(Re)producing “Whiteness” in Health Care: A Spatial Analysis of the Critical Literature on the Integration of Internationally Educated Health Care Professionals in the Canadian Workforce

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Abstract

Purpose
There is a gap in the literature to understand how professionalizing systems intersect with socioeconomic and political realities such as globalization to (re)produce social inequities between those trained locally and those trained abroad. In this critical review, the question of how systemic racism is reproduced in health care is addressed.

Method
Electronic databases and nontraditional avenues for searching literature such as reference chaining and discussions with experts were employed to build an archive of texts related to integration of internationally educated health care professionals (IEHPs) into the workforce. Data related to workplace racialization were sought out, particularly those that used antiracist and postcolonial approaches. Rather than an exhaustive summary of the data, a critical review contributes to theory building and a spatial analysis was overlaid on the critical literature of IEHP integration to conceptualize the material effects of the convergence of globalization and professional systems.

Results
The critical review suggests that professions maintain their value and social status through discourses of “Canadianness” that maintain the homogeneity of professional spaces through social closure mechanisms of credential nonrecognition and resocialization. Power relations are maintained through mechanisms of workplace racialization/spatialization and surveillance which operate through discourses of “foreign-trainedness.”

Conclusions
Movement of professionals supports a professional system that on the surface values diversity while maintaining its social status and power through the (re)production of the discourse of “Whiteness.” The analysis shows how in the process domestic graduates are emplaced as the “rightful” citizens of professional paces while IEHPs are marginalized in the workforce.

There is an urgent need to reexamine issues of bias and discrimination in health care.1 Recent editorials in the Lancet2 and in the New England Journal of Medicine3 call for an examination of systemic racism in medicine, and in a special edition of Academic Medicine, authors discuss multiple approaches to mitigate bias and discrimination through widespread changes in medical culture,4–11 curriculum development,12–14 and assessment and evaluation.12,13 However, as the editors note, there are still many limitations in our understanding of bias in health care, including the impact of xenophobia and discrimination on the integration of international medical graduates (IMGs).1

Research on IMGs discusses biases in the residency selection process14–16 and discrimination in the workplace,17–21 but there is a gap in understanding the root causes or structural forces that makes bias and discrimination possible, even amidst reform efforts to better integrate IMGs into the workforce. The structural elements that reproduce inequities against internationally educated health care professionals (IEHPs) will be the focus of this article.

Introduction
The movement of health professionals has intensified over the past 2 decades as globalization culturally, technologically, and economically took hold as a value.22,23 Canada specifically, has encouraged highly educated and trained individuals to relocate to Canada as part of a national immigration and economic strategy.24,25 However, for health professionals trained outside of Canada, relocating to Canada has not automatically translated to working in Canada.26–30 Issues with the integration of IEHPs impact health delivery more broadly, as locally trained physicians are unable to meet the service demands. Although much has been written about the integration of IEHPs,31–37 there is a gap in the literature to understand how professionalizing systems that affect the licensing process of IEHPs intersect with socioeconomic and political realities such as globalization to (re)produce inequalities in health care between those trained locally and those trained abroad. Theories related to professionalization such as social closure theories generally focus on relationships between professions or within professions in a national setting.38,39 To appreciate more fully how structural racism impacts health care, we need analytical tools that tie macro systems of globalization to the meso level of professional regulation.39 Or put another way, we need an approach that allows scholars to connect analytically the global to the local in the micro-level spaces of professions. Spatial analysis is one such approach.

Spatial analysis examines social issues through the concrete,40 whether it is a geographical area or something more specific such as a ward in a hospital. It uncovers systems of power that map out dominant social relations such as

Contextualizing Personal and Professional Identities

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those that emplace White professionals as “rightful” citizens while at the same time keeping “Others” in their place. Antiracist scholar Razack refers to the process of making visible the “neutrality” of space as an “unmapping” which she defines as “undermin[ing] the idea of [W]hite … innocence … to uncover the ideologies and practices of conquest and domination.”40 Unmapping or problematizing space allows researchers to question the existing racial order by asking, “How are people kept in place?” and “How does place become race?”40 Spatial analysis is a popular and established methodological approach in sociology research since the 1990s. However, health professions research has not experienced this “spatial turn.”

This paper examines the racialization of health care spaces through a spatial analysis of the critical literature on the integration of IEHPs in the workplace. Spatial theorist Henri Lefebvre and postmodern scholar Michel Foucault provide theoretical constructs to investigate how systemic racism is reproduced in health care. In this analysis, we problematize the “neutrality” of professional spaces, to show how they are socially produced as “White” and how “Others” are by consequence “kept in their place.” We argue that the movement of health professionals supports a professional system that on the surface values diversity while maintaining its social status and power through the (re)production of the discourse of “Whiteness.” In the process, we demonstrate the potential of spatial analysis to inform antiracist and antioppression work in health care education and practice.

Lefebvre was a Marxist scholar whose English translation of The Production of Space informed the so-called “spatial turn” in sociology in the 1990s. He challenged the neutrality of space arguing for a method that would reininsert social relations (in particular, class relations) in the production of space. He claimed that there is a “need for an approach which would analyze not things in space but space itself, with a view to uncovering the social relations embedded in it.”43 In other words, by reframing the issue to how a particular space was established, including consideration of who was involved in the making and who was not, the boundaries of a space would emerge as contested. He used this approach to theorize that spaces produced under capitalism must foreground class relationships, if the goal is to make visible the explicit or implicit structural exploitation of some groups for the profit of others.42 We expand on Lefebvre’s analysis with this review to explain how professional spaces construct (and are constructed by) gender and race, in addition to class.42

The second theorist we draw upon, Michel Foucault, did not make space his central concern but is noted for 2 spatial concepts: the panopticon and the lesser-known heterotopia (or other space). His concern was not space in itself, but how space is situated within power/knowledge relations.43 Foucault described space as being part of the “history of powers” whose influence stretched “from the great strategies of geopolitics to the little tactics of the habitat, [from the] institutional architecture [of] the classroom to the design of hospitals.”44 Thus, space for Foucault is not a “preexisting” terrain but tied to power relations and the maintenance of social order.43 Historically, for example, the bourgeoisie separated themselves spatially to protect themselves from groups constructed as “degenerate” and “abnormal” in society and who were thus placed in asylums for the protection of society.45,46 Seen through this theoretical framing, schools, prisons, and hospitals are conceptualized as spaces that reproduce social norms through techniques of discipline and surveillance.46 The act of surveillance produces normal and abnormal bodies in which “the former belongs to a homogenous social body [while] the latter [is] exiled and spatially separated.”40 We draw on Foucault’s conceptualizations of space to explore mechanisms of socialization and structural systems of exclusion specific to health care and education.

Spatial metaphors help conceptualize the social production of space. In this review, we will use 2 metaphors: “peripheral space” and “purity” of space. The first metaphor, peripheral space, acts as a social mechanism (with material and symbolic dimensions) that creates homogeneous or pure space through the containment of social difference. Because these contaminations are ahistorical, they appear “innocent”; thus, their occupants appear “naturally” placed.40,44 Therefore, as critical scholars have shown, we never think of the power relations that contain but also construct different races and spaces—only the notion that Chinatowns were constructed because Chinese people wanted to live together, Whites are “natural” occupants of the suburbs, and Black and Indigenous peoples somehow “belong” or cluster in housing projects and slums.40

Pure spaces are elite spaces that reproduce privileged identities and social status, and to prevent loss of privilege and respectability, they must be protected from outside influences.47 An example of a pure space is the university as an institution. The purity of the university as a space for unfettered knowledge-making contributes to its elite status. As an institution the power relations upon which knowledge-making was historically constituted within universities, discursively normalized White Eurocentric knowledge-making approaches as rational.47 In the process, alternative or diverse ways of knowing are often characterized as irrational and obsolete, and pursued as a threat to established knowledge.47 Arguably, professional spaces can also be conceptualized as constructed pure spaces since a profession’s status and ability to control its own work depends upon having an exclusive body of knowledge produced in universities.48–50 A profession’s legitimacy and power to establish autonomy relies on the exclusivity of its knowledge base. Thus, health professionals, who have been trained differently than the system they are entering, bring diverse or alternative knowledge that threatens the purity of the local space. The following section will link these theoretical concepts with the methods of the literature review and discuss how it informed the analysis of the data.

Method

The current project topic emerged from observations made during an empirical study conducted by the first author exploring international pharmacists and their experiences of professional identity formation in Canada.51 Participants in the aforementioned study discussed how they felt out of place in Canadian pharmacies until they learned to negotiate cultural identities with their emerging professional identities requiring
In contrast to systematic reviews, critical reviews do not aim to generate an explanation of a problem or a summary of evidence on a particular topic. Instead, critical reviews focus on the conceptual contribution of each item of included literature, not on formal quality assessment. Compared with more traditional systematic reviews, critical reviews are better suited for exploring social issues because they draw upon qualitative methods to synthesize and analyze the data. Although there is no formal requirement to outline the precise methods for reproducibility, a brief discussion will follow that outlines the steps taken to search, synthesize, and analyze the texts.

The archive

The first author began compiling literature through a combination of online searches and expert recommendations on IEHP integration and workplace discrimination creating a starting point for analysis. More specifically, to compile the archive, the University of Toronto library's search engine was used. The terms internationally educated health care professional, international nursing graduate, international pharmacy graduate, and international medical graduate were searched in combination with the words racism, discrimination, professional identity, diversity, and professional integration. Consistent with a critical review, the goal of the analysis was to provide an analytical entry point for studying the problem of IEHP integration and not an exhaustive summary of all literature written on the topic. While sorting through the papers, we kept track of thematic patterns. We started grouping articles into 4 main themes: credential nonrecognition, resocialization, discrimination, and surveillance. To further isolate relevant texts, we used a purposive sampling approach to select papers that researched or theorized the integration experiences of IEHPs and offered a strong conceptual contribution related to understanding marginalization in the workplace. For example, we intentionally looked for papers that employed antiracist and postcolonial approaches for their critical framing of the integration experiences of IEHPs. A general exclusion strategy was to reject papers that were considered too "mainstream" (i.e., described problems without examining power relations) because their methodological approaches glossed over the marginalization of IEHPs. Primarily, we looked at research on international medical, nursing, and pharmacy graduates, but in keeping with a critical review, the inclusion strategy was more porous as some papers focused on the integration experiences of immigrant professionals from a variety of professions and these were selected because of their conceptual contributions which could assist in critically framing the experiences of IEHPs. This approach generated 31 papers for further analysis.

Maintaining the openness of the method, this initial investigation of the literature served as a "compass rather than an anchor," allowing us to settle on the exact focus of the review at the end of the analysis. Secondary texts, although not included as the archive's primary texts, provided additional context. Traditionally, when embarking on an archive, the choice of context is important (geography, time period, actors involved), but for the purposes of this review, the content of the text and how it related to the research question was more important than assigning strict geographical and temporal boundaries. There were no limits placed on time periods (the oldest article was from 1993), and geographical areas included countries such as the United States, Canada, the United Kingdom, Israel, Sweden, and Norway. Given our own locations, we use the Canadian context as the primary case example to situate our analysis and discussion. This does not suggest a complete saturation of the literature on the topic of IEHP integration, but rather the result of a "constant dialectic process" in which the selection of articles occurred at the same time that understanding was being generated. The final number of papers included in this review provide a tangible sample for demonstrating the theoretical insights derived from the application of the concept of spatiality to understand IEHP experiences in the workplace.

Analytical approach

Interacting with the data required a degree of reflexivity because there were tensions felt between the standpoint of the first author, who locates himself as a critical scholar writing within the professions, and those critical scholars who write from outside the professions. The first author, trained in the social sciences and a pharmacist, worked as an instructor for international pharmacists going through re-licensure. He recognized his own involvement in processes that were critiqued in the literature such as credential nonrecognition and reproducing the White social order. However, from his standpoint, there was an understanding that credential nonrecognition and resocialization were important aspects of professional boundary work that ensured patient safety and professional legitimacy. The second author is trained in the sociopolitics of education and has studied the movement of health professionals. She does not have clinical training but works in a clinical department and collaborates with clinical educators to address hidden curriculum effects, including discrimination in the learning environment. Their combined vantage points, through regular conversations allowed them to maintain insider/outside perspectives in the analysis and writing. This process is described in more detail in the Results and Discussion sections.

A critical framework informed the identification of the 4 themes related to the integration of IEHPs in the workplace. This analysis, however, did not fully capture the identity work described by participants in the first author's original study. We thus turned to the literature on space and race, and reexamined the archive for concepts related to space that would make visible how conditions of work relate to identity negotiations. In the social sciences, spatial methodologies
use a diverse number of theoretical constructs that focus on social inequity-related class, gender, and race. Despite its heterogeneity of approaches, one commonality is the need to problematize space by uncovering the social relations that make up its construction. One practical method used in this critical review was to reconceptualize each theme using spatial concepts such as periphery center, homogeneity and difference, containment and eviction, and pure space to make race and space visible in the analysis. For those wanting more information about spatial analysis and how it relates to issues of social justice in the Canadian context, including issues in health care and academia, they can refer to an edited volume by Razack. 40

From the spatial analysis, the theme of “Whiteness” emerged as the dominant discourse that organized social relations and from this, the final research question, of how is Whiteness (re)produced in health care spaces was determined. The category of “discrimination” was changed to workplace racialization/spatialization to more accurately reflect the spatial process that (re)produce workplace hierarchies. We present representative examples of this analysis in our results. Only the papers that are referred to specifically as examples in the results section are cited. The entire archive is included as Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B151.

Results
Our analysis reveals that “Whiteness” is supported by 2 additional discourses. The first is the national discourse of “Canadianness,” which in the context of health care professions is constructed from both professional knowledge produced in Canadian universities and also locale-specific discourses. While having professional knowledge is crucial for professions to maintain their status, Foucier argues that professions must also “establish their reputation with their local clientele.” 54,55 Thus, winning local trust may depend “more upon conformity with local customs and beliefs than on professional criteria.” 55 Nationalistic discourses have been identified elsewhere. “Norwegianness” has emerged as a cultural divide that separates insiders and outsiders in Norway’s health care system. 56 Immigrant workers find themselves on the lower rungs, while in comparison, Norwegians occupy higher status positions. 56,57 Nationalistic discourses result in the racialization and ethnicization of workers in which “Norwegianness” becomes a type of Whiteness that cannot be achieved by non-White immigrants and White immigrants from Eastern and Central Europe. 56,57 The second interlocking discourse is “foreign-trainedness.” Despite resocialization into Canadian cultural “norms,” some IEHPs will always be constructed as being “foreign-trained.” There are some international professionals who are closer to the center of “White” norms and seamlessly enter into the professions; however, as indicated by the experiences described in this review, some IEHPs, despite having a Canadian license, may always be constructed as professional outsiders. From the literature review, 4 mechanisms emerged that reproduce health care spaces as White: credential nonrecognition, resocialization, workplace racialization/spatialization, and surveillance, and in the next section, there will be a detailed discussion of how each operates to maintain the health care status quo.

Credential nonrecognition
Immigrants are kept out of professional spaces and the labor market through mechanisms of credential nonrecognition. 26,30,58-61 As noted earlier, professional spaces are constructed as “pure” spaces, and because these spaces (re)produce identities and social status, they must always be protected from difference. As noted by Schick, “the production of space is never complete, and the identities that depend on the legitimacy [of space] are forever insecure,” there needs to be “continuous surveillance … to prevent the loss of privilege and respectability.” 47 Critiques of the professional accreditation process point out that the nonrecognition of foreign credentials is antithetical to Canada’s commitment to pluralism and differences that challenge the status quo, such as foreign-trained knowledge and qualifications, go unrecognized. 58 From this critical perspective, the nonrecognition of foreign credentials is defined as a “deficit model of difference,” according to which any difference that threatens the status quo is perceived as “deficient, deviant, pathological, or otherwise divisive.” 58

The problematization of professional space reveals how social closure mechanisms such as credential nonrecognition interlock with systems of capitalism; racism; and patriarchy (re) producing spatialized, racialized, and gendered labor markets. Scholars argue that devaluing of foreign degrees and experience constructs immigrants as “cheap labor” who are delegated into low-paid, part-time work with little security or benefits. 52,63 Immigrant women face more barriers entering professional spaces compared with immigrant men. 53,64 And some who come from male-dominated fields such as engineering are retrained into female-dominated work such as early childhood education, daycare assistance, and community work. 65

Resocialization
The second mechanism that maintains the purity of space is resocialization. It acts as a gatekeeping mechanism that keeps IEHPs outside of professional space until the adoption of Canadian professional (technical knowledge) and communicative discourses. The process has been criticized by researchers for upholding the “Canadianness” of professional spaces with curricula closed to input or change from those immigrating to Canada, thus maintaining the labor market status quo. Critical scholars problematize the discourse of skills upgrading for international professionals. It is argued that immigrant settlement agencies (and arguably bridging programs) act as mechanisms to produce “desirable” workers for the Canadian labor market by “Canadianizing” immigrants’ codes of conduct and reproducing dominant cultural norms.” 66 They note how these services not only instill Canadian cultural norms but reshape immigrant identities by subduing differences, which, noted earlier, are considered a threat. Through skills training, immigrant professionals learn they need to “cast off their culture and take on local manners” to “fit” into the Canadian workplace. 60 In the first author’s study of international pharmacists and professional identity construction, participants noted how they had to connect with the local culture of their clients by engaging with the discourse of “Canadianness.” Integration into Canadian professional spaces requires taking on locale-specific discourses to gain legitimacy. As one
Workplace racialization/spatialization

While credential nonrecognition and resocialization act to maintain the purity of space, other mechanisms such as workplace racialization/spatialization and surveillance create peripheral spaces that organize difference into spatial hierarchies that are highly racialized and gendered.66 IEHPs are at the center of interlocking systems of oppression (namely gender, ethnic, racial), which cannot be understood as "simple layers of social inequality"; instead, these systems operate jointly to construct the lived experiences of IEHPs in the workplace.67 These interlocking systems construct hierarchies that give shape to symbolic and material organization of the nursing profession, where White, English-speaking nurses are located at the highest level, in administrative and management positions, with nurses from the Philippines, Eastern Europe, the Middle East, and India located in the middle, while Black INGs are positioned at the bottom.68–69 DiCicco-Bloom quotes from a nurse from India who experiences the material effects of this hierarchy and says, "I feel like I am treated better than Blacks. White is on top, and Black is [on] the bottom. I am somehow this blend."69 Ethnicity intersects with race to position INGs from Africa at the lowest level of the hierarchy compared with African American nurses and nurses from the Caribbean.70

Spatially, White nurses are located closer to the center of professional privilege in higher-status jobs that require more technical expertise such as the operating room or transplant units where there are more opportunities to advance. In contrast, INGs are more likely to work in the periphery, in lower-status positions such as nursing homes where the work is more routine compared with hospital work and less valued than working in tertiary and ambulatory settings.66,67,71 Positions in the labor force which racialized women occupy may seem “natural” rather than a result of discrimination.66 For example, Polish nurses were exploited by their Norwegian colleagues by making them work less-desirable shifts and longer hours because they were constructed as being “naturally” hardworking and caring. Thus, the stereotype of being “naturally” hardworking and caring acts as a mechanism to keep Polish nurses in their place in the nursing hierarchy.57

IMGs face a similar spatialization as do INGs in the health care workforce. For example, IMGs work in peripheral spaces that are “shunned” by locally trained physicians17,67,72 creating a “dual labor market” in which gaps in the labor market are filled by outsiders.72 The periphery is constructed differently depending on the country where the physician is practicing.73 In Israel, international physicians are more likely to be slotted into nursing homes, whereas in the United States, IMGs are located in inner-city hospitals, veterans’ hospitals, and similar to Canada, IMGs are expected to work in remote underserviced areas.72 However, despite work limitations, there are IMGs who rationalize that they are grateful to have a job and consider it “part of the deal” of becoming a physician outside their home country. In general, IMGs are drawn by the hope that there are more professional opportunities outside their home country, especially for female physicians.17

Surveillance

The last mechanism is surveillance. Surveillance operates to keep IEHPs in the periphery through monitoring of work performance and accents. As noted earlier, surveillance produces identities that belong and don’t belong to a particular context. Belonging is tied to work performance and having the “right” knowledge. Accounts abound of how IEHPs’ knowledge is constructed as “inferior” to Western education and experience. It is reported that IMGs’ competence is often challenged by local physicians who question the quality of their education and training as it comes from countries that are not as “technologically advanced” as Canada.36,73 The lack of trust in IEHPs’ abilities keeps them in their place as deskilling results in a lack of advancement. The literature reports that IEHPs are not given the same opportunities to grow as practitioners and scholars as domestic graduates.69,74–77

These effects perpetuate and are perpetuated by racist and neocolonial discourses that construct a hierarchy of knowledge of local ways of knowing and practicing as better than extra-local. It has been reported that domestic coworkers act as the eyes and ears of the administration to ensure that IEHPs do not compromise quality of care.67 The surveillance of IEHP workplace performance ensures that “mistakes” are never forgotten and international training is blamed for routine errors. International training becomes a permanent label that is attached to negative performances67 leading to a loss of self-esteem and confidence.68,74–77

Surveillance produces identities that belong (or do not belong) to the space by equating professional competence with having the “right” accent. IEHPs who speak with an accented English from the Global South are marked as having “inferior” skills76; thus, the “Canadian” accent becomes the yardstick to measure competence.78 Diminishing one’s authority because of an accent is a phenomenon described by Bourdieu as the “index of authority” in which “the efficacy of a discourse, its power to convince depends on the authority of the person who utters it.”79 Although resocialization requires the adoption of Canadian communicative discourses, this does not always guarantee full acceptance as a professional.66 Accents become a phenomenon to be surveilled and is designed to maintain the spatial order. Domestic graduates who speak an “unaccented” English are constructed through discourses of “Canadianness” as rightful occupants of the homogeneous space, but when these normative professional communicative discourses intersect with “foreign-trainedness,” IEHPs are constructed as not belonging, no matter how hard they try to “fit in.”

Discussion

What is the influence of globalization on the professions? In the presence of diverse bodies and knowledge, professional systems maintain their status and produce “privileged” identities by (re)producing professional spaces as “White.” The literature review suggests that IEHPs threaten the homogeneity of professional spaces and are met with an assemblage of technologies such as credential nonrecognition, resocialization, workplace racialization/spatialization, and surveillance. Processes such as credential nonrecognition and resocialization act as professional closure
mechanisms, which are linked to the adoption of “Canadianness” discourses and construction of “foreign-trainedness” as a “threat.” Power relations are maintained through technologies such as workplace racialization/spatialization and surveillance, which seek to “other” IEHPs because of their “foreign-trainedness” while preserving higher status positions through the discourse of “Canadianness.”

The problematization of professional spaces allows for an examination of how social relations are maintained through intersections of globalization and professionalizing systems. Closure mechanisms such as nonrecognition and resocialization protect the purity of professional space from outside influences, but as critical scholars point out, these mechanisms are antithetical to Canada’s commitment to pluralism as they diminish diversity. However, it would be antithetical for a profession to adopt pluralism as long as its professional autonomy relies on a unified cognitive base produced in Canadian universities. Ethnocentric approaches to knowledge position professions as having to protect the value ascribed to their expertise to safeguard their position in society and meet expectations of the public and their members.38,48 Equity-orientated scholars would specify that the use of professional closure discourses, whether they be for patient safety or protection of the profession, should only be a temporary measure to ensure competence and not exclude groups such as women or internationally educated health professionals from achieving full recognition as members of their profession. The constructs of “Canadianness” and “foreign-trainedness” intersect in processes of resocialization and surveillance. Resocialization is a process that maintains the purity of professional space by (re)producing professional norms essential for legitimacy. However, in the presence of diverse bodies, critiques of resocialization suggest that it acts to eliminate social differences and maintain dominant Canadian cultural norms. IEHPs may have little choice but to adopt locale-specific discourses to gain legitimacy, but the problem arises when these professional systems intersect with surveillance mechanisms such as linguicism, and IEHPs with “accents” are permanently marked as “incompetent” despite engaging in normative professional discourses. Finally, when professional processes designed to protect status intersect with systems such as capitalism, patriarchy, racism, and neocolonialism, maintaining the purity of professional spaces and its privileged identities manifests as the containment of “Others” in the margins away from higher-status work aligned with biotechnological expertise found in elite spaces of large metropolitan hospitals.56

**Conclusions**

The strength of this review is its potential for theory building.53 Our approach allowed us to go beyond a thematic summary of what we know about the integration of IEHPs to considering the sociopolitical mechanisms that impact successful integration into the Canadian workforce. A spatial analysis was overlaid on the critical literature of IEHP integration to conceptualize the material effects of the convergence of globalization and professional systems. In the process, we describe a number of structural and cultural practices that constitute health care professional spaces as socioeconomically privileged workplaces, with all the associated power relations that go along with privilege including closure strategies used to maintain self-regulating status. Such contests in the Canadian health care contexts make it difficult both ideologically and procedurally for IEHPs to enter the workforce. Our analysis shows how “Whiteness” is reproduced as the dominant discourse that organizes social relations in Canadian health care spaces that emplace domestic graduates as the rightful citizens of professional spaces while marginalizing IEHPs in the workforce.

Future directions for research may inform issues of diversity and equity in learning environments with regard to inclusion, in particular an appreciation of psychological safety for international trainees who may be othered because of difference. A focus on spatiality may make educators aware of their own involvement in the social (re)production of mainstream Canadian identities in professional practice which in turn create unsafe or unwelcome spaces for IEHPs, both conceptually and symbolically. Disrupting the production of spatial inequities requires researchers and educators to be reflexive to understand when these processes are part of productive professionalization and when they result in the systematic marginalization and exclusion of IEHPs. White professional educators and researchers, like the first author, who was part of the resocialization process for international pharmacists, need to be aware of these contradictions. Credential nonrecognition is intended to preserve standards of practice and protect the safety of patients. However, without deliberate attention to its implication in structural forms of oppression, it also acts as a mechanism for maintaining the homogeneity of a professional space. Thus, mechanisms designed to protect professional status and ensure patient safety, encountered in the typical work of clinical educators, become permanent barriers that exclude. The influx of international professionals expands the discourses of professional legitimacy to include “Canadianness,” but this needs to be balanced with a recognition that non-Canadian accents, and cultural differences in engaging with patients, are not directly correlated with competence and quality. Reducing bias and discrimination against IEHPs necessitates the need to problematize space and trace the interlocking systems that emplace IEHPs in marginal spaces. Research needs to question how IEHPs are constructed as “naturally” suited for certain work or why a disproportionate number of IEHPs work outside the elite spaces of health care. These are not natural placements but spatial ordering of health care professionals emerging from systems of oppression. It is only then that health professions education and regulatory bodies can make evidence informed changes to address systemic racism and discrimination in health care education and practice.

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