/pdf/canmedaj01417-0121.pdf> (accessed 2024 Apr 24).

⁵¹ Marshall D. The "Eve" decision: "It may turn out to be a meek authority indeed" [Letters]. *CMAJ* 1987 Mar 15; 136:650-651. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1267407/pdf/cmaj00155-0012a.pdf> (accessed 2024 Apr 24).

⁵² Collier R. Reports of coerced sterilization of Indigenous women in Canada mirrors shameful past. *CMAJ* 2017 Aug 21;189(33):E1080-E1081. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5566614/pdf/189e1080.pdf> (accessed 2024 Apr 24).

⁵³ Kirkup K. Coerced sterilization reports sparking concern in Canada's medical community. *National Post* 2018 Dec 20. Available: <https://nationalpost.com/pmnl/news-pmnl/canada-news-pmnl/coerced-sterilization-reports-sparking-concern-in-canadas-medical-community> (accessed 2023 Nov 21).

⁵⁴ Canada. Standing Senate Committee on Human Rights. *The scars that we carry: Forced and coerced sterilization of persons in Canada – Part II*. Ottawa: Government of Canada; 2022 Jul. Available: <https://senCanada.ca/en/info-page/parl-44-1/ridr-the-scars-that-we-carry-forced-and-coerced-sterilization-of-persons-in-canada-part-ii/> (accessed 2023 Nov 21). p. 7.

detailed the long history of these practices in Canada, which were rooted in discrimination not only against Indigenous Peoples but also against Black communities and “people with intersecting vulnerabilities relating to social and structural determinants of health, ethnicity, and disability.”⁵⁴ The statement denounced the practice of forced and coerced sterilization, stating, “the medical profession must acknowledge its role and commit to upholding its ethical obligations.”⁵⁵ As well, the CMA posted on X on

July 22, 2022, that “we support recommendations to prohibit forced and coerced sterilization in Canada and enhance training and regulation of medical professionals to halt these practices in the future.”⁵⁶

MEDICAL EXPERIMENTATION ON INDIGENOUS CHILDREN AND ADULTS

It may be shocking to many Canadians to learn their government used vulnerable children to conduct studies on

malnutrition; yet that is exactly what happened in residential schools in the last century. Researchers provided vitamin C supplements to some and placebos to others, tripled some children’s milk allowance while giving others less than half the daily recommended intake, and gave children bread made with a type of fortified flour that was not approved for sale in Canada (many later developed anemia).⁵⁷ Researchers even went so far as to prevent children at six residential schools from receiving preventive dental care because oral health was an important tool in assessing a person’s nutritional well-being.⁵⁷ Dr. Lionel Pett oversaw many of the experiments conducted in residential schools during the 1940s and is also considered to be the “architect” of the *Canada Food Guide*.⁵⁸ His experiments were the basis of *Canada’s Food Rules*, the predecessor of the *Canada Food Guide*, which has been widely promoted as an important tool for healthy eating in Canada for over 70 years.



⁵⁵ Canadian Medical Association (CMA). *CMA condemns forced and coerced sterilization* [media release]. Ottawa: The Association; 2022 Jul 22. Available: <https://www.cma.ca/about-us/what-we-do/press-room/cma-condemns-forced-and-coerced-sterilization> (accessed 2023 Nov 21).

⁵⁶ @CMA Docs [X social media account]. *In response to a report from the Standing @SenateCA Committee on #HumanRights, we support recommendations to prohibit forced and coerced sterilization...* [X]. Ottawa: Canadian Medical Association (CMA); 2022 Jul 22. Available: https://x.com/CMA_Docs/status/1550471976535203840 (accessed 2024 Aug 21)

⁵⁷ Owens B. Canada used hungry indigenous children to study malnutrition. *Nature* 2013 Jul 23. Available: <https://doi.org/10.1038/nature.2013.13425> (accessed 2023 Nov 20).

⁵⁸ Unreserved with Zoe Tennant. *The dark history of Canada’s Food Guide: How experiments on Indigenous children shaped nutrition policy* [podcast]. Toronto: CBC Radio; 2021 Apr 19. Available: <https://www.cbc.ca/radio/unreserved/how-food-in-canada-is-tied-to-land-language-community-and-colonization-1.5989764/the-dark-history-of-canada-s-food-guide-how-experiments-on-indigenous-children-shaped-nutrition-policy-1.5989785> (accessed 2024 Apr 24).

Indigenous adults did not escape this terrible research, with many subjected to experimental tuberculosis vaccines and treatments, as well as nutritional studies in remote communities that were conducted from 1942 to 1952. In March 1942, a group of scientists and researchers led by Indian Affairs Branch Superintendent of Medical Services Dr. Percy Moore and Royal Canadian Air Force (RCAF) Wing Commander Dr. Frederick Tisdall, who was a leading nutritional expert at that time, travelled to the Cree communities of Norway House, Cross Lake, God's Lake Mine, Rossville and The Pas in northern Manitoba.⁵⁹ The goal was to study "the state of nutrition of the Indian" by using so-called "newly developed medical procedures." What this meant was conducting medical tests and procedures such as x-rays, blood tests and physical exams on roughly 400 Indigenous inhabitants. The findings were startling — malnutrition and hunger were rampant, tuberculosis rates 27 times greater than in the non-Indigenous Manitoba population and infant mortality eight times greater than in the rest of Canada.

While this information did highlight the health disparities these communities faced and shone a light on how malnutrition could lead to a host of health and social issues, it did not lead to positive changes that may have improved conditions but instead provided researchers with a living laboratory where they could study the effects of nutritional interventions (or non-interventions) on human beings. For the next 10 years, Indigenous Peoples residing in communities in northern Manitoba and in six residential schools were subjected to experiments, without their informed knowledge or consent.

A targeted review of the CMA archives and social media accounts related to medical

experimentation and Indigenous Peoples yielded few results specifically related to this issue. An article published in the March 1946 edition of *CMAJ* entitled "Medical Survey of Nutrition among the Northern Manitoba Indians" detailed the results of the study referred to above. It outlined the economic (including housing) and health conditions of the "bush Indians" and went into great detail regarding the dietary habits and nutritional status of the Indigenous Peoples surveyed. The results of the study were bleak, with all inhabitants consuming far fewer than the recommended daily amount of nutrients. The impacts of this on their health were impossible to ignore:

It is not unlikely that many characteristics, such as shiftlessness, indolence, improvidence and inertia, so long regarded as inherent or hereditary traits in the Indian race, may, at the root, be really the manifestations of malnutrition. Furthermore, it is probable that the Indians' great susceptibility to many diseases, paramount amongst which is tuberculosis, may be attributable among other causes to their high degree of malnutrition arising from lack of proper foods.⁶⁰

⁵⁹ Mosby I. Administering colonial science: Nutrition research and human biomedical experimentation in Aboriginal communities and residential schools, 1942–1952. *Histoire sociale/Social History* 2013 May;46(91):145-172. Available: <https://doi.org/10.1353/his.2013.0015> (accessed 2023 Nov 20).

⁶⁰ Moore PE, Kruse HD, Tisdall FF, et al. Medical survey of nutrition among the northern Manitoba Indians. *CMAJ* 1946 Mar;54(3):223-33. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1582628/pdf/canmedaj00594-0012.pdf> (accessed 2024 Apr 24).

Although the study clearly demonstrated that the inhabitants of these communities were experiencing hunger, poor nutrition and a myriad of health issues, there is no mention of what could be done to provide aid or any suggestion of structural changes that could have improved the living conditions of the Indigenous populations. The authors do note that the nutritional issues appeared to be in part related to the quality of the food available for purchase at stores, in contrast to the historically healthier diet consumed by the population being discussed, and that the population had been healthier previously. They did not draw a link between those observations and colonization. No further reference to the study or subsequent nutritional experiments was found in the search of the CMA archives.

It is worth noting that one of the primary researchers involved with the study, Dr. Frederick Tisdall, was the first chair of the CMA Committee on Nutrition and, as documented in the *History of the Canadian Medical Association, Volume II [1920-1956]*,

“the Committee’s work was so closely identified with Dr. Tisdall that on his death in 1949 there was a pause in its work, until the appointment in 1951 of Dr. E. H. Bensley as Chair-man.”⁶¹ There is no reference in any documents in the archives to the fact that Dr. Tisdall continued to participate in nutritional experiments on Indigenous adults and children until his death in 1949, described by the *Toronto Sun* as “one of the worst breaches of medical ethics in Canadian history.”⁶²

A search of the CMA archives regarding experiments carried out on Indigenous patients with tuberculosis without their knowledge or informed consent and a search of the CMA’s social media accounts using

keywords such as “tuberculosis,” “sanatorium” and “medical experiments” produced only a few results, although we now know of numerous examples of the trauma inflicted on Indigenous patients with tuberculosis, from forced relocation to abuse at the hands of hospital staff.⁶³ The film “The Unforgotten” includes the story of Sonny MacDonald, a Métis man who at the age of seven, was sent to the Charles Camsell Indian Hospital for tuberculosis treatment.⁶⁴ His two and a half years in the hospital were marked by abuse, loneliness and despair. To prevent him from walking around and visiting other patients after he had surgery to treat his tuberculosis, hospital staff put casts on his lower legs with a bar connecting the two casts.



⁶¹ McDermot HE. *History of the Canadian Medical Association, Volume II [1920-1956]*. Toronto: Murray Printing & Gravure Limited; 1958. p. 135.

⁶² Mackenzie P. Sick Kids website must reflect immoral research on Indigenous children. *Toronto Star* 2018 Jul 25. Available: https://www.thestar.com/opinion/contributors/sick-kids-website-must-reflect-immoral-research-on-indigenous-children/article_3f6ec670-bd34-587d-8412-24068de889d0.html.html (accessed 2023 Dec 4).

⁶³ Pelley L. Mistreated: The legacy of segregated hospitals haunts Indigenous survivors. *CBC News* 2018 Jan 29. Available: <https://www.cbc.ca/news2/interactives/sh/jTCWPYgkNH/mistreated/> (accessed 2024 Apr 24).

⁶⁴ Canadian Medical Association (CMA). *The Unforgotten: a film about Indigenous health*. Ottawa: The Association; 2021. Available: <https://theunforgotten.cma.ca/> (accessed 2024 Jun 25).

In addition, a search for CMA activity regarding Prime Minister Justin Trudeau's formal apology in 2019 for the mistreatment of Inuit with tuberculosis,⁶⁵ including any public comments by the CMA on the apology, yielded no results. This silence is noteworthy given the gravity and scope of the harms caused to Inuit by Canada's tuberculosis policies.

FORCED RELOCATION AND RESIDENTIAL SCHOOLS

The Truth and Reconciliation Commission of Canada was born from the Indian Residential Schools Settlement Agreement, which called for a commission to acknowledge the impact of residential schools and provide a safe space for Indigenous Peoples to share their stories of being taken from their families as children, at times by force, and the intergenerational trauma this inflicted on families and communities.⁶⁶ The final report of the commission was released in December 2015 and contained heartbreaking stories of loss, neglect, abuse and sorrow. It also contained 94 Calls to Action, eight of which specifically call

for measures to address the impact residential schools have had on the health of Indigenous Peoples to close the gap in health outcomes between Indigenous and non-Indigenous communities. The report of the Truth and Reconciliation Commission of Canada has been the inspiration for much of the CMA's work in Indigenous health.

The harrowing accounts of residential school survivors are not the only stories of forced or coerced relocation in Canada. In 1953 and 1955, the Canadian government relocated approximately 92 Inuit from Inukjuak, formerly called Port Harrison, in northern Quebec, and Mittimatalik (Pond Inlet), in what is now Nunavut, to Resolute Bay and Grise Fiord in the high Arctic.⁶⁷ They were promised better living conditions with abundant wildlife; what they found was darkness, bitter cold and very little to hunt. By moving Inuit populations, the Canadian government hoped to establish sovereignty in the Arctic and force Inuit to return to a more "traditional lifestyle" and end their reliance on trading posts or government support.⁶⁸ Despite

the strength and resilience of the forcibly relocated Inuit, the move would have a lasting impact on their health and socioeconomic well-being.

A search of the CMA's archives and social media accounts for anything specifically relating to the residential school system or forced relocation of Indigenous Peoples yielded minimal results. For example, the work of Dr. Peter Bryce to expose the alarming rates of tuberculosis and deaths of Indigenous children in the care of the residential school system went seemingly unaddressed by the CMA. Dr. Bryce, who in 1904 was appointed the first chief medical officer for the Department of the Interior, making him responsible for the health of Indigenous children in residential schools, began to collect health statistics on hundreds of Indigenous bands across Canada.⁶⁸ In 1907, he produced a report for the Canadian government highlighting that according to the data he had gathered roughly one-quarter of all Indigenous children attending residential schools had died of tuberculosis.⁶⁹ In his report, Dr. Bryce blamed the deaths on poor conditions at the

⁶⁵ Trudeau J (Prime Minister of Canada). *Statement of Apology on Behalf of the Government of Canada to Inuit for the Management of the Tuberculosis Epidemic from the 1940s-1960s* [Speeches]. Ottawa: Government of Canada; 2019 Mar 8. Available: <https://www.pm.gc.ca/en/news/speeches/2019/03/08/statement-apology-behalf-government-canada-inuit-management-tuberculosis> (accessed 2024 Aug 28).

⁶⁶ Truth and Reconciliation Commission of Canada. *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Ottawa: Government of Canada; 2015. Available: https://publications.gc.ca/collections/collection_2015/trc/IR4-7-2015-eng.pdf (accessed 2023 Dec 19).

⁶⁷ Madwar S. Inuit high Arctic relocations in Canada [Internet]. *The Canadian Encyclopedia, Historica Canada*. 2018 Jul 25. Available: www.thecanadianencyclopedia.ca/en/article/inuit-high-arctic-relocations (accessed 2023 Dec 19).

⁶⁸ Hay T, Blackstock C, Kirlew M. Dr. Peter Bryce (1853-1932): whistleblower on residential schools. *CMAJ* 2020 Mar 2;192(9):E223-E224. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7055949/pdf/192e223.pdf> (accessed 2024 Apr 24).

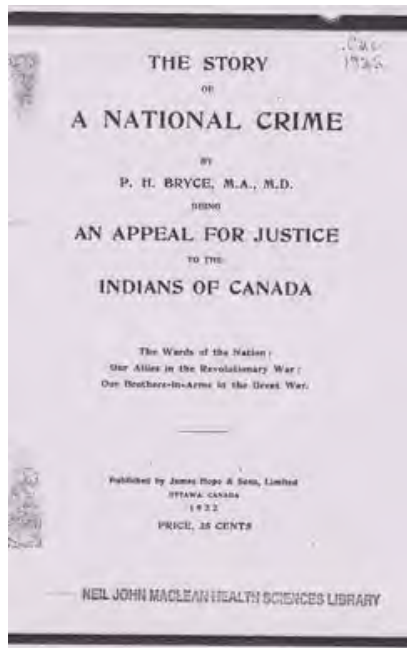
⁶⁹ Bryce PH. *Report on the Indian schools of Manitoba and the Northwest Territories*. Ottawa (ON): Government Printing Bureau; 1907. Available: https://publications.gc.ca/collections/collection_2018/aanc-inac/R5-681-1907-eng.pdf (accessed 2024 Jan 2).

residential schools, rather than the “racial susceptibility” theory that was popular at the time.⁶⁹

The report did attract the attention of the public, as several news outlets ran stories based on it, including the Ottawa paper *The Evening Citizen*, which published a front-page story on the report with the headline “Schools Aid White Plague — Startling Death Tolls Revealed Among Indians — Absolute Inattention to the Bare Necessities of Health.”⁷⁰ Tragically, the report did not spark change and all of Bryce’s recommendations were dismissed. In 1913, Dr. Bryce’s tuberculosis research funding was cut by the newly appointed deputy superintendent general of Indian Affairs, who also blocked Dr. Bryce from presenting his findings at academic conferences. This did not stop Dr. Bryce from speaking out, and he was effectively forced to leave the public service in 1921.⁷¹ In 1922, he self-published a pamphlet entitled *The Story of a National Crime - An Appeal for Justice to the Indians of Canada*, which outlined the government’s role in creating and maintaining the appalling conditions that led to the deaths of countless Indigenous children

in the care of the residential school system.⁷²

Despite the efforts of Dr. Bryce to draw attention to the poor conditions in residential schools, a search of the CMA archives for



any mention of the 1907 report, the pamphlet from 1922 or Dr. Bryce’s work in this area yielded no results. It would appear from a review of the CMA archives that his work related to Indigenous health was ignored by the CMA from when he published his first report in 1907 to his death in 1932. There is also no mention of Dr. Bryce’s endeavours to raise awareness of the maltreatment and abuse Indigenous children

experienced in residential schools in his obituary published in *CMAJ* the year of his death.

It should be noted that while Dr. Bryce’s determination to expose the terrible conditions at residential schools is admirable, he was not without his faults. Some of his views expressed in government reports seem to support the view that “civilization” of Indigenous Peoples should be carried out through assimilation.⁶⁹ Other views on poverty and the superiority of the Anglo-Saxon race are also problematic when looked at through a 21st century lens and are a reminder of the complexities associated with celebrating the accomplishments of an individual.

A search of the CMA archives for specific events, such as the coroner’s inquest into the death of Chanie Wenjack, a 12-year-old Ojibway boy who died in 1966 from exposure trying to escape a residential school in Kenora, Ontario, yielded no results. Nor did searches related to the coerced relocation of Inuit to the high Arctic as outlined above, or the killing of Inuit sled dogs from the 1950s to the 1970s. During this period the RCMP slaughtered

⁷⁰ School aids white plague — Startling death rolls revealed among Indians — Absolute Inattention to the bare necessities of health. *The Evening Citizen* [Ottawa] 1907 Nov 15. p. 1.

⁷¹ First Nations Child & Family Caring Society of Canada. *Dr. Peter Henderson Bryce: A story of courage* [information sheet]. Ottawa: First Nations Child & Family Caring Society; 2016 Jul. Available: <https://fncaringsociety.com/publications/dr-peter-henderson-bryce-story-courage> (accessed 2024 Jan 2).

⁷² Michelin O. Canadian Inuit Dog [Internet]. *The Canadian Encyclopedia, Historica Canada* 2021 Dec 17. Available: <https://www.thecanadianencyclopedia.ca/en/article/canadian-inuit-dog> (accessed 2024 Mar 6).

tens of thousands of sled dogs in the name of “public health and safety.”⁷² The killing of Inuit sled dogs is widely viewed as part of the Canadian government's efforts to force Inuit to abandon their nomadic way of life and culture and relocate to permanent settlements.

In more recent times, the CMA has addressed the issue of the residential school system and its negative impacts on the health and well-being of Indigenous Peoples through multiple generations. After the publication of the Truth and Reconciliation Commission of Canada's *Executive Summary Report* in June 2015, which included the 94 Calls to Action,³⁴ CMA General Council passed a resolution to “promote practical advocacy strategies to support the health and well-being of First Nations, Métis and Inuit communities in Canada.”³⁵ The CMA committed to reviewing the report's recommendations, particularly those dealing with health, and identifying areas where the CMA could play a role to advance implementation of the relevant recommendations.

With the Calls to Action acting as a catalyst for change, the CMA has been working to address the harms done to Indigenous Peoples at the hands of the health system. As Dr. Kirsten Patrick, Editor-in-Chief of *CMAJ*, said in an editorial in May 2022:

CMAJ did not mention the residential school system as a determinant of health in its first 7 decades. A search of the journal's archive reveals that only 1 article made any mention of Canada's residential schools before the last institution was closed in 1996. While thousands of Indigenous children died while enrolled in residential schools and thousands more survived brutal conditions that led to disease and trauma, CMAJ, like many institutions, was all but silent. The journal first discussed the health harms of the residential school system in its editorial pages in 2015, when the work of the Truth and Reconciliation Commission of Canada was already well underway.⁷³

The CMA was silent for many years on the intergenerational impacts of the residential school system on the physical, mental and cultural well-being of Indigenous Peoples. It is also important to note that First Nations, Inuit and Métis Peoples continue to be displaced because of the ongoing limitations to access to care facing rural and remote communities, as well as gaps in on-reserve public health standards (e.g., access to clean water). Moving forward, the CMA will need to address its past silence and amplify the voices of Indigenous Peoples so these issues receive the attention they deserve.

⁷³ Patrick K. Extending the impact of *CMAJ*. *CMAJ* 2022 May 24;194(20):E706-7. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9188791/pdf/194e706.pdf> (accessed 2024 Apr 24).



SECTION 2: HISTORICAL REVIEW OF PARLIAMENTARY RECORDS

INTRODUCTION

This section summarizes the results of a targeted review of publicly available records of parliamentary debates and committee hearings relating to the CMA and Indigenous health. The results of this review complement the review of archival and other documents. The ethics review section in this report includes an ethics-based analysis of these findings.

INDIGENOUS-SPECIFIC RACISM AND INEQUITY IN THE HEALTH SYSTEM

The search revealed several instances where it is likely that CMA advocacy and policy positions, if implemented by government, would have been harmful to Indigenous patients or groups or violated medical ethical norms. These included instances of CMA advocacy at committee hearings on the remuneration of physicians providing care to Indigenous Peoples that focused primarily on physicians' financial interests, rather than Indigenous patients' health interests.

The most explicit example of this attitude can be found in the transcript of a session of the Joint Committee on Indian Affairs in 1961, which includes a record of the CMA spokesperson expressing racist, colonial and paternalistic attitudes regarding Indigenous patients. The spokesperson indicated support for a system where Indigenous Peoples should pay a portion of the cost of health services to “introduce them to citizenship in this country, which is our main objective.”⁷⁴ It is clear this was not a universal view, as a Progressive Conservative committee member questioned the proposed approach at a



⁷⁴ Canada. Parliament. Joint Committee of the Senate and the House of Commons on Indian Affairs. *Minutes of proceedings and evidence*. 24th Parl, 4th Sess, Vol 1, No 3, 1961 Mar 16. p. 75. Available: https://parl.canadiana.ca/view/oop.com_SOCHOC_2404_1_1/87 (accessed 2024 Apr 16).

time when universal health care was being actively debated and investigated.⁷⁵ CMA advocacy failed to acknowledge that Indigenous Peoples had no or limited treaty rights to medical care.

RECORDS POINTING TO POSSIBLE CMA OMISSIONS

In addition to records that are evidence of harmful CMA policy positions, the search uncovered advocacy on a range of topics where it can be argued that the CMA failed to give sufficient



(or any) attention to Indigenous health considerations.

For example, records indicate it had been well understood by the CMA since at least the 1960s that Indigenous patients were facing inequitable access to care because of jurisdictional and bureaucratic wrangling and blame shifting, yet the CMA did not formally endorse Jordan's Principle for eight months.⁷⁶ There was nothing found in the various sources searched to indicate the CMA engaged in any advocacy on Jordan's Principle.

Other examples of topics disproportionately impacting Indigenous Peoples for which the CMA has engaged in advocacy without specifically identifying the impact on Indigenous Peoples or calling on the government to provide solutions specific to them are as follows:

- universal health insurance⁷⁷
- health system funding⁷⁸ and service levels⁷⁵
- child welfare⁷⁹
- poverty and income inequality⁸⁰

The review of parliamentary records did not uncover records on several topics covered in the archival review:

- forced or coerced sterilization of Indigenous Peoples
- medical experimentation on Indigenous children and adults
- forced relocation and residential schools

Given that Indigenous patients and groups have faced and continue to face systemic disadvantages relating to health, failing to give sufficient and specific attention to Indigenous health considerations can be a breach of ethical norms, a failure to consider equity issues, and a failure to support Crown and other obligations toward Indigenous Peoples. In certain cases, additional ethical or other norms may have been breached as well. A more complete ethics analysis of these omissions can be found in the third section of this report.

⁷⁵ Canada. Parliament. Joint Committee of the Senate and the House of Commons on Indian Affairs. *Minutes of proceedings and evidence*. 24th Parl, 4th Sess, Vol 1, No 3, 1961 Mar 16. p. 61. Available: https://parl.canadiana.ca/view/oop.com_SOCHOC_2404_1_1/73 (accessed 2024 Apr 16).

⁷⁶ Canada. Parliament. House of Commons. Standing Committee on National Health and Welfare. *Minutes of proceedings and evidence*. 33rd Parl, 2nd Sess, Vol 3, No 52, 1988 Jun 22. p. 103. Available: https://parl.canadiana.ca/view/oop.com_HOC_3302_49_3/573 (accessed 2024 Apr 16).

⁷⁷ Canada. Parliament. House of Commons. Special Committee on Social Security. *Minutes of proceedings and evidence*. 19th Parl, 4th Sess, Vol 1, No 1, 1943 Mar 16. p. 13. Available: https://parl.canadiana.ca/view/oop.com_HOC_1904_5_1/25 (accessed 2024 Apr 16).

⁷⁸ Canada. Parliament. House of Commons. *Votes and Proceedings*. 32nd Parl, 1st Sess, No 234-251, 1981 Oct 14. p. 3227. Available: https://parl.canadiana.ca/view/oop.proc_HOC_3201_6/359 (accessed 2024 Apr 16).

⁷⁹ Canada. Parliament. House of Commons. *Debates*. 18th Parl, 1st Sess, Vol 3, 1936 Apr 24. p. 2164. Available: https://parl.canadiana.ca/view/oop.debates_HOC1801_03/112 (accessed 2024 Apr 16).

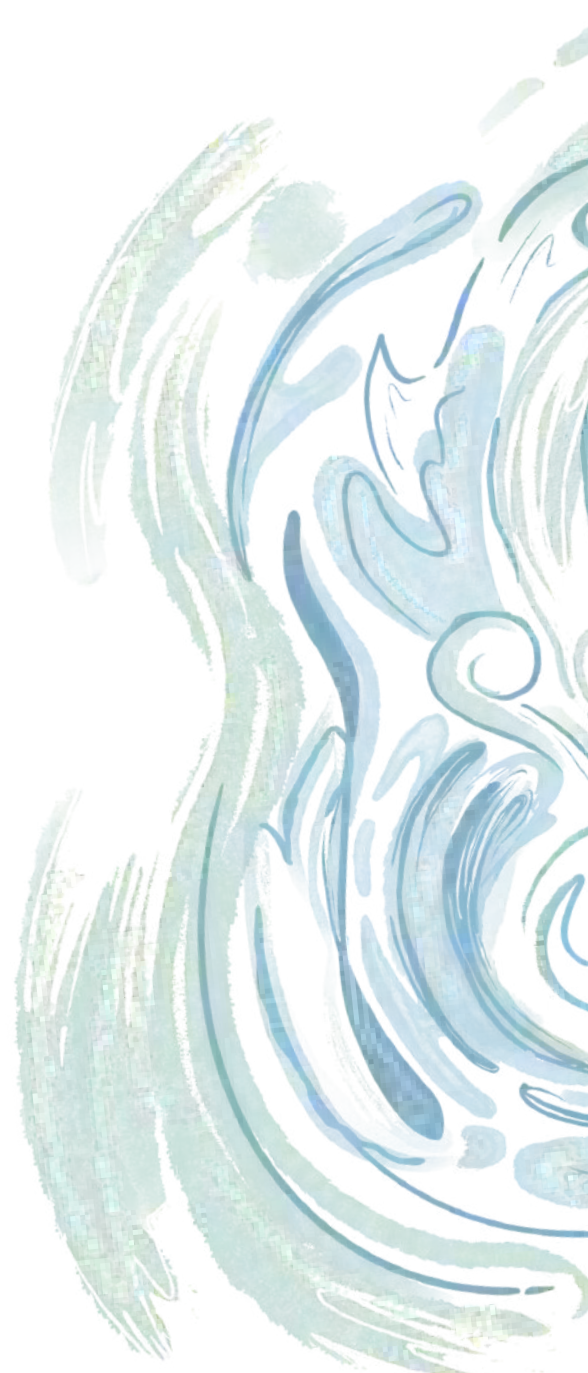
⁸⁰ Canada. Parliament. House of Commons. Standing Committee on Finance. *Minutes of proceedings and evidence*. 41st Parl, 1st Sess, No 116, 2013 Apr 25. Available: <https://www.ourcommons.ca/documentviewer/en/41-1/FINA/meeting-116/evidence#Int-7979337> (accessed 2024 Apr 16).

OTHER NOTABLE RECORDS

While many records indicate harmful advocacy or omissions on the part of the CMA relating to Indigenous health, there are several instances of the CMA advocating for policies that might have benefited Indigenous Peoples or helped support Indigenous health, including the following:

- some advocacy raising the lack of clarity relating to government obligations to provide health care to Indigenous Peoples and the need for government to provide greater clarity on eligibility and who is responsible for providing and funding care⁷⁴
- advocacy in support of improving conditions relating to determinants of health affecting Indigenous Peoples⁸¹
- advocacy in support of Indigenous self-determination and identifying it as a determinant of health for Indigenous Peoples^{82, 83}
- some advocacy in support of increasing the number of physicians working in Indigenous communities⁸⁴
- more recently, calls for more supports to increase the number of Indigenous health workers⁸⁵

This advocacy was included in the review not to excuse any of the acts or omissions above, but rather to create a more complete picture of the CMA's activities relating to Indigenous Peoples and their health found in the parliamentary record. Even where the CMA advocated for Indigenous health in a generally positive way, it might be argued that the CMA might have done more to advance Indigenous health and advance other principles of reconciliation.



⁸¹ Canada. Parliament. House of Commons. *Debates*. 35th Parl, 1st Sess, Vol 5, 1994 Sep 26. p. 6138. Available: https://parl.canadiana.ca/view/oop.debates_HOC3501_05/356 (accessed 2024 Apr 16).

⁸² Canada. Parliament. House of Commons. *Minutes of proceedings and evidence*. 39th Parl, 1st Sess, No 21, 2006 Oct 19. Available: <https://www.ourcommons.ca/documentviewer/en/39-1/HESA/meeting-21/evidence> (accessed 2024 Apr 16).

⁸³ Canada. Parliament. House of Commons. *Debates*. 41st Parl, 1st Sess, Vol 146, No 236, 2013 Apr 19. Available: <https://www.ourcommons.ca/documentviewer/en/41-1/house/sitting-236/hansard#Int-7969953> (accessed 2024 Apr 16).

⁸⁴ Canada. Parliament. House of Commons. Standing Committee on Indian Affairs and Northern Development. *Minutes of proceedings and evidence*. 28th Parl, 2nd Sess, Vol 1, No 2, 1969 Dec 16. p. 31. Available: https://parl.canadiana.ca/view/oop.com_HOC_2802_8_1/53 (accessed 2024 Apr 16).

⁸⁵ Canada. Parliament. Proceedings of the Special Senate Committee on Poverty. *Minutes of proceedings and evidence*. 28th Parl, 2nd Sess, Vol 3, No 45, 1970 May 28. Available: https://parl.canadiana.ca/view/oop.com_SOC_2802_7_3/47 (accessed 2024 Apr 16).



SECTION 3: ETHICS REVIEW OF CMA ARCHIVES AND PARLIAMENTARY RECORDS

INTRODUCTION

This section summarizes the results of an ethics review of records found in the CMA archives and parliamentary databases relating to the CMA and Indigenous health. The results of this review were used to inform the CMA apology statement and action plan. The previous sections in this report discuss the specific events referred to here in greater detail.

METHODOLOGY

Documents identified in the search of the CMA's archives were reviewed using the ethics assessment framework developed by CMA staff for the project with guidance from the CMA Committee on Ethics. The framework provides the relevant information and tools to apply a biomedical ethics lens to the

review of documents and other evidence in support of the project. It includes relevant ethical norms, principles, requirements and other key concepts grouped by theme.

The concepts in the framework were drawn from current and past versions of the CMA Code of Ethics and Professionalism, supplemented by other Canadian, Indigenous and international

sources of ethical norms that are relevant to the historical events identified during the apology process, all outlined in the framework. The framework also includes a template that was used to apply the concepts in the framework to the various documents, themes and findings from the searches (archives, parliamentary records, etc.) carried out as part of the project.

NOTE ON MEDICAL ETHICS AND ITS APPLICATION

The ethical norms that guide the medical profession today are the product of an evolution. A significant evolution of ethics and human rights concepts occurred in the aftermath of the Second World War and the Holocaust when it was recognized that some physicians had committed abhorrent acts in the name of medicine during the Nazi regime in Germany and elsewhere. This means that, broadly speaking, the core ethical principles that govern medicine today have existed since the period after that war and can be applied to the actions of the medical community and the CMA toward Indigenous Peoples in Canada.

Before this time, general medical ethical principles existed that might have been applied to the treatment of Indigenous Peoples in Canada, such as the fundamental principle of prioritizing the well-being of the patient over other interests.

In addition to the ethical norms specific to the medical profession and areas such as research involving human subjects, this review is informed by nationally and internationally recognized norms relating to Indigenous Peoples that have influenced and been adopted into medical ethics. These include norms and concepts in the Truth and Reconciliation Commission of Canada's reports and Calls to Action⁶⁶ and the United Nations Declaration on the Rights of Indigenous Peoples.⁸⁶ Despite this, it is important to acknowledge that this review was conducted primarily from a western biomedical ethics lens. It is not intended to be the primary way of understanding the harms caused by the CMA, which must prioritize Indigenous perspectives, but as a secondary lens to understand how the CMA and the medical profession's own commitments can be applied to the CMA's actions.

Finally, the approach inherent in reconciliation involves evaluating past actions not only on the basis of the standards of the time but also on the basis of what we now understand the standards ought to have been and what may in some cases have been known at the time. With this in mind, the ethical standards of both the time in which specific actions occurred and today's ethical standards have been applied to these past events.

KEY FINDINGS

The findings in this section have been grouped by theme and summarized. The sources (CMA or third party) outlining the ethical norms that apply are referenced in the footnotes. References to the records they are based on can be found in the sections reporting the findings (e.g., the findings in the CMA archives or in publicly available parliamentary records). In many cases, the link between the theme or activity and an ethics violation is clear and an in-depth analysis is not provided.

⁸⁶ United Nations. *United Nations Declaration on the Rights of Indigenous Peoples*. New York: Department of Economic and Social Affairs; 2007. Available: https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf (accessed 2024 Apr 24).

Indigenous-specific racism, inequity and systemic discrimination in the health system

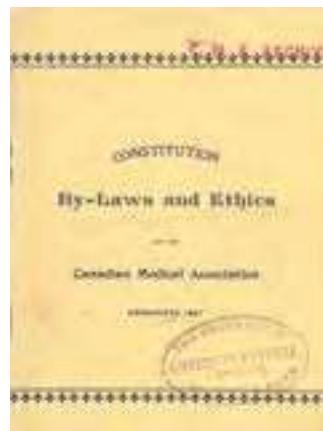
The pattern of systemic discrimination in the health care system (exemplified by stories such as that of Joyce Echaquan), racist attitudes toward Indigenous Peoples and communities in medical journals and records, and the CMA's own racist, colonial and paternalistic attitudes toward Indigenous Peoples found in the records, contravenes several ethical norms, including the following:

- the physician's key ethical duties to consider first the well-being of the patient, respect for persons and minimization of harm^{87, 88, 89, 90, 91, 92}
- the prohibitions against discrimination and cruel, inhuman or degrading practices or punishments^{87, 89}
- the rights to equal treatment and to life, physical integrity and security of the person⁸⁶
- justice, including promoting the well-being of communities and reducing health inequities and disparities in care^{87, 88}
- Indigenous-specific and reconciliation-based concepts, including:
 - the equal right to the highest attainable standard of mental health⁸⁶
 - the responsibility to call for recognition that the state of Indigenous health in Canada is a direct result of previous government policies and that there is a gap in health outcomes between Indigenous and non-Indigenous people and a duty to address them^{34, 86}

While the CMA has conducted some engagement and at times made statements to try to address these issues over the years, the effort was uneven and not consistent with the issues' importance and urgency. Some instances, such as the CMA's late endorsements of the United Nations Declaration on the Rights of Indigenous Peoples

and the Truth and Reconciliation Commission of Canada's Calls to Action, indicate the CMA clearly fell short of these norms.^{34, 86}

The failure of the CMA to follow through on the commitments it made to Indigenous groups and communities to promote Indigenous health also failed to support Indigenous Peoples' right to participate in decision-making in matters that affect their rights.⁸⁶ It is also reasonable to conclude, on the basis of their participation in health systems and other systems such as education, that many physicians were complicit in or participated actively in the systemic discrimination of Indigenous patients.



⁸⁷ Canadian Medical Association (CMA). *CMA Code of Ethics and Professionalism* [policy]. Ottawa: The Association; 2018. Available: <https://policybase.cma.ca/link/policy13937> (accessed 2024 Apr 18).

⁸⁸ Canadian Medical Association (CMA). *CMA Code of Ethics*, historic versions [policy]. Ottawa: The Association; 1867–2004.

⁸⁹ World Medical Association (WMA). *WMA International Code of Medical Ethics*. Ferney-Voltaire (France): The Association; 2022. Available: <https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/> (accessed 2024 Apr 24).

⁹⁰ World Medical Association (WMA). *WMA Declaration of Geneva*. Ferney-Voltaire (France): The Association; 2017. Available: <https://www.wma.net/policies-post/wma-declaration-of-geneva/> (accessed 2024 Apr 24).

⁹¹ Public Health Agency of Canada (PHAC). Public Health Ethics Consultative Group. *Framework of ethical deliberation and decision-making in public health: A tool for public health practitioners, policy makers and decision-makers*. Ottawa: The Agency; 2017 Mar. Available: <https://publications.gc.ca/site/eng/9.818019/publication.html> (accessed 2024 Apr 24).

⁹² Canadian Institutes of Health Research (CIHR), Natural Sciences and Engineering Research Council of Canada (NSERC) and Social Sciences and Humanities Research Council of Canada (SSHRC). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. Ottawa: Secretariat on Responsible Conduct of Research; 2022 Dec. Available: <https://ethics.gc.ca/eng/documents/tcps2-2022-en.pdf> (accessed 2024 Apr 24).

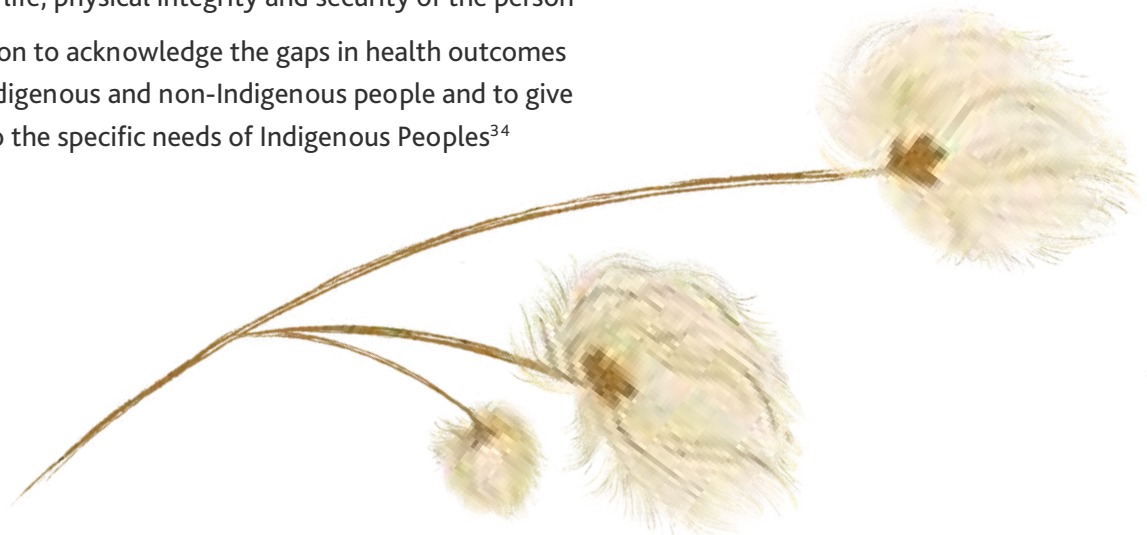
Access to care, Jordan's Principle and recent advocacy

At times, the CMA's advocacy prioritized physicians' interests over Indigenous patients' interests, possibly resulting in a breach of several ethical norms and concepts. An example of this is the CMA's focus at certain periods in its history on physician remuneration over patient interests (such as adequate care and funding for Indigenous patients), which at times included racist, colonial and paternalistic language and attitudes toward Indigenous patients. In one key instance that exemplifies these approaches, in 1961 a CMA spokesperson supported charging Indigenous patients a nominal fee to "introduce them to citizenship in this country, which is our main objective."¹⁷⁴

These findings and examples indicate a breach of the following:

- the fundamental ethical duty to consider first the well-being and welfare of the patient over physicians' interests^{87, 88, 89, 90}
- the duty to manage conflicts of interest appropriately^{87, 89}
- several ethical concepts related to equity, including respect for persons, justice, equal treatment and freedom from discrimination^{86, 87, 88, 89, 90}
- Indigenous-specific and reconciliation-related concepts, including:
 - respect for treaty relationships (including Crown obligations to provide health care)^{34, 86}
 - the right to life, physical integrity and security of the person⁸⁶
 - the obligation to acknowledge the gaps in health outcomes between Indigenous and non-Indigenous people and to give attention to the specific needs of Indigenous Peoples³⁴

A number of major initiatives over the past decades in Canada have sought to address inadequacies in access to care. The CMA arguably did not act in a timely, sufficient or focused manner when it was well understood that Indigenous patients were facing inequitable access to care and falling through the cracks because of a failure of different health systems and levels of government to take accountability for their care. Other initiatives include the Royal Commission on Aboriginal Peoples, the Kelowna Accord, the United Nations Declaration on the Rights of Indigenous Peoples and the work of the Truth and Reconciliation Commission of Canada.^{34, 86, 93, 94}

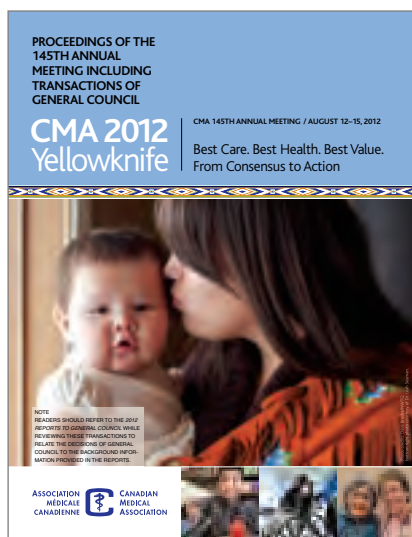


⁹³ Canada. Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples. 5 vols.* Ottawa: Royal Commission on Aboriginal Peoples, 1996. Available: <https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx> (accessed 2024 Aug 28).

⁹⁴ deBruin T. Kelowna Accord [Internet]. *The Canadian Encyclopedia, Historical Canada*. 2021 Sep 10. Available: <https://www.thecanadianencyclopedia.ca/en/article/kelowna-accord> (accessed 2024 Aug 28).

The failure of the CMA to adequately advocate for governments to meet their obligation to provide access to care regardless of jurisdictional barriers indicates a breach of several ethical norms:

- justice, including promoting the well-being of communities and reducing health inequities and disparities in care^{87, 88}
- the need to support health equity and equitable access to health resources^{87,89, 95, 96}



- norms relating to equal treatment and freedom from discrimination^{86, 87, 89}
- the duty to report circumstances that impede physicians from providing care to the highest standards⁸⁹

- Indigenous-related ethical concepts, including:
 - Jordan's Principle of equitable access to health regardless of residence, jurisdiction or service provider³⁴
 - respect for treaty relationships (including Crown obligations toward Indigenous communities)^{34, 86}
 - the right to life, physical integrity, liberty and security of the person⁸⁶
 - the equal right to the highest attainable standard of physical and mental health⁸⁶

More broadly, while the CMA has engaged in advocacy on Indigenous health since the 1990s, its advocacy has, at times, been slow and uneven. This includes being slow to endorse the Truth and Reconciliation Commission of Canada's Calls to Action and Jordan's Principle, and developing a comprehensive action plan on Indigenous health but failing to fully implement it.

31, 34

Given that Indigenous patients and groups have and continue to face systemic disadvantages relating to health, the CMA's failure to give timely, sufficient and specific attention to Indigenous health considerations means that the organization fell short of the ethical norms outlined above.

Indian hospitals, experimentation and forced sterilization

The evidence suggests multiple experiments were carried out on Indigenous patients in Canada without their knowledge or consent. There is also documented evidence that Indian hospitals were rife with medical experimentation, aggressive treatments involving forced confinement, poor or substandard conditions, and forced sterilization. Human experimentation also occurred in Indigenous communities and residential schools, in some case depriving children of adequate nutrition. It is reasonable to conclude that physicians were involved in such activities at Indian hospitals and elsewhere as well. Experimentation without consent was also carried out in remote communities.

⁹⁵ Canadian Medical Association (CMA). *Ensuring equitable access to health care: Strategies for governments, health system planners, and the medical profession* [policy]. Ottawa: The Association; 2013. Available: <https://policybase.cma.ca/link/policy11062> (accessed 2024 Apr 18).

⁹⁶ Canadian Medical Association (CMA). *Health equity and the social determinants of health: A role for the medical profession* [policy]. Ottawa: The Association; 2012. Available: <https://policybase.cma.ca/link/policy10672> (accessed 2024 Apr 18).

The CMA may have been aware of these activities. The targeted search of the CMA archives and the parliamentary records review did not reveal any evidence that the association ever intervened. With respect to sterilization, while forced sterilization was known publicly to be a matter of government policy in certain provinces throughout the early 20th century, the CMA did not change its policy to explicitly call for its prohibition, until 1970. Sterilization without informed consent occurred after that time.⁴⁹ Indigenous populations were also forcibly relocated to treat tuberculosis-related epidemics.



These actions violated many norms within past and current CMA ethics codes as well as Indigenous, domestic and international ethical norms relating to human experimentation, including the following:

- key ethical duties to act for the well-being of the patient, avoid or minimize harm, and demonstrate respect for persons^{87, 88, 89, 90, 91, 92}
- patient autonomy (including the duty to obtain the informed consent of a patient for care, sterilization and any research)^{87, 88, 90, 92, 97}
- the duty to avoid or appropriately manage conflicts of interest^{87, 89}
- duties relating to privacy and confidentiality^{87, 89, 90, 92, 98, 99}
- the duty to communicate accurately, honestly and in a way that the patient can understand and providing information that they can apply to their situation, to support the principles of patient autonomy and decision-making^{87, 89}
- the duty to report circumstances that impede physicians from providing care to the highest standards⁸⁹
- justice, health equity and non-discrimination, and the duty to promote the well-being of the community^{87, 88}
- the right to life, liberty, physical integrity and security of the person⁸⁶

The right not to be subjected to any act of genocide is also relevant as forced sterilization can be considered a form of genocide.^{86, 100}

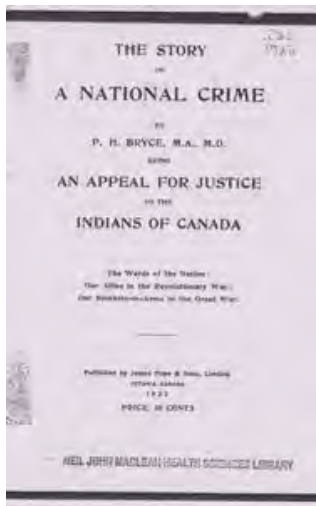
In failing to challenge any of the research it was aware of, the CMA failed to uphold these ethical norms.

⁹⁷ First Nations Information Governance Centre (FNIGC). *The First Nations Principles of OCAP*[®]. Akwesasne (ON): FNIGC; 2019. Available: <https://fnigc.ca/wp-content/uploads/2021/08/OCAP-Brochure-2019.pdf> (accessed 2024 Apr 24).

⁹⁸ Canadian Medical Association (CMA). *Principles for the protection of patient privacy* [policy]. Ottawa: The Association; 2017. Available: <https://policybase.cma.ca/link/policy13833> (accessed 2024 Apr 18).

⁹⁹ World Medical Association (WMA). *WMA Declaration of Taipei on ethical considerations regarding health databases and biobanks*. Taipei (Taiwan): The Association; 2016. Available: <https://www.wma.net/policies-post/wma-declaration-of-taipei-on-ethical-considerations-regarding-health-databases-and-biobanks/> (accessed 2024 Apr 24).

¹⁰⁰ United Nations Office on Genocide Prevention and the Responsibility to Protect. *Framework of analysis for atrocity crimes: A tool for prevention*. New York: United Nations; 2014. Available: https://www.un.org/en/genocideprevention/documents/publications-and-resources/Genocide_Framework%20of%20Analysis-English.pdf (accessed 2024 May 21).



Forced relocation and residential schools

In the face of Dr. Peter Bryce's damning reporting in the 1920s on the systematic institutionalization of Indigenous children in poor conditions that led to the spread of disease, as well as government-mandated forced relocation of Indigenous Peoples to achieve Arctic sovereignty and other objectives, the CMA and the medical community failed to advocate for improved conditions for Indigenous Peoples.

In some instances, physicians participated actively in residential school programs and the forced relocation of Indigenous Peoples related to medical treatment. That Dr. Bryce raised federal treaty and Crown obligations toward Indigenous Peoples in his efforts to highlight the inequitable treatment of Indigenous patients suggests that these obligations were long known in the medical community, but inadequate action was taken.

The treatment of children in residential schools violates many ethical norms, including the following:

- the key ethical duties to act for the well-being of the patient, minimize harm and show respect for persons^{87, 88, 89, 90, 91, 92}
- justice and the duty to the welfare of the community^{87, 88}
- the duty to report circumstances that impede physicians or other health professionals from providing care to the highest standards⁸⁹
- universal and Indigenous ethical norms, including:
 - the right not to be assimilated or forcibly removed from lands (especially children)⁸⁶
 - the right to peace and security⁸⁶
 - respect for treaty relationships and obligations^{34, 86}
 - norms relating to systemic discrimination (see below)

The norms described above associated with forced relocation, including the rights to freedom and not to be forcibly removed from lands, may also apply to relocation for medical care, especially where coercion is involved.

Determinants of health

The negative impact of determinants of health, including inequities in income, housing, employment, education and access to clean drinking water, on Indigenous Peoples are well documented. Lack of self-determination and many land claim-related issues can also be considered determinants of health for Indigenous Peoples.

These inequities relate to several ethical norms, including the following:

- the key ethical duty to act for the well-being of the patient^{87, 88, 89, 90, 91}
- justice (including promoting the well-being of communities and reducing health inequities and disparities in care), and support for health equity⁸⁷
- the duty to report circumstances that impede physicians from providing care to the highest standards⁸⁹
- the Indigenous right to self-determination, including the right of Indigenous groups to determine and develop priorities in areas including health, housing and other economic and social programs and the related patient right to autonomy⁸⁶

The CMA may have fallen short of these ethical norms in not adequately or specifically addressing the needs of Indigenous patients and populations when doing advocacy related to the determinants of health and other health-related issues. There are numerous examples of advocacy on topics disproportionately impacting Indigenous communities where the CMA did not specifically identify the impact on Indigenous Peoples or call on the government to provide solutions specific to them. Such topics include universal health insurance, health system funding, child welfare, poverty and income inequality.

Indigenous health workforce

Increasing the number of Indigenous physicians and other health workers is considered a priority to enhance Indigenous health and health equity, something the CMA has periodically advocated for. The CMA identified this as a priority in recent decades in various policy positions and created an Indigenous medical student bursary in the 2000s.

Advancing Indigenous representation in the health workforce relates to several ethical norms, including the following:

- the principle of justice, including promoting the well-being of communities, supporting health equity and reducing health inequities and disparities in care^{87, 88}
- the CMA Code of Ethics and Professionalism's call to support equitable access to health resources⁸⁷
- The Truth and Reconciliation Commission of Canada's Call to Action number 23 to increase the number of Indigenous providers and address retention³⁴
- the CMA's policy positions to enhance equity, diversity, inclusion and anti-racism in the workplace¹⁰¹
- the CMA policy to reduce structural inequities, barriers and biases that exist in learning and practice environments and provide opportunities for all learners (it also engages the ethical norms of justice, especially promoting the well-being of communities and reducing health inequities and disparities in care¹⁰¹)

Much like other issues discussed above, the CMA's uneven efforts on this issue may have fallen short of these norms and may not have matched the importance and urgency of the issue. It is reasonable to conclude that many physicians have failed to promote an increase in Indigenous participation in the health workforce either through inaction or through actions such as discrimination against physicians, other health workers and learners.

CONSEQUENCES

The experience of Indigenous Peoples in Canada is a stark example of the reason why medical ethics were developed, the reason why they matter and the consequences of failing to live up to them.

Failing to live up to these ethical standards has caused significant and lasting harm to Indigenous Peoples and created justifiable mistrust of western medicine and the health care system. This has further compounded issues of access to care and health disparities. The CMA failed to adequately address these issues in accordance with its own ethical norms and those of the profession it represents and, in some cases, perpetuated them and helped support a systematically discriminatory and harmful system, rather than working to fix it.

¹⁰¹ Canadian Medical Association (CMA). *Equity and diversity in medicine* [policy]. Ottawa: The Association; 2019. Available: <https://policybase.cma.ca/link/policy14127> (accessed 2024 Apr 24).

SECTION 4: REVIEW OF THE CMA'S LEADERSHIP SELECTION PROCESS

INTRODUCTION

This section details the evolution of the CMA's leadership selection process and outlines efforts to increase equity, diversity and inclusion.

The CMA Nominations Committee follows a rigorous process to select nominees for the following positions, and those nominees are approved by General Council at the AGM:

- CMA AGM Chair/Speaker and AGM Vice-Chair/Deputy Speaker
- Most CMA Board Directors
- Most CMA Nominations Committee members
- Most CMA Committee on Ethics members
- Two members on the CMA Governance Committee, two members on and the CMA Audit and Finance Committee, and one member on the CMA Appointments Committee

The CMA presidency is rotated alphabetically among the provinces and territories (excluding Nunavut). Each year, the CMA issues a call for expressions of interest for the president-elect position in the respective province or territory. Members in that province or territory then elect a final CMA president-elect nominee to be presented for approval by the Nominations Committee and then General Council delegates at the AGM.

All other CMA leadership roles (on the board and its committees, as well as appointments to certain external bodies) are under the purview of the CMA Board of Directors largely via recommendations from the CMA Appointments Committee, which follows a rigorous candidate selection process.



THE CMA'S LEADERSHIP SELECTION PROCESS PRIOR TO 2022

Historically, the CMA's leadership selection process was heavily influenced by the provincial/territorial medical associations (PTMAs), and the pathway to leadership was very narrow. For example, prior to 2022, board directors could only be nominated by a PTMA or by 10–50 members of that PTMA, based on membership size. As well, Nominations Committee members needed to be nominated by a PTMA or 50 of its members, and the affiliate, student and resident members on the committee could only be nominated after consultation with the organizations representing those groups. PTMAs were encouraged to consider diversity when submitting nominees and the committee itself was required to consider age, gender, cultural and regional balance in seeking nominations that reflected the diversity and demography of the physician population. The reality is that many excellent, highly qualified members may have been overlooked for CMA leadership positions because they were not involved in medical politics at a provincial or territorial level. There was also no concerted effort to encourage Indigenous representation.

In 2021–22, a requirement was put in place that all Nominations Committee members must undergo unconscious bias training. At the AGM in the summer of 2022, CMA members approved changes to the Bylaws to make the leadership selection process more open and inclusive.

The changes enabled members to apply directly to the CMA for leadership opportunities and authorized the CMA to select its own leadership rather than accepting nominees largely put forward by the PTMAs and affiliate organizations. Bylaw changes were also approved to require the Nominations Committee to consider sexual identity, race/ethnicity, Indigeneity and disability (in addition to age, gender, cultural and regional balance) in the leadership selection process.

THE CMA'S CURRENT LEADERSHIP SELECTION PROCESS

Every August, the Nominations Committee issues a call for expressions of interest in upcoming leadership vacancies. All interested and eligible members are encouraged to complete an online application form. The Nominations Committee collaborates closely with over 75 organizations including PTMAs, affiliate and associated societies, and medical organizations representing historically underrepresented groups (including the Indigenous Physicians Association of Canada, Black Physicians of Canada, Canadian Women in Medicine and Canadian Association of Physicians with Disabilities) to encourage applications and secure skilled and diverse leadership candidates.

In addition to explaining their skills and experience, applicants are asked to voluntarily self-identify across a range of attributes (gender identity, sexual orientation, ethnicity, race, Indigeneity and disability) and to explain their achievements in supporting underrepresented perspectives. Applicants are also invited to share their authentic selves with the CMA by voluntarily including a brief

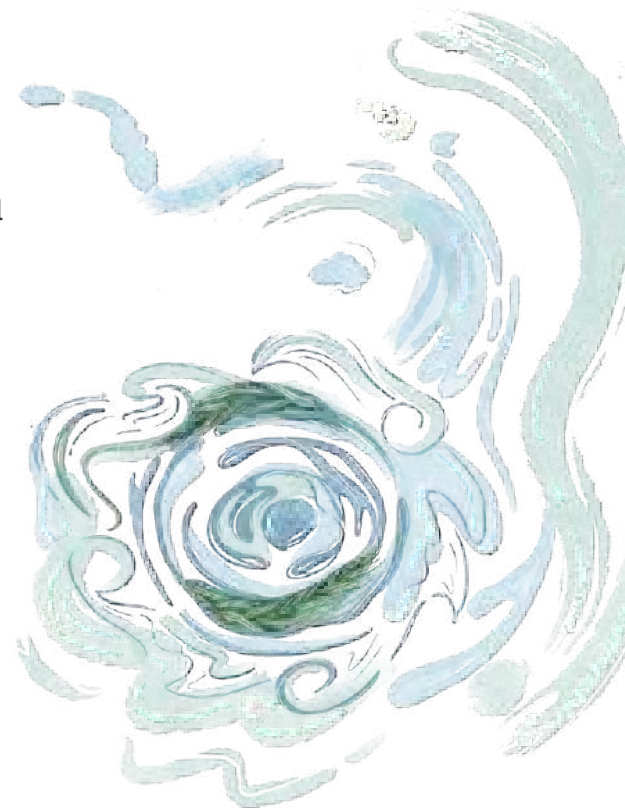
paragraph in their public-facing biographies about their self-identity and/or lived experiences. The Nominations Committee considers all this information during the application review and candidate selection process.

The ability for members to submit their applications directly to the CMA has doubled the number of applications received. In the year prior to the 2022 Bylaw changes, there were 21 applications for 10 positions. Two years after the changes, over 100 applications were received for 23 positions. Specific equity, diversity and inclusion (EDI) data is not published as candidates share their EDI self-identification information voluntarily and in confidence. However, the data shows the CMA is moving in the right direction with respect to increasing diversity on its board and committees. [Access the latest Nominations Committee report](#) for more information about the leadership selection process and the biographies of nominees who were approved at the 2024 AGM.

THE CMA BOARD'S JOURNEY TOWARD RECONCILIATION

In recent years, the CMA board has taken several actions to ensure inclusivity at the board table and commit to a path toward reconciliation. All CMA board members are required to complete Indigenous cultural awareness training, and board meetings are opened with a land acknowledgement and reflection on one of the Seven Grandfather teachings to ground the board in its commitment to reconciliation at each meeting. The board has demonstrated this commitment to reconciliation, from formally endorsing the Truth and Reconciliation Commission of Canada's Calls to Action to including an Indigenous health goal guided by Indigenous voices in the long-term strategy of the organization and supporting the development of an official apology to Indigenous Peoples from the CMA and as the national voice representing physicians across Canada.³⁴

In 2023, the CMA board was honoured to be presented with seven eagle feathers from the First Nation Elder on the IGC, Mr. Mel Hardie. The eagle feathers were given in recognition of the CMA's commitment to apologize for past and ongoing medical harms experienced by Indigenous Peoples and for walking the path of truth and reconciliation together with Indigenous Peoples. There is still much work to be done, but these changes and actions are a step in the right direction on the path toward reconciliation.



CONCLUSION

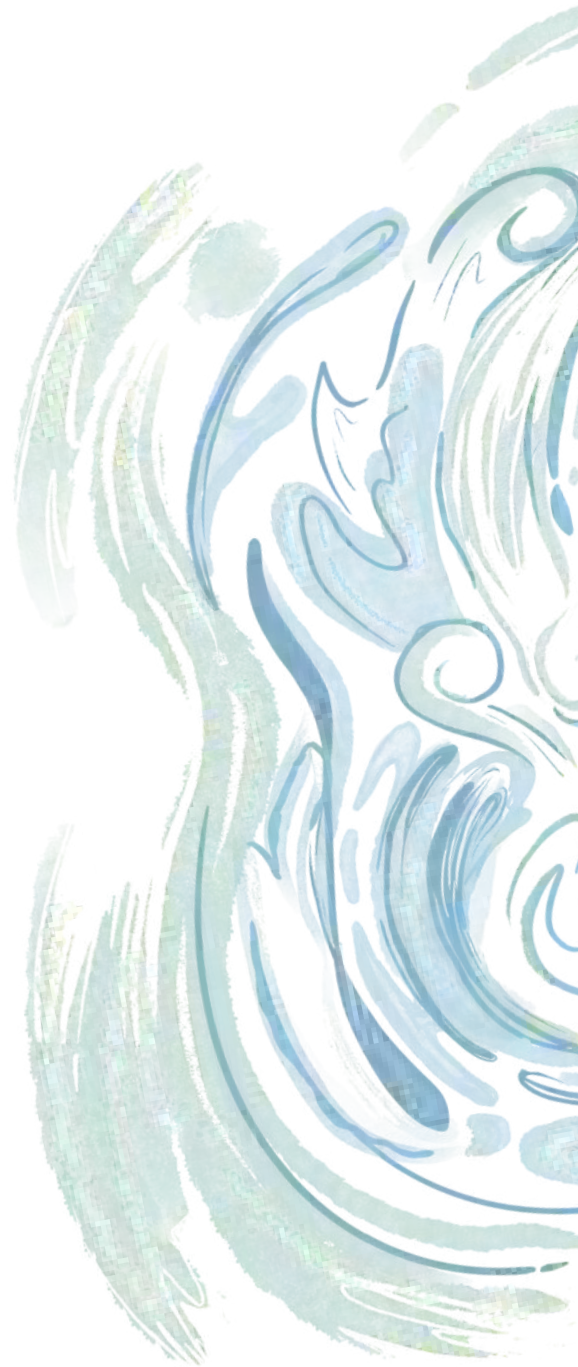
There is no denying that anti-Indigenous discrimination exists in the health system, nor is there any denying that Indigenous Peoples have experienced abuse, mistreatment, neglect and racism at the hands of the medical profession. Throughout much of its 157-year history, the CMA remained largely silent on this issue. While there are examples of the CMA advocating for better access to care for Indigenous patients or highlighting inequities in the health system, there were also many times the CMA failed to advocate in an appropriate or timely manner, as outlined in this report.

The medical ethics review revealed that, at times, the CMA did not meet ethical norms, from inadequately addressing Indigenous health matters or failing to acknowledge the disproportionate impact of certain issues (e.g., health system funding, poverty, child welfare) on Indigenous populations, to not following through on promises made to Indigenous Peoples. As well, for most of the CMA's history its leadership selection process was not particularly open or inclusive.

In the last few years, the CMA has endeavored to atone for past conduct and inaction and commit to reconciliation with Indigenous Peoples. The issuing of a formal apology statement is an important step on the CMA's journey of reconciliation, and this examination of the CMA's history in relation to Indigenous Peoples is a critical component of the apology.

The CMA is also developing future commitments to action to demonstrate the association's authenticity and convey its continued commitment to advancing reconciliation. Most importantly, these actions will include a pledge to combat anti-Indigenous racism and to act as a catalyst for ongoing change to improve Indigenous health outcomes and advance meaningful truth and reconciliation in the health system.

*The past cannot be undone,
but we can learn from it and
commit to improving the health
system for all Indigenous Peoples.*



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