

September 2025

When I opened the CSF yesterday, I started my remarks with a land acknowledgement. Land Acknowledgements have become a habitual statement read to give the impression that we are taking action against injustices imposed on Indigenous people by colonization. We now recite a few words in recognition that the First Nations people were, in fact here first, that we are on their land, and I suppose we are meant to be expressing our gratitude that they are sharing it with us. But we stand on unceded land today, so is sharing really going on?

I have several issues with land acknowledgements as they are used today. While they may be a good first step, they are merely words. They do not erase the systemic institutional racism faced daily by Indigenous patients. What we need are actual actions; steps taken to break down the barriers faced by First Nations people, steps taken to ensure that an Indigenous patient feel safe, seen, and understood by health care providers. Land acknowledgements fall short as they are often rote and performative. They become more so every time the same words are repeated, especially if no reflection is given to their meaning. Simply reciting the same few standardized sentences written for your section or faculty does not demonstrate a true understanding of the devastating effects that the residential school system, nor do they instruct us on the complex and multifaceted effects of intergenerational trauma. They are not a cure, but a simple salve put on deep wounds that lose their effectiveness when repeated ad nauseum without insight and reflection. They are even delivered in some cases by the wrong person – that is a direct jab at all my colleagues here today who are Oilers fans.

Land acknowledgements are a good first step, but they must show that we are coming together with the actual intent of making amends. In my opinion, they should be researched and written for the specific gathering they are opening. They should direct self-reflection. They should recognize not only the people of who occupied this land historically, but who are here now. They should demonstrate gratitude for the many relationships that we have, and pledge to build newer and stronger connections and communities.

In that spirit.... My name is Brent Peter Zabolotny. I am from Treaty 1 lands, but I come before you in a gathering of friends and colleagues from coast to coast of this great nation. We must acknowledge that we come from lands, ceded and unceded, originally and currently occupied by a rich tapestry of First Nations peoples and cultures from the Mi'maq, Beothuk and Maliseet on the east coast, to the Innu in the north, the Anishinaabe, Dakota and Lakota peoples of

prairies, the Coast Salish, Haida and Nisga'a peoples of the west coast, as well as many Metis nations from Ontario to BC. Today we meet in the traditional lands of the Haudenosaunee confederacy. I ask that we all take a moment to quietly reflect on the individual relationships we have with the First Nations peoples in one's own region. As you do so, ask yourself how you can help build relationships and communities with your Indigenous neighbours. Ask yourself what you can do to make amends for the inequities that exist.

We gather today with gratitude that we are able come together. We gather with the intent of learning about the delivery of health care. We pledge that our learning will be done to benefit all Canadians equitably and without bias. We pledge to use our knowledge new and old to build stronger, respectful relationships with those who were here before us, with those who are her now, and with those who are yet to come.

Parce que nous sommes ici a Montreal, dans la belle province du Quebec, et parce notre pays, Canada, et l'Association Canadienne de Chirurgiens Genereux sont bilingues, Je vais essayer de dire quelques mots en Francais. Je suis un peut nerveux. Cela fait longtemps j'etais etudiant a McGill pour devenir chirurgien oncologue. Quand J'habitais a Montreal, je suis devenu assez a l'aise pour parler francais, mais maintenant, apres plus de vingt ans, je n'en suis plus si sur. Aujourd'hui, je vais faire une confession. C'est une confession difficile, et je pense que je dois passer a ma langue maternelle pour s'assurer que toutes les nuances soient bien presents. Alors maintenant je vais revenir a l'anglais.

This morning, I am going to share with you a confession. It is a very personal confession. I am going to reveal to you a different side of me, one that I hope with all my heart no longer exists, but one that I cannot deny, at one time, did. I am not proud of it, but I am learning to make peace with it. I strive daily to make amends for it. It is the driving force behind one of the major goals I wish to achieve as president of CAGS. Along with my confession I plan share with you several of the events and experiences that slowly opened my eyes to this darker part of me. These experiences were instrumental in bringing me back to the person I actually want to be. These lessons they were hard and have left scars. But I am thankful for these scars because they are evidence that I have grown and I am a better person for having them.

Before I get to my confession, I think you need some context, some understanding about where I come from and how I was reared.

I grew up in middle class Winnipeg, a second generation Canadian, here like all of us because someone in my family, in my case my grandparents, immigrated to Canada in search of a better life. Life was not easy for my grandparents. They had to learn a new language. They had to navigate the biases that new immigrants faced, especially as they came from a different country than the waves of immigrants before them. But they persevered, took advantage of opportunities that presented, and found success.

Both of my parents were educators. My dad a high school physics teacher at one of the more highly respected public schools in an affluent area of Winnipeg. My mom taught the younger years in the working class/poor area of Winnipeg. She took time off to be a full-time mom and returned as a substitute teacher when my sister and I reached an age of increasing independence.

I had endless support, and I was loved. I was taught to be kind, to work hard, and to choose good over bad. I had every advantage a child could have, and I know am here today because of that. My parents made sure to let me know that I was privileged, and that I should not take that privilege for granted. I was also taught my privilege could, and should, be a tool to help the marginalized and disenfranchised members of society.

I was educated in the same public system my parent taught in. I was shown a white-washed view of the world. I use that phrase both literally and figuratively as I was taught the cleansed “white” version of Canada’s history. Residential schools were at most a paragraph in a textbook; I was told this man was a traitor. I knew nothing of cultural genocide or intergenerational trauma.

What I did know was a mother who, when she returned as a substitute teacher, bravely went where many of her colleagues feared to go. She spent most of her years going into difficult classrooms in the poorest areas of Winnipeg. She worked at schools where privilege did not exist; where hunger distracted children from the ABCs; where a kind word or hug from a teacher might be the only affection a child might receive that week.

My mom jokingly called herself the “bag lady” because she hauled four to five huge bags into every class she attended. Of course she carried bags of schoolwork – math questions, writing assignments, art projects, the usual – but she also had a bag with her full of snacks, fruit, granola bars, juice boxes. And in another bag, little toys, crayons and colored pencils and

trinkets for rewards. And in yet another bag, warm mittens, scarves and hats just in case, so no child would be left exposed in the cruel Winnipeg winters.

I saw my mother do this, and I saw it break her heart that she had to. That there could possibly exist young innocent children who did not have the basics of food and warm clothing. Young children who didn't get a gift under the tree at Christmas or for their birthday. Children who didn't know the security of a warm, loving home. I reflect on those times and wonder what if my mother knew about the damaging effects of the residential school system? What if she knew about intergenerational trauma. I suspect she might have added another bag to her collection, this one for the parents of those children she taught.

Unfortunately, she did not know the true history between the colonizers and the First Nations peoples in Canada. She only could see the suffering of the children which she erroneously blamed on the failings of their parents. I am sure this was surreptitiously passed onto me.

I remember being asked at my medical school interview: "If you and another equally qualified candidate of Indigenous ancestry were up for the last available position at the med school, who should be granted admission?" I answered the candidate of Indigenous ancestry should get the position, because even at that time I recognized that there is value to a community in having someone of their own skin color/religious beliefs/gender/ethnicity provide them care. Given the lack of First Nations doctors, I did see the need for more indigenous candidates to be accepted into medical school. I also emphasized the point that I would not give up and keep re-applying until I did get into medical school. I got into medical school on my first try. To this day, I still do not understand what the interviewers were looking for. Did they want me to advocate for the Indigenous candidate, or were they gauging the depths of my desire to get into medical school?

I do recall that once in med school my sensitivity training was not directed at cultural sensitivity issues. We had but one memorable session which was focused on persons with disabilities. At that session we were subjected to an overly aggressive advocate for persons with disabilities who yelled at us from her wheelchair at the front of the lecture theatre about the width of doors in one of Winnipeg's hospitals. I couldn't help but think that perhaps the faculty of engineering or architecture would have benefitted from this event more than I did. My exposure to Indigenous education was via a sweat lodge ceremony arranged by a Metis

classmate, and a lecture from a professor where we were advised to not make eye contact with First Nations patient because it was not part of their social convention to do so.

As I progressed through residency, I saw a strangely skewed version of reality. Yes, I witnessed many overtly racist acts – unfortunately, they were acts that I could not call out because of my lowly station as the learner. On the flip side I also saw and experienced firsthand the frustration of trying to help people whose only answer to questions on a history were “fuck-you”; the never-ending carousel of the same patients who would return time after time with a new stab wound, another beating, another alcohol induced fall; the patients who refused to take advice on medical management; the missed appointments, the late arrivals; the missed OR slots; on and on and on.

During this time, I was gaining my independence, especially financially. I was making a living wage (barely) and I had begun to pay my own way. With that came the burden of paying taxes and the reservation that perhaps the government was not spending my hard-earned money in the most effective ways possible. Finally, I was coming the realization that health care was outrageously expensive and only getting more so, which lead to fears about where the funding to sustain any level of care would come from.

Insidiously, I was pushed into developing a belief system that was misinformed.

Here now is my confession: I had begun to view the world through a biased and often racist lens. I was judgemental, and my thought processes and attitudes had similarly become biased and often racist. Overtly, I used inappropriate phrases, like “let’s have a pow-wow” instead of “let’s have a discussion” or I referred to lower ranking people such as R1s or medical students as being the “low man on the totem pole” – a turn of phrase that is wrong on so many levels. I would like to think that at no time did I provide limited or inadequate care due to my biases, but I am certain that my biases were overt and even hurtful in other ways. I do not have the words to describe just how sorry I am that I did not catch this sooner, that I did not correct my shortcomings earlier, that it has taken so long to cultivate a new and improved attitude and belief system that would allow me to make amends for my failings.

Finishing my training and becoming an attending changed many things for me. Most importantly it gave me an undeniable autonomy. I no longer had to put certain inquiries on the backburner to focus exclusively on gaining the essential skills and knowledge to satisfy my Royal College Exams. I had successfully achieved a level of expertise that allowed me to practice

cutting edge health care. In addition, I had become a surgeon skilled at teasing essential information from patients and could take a history on autopilot. This gave me the freedom to focus on other aspects of conversations I was having with my patients – freedom to pursue other things that I was curious about.

Viewing the world through newly -or perhaps I should say differently - curious eyes, allowed me to finally see some of the important lessons that were there right in front of me. These experiences shook me, they awakened me to truths, and they forced me to re-evaluate the person I had become. I felt moved, challenged to seek new knowledge, to explore the world I lived in with a newer nuanced understanding of what I was seeing. I would like to share with you some of these encounters and what they taught me

Anecdote 1: Caring For the Right Honourable Justice Murray Sinclair

I had the amazing privilege of providing care for Justice Murray Sinclair. This was before the Truth and Reconciliation commission was called, but Justice Sinclair was already well known, especially in Manitoba as he was the first Indigenous judge appointed in Manitoba and only the second in all of Canada.

In the time he was hospitalized I made the observation that when Justice Sinclair spoke with doctors and nurses he spoke without an accent. He sounded like any non-indigenous, English as a first language person I have ever heard. Yet, when family and friends visited, I noted that he slipped into the cadence and accented speech patterns all too familiar to my Manitoban ears. One I am sorry to admit I having perfected through years of telling jokes and having conversation with my friends that I realize now were horribly racist. I was so good at in fact that I remember a new ENT resident on the trauma service with me – who did his med school in Toronto -- said one day “Wow! You guys sound exactly like the aboriginal patients. How do you do that?”

As I had clearly mastered speaking in another accent and I now met an Indigenous patient who could clearly master a white Canadian accent, I wondered why more hadn't done so? In a quiet moment, well after Justice Sinclair was on his way to full recovery, I took a private moment with him to try to get some understanding around my observations. I ask him if I could ask a non-health related question. He agreed, so I gave him a brief sketch of my observations about how his accent changed according to the people with whom he was speaking. I asked for his insight as to why that happened. He chuckled to himself and then explained that as a young student of

law he thought it best that he adopt a manner of speech consistent with those he would work with, those he would argue against, and those in front of whom he would present cases, as he felt it was necessary to avoid being perceived as a “dumb Indian” . Hence, he learned to speak with a “white” accent. But when he was speaking to his own people, he was concerned that they might feel he was becoming “too white” and so spoke to them the way he would around a campfire, or at a kitchen table. He did not want to lose the trust of his own people.

All I could think was “what a crazy situation “– having to straddle two worlds and sound a certain way to fit in on one side and not lose trust on the other. Just how far was the gap between our societies? Little did I realize that the first pebble of what would become a massive landslide of transformation in myself, my worldview, and my approach to relationships with the people around me.

I wish I had the wisdom then that I do now. I might have responded to Justice Sinclair with something profound like: “Feel free to speak to me in whatever accent you are comfortable with, for I promise not to let the way you say things ever outweigh the meaning of your words,” but alas, I think I mumbled a thank-you and reassured him he was improving and would soon be discharged. I regret that I never did have a chance to speak with him again before his death. Justice Sinclair was a wise man who spent his life trying to educate the ignorant among us to better the future of his own people. He certainly taught me a lesson which I believe has made me a better person and had a positive impact on my relationships with the First Nations people of this shared land. I am forever indebted for that and hope I can service this debt by paying it forward.

Anecdote 2: Patient with own name tattooed on arms

I was working at the Breast Centre quite early (i.e. about 15 years ago) in my career. I was asked to see a younger woman... probably in her 30s. She had a typical referral from a nursing station in the north – vague problem, no imaging, incomplete work-up. Now I had already come to terms with the vague and incomplete referrals from our rural and remote nursing stations and other clinics. My wife was a fly-in doc for a northern community and the stories she told me were extremely eye-opening. The lack of resources, frankly, is embarrassing. Health care practitioners in these regions are continuously asked to provide a service, and provide it with accuracy, without having the luxury of even simple tools such as radiology or labs. The health practitioners know they should get a mammogram or an ultrasound when a patient presents

with a new breast mass, but they just can't. It is that simple. I am proud to say that this was recognized at the Winnipeg Breast Centre and steps were taken to try to make up for the lack of resources in remote areas. Patients are vetted before they are given appointments. If they come from a remote area and they have not yet had imaging, an imaging appointment is automatically booked into their clinical assessment at the Center, thus patients are not forced to make 2 trips into an urban centre – one for imaging and then a second trip for their consult.

So, I entered the room to see this patient with her vague complaint of breast fullness and discomfort, not expecting much, other than to spend some time reassuring her that there were no serious issues, and perhaps take the opportunity to impart into this patient some knowledge about breast health in general. Little did I know that in about 5 minutes I would be hit with a profound and life changing experience.

As I examined the patient I noted a plethora of tattoos – some artistic, some obviously homemade, but 2 tattoos gave me pause... tattooed on the inside of this young lady's forearms on one side was her first name, and on the other her surname. This was peculiar, I had not seen something like it before. I wondered if somehow, I was witnessing a strange tribute to the movie "Momento". My curiosity got the better of me and I felt compelled to ask the reason behind the tattoos such as these. This was my first glimpse into the power of pure and honest curiosity and how it can open doors and bridge gaps in relationships. I didn't know at first how to ask about the tattoos, so I simply said "I noticed that you have your first name tattooed on your right arm and you last tattooed on the left. I am curious as to why you have those tattoos." No judgement, no jokes, just pure honest curiosity. Her response still moves me to tears all these years later. When I heard it, I felt as if I had been punched in the gut. She plainly told me "My older sister told me to get them... they are for when my murdered body parts are found. It will make it easier to identify me and return me to my family.

Let that sink in... "they are for when my murdered body parts are found"

Not if, but when. Like an inevitable future that she had simply made peace with.

How can anyone live with that kind of weight on them? How can you feel free to be happy, to dream, to think of a future with such a burden?

Not if, but when....

I was savvy enough at that time to understand that all women, to a variable extent, live with degree of fear in the presence of men unknown to them. The power imbalance is real, and women get the short end of the stick. But this degree of fear, this degree of inevitability? I doubt there are many, if any, non-indigenous women who share such a fatalistic view of their station in life.

I was shaken, and I was moved. As a surgeon with a significant breast practice, I would be seeing many women over my career. I made a pledge to myself that I would endeavour to always be the least threatening I could be (not an easy task at my size), always be respectful to women, and be especially cognizant of this particular burden that must be borne by being Indigenous in our society as it currently is. I also promised to learn more about our First Nations people, about their plight, and make sure that I was not contributing to the inequities between us.

Anecdote 3: An amazing, but misunderstood father

This past summer, Manitoba (along with much of the country) has just endured a record season for wildfires. But we have many bad years in my memory. In 2013 close to 1.1 million hectares burned. As many of the fires occur in the remote northern regions of the province where forests are the densest, this is the area to suffer the most. Of course, this is also the area of the province where many reserves are located. As such, the first nations people of Manitoba suffer more extensively, bearing the burden of displacements and not just loss of property and but also prosperity. It was in this year that I met an amazing young father who left a profound impact on me for several reasons.

I was on night call on the acute care service and was asked to see a 24-year-old with ultrasound confirmed gallstones and acute cholecystitis. I came to see the patient in the ER and he was restless and agitated and kept asking to be released. He was also clearly in discomfort from his gallbladder. It was suggested to me by some of the ER staff that this patient seemed in too much distress for just gallbladder pain and that there was probably a component of drug seeking. This did not sit well with me.

Clearly, he was distressed, and we were missing something. I asked him why he was so agitated. He told me he didn't understand what I meant. He went on to tell me that he was having trouble both understanding us and making us understand him. He revealed the fact that he did not speak English as a first language, and he was afraid that he couldn't make us understand

him properly. I was quite taken aback – it is not common that a First Nations person in his generation would have primarily learned his native language and learned English secondarily. I was impressed, but I was also impressed with his command of the English language. I felt I beginning to understand this patient's anxiety.

I reassured that I was having no trouble comprehending his English, but I would try to communicate with simple words and phrases and check in frequently to make sure he was understanding me. He explained that he needed to get to his wife. I offered the suggestion that we could get him a phone and help him call her, but it would be in his best interests if he allowed us to admit him and take him to the OR to remove his gallbladder. He went on to explain that he needed to get to her because she was in labour, about to deliver their third child. Then he told me that he also needed to find his other 2 children and his mother. He informed me that he and his wife had been medivaced earlier in the week because of her pregnancy. At that time forest fires were raging near his home. In addition to his wife starting her labour, he found out the fires burning near his reserve took a sudden turn towards the reserve, threatening his entire home community. His home community was now under emergency evacuation orders – as a result his other children, who had been left in the care of his mother, had just been airlifted all together out of their community into the city. He was devastated and distraught that his family had become separated from each other and from their home. He felt compelled reunite with his family to protect them and then get to his wife's side to support her in the birth of their child. The ER department had become an impediment to his mission.

An extremely valid reason to be completely frustrated with the medical system.

And really, we all know that usually late teenaged/early 20-year-old males are the worst patients. All that bravado and machismo but so little life experience. Could the whining be louder?? But here was a 24-year-old, ignoring his own suffering and putting the needs of his young children, his own mother, and his pregnant wife and unborn child ahead of his own.

The solution was clear to me at that point. There was no way he could agree to stay and would ultimately discharge himself AMA. So, real question was: what could I do to help? Simple:

- A prescription for one week's worth of antibiotics with the instruction to return to the hospital if he did not improve

- A taxi slip to get him to the shelter where his mother and 2 children were staying, so he could assure himself of their safe escape from the fires and take a few moments to reassure them that all would be well, and a second taxi slip to take him to the hospital where his wife was in labour.
- The contact information to my office so he could book a follow-up to arrange an elective cholecystectomy
- My cell phone number so he could reach out if anything went sideways while he was in Winnipeg.
- A hand-shake, wishing he and his wife luck on the arrival of their third child.
- Trust in the patient that he knew what was best for his family and his own health.

I have to admit, I was a bit fearful that my relationship with this gentleman, and perhaps my career might have ended right there. I could see the headlines: “Local White Surgeon Discharges Indigenous Patient Without Treatment: Systemic Racism Confirmed.” But, as it turns out, I made the correct decision by listening to the patient and accepting that he knew what his needs were better than I. He did call my clinic for follow-up. He returned to see me and shared the news that on the day I met him he was able to find his displaced family and gather them together, all in good time to witness the birth of his new son. He beamed. He also agreed that he never wanted to have another attack of gallbladder pain as bad as the one that landed him in the hospital in the first place. So, he consented to a lap chole.

Skip forward to a few months later... The day of his surgery arrives. But guess who doesn't? This was now well into winter, and there are many reasons why our patients from the north miss appointments. As I mentioned earlier, I have much experience and inside information that has given me insight as to the “why” this happens, so I am much more accepting of this situation. Unfortunately, many of my colleagues do not share in my experience. Upon hearing the news that the case was to be cancelled because the patient did not show up one of the nurses assigned to my OR theatre looked at the slate, noted the patient's name and made the comment, “No wonder he didn't show, look at his last name, he was probably busy doing something else,” and as she said this made the ubiquitous beer-drinking gesture.

I was deeply saddened for so many reasons. How could I not be depressed? The very career I had chosen to dedicate my life to, based on a principle of caring for my fellow human beings was, in fact, completely and profoundly racist both at an individual level all the way to the

collective institutional level. People that I knew and respected, people that I thought of as generally good people could come to poor, misguided, conclusions re-enforcing the racism I was finally opening my eyes to. What hope was there if even the good people fell prey to stereotypes and tropes that are used to portray our First Nations peoples? Just because my eyes had been opened how could I make sure others could see the inequities and racist attitudes Indigenous patients experience with every interaction they have with the health care system? How could I, as one person, fight an entire system? How could I navigate the enormous task of affecting change without offending and alienated those in my sphere?

In my heart, at that moment, the only solution I could see was to be the best parent I could be, to rear my own children to love and be kind to all human beings -- regardless of their ethnicity, culture, gender, sexuality or beliefs -- in the hope that future generations could repair damage done by my generation and those before me.

Knowing my patient as I did and being a party to his story from the beginning, I could not abide by the character assassination of that one small gesture. "Did you know there are probably 50 reasons why this patient did not make his appointment that have nothing to do with drinking?" It was a rhetorical question, so I answered for her and ran through the first several that popped into my head: like being weathered in – none of us had checked the weather forecast for the remote north that morning – there could have been a blizzard, there could be fog; maybe the flight he was to come in on was cancelled due to mechanical issues; maybe he got bumped by a patient more urgently needing the flight south; maybe he had a family emergency to deal with. There are so many plausible reasons to explain why our remote patients miss appointments that we need never succumb to damaging stereotypes. I then took a moment to share the story of this patient, his family's displacement and separation due to the forest fires, his frantic efforts to re-unite everyone and ensure their safety, his determination to overcome all obstacles, including his own pain and suffering to be present with his partner for the birth of their child. I do not know if my words had impact, if they gave the OR team new insight into how we relate to our Indigenous patients, but I can hope that maybe I planted a seed of an idea that might take root and grow into a better understanding of our Indigenous patients and the difficulties they face in accessing the simple care that we all take for granted. My hope was that even a little bit of education could prevent my colleagues from falling into the trap of tropes and stereotypes, and they could begin to see each patient on his/her own merits.

Upon reflection I realize now that at that time I had more reason to hope – I discovered that I was capable of navigating the precarious balance between acting as an ally and advocate for First Nations patients, calling out racist beliefs and actions when I encountered them, and do so without damaging work relationships or offending colleagues in the process. Education was key.

Anecdote 4: Meeting Kevin Chief

I was again on call when I met Kevin Chief as a patient. As I share my experiences with you today, it might seem that my only encounters with the indigenous population are via my work as a surgeon. Upon reflection I would absolutely concede that point. None of my friend group is Indigenous. I know of only one surgeon in Manitoba who recognizes herself as being from First Nations ancestry – she is a pediatric surgeon and our worlds rarely, if ever, overlap. I have coached a few kids in soccer and basketball who were of First Nations ancestry, but the connection I have had with their parents is fleeting, and seasonal at best. My relationship to our First Nations people is almost exclusively through medicine. It is easy to achieve that in Manitoba. A recent report released this past summer indicates that patients identifying as North American First Nations make up 36.9% of emergency department visits. Those who identify as First Nations make up 18.1% of Manitoba's population as per the 2021 census.

Upon further reflection, I also realize I may have been acting in a less than professional manner by asking some personal, non-medical questions of my patients. I did always ask permission to ask any non-medical questions, and in all honesty, I truly got the impression that those First Nations patients I approached were willing and happy to answer questions – it was almost as if they wanted to be better known to the white community, perhaps to help undo many of the stereotypical beliefs about them and their community that they faced day after day.

By the time I had met Kevin I had become significantly more aware of the issues that our First Nations patients faced. I had a library of stories of abuse and poor care received in the health care system. I was witness to innumerable acts of racism, some overt and intentional and others more subtle, perhaps accidental, and quite often unintentional. I had enough leadership experience to realize that institutionalized health care is set up in a way that it cannot help but be exclusionary, and that Indigenous patients often were the most excluded. My leadership experience also taught me that in the face of rising expenditures and the absolute need for cost restraint to keep health care sustainable, that we really don't have the resources to correct these issues on a grand scale. I, myself, had made mistakes in how I approached and interacted

with my Indigenous patients. I made assumptions and jumped to conclusion based on false information. My early steps into educating myself were enough to show me just how much I didn't know, and I was daunted by the volume of learning I thought might be required to become a successful ally for our First Nations patients.

I shared my despair with Kevin Chief and asked him, "How do we as a society move beyond truth into true reconciliation?" His answer was surprisingly easy – "I can give you a talk about that." Kevin, himself, had been wrestling with this same issue from the First Nations perspective. He had consulted elders and community members. He had reflected on his many relationships, good and bad, with non-Indigenous people and he had some ideas. Many were rooted in the need for education. As a community leader he made the effort to create what he hoped was a positive and inspiring talk to share with people to shed light on how we can bring communities together to address wrong-doings and make plans for a more unified future. I promptly invited Kevin to give this talk at the CSF in Winnipeg. What better place than where Macleans magazine called the most racist city in the country. What better group to start with then surgeons – we have been and always will be leaders in field of medicine. It was time for us to tackle this issue.

Those who attended Kevin's talk last year can attest that it was inspiring. It was educational. It shone a light on some very dark aspects of human relationships and racism, but it did so in a way that did not lay blame. He educated us and shared his story and the story of his people. In my mind he succeeded in addressing a very difficult topic in motivating way. It certainly pulled me from my despair and gave me hope that perhaps I did not have to wait for my children to achieve reconciliation, that there were very real steps I could embark on that would make a difference.

Anecdote 5: Overt Patient Abuse

Many, if not all, of my experiences to this point have mostly left me saddened. Saddened that there can exist a wide gulf between human beings; saddened witnessing the clear suffering that occurs because of our inability to recognize that the systems we have created to provide care, in fact, have become instruments of oppression; saddened by my sense of powerlessness to affect change. The final patient experience I would like to share with you saddened me, but more so it angered me.

I took over the care of a patient on the ACSS who was post-operative from a laparotomy and resection of a segment of ischemic small bowel. The patient had presented quite unwell, in florid sepsis with frank peritonitis. The OR team on before me took immediate corrective action and saved this patient's life. By the time I became involved in his care, he was well on his way to recovery, and his sensorium had cleared. We were mostly involved in improving his sugar control and making sure his wound remained healthy. One day during rounds, he and his wife sheepishly asked if they could talk to me about an issue that had occurred during his transfer to Winnipeg. This patient shared with me his fever-dream memories of transport into Winnipeg. I should say fever-nightmare because what he endured was unacceptable. In all honesty, I have to admit that I wondered if some of what he was telling me was in fact imagined because of the profound state of sepsis he was in -- if it was his delirious mind that had invented of these scenarios that he was reporting. Unfortunately, his wife corroborated even the most disgusting aspects of his tale and to this day I get enraged thinking of them.

The journey to Winnipeg for this patient was quite involved. He was from a remote community in the far north of the province. His reserve was too small to have an airport or landing strip of its own, and the nearby waterways were insufficient for a pontoon plane to land. He therefore had to travel on the bed of a pick-up truck over gravel roads at best, to a clearing near town where he could be picked up in a helicopter. He was then transferred via helicopter to the closest town that has an airport where a plane could meet him and fly him to Winnipeg. He was in no state to move from the helicopter to the plane under his own power, so airport staff and flight crew had to assist him. Unfortunately, there were no stretchers available, so he was unceremoniously dumped onto a baggage trolley and man-handled to the plane. Along the way he was asked by someone allegedly trying to assist him, 'Why do you people do this? Get so drunk you get sick and need to be transferred to the city for help.' No regard for the fact that his stuporous state was induced by infection not alcohol. No regard for his physical well-being. And if his wife's corroboration wasn't enough, the hand shaped bruises on his arms where he was grabbed, and the bruises on his back and buttocks where he was thrown onto the luggage cart were there to validate his story. I was sickened and dumbfounded. I was in a state of desolation. Mostly though, I was angry. Angry at a government that forces people to live in out of the way, remotely located reserves; angry at a system that requires not one, not two, but four separate modes of transport for a patient access care; angry at the perpetuation of tropes and stereotypes to the point that the truth is longer even considered; and, angry that we, as human beings, have the capacity to act in a seemingly unlimited immoral and indecent manner.

Anger with yet again a sense of hopelessness. I could not undo what this man had to endure. I did not have the restorative powers of a superhero which I could use to fly into the community where this abuse occurred, knock a few heads and shake some decency into those involved and return in time for my next OR case. No, all I could do for this patient was to arrange a meeting with both Indigenous Patient Services and the hospital ombudsperson to facilitate a formal complaint. But I realized that I could also take this man's story and share it, amplify it and use it to educate learners and colleagues in the medical system to prevent this from happening to someone else in the future. And maybe this sense of anger could drive me to do something more....

I know it sounds cliché, but I went into medicine because in the deepest part of me, in my very soul, I want to help people. I believe that such motivation is undoubtedly true for virtually everyone in this room today. Yet I stand here today acknowledging that I am part of a system replete with inherent institutional biases which initiate and perpetuate inequitable care. I admit that I have had thoughts, beliefs and attitudes, that with experience, education and self-reflection, I have come to learn were biased and racist. I have spent countless hours striving to understand why and how this occurred because having such thoughts, beliefs and attitudes was the antithesis to my personal motivation to become a surgeon. How could I have strayed so far from what I thought made me, me? Experience, education and self-reflection have slowly returned me to my true self. Lessons learned, both easy and hard, experiences like those I have shared with you today have influenced me and stimulated me to make changes in my thoughts, beliefs, and attitudes and now I stand ready to make amends. To move beyond truth to reconciliation. But two thoughts haunt me: How do I keep those insidious forces that derailed me from my ideal self the first time from doing so again? And, how can I -- one person -- possibly influence the changes that our health care system so desperately needs?

The answers, much to my surprise, might actually be easy to achieve

What do I mean when I make the statement "Move beyond Truth to Reconciliation?"

To me this means we have reached a time for action.

We have already spent much time talking about hardships faced by Indigenous patients. We have been shown the damage the residential school system has had on generations of first nations people; we have been made aware of the ongoing devastating impact of

intergenerational trauma; we have been shown the countless ways the Indigenous people of Canada have been and continue to be treated as second class citizens.

The data are plentiful and clear – first nations patients have reduced access to care. Even when they can access care, they face higher complication rates and inferior outcomes. We know this, we have known this for some time and yet what has been done about it?

The Truth and Reconciliation Commission published its findings 10 years ago. To date only 13 of the 90+ Calls to Action have been completed. The commission had the following 7 Calls to Action regarding the delivery of health care.

Many of the calls are directed to Government, but we, as significant stakeholders in health care have an obligation to ensure that the Calls to Action are answered. We can put pressure on government to complete these calls. We can also take the lead in developing systems and programs that provide solutions for government so the calls can be answered. Call to Action # 24 is a great place to start. I suggest that it should not be only medical and nursing students who are educated about Indigenous health issues, but all practitioners of health care need this essential training

We have not achieved these recommendations 10 years later. Enough is enough, we can no longer just talk about the problems, we **MUST** take steps to rectify the issues facing the indigenous people of Canada.

But are we truly seeking reconciliation? Many thought leaders think reconciliation is the wrong word. According to the Oxford Dictionary definition reconciliation means to “retore friendly relations”, but were the relations between the First Nations and European settlers ever truly friendly? I like writer David A. Robertson’s take on what we should be trying to achieve: “What we’re trying to do, it’s building relationships, it’s building community. It’s doing that through mutual understanding and respect” In my mind this makes the task infinitely easier – we are not trying to return to a previous state of utopia, of settlers and Indigenous people living side-by-side, sharing equitably the benefits of this great land we call home. We don’t have the burden of trying to recreate something because it never existed. We get to start from scratch. We get to create something new. We have the opportunity to build **new** relationships, to build a **new** community, to work together and create something innovative and inventive that works for all.

When we approach the calls to action, when we take steps towards building new relationships and communities there is a simple fact that we keep foremost in our minds: ***We are all the same.***

All human beings regardless of where they live on our planet, what they eat, the air they breathe, have 5 main things in common

1. Biology – we share DNA. We share anatomy. We have hearts that beat, lungs that breath, anuses that fart. We bleed the same red blood. We bruise when handled roughly. As surgeons we know better than anyone that our insides are the same – the gallbladder is attached to the liver; the stomach leads to the duodenum; the appendix extends from the cecum. Remember this.
2. Emotions – we laugh when happy, we cry when sad. Mothers love their children - it has yet to be proven but I think all fathers do too. We are capable of anger; we are capable of hate. We fear, and when we are afraid, we can make some very bad choices.
Remember this
3. Cognitive abilities – we think, we question, we observe, we reason, and we seek to explain. We solve problems. We ALL do this. It is this capacity that has set us at the top as the apex species. Remember this
4. Social connections – we form pair bonds, we form teams, we come together because we are stronger and more likely to survive in a group. The innate drive to form a community is one of the strongest drives we have, and all humans share this trait. Remember this.
5. Culture – All people regardless of who they are or where they exist, when coming together in a community will engage in cultural practices, rituals and traditions. We make art, we make music, we sing, we dance. The lyrics we sing might be different, the canvas upon which we create may vary, the deities we worship may have diverse names, but at their core these practices are the same. Remember this.

I ask you to remember these incontrovertible facts because it makes it easier to treat each other with respect, with empathy, with compassion when we remember that we are the same.

Whenever you face a patient who has a different color skin, ignore the skin color and remember that they bleed red as well; whenever you meet someone who loves and pair bonds with a gender different than you do remember that we all love, that we seek groups and relationships because we are stronger together than apart; whenever you meet someone who acts out because they are afraid – afraid of pain, afraid of having surgery, afraid of a difficult diagnosis,

afraid of dying – remember what scares you and how you would want your fears addressed. Remember we are all the same.

Education and Self-reflection: The Circle of success

Call to Action #24 is an excellent starting point. My College of Physicians and Surgeons in Manitoba has recently made cultural sensitivity training mandatory for licensure. A bold step, but one I fear is misguided. I would have much preferred that they made learning resources available to us and rewarded those who immersed themselves in such training efforts. I fear that in the effort to make something mandatory that a certain group will simply take a course because they “have to” as a job requirement, not because they are trying to improve themselves as care providers. I do not think this kind of instruction stimulates the learner to appreciate the nuances of the lessons being taught. How many will simply scroll through an online course to get the certificate at the end? This is too important to do simply because it is a job requirement. Time must be spent absorbing the material presented, but just as importantly, time must be spent reflecting on what has just been learned. Self-reflection allows for a more nuanced and deeper understanding of what has been learned. Pondering such questions as: Are there experiences from one’s own life that correlate to the newly learned material? What practical impact might this new knowledge will have on a clinical practice? What gaps in my knowledge need to be filled? Answers to questions like these can offer guidance regarding what education opportunities we need to pursue.

The past year CAGS has worked diligently to help its members achieve appropriate and necessary training. Today, I am proud to announce that we have signed an agreement with NOSM (Northern Ontario School of Medicine) for all members of CAGS to be able to take their online courses entitled “Stand-up: Understanding and Combatting Microaggressions” and “Hearing Our Voices: Indigenous Cultural Safety Training”. Access to these courses will be posted in the LRC. We have secured the courses at a deeply discounted rate and are exploring options for the CGSF to cover the remainder of costs so members may access this training for free.

Furthermore, in the Province of Manitoba the College of Physicians and Surgeons has recognized the NOSM Indigenous cultural safety training course as an acceptable learning program to satisfy licensure requirements on an individual basis. We at CAGS are now in discussion with the College for them to add it to their list of approved courses.

There are, of course, other means of learning that we can all access. The Truth and Reconciliation webpage offers an in depth and constantly updating anthology directed at addressing the work of the commission. The CMA offers links to many learning resources on the topic of cultural awareness and sensitivity.

Finally, there are many good books on the topic. I am currently working my way through “52 Ways to Reconcile” by David A. Robertson. Each chapter outlines a task that can be completed with the purpose of educating and cultivating in the reader a deeper understanding of what it is like to be an Indigenous person in Canada. This is essential knowledge that serves as the foundation for the new relationships and communities we so desperately need to build. Chapters are short and the tasks are, for the most part, easily achievable. I highly recommend reading it.

We are all committed life-time learners – we really have no choice in the ever-evolving world of medicine. But we need to know about our *patients* as much as we need to know the steps of a laparoscopic cholecystectomy. We are committed to a cycle of education and self-reflection on a scientific front. I believe the time has come to commit to it on a humanities front as well.

Justice Murray Sinclair summed it up best – “Education is what got us here and education is what will get us out” -- I think most of us here today have increased our knowledge and awareness of the failings of the health care system when treating Indigenous patients and we have a deeper understanding of the history the First Nations people faced as they succumbed to European colonization. Having that knowledge can sometimes feel like a double edge sword. I spoke of the despair that I often felt in treating Indigenous patients. It came from many places, but as my knowledge grew my despair seemed to become intensified by a fear of failure. I was scared that if I said something inappropriate, if I acted in a way that my patient felt was offensive, I could undo all the trust and efforts to build relationships and communities I had worked on so diligently. Earlier, I referred to the insidious factors that direct us to develop beliefs and attitudes that are in conflict with the way we see our true selves. This is an example of such a factor. In many ways I became almost paralyzed by the fear of offending someone. My usual light-hearted approach to patients was gone. I parsed every word in my head before letting them pass my lips, fearing that seemingly innocuous words in my mind only became offensive in the ears of the listener. Then I participated in a session on microaggressions, and I learned that there are 2 very simple things that can help overcome this anxiety.

Curiosity and Being in the Moment

We are all curious. Innate curiosity is what drives us to research illness. Innate curiosity is what pushes us into administrative roles – How can I make the system better? Day-to-day curiosity drives us to ask the questions that unravel the mystery of our patient’s illnesses so we can propose treatment. I think curiosity at its very meaning implies an honest interest, an innocent line of questioning. When we are curious, we wonder about something. Wonder – in a thesaurus next to the word wonder you will see the words marvel, awe, amazement, admiration. Wonder is a very positive word. When we are curious and we wonder, we enter a positive relationship with the person we are curious about. Take the example of my patient with her name tattooed on her arms. If I had asked, “Do you have those tattoos because you think you might forget your name?” I am judging. I have already assumed that she has moments where it is plausible she might forget her name. But by saying, “I am curious, can you explain to me why you have those tattoos?” I approach the topic from an innocent and honest desire to learn more about the patient.

So, I implore you to remain curious about your patients. Learn about them, their culture, their beliefs, what brings them joy, what causes them fear. Wonder and curiosity will open doors allowing the relationships you have with patients to grow deeper, and your knowledge of your patient will be more profound.

Pure curiosity is best achieved if you remain In the Moment. I learned about being In the Moment via an interaction I had with the preceptor leading the Microaggressions course I had taken. In a private moment, I expressed my concern that microaggressions were so stealthy that I feared I might be committing one without even realizing it. I confessed to a significant, almost crippling, angst that I felt was holding me back. Her advice to me was to simply relax and be In the Moment. Stop my worrying, let go of my biases and focus exclusively on the job I was trying to do. My job – our job -- is to gather information about a patient and their presenting problem to formulate an accurate diagnosis and develop an appropriate treatment plan. Our job is to be curious.

Take again the example of the patient with the name tattoos. As I read her chart prior to entering the exam room I had all sorts of biases and tropes floating through my thoughts. Inwardly, there was significant eye rolling – here we go, another patient with a lump that is just normal breast tissue, why is my time being wasted? Why can’t her own primary care provider

save the system money and get the test prove the lump is nothing and reassure the patient themselves? Why do I even have to be involved? But I checked my human *nature* at the door and focused instead on being *humane*. I let myself be In the Moment and began this relationship with genuine curiosity aimed at figuring out why the patient had been referred, what her symptoms were, what her physical findings were, how this information would support one diagnosis over another.

For us, as health care practitioners when we are “In the Moment” we let go of all our baggage before engaging with a patient. We leave biases, preconceived notions, beliefs, worries, inner turmoil out of the equation. When we meet with a patient, we must simply be curious. From there strong and trusting relationships can be built.

I implore everyone in the room: Be curious and remain in the moment.

I want leave with one final thought before concluding this session. We do have an enormous task ahead of us if CAGS is to take a leadership role in improving our relations with the First Nations people of this country. It is not something we can fix overnight. I have made it a primary mandate of my presidency, but I only have 2 years in this position. Given the enormity and importance of this mission we have created a new working group under the direction of the IDEA committee to address this issue. It will be focused on devising ways to improve the surgical health care experience of the First Nations people of Canada. The ultimate goal will be to create and warehouse a suite of educational tools and identify a variety of measures and/or processes which members can access and use to build relationships and communities with the Indigenous population in their own locations. I have personally reached out to several CAGS member who self-identify as Indigenous, and I am excited to let you know that most of them have already agreed to participate on this working group. We will be seeking non-medical First Nation community members such as elders, leaders, and other interested participants to ensure the voice of Indigenous patients is heard clearly and consistently. We will adhere to the principle of “With us, not for us”. What is now needed is you. We are still looking for volunteers to commit to the working group. Beyond that we will need members to bring these efforts back to their own communities and build better, stronger and more equitable relationships with your own local First Nations Patients.



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For the first time in a longtime I am hopeful. I leave you with this image as a symbol of my hope. I come from Treaty 1 lands. Treaty 1 was signed August 3rd, 1871. One hundred and fifty-four years later arguably it has not been fully honoured. A major step forward came a few years ago when the federal lands that had been used to house the Patricia Pats – an armed forces regiment originally stationed in Winnipeg, finally found their way back under the control of the Anishinaabe and the Swampy Cree. An urban reserve has been created, and the hope is this act will add to the cultural and economic prosperity of these First Nations. This is the first business to be built on this land. If we try hard enough we can build anew.

- Dr. Brent Zabolony