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A Critical Discourse Analysis of Medical Students' Reflective Writing: Social Accountability, the Hidden Curriculum, and Critical Reflexivity

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A thesis submitted in partial fulfillment of the requirements for the Master of Education degree in Education

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A CRITICAL DISCOURSE ANALYSIS OF MEDICAL STUDENTS' REFLECTIVE
WRITING: SOCIAL ACCOUNTABILITY, THE HIDDEN CURRICULUM, AND
CRITICAL REFLEXIVITY

(Thesis format: Monograph)

by

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Graduate Program in Curriculum Studies - General

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Education

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Abstract

In recent years, many medical schools have adopted a 'social accountability' approach, implementing a variety of activities and curricula aimed at developing a sense of social responsibility in medical students. The research of this thesis uses critical discourse analysis (CDA) to scrutinize the writing of senior medical students, with a view to uncovering how identity, ideology, and social position are expressed by students who have undertaken a curriculum designed with social accountability in mind. The analysis examines the conditions of discourse practice, student orientations to a professional medical identity, and ideologies of community, rurality, indigeneity, and gender. I discuss these findings in the larger context of the hidden curriculum in medical education, social accountability, reflective and reflexive practice, and propose a framework for moving forward toward the development of a curricular intervention to address these issues.

Keywords

Medical education, critical discourse analysis, identity, ideology, social accountability, critical reflexivity, hidden curriculum.

Acknowledgments

Going back to do an MEd degree has been a radically different experience from when I did my PhD. I wish to acknowledge the support and assistance I have received from many mentors, friends, family, and colleagues who helped me get through this second (and LAST) whirl through grad school.

First and foremost I thank Dr. Kathy Hibbert, my thesis supervisor, who has supported me in so many ways in making this transition in my professional life. Kathy has been a great match for me as a supervisor, with academic expertise that compliments my own background, generously mentoring me as I have stretched my legs in the scholarship of medical education and in critical discourse analysis. Having some uncanny coincidences in our personal histories as well, I have especially valued her care, understanding and advice on both personal and professional levels. It was my exceedingly good fortune to have such a gifted educator assigned as my faculty mentor, and I am grateful to have been the beneficiary of her teaching and guidance over the last 3 years.

Second I thank Dr. Anne Kinsella, who has served on my supervisory committee and was my professor for the transformative course she offers on the epistemology of practice in the health professions. I cannot thank her enough for the rather extraordinary lengths she went to so that I was able to take that course as a distance student. Although we have only met in person once as of this writing (!), she has had a tremendous influence on my scholarship, and her email with comments on this thesis has gone into a special file folder I keep to cheer me up when I'm having a bad day. I look forward to collaborating with you in the future, Anne!

I'd also like to acknowledge a number of other faculty at Western who have been influential and supportive over the course of this degree. Dr. Luigi Iannacci skillfully helped me work through my initial resistance to narrative research; I thank him for opening my eyes to the value of critical autobiographical narratives in research. Dr. Wayne Martino's feedback during the gender and education course helped me to

expand my thinking in this area. Dr. Lorelei Lingard was a valuable sounding board as I worked out the scope of this project, and her sage advice helped me to keep things reined to a manageable size for this thesis.

My colleagues at the Northern Ontario School of Medicine (NOSM) have also been helpful in myriad ways. My friend, collaborator, and office neighbour Dr. Rachel Ellaway is my day-to-day go-to when I need advice or someone to bounce an idea off of; she unfailingly challenges me in all the best ways. I also thank my other colleagues (friend-colleagues) Dr. Brian Ross, Dr. Elaine Hogard, Dr. Tim Dubé, Patty Fink, Dr. TC Tai, and Kristy Côté for advice and encouragement. My Division Head, Dr. Doug Boreham, supported me in adjusting my teaching workload this year to facilitate the timely completion of this thesis. In addition, I'd like to thank the other faculty and staff who helped me recruit participants and pull the data out of the archives: John Dabous, Marissa Giusti, Stephanie Michaud, Betty-Ann Serre, Dr. Cathy Cervin, and Karen Tokaryk. I also want to acknowledge financial support from the NOSM/NOSMFA Research Development Fund for the funds used to purchase the NVIVO analysis software, and which also allowed me to secure a grant from the Associated Medical Services Phoenix Project to fund the follow-up project I describe in section 5.4.

Of course I would be remiss if I didn't thank the participants in this study, the NOSM alumni who entrusted me with their writing for this analysis. I appreciate your trust and generosity in sharing your work with me. As a teacher, I am so proud of all of you and the work you are doing for the people of Northern Ontario.

Finally I offer my gratitude to my family and friends who have supported me during this work, especially Scott Neigh, Liam Ritz Neigh, Shana Calixte, Kate Barber, Tammy Gaber, Liz Cates, Sari van Anders, the Ritz family, and the Neigh family. Thanks for making dinner, giving me hugs, listening to my grumbling, encouraging me, and celebrating with me.

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Chapter 1 : Introduction

“The language of medical science can convey ideologic content, especially when it converts social problems into technical ones....by a lack of criticism directed against sources of distress in the social context, medical discourse ideologically reinforces the status quo.”

(Waitzkin, 1989)

Part of the ethos of the profession of medicine is a sense of a ‘social contract’ between the physician and the patient, in which the physician is accountable to patients and the public (Caelleigh, 2001). More recently, there has been an emerging sense that not only do physicians as individuals bear responsibility to patients and society, but also that the larger institutions of medicine have similar obligations (Busing, Rosenfield, & Rourke, 2010). Many medical schools have taken on the mantle of ‘social accountability’ and recognize “the obligation to direct their education, research, and service activities towards addressing the priority health concerns of the community, region, and or nation they have a mandate to serve” (Boelen & Heck, 1995, p. 3). Many schools, including my own, have implemented a variety of activities and curricula aimed at developing a sense of social responsibility in medical students, with the intent of producing socially-responsible physicians who will practice so as to address health inequities produced by social and economic forces, rather than focusing solely on biomedical issues isolated from social context.

As a medical educator, I feel a sense of personal responsibility to contribute to achieving these ends. A central principle in my own work as an academic is to attempt to bring a critically reflexive perspective to my activities, in order to problematize the taken-for-granted constructs that frame my research and teaching. With respect to social accountability, I argue that there is a real danger that social accountability activities may perpetuate the very inequities they are intended to address if we do not bring a vigorous critically reflexive approach to their implementation (Ritz, Beatty, & Ellaway, 2014).

The research of this thesis uses critical discourse analysis (CDA) to scrutinize the writing of senior medical students, with a view to uncovering how identity, ideology, and social position are expressed. In doing so, I attempt to set the stage for future work in the development of curricula for medical students that will aid in the development of their own capacity for critical reflexivity and the examination of how their values, ideologies, identities, and social position may influence the way they interpret and relate to their patients, particularly those who hold different values or positions from their own.

1.1 Context and Motivation

I have been a professor at the Northern Ontario School of Medicine (NOSM) since 2005. NOSM was the first medical school to be founded with a 'social accountability mandate', with the commitment to be responsive to the needs and interests of the communities we serve (Strasser & Lanphear, 2008; Strasser et al., 2009). In the parlance at NOSM, communities are generally understood as including the geographical communities of Northern Ontario in general (particularly the rural and remote ones), as well as the ethno-cultural communities of Francophones and Aboriginal peoples in Northern Ontario. To fulfill this mandate, our curriculum is designed to provide significant opportunities for students to engage with communities directly, and learn about the historical and contemporary social conditions of those communities insofar as these have implications for health and medicine. In addition, our students are heavily recruited from amongst these communities.

Over the last 9 years at NOSM, I have had the opportunity to interact with, teach, learn from, and evaluate hundreds of medical students. In my observations, there have been many instances where I was struck by the extent to which students were apparently unconscious of their own power, privilege, and ideological investments, and frequently did not recognize that they were imposing their own values and worldviews on to people and communities they were not a part of. This first became apparent to me a

number of years ago while I was acting as a faculty evaluator of student presentations in which they reflected on their first community placements. I had had a number of opportunities to interact with these particular students, and I knew them to be bright, eager, and idealistic young people who entered medicine with the best of intentions. In the interests of confidentiality I will not discuss specifics of what they conveyed that I found so problematic, but suffice it to say that it was obvious to me that they had not considered that the residents of the community they visited did not necessarily share their views of what was important in life or have the same latitude to 'make choices'.

For the most part I do not doubt the sincerity of these students' intentions to 'do good' or 'help', but find it problematic that there are few opportunities for students to question the potentially contested meanings of 'good' or 'help', particularly when those being 'helped' do not share the same social position as the physician and may not share the same values around what is taken to be 'the good'. Waitzkin and Waterman (1974) have emphasized that the typical 'helping ideology' operating in medicine "contains elements of *noblesse oblige* strikingly reminiscent of the ideological line enunciated by international colonialists" (p. 88). I contend that in order to truly address the needs of the communities we serve in fulfilling the mandate of social accountability, we should first recognize that we must honour the perspectives of the people in those communities over our own in defining what those needs are; and in order to do that, we must recognize that our perspectives may be informed by different values and worldviews than those in other communities. In doing so, we must take steps to identify what our own values and ideologies are, and how they are informed by our social position.

It has become clear to me that in order to educate medical students so that they are able to address the needs of those in the communities they serve, a crucial dimension is to assist them in being able to actually attend to the needs *as defined from the perspectives of the communities, as opposed to only from their own perspectives*. The entire idea behind social accountability is to address health inequities, and if we do not

attend to inequity in our conception of what it means to enact social accountability, then we run the risk of perpetuating the very inequities that social accountability means to confront.

1.2 Recognizing Medicine as Social Practice

“The idea that medicine is not just a personal affair between a doctor and a patient...has become commonplace, something we all know, a truism: that medicine is as social an endeavor as it could be and that knowledge and power, science and society, are intertwined.”

(Mol, 2002, pp. 61–62)

There can be no doubt that the professional practice of medicine is a socially-situated one, and as such it is imbued with values, investments, interests, and commitments that are situated socially and historically (Green, 2009). Many social theorists have noted the ways in which the institution of medicine functions to maintain the status quo, and the importance of medical and scientific discourses as mechanisms of social control (Fairclough, 1993; Foucault, 1974b; Illich, 2000; Mol, 2002; Waitzkin, 1989). Through the processes of medical education (as in most professional education), future physicians not only learn the technical knowledge and skills they required to be competent practitioners, they are simultaneously assimilated into the culture, values, ideologies, discourses, sensibilities, and habitus of medicine (Costello, 2006; Haas & Shaffir, 1991; Schön, 1987). As emphasized in the perspectives of critical theory and poststructuralism, it is inevitable that these will be materialized in the interactions between physicians, allied health professionals, and patients (Lather, 1991).

In most clinical settings, physicians see their work as a form of problem solving, where the patient brings a problem to the encounter to be addressed. However, this is not how most clinical encounters proceed: in many instances, patients do not come to see a physician with a simple, well-defined problem, but rather, with a “messy problematic situation” (Schön, 1983, p. 47) that must first be resolved into a solvable problem. By

framing clinical practice principally in terms of its problem solving function, the related issue of 'problem setting' becomes largely implicit and unexamined (Schön, 1983). As described by Schön, problem setting:

is a necessary condition for technical problem solving, [but] it is not itself a technical problem. When we set the problem, we select what we will treat as the 'things' of the situation, we set the boundaries of our attention to it, and we impose on it a coherence which allows us to say what is wrong and in what directions the situation needs to be changed. Problem setting is a process in which, interactively, we *name* the things to which we will attend and *frame* the context in which we will attend to it. (1983, p. 40)

This process is inherently a social one, and one which is clearly a discursive exercise ('naming' and 'framing') which will be inevitably influenced by the physician's subject position, values, ideologies, and privilege. The practitioner thereby constructs the situations of practice (Kinsella, 2006b), making decisions about selecting the relevant 'things', imposing a coherent narrative on it, and choosing the ends to be achieved. These are seldom consciously experienced as 'decisions', and in fact are probably experienced by the practitioner as taken-for-granted and self-evident (Schön, 1983). In recognizing this constructivist view of professional practice, Schön (1987) suggests that we might understand one role of professionals:

as worldmakers whose armamentarium gives them frames with which to envisage coherence and tools with which to impose their images on situations of their practice. A professional practitioner is, in this view, like an artist, a maker of things. (p. 218)

These frames also constrain the language to be used, as patients who enter the clinic "tacitly agree to tell stories in medical terms that adopt the language of the medical profession and alienate them from their own voice" (Kinsella, 2006a, p. 38). Thus, the frames that are brought to the practice will determine the nature of the practice.

These institutional practices and structures of problem-setting in medicine have a powerful influence on the way that medicine is practiced, by channeling activity into

acceptable (primarily biomedical) channels and precluding consideration of alternatives (Fleming & Mattingly, 1994), as one of many mechanisms of power that encourage conformity to societal norms (Foucault, 1995). The 'biomedical frame' is very powerful, prevailing over other frames of consideration, like the psycho-social, cultural, political, economic, or environmental dimensions. Given the power of the physician to control the discourse in a clinical encounter, they are usually able to assert their preferred frame, unless the patient is very persistent and persuasive, thus granting the physician a kind of 'cognitive authority' in the clinical context (Kinsella, 2005). In many respects, the institution of medicine enacts, monitors, adjudicates, and otherwise encourages conformity to societal 'norms', as described by Mol (2002):

In establishing the power of the norm, medicine is a crucial discipline, because medical knowledge mediates between the order of the body and the order of society. It is within medical knowledge that the normal and the deviant person are differentiated....Medicine has started to set the standards that modern people want to live up to (p. 60).

Thus the power of the physician to frame clinical problems tends to exert controlling functions over the patient, and "to the extent that doctors' allegiance with their patients is not unconditional, they may at times serve the interests of the social order more than those of the people they claim to help" (Waitzkin & Waterman, 1974, p. 21).

Schön has emphasized the ways that professionals "make and maintain the worlds matched to their professional knowledge and know-how" and that they have "particular, professional ways of seeing their world and a way of constructing and maintaining the world as they see it" (Schön, 1987, p. 36). Extending Schön's conceptualization, I argue that it is not only the subject position as 'professional' that influences the ways that professionals frame and construct their practices, but that all of the other elements of their embodied social position and worldview are brought to bear as well. The unconscious beliefs held by a health care provider can have profound effects on the nature of the interaction between practitioner and patient, with respect to the manner of communication, the interpretation of symptoms and information, the

setting of lower or higher expectations for the patient, and clinical decision-making (Teal, Gill, Green, & Crandall, 2012; van Ryn & Fu, 2003). Such biases can function to reconstitute and perpetuate dominant perspectives about the patient's value as a person, their competence, and their deservingness of care (van Ryn & Fu, 2003). Moreover, this can have a compounding effect, as the responses of the patients themselves will feed into the dynamic between them; where the practitioner's approach is informed by negative biases about the patient, the patient may respond in a negative way, feeding into the dynamic; but a positive bias can also push the dynamic in positive directions (van Ryn & Fu, 2003). When the underlying assumptions of the physician's worldmaking processes are different from the patient's – especially when these are in tension or at odds with one another – the physician's construction is bound to prevail in most instances, given their relative power. Although the encounter may be founded on the patient's complaint, in 'reading' the patient, the physician plays an active role in creating the meanings that are derived from it, 'collaborating' with the patient to produce new meanings (Bleakley, Bligh, & Browne, 2011, p. 209). Thus it is important for physicians to interrogate what they are bringing to this dialogic encounter with the patient, and the consequent meaning-making that occurs.

This is particularly relevant when one considers that the physician is responsible for the care of a diverse population of patients, many of whom will not share the same social position, values, and power. Waitzkin (1989; 1991) and others have convincingly shown how interactions between physicians and patients contribute to establishing and reinscribing power dynamics in ways that serve to reiterate oppressive discourses. It follows that physicians who unwittingly make use of such discourses can create additional barriers and difficulties for patients who are already vulnerable, particularly those who have been subjected to racialization, sexism, homophobia, or colonization, for example. In the absence of efforts to understand one's own position, privilege, and ideology, people are likely to leave dominant cultural values and social systems unchallenged and reproduce patterns of inequity in their own practice (Brookfield, 2000). McLeod and Sherwin (2000) have also articulated this problem in terms of the

effects of oppression in undermining individual autonomy, which invokes important ethical implications for the provision of health care. When health professionals fail to acknowledge the ways that their own conceptual frames and values influence patient care:

they may become selectively inattentive to data that fall outside their categories...or they may try to force the situation into a mold which lends itself to the use of available techniques. ...members of the helping professions may get rid of clients who resist professional help, relegating them to such categories as 'problem tenant' or 'rebellious child'. All such strategies carry a danger of misreading situations, or manipulating them...[so that] the practitioner may preserve his sense of expertise at his clients' expense (Schön, 1983, p. 45).

The crucial point here for me is that where a physician finds a particular patient difficult or undesirable, the problem does not lie simply in the patient's behaviour, but rather the physician may also be understood as collaborating in the construction of 'difficult patients' by uncritically applying their own assumptions, values, and perspectives in the encounter.

Not only does the physician have a meaning-making role in these encounters, but the patient simultaneously 'reads' the physician and interprets the doctor as 'text' as well (Bleakley et al., 2011). As a result, there is a reciprocal meaning-making process occurring at all times represents a fusion of the 'horizons' of the physician and patient, as there is in all human interactions (Gadamer, 1996; Kumagai, 2012). Although this may appear on the surface to create a certain symmetry between physicians and patients, who both collaborate in generating meaning in the clinical encounter, such collaboration does not guarantee consensus, because "the interpretations doctors and patients give must differ, linked as they are to the specific history, interests, roles, and horizons of each group" (Mol, 2002, p. 10). Since the power and authority of the physician in a clinical setting alone will tend to tip the balance in favour of the physician's perspectives, when the patient also occupies a less privileged social location

than the physician, such encounters may emphasize and re-instantiate the patient's marginalized position to an even greater extent.

1.3 Social position of medical students

"The standpoint of medical privilege, like the standpoint of male privilege, is precisely the one from which important features of the lives of those below are not visible. And as it is the lives of those below with which the physician is professionally concerned, the inability to see clearly here is particularly unsatisfactory."

(Lindemann Nelson, 1999, p. 112)

Although there are certainly exceptions, medical students come predominantly from relatively privileged backgrounds (Dhalla et al., 2002; Kumagai & Lyson, 2009; Kwong et al., 2005). Even for those who enter medical school with relatively little privilege, the very fact of being a medical student in itself confers a degree of privilege, and their training and ultimate status as a physician inculcates more.

My observation that most medical students do not seem to be aware of their privileged social locations is substantiated by the research of Beagan (2003), who noted that:

most [medical students] failed to recognize, or even denied, the effects of race, class, gender, culture, and sexual orientation. Those who acknowledge the effect of social differences tended to deny social inequality, or at best recognized disadvantages experienced by Others, but not the accompanying privileges enjoyed by their own social group (p. 605).

Beagan's findings take on an additional significance when one notes that these observations were made *after* specific curriculum on social and cultural awareness had been implemented.

This is particularly germane in light of research showing that although most medical students enter medical school with altruistic and idealistic intentions, as they progress through their training "medical students lose faith generally in the value of a socially

aware approach to medicine that includes sensitivity to patients' life contexts" (Bleakley et al., 2011, p. 190), and tend to favour patients whom they find physically or socially attractive or with whom they are able to make a personal connection, while finding other patients 'difficult' or 'undesirable' (Bleakley et al., 2011). In other words, they appear to prefer patients who are like themselves. This presents an obvious problem in that such preferences are more likely to extend to patients who occupy similarly privileged social locations, and further marginalize patients who are already marginalized, as suggested by Bourdieu's model of social capital (2010) (in which an individual is accorded certain kinds of recognition and resources as a function of their association with a particular social group).

Although most medical schools now include at least introductory curriculum to support student learning around issues of 'cultural sensitivity' (sometimes called 'cultural competence' or 'cultural safety') and an understanding of the social determinants of health, there is still a significant gap to be closed. Although an atmosphere of cultural inclusion may heighten awareness of difference and even celebrate diversity, in the absence of critical reflection about the political, social, and economic causes of such differences, their manifestations may be overlooked or even repressed as a way of incorporating or deflecting views that challenge the mainstream (Brookfield, 2000). As Beagan's (2003) study suggests, although specific curriculum on these topics may raise students' awareness about how people may be disadvantaged, it does not necessarily foster insight into the ways that physicians themselves may inadvertently perpetuate and reinscribe these oppressions. Kumaş-Tan and colleagues (2007) highlight the ways in which ethnocentrism and racism are seen "as issues affecting only ethnic and racialized minority groups" (p. 551) and that most of the approaches to cultural competence "do little to address ethnocentrism and racism, but when they do, they frequently imply that the problem lies in the disadvantages borne by minority groups – not in the advantages of dominant group membership" (p. 551). I agree with Beagan when she suggests that a critical perspective must inform educational interventions in

this arena, in order to avoid reinforcing stereotypes or ‘othering’ those who do not share one’s own social position.

1.4 Discourse, Power, and Ideology

Before proceeding further to explicate the nature of my own project, it will be useful to elaborate on some of the key terms and ideas that have been touched on already and will be used throughout the remainder of this work. The first of these is the idea of ‘discourse’.

Discourses are not simply language, but rather they are the combination of language, action, interaction, ways of thinking, beliefs, values, the use of symbols or tools, and more, all of which coalesce publically to enact a socially recognizable identity, marking out identifiable systems of knowledge, belief and meaning, and particular ways of acting and being in the world (Davies & Harré, 1990; Gee, 2011; Luke, 1996); discourse is “a form of action that both presupposes and at the same time brings about unique ways of being in the world” (Keating & Duranti, 2011, p. 332). ‘Discursive practices’, then, are the ways in which people make use of discourses to produce particular social realities (Davies & Harré, 1990). Under this view of ‘discourse’, in contrast with traditional linguistics, “words themselves do not carry meaning” (Davies & Harré, 1990, p. 57), but rather language only has meaning in a social context and the meaning of what is said depends on the subject position of the participants in the communicative act (Davies & Harré, 1990). According to Foucault’s definition, discourse “creates a field of knowledge by defining what is possible to say and think, declaring the bases for deciding what is true and authorising certain people to speak while making others silent or less authoritative” (Foucault, 1974a, p. 49).

Discourse is inevitably dialectical, not only constrained by social relations but simultaneously articulating and creating them:

On the one hand, discourse is shaped and constrained by social structure in the widest sense and at all levels: by class and other social relations at a societal level, by the relations specific to particular institutions..., by systems of classification, by various norms and conventions of both a discursive and non-discursive nature...On the other hand, discourse is socially constitutive...[it] contributes to the constitution of all those dimensions of social structure which directly or indirectly shape and constrain it (Fairclough, 1993, p. 64).

Discourses are not static entities, and can have shifting meanings in different contexts, and in relationship to other discourses with which they may be complicit or in contrast (Gee, 2011). Fairclough, one of the dominant theorists of CDA, emphasizes the ways that discourses are invested with ideologies, and that they help “to sustain particular relations of power within society” (1993, p. 15). Understood in this way, language is taken to be a form of social practice, and so no instance of language use is an idiosyncratic act – it is always tied to, constrained by, reinstantiates, and transforms the social world (Fairclough, 1993).

Language is always used for a purpose, and so people make choices about what to say and how to say it in order to accomplish a particular end. Discourses shape our experience of what is ‘real’, and “the way we speak and write reflects the structures of power in our society” (Lather, 1991, p. 25). In practice, people are seldom aware of ‘participating in a discourse’ and “may simply regard their words as ‘the way one talks’ on *this sort* of occasion” (Davies & Harré, 1990, p. 49). However, it is exactly this practice, of identifying what ‘sort’ of occasion it is and what kind of talk is appropriate, that mark the choices of the subject in participating in one discourse or another. When authoritative discourses are assumed by an individual in their professional practice, there is a danger of being dismissive towards those aspects of another’s perspective that do not fit easily with that authoritative discourse (Kinsella, 2005). Dominating discourses have the effect of marginalizing other discourses while making themselves appear self-evidently transparent (Bleakley et al., 2011), and it is in this way that discourses operate oppressively, as “the citing of particular discourses which frame how

people think, feel, act, and interact. In other words, oppression is the citing of harmful discourses and the repetition of harmful histories” (Kumashiro, 2000, p. 40). Thus interrogating discourse can be a useful strategy in attempting to remediate oppressive practices.

In our everyday discourses, ‘power’ is usually thought of as a force that is wielded by an individual, someone who has ‘power over’ or ‘power to do’ something, or as a synonym for ‘authority’, ‘clout’, ‘force’ or ‘dominance’, and tends to be understood as oppressive or controlling. Foucault termed this kind of power ‘sovereign power’, and although it certainly operates in medicine to some extent, there are also other forms of power that play a significant role in shaping medical encounters. At this point I think it is useful to introduce some concepts of power that have informed the shaping of my research question, as well as the analysis and interpretation of the data.

Building on Foucault’s concepts of power, Bleakley et al. (2011) have usefully distinguished four kinds of power; their formulation is particularly relevant for this thesis because Bleakley et al. are similarly concerned with the operations of power in medicine and medical education in particular. Like Foucault, they recognize *sovereign power* as ‘power over’ somebody, as in a typical hierarchical, authoritarian context, and emphasize that this type of power is principally *reproductive*, in that it often serves to reproduce and sustain existing power relations. That being said, Bleakley et al. note that sovereign power can be acquired “through particular knowledge or technical expertise...and can be exercised in a benign manner” (p. 124); such power can be exercised in an authoritative, rather than authoritarian, way, as paternalism, but in doing so it tends to “[mirror] colonial and imperial traditions of conquer, govern and exploit, however benign this may appear outwardly” (p. 125).

Bleakley et al. (2011) also distinguish *virtue power*, as power exercised in a morally-charged fashion and “on behalf of the democratic virtues of equity, equality and citizenship” (p. 130), and “speaking up for oppressed positions” (p. 131) which “produces a change in identity” (p. 130), borrowing on concepts of power from

Nietzsche and Spinoza in doing so. However, although they identify this as a distinct form of power, I remain unconvinced that it is essentially different from sovereign power; virtue power appears to be similar to sovereign power in its operation, but is deployed in aid of others rather than of oneself, or as resistance to hegemonic power structures rather than in support of them.

At the same time, there are elements of their account of virtue power that draw on the concept of *capillary power*. Foucault (and Bleakley et al.) emphasizes that in modern structures, power is not usually exercised as sovereign power, but instead as a form of power that runs through all systems, operating in subtle ways in a pervasive form, a social-level system of power internalized by individuals and manifesting itself at the level of the individual; Foucault coined the term *capillary power* to refer to this. Such capillary power “is not employed to oppress or rule, but...is a *potential* that flows through a system” (Bleakley et al., 2011, p. 128) that has productive, transformative potential in its ability to generate new values, identities, knowledges, and relationships; moreover, it can also have radical effects, as when it is harnessed as resistance. Capillary power is particularly transacted through discourse.

Also related to the idea of discourse is that of ‘ideology’. All discourse is in some way ideological – it expresses a worldview or a particular outlook; in other words, ideology can be understood as epistemically ‘prior’ to discourse. Although the notion of ideology has a long and rich history (Eagleton, 2007), a generally accepted contemporary understanding of ‘ideology’ is expressed by van Dijk (2011) as “general systems of basic ideas shared by the members of a social group, ideas that will influence their interpretation of social events and situations and control their discourse and other social practices as group members” (p.380). Central to the concept of ideology is that these are not individually-held personal belief systems but are social and shared by members of social groups, and as members of different social groups simultaneously, individual people may hold and enact several different ideologies (van Dijk, 2011). Individuals are usually not conscious of the ideologies they hold, as one of the

characteristics of an ideology is that it ‘feels’ like ‘common sense’ to those who hold it, rather than a political position (Brookfield, 2000). People are much more likely to be aware of their attitudes – that is, their beliefs about specific issues -- which are usually ideologically-based (van Dijk, 2011). Although ideology is often taken to have negative connotations, as though things that are ideological are in some way flawed, ideologies are more neutrally understood as conceptual and value systems that inform our norms (van Dijk, 2011).

Language is a tool of ideology when it serves to establish, sustain, or transform relations of domination (Fairclough, 1993), which is to say, always. Like discourses, some ideologies may become dominant and authoritative in a given context, so that one ideology is privileged over others, which are marginalized or displaced (Bleakley et al., 2011). Van Dijk (2011) makes the useful suggestion that ideologies can be understood as structured by certain propositions about the basic properties of groups relating to identity (‘who are we? who belongs to us?’), activities (‘what do we do? what is our task?’), goals (‘what do we aim to achieve?’), group norms and values (‘what is good or bad? what is permitted or prohibited?’), relations between groups (‘who are our allies? who are our opponents?’), and resources (‘what is the basis of our power?’). For this project in particular, this schema is very useful in helping to relate ideology to discourse and power, but also highlights the importance of identity as relating to these concepts.

1.5 Identity and Social Position

“Any and every statement made can be tied back in some way to subject position.”

(Anton & Peterson, 2003, p. 411)

The meaning of ‘identity’ lacks a coherent consensus and varies widely among disciplines and theorists. In a general sense, it can be understood as an individual’s self-concept, although how there is considerable diversity and controversy about exactly how this is conceptualized (De Fina, 2011). Recent theorizing around identity has emphasized its social construction and shifting nature, continually created and

performed in transaction with others, rather than as a fixed entity that one ‘possesses’ (De Fina, 2011), and discursive practices play a large role in the crafting and construction of such identities (Anton & Peterson, 2003; Davies & Harré, 1990; De Fina, 2011; Luke, 1996). From this perspective, ‘identity’ is not simply one’s personality, but rather it “stands between socially sanctioned roles and idiosyncratic personality, and is dynamic and historical” (Bleakley et al., 2011, p. 63). In thinking about identity as a role that one inhabits as a part of a community of practice, it becomes more obviously embedded in a social context, and occupying a given identity can be seen as a cultural and participatory act, where the dynamics of the individual’s relationship with the community of practice are formative in the individual’s identity (Bleakley et al., 2011; Wenger, 1998).

Identity and subject position can be understood as related but distinct concepts. Whereas a person’s identity relates more to one’s self-image, one’s subject position has more to do with the perspective taken by an individual on the world (Anton & Peterson, 2003). Understood in this way, it follows that there may be considerable disjunctures between a person’s claimed identity and their subject position: for example a person may not conceive of themselves as middle class as part of their self-concept, and yet their discourses may make abundantly clear that this is their subject position, whether they recognize it or not.

From a Foucauldian perspective, in taking up an identity and subject position, the individual “takes a place in the social order, making sense of the world from this vantage point while also being subjected to discourses common to it” (Anton & Peterson, 2003, p. 406). Thus, subject position relates to discourse in that when one takes up a particular subject position, the world is inevitably viewed through the discourses operating at that location, and simultaneously uses those discursive practices to constitute themselves in that position (Davies & Harré, 1990). In so doing, the subject brings to the position a concept of the kinds of expectations and norms that are appropriate for that position, and makes choices about their speech acts in ways they regard as fitting for that position (Davies & Harré, 1990).

The idea that a person's identity and subject position are 'produced' and manifested in the discourses they employ is not new: as far back as the Ancient Greeks and Romans, a person was understood as something to be 'made' through that person's action (Bleakley et al., 2011), and rhetoricians have long recognized that the character of the speaker is discernable in the speech act itself (Anton & Peterson, 2003). Such understandings of identity as performance persist in to contemporary theorizing as well (Mol, 2002). In discursively enacting these identities and positions, individuals are constrained in the kinds of "knowing or telling we can do" (Davies & Harré, 1990, p. 59), but we are seldom conscious of participating in a given discourse. Instead, "we experience these selves as if they were entirely our own production. We take on the discursive practices and story lines as if they were our own" (Davies & Harré, 1990, p. 59). Thus, a major task in discourse analysis is to examine the implicit meanings and consequences when people take up particular social identities.

1.6 The Present Project

"If medical education were to be reduced to a formula it might be: medical education = identity + location + power."

(Bleakley et al., 2011, p. 7)

As the foregoing makes evident, as a medical educator at an institution with a commitment to social accountability, I feel an intellectual and personal commitment to developing a curriculum for medical education that foregrounds social justice and the need to address health inequities. I contend that unexamined privilege on the part of physicians is a contributor to the perpetuation of such inequities, and thus it would be useful to develop curricula that help medical students to (a) recognize their privilege and power, (b) examine how that may function to sustain and re-instantiate oppression and marginalization for many patients who are already marginalized, and (c) attempt to counter those tendencies. A curriculum that fosters the capacity for critical reflexivity may play a pivotal role in closing this gap, enabling health practitioners to develop a

sense of their own complicity in oppression, and in doing so “look closely at our own practice in terms of how we contribute to dominance in spite of our liberatory intentions” (Lather, 1991, p. 15).

As a foundational piece to inform the development of such a curriculum, I have undertaken the research of this thesis to develop a more nuanced understanding of the discourses employed by NOSM medical students, and the ways that their identity, social location, ideology, and privilege are manifest in these discourses. The quote from Bleakley et al. that I used as a header for this section incisively connects the main themes underpinning this thesis, that the process of medical education (and further, medical practice) is one in which the individual is acculturated and trained in framing and intervening in the world in particular ways as informed by the identity, social location, and power of the physician. By having a clearer understanding of these, I will be better able to approach the development of a curricular intervention with some awareness of the major tropes and themes that should be addressed. I contend that identifying these aspects of ideology and privilege in medical student writing is important because they will likely manifest themselves in doctor-patient relationships, since “our invested positionality [inevitably] shapes our rhetoric and practice” (Lather, 1991, p. xvii).

This research consists of a critical discourse analysis [CDA] of writing produced by 4th year NOSM medical students for mandatory essays on the northern and rural health curriculum, focused on the ways that identity and social position, ideology, and privilege are manifest in their writing. 8 recent NOSM alumni consented to the analysis of their written essays in the study, and 35 distinct pieces of writing were analyzed. The principal objectives of the study were to:

- examine the ways that the subject position and identity of 4th year medical students are expressed in their writing;
- explore how various ideologies are manifested in medical student writing;

- consider the possible implications of these subject and ideological positions for relationships with patients and for social accountability more generally;
- inform the development of a curricular intervention to promote critical reflexivity.

The thesis is organized into 5 chapters. This introductory chapter provides the context for the work and elaborates on some of the theoretical foundations underpinning the approach. In Chapter 2, I offer a critical autobiographical narrative of elements of my own personal history that inform and shape this research, focusing on how aspects of my own social position (especially class and gender) have shaped and informed my current research agenda. Chapter 3 describes the methodology of this work, elaborating further on CDA as a method for inquiry, more detail regarding the subjects and the production of the essays, and description of my analytical approach. Chapter 4 discusses the findings, organized around several key themes including: the conditions of discourse practice; student orientations to a professional medical identity; and ideologies of community, rurality, indigeneity, and gender. In the final Chapter, I discuss these findings in the larger context of the hidden curriculum in medical education, social accountability, reflective and reflexive practice, and propose a framework for moving forward toward the development of a curricular intervention to address these issues.

Pursuing this line of inquiry is a first step in responding directly to the challenge levelled by Novack, Epstein, and Paulsen (1999), who argued that medical educators “must think of creative ways to bring the advances in self-awareness and interpersonal psychology to the early and ongoing education of physicians” (p. 519). It is my view that such awareness is even more crucial when situated in the context of the social accountability movement; I agree with Bleakley and colleagues (2011) that:

Doctors come with particular mindsets and read patients accordingly. It is imperative that they are able to be reflexive about these ways of reading patients, or capture the values that drive such readings...[we] think that it is important that medical educators help doctors to understand some key ideas in textual

appreciation so they can apply these to their daily medical practice. (p. 205)

This is a complex challenge that I cannot hope to fully address in the work of one Master's thesis, however, this work takes an important step toward this aim.

Chapter 2 : Critical Autobiographical Narrative

"All research is in one way or another autobiographical or else the avoidance of autobiography."

-- Diane Reay

My decision to pursue this research is unquestionably not detached or objective; rather, it flows directly from my personal history and professional experiences. Although I developed an awareness of the ways in which research is heavily invested in politics, ideology, and culture years ago, until recently my thinking on these issues was largely limited to the abstract, large-scale, paradigmatic level. More recently, I have become more aware of the value in drilling down to the more specific, fine-grained, and personal elements that influence my research, and in probing the dialectical relationships between these two levels. Although positivist perspectives on research would hold these political and personal investments to be a problematic source of bias in the inquiry, social constructivist scholars embrace the idea that the researcher's personal experiences can be a valuable asset that "enriches rather than compromises their inquiry" (Iannacci, 2009, p. 328). In order to contextualize my personal perspective, this Chapter consists of a critical autobiographical narrative that attempts to make explicit the links between my lived experience and the research I undertook in this thesis, in order to allow others to better understand and evaluate my work and the experiences, political influences and commitments, and social position informing it. Doing so seems particularly important in this project, where I aim to examine the ways that the participants' identity and subject position are manifest in their writings; thus it is all the more incumbent on me to acknowledge and reckon with and critically interrogate the same in my work – that is, to recognize that "my experiences, beliefs, and identities are necessarily reflected in how I view and interact with the world" (Glazier, 2005, p. 232) as the researcher.

Inevitably, my social location, identity, and experiences as a white, settler, middle-class, currently able-bodied, and cis-gendered queer woman shape my approach to this research. To begin, I will examine how I came to be a scientist and academic, identifying crucial moments in my early life that trace a thread of recurring interest in medicine generally and in immunology in particular. The second part of my autobiographical narrative explores the ways in which I came to develop a conscious awareness of the ways in which politics and ideology shaped my own experiences, science, and the world at large. The third piece focuses on my transition toward medical education research and critical discourse analysis, highlighting the role of the tensions between my working-class origins and my experiences of teaching medical students in motivating that transition. This inquiry into the nexus between my life history and my research trajectories serves to contextualize the subjectivity I bring to my MEd thesis research.

2.1 Immunology & Medicine

When I was about 5 my grandparents gave me a book¹ about the human body, and I pored over it regularly for years. One page in particular stands out in my mind: it depicted many of the different cell types in the body, and I was especially fascinated to learn that nerve cells could be over 3 feet long. Another page described the host defense functions of the immune system, with white blood cells depicted as tiny white men fighting against little pink men representing bacteria; whenever I'd have yet another one of my ear infections, I liked to imagine my cells fighting against the bacteria causing me pain.

Looking back, I can identify a number of moments where immunology seemed especially inspirational for me. In Grade 4, I gave a book report about a book called "Blood"; I was especially intrigued by the white blood cells, and in the conclusion of my report I said

¹ Kaufman, J. (1975) How we are born, how we grow, how our bodies work, and how we learn. Goldencraft.

that when I grew up I wanted to find a way to make ‘super white blood cells’ to cure the common cold. Later, in Grade 10, I wrote a paper about emerging cancer treatments, and read about a scientist who had developed a method for isolating white blood cells from cancer patients, treating the cells in vitro to enhance their tumour-fighting capacities, and infusing them back into the patients to kill the tumours. I remembered my idea of making ‘super white blood cells’, and found it thrilling that real scientists had used the same idea in some fashion. A couple of years later, late in high school, I learned that this same scientist had published a popular account of his research²; I rushed out to buy it and read it eagerly. I started to think about maybe doing an MD/PhD like Dr. Rosenberg, and maybe someday working for him. Around the same time, my grandmother was diagnosed with a rare autoimmune liver disease and required a transplant, which further fuelled my burgeoning interest in immunology.

After high school, I went to McMaster University, and did a degree in biology with a minor in philosophy. In my third year I took my first course in immunology, and I was completely hooked. Learning the complexities of this amazing system was a revelation – the exquisite specificity of T and B cell receptors, the intricate processes by which lymphocytes rearrange their own DNA and then manage to eliminate those that may be harmful, the remarkable emergent properties of the system as populations of these cells interacted – I found it all breathtaking. I took every immunology course they offered, and sought out a summer position in immunology research after my 3rd year. The first professor I approached had no funding, and referred me to a scientist whose laboratory did work on allergic disease. As a life-long allergy sufferer myself, I was drawn to the idea of doing research to understand its origins; coincidentally, it excited me that my supervisor collaborated with colleagues who engineered adenoviral vectors that could modify cellular functions – a technology that could be used to make ‘super white blood cells.’

² Rosenberg, S. (1993) The transformed cell: Unlocking the mysteries of cancer. Avon Books.

It is easy to look back and pick out instances in my early life that might be taken as 'signs' that I was 'destined' to be an immunologist; however, I, myself, do not believe that would be a justifiable interpretation of this narrative. Retrospective accounts like these are often little more than an exercise of selective memory, and mine is no exception. Had I become a meteorologist instead of an immunologist, my story could just as easily focus on memories of sitting on the porch with my dad watching a thunderstorm roll in, and examining the crystal structures of snowflakes under a magnifying glass. Likewise, if I had joined the family business, I would be talking about the 150 year history of the Ritz Family Printers, and how much I loved poring over paper catalogues as a child, and the chemical smells of ink and solvents in the back of the print shop. My narrative regarding my interest in immunology is typical of many first person narratives, in that they emphasize those things the teller considers noteworthy, and are "selections rather than reflections of reality" (Ochs, 2011, p. 71); in that sense, "stories are not so much depictions of facts as they are construals of happenings" (Ochs, 2011, p.71).

What this story does illustrate, however, is that deciding to pursue research in immunology was not a completely stochastic outcome. Most likely, I arrived at this destination through a spiral pattern of small positive experiences that came to reinforce one another and consolidate that academic direction over time. The gifting of the book to me from my grandparents was probably in response to my own little-girl expressions of interest in medicine and biology, and they approved of these interests and wanted to encourage those kinds of upwardly-mobile aspirations. Seeing my enthusiasm for those topics, my parents and teachers would likely have provided further encouragement, affirming those nascent interests as legitimate and worthy of my time and attention. Although such events would probably have been insignificant in isolation, their cumulative reinforcing effects over a long period of time were substantial.

My early forays into immunological research during graduate school reflect my somewhat naïve political perspective. At that time, I understood my choice of research

projects as driven by ‘pure’ intellectual interest, and also by the opportunity I was afforded to work in the lab. While there, I was doing very basic research into the cellular and molecular mechanisms underlying the initiation of allergic disease. Certainly I was idealistic and wanted my work to make the world a better place, but at that time my outlook was driven primarily by a conventionally techno-scientific view of progress – that more knowledge and understanding of fundamental natural processes would enhance our ability to control and intervene in those processes to create the kind of world we wanted. The research I undertook at that time can be understood from that point of view: in the absence of a critical lens on positivistic empirical science, or a sense of personal responsibility for promoting social justice in my research, I did not initially question the values and ideologies that underlay the work I was doing.

It should be emphasized that this does not mean that my work to that point was in any sense apolitical – all research is “inevitably enmeshed in a web of power relationships and therefore...inherently value saturated and political”(Barone, 2009, p. 592), and thus “the issue is not whether one is ‘biased’; but rather, whose interests are served by one’s work” (Simon & Dippo, 1986, p. 196). In spite of its frequent claims to objectivity and detachment, science “is a supremely social institution, reflecting and reinforcing the dominant values and view of society at each historical epoch”(Lewontin, 1996, p. 9). In this case, the ideologies I brought to my work at that time were consistent with the norms of contemporary science, and also with a broader capitalist and individualistic paradigm, which rendered them less visible than when the politics underlying one’s work are more critical of the prevailing dogma.

2.2 Feminism & Politicization

I haven’t always considered myself a political person, much less a radical one. I remember a conversation with some friends in the cafeteria of my high school where we were talking about abortion, and one of them accused me of being a feminist; I took

umbrage to that description and asserted that I was not a feminist, I was an “equalist”. Looking back, I’m both amused and mildly embarrassed by my resistance to these ideas when I first encountered them.

*As it is for many people, the university environment was conducive to my politicization. Through the coursework for my minor in philosophy, I came to identify as a feminist (albeit a liberal one, to begin with). During grad school, my feminist awakening continued and broadened: I read Naomi Wolf’s *The Beauty Myth* and other ‘gateway’ feminist literature, and came to see the ways in which normative gender roles had shaped my life and outlook, and the ways that women were silenced and marginalized in science. I started to notice the absence of female voices in scientific spaces, even when their bodies were present. At our departmental seminars, lab meetings, and conferences, I began keeping track of how often men and women spoke and asked questions; I noted some troubling disparities, and brought it up for discussion in our lab meetings. When it was my turn to choose a paper for our departmental journal club, I chose a book chapter entitled “What is feminist science?” (Harding, 1991). Although it was the best attended journal club of the year, the paper was not received warmly; most of the attendees became confrontational and hostile (and a new rule was subsequently imposed prohibiting the discussion of ‘non-scientific’ papers at journal club). At one point, my PhD supervisor asked me “why do you insist on bringing gender into everything? I don’t go around thinking of myself as a male scientist; I’m just a scientist, period.” I countered by pointing out that he might feel differently had he been a kindergarten teacher or a nurse.*

In addition to the awakening of my feminist consciousness, my experiences in graduate school were also significant in that I was becoming frustrated by the prevalence of commercial interests in biomedical sciences, and felt distaste for the idea of spending my career working for the pharmaceutical industry, whether directly or indirectly. Late in my PhD I came across a vein of research about air pollution and allergic disease, and in it I found an apparent solution to my aversion to commercializable research – I would

pursue work in environmental health instead, a realm of research in which my emerging anti-capitalist and social justice leanings would be more at home. When I took up a faculty position at the Northern Ontario School of Medicine in Sudbury, a town that is home to a major nickel mining and processing industry where the public is very concerned about the health effects of the air pollution produced by the smelters, I was well-positioned to do the kind of community-responsive research I wanted to do, and I set out to establish a research program looking at the effects of air pollution on the immune system.

My evolving identification as a feminist influenced my research outlook in a variety of ways. Although women make up a growing proportion of working scientists, this is a relatively recent phenomenon, and there are fewer and fewer of them as one moves up the academic ladder from undergraduate students to tenured full professors; as a result, the research environment is still governed primarily by masculine norms of work and socializing. Consequently, I had to “learn to operate within multiple discourses that [were] in conflict with each other” (Keddie, 2005, p. 239). The incidents referenced in my narrative above were materializations of the tensions between my emerging feminist consciousness and the research environment I worked in, which proved to be “choice-points between one discourse and another [which were] critical moments in the development of [my] identity” (Keddie, 2005, p238) as a scientist, feminist, and academic.

My growing feminist consciousness created fertile ground for the germination of other critical perspectives in my worldview. Though I had been inculcated with socialist tendencies by my family of origin, these were reinforced and expanded during this period by my exposure to radical feminist thinkers (many of whom were also Marxists), and by the influence of my partner, whose turn to social activism was somewhat contagious. Many of the feminist critiques of science that I was reading during the period (by authors such as Donna Haraway, Sandra Harding, Evelyn Fox Keller, Ruth Hubbard, and others) laid bare the ways that capitalism, militarism, and racism were

embedded in the everyday practices of most scientific research. In this way, my mounting aversion to commercially-driven science was heavily influenced by my readings in feminism.

Among other things, my growing awareness of the ways that ideology influenced scientific work, and how it functioned in my own world, changed the way I thought about 'causes'. Lewontin (1996) points out that in mainstream contemporary biology (and the natural sciences more generally), "generally one looks for the cause of an effect, or even if there are a number of causes allowed...these causes are separated from each other, studied independently,...and usually seen to be at an individual level" (p41). As an example, Lewontin (1996) elaborates on the way that, under the prevailing medical-scientific discourse, 'the cause' of tuberculosis is understood to be the bacterium *Mycobacterium tuberculosis*; however, he goes on to note that:

tuberculosis was a disease extremely common in the sweatshops and miserable factories of the nineteenth century, whereas tuberculosis rates were much lower among country people and in the upper classes. Then we might be justified in claiming that the cause of tuberculosis is unregulated industrial capitalism... When we look at the history of health and disease in modern Europe, that explanation makes at least as good sense as blaming the poor bacterium (p42).

To some extent, Lewontin's analysis parallels the evolution in my own thinking about the causes of allergic disease. Early in my graduate research, I had thought of allergy as being 'caused' by changes in gene expression at the cellular level; as I began to critique and reject many of the assumptions implicit in the prevailing discourse of medical sciences, I began to think about 'cause' differently. I no longer located the 'cause' of allergy as being exclusively at the level of the individual gene, or cell, or person, but began instead to see the ways in which allergic disease could arguably be construed as a product of industrial capitalism. The shift I made toward an environmental health approach to studying allergic disease can be understood as a form of resistance to the

ideologically-driven push to see causality as residing primarily at the individual level, and locating it instead in the social and economic realms. As Noble Tesh (1998) puts it:

...one reason for assigning responsibility to individuals is that this seems politically neutral. This is so because individualistic ideology politicizes categories beyond the individual level. 'Will I get sick if this stuff is in the air?' sounds like a value-free question. On the other hand 'should this stuff be in the air?' appears political. But the first question is as political as the second; it just hides its acquiescence to the status quo... The individualistic question takes the structural conditions as given. In particular, it requires that we not question why these structural conditions are what they are but that we limit our questioning to states of affairs consistent with the structure (p162-3).

Thus, addressing air pollution as a potential cause of immunological disorders was a way for me to hold society responsible for these kinds of consequences of industrial capitalism, rather than the individual and their genes. In other words, I was refusing to be complicit in the tendency of the dominant medical discourse to "create the illusion that health is a technical problem rather than a social problem" (Hubbard & Wald, 1997, p. 60). These kinds of considerations have been important motivators of my choice of research questions, and as such I have become much clearer about whose interests my research is serving than I was prior to my politicization.

Perhaps more obviously, my feminist turn also led me to an interest in how sex and gender considerations are addressed in laboratory research. Over the past several decades in particular, a male-centric bias in medical knowledge has been recognized, and there have been repeated calls for an inclusive approach to health research that ensures appropriate representation of sex and gender in research studies (Sharman & Johnson, 2012). Progress has certainly been made on this front in some areas such as epidemiology and clinical trials, but not in the kind of basic biomedical research I have engaged in (primarily using cultured cells and experimental animals). As a feminist, this disparity is something I have sought to address in my own work, but I have yet to find practical and feasible ways to do this without fundamentally changing the focus of my

work. Most of the advice promulgated to basic scientists by ‘experts’ in sex and gender is overly simplistic: they will argue ‘why don’t you just use male and female cells?’ without any sense of how difficult, expensive, and in some cases, actually impossible, that would be. This has become a major scholarly interest of mine in recent years (Ritz et al., 2014a), and the graduate students I have been supervising in the past few years have been changing their experimental designs to account for sex and gender concerns, and including analyses of sex and gender as part of their theses and manuscripts. Thus, my feminist identity and my active involvement in these issues have shaped my research directions and had a material impact on the research itself.

2.3 Education, Class, & Privilege

After high school, I applied to McMaster University, where I hoped to attend medical school after completing my undergraduate degree. No one in my family had ever attended university before, and there was a bit of a culture shock. For example, when I arrived to move into residence I discovered that although the university provided bedding, everyone else had actually brought their own fancy matching bedding sets from home; I had no such thing, and when my parents noticed that I was the only one on my floor who was using the residence bedding, they took me shopping to get sheets and comforters like the other girls had.

Although my socioeconomic background hadn’t fully prepared me for some of the social aspects of university life, I excelled academically. My aspiration had always been to become a physician, and I applied as soon as I was eligible. I was interviewed at every school I had applied to, and wait-listed at several, although I wasn’t ultimately accepted in that first round. A few weeks later I received a letter in the mail providing an analysis of my application, and it indicated that the biggest weakness was a relative lack of volunteer work compared to other applicants. This frustrated me, because although I had done a fair amount of volunteer work, I also had to work to earn money for school,

and it seemed to me to be an unfair advantage for applicants from wealthier families who didn't have to spend their summers working and could flesh out their dossiers with impressive experiences like international aid trips and unpaid work.

Although I was disappointed that I hadn't been admitted in that first attempt, the upside was that I could continue doing research in the lab; my experiences there had been very positive and affirming, and I abandoned my second round of medical school applications and embarked on a research career track instead. As it happens, although I have a great head for scientific research, my hands are somewhat lacking. I loved the intellectual parts of being a scientist, but I often couldn't be bothered with the meticulous precision required for many laboratory procedures, and I hated all the tedious troubleshooting when things (inevitably) didn't work. In contrast, I loved the teaching aspects of being a graduate student: I was a dedicated and engaged TA, and I voluntarily undertook elective course work in education. I also taught in the innovative Bachelor of Health Sciences Program, and being part of the team of committed educators who ran the inquiry-based curriculum was exciting and rewarding.

After my PhD I did the requisite post-doctoral fellowship, but it did not suit me -- it was just laboratory bench work, all the time, and there was no teaching. I started applying for faculty jobs with less than a year's post-doc under my belt, and to my surprise and relief, I was hired at the new Northern Ontario School of Medicine. I enjoyed writing grant proposals – beautiful ideas and concepts as yet unsullied by experiments-gone-wrong or colossal standard deviations! -- but actually running a research lab quickly came to be a source of frustration and anxiety. This was offset to some degree by my enjoyment of the education part of my job: I had myriad opportunities to contribute to the building and shaping of the curriculum, assumed leadership roles in student assessment, developed curriculum and policy, and took great pride in delivering engaging lectures and offering thoughtful feedback to students in my small groups. I could see my career arc clearly bending toward education more than laboratory research.

Though it had many gratifying moments, working with medical students was also troubling sometimes. Medical students disproportionately come from economically privileged backgrounds (Dhalla et al., 2002), which becomes obvious when you see their application packages often overflowing with volunteer summers overseas and copious extra-curricular activities; this was particularly irritating for me, having been criticized for the relative dearth of such activities in my own medical school applications. The significance of this became starkly apparent to me on one occasion when I was evaluating student presentations about their experiences during community placements³: in a number of cases, their presentations made clear that their experiences were largely understood through the lens of their own privilege and values, which they had projected on to a culture and community they were not a part of. After that realization, I became more attuned to the ways in which their social position and identity informed the ways that the medical students spoke about things, and I began to wonder what the consequences of this might be for their clinical practice, and how I might intervene in that somehow through research.

My lack of affinity for conducting laboratory-based science goes a long way towards explaining my research trajectory since leaving graduate school. Most science PhDs undertake at least 3-5 years of postdoctoral training before taking up a faculty position; when I accepted my faculty position after only 1 year of post-doc, it was a risk because I had not accumulated many publications, and I was aware that this could hurt my ability to secure grants in the future (which indeed proved to be the case). My underwhelming enthusiasm for running a laboratory continues to be evident in my rather spotty scientific publication record since establishing my own lab.

Spending a number of years doing what felt like mediocre laboratory research was fuelling my 'impostor syndrome' (see Ryan & Sackrey, 1996). With every career milestone or raise, I felt that I had accomplished it by somehow fooling people into

³ This is the same incident I alluded to in the introduction.

thinking that my research record was better than it was; as the years unfolded and my laboratory research failed to gather any real momentum, my anxiety about being 'exposed' as an 'imposter' mounted. The turn I am making to education research is not an especially principled one; rather, it reflects not only my personal interests but also my sense of greater competence and success in the educational aspects of my career. From the very beginning, teaching and education have been areas in which I have felt capable, confident, affirmed, and valued. In addition, being on the faculty of the first new medical school in Canada in over 30 years means that there are a lot of opportunities for doing education research, so this change in direction is capitalizing on the current situation in my workplace for my own ends as well as the School's.

This explanation helps to shed light on my decision to shift my efforts away from laboratory research in general, but my choice of a specific focus for my intended research is heavily informed by my social position and class. My mother's family were Old Order Mennonites and farmers, and my father's family were small-town business owners. Although this background may not be what is typically considered to be the 'working class', my parents earned modest incomes for my entire childhood and early adulthood, did not have post-secondary educations, and sometimes struggled to make ends meet. My decision to become a university professor was a pivotal moment of upward mobility; like hooks, "I had planted my feet on the path leading in the direction of class privilege" (hooks, 2000, p. 37). As Ryan & Sackrey (1995) point out, coming from a more modest background to "take on the full trappings of a college professor's life, causes the conflicts inherent in the hierarchy of the class system to be internalized within the individual, upwardly mobile person" (p.4). My experience of 'imposter syndrome' over the years might be understood in part as "the denial of a legitimate claim to a professional role [as] a mechanism to sustain both identity and a sense of affiliation with class of origin. It is a flawed strategy of accommodation aimed at resolution of internalized class conflict..." (Ryan & Sackrey, 1995, p.121). Indeed, I find that this analysis resonates with my experience.

This internal tension has also served me well, in that it has kept me sensitized to the ways in which unexamined privilege is expressed by many of the medical students I am teaching. Although these students are usually well-intentioned, my observations are consistent with those of Beagan (2003), who found that most medical students are apparently unaware of their own privilege, and find it difficult to recognize the effects of race, class, gender, sexual orientation, or other markers of social location. Having been unsuccessful in securing a seat in medical school myself because of a relative lack of volunteer experience, it touches a nerve when I hear a medical student (whose parents I know to be professionals) fail to acknowledge their class privilege as having played a role in their success, and instead to “see their good fortune as a sign they are chosen, special, deserving” (hooks, 2000, p.2-3). The work I am proposing to do around social position and critical literacy is directly informed by these kinds of experiences; like Iannacci (2009), “I came to the work from a personal place spurred by professional experiences rather than any attempt to address research gaps” (p.330). In fact, moving in this direction may be a subconscious effort to resolving the internalized class conflict as a result of my upward mobility: instead of “joining the oppressors, assimilating oneself into roles, behaviours, values, and viewpoints that sustain the system of oppression” (Ryan & Sackrey, 1995, p.121), my new research direction might be understood as an expression of allegiance and solidarity with working people, and by extension, with other marginalized groups (hooks, 2000).

2.4 Reflexivity & Praxis

In the research I plan to undertake, I do not feel that it is good enough to simply scrutinize the ways in which social position, identity, and privilege are manifested by medical students through their discourse; I aim to go “beyond the documentation of existing evils to effect real change in the world outside the texts...” (Barone, 2009, p. 593) to a larger form of ‘praxis’. Although the work in this thesis itself is purely analytical, I see it as the initial step in a larger research program, with the explicit

intention that my future work will intervene to raise students' consciousness of how medical discourses represent the lives of poor and marginalized people (Fairclough, 2005), and to examine the ways in which their own personal histories, biases, and values may affect their relationships to their patients (Novack et al., 1999); in fact, I have secured a research grant to continue this line of work into the interventional realm, and as of this writing (November 2014) the study has just launched. In working for change – whether it is me doing this research project, or physicians who aim to improve the lives of patients -- it is important that we “know where we stand” (hooks, 2000, p.8).

Knowing where we stand, however, is not a safeguard against bias or the danger of perpetuating oppression. I agree with Iannacci (2007) that:

I do not believe that I or any other researcher for that matter can bracket or suspend beliefs and biases once they have been acknowledged...acknowledging these beliefs and biases did not ensure that they were not reinscribed in my inquiry...it is important to continually locate, name, examine and reflect upon biases and beliefs throughout the research to remind the reader that the researcher is very much present within the narratives they are constructing and theory choices they are making (emphasis in original, p.68).

Thus, undertaking this analysis of how my own autobiography has shaped my research interests is an important first step in that direction, but a similar reflexive process must be engaged and disclosed in moving forward with this research project in a “process of continual self-conscious critique” (Viruru & Canella as quoted in Iannacci, 2007, p.57). In section 5.5 of this thesis, I revisit these questions from the perspective of the end of the project.

Chapter 3 : Methodology

This chapter describes the methodology used in the research of this thesis. To begin, I outline a general description of critical discourse analysis and the particular scholars, theories, and approaches which have been most influential in my work. Next I describe the sources of the data used for this research, the subjects who participated, and ethical issues in this work. Finally, I discuss the specific analytical approach I brought to this work.

3.1 Critical Discourse Analysis

CDA is a cluster of methodologies which resist absolute definition, but which might be best understood as “a problem-oriented interdisciplinary research movements....[with] a shared interest in the semiotic dimensions of power, injustice, abuse, and political-economic or cultural change in society” (Fairclough, Mulderrig, & Wodak, 2011, p. 357). One of the crucial aspects of CDA that distinguish it from other similar approaches is its emphasis on discourse as a *dialectic social practice*; that is, as an act that both takes place in a particular social, cultural, political, and economic context, and simultaneously contributes to and shapes the nature of that context. CDA also emphasizes a recognition of the way that discursive practices are ideological, and “help produce and reproduce unequal power relations” (Fairclough et al., 2011, p. 358); CDA focusses on the implications of social practices for status, distribution or attribution of social goods, power, and whose interests are served or subjugated by a particular discourse (Gee, 2011).

Discourse analysis more generally recognizes that in every instance, language expresses information, action, and identity simultaneously – that saying, doing, and being coexist in every instance (De Fina, 2011; Gee, 2011); further, it recognizes that language does

not derive its meaning only or simply from the definitions of the words being used, but rather derives its meaning from what it is used to *do* (Gee, 2011). These language practices serve to make certain things significant, enact relationships between the text producer and its audience, privilege some things over others, and imbue some things with value over others (Gee, 2011).

What makes CDA different from non-critical approaches to discourse analysis is that CDA does not only describe the discourse practices, but it also attempts to problematize and expose oppressive discourses by “showing how discourse is shaped by relations of power and ideologies, and the constructive effects discourse has upon social identities, social relations and systems of knowledge and belief” (Fairclough, 1993, p. 12). In this way, Fairclough considers CDA to be not only an approach to analysis, but also an intervention, in that it disrupts the oppressive exercise of power by exposing it, as oppressive power relations become intolerable when exposed, and so subject to the possibility for change (Fairclough, 1993).

The objective in a post-structuralist CDA is not to claim ‘objectivity’ or to evaluate or make truth claims *per se*, but rather to examine how objects become formed and understood through certain discourses, and in this sense one might understand this as a ‘Foucauldian’ CDA (Graham, 2005). In CDA, the analyst aims to “tread a fine line between respecting [individuals’] sense-making efforts and providing a critical analysis of the underlying assumptions upon which sense making is based” (Mumby & Mease, 2011, p. 297).

In discourse analysis, we essentially ask “[w]hy has X chosen (or why is X obliged) to use such-and-such a pronunciation/intonation/wording/phrasing/text-type rather some other possible one?” (Chilton & Schaffner, 2011, p. 314). Such choices and obligations reflect elements of the text producer’s perspective, social position, identity and worldview, but also have a hegemonic function, in that the effect of discourse “is to establish itself as a form of common sense, to naturalize its own functions through its appearance in everyday texts” (Luke, 1996, p. 20). The function of CDA (and other

forms of critical language studies) is to reverse that process and attempt to 'denaturalize' language practices and expose these commitments, which are normally invisible (Luke, 1996).

3.2 Research Ethics, Subjects, and Data Sources

Research Ethics

The research herein was approved by the Faculty of Education Sub-Research Ethics Board at the University of Western Ontario, the Research Ethics Board at Lakehead University, and the Research Ethics Board at Laurentian University, and conforms to the requirements of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* which governs human research in Canada.

Research Subjects

The individuals invited to participate in this research were alumni of the Northern Ontario School of Medicine MD Program, ranging from members of the Charter Class who graduated in 2009 through to those who graduated in 2013. Invitations to participate were extended to all NOSM alumni who were currently residents in a NOSM post-graduate program; this particular subject pool was selected to address some ethical issues related to this project and my position at NOSM.

Firstly, at the time that I submitted my ethics proposals and was intending to recruit the subjects, I was the Chair of the Student Assessment & Promotion Committee at NOSM, and as such, I was in a position of influence over students who were currently in the MD program; in order to mitigate this, I opted to target my recruitment to alumni of the program who were no longer within that sphere of influence.

This decision to recruit from among NOSM alumni created the new dilemma that I would have to obtain contact information for these individuals, which was not always readily available, and privacy issues prevented others from providing this contact information to me. Thus, since a substantial proportion of medical residents in the NOSM post-graduate residency programs are MD graduates of NOSM, it was possible to extend invitations to potential participants through the residency program coordinators at NOSM, without them having to provide the email addresses to me. I provided the text of an email and letter of information and consent to the program coordinators, who in turn forwarded that email on to all of the residents in their programs who were NOSM alumni.

Ultimately, 8 individuals gave their informed consent to participate in the research. Of these, 3 were from the 2010 graduating class, 1 was from the 2011 graduating class, and 4 were from the 2013 graduating class. There were 5 women and 3 men, which is a reasonable reflection of the gender division in the NOSM student body. No data were gathered with respect to other subject characteristics, in accordance with the requirements of the ethics boards.

Data Sources

After consent was obtained from all 8 subjects, administrative staff in the Assessment Office at NOSM accessed the assessment archives and located the written assignments that subjects had submitted as part of their 4th year Northern and Rural Health curriculum requirements. Staff members removed personal identifying information such as names and student numbers from the documents before providing them to me. Once I obtained them, I removed any additional information within the texts themselves that may identify individuals or communities; where any individuals (such as preceptors), communities, or hospitals were named in the text, I replaced such

information with a string of repeated capital letters (eg. “TTTTTT”); the letter chosen was selected randomly and did not related to the word replaced in any way.

The assignments used in the 4th Year Northern and Rural Health curriculum over the period of study varied considerably in form and content. For the early years included in the study, students were asked to provide relatively short (ie. one or a few paragraphs) responses to very targeted questions about issues in Northern and rural health; in a few instances, the questions that prompted the writing were not available. In the later years, students were given a topic and asked to submit an essay approximately 1500 words in length. Some of these prompts are quite lengthy, and so the full texts of the questions posed to the students (where available) are contained in Appendix 1; to summarize briefly, the questions posed addressed the following topics:

- Distinguishing ‘cultural safety’ from ‘cultural awareness’, ‘sensitivity’, or ‘competence’;
- Access to health care in northern, remote, rural, and Aboriginal communities;
- Aboriginal health, including cultural values of health, and health inequities;
- Relationships between Aboriginal peoples, physicians, and the health care system;
- Women and Aboriginal health;
- Unique aspects of medical practice in rural communities;
- Women in the health care workforce in the North;
- Interprofessional collaboration;
- Medical education and social accountability;
- Impact of the Drummond Report⁴ on northern health.

⁴ The 2012 report from the *Commission on the Reform of Ontario’s Public Services*, formally entitled Public Services for Ontarians: A Path to Sustainability and Excellence, has been dubbed “The Drummond Report” in popular and media parlance after the Chair of the Commission, economist Don Drummond. The report made numerous recommendations about how to constrain spending on health care in the province.

The responses to each question were isolated and analyzed as individual pieces of text. In total, 35 distinct pieces of text were derived from the materials produced by the 8 subjects in their final year of medical school. These 35 pieces were treated as distinct texts in the analysis, as the texts created by the same individual are not linked in the analysis.

3.3 Analytical Approach

In contrast with a formal linguistic type of discourse analysis, this work employs an empirical and critical approach to discourse analysis, and as such I did not make use of a highly structured coding method. Instead, this form of discourse analysis is broadly thematic, and examines the function of language-in-action with particular attention to the ways power is expressed and transacted, and what can be understood as 'legitimate' or 'true' through that discourse (Hodges, Kuper, & Reeves, 2008). My analysis is informed by Foucault in the sense that I have brought Foucauldian notions of power to bear on this analysis. For example, following Hodges et al (2014) I recognize the interdependence of power and knowledge, and conceptualizes it as inevitably present in all relations and is constantly negotiated and transacted, which may have negative or positive effects.

A first reading of the texts was undertaken to review all of the samples and identify broad themes to inform the development of a more structured coding framework. This initial review yielded the general themes as detailed in Table 1. After this first round, the structured coding framework was developed based on the topics above. Texts were imported into NVivo 10, the coding framework was constructed as 'nodes' for coding, and I manually analyzed and coded each text in-depth. During the coding process, I kept "field notes" to capture my thoughts, insights, and comments as to what might be fruitful areas for discussion and evaluation. Once the texts were coded, I developed my

analyses of the themes that were most prevalent and relevant for informing the curricular intervention I intend to develop as part of the larger project.

relationship to authority	deference vs. critique; consciousness of status, hierarchy; orientation to received knowledge
modernist views of progress	tradition vs. innovation, status quo vs. change, future vs. past orientation; expansion of medical knowledge; complexity and 'new' challenges
epistemological values	positivism/empiricism vs. constructivism; privileging clinical knowledge/expertise over other forms; experience, exposure, awareness;
race and ethnicity	determinist vs. constructed; terminology used for Aboriginal peoples; relationship to 'others'; colonization
gender	determinist vs. constructed; family roles; personal characteristics; the 'problem' of female MDs; as determinant of health
rurality	as 'challenge' vs. 'benefits'
identity	as related to: <ul style="list-style-type: none"> • profession (medical student, physician, specialty) • geography (Northern Ontario, rural, Canadian) • institution (NOSM, physician communities) • ethnicity, race, culture (implicit or explicit) • gender
professional relationships	as colleagues, collaboration, partnership, teamwork, interprofessionalism, with patients
agency	who is an agent?
individual vs. collective orientation	private vs. public goods; 'lifestyle' vs. social determinants of health; public vs. private medicine
helping vs. social justice orientation	helping, advocacy, structural change, charity, altruism, equity
community	as geography, shared purpose, common values or concerns

Chapter 4 : Findings and Analysis

“What counts in the things said by men [and women] is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systematizes them from the outset, thus making them thereafter endlessly accessible to new discourses and open to the task of transforming them.”

(Foucault, 1974, p. xix)

The 35 texts analyzed for this research are rich data sources with myriad possibilities for analysis. For the purposes of this thesis, I have chosen to focus on a subset of the possible themes for substantive analysis, setting aside the others for future work.

In analyzing these pieces of text, my intention was to examine the ways in which the learners' writing expressed “connivance with, and even uncritical acceptance of, wider social narratives or ‘norms’” (Bolton, 2006, p. 207). In other words, the emphasis in my analysis was not on the literal meaning of the texts, but rather an examination of those aspects of their discourse that indicate their personal investments with respect to their self-understanding (particularly in their role as medical professionals), and their ideological investments. As highlighted in 3.1, I want to reiterate that the objective of CDA is not to make truth claims about what the texts are ‘really saying’, but rather to examine the ways that the discourses employed foreground certain perspectives and identities, and consider what interests might be served by these discursive choices.

The Chapter starts by considering the conditions under which the texts were produced as crucial influences on the discourses employed by the learners. The remainder of the Chapter is divided into sections each exploring a different theme: professional medical identities; discourses of ‘community’; the ‘challenge’ of rurality; indigeneity, ethnicity, and culture; ideologies of gender; and the social determinants of health.

4.1 Conditions of Discourse Practice

In CDA it is important to consider not only the text itself, but also the processes of text production and interpretation, and the social context of the discursive event, thus recognizing that language is not simply an individual activity, but rather a form of social practice (Fairclough, 1993). Writing of any kind does not take place in a social vacuum, and the texts examined here were produced in a very specific context, with particular expectations, and this will have concrete effects on what is written; as Richardson (1994) points out, “how we are expected to write affects what we can write about” (p. 520). Thus, prior to delving into my analysis of content of the texts themselves, it is important that I take some time to consider the contexts in which these texts were produced, and the implications these contexts may have for the texts that were produced.

The written texts I analyzed were produced in response to specific prompts (see Appendix 1) related to the intended learning outcomes for students in northern and rural health, for the purposes of student assessment. This will obviously have major implications not only for the content of the texts, but also their form and structure. The faculty members on the Northern & Rural Health Curriculum Committee determine the topic based on the learning objectives, set the specific agenda for each question to be answered, and demand specific types of structures (eg. “give 2 examples from your own experience”, or “in an essay of no more than 1500 words...”), thus constraining the students in their expression. Many of the questions posed to the students demanded a highly structured answer addressing specific points – in fact, one of the questions posed was so highly detailed in its specifications for the desired answer that the length of the question itself (318 words) was longer than the maximum length the students were allowed to write (250-300 words). The conventions of academic writing insist that they address the topic or question set for them, with restricted scope for discretionary digression on the part of the student.

The fact that these texts were produced for the purpose of evaluation will undoubtedly have a significant impact on what is produced by the students. It is the faculty on the curriculum committee who evaluate the texts produced, passing judgment and accepting or rejecting the responses. The ability to not only make demands of the text producers but also to evaluate them creates a set of power dynamics in this exchange that constrain the students in their ability to express particular views, emphasize or deemphasize certain elements, or frame the issue according to their own perspectives. They are required to be 'polite', conforming to the conventions of academic writing (which will be somewhat formal), and to largely refrain from challenging the question itself. What is being said or not said will arguably be only a partial – and maybe even a minimal – an expression of their own views, but will be heavily shaped by what they perceive the medical school wants and expects to hear from them; they will produce what they think a medical student, and in this case, specifically a *NOSM* student, *ought* to say. After 3-4 years of exposure to these topics, the curriculum makes clear to the students what they are expected to have gained from it. In producing texts in response to these prompts, it is reasonable to question to what extent the values expressed by the students are truly held by them, and the extent to which they are derived from or imposed by the values of the School as communicated through the formal and informal curriculum. In other words, in each case, we must be conscious that the students may be writing what they genuinely have learned or believe, but it is also possible that they have developed insight as to what perspectives are acceptable to express and are writing to conform with the expectations of the School.

In any use of language, the producer must anticipate a particular kind of 'interpretive subject', and structure their utterance to the background, resources, and experiences that the interpreter is presumed to have. Clearly, in a situation of this nature, the audience for the text is presumed to be a faculty member with some variety of expertise in northern and rural health. This will also shape what they say and how, since they can rely on certain kinds of presumed knowledge, common ground, and mutually-available assumptions, and anticipate certain kinds of expectations. One somewhat unusual

aspect of the conditions under which these texts were produced is that, unlike in most university contexts where the students would know the professor whom they were writing for, the faculty writing the questions and doing the marking were often not known to the students – that is to say that not only had most of them never met (either in a classroom or otherwise), but also that the students literally did not know the identity of the person they were writing for or who would be marking them. The questions were provided to them ‘by the committee’, and the evaluator would be one or more unspecified faculty members of that committee. Thus in crafting their responses to the prompts, the students would not necessarily know precisely who their audience was – it could be a medical anthropologist with expertise in Aboriginal health, a family physician who had practiced in a remote and isolated town in Northern Ontario for 20 years, a retired physiotherapist in Sudbury, or a PhD in medical education. Such uncertainty about the audience who will be evaluating the work affects what the students can presume about the audience in terms of their shared referents, values, and perspectives. In the context of writing produced for evaluation, this uncertainty is likely to elicit a sort of conceptual conservatism from the students. Not knowing exactly who the audience is, and simultaneously knowing that that person is in a position to judge them, students may be more likely to write something ‘safe’ that they believe will be palatable and acceptable across a broad range of possible evaluators.

Although these essays are assigned with the professed purpose of stimulating reflection in the students (in the earlier iterations, they were titled “reflective essays” by the curriculum committee), it seems likely that the scope for students to be entirely honest in their reflections is highly constrained, and that the production of these essays represents a sort of “paradoxical discipline, as a technology of the self in which...there are certain things that may be said and those that may not be said. Growth becomes subjection” (Bleakley, 2000, p. 14). Given the power relations between students and faculty, and the evaluative nature of the exchange between them, there will be greater pressures for the students to reproduce the content and values conveyed to them in the curriculum rather than to transform or challenge them. This places rather restrictive

limits on the kinds of reflective interrogations that it will be 'permissible' for the students to express.

Given all of these factors impinging on the students as text producers in this case, I believe it is exceedingly important to be very conscious that the positions expressed (explicitly or implicitly) in these texts reflects the conditions of discourse practice at least as much (or perhaps even more than) the actual perspectives of the students themselves. In fact, one of the participants explicitly made reference to this in their email response when they provided their consent to participate:

Although I do not recall the exact content of some of the essays I wrote...I do remember that the 'opinions' I expressed in these essays for marks were not always my 'true opinion'. I imagine the same can be said for others. (personal communication)

Thus, certain kinds of constructions and representations may be the product of the conditions of the discourse practice and not necessarily reflect the ideological commitments of the writers, since the conditions of these discourse practices will have a heavy hand in determining *what* can be said and *how* under these circumstances. Although the discourse practice may appear at first glance to be unidirectional (the student producing text for the audience), in fact the exchange is much more complex, where the students are producing text in response to the prompts set for them, simultaneously anticipating certain kinds of responses from the evaluators, all while situated within the larger context of the curriculum, the School, and the larger social milieu of medicine. Thus the texts can be read as implicitly in dialogue with a multitude of dimensions, in spite of the fact that only the student's voice is literally present.

4.2 Professional Medical Identities in Transition

As discussed in section 1.6, one's identity is established through discursive acts; discourse constantly constitutes, enacts, and negotiates identity, and in doing so it distinguishes 'self' from 'other' and classifies and judges others relative to the self, and

signals alignment, similarity, and difference, as performed and recreated through interaction with others (De Fina, 2011). Like many forms of professional education, medical education is not only a process of inculcating clinical skills and knowledge, but “is fundamentally a process of identity construction (and reconstruction)” (Bleakley et al., 2011, p. 63). Those who take on the identity of ‘physician’ are not at liberty to define and enact it as they see fit; the position is only available to those willing to conduct themselves in a way that is largely consistent with societal norms about it, and it may be withdrawn or contested (Anton & Peterson, 2003) – through official channels (like the College of Physicians and Surgeons of Ontario), professional socialization and peer influences, and the processes of medical education.

One of the crucial tenets of critical discourse analysis is a recognition that discourse is dialectical, both shaping and shaped by social practices. Any organization is defined to a large extent through their members’ discursive practices (Mumby & Mease, 2011), and so the discourses of medical students are not only shaped by the discourses of the medical profession, but simultaneously serve to shape it. For medical students, the adoption of a professional medical identity “is constituted through a configuration of enunciative modalities and subject positions which is held in place by the current rules of medical discourse” (Fairclough, 1993, p. 44). From a constructivist standpoint, the identities articulated through the students’ discourses are as much about identities being *constructed through* their texts as they are about the texts *revealing* their identities (Bleakley, 2000). In this case, I must be careful to interpret these writings not simply as *revealing* students’ identities, but recognizing that these are also, concomitantly, *constructing* their identities, or the identities they perceive as being ‘acceptable’ to the audience of evaluators. To some extent, the norms of the context (ie. essay writing for a professional school) will heavily influence the stylization of the texts....the students know that they are expected to have a particular identity (ie. medical student) for these essays. In situations like these, it is likely that the social identities projected by the medical students are in part a response to the stereotypes of roles, characteristics, and ideologies that are associated with and considered to be

appropriate for the medical profession and for conventions of academic writing. Nonetheless, it is of interest to examine the ways in which this is taken up by students, and what they perceive to be the 'appropriate' representation of a medical student identity. In this section I am focusing exclusively on the theme of the transitional professional identity expressed by students in these writings; other aspects relating to identity will be raised in the subsequent thematic sections (for example, discourse related to gender identity will be discussed in section 4.6).

As Bleakley and colleagues (2011) point out, the development of a medical identity takes place in the context of a community of practice, with initiates coming to develop an increasing sense of belonging to the target community. In these texts, the participants' identities as medical professionals appear to be largely in transition; by-and-large the participants have not yet fully claimed the identity of 'physician' for themselves, and often explicitly identify themselves as a medical student or a *future* physician.

The predominant way that the learners explicitly characterized their professional medical identity in these texts was as a medical student. When introducing an example, they frequently framed the anecdote as 'based on my experience as a medical student...' or 'clerk', or to say 'while on placement...'. They also signaled their student identity in other less direct ways. In several instances, the students made reference to other medical students as 'my peers' or 'my colleagues', clearly aligning themselves with other students. Speaking from the subject position of 'student' appeared to correspond with several other characteristics as well. For example, from the 'student' position, the learners frequently characterized their learning in relatively passive terms, described as 'observing', 'seeing', or otherwise painting themselves as relatively inert observers. Certain constellations of relationship to physicians and patients were also apparent when participants spoke from the 'student' role. The ways that physicians were described were characteristic when speaking from the subject position of 'student'; participants tended to view them as authority figures, and frequently alluded to the

educational role of the physician, describing them often as a ‘preceptor’ or ‘mentor’. The representation of the relationship to patients was also notable when positioning themselves as students; most often, students related themselves to patients through their preceptor (eg. “when we were through with his patients...”); in one instance, a student referred to a patient as “my’ patient”, the quotation marks around ‘my’ suggesting that this student felt that forthrightly claiming the patient as their own needed to be qualified in some way. In contrast, when identifying as a “future physician”, participants were much more likely to use the first person, and to refer to patients unqualifiedly as “my patients”. This suggests that they may not yet feel legitimate in claiming the physician identity for themselves in the present, but that it is acceptable to do so in an aspirational, future-oriented framing.

Even where explicit claims about identity are not made, it is possible to tease out aspects of alignment and identity through the use of prepositions such as ‘we’, ‘you’, and ‘they’. Where the word ‘we’ is used, it strongly signals an alignment with the author’s own identity and affiliation. In these texts, ‘we’ was most often used in the context of affiliation with the medical profession in some form -- as medical student, future physician, physician, or rural physician, consistent with the more direct signifiers examined above. Notably, ‘we’ was also used numerous times in order to draw a contrast between the writer and Aboriginal peoples; for example, one student wrote “When dealing with some patients, especially native patients, we need to remember to slow down...”; another noted “We are often taught how aboriginal [sic] people see health as a mind body soul community connection...”.

When a more general physician identity was invoked (as opposed to a *future* physician), the students tended to ‘hedge’ their identification with this role by placing the physician in the 2nd or 3rd person – for example, in describing the advantages of rural practice, one participant writes:

...you are able to perform a greater amount of skills and procedures as you are often one of the few physician [sic] who is present to do them...You get to know your patients better as you

may see them more often in the community. In terms of hospital functioning, you may have greater input in how things are run if you are one of a few physicians in a community.

This use of the word 'you' also signals something about identity. Depending on how it is used, it may signal that the text producer expects the audience for the text to differ from themselves, or alternatively, may be used similarly to 'one' as a way of signaling a generic subject. In many instances in the texts under analysis, the subjects talk about things like 'as a physician, you have to...', which suggests the second reading. In cases like these, where the generic 'you' is referencing the physician role, the use of 'you' may be a marker for the student being not yet ready to unqualifiedly adopt the identity of physician and say 'we', but yet not so distant from the identity that they use 'they'.

In other cases, however, 'they' is used even in instances where the author clearly identifies themselves as part of the group they are 'they'-ing. For example, in one text, the writer starts by identifying herself as "a Canadian woman who has lived a majority of my life in rural Northern Ontario," but shortly thereafter, she references literature indicating that "not only do rural women experience the effects of geographic isolation and limited access to health services, but also *they* must contend with certain sociocultural realities...that may influence *their* health and *their* decision to seek out health care" (emphases mine). Having identified herself clearly as a member of this group, I am compelled to consider the significance of the writer's choice to refer to rural women as 'they' in most of the remainder of the text. One possibility is that the conventions of most academic writing discourages people from writing in the first person, but this seems unlikely to be a major contributor in this specific text (or any of the others in the data set), as personal reflection and examples of first-hand experience are encouraged or even demanded in some of the questions; there are many examples of the use of the first person throughout the data set. In this instance, it may be that the use of 'they' to refer to rural women is another marker of the writer's burgeoning physician identity. By referring to rural women as 'they', it implies that the writer is downplaying alignment with that group (in contrast with the opening in which she

explicitly identifies as a rural woman), perhaps to reinforce the burgeoning physician identity. This interpretation is borne out by a later passage from the same text:

As a...future female physician who aspires to practice in rural Northern Ontario, I am aware of the factors that affect the health of my female patients; in fact, my own health over the years as a rural woman has been affected by many of the above-mentioned sociocultural realities of rural living. Now, by transitioning into the role of a rural female physician, I am faced with a new set of challenges unique to rural practice that I will encounter throughout my career.

Here, not only does the student claim the identity of “future physician” (and from that position is also able to refer to “my” patients), she simultaneously locates her identification with the general category of rural women in the past (“*has been affected*”) in transition to a new identity as a specific kind of rural woman – a rural female physician.

There are some exceptions to these tendencies among the texts, and notably these were prominent in the texts of medical students who identified strongly with a previous professional role, particularly a health care role. Where the students identify with a previous profession, they seem to cast themselves more as colleagues of their preceptors than as students, as evidenced by the use of phrases like ‘working with’.

As with many other professions, medicine is viewed not simply as something that one *does*, but it is also who one *is*, by practitioners and laypeople alike; it is both “a vocation and a form of identity construction” (Bleakley et al., 2011, p. 16). The developmental nature of a professional medical identity is clearly in evidence in these texts, where senior medical students in this study are clearly transitioning from a principal identity as ‘medical student’ and ‘future physician’, but not yet fully claiming an unqualified physician identity.

4.3 Ideologies of Community

Many of the texts under consideration made use of the term ‘community’ at some point (appearing 266 times in 23 of the 35 texts), and in many cases the idea of ‘community’ was quite prominent. This is not surprising, given that the curriculum being evaluated through these essays was on northern and rural health, and many of the questions and topics provided to the students explicitly directed them to discuss ‘community’ in one way or another (see Appendix 1). In discourse analysis, this kind of ‘overwording’ often signals the need for close consideration of the meanings of a word in a text, comparing and contrasting the use of the term in the text under examination with other uses, and to consider whether the meanings of these terms are variable or changing, or have a general or local significance. In *critical* discourse analysis specifically, it is important to query whose interests are served and whose are subjugated by the particular ways that the term ‘community’ is used.

In these texts, ‘community’ is almost exclusively used with reference to geographic settlements – principally small settlements – with a handful of notable exceptions (to be discussed below). This nearly uniform use of the geographic sense of ‘community’ is noteworthy because it largely neglects other concepts of community that are relevant for medicine (for example related to common interests, common practices, or common values), and thereby lends the geographic sense of community a certain primacy while marginalizing other senses of community. In addition, ‘community’ is often used with reference to small and/or rural communities. Although this is sometimes explicit, in other cases it is implicit. For example, one text states “if the community has no other practicing physician...”, which implies that the community is too small to have more than one physician; similarly, another student writes “In additional [sic] to isolation from other health care providers is the possibility of lack of resources within the community”. In contrast, among these data it was rare to see the word ‘community’ used with reference to a city; where referring to larger settlements, the predominant tendency was to use ‘urban centres’, ‘larger centres’, or ‘urban areas’, which implies that urban areas may not be perceived to be ‘communities’ at all. Thus it seems to me that by largely

using 'community' with respect to smaller towns and refraining from using it in reference to cities, the implication is that the concept of 'community' held by the students entails more than just a geographical basis alone, but also a certain social cohesion and personal knowledge amongst those living in the community that they associate with smaller settlements; in other words, 'community' as used in these texts may be understood as a *settlement* in which people *know each other*.

Understanding 'community' in this way potentially serves some interests while subjugating others, and so the relative absence of references to 'community' in senses other than the geographic may be notable. In communities of *interest*, individuals share something other than place, such as religion, sexual orientation, culture or ethnicity, occupation, or other forms of common identity or experience (Smith, 2001). It seems to me that such communities of interest may be especially important to individuals who fall outside societal norms, and this may be a clue as to why this sense of 'community' is relatively absent in the texts examined: for people whose identities and values are in strong alignment with those predominating in the geographic community, the 'place' and 'interest' communities may be experienced as coincident with one another, and no distinction is perceived between them. In contrast, individuals who feel a sense of tension between their identities and values and those predominating in their geographic communities will probably be very acutely aware that the geographic community they reside in does not reflect them (or is maybe even hostile to them), and identify more strongly with a community of interest than with their immediate local geographic community. Thus, I am led to consider the possibility that the heavy emphasis on 'community' as place within these texts may be a marker of the relative privilege of the writers, occupying social positions that are largely accepted and valued in mainstream society.

A major exception to the foregoing is with respect to the frequent reference to 'Aboriginal communities', which seems to reference both geographic and ethnocultural community. This concept tended to be used with reference to communities that are

both geographic *and* ethnocultural (ie. reserves), as opposed to describing an Aboriginal community existing as a community of interest that is separate from place. Where there are references to cultural communities, they tend to focus on Aboriginal and Francophone, and on the ‘challenges’ of working with cultural communities (which will be taken up in section 4.5)

Another prominent usage of the term ‘community’ was as a modifier, as in “community care” or “community-based health professionals”. In these instances, the term ‘community’ appears to be used in order to create a distinction between medical practices taking place inside or outside a clinic or hospital, emphasizing a sense of separation between the community and the institution of medicine; in other words, it appears that medicine (and the physician) is presumed *not* to be part of the community unless it is specified as such. This idea that the institution of medicine and the physician are somehow distinct from the community is substantiated in these texts in other ways as well. For example, in many of the discussions about rural physicians there is considerable emphasis on boundary setting, and about the need for the physician to actively maintain and sustain a sense of one’s separateness from others in the community (in the name of setting and maintaining appropriate professional boundaries). This can also be understood as relating to ideas of a professional medical identity, in which physicians see themselves as *in service to* a community, but remaining outside of it in some ways. In fact, the sole uses of the term ‘community’ in these texts that did not refer to a geographical or Aboriginal community were 2 references to the “medical community” – which again could be understood as physicians setting themselves apart from their more immediately local communities.

Of course, the students’ discussions on community do not arise in a vacuum, and I would argue that these are heavily influenced by the formal and informal curriculum of ‘community’ at NOSM, and by the questions posed for them to respond to. For example, searching the NOSM curriculum database, the word ‘community’ or ‘communities’ is used 1046 times in 758 learning objectives (out of a total of 13 288

learning objectives), and patterns in the use of the word ‘community’ described in my analysis of the texts are also seen in the learning objectives – most usages are with reference to geographical communities (often qualified as “small”, “rural”, “northern”, or “Northern Ontario” communities) with some references to Aboriginal communities. In addition, other usages of the term ‘community’ at NOSM tend to reinforce the geographical sense (as in the “Comprehensive Community Clerkship” and the “Integrated Community Experience”, where students undertake placements in locations other than their home campus); these examples not only reference the geographic sense of community, but, as in the student writings, they also emphasize a certain separateness of the medical school from the community – the designation ‘community’ in each case indicates that the experience occurs somewhere other than the medical school itself. To be fair, this tendency to consider ‘community’ as something apart from the medical school or the clinic is not specific to NOSM; the expression “community-based care” in reference to medical care that is not provided at the hospital or clinic is prevalent in medical discourse generally.

The understandings of ‘community’ expressed in these texts may have implications for the ways that these medical students relate to and engage with their role as health advocates, and is very likely linked to the power and objectives of the medical school with respect to their social accountability mandate. At the same time, restricting our conceptions of ‘community’ to the geographical will shape and constrain the ways that we are able to think and act in relation to communities (as I will elaborate in section 5.2).

4.4 The ‘Challenge’ of Rurality

Given that the essays analyzed were produced for the Northern & Rural Health Curriculum Theme at NOSM, it is no surprise that the topic of rurality was frequently discussed. What became quickly apparent was the extent to which the discourse

around ‘rurality’ emphasized the ‘challenges’ of rural medicine; my coding reveals that rurality was discussed in a negative way more than three times as often as it was discussed in a positive way. This becomes particularly noteworthy when one considers that a major part of NOSM’s mission is to produce graduates with an inclination for rural practice, and that the formal curriculum objectives around rurality tend to be quite neutral in their framing.

Where rurality was framed in positive terms, the discussion tended to centre around either the benefits for patients or the benefits for physicians. For patients, students identified increased access and closer relationships with physicians as benefits, especially more continuity-of-care; some identified continuity-of-care as a benefit for physicians as well. This is a little bit ironic, since access to health care is widely acknowledged to be a major problem for rural communities in Northern Ontario, and in fact is one of the problems that NOSM was established to address. In this case, it seems likely that the students’ perception of better access to care in rural communities is skewed by their experience of having been placed in communities that – by definition – have physicians present; obviously they do not have placements in any of the many rural communities where there are no doctors. In the majority of cases, however, most of the positive sentiments about rurality were in regards to the benefits for the student or physician’s personal self-interest. Several students cited the greater scope of practice of many rural physicians, and the greater diversity of practice associated with this (for example, delivering babies, or practicing emergency medicine) as making medical practice more interesting and varied. In their first-hand experience as students, this had translated into more opportunities for their own learning that “my colleagues in clerkship at larger hospitals can only dream about”; training in a rural environment was a direct advantage for them because they were not crowded out by other trainees. Another element cited by the students as a benefit of rural practice is the relatively larger influence of an individual physician on health care delivery, described as “you may have greater input in how things are run if you are one of a few physicians in the community”, and “having a central role within a community”; in other words, they

seemed to value the idea of being a ‘big fish in a small pond’. Several students also mentioned proximity to their own family and friends as an asset, or the familiarity of a rural community as similar to their own upbringing.

That being said, the positive characterizations were vastly outnumbered by those that cast rurality as a ‘challenge’. The relative paucity of medical resources was a common refrain, as was professional isolation, heavy workload, ethical quandaries in a small community (such as maintaining confidentiality, providing care to close friends and family members, or maintaining professional boundaries with patients), difficulty in accessing continuing medical education opportunities, or barriers to taking vacation time. These aspects of rural practice are well-documented in the literature, and re-enumerating them here is not my primary interest in this analysis. Rather, I am more interested in evaluating the ways that these issues are framed by the students.

The idea that rurality poses ‘challenges’ was very dominant in these texts. Although other terms with negative connotations were used in describing the conditions of rural practice (such as ‘disadvantages’, ‘difficulties’, ‘problems’, ‘barriers’, ‘struggles’ or ‘burdens’), ‘challenges’ was by far the word students used most often. I suspect this is because the word ‘challenge’ has probably the most positive connotation of all of the words used to describe these situations, because it implies an aspirational quality – a challenge is typically understood as something to be overcome, or even an opportunity – as opposed to the other words which are much more uniformly negative. Indeed, the motivation to put a positive spin on things is evident in some of the discursive moves students made to describe the difficulties of rural practice. For example, one student said “I appreciate the positive influence a physician can have while working in a rural practice. There is a unique ability to respond to a lack of resources...”; similarly, some students referred to the “exciting challenges” or “rewarding challenges” of rural practice.

The predominance of the word ‘challenge’ in this context probably reflects a tendency to want to put a positive spin on things, recognizing that NOSM is a school which values

and promotes rural practice; thus these efforts may indicate a recognition that it would not do to disparage rural medicine too overtly, in response to an implicit demand that it be cast in a positive light. When I looked at the formal learning objectives touching on rurality (there were 251 of them), the majority of them were markedly neutral in their framing, with only a handful of them using terms with negative connotations. Overall, although the word ‘challenge’ does appear amongst the learning objectives on rural practice, many more of the objectives used the term ‘benefits’. Thus the preponderance of negative sentiments among the student essays stands in contrast to the preponderance of neutral or positive sentiments among the learning objectives. This may be due in part to the fact that the essay prompts themselves cue the students to these particular characterizations (see Appendix 1), but I suspect that this may also be the students’ attempt to resolve some of the tensions they experience between their lived experiences of health care in rural communities with the expectations of the school and the curriculum to champion rural medicine. Whereas the formal learning objectives ask students to “describe how issues of confidentiality impacts [sic] information they would communicate to family members, allied professionals and colleagues”, the anecdotes offered by the students often discuss this in terms of the *difficulties* of maintaining confidentiality in rural communities. Similarly, where the learning objectives are neutral in asking students to “describe how individuals in a small rural community are able to access diagnostic testing, rehabilitative services, and continuing care”, students often described the *lack* of local specialized health services and the *difficulties* in obtaining such services. That being said, even where the students enumerate the difficulties of rural practice in more negative terms, the denouement of their texts tended to use terms that left the account on a positive note.

Taken together, the predominantly negative sentiments expressed by the students about rurality, along with their tendency to frame them as ‘challenges’ or otherwise find a positive framing, and also to end on a positive note, suggests to me that the students are strongly motivated to express positive attitudes in their experiences of rural medicine. Given the school’s explicit mandate to promote rural medicine and the

emphasis on neutral or positive framing in the formal learning objectives, it seems to me that although they have experienced negative things in their rural experiences, students are responding to the school's discourse on rural medicine by making efforts to cast even their negative sentiments in a positive light. With the additional contextual factor that they are being evaluated (see section 4.1), it may be perceived (consciously or subconsciously) as too risky to overtly express negative sentiments about rural medicine.

4.5 Discourses of Indigeneity and 'Cultural Competence'

The Northern and Rural Health Curriculum at NOSM places considerable emphasis on Aboriginal cultures, histories, and health, and requires students to develop knowledge and skills in so-called 'cultural competence'. This is in keeping with a broader trend in medical education to address these issues in response to the increasing diversity of many populations, and a recognition that there are significant health disparities among such populations. Notably, a number of scholars have noted that in most cases of medical curricula on cultural competency, 'culture' is understood to refer principally to race and ethnicity, largely ignoring other aspects of culture (Kumaş-Tan, Beagan, Loppie, MacLeod, & Frank, 2007; Paul, Ewen, & Jones, 2014; Taylor, 2003), and NOSM is no exception. The terminology around this has become somewhat diversified, with terms such as 'cultural sensitivity', 'cultural awareness', 'cultural humility', and 'cultural safety' found in the literature alongside cultural competence. Scholars in this area have made arguments for the use of one of these terms over the others, but such distinctions are not of primary interest to me here; rather, it is of greater interest to me to explore the ways that medical students relate to discourses of cultural diversity in the context of their medical training, regardless of the specific terminology used. Given the emphasis in the NOSM curriculum on Aboriginal health, it is not surprising that this was the most dominant cultural issue raised: of the 35 texts analyzed, 10 were produced specifically in response to prompts and topics relating to Aboriginal health or culture, but issues of

culture and ethnicity more generally came up in 26 of the texts, and Aboriginal peoples were referred to in 27 of the texts.

Although approximately 10% of NOSM students self-identify as First Nations, there was no indication that any of the 8 participants in the study identify as Aboriginal themselves. I did not collect any information from the participants during the consent process about their self-identified race or ethnicity, but in the texts themselves, there is considerable evidence that none of them self-identify as Aboriginal. Most prominent among this evidence is the ways in which the terms “we”, “they”, “our”, “them”, “us”, and “their” were deployed by the students with respect to their discussions of Aboriginal peoples. For example, when a student writes “This is important because it allows the First Nations patient to see that we are receptive to the teachings in First Nations culture, and willing to incorporate it into our management plan”, the use of the terms “we” and “our” suggest strongly that they do not identify with the First Nations patient themselves, but rather identify with the professional role of the physician. Examining the texts carefully, I found no indications that any of the participants identified as Aboriginal. Participants’ use of ‘we’ in many discussions of Aboriginal peoples served to differentiate the participant, usually ‘we’ meaning non-Aboriginal, white, or physician/medical-student; “Aboriginal” was very often used in opposition to “Western”. Such alignments should not necessarily be read as a negative thing; marking one’s self as ‘not Aboriginal’ can be understood as an appropriate recognition of one’s lack of experience with the same referents, privilege, and indeed this sense was evident in a number of the student texts. However, in most instances it seemed to reflect an understanding of ethnicity and race in which “some people are ‘ethnically diverse’ and others are not...[where] whiteness is understood and presented as the norm...[and] excluded from the concept of cultural diversity” (Kumaş-Tan et al., 2007, p. 551), thus rendering the dominant culture invisible, and operating as though members of dominant groups are not also shaped by culture. This was expressed most directly by one student, who said “I need to know how to be able to accommodate my patient’s diversity.”

Referential strategies – that is, how people are named – are one of the ways that ideologies about race are made manifest in discourse (Jiwani & Richardson, 2011), and so it is notable that the students used a variety of different ways of naming and referring to Aboriginal peoples. In the 27 texts that made reference to Aboriginal peoples in some way, there were 209 distinct references to Aboriginal people. The term “Aboriginal” was far and away the most common of the terms used to describe Aboriginal people (117 times), with “First Nations” a distant second (42 times). Other terms used less frequently included “indigenous” (9 times), “native” (8 times), “Metis” (4 times), and “Elder” (4 times). In examining the use of these terms with reference to the prompts in Appendix 1, I noted that the students often reflected the language used in the question or readings themselves; for example, in the writings in response to the prompts on ecospirituality, the question and the readings use the term ‘indigenous’, and the writings on this topic use the term ‘indigenous’ as well. In these cases, it seems likely that the students are taking their cues from the texts (questions and readings) provided by ‘experts’ as to which term is appropriate for the context. In a few of the texts, students referred to Aboriginal peoples in the possessive form, such as “our Aboriginal population”, “our Canadian Aboriginals”, “our Aboriginal patients”, and “our First Nation’s [sic] patients”. In cases where the possessive was used in this way, the students seemed to be denoting that they felt some sense of responsibility towards Aboriginal peoples. Although probably meant with good intentions, this also suggests a paternalistic orientation to Aboriginal peoples which may be quite problematic.

In addition to naming, predicational strategies – that is, how people are described and the characteristics ascribed to them – are also important (Jiwani & Richardson, 2011). One common pattern amongst the texts examined was a tendency to make generalizations about Aboriginal peoples and presume a kind of homogeneity of beliefs and perspectives. For example, one student wrote:

“aboriginal [sic] people have great respect for their environment and that we need to be living in harmony with it...aboriginal [sic] people see health as a mind body soul community connection...”

It was very common to see students refer to “*the* Aboriginal culture”, though some students did also speak of “Aboriginal culture” (without use of the definite article), ‘cultures’, ‘peoples’ and other markers of a recognition of diversity amongst Aboriginal peoples. This is notable because the NOSM Northern and Rural Health curriculum deals explicitly and frequently with issues related to Aboriginal cultures, and of the 63 learning objectives relating to Aboriginal culture specifically, 52 of these emphasized the diversity of Aboriginal cultures by referring either to “Aboriginal cultures” (plural), “Aboriginal peoples” (plural), and in a number of cases by requiring students to recognize “the diversity of Aboriginal cultures in Canada”. Given this emphasis in the formal curriculum, the fact that this is not consistently reflected in the students’ writings on Aboriginal peoples in the 4th year of medical school is somewhat curious. I wonder if the expression of these homogenizing views of Aboriginal peoples reflects the persistence of broader socio-cultural norms in Ontario/Canada/settler cultures that fail to recognize the diversity of Aboriginal peoples and cultures that many students brought with them into their medical training, and which appear to have been largely unaffected by the curriculum on Aboriginal culture. Of course, it is also possible that they entered the program with extremely negative views of Aboriginal people which have been somewhat moderated by the curriculum; from these texts produced at a single point in time it is impossible to know the trajectory of the students’ thinking on the subject.

In addition to the lack of recognition of diversity amongst Aboriginal peoples, the specific content of the representations of Aboriginal people fell into two major categories. On the one hand, a lot of the sentiments expressed seem to be idealizing aspects of indigenous cultures and ways of life as being more ‘in harmony with nature’, more holistic, and more communally-based. In other respects there were some other attributions made about Aboriginal ways of being that may be interpreted as veiled negative stereotypes; for example, students wrote that “being ‘on time’ means something very different to an Aboriginal patient, and...are likely to take much more time than other non-Aboriginal patients”, or that “we need to remember to slow down as they may take more time to reflect on their medical problems”, or “they don’t make

as much eye contact". However, some students did directly identify that these kinds of characterizations are stereotypes; one said:

An Aboriginal patient walks into a physician's office. The physician sees the patient is Aboriginal, and immediately makes a mental note not to make eye contact and to refrain from asking direct questions. While these two tactics *may* be appropriate in this situation, they are based on stereotypes about Aboriginal people, and are a very superficial way of trying to make the experience culturally appropriate....Instead, a culturally safe encounter may include the above, but would move beyond stereotypes like beginning the encounter with social, non-illness related conversation to learn more about the patient...

This student raises a concern raised by a number of commentators, that when cultural competence overemphasizes knowledge of characteristics of cultural groups, there is a significant risk that these general characteristics may be overapplied to individuals within the group, which could actually end up further marginalizing and perpetuating inequities for the groups which cultural competence training is intended to help (Kumagai & Lybson, 2009; Kumaş-Tan et al., 2007; Paul et al., 2014; Taylor, 2003; Teal et al., 2012; van Ryn & Fu, 2003). Although the student quoted above seems to understand this issue, many of the other texts suggest that this is not universal, and that many students seem to have fallen into this trap of homogenizing and overapplying generalizations to individuals. Encouragingly, at least some of the students' work analyzed in this study demonstrates an awareness of the effects of colonization, oppression, and inequitable power relations in creating the health inequities for Aboriginal populations in Northern Ontario. The question for me at this point is why only some of these students expressed these kinds of critical views, but others did not – and in fact, some other students seem to have had their negative perceptions of Aboriginal people entrenched by their experiences in the NOSM curriculum (see below). Several possibilities come to mind: some of these students may have come into the MD program with a critical perspective in the first place; some students may have come into

the program with stronger negative biases than others; or the curriculum may have been more effective in developing critical faculties for some students than for others.

Expression of explicit racist sentiments have largely become socially unacceptable, and all the more so at a medical school that aims to serve Aboriginal people and communities and where cultural competence is prominent in the curriculum. However, it would be naïve to presume that racist sentiments do not exist even in this context, and I have had numerous experiences as a teacher in the small-group problem-based settings used at NOSM where I have witnessed students expressing racist sentiments – usually couched in careful terms of course, but frequently denying or minimizing the impact of structural oppression, historical and ongoing colonization; in a number of cases, students appear to struggle mightily with the knowledge that it would be impermissible to express racist sentiments, but still want to criticize or chastise certain kinds of behaviours and actions they perceive as ‘anti-social’ or ‘disruptive’ or otherwise ‘negative’. This was occasionally evident in the texts analyzed as well. One student wrote:

Throughout my time at NOSM, I have experienced some clinical encounters whereby Aboriginal patients have asserted blame on others for their own ill health. This is further illustrated in published resources as assigned by NOSM in which the Aboriginal authors fault ‘the Western world’ for the prevalence of type II diabetes in their culture. The notion of avoiding responsibility for one’s own health emphasizes one conflict between my health values and that of some Aboriginal persons....During certain encounters, Aboriginal patients have assumed that I am judging them based on the fact that I [have a different ethnic background than they do].

In this case, I see the imposition of the individual’s own values onto Aboriginal patients, and a lack of insight as to the machinations of power, oppression, and colonization as influencing the social determinants of health. Sentiments like these were rare in this sample, however. A number of students expressed a clear recognition of the impacts of colonization and racism on Aboriginal peoples and the implications of this for health; although some deny that this is a contemporary reality (for example, the student who

wrote “...the colonization and oppression of First Nation’s [sic] people that occurred many years ago...”), others overtly recognize that colonization and oppression is ongoing (for example, the student who wrote “health services...implemented and offered by non-Aboriginal people....is undesirable, as it imposes on Aboriginal people western ideas of health care, and contributes to the culture of colonization we’re trying to avoid.”). Some students even went so far as to acknowledge the importance of physician self-reflection and recognition of power differentials as a requisite for the provision of culturally-safe care.

Overall, this analysis suggests that the curriculum on Aboriginal health has had uneven effects on students in terms of developing their understanding of these issues. This is not entirely surprising to me, as Beagan’s (2003) work similarly demonstrated a disappointing minimal impact of curriculum on cultural competence. She and others (Bleakley et al., 2011; Kumagai & Lyson, 2009; Kumashiro, 2000; Kumaş-Tan et al., 2007; Paul et al., 2014) suggest that for these curricula to be most effective, they would be advised to focus on the power dynamics between hegemonic and marginalized cultures in creating health inequities, talking explicitly “about racism, not just cultural difference” (Beagan, 2003, p. 614). This may be worth considering in future iterations of a curriculum in cultural competence.

4.6 Gender Ideologies and Identities

Gender has been a prominent issue in medical education in recent years, and with the dramatic influx of women into the medical profession over the last century, it has been easy for some to conclude that there is no longer a gender equity problem in medicine. Indeed, the success of women in medicine has fostered a counter-discourse of the ‘disadvantaged male’ (Abraham & Hammer, 2010), paralleling the moral panic in the broader public discourse about the ‘boy crisis’ in education more generally. At the same time, the increasing representation of women in medicine raises legitimate questions

for health care workforce planning, as differences in practice patterns have been documented between male and female physicians (Abraham & Hammer, 2010; Burton & Wong, 2004; Elston, 2009).

Of the 8 participants in the study, 3 were men and 5 were women. However, the requirements from the ethics committees to strip the essays of their identifiers prior to their provision to me means that for many of the texts, the gender of the author is not known except in those cases where the student identifies their gender in some way. In the 4 texts produced for the essay on the role of women in medicine, 3 of the students identified their gender explicitly in the writing (2 female, 1 male), while the 4th did not give any indication one way or the other. However, in addition to the texts where a discussion of gender was required, gender was discussed in 5 other texts as well. I have chosen to focus my analysis on 3 major aspects of the discourse of gender in these texts: gender as relating to professional identity, biologically determinist and heterosexist ideologies of gender, and postfeminist neoliberal ideologies of gender.

Like Trethewey (1999, 2001), in this work I found that women's professional identities were more conspicuously gendered than men's. Not only were women more likely to explicitly indicate their gender in their writing, they more often addressed their professional identity in gendered terms (such as "female doctor"). Interestingly, in all of the texts where the writers self-identified as female, the students seemed to have given these issues a lot of thought, and identified multiple issues relating to gender with respect to their professional life; in contrast, one self-identified male student acknowledges that he had not previously thought about how gender might affect physicians, and noted that in a placement he had been on "there was only one woman physician out of 6 practitioners, but I had never pondered on its implications", describing it as a "curious phenomenon of gender-specific roles and expectations." Many of the students remarked on their perception that female doctors were less likely to work full time than male doctors, consistent with literature documenting differences in the practice patterns of men and women (Burton & Wong, 2004; Elston, 2009). In

addition, they perceived that women were less likely to be specialists, consistent with discourses around ‘family-friendly’ (read ‘women-friendly’) careers, largely underpinned by the expectation that women will be the primary caregivers for children (Bright, Duefield, & Stone, 1998; Phillips, 2009). Several students described female physicians that they had worked with as struggling, having difficulties, and having had to ‘sacrifice’ home life for work or vice versa: for example, “I observed a female family physician working a tremendous number of hours and it seemed to me that it would be difficult for her to focus on building a family with these hours”. Notably, no such descriptions were offered with respect to male physicians. In a number of instances, references were also made to women’s presumed ‘superiority’ in certain aspects of clinical practice, such as communication and compassion. For example:

I believe another positive step forward in medicine with the increase in women physician [sic] is how compassion and attentive listening have humanized the approach to patient care. Rather than treating patients as objects that require fixing I am a strong proponent of comprehensive care focusing on the patient as a whole and addressing all the facets of health (physical, emotional, psychological and social). I believe that building a strong relationship with patients, especially in a family practice, allows for better care. Gone are the days of five minute consults with every patient, especially with an aging population presenting with complex, chronic conditions. This is a great asset that women have contributed to medicine....I embrace the new coming of women in medicine...and believe that they have brought great new abilities that allow for a more comprehensive care of patients.

Men were also taken to be the default standard for comparison with respect to working patterns, as in the case where a student described a physician she had observed who “verbalized tremendous pressure to keep up with the hours of her 2 male partners”. One female student described a preceptor who supervised her as an “old school’ male doctor” who “felt that because I was a mother with a family I had no business being in medical school working towards a career in medicine because it would be too hard to do both well.” For women, the impact of gender on one’s professional identity was clearly evident.

In many of the texts that touched on gender, there was an implicit acceptance of stereotyped gendered social and family roles for women and men, with women tied more strongly to family responsibilities than men, reflecting a perspective informed by biological determinism and heterosexism. The impact of child-bearing and parenting on women was taken to be intractable and natural, as was the assumption that the primary responsibility for addressing the demands of parenthood would be assumed by women; for example, one student said:

as women become pregnant, this inevitably is associated with lapses in the amount of time spent at the office...I have met a female resident in [town] who has been pregnant twice during her family medicine residency which has inevitably doubled in time. This severs somewhat the continuity of learning and means extra work on the doctor's part to keep up with her learning.

The use of the word 'inevitably' takes for granted that women's careers will be affected more than men and that women are perceived as having a greater 'burden' than men. This reflects the tendency Beagan (2003) also observed of tending to see the disadvantages experienced by the marginalized without recognizing the advantages of those with privilege. Moreover, in such discussions, students are primarily reproducing normative, stereotyped ideologies of gender and presuming that these issues are confronted in an exclusively heterosexual context. In describing their observations of medical couples, a student noted:

Interestingly, even though both are professionals, I have often witnessed that the woman's work-load has been less in exchange for caring for the children and family. However, this seemed more prominent if the woman was a family physician compared to being a specialist (which may be in part due to different schedules or access).

The naturalization of women as care-givers was extended beyond the care of children, but also to other family members, and the community at large. One student commented that "specialized housing for the elderly can be infrequent and waiting lists extensive which burdens women put in this situation". Women's responsibility for

community well-being was especially evident in texts talking about Aboriginal women, likely intersecting with the representation of Aboriginal culture as highly community oriented. Here, women are repeatedly identified as not only principally responsible for the family but for the larger community as well, describing them as being “the ‘gatekeepers’ of their family’s health, thus influencing the health of the broader community”.

That being said, there were also instances where students articulated a somewhat more progressive stance on gender issues – especially amongst the male students. For example, the same male student who talked about the ‘inevitable’ impact of child-bearing on women also articulated that “I do not believe that there is an over-feminization of medicine. I believe there is an evolution of medicine in keeping with the forward momentum of society...” and that gender shifts in the workforce “will require some more adaptations”. In other texts written by male students, they expressed positive orientations towards the possibility of men taking on a greater proportion of family responsibilities:

there is also the ever growing option of a ‘paternity’ leave for male residents, something I personally am considering in my future. The shift from home-life to work-life for women has left somewhat of a void that many male partners are eager to fill.

and

Many doctors and residents are realizing that family life is also an important aspect of personal health and that it can benefit you as a whole (and the opposite is true as well where some female physicians choose not to have children and focus more intensively on their career).⁵

⁵ Note here also, the way that the student has understood the unspecified “doctors and residents” to mean “male doctors and residents”, using “female” to qualify the description later on, reflecting the common trope of male as default.

Not only did the students primarily reproduce these normative, stereotyped ideologies of gender, they also tended to frame them in terms of neoliberal and postfeminist discourses. Equality and empowerment were sometimes taken as a 'given', and discussed in a somewhat congratulatory or victorious tone in which men were positioned as gatekeepers for women, expressed by one student as "An initial all-male inclusive collection of students in the early twentieth century slowly and reluctantly allowed women to first attend medical school and then eventually practice amongst them...I embrace the new coming of women in medicine." I was also struck by the way that several students invoked socioeconomic status as being able to offset gender inequities; students offered examples of physicians they had seen as models for this, as "One [doctor] was a single mom who worked within the hours of her children's school hours", "Another family doc who had teenagers worked 40+ hours per week but had a nanny at home ensuring home obligations were met," and "The last family doc I worked with had little kids and worked hard when she was there but had 2 half days off per week to spend with her family." These strategies that the students identified for addressing gendered responsibilities (such as employing a nanny and working flexible or shorter hours) are usually framed as adaptations to the demands of medicine, taking the gendered social roles for granted, and simultaneously demonstrating an assumption that socioeconomic privilege can mitigate gender inequity; there was no apparent acknowledgement that such strategies are only available to women with significant financial resources at their disposal. Such a framing of the issue tends to deflect attention from the inherent inequity of stereotyped gender family roles, thereby tending to support the status quo in which women are presumed to be principally responsible for children and the home.

I was not surprised to see these discourses of gender in the student texts, as they reflect the dominant norms of gender in this culture. The NOSM curriculum at present does not challenge these norms, and much of the discussion in medicine on gender tends to presume a biological determinism (in fact, one of the NOSM learning objectives asks students to "describe the biological basis of gender") and discusses gender with respect

to professional identity principally in terms of a discourse of ‘work-life balance’ that is ostensibly gender-neutral, but usually invokes gendered tropes such as ‘family-friendly specialties’.

4.7 Social Determinants of Health and Health Advocacy

The NOSM curriculum has a considerable emphasis on the social determinants of health⁶, relating to its mandate to respond to the needs of the people and communities of Northern Ontario where there are significant health inequities derived partly from inadequate access to health care, but also from suboptimal social and economic conditions (Rural and Northern Health Care Panel, 2010). Several of the prompts for the texts analyzed specifically required students to address issues related to the social determinants of health, but given the emphasis on them in the Northern and Rural Health curriculum, it is not surprising that it turned up in the students’ discourses even outside of these questions themselves. Many of these discussions of the social determinants of health make reference to physician advocacy, reflecting the Royal College of Physicians and Surgeons of Canada’s definition of ‘Health Advocate’ as one of seven domains of competence required for effective medical practice; under the Royal College’s CanMEDS framework, this includes the ability to “identify opportunities for advocacy, health promotion and disease prevention in the communities that they serve, and respond appropriately” and to “identify vulnerable or marginalized populations within those served and respond appropriately” (Frank, 2005, p. 20).

⁶ The concept of the social determinants of health recognizes that, in addition to individual factors like genetics or lifestyle, the social conditions in which people live have a profound impact on their health, and that “life expectancy is shorter and most diseases are more common further down the social ladder in each society” (Wilkinson & Marmot, 2003, p. 10). Various bodies have conceptualized the social determinants of health in a number of ways, but a prominent Canadian version identifies the following 14 social determinants of health: Aboriginal status, disability, early life, education, employment and working conditions, food insecurity, health services, gender, housing, income and income distribution, race, social exclusion, social safety net, and unemployment and job security (Mikkonen & Raphael, 2010)

In discussions relating to social determinants of health, as with other topics previously discussed in this Chapter, the student writings I analyzed typically identify disadvantages of some groups leading to poor health outcomes, and almost never reference the ways that privilege contributes to better health outcomes. This was reproduced multiple times, particularly with reference to class and socioeconomic status (where poverty was recognized as associated with poor health outcomes), race and ethnicity (where Francophone and Aboriginal people are identified as having difficulty accessing culturally appropriate health care, and in a handful of cases, acknowledging historical and contemporary colonization as a factor in health inequities for Aboriginal people), gender (where women are identified as facing a variety of barriers to accessing health care), and rural residence (where rurality is associated with lack of access to health care). This again reiterates Beagan's (2003) observation that students more readily recognized disadvantages rather than privilege.

A fairly consistent pattern in the student writings was to identify an aspect of the social determinants of health in terms of a group experiencing some form of disadvantage, identify the adverse health impacts resulting from the disadvantage, and offer one of two types of solutions: occasionally relating to individual 'lifestyle' choices, but most often relating to an increased provision of health care (in terms of more health care professionals or increased access to care). I was struck by the very descriptive nature of the student's discourse on the social determinants of health, and a virtual absence of any discussion about how to intervene in the causal process itself. The students emphasized the importance of 'understanding' how a wide range of social factors impacting negatively on people's health in Northern Ontario (including poverty, food insecurity, lack of employment, racism, colonization, geographic isolation, inadequate housing, occupational exposures to chemicals, difficulty accessing education, etc), but the definition of 'understanding' employed appeared to be predominantly about describing the shape of the association between one of these factors and the health outcomes, not the substantive mechanisms linking cause to effect. This is a tendency I have also observed in the classroom on many occasions: when asking the students to

consider how gender is a social determinant of health with respect to depression, for example, I have noticed that students tend to respond by quoting statistics about the differing prevalence of depression in men and women, and need to be prompted to consider the mechanisms that may explain such a relationship.

In general, the texts appear to relate to the social determinants of health as risk factors for poor health, with the role of the physician to ‘understand’ or ‘be aware of’ them, as expressed by the student who wrote: “reducing these health disparities requires that medical professionals understand these significant barriers to health care”. Where they make reference to actions physicians can take to intervene, they appeared to understand this predominantly as appropriately taking place through formal bodies (like lobbying through professional organizations), within the health system itself, or on an individual basis (as in the case of one student who described a physician advocating for a patient to be able to take a placenta home even though it was against hospital policy). Encouragingly, there seemed to be some recognition that physicians occupy a position of privilege and can put that privilege to use as advocates, with one student saying:

as physicians, our voices are often heard, and our opinions taken seriously. We must take our roles as health advocates seriously, and advocate for better health for *all* Canadians...we are in a position that affords us the opportunity to focus direction on the health and safety of Aboriginal people.

These seem to align with Schön’s (1987) analysis that professional training tends to mold and constrain their thinking about advocacy into “worlds matched to their professional knowledge and know-how” (p. 36), rather than thinking more broadly about possibilities for change they can participate in and support.

To some extent, the focus of these students on the health system and access to health care itself is not entirely of their own choosing – the questions posed to them on these issues (see Appendix 1) tend to emphasize these aspects in their framing of the questions, and so of course the students comply with the demands of the prompts. That being said, this in itself speaks to the hidden curriculum and the ways that the

framing of these topics by the school may influence the students' perspectives. If the role of 'health advocate' is presented to students (in the curriculum or in the assessments) such that the scope of activity is framed exclusively in these forms that have been signaled to them as appropriate for physicians, even if that is not the explicit intention, it is not surprising that students would internalize these perspectives and overlook alternative forms of advocacy. The CanMeds roles also promote this way of thinking, although they do explicitly call for physicians to use their expertise "to identify and collaboratively address broad health issues and the determinants of health" involving both "individual and collective actions of physicians" (Frank, 2005, p. 19) in achieving those ends.

Chapter 5 : Discussion

The research described in this thesis used CDA to scrutinize the ways in which social position, ideology, identity, and privilege are manifested by medical students through the discourses they utilized in their writing on various topics related to northern and rural health. My scholarship moving forward will make use of these findings in order to go beyond simply documenting the use of these discourses by medical students, and to develop curricular interventions intended to cultivate students' consciousness of the ways in which medical discourses represent the lives of marginalized people, and to examine the ways in which their own personal histories, biases, and values may affect their relationships to their patients and their provision of health care. Although this initial piece of research is purely analytical, the intent is to move this into the realm of *praxis* in the Marxian sense, where the point is not simply to understand the world, but to change it (Freire, 2000; Green, 2009). In this Chapter, I will elaborate on the analysis described in Chapter 4, tying aspects of that analysis to a broader picture of medical education, social accountability, and reflection and reflexivity in medicine. I will also sketch out a framework for future work following on this research to develop curricula for enhancing critical reflexivity in medicine. Finally, I will spend some time examining and accounting for my own practice as a researcher as I have undertaken this work.

5.1 Hidden Curriculum

Although the term 'curriculum' is often understood to refer to a program of teaching and instruction, educational theorists often distinguish several different aspects of curriculum that operate at different levels (Kelly, 2009). The 'formal' curriculum is what most people understand as curriculum – the official planned content and activities that students are intended to engage with in their learning. However, most of us can attest

from experience that we learn more in an educational environment than simply what was written in the syllabus; the 'received' curriculum describes the actual experiences of the students, and may differ in a variety of ways from what is explicitly stated in the formal curriculum. The hidden curriculum can be understood as the difference between the formal and the received curriculum, and consists of those influences functioning at the level of an organization's structure and culture but which are not openly apparent. These may be intentional or unintentional, but regardless, they are transmitted to students both formally and informally, influencing what is ultimately learned (Hafferty, 1998; Hafler et al., 2011; Kelly, 2009). Hafferty (1998) delineates several ways in which the hidden curriculum may be expressed, but most relevant to this thesis are the ways that the 'institutional slang' at NOSM communicates a particular set of values, understandings, and ideologies to the students in the ways that we define and use certain terminology. Hafferty (1998) gives the example of the increasing use of business terms and metaphors in medicine, recognizing that referencing these discourses resulted in him "being oh-so-subtly resocialized to think of medicine *as a business*" (p. 405) even though such a shift in values was not overtly reflected in the official policies or curriculum of his medical school.

Turning our attention to the hidden curriculum can be useful in highlighting the nature of medical education as a process of enculturation into a particular professional community. Such enculturation includes an initiation into the traditions of the community, "their conventions, constraints, languages, and appreciative systems, their repertoire of exemplars, systematic knowledge, and patterns of knowing-in-action" (Schön, 1987, pp. 36–37). In this sense, medicine is not only a technical education, but a moral and ideological one as well. Much of this education is not done deliberately or consciously or explicitly spelled out in the 'official' curriculum, but is learned in the hidden curriculum of medical training. Like many other professional educational milieu, learning medicine "means coming to terms with particular orientations toward knowledge, power, and identity, and...it is experienced in a context characterized by an unequal distribution of power that acts to constrict people's lives" (Britzman, 2003, p.

33). In analyzing these texts, I identified a number of instances in which a hidden curriculum was apparently at work in shaping the discourses of the students, particularly with respect to the ways they talked about community and about Aboriginal people and cultures.

As discussed in section 4.3, the ways that students deployed the term 'community' was consistently and almost entirely focused on an understanding of community as defined by a geographical place, and tended to assume a relatively small place; in addition, 'community' is often taken to imply 'not at the medical school or clinic'. Being a faculty member at NOSM, subject to and an active participant in the hidden curriculum of the school myself (Hafler et al., 2011), once this tendency became apparent in the analysis I was quickly able to recognize that such an understanding of 'community' is consistently and insistently present not only in the curriculum itself, but also in most aspects of the school's operation. This fits well with Hafferty's (1998) attention to 'institutional slang' as an important indicator of the hidden curriculum. For example, a typical NOSM learning objective addressing community, found in Module 103 of the curriculum, reads "Describe the interaction and collaboration between professionals required to provide care in complex or emergency situations when those situations occur in a small community" (NOSM Phase 1 Curriculum, Theme 1, CBM103), utilizing 'community' in the sense of 'settlement', and also emphasizing the smallness of the settlement as significant. The jargon the school uses to describe a variety of placements further reinforces this sense of 'community', as we send students out for "Integrated Community Experiences" (4-week placements in Aboriginal and rural communities), "Comprehensive Community Clerkship" (an 8-month placement in a small urban or large rural settlement), and "Community and Interprofessional Learning" (weekly half-days spent in community-based health care settings). In the rare cases where students referred to other types of communities, it was to the professional medical community or to the ethnocultural Aboriginal and Francophone communities in Northern Ontario. This directly reflects NOSM's own institutional concepts of its commitment to communities: the NOSM Community Engagement Unit defines its mandate as being to

“pursue a culture of inclusiveness and responsiveness within the medical communities, the Northern Communities, the rural communities, and the Aboriginal and Francophone communities it serves” (Northern Ontario School of Medicine, n.d.). Although these concepts of community are reflected directly in the formal curriculum, I believe it makes sense to also consider it as part of the hidden curriculum in that there was likely no intention on the part of the School to actively exclude other forms of community; however, the upshot is that the consistent use of ‘community’ to refer to geographical settlements, the professional medical community, and the ethnocultural Aboriginal and Francophone communities makes other formations of community less visible.

Similarly, my analysis suggests that the hidden curriculum of ‘culture’ has had a strong influence on student perceptions and attitudes about what ‘culturally competent’ care would look like. At NOSM as at many other medical schools, it appears that ‘culture’ serves principally as code for race and ethnicity, and therefore largely ignores other aspects of culture such as gender, age, income, class, language, education, sexual orientation, ability, faith, among others (Kumaş-Tan et al., 2007; Paul et al., 2014; Taylor, 2003). At the same time, ‘culture’ is also taken as slang for ‘different’, something that ‘Others’ have; in other words, “some people are ‘ethnically diverse’ and others are not...whiteness is understood and presented as the norm...[and] excluded from the concept of cultural diversity” (Ewen, Mazel, & Knoche, 2012; Kumaş-Tan et al., 2007, p. 551). Such a rhetorical move simultaneously implies that the ‘Other’ is different, aberrant, or abnormal compared to the ‘normal’ dominant culture (Ewen et al., 2012; Paul et al., 2014). In placing the focus on the ‘Other’, these discourses of culture render the dominant culture invisible, ignoring the fact that “members of dominant cultural groups also have identities and worldviews that are shaped by culture and racism” (Kumaş-Tan et al., 2007, p. 551). One result of this is that “the overarching vision [of the cultural competence movement] is one of confident, competent white health professionals comfortably entering and serving the communities of ethnic and racialized minority groups, armed with specialized knowledge and skills” (Kumaş-Tan et al., 2007, p. 555). This aspect of the hidden curriculum on Aboriginal health is particularly evident

in that most of the learning students undertake “is primarily constructed through case based learning examples, or as patient or public health data,” (or at NOSM, as part of community immersion experiences) “but rarely as physician, colleague, or equal” (Paul et al., 2014, p. n.p.).

Similar dynamics are at work with respect to the other themes analyzed as well (gender, rurality, and the social determinants of health). Gender is an interesting case in this instance because there is little explicit curriculum on gender at NOSM, and none with respect to gender and professional roles, but clearly the students have learned from their informal experiences and exposures during their medical education about how gender can be expected to affect their professional lives. For rurality, the formal curriculum’s neutral-to-positive framing of rurality stands in stark contrast to the students’ predominantly negative characterization of rurality, likely reflecting the tensions between the School’s explicit commitment to the promotion of rural medicine and the students’ lived experiences both as residents of rural communities and as medical trainees in such communities. Finally, it may be useful to examine the ways that the formal, informal, and hidden curricula interact to produce the relatively consistent patterns of discourse around the social determinants of health.

Many of these learning outcomes are assuredly not the intention of the curriculum writers themselves, and this is exactly why attention to the hidden curriculum is so crucial – so that we can identify and address instances where the implicit messages we send to students may be at odds with our intentions. If we do not confront the hidden curriculum itself and change the institutional culture that gives rise to these implied values, “no amount of fine-tuning the theoretical definitions that students are assigned to read on ‘touchy-feely Tuesdays’ is likely to unsettle the tendency of medical education to produce and reproduce itself as a ‘culture of no culture’” (Taylor, 2003, p. 558). Taking a critical approach to medical education in which we interrogate the unspoken and implicit values and assumptions of the hidden curriculum can be useful in

making the implications and potential adverse effects of it more visible, and hence, tractable to change.

5.2 Social Accountability, Equity, and Social Justice

As mentioned in the Introduction, NOSM is the first medical school to have been founded with a 'social accountability mandate', and the School explicitly commits itself to the World Health Organization's definition of the social accountability of medical schools as "the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region and the nation that they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public" (Boelen & Heck, 1995, p. 3). The movement for the social accountability of medicine has been growing considerably in recent years in response to concerns that medical education had drifted too far into a biomedical and technologically focused practice, as a way to reaffirm the human and moral character of medical practice. The Boelen & Heck (1995) framework has become globally influential in medical education, and many medical schools and other organizations related to medical education have adopted the mantle of social accountability in one form or another.

As a founding faculty member at NOSM, I am both a participant and an observer of the ways that social accountability has been taken up in medical education. As my colleagues and I have expressed in a recent paper (Ritz et al., 2014b), I have often been troubled by the ways I have seen social accountability articulated and operationalized, both at my home institution and further afield. In particular, I am concerned that initiatives launched under the banner of social accountability often appear to lack a critical perspective on what it means to be socially accountable, and in that absence I fear that efforts towards social accountability may inadvertently serve to entrench and perpetuate the very inequities they mean to address. In some places, social

accountability seems to be understood largely through a neoliberal lens, with an emphasis on cost-efficiency and the use of capitalist metaphors of production to describe medical education (Boelen, 2000; Leinster, 2011; The Training for Health Equity Network, 2011). Others foreground the engagement of the medical school with the community as being paramount, manifested as consultation, collaboration, dialogue, or partnership (Health Canada & Steering Committee on Social Accountability of Medical Schools, 2001). As is likely apparent by now, I am personally more committed to a discourse of social accountability as social justice-oriented praxis (Murray, Larkins, Russell, Ewen, & Prideaux, 2012; Worley & Murray, 2011), which demands a commitment to action so as to change the systemic structures that perpetuate the power dynamics which create and sustain inequity. Although 'altruism' and 'charity' have conventionally been held to be virtues of medicine, in my view, a socially accountable medicine should be informed instead by 'equity' and 'justice'.

There is little doubt in my mind that those who undertake projects in the name of social accountability have noble motives with a genuine intention to address serious health inequities. One of my main concerns is that the privileged social positions of most medical educators (of which I am one), physicians, and medical students can make it difficult for us to see the ways in which we may be complicit in perpetuating various forms of oppression. Occupying a privileged social position generally deters us from criticizing the social structures that form the basis of our comfort and privilege (Simon & Dippo, 1986; Waitzkin, 1989), and so the machinations of oppression which create the health inequities we are most concerned about are not readily visible from our standpoints. This concern was expressed 40 years ago by Waitzkin & Waterman (1974):

To the extent to which doctors' allegiance with their patients is not unconditional, they may at times serve the interests of the social order more than those of the people they claim to help. ... These same patterns inhibit doctors from allying with their patients in fighting the sociopolitical conditions which often are the source of suffering. (p.21)

Given our privileged social positions, those of us working in medicine and related fields may indeed have a stronger identification with and allegiance to the hegemonic order which is the foundation of our privilege. In my view, one of the weaknesses of the 'Social Accountability' movement as enacted in many medical schools is that it does not usually incorporate a critical perspective on health inequity that directs attention to the potential complicity of the institution of medicine in perpetuating them.

I would argue that one of the most common pitfalls in the pursuit of equity is to fall into the liberal trap of trying to 'help' marginalized individuals adapt to a system built on hegemonic and oppressive norms, rather than directing our efforts to remediating the structural elements that create inequities in the first place. Given that it is the unjust social order which creates the conditions under which such 'generosity' can be offered in the first place, and the elite 'helpers' themselves are complicit in perpetuating that unjust social order, the 'help' itself becomes highly suspect (Freire, 2009, p. 44). When such 'helping' activities are conceived in the absence of a critical framework they run the risk of reflecting the preoccupations of the dominant elites, largely arising from "an egoism cloaked in the false generosity of paternalism...[which] makes the oppressed objects of its humanitarianism" (Freire, 2009, p. 54), therefore further perpetuating the oppression. Although individuals of the dominant elite may become genuinely interested in transformative social change and liberation of the oppressed, Freire (2009) notes:

Certain members of the oppressor class join the oppressed in their struggle for liberation...theirs is a fundamental role, and has been so throughout the history of this struggle. It happens, however, that as they cease to be exploiters or indifferent spectators or simply the heirs of exploitation and move to the side of the exploited, they almost always bring with them the marks of their origin: their prejudices and their deformations, which include a lack of confidence in the people's ability to think, to want, and to know. Accordingly, these adherents to the people's cause constantly run the risk of falling into a type of generosity as malefic as that of the oppressors. (p. 60)

In health care specifically, Phelan (2011) warns us that “we must consider the risks and dangers associated with planning interventions with the sole purpose of helping clients approximate norms and ask ourselves what ideologies are we perpetuating? Is this truly our intention?” (p. 169). Given that those who suffer from health inequities are likely to have suffered from colonization, racialization, sexism, homophobia, poverty, and other forms of systemic oppression, forms of uncritical ‘helping’ by the dominant elites that are subserved by hegemonic ideologies will more than likely function to reinscribe and sustain relations of domination.

At a medical school founded with a social accountability mandate, one would expect that the curriculum would be informed by the principles of social accountability, and hope that the students would internalize these principles during their training. The analysis conducted for this thesis gives some indications as to how this may actually play out with the interactions of the formal and hidden curricula to produce potentially unintended consequences. For example, the pervasive use of ‘community’ to refer almost exclusively to the geographical sense of the term as a settlement could limit the scope of one’s sense of possibilities for action to address health inequities. As I elaborated in section 4.3, where an individual does not perceive a difference between their geographical community and other potential communities of interest, this suggests to me that the individual’s own values and perspectives are largely reflected in the dominant culture. If social accountability activities are oriented to serve the community as read geographically, then there may be a significant risk of perpetuating hegemonic norms that sustain the health inequities for people whose needs are not in alignment with the dominant culture of the geographic community. For example, racial and ethnic minority communities of interest within a geographical community may not be well-served by activities that are driven by the priorities as understood through the frame of the geographical community; in fact, addressing inequity may sometimes (or perhaps even *often*) require that we take actions that may be perceived as going against the desires or interests of the dominant cultural majority. Thus it seems to me that if our conception of social accountability frames service to the ‘community’ principally in

terms of geographical communities, we could inadvertently end up perpetuating rather than ameliorating the inequity. Kumaş-Tan et al (2007) recognize this kind of problem around the teaching of cultural competence, and advocate for an approach in which the dominant culture is opened for scrutiny, and the mechanisms through which unequal distributions of power are created and sustained in support of the dominant culture are interrogated.

Moreover, as suggested in 4.3, I suggest that where 'community' is so prevalently equated to geographical settlement, this may indicate that the individual identifies more strongly with the dominant culture, and is therefore less aware of the possibility that the geographical community may not share the same concerns and norms – and in this sense the conflation of 'community' and 'settlement' might be understood as the expression of occupying a privileged social location. Feminist standpoint theory suggests that the knowledge of marginalized people is epistemologically superior to that of those in privileged social locations; thus I would suggest that in order for a privileged person to enact social accountability in ways that address the structural power dynamics that create the inequities in the first place, they must first acknowledge that their privilege blinds them to some of the most important facts of the matter. Certainly it is possible that I have over-interpreted this discourse, and some may feel it is a stretch when I suggest that such use of 'community' can be an expression of privilege *per se*; even if that were to be the case, I maintain that a purely place-based framing of 'community' has the potential to obscure or make less visible the ways that power operates for people who may feel marginal to the dominant culture, and so it discourages taking the kind of intersectional perspectives (ie. those that recognize the complex interplay of power and privilege for people in differing social locations) that can be so valuable in addressing inequities.

Similarly, it might be argued that where students have adopted homogenizing and stereotyped perceptions of Aboriginal peoples, they will be less capable of working to address health inequities in these populations effectively. Where people perceive that

culture is something that the 'Other' possesses, there can be a failure to examine and interrogate the ways in which the dominant culture creates and sustains inequity. Reflecting this concern, Kumaş-Tan et al (2007) propose a new conceptualization of cultural competence as that of "culturally diverse health professionals serving culturally diverse patients...bravely acknowledging, recognizing, and challenging the many forms of oppression that produce the enormous disparities in health and well-being we witness today" (p. 555). Similar issues arose in my analysis of the student writing on social determinants of health, with the problems largely framed as the disadvantages experienced by marginalized groups, with scant recognition of the advantages experienced by privileged ones. Thus the impetus to counsel people to make lifestyle changes and advocate for increased access to health care makes sense from the perspective of social privilege, but fails to redress the underlying issues that create the inequities in the first place.

So how can we rescue social accountability from these tendencies? When I consider the ways that the institution of medicine naturalizes and perpetuates inequalities and oppressions, I am drawn to the conclusion that in order for practice to be ethical, it is necessary that medicine is constantly problematized, critiqued, and subjected to interrogation. Medicine tends to cling to values of objectivity as strengths of its form of knowledge production and application, but in order to address inequity, medicine and its practitioners must acknowledge that it is also a political practice, and consider carefully what kind of politics those ought to be. What this means for medical education is that we must actively challenge the notion that medicine is a "culture of no culture" (Taylor, 2003, p. 555), and embrace a pedagogy that recognizes that "teaching physicians to be citizens of the world is thus irrevocably linked to politicizing medical practice" (Martimianakis & Hafferty, 2013, p. 36) instead of pretending to be working from a neutral stance, or employing an ideology of 'helping'. Freire (2000) speaks to the dangers of educating to such tendencies:

No pedagogy which is truly liberating can remain distant from the oppressed by treating them as unfortunates and by

presenting for their emulation models from among the oppressors... Pedagogy which begins with the egoistic interests of the oppressors (an egoism cloaked in the false generosity of paternalism) and makes of the oppressed the objects of its humanitarianism, itself maintains and embodies oppression. (p. 54)

In my view, critical pedagogy is an important ingredient in achieving the social accountability of medical schools, in that “the primary preoccupation of Critical Pedagogy is with social injustice and how to transform inequitable, undemocratic, or oppressive institutions and social relations” (Burbules & Berk, 1999, p. 2); for the social accountability movement in medical schools to do this, we must move beyond approaches that treat the symptoms of inequity without addressing the underlying causes, and actually work to transform the structures that create and perpetuate the inequity in the first place. Thus, medical education must include a form of training that allows young physicians “to recognize when actions and inactions that support the status quo and business-as-usual unintentionally, but systematically, privilege some and marginalize others” (Kumaş-Tan et al., 2007, p. 554). A pedagogy of critical reflexivity may be of considerable utility here.

5.3 A Role for Critical Reflexivity in Medical Education

One of the major critiques of the scientific-technical emphasis in medical education is that when a physician conceives of themselves as principally a technician, their moral agency is diminished (Schön, 1983). Where education overemphasizes the acquisition of knowledge, it becomes less likely that students will become critical thinkers:

The more students work at storing the deposits [of information] entrusted to them, the less they develop the critical consciousness which would result from their intervention in the world as transformers of the world. The more completely they accept the passive role imposed on them, the more they tend simply to adapt to the world as it is and to the fragmented view of reality deposited in them. (Freire, 2000, p. 73)

Although articulated about education in general, Freire's point applies well in medical education specifically. In response to these kinds of concerns, 'reflective practice' has become a hot topic in health professional education in recent decades, and the capacity for reflection is increasingly regarded as an "essential characteristic for professional competence" (Mann, Gordon, & MacLeod, 2007, p. 595); however, the precise meanings and philosophical underpinnings of what is intended by 'reflection' are usually not spelled out (Kinsella, 2009), which may be a factor relating to the relatively limited success that has been documented in trying to teach reflective practice to medical students (Mann et al., 2007). The idea of *reflexive* practice (as a form of reflective practice) is somewhat less prevalent, particularly in medical education.

Although 'reflection' is often used as a blanket term for any kind of introspection, for the purposes of this inquiry it is important to delineate the distinction between reflectivity and reflexivity. Although reflective practice is discussed frequently in the health professions literature, the idea is surprisingly ill-defined (Kinsella, 2009). In his landmark works on reflection in the professions, Schön (1983, 1987) characterizes reflective practice as a process of critically evaluating one's actions so as to enhance one's skills and practice as a professional, linking thought to action in order to produce better actions; in other words, "reflective practice acts as a kind of feedback loop on keeping practice activity on course" (Bleakley et al., 2011, p. 17).

In contrast, reflexivity does not only look at actions themselves, but examines the values that inform those actions, and questions the very nature of what we take to be knowledge in any given setting, and differs from reflection in that it delves into a consideration of the epistemic conditions within which certain knowledges are produced and deemed legitimate, and recognizes that such processes are social in nature (Kinsella & Whiteford, 2009; Sandywell, 1996). Bleakley and colleagues (2011) describe reflexivity as "a deeper practice of inquiry into what values drive practices and activities in the first place and how activities are conceived, legitimated and executed through the interplay of identity, power and location" (p. 17), disrupting our 'common

sense' about the world to carefully examine the ideas that form the foundations of our thoughts and actions. Reflexivity becomes 'critical' when it explicitly addresses issues of power; it asks us to go beyond recognizing the fundamental assumptions that shape our worldview and to interrogate the ways that power operates through us and on us as a result of our embodied social position. Thus, engaging in reflexive work provides an opportunity to consider some of the implicit framings we bring to practice, the consequences of such framing, and to contemplate alternate framings which may create more possibilities for action than we had originally envisioned (Kinsella, 2007b, p. 399).

As described in section 5.2, if those of us in a position of social privilege are to engage in social accountability efforts, we must take care to understand our own assumptions, biases, and values, to avoid perpetuating the conditions that created the inequities in the first place. I argue that critical reflexivity will be an important element in successful social accountability activities, and as such, medical schools committed to social accountability should develop the capacity for critical reflexivity in their learners. This is echoed by Kumashiro (2000), who also calls for self-reflexivity as part of anti-oppressive education:

Learning about Others is an important step in changing oppression, but that alone is not enough. Learning about the Other with the goal of empathy often involves seeing how 'they' are like 'us'...thus, maintaining the centrality and normalcy of the self. Learning about the Other and about oppression, then, can serve to reinscribe sameness by allowing the privileged Self to see itself no differently than before....Thus, a student should engage not only in self-reflection (in which the student asks how he or she is implicated in the dynamics of oppression), but also in self-reflexivity (in which the student brings this knowledge to bear on his or her own sense of self). (p. 45)

This may have particular relevance in medicine for teaching around cultural competence. Paul et al (2014) concur that an educational approach to cultural competence focussed on the 'Other' will be insufficient to address health inequities, and that a curriculum of self-reflexivity is necessary. Indeed, as described in section 4.5, the analysis conducted in this work affirms the concern that a curriculum heavy on cultural

competence but without the inclusion of critical reflexivity may produce physicians who recognize cultural issues as relevant to their practice, but who do not acknowledge that their own culture is as much in play as that of the patients they perceive as 'Others'. The use of critically reflexive approaches in the classroom may help to highlight the "multiplicity and situatedness of oppression" (Kumashiro, 2000, p. 25), and to emphasize that all people are raced, gendered, classed, sexualized, and experience privilege or oppression along multiple, intersecting axes. That Glazier (2005) has shown some success in using critical discourse analysis with teachers to accomplish this end is encouraging to me that it may be effective in the context of medical education as well.

5.4 Towards a Pedagogy for the Oppressors

This thesis is the beginning of a longer-term research project in developing and implementing curricular interventions for use in medical education that will enhance medical student reflexivity in the service of a social justice-oriented social accountability. Such a curriculum would provide a framework in which students could come to develop insight into how their social location, identity, values, and ideologies are made manifest in their discourse as physicians, and consider how these will impact their relationships with patients – particularly those who do not share their social position or privilege. Bringing a critical pedagogical approach into medical education may be an important mechanism for doing so, since such an approach "functions to encourage students to understand and question the nature of people's everyday lives and to challenge unequal forms of power" (Larkin & Staton, 2001, p. 371). However, the question of how to best incorporate critical pedagogy into medicine is a challenging one.

In a field dominated by technoscientific epistemologies of positivism, empiricism, and objectivity, there is a certain hostility to the idea of 'bringing politics into the classroom', although of course we know that the politics are there whether we acknowledge them or not (Noble Tesh, 1998); for example, the content and values in much of our curricula

on clinical skills, professionalism, and communication skills can be understood as reflecting certain middle-class values and preoccupations about politeness. Kinsella (2007a) emphasizes that “an education that helps practitioners to recognize the partiality of their knowledge, as opposed to infusing a false sense of one ‘fixed’ view of the world, seems to me to be an important and overlooked consideration in how we prepare health professionals for practice” (p. 43). Teaching for reflexivity will be particularly important in the context of social accountability, where there is some danger that the activities undertaken to address inequity may inadvertently contribute to their perpetuation. It is unrealistic (and possibly harmful) for physicians to know how best to ‘help’ marginalized patients, but if they are able to begin from a position of acknowledging their own privilege and the values and ideologies they bring to their practice, they might be better positioned to contribute to a constructive resolution of the tensions that arise when there is a mismatch in worldview.

Paolo Freire’s *Pedagogy of the Oppressed* (2000) is one of the foundational texts in critical pedagogy, and one of the key points in Freire’s work emphasized the goal of “bring[ing] members of an oppressed group to a critical consciousness of their situation as a beginning point of their liberatory praxis” (Burbules & Berk, 1999, p. 6). However, medical students by-and-large are not an oppressed group, and the social privilege of the physician almost inevitably creates a significant power differential between physicians and their patients (as well as their interprofessional colleagues) favouring the physician in nearly every instance (Kinsella, 2005; Lindemann Nelson, 1999). Hence, in this instance, the goal of critical pedagogy in medical education is not to raise the critical consciousness of medical learners about their oppression, but rather to develop an awareness of their privilege in hopes that they will use that consciousness as a starting point for their own liberatory praxis – a praxis that is focused on reducing the oppressive potential of their practice as physicians. In this sense, I have thought of this

thesis as the starting point of a larger project in a ‘pedagogy for the oppressors’⁷, in deliberate contrast with Freire’s turn of phrase.

As I have developed my knowledge and expertise in CDA during the course of this Master’s degree and this thesis, it has become clear to me that CDA itself is not only useful in analysis, but could be an effective pedagogical tool for helping learners to disrupt the ‘common sense’ of their ideological positions, examine their own language and discourse experiences, and direct their attention to the ways that social location, ideology, and power relations shape our/their practice (Fairclough, 1993; Kuper, Whitehead, & Hodges, 2013; Luke, 1996). Both Fairclough (1993) and Luke (1996) have explicitly argued that the use of CDA in education can accomplish these ends. As an educational intervention, CDA:

aims to draw upon learners’ own language and discourse experience, to help them become more conscious of the practice they are involved in as producers and consumers of texts: of the social forces and interests that shape it; the power relations and ideologies that invest it; its effects upon social identities, social relations, knowledge, and beliefs; and the role of discourse in processes of cultural and social change... Through consciousness learners can become more aware of constraints upon their own practice, and of the possibilities, risks, and costs of individually or collectively challenging those constraints to engage in an ‘emancipatory’ language practice. (Fairclough, 1993, pp. 239–40)

Bleakley and colleagues (2011) also suggest that concepts in textual analysis may be useful in medical education specifically. For physicians, utilising CDA approaches as a form of self-reflexivity may be useful in directing their attention to the ways they ‘read’ and interact with patients, examine the values that underpin such readings, and consider the possible effects on their practice with a view to positive change.

⁷ After this phrase occurred to me spontaneously, I discovered that it had already been used by several others, including Allen (2002) and Kimmel (2010).

In considering CDA as a possible curricular intervention, I have used the work of Glazier (2005) as a model. In that work, CDA was used as a technique in professional development for high school English teachers, guiding them in a process of analyzing their own discourse and identifying the ways in which their own subject positions were made manifest in their teaching practice. Glazier's work appears to be quite transferrable to the context of medical education, as her theoretical framework, methods, and goals are all congruent with what I hope to accomplish in the larger project; just as she attempted to "help teachers understand the way their subject positions, as raced, classed, and gendered for example, play out in the classroom" (Glazier, 2005, p. 231), it is my intent to similarly create educational environments in which medical students can confront how their subject positions and discourses serve to unconsciously privilege some patients over others – particularly those whose subject positions and discourses are more like their own. The use of CDA for this purpose could be particularly effective, because it moves beyond teaching students to simply 'understand' or reproduce some particular critical perspective, and requires them to "engage with relevant aspects of critical theory and extend its terms of analysis to their own lives" (Kumashiro, 2000, p. 39). Using CDA may also enable physicians in training to become more actively critical of the professional discourses handed down to them, creating the kind of 'disruptive knowledge' that is essential for intervening in oppression: examining how some groups are privileged and normalized, and how such inequities are perpetuated and legitimized by the structures and institutions of medicine, and that physicians themselves are complicit in this (Kumashiro, 2000). In late 2013 I was awarded a 'Call to Caring' grant from the Associated Medical Services Phoenix Project to pursue exactly this work.

I do not pretend that this will not be challenging work, and I will likely encounter considerable resistance from multiple corners. For one, poststructural, constructivist approaches may be resisted by people committed to the dominant view of professional medical practice as a form of 'technical rationality' (Schön, 1983). Prior to entering medical training, most physicians are students in the natural sciences, disciplines which

typically tend to perceive themselves as ‘objective’ and ‘value-free’, so the idea that scientific knowledge might be laden with ideology is a tough pill to swallow for many people in the first place. In addition, many medical students will likely resist recognizing their own privilege (as do most privileged people when they first encounter the concept) (Case, 2013; Kimmel & Ferber, 2010); they like to think of themselves as special, as having ‘worked hard’ to meritoriously secure their position (hooks, 2000; McIntosh, 2013). As with any equity strategy, attempts to transform power relations are “likely to generate strong resistance from those who benefit from the current power hierarchy” (Larkin & Staton, 1998, pp. 20–21). However, I believe that the likely difficulty is worthwhile, for several reasons. First, developing an understanding of the machinations of privilege in their own lives and in those of others will benefit students themselves by contributing to their own self-understanding (McIntosh, 2013). Second, such insights may help physicians develop more respectful, productive relationships with patients who are significantly different from themselves. Finally, developing a recognition of their own privilege may help physicians, as members of a dominant and powerful elite, “realize how much unused power [they] hold and could use for social change” (McIntosh, 2013, p. xv)

Finally, following Glazier’s (2005) caveat, I should emphasize that this kind of critical pedagogical approach does not – and cannot – alter the positions of power and privilege that a physician will have. One cannot simply divest oneself of privilege or power in any context. However, developing the capacity for critical reflexivity through the use of CDA may be useful in helping medical students to become aware of their position and how that may influence their practice, with the aim of changing their practice so as to limit the extent to which they favor certain patients over others.

5.5 Reflexivity of the Researcher

“Feminist research suggests that the research product cannot be separated from the conditions of its production. Research cannot be neutral or

value-free and objectivity is a fiction. Better to cultivate an aware subjectivity”
(Bleakley et al., 2011, p. 230).

Having begun my academic life in the natural sciences, my initial training implicitly took an epistemological view of positivism and empiricism, placing an extremely high value on ‘objectivity’ in research. Over the last ten or fifteen years I have become increasingly convinced that instead of claiming the (non-existent) position of the value-free objective observer, it is important for researchers to contemplate and be explicit about the values and perspectives they bring to their inquiry. Philosopher of science Sandra Harding (1991) has argued that failing to account for one’s own subjectivity is an important source of bias in any process involving knowledge generation or utilization, and that in order to be maximally ‘objective’, the goal should not be to shed one’s subjectivity, but rather to acknowledge and be critical about what that subjectivity brings to the issue at hand. In Chapter 2 I provided a critical autobiographical narrative written before I began working on this project in order to elaborate on some of the ways that my personal experiences brought me to the point of embarking on this research project, and how they shape and inform my approach, my priorities, and the principal objects of my interest. In this section I undertake a complementary reflexive exercise from the other end of the process, looking back at how I have engaged with this research and attempting to account for choices made in this research practice, and the values that were driving it. As Brookfield (2000) states, “a critically reflective stance towards our practice is healthily ironic, a necessary hedge against an overconfident belief that we have captured the one universal truth about good practice” (p. 47). In a project of this nature, where I was applying a critical perspective to unpack the discourses of others, it seems only fair that I turn the lens on myself as well.

In undertaking this CDA of the writing of others, I am aware that the analysis I offer says as much about me as it does about the students participating in the study or the NOSM curriculum and culture. One of the foundational concepts in CDA is that any utterance is an act that is situated, reflects a particular historical location and position, and has material consequences (Luke, 1996). This is no less true of textual analysis, where it is

impossible to be purely descriptive; in every act of analysis, we are also inscribing, constructing, and producing the subjects of the research (Bleakley et al., 2011; Luke, 1996). Research in general can be understood as an aspirational endeavor; when we engage in research, I don't think we do so out of idle curiosity. Most, if not all, researchers do what we do because we see problems that we want to solve or questions we want to answer – not just generic problems that need solutions, but problems that we want to solve, because they hold some resonance or significance for us on a personal level. Our personal investments don't only influence the content of our research, however, as Lather (1991) points out that our “research *approaches* inherently reflect our beliefs about the world we live in and want to live in” (p. 51; emphasis mine).

Although my autobiographical narrative in Chapter 2 focuses on a handful of ways in which I understand myself to occupy somewhat marginalized positions (for example, as a woman in a patriarchal society, especially in science; and as having come from a working-class background), I would be remiss if I did not acknowledge that along many other axes of identity and social position my interests are aligned with the dominant culture. As a white, educated, cis-gendered professional, I have a great deal of privilege; although I self-identify as queer I am almost always read as straight, and so I benefit from heterosexual privilege; my ancestors immigrated to Canada in the early 19th Century, and as a settler I derive benefit from the historical and ongoing colonization of the people indigenous to this land. This privilege creates exactly the kinds of blind spots in my own perspective that I discussed in section 5.2, and I am often drawn back to the passage from Freire (2000) in which he acknowledges a role for those with privilege to ally themselves with the oppressed in the struggle for liberation, but cautions against slipping into a mindset where “they believe that they must be the executors of the transformation” (p. 60); he cautions that this “is especially prevalent in the middle-class oppressed, who yearn to be equal to the ‘eminent’ men and women of the upper class” (p. 62). Given my personal history of upward mobility and class aspirations, I realize this is something I need to constantly interrogate and challenge in myself. Calling on feminist standpoint theory (Harding, 2004) helps to remind me that in my intent to work

for social justice, my particularly situated perspective on the world is necessarily partial and that the structures that form the basis of my own privilege are the most difficult for me to see and may be the structures that need change the most.

Bearing this in mind, it will be important for me to be cautious as I move into the next, interventional phase of this research in developing and implementing a form of critical pedagogy. Brookfield (2000) frames the problem thusly:

The challenge of postmodernism is, in my opinion, a necessary correction to the tendency in discourse on critical reflection for its theorists to erect a model of the liberatory educator as one who always has a more authentic and accurate view of the prevailing, oppressive reality, and who therefore has a duty to awaken learners from their intellectual slumbers...A form of triumphalism sometimes creeps in whereby critical educators portray themselves superheroes of hegemonic analysis, the only ones who possess an accurate vision of the oppressive reality hidden from the masses. (p. 46)

In working with the medical students to use CDA as a tool for reflexivity, I will need to find a balance between positioning myself as the ‘teacher’ for a process of critique, without foisting my perspectives on the students, or suggesting that there are ‘correct’ ways of thinking (Hodges, 2004; Lather, 1991); although it is fully expected that I will come to the project with my own values, I must be careful not to use the project as a means of *imposing* those values (Freire, 2000). In fact, bringing CDA into the classroom could be considered a colonizing act in a sense, given that the intellectual traditions from which it springs are highly eurocentric, and “some ethnic groups experience critical reflection as a threatening imposition of alien ways of knowing, learning, and being, a form of intellectual genocide wiping out valued components of their culture” (Brookfield, 2000, p. 43). In this regard, I think that the conditions we set out for a critically reflexive social accountability (Ritz et al., 2014b) apply well in this situation as well; I must recognize the cognitive authority of ‘others’, listen carefully in authentic exchanges, be willing to change my purposes and objectives in response, and relinquish

a need to control the dynamics in the classroom. Opening myself up to the students as an object for their critique could be an important element of this praxis.

In some ways, the more time I spend in this kind of self-critique, the more fraught and precarious my position feels. Lather's (1991) imperative that we "look closely at our own practice in terms of how we contribute to dominance in spite of our liberatory intentions" (p. 15) sometimes feels like an impossible task, recognizing that my perspective is inevitably partial and that my privilege creates many blind spots. However, continuing to engage in self-critique in the pursuit of some non-existent ideal of perfect, non-oppressive educational praxis is counterproductive if it renders us unable to speak or act until we are absolutely confident that our teaching is "untainted by any form of domination" (Lather, 1991, p. 45). Thankfully, along with her cautions, Lather delivers these words of encouragement as well: "In an era of rampant reflexivity, just getting on with it may be the most radical action one can make" (Lather, 1991, p. 20). At some point, we simply have to move forward and act, bringing our reflexivity with us and employing it on the way, with the sure knowledge that we will make mistakes *en route* but committing to be accountable for those mistakes, to be humble and modest in facing them, and to listen attentively to our critics.

5.6 Concluding Remarks

I began this thesis by noting that NOSM was the first medical school established with a 'social accountability mandate', an institutional environment that has been quite thought-provoking for me as an academic and medical educator with a social justice orientation. As my coauthors and I articulated in a recent paper, I believe that the social accountability movement has tremendous potential to drive the kinds of transformative changes needed to redress health inequity, but that this can only be achieved if we are able to acknowledge the oppressive social relations that cause these health inequities and work to change them (Ritz et al., 2014b). These social relations include every

instance of contact between marginalized populations and the institution of medicine, right down to each encounter between patient and physician.

The research of this thesis aimed to examine the ways that the identity, subject position, ideologies and values of medical students were expressed in their writing on northern and rural health topics. As an isolated piece of scholarship, this work is valuable in that it contributes to the literature on the ways that the formal, informal, and hidden curricula interact in shaping student perspectives on medical practice and their identity as physicians. Stepping back to the larger perspective of social accountability, if our aim is to serve the interests of the marginalized and the disadvantaged, then we must consider whether aspects of the medical training may unintentionally reinforce forms of dominance that created the inequities of concern in the first place. This analysis makes a contribution to this larger project as well, by identifying a few areas in which the discourses employed by students may be somewhat at odds with the goals of social accountability, and prompting us to consider how we might intervene to bring these into better alignment.

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Appendix 1 – Essay Questions on Northern & Rural Health

Table 1: Specific questions asked of students in 2010.

<p><i>How is the concept of cultural safety different from the ideas of cultural appropriateness/awareness/sensitivity/competence? Be specific in your explanation using an example from your present practice.</i></p>
<p><i>In the article by Peiris, Brown, and Cass (2008), the authors suggest that “we need to move beyond patient-provider interactions in developing a policy informing agenda on access.” Explain what this statement means in general and what, in your opinion, it means in the context of Northern Ontario given that it is composed largely of remote, rural, and Aboriginal communities.</i></p>
<p><i>Based on the article by Towle, Godolphin, and Alexander (2006), identify two reasons why the health of Aboriginal people in Canada is poorer than that of other Canadians. Provide examples based on your experience with Aboriginal people and communities in northern Ontario to illustrate these reasons.</i></p>
<p><i>What three themes do Towle, Godolphin, and Alexander (2006) identify as contributing to positive and negative experiences of Aboriginal patients with physicians? Describe three specific strategies a physician might adopt in order to ensure positive experiences for his or her Aboriginal clients.</i></p>
<p><i>Outline, with rationale, one area in which you would like to see policy development occur with the goal of improving health services in northern Ontario. You are welcome to draw on your experiences.</i></p>
<p><i>It is unclear from the literature whether relatively poor outcomes and high rates of complications among Aboriginal patients can be explained solely by factors such as Northern isolation, rurality, varying levels of cultural awareness by care givers, and reduced access to care. An alternate position is that these outcomes and complications may be due to Aboriginal-specific factors. In a recent paper, Marr, Gzik, and Larose (2010) explored this idea by studying well-defined Aboriginal and Euro-Canadian communities of Manitoulin Island. Their conclusions were startling and are reflected below: “Compared to previous Canadian studies, both Aboriginal and Euro-Canadian patients in this study demonstrated better control of glycemic and lipid levels despite their relatively isolated, rural place of residence. Unexpectedly small differences in these physiological measures were observed between the 2 patient groups. The positive findings are likely a result of high-quality, culturally sensitive, interdisciplinary care” (Marr, Gzik, & Larose, 2010) Please review this paper and comment on the following four ideas in an essay of about 250-300 words:</i></p> <ol style="list-style-type: none"> <i>(a) Use your introduction to comment on the health significance of “high quality, culturally sensitive, interdisciplinary care” in an environment challenged by geography, economic hardship, scarce health resources, and decreased access to care.</i> <i>(b) Use 2 or 3 examples or data from the article illustrating tangible evidence of improved diabetic control in that community compared to other Canadian studies and the long term health implications of improved diabetic control.</i> <i>(c) Although not the authors’ primary objective of the article, they outline in broad brush strokes a delivery model: “Diabetes care is enhanced by multidisciplinary clinics and outreach services, primarily provided by nurse practitioners, nurses, dieticians, diabetes educators and lay educators. Services are offered in medical clinics and First Nations/Aboriginal health centres.” Reflect on the importance of this approach in achieving success stories such as this one. Use examples from your own, positive or negative, experiences in placements or electives to illustrate this.</i>

<p>(d) Reflect on whether the curriculum at NOSM has prepared you to understand and function within an interprofessional collaborative (IPC) model similar to that described on Manitoulin.</p>
<p>Based on your reading of Graveline's (2001) article called "Imagine My Surprise: Smudge Teaches Wholistic Lessons" and your own experiences as a medical student in Northern Ontario, identify and comment on three areas of possible conflict or tension between your values about health and those of some Aboriginal persons.</p>
<p>The role of women in relation to health is highlighted in "Metis Women and Families: We Got a Moose, Mom!". Based on this role, how might physicians and other health care providers work with Aboriginal women and mothers to promote health practices? Please suggest two areas.</p>
<p>Why might it be important for physicians and other health care providers to understand the concept of ecospirituality (Coates, Gray, & Hetherington, 2006)? Please be specific.</p>
<p>Graveline (2001) discusses an Aboriginal professor's experiences of conflict between personal and cultural values and her place of employment: the university. Have you experienced, during your time as a medical student, similar conflict between your personal and cultural values and:</p> <p>(a) the medical school? (Please note that your opinion will not in any way negatively affect your score or your identity within the school)</p> <p>(b) the general values of Northern Ontario?</p>
<p>Identify and comment on two health-related Aboriginal values or practices that persons who generally ascribe to Western thinking might wish to adopt. Feel free to draw on any or all of the articles.</p>
<p>Based on what you have learned in your studies as well as during your clinical work and community involvements in northern Ontario, describe the challenges, advantages, disadvantages, and risks of practicing in small rural communities. In addition to more general considerations, be sure to comment on the personal and family needs the physician will need to consider in order to be confident that he or she will remain in the community for some time.</p>

Table 2: Essay topics from 2011 and 2013

<p><u>Essay 1: The Challenges of Practicing in Northern Ontario and Rural Communities</u></p> <p><u>Introduction</u> This essay addresses the challenges of choosing to practice primary care in a rural and Northern environment. Since women now constitute a sizeable majority of the medical workforce as evidenced in NOSM's first three graduating classes, students are asked to describe their observations of the female physicians they have encountered during their rural and Northern ICE placements. Students are also asked to reflect on the sizable female physician workforce in the North and challenges facing this workforce in Northern and rural environments.</p> <p><u>Essay Topic</u> In a 1500-word essay, based on the literature, what you have learned in your studies about human health resources, and what you have experienced and observed in your clinical work and community involvements in northern Ontario, describe and reflect on the challenges, advantages, disadvantages, and risks of practicing in rural communities giving special consideration to issues of gender in the workforce.</p>
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In your essay, in addition to the more general challenges of rural practice, explore the lifestyle challenges that female physicians in Northern and rural communities may encounter. These challenges may pertain to traditional definitions of family as well as nontraditional families, single parenthood, the desire of many non-gestating parents to play a greater role in the family, and so forth. The female physician may likewise contend with challenges related to leisure, privacy, and so forth.

Learning Objectives

The student will:

- Show understanding of general patterns in health human resources as they pertain to physicians.
- Explain the issues that rural physicians face in their personal and professional lives
- Explain the issues that female rural physicians face in their personal and professional lives.
- Suggest strategies that female rural physicians may use in order to balance their practices and personal lives in rural settings.

Resources:

In addition to using the resources listed below, please find and use three other resources from recognized literature in your essay. Careful citing and preparation of a References list are also required.

Many students today, including most women students, may have a vague idea of the long struggle to the admission of women to the study of medicine. When the article was published in 1972 there were only a handful of women amongst the 150 students at McGill. This paper is included to invite students to learn about a page of history of the medical profession and reflect on consequences of discrimination based on gender, color, ethnicity and other characteristics.

Introduction:

In your community placements, you have witnessed various aspects of interprofessional collaboration (IPC) in Northern Ontario: the successful, the challenging, and the unsuccessful. This assignment is an occasion to reflect on interprofessional practice in Northern Ontario.

Essay Topic:

In a 1500-word essay, reflect on the interprofessionalism as you have lived it in Northern Ontario during your undergraduate years at NOSM. Ground your remarks in your observations of IPC as well as your personal reflections. In your essay, be sure that write a short paragraph for each of the three questions and the three Likert scale items provided below:

1. *Based on your experience, what are the three most important aspects of IPC practices in rural and small communities? Identify both positive and negative components.*
2. *Are there barriers or facilitators to the development of IPC that are unique to the Northern and rural environment compared to those in larger urban centers? Please provide examples based on what have you have observed.*
3. *What final observations or comments would you like to offer about your experiences of IPC in Northern Ontario?*

Essay Topic: Medical Education in a Socially Accountable World

Introduction

It is well recognized that the medical education model used in the training of physicians has a major influence on how physicians ultimately practice. For the greater part of the twentieth century, medical education was influenced by the landmark Flexner report of 1921.

Essay Topic

The three articles provided to you are background reading for this essay. After careful reading and analysis of these resources, do the following in a 1500-word paper:

- summarize the key weaknesses of the medical education model set out in the Flexner report
- explain the challenges facing medical education to address the mismatch between physician training and population needs
- reflect on how NOSM has addressed the challenges to prepare its students to connect education and health needs of Northern Ontario and special populations such as Francophone and Aboriginal populations
- discuss specific educational initiatives you have experienced at NOSM that tie directly to the goal of professional practice grounded in Northern and rural settings

Essay Objectives

The student will:

- Describe, compare, contrast, and evaluate two models of medical education.

The above essay-specific objective reflects the following syllabus objectives:

From Concept 6 - The Role of Technology in the Delivery of Health Care

- Participate effectively in a telehealth or telemedicine consultation at both the consulting and the referring provider end of the consultation.
- Choose appropriate technological applications for physician consultations, diagnoses, planning patient management, and follow-up.

NOTE: while not directly assessable in this essay, the nature of the experiences provided in terms of learning and practicing using remote technologies is an integral part of the educational experience at NOSM and is therefore reflected in this essay.

From Concept 11 - Health Research in Northern Ontario

- Translate current clinical research into lay language for patients and families in northern and rural settings.
- Demonstrate skill in accessing and retrieving high quality information resources and in evaluating resources.

Resources

Cooke, M., Irby, D. M., Sullivan, W., & Ludmerer, K. M. (2006). 100 Years after the Flexner Report. *The New England Journal of Medicine* 355(13), 1339-1344. Retrieved from the NOSM website in the Health Sciences Library (HSL) e-Journals section.

Browning, R.C. (n.d.). Flexner's Impact on American Medicine. Accessed the 29 May, 2012 on the World of Rural Medical Education Web site (<http://www.ruralmedicaleducation.org/>) at: <http://www.ruralmedicaleducation.org/flexner.htm>

Frenk, J. et al. (December 2010). *Health Professionals for a New Century: Transforming Education to*

Strengthen Health Systems in an Interdependent World. The Lancet 376(9756) 1923-1958. Retrieved from the NOSM website in the Health Sciences Library (HSL) e-Journals section.

Essay Topic: The Impact of the Drummond Report (2012) on Northern Health

Introduction

In the spring of 2012, under the leadership of the Liberal government, Ontarians were presented with the Drummond report. The report is far reaching in scope with considerable potential to affect health policy and services in Northern Ontario.

Essay Topic

After carefully reviewing Chapter 5 of the report, prepare a 1500-word essay that meets the requirement noted below. You may use the resources provided as a springboard for your essay. Also, please draw on your experiences in Aboriginal and Northern communities and knowledge you have acquired through Theme 1 content to support your viewpoints.

Your essay requirements are as follows:

- *summarize key recommendations as they pertain to health*
- *outline implications of these recommendations on health care delivery and access to health care in Northern Ontario*
- *reflect on the impact these changes would have on the general health and well-being of Northerners*
- *identify the impact of changes (or challenges for people of Northern Ontario) stemming from the report that you would become actively involved in advocating on behalf of your community and patients*

Essay Objectives

The student will:

- *Describe recommendations of the Drummond report and hypothesize the impact that the report can have on policy and programs based on thoughtful reading of the literature, existing practices, and personal experience of practice in Northern Ontario.*

The above essay-specific objective reflects the following syllabus objectives:

From Concept 1 - The Setting for Practice in a Northern and Rural Setting, Clerkship Objectives - Health Care Resource Distribution:

- *Critically discuss health policy affecting northern and rural regions.*
- *Identify ways that northern and rural communities have adapted local systems of care to meet their needs, including the use of various forms of information and communication technologies (ICTs) and other relevant technologies, agency partnerships, and shared care models.*
- *Apply knowledge of distribution of regional services (i.e., cardiac care, renal services, cancer care, and rehabilitative services,) to find and refer to identified best resources available for individual patients.*

From Concept 6 - The Role of Technology in the Delivery of Health Care:

- Describe the impact and application of e-health policies and programs such as Ontario's eHealth Strategy and the work of agencies such as eHealth Ontario, Canada Health Infoway and the Ontario Telemedicine Network.

Resources

Drummond Report

Commission on the Reform of Ontario's Public Services. (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Toronto: Queen's Printer for Ontario. Available at <http://www.fin.gov.on.ca/en/reformcommission/>

Ontario Ministry of Health and Long Term Care. (2012). Ontario's Action Plan for Health Care: Better patient care through better value from our health care dollars. Toronto: Queen's Printer for Ontario. Available at http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf

The following offers perspective and criticism of the report:

RWS Advisory. (2012). Drummond vs. Duncan: Comparing Health Care Reform in the Drummond Report and the 2012 Ontario Budget:. Toronto : Author. Available at <http://www.rwsadvisory.com/index.php/our-firm/media/drummond-vs-duncan>

Curriculum Vitae

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Post-secondary Education & Degrees	<p>McMaster University Hamilton, Ontario, Canada 1993-1997 B.Sc.</p> <p>McMaster University Hamilton, Ontario, Canada 1997-2003 Ph.D.</p> <p>The University of Western Ontario London, Ontario, Canada 2011-2015 M.Ed.</p>
Honours & Awards	<p>“40 under Forty” Award Northern Ontario Business, 2013.</p> <p>Alan Blizzard Award for Collaborative Teaching (team award) Society for Teaching & Learning in Higher Education, 2005.</p> <p>President’s Award for Course or Resource Design (team award) McMaster University, 2005.</p> <p>Graduate Student Award Canadian Society for Immunology & Cedarlane Canada, 2003.</p> <p>Memorial Scholarship IODE Canada, 2002.</p> <p>Milic-Emili Award for Best Basic Research Presentation Canadian Resident-Fellow Competition in Respiratory Research, 2001.</p> <p>Doctoral Fellowship Canadian Institutes for Health Research, 1999-2002.</p> <p>Professional Fellowship Canadian Federation of University Women, 1998.</p> <p>Ontario Graduate Scholarship Ontario Ministry of Education & Training, 1998.</p>
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Post-Doctoral Fellow, Clinical Immunology & Allergy
University of California – Los Angeles
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McMaster University
2004

Teaching Assistant
McMaster University
1997-2003

**Publications
(last 5 years)**

Ritz SA, Beatty K, Ellaway RH. (2014) Accounting for social accountability: Developing critiques of social accountability within medical education. *Education for Health* 27(2):152-157.

Dorman SC, **Ritz SA**. (2014) Smoke exposure has transient pulmonary and systemic effects in wildland firefighters. *Journal of Respiratory Medicine* Article ID 943219.

Dorman SC, Sutcliffe KM, Abourbih J, **Ritz SA**. (2014) Inhalation of nebulized diesel particulate matter: A safety trial in healthy humans. *Journal of Respiratory Medicine* Article ID 797050.

Ritz SA, Antle D, Côté J, Deroy K, Fraleigh N, Messing K, Parent L, St-Pierre J, Vaillancourt C, Mergler D. (2014) First steps for integrating sex and gender considerations into basic experimental biomedical research. *The FASEB Journal* 28(1):4-13.

Ritz SA, Bussoli MB, Dorman SC. (2010) Alcohol fixation of induced sputum for application in rural communities. *Canadian Respiratory Journal* 17(3):115-121.

Ritz SA. (2010) Air pollution as a potential contributor to the 'epidemic' of autoimmune disease. *Medical Hypotheses* 74(1):110-7.