Adv in Health Sci Educ (2014) 19:161–181
DOI 10.1007/s10459-013-9468-2

The more it changes; the more it remains the same: a foucauldian analysis of Canadian policy documents relevant to student selection for medical school

Saleem Razack · David Lessard · Brian D. Hodges · Mary H. Maguire · Yvonne Steinert

Received: 20 February 2013 / Accepted: 10 June 2013 / Published online: 18 June 2013

Abstract Calls to increase the demographic representativeness of medical classes to better reflect the diversity of society are part of a growing international trend. Despite this, entry into medical school remains highly competitive and exclusive of marginalized groups. To address these questions, we conducted a Foucauldian discourse analysis of 15 publically available policy documents from the websites of Canadian medical education regulatory bodies, using the concepts of "excellence" (institutional or in an applicant), "diversity," and "equity" to frame the analysis. In most documents, there were appeals to broaden definitions of institutional excellence to include concerns for greater social accountability. Equity concerns tended to be represented as needing to be dealt with by people in positions of authority in order to counter a "hidden curriculum." Diversity was represented as an object of value, situated within a discontinuous history. As a rhetorical strategy, documents invoked complex societal shifts to promote change toward a more humanistic medical education system and profession. "Social accountability" was reified as an all-encompassing solution to most issues of representation. Although the policy documents proclaimed rootedness in an ethos of improving the societal responsiveness of the medical profession, our analysis takes a more critical stance towards the discourses

S. Razack
Department of Pediatrics and Centre for Medical Education, McGill University, 2nd Floor, Lady Meredith House, 1110 Pine Avenue West, Montreal, QC H3A 1A3, Canada

D. Lessard (✉)
Department of Anthropology, McGill University, Montreal, Canada
e-mail: david.lessard2@mail.mcgill.ca

B. D. Hodges
Richard and Elizabeth Currie Chair in Health Professions Education, Wilson Centre, University Health Network, Toronto, Canada

M. H. Maguire
Integrated Studies in Education, McGill University, Montreal, Canada

Y. Steinert
Center for Medical Education, McGill University, Montreal, Canada

identified. On the basis of our research findings, we question whether these calls may contribute to the maintenance of the specific power relations they seek to address. These conclusions lead us to consider the possibility that the discourses represented in the documents might be reframed to take into account issues of power distribution and its productive and reproductive features. A reframing of discourses could potentially generate greater inclusiveness in policy development processes, and afford disadvantaged and marginalized groups more participatory roles in the discussion.

Keywords Discourse · Social accountability · Diversity · Equity · Medical student selection

Introduction

The demographic composition of the medical profession is a concern for institutional bodies regulating medical education at an international level. The *Future of Medical Education in Canada* document from the Association of Faculties of Medicine of Canada (2010), the *Roadmap to Diversity* in the United States (Addams et al. 2010), and the UK policy document, *Tomorrow's Doctors* (General Medical Council 2009), are all remarkably similar in their calls for enhanced student selection practices, with the goal of promoting greater demographic representation of the population within the medical profession. These documents generally argue that such representation will lead to improved health care and equity for populations that are currently marginalized. Addressing diversity at the level of selection for medical school is seen as a key step in achieving these goals. In Canada, several national bodies responsible for the regulation of medical education have highlighted the importance of ensuring a medical profession that is more representative demographically of the general population, as a cornerstone to improving health care access for these marginalized populations (e.g. AFMC 2010; CFPC 2004; RCPSC 2006).

However, medicine remains a highly competitive profession. A national demographic survey of the applicants at four central Canadian medical schools (Young et al. 2012) indicates the exclusivity of entry to medical school, with a success rate for student applicants reported in the literature between 16 % and 25 %. Young et al. noted that the proportion of students coming from families earning greater than $CDN 100,000/year was eight times greater than in the general population. Students from Aboriginal, Black and Filipino backgrounds, as well as for students from rural backgrounds, remain significantly underrepresented. However concerns have been raised both within the profession and in broader society calling for greater equity in care provided to marginalized populations. In situations in which a problem persists, despite repeated calls for change, it is important to consider that there may be power dynamics operating to resist change. This paper thus analyzes policy documents from medical education regulatory bodies that aim to tackle such imbalances and broaden the diversity of medical school classes. It sheds a particular light on how they may unintentionally serve to reproduce the processes of exclusion that they seek to address.

According to Foucault, power dynamics are embedded in individual and institutional discourses and practices in ways that are not always immediately visible, even to those who reproduce them. In this study, we were interested in gaining an understanding of policy development at the national level in Canada, with respect to the addressing of demographic imbalances pertaining to student selection and admission to medical school.

We were fundamentally concerned with what these policies might reveal about positioning and power for the participating institutions, and what we might learn about the social, political, and historical contexts in which the policies have emerged. We also wanted to gain an understanding of the rhetorical strategies the institutions used in advocating for change. To answer these questions, we undertook a Foucauldian discourse analysis of fifteen policy documents pertaining to medical student selection and recruitment, from relevant Canadian medical education regulatory bodies. These documents share the characteristic of proposing changes to the selection and admission process to medical school, with the goal of improving the responsiveness of the profession in addressing specific diversity and equity concerns.

Understanding and making transparent the competing discourses embedded in the admissions process to medical school can provide insights into how discursive statements may empower or disempower specific subjects participating in the discourses, such as the medical profession or groups seen as marginalized in medical education. Through our analysis, we sought to shed light on the social contexts in which these discourses have arisen, in terms of power, politics, and ideologies, and how the identified discourses might link to changes in student selection.

Conceptual framework

Discourse is a term used by many in the social sciences disciplines, with a wide range of significations depending on the discipline and context (Mills 1997). Foucault defined discourse as a set of statements of truth (*énoncés*) and the objects, subject roles, and concepts made possible by these statements. Discourses are "practices that systematically form the objects of which they speak" (Foucault 1972: 49), and they imply systems of exclusion and distribution of power, which may lead to either the reproduction of existing structures or the production of new ones. Thus, discourses allow the emergence of a limited set of "discursive objects" and "subject positions," i.e. ways to participate in the discourses. In occupying these positions, individuals may contribute to the perpetuation of discourses that make these subject positions possible. Consequently, discourses invest people and institutions with power, create objects, and, through repetition, continually define key concepts accepted and valued as "true."

Foucault's definition also mentions that a discourse has "conditions for possibility," which include the broader social and cultural contexts that make possible and legitimate any given statement of truth. Statements of truth, in turn, make it possible to think, say, and do certain things and not others. They make possible what Foucault called "dividing practices;" processes that categorize, classify, and separate individuals in societies (Foucault 1971, 1972). The process of admission to medical schools, with all of its categorization and classification, has significant effects on the trajectory of individuals, and is an excellent example of a Foucauldian "dividing practice." As such, we assume that medical schools' admissions processes embed significant power that shapes not only individuals but also the institutions which simultaneously make possible and also constrain the process. In *Discipline and Punish*, Foucault stated that power can be 'sovereign' and can aim to reproduce identities and practices, but can also exist at the level of micro-structures, in 'capillary' forms. Capillary power is said to be socioculturally productive (Foucault 1977).

Foucault was not interested in a traditional linguistic understanding of discourse as statements that are merely a symbolic representation of some "reality." McHoul and Grace write: "Discourse is not simply the means by which a human subject—existing prior to the

discourse—expresses him/herself or accomplishes something. Rather, the discursive conditions (rules and criteria) set up specific places or positions in which subjects can be situated as, for example in the discourse of "madness," where subjects might participate as 'patients,' 'doctors,' 'schizophrenics,' 'criminals,' and so on" (1993, p. 48). Foucault uses discourse analysis as a way to understand what makes certain statements possible in the first place, who is authorized to repeat them, how they come to be understood as "truth," and what a specific discourse permits with respect to the production of subjects, objects, and effects in the "world." The relationship between discourse and power is fundamental to any Foucauldian analysis, and this relationship raises compelling questions, when considering the documents reviewed in this inquiry with respect to the political issues of identity, authority, power, and control (McHoul and Grace 1993). Discourses produced by organizations imply the creation, transformation, or maintenance of given relations of power and control. They play a central role in social and institutional practices in the emergence and implications of institutionalized ways of believing, thinking, and acting. These include social boundaries defining what can and cannot be said about a particular topic in particular contexts (Pennycook 2001; Hodges et al. 2008). We were interested in statements of truth about what makes a "good applicant" for medical school, from which discourses these statements draw their legitimacy, and which institutions and individuals are authorized to pronounce them. Thus, analysis of the published documents consisted of identifying such statements, discursive objects and subject positions created by them, all with respect to the social process in question—student selection for entry into medical school. Policy and recommendation documents took the form of what we termed "texts of transformation," i.e. texts that advocate for change, open different possibilities, or critique the present situation.

Analysing the content of three Canadian medical schools' websites in an earlier phase of this research, Razack et al. (2012) found that those schools implicitly suggested that asserting principles of equity and diversity could potentially undermine institutional and individual excellence among their student body. For this reason, through the analysis of texts, we sought to uncover interactions between repetitive and consistent discursive formations with respect to the key concepts of "social accountability," "excellence," "equity," and "diversity."

Research questions

1. In a select body of publically available policy documents from Canadian medical education credentialing and licensure bodies (written in either English or French), which pertain to student selection practices for entry into medical school, in what statements of truth, and discourse, are the concepts 'excellence,' 'equity,' and 'diversity' deployed and used?
2. Assuming that discourses regulate social institutional practices, what might the identified discourses signify for the relationships between knowledge and power in the social world, with respect to student selection practices for entry into medicine in Canada?

Analytical framework for the interpretation of the texts

Hodder (1994) provides a framework for the interpretation of textual documents. In Hodder's framework, documents are understood as both material texts and objects. Thus, there are two threads in the qualitative analysis of documents. In the first, we seek to situate

the document in its context. In the second we seek to develop an understanding of the meanings conveyed within the document and the conditions that make such interpretations possible. In the Foucauldian discourse analysis sense, we attempted to discern the various statements of truth represented within the documents.

Specifically, we produced a description of each document with the goal of situating the document within the context of the organization that produced it. These descriptions mention the context of production of each document, the pool of potential or expected readers, making explicit the "historical context" in which it might be interpreted for meaning. Indeed, Hodder argued: "there is no "original" or "true" meaning of a text outside specific historical contexts" (1994, p. 394). However, because most of these documents were quite recent, dating from 2001 to 2012, we were unable to assess how they actually have been read, interpreted, transmitted, transformed into policies, used, or discarded, or even recycled. These texts can be seen as reflections of and on the past and present situation of medical education.

Foucault's method arose within the constraints of specific historical conditions. His approaches in his writings about historical changes is commonly considered as either *archaeological*—a diachronic method to unearth structures that constitute discourse—or *genealogical*—a synchronic analytical method concerned with associations and effects of power that arise from and in association with the use of particular discourses (Gutting 2005). Foucault's method built on Nietzsche's genealogy, which aimed to explain morality as contingent phenomenon (Nietzsche 1994[1887]). Unlike Nietzsche's method, Foucault's analysis involves meticulous archival research. However, both approaches involve an acute critical component serving to deconstruct official meanings and understandings to show how these emerge from series of accidents and contingent deviations: "Like Nietzsche, (Foucault) also wanted to use genealogy as an argument against particular possibilities that has become realities" (Visker 1995: 100). The objective is not to understand the past—genealogies are in fact quite critical of genetic or chronological accounts—but to produce a history of the present that questions claims of authority (Gutting 2005). The point of Foucault's analyses is not to unveil "truth" about the world. Rather, it is constituted by historically situated discourses making visible and dissecting historical nodes in order to reveal discursive—and thus power—shifts.

It is important to note that three of the authors (Razack, Steinert, and Hodges) occupy positions in the medical education community in Canada and have collaborated at various times with the medical education organizations that created the documents examined in this study, while two (Lessard and Maguire) do not.[1] An important and challenging aspect of research within the critical paradigm was to strike a balance between "insider" and "outsider" perspectives. Throughout the research the three authors who are positioned

[1] Dr. Razack is pediatric intensive care physician, associate professor of pediatrics, assistant dean of admissions, equity, and diversity, and core member, Centre for Medical Education, McGill University Faculty of Medicine, Montreal, Quebec, Canada. David Lessard is a PhD candidate in Anthropology at McGill University, Montreal, Quebec, Canada. His research interest focuses on the concepts of community and emergence in indigenous contexts. Dr. Maguire is professor of multilingual/multicultural literacies, qualitative & ethnographic methods, Department of Integrated Studies in Education, McGill University, Montreal, Quebec, Canada. Dr. Hodges is professor of psychiatry, University of Toronto Faculty of Medicine and Department of Theory and Policy Studies, Ontario Institute for Studies in Education, both in Toronto, Ontario, Canada. He is Richard and Elizabeth Currie Chair in Health Professions Education Research, Wilson Centre for Research in Education, University of Toronto, Toronto, Ontario, Canada. Dr. Steinert is clinical psychologist, professor of family medicine, Richard and Sylvia Cruess Chair in Medical Education, and director, Centre for Medical Education, all at McGill University Faculty of Medicine, Montreal, Quebec, Canada.

within the medical education community have had to be continuously reflective about how their experiences shape their interpretations of organizational intentions and statements. We have found much value in this process of reflection and hope that it will benefit our "insider" colleagues as well.

Method

One of the authors (David Lessard) reviewed documents produced by Canadian national medical organizations and then selected public policy documents on the internet website of five national organizations between September and November 2011: The Association of Faculties of Medicine of Canada (AFMC), the Canadian Medical Association (CMA), the College of Family Physicians of Canada (CFPC), the Medical Council of Canada (MCC), and the Royal College of Physicians and Surgeons of Canada (RCPSC). We chose these organizations because they constitute the main regulatory bodies for medical education in Canada. Fifteen documents were selected for this portion of the research project.

We selected the documents based upon the following criteria:

1. Public accessibility on the organizations' respective websites;
2. Consisting of policies, discussions, and recommendations for the organization on whose behalf they were prepared;
3. Treating the subject of, at least in part, the organizations' orientations with respect to the selection of students for medical school; and,
4. Mentioning the key concepts of our research, i.e. diversity, equity, and excellence, in the selection of medical students.

We searched the websites using organizations' internal internet search engines with the following keywords: admission, selection, equity, diversity, excellence, social accountability and medical education. The documents that we found were all quite recent, the oldest going back to 2001, and can be divided in four categories: (1) documents mainly discussing the concept of social accountability (AFMC 2001, 2003, 2010); (2) documents discussing the situation of specific groups in relation with medical education (AFMC and IPAC 2007; AFMC 2011; CFPC 2004; MCC 2012); (3) documents making recommendations to improve the health system through changes in medical education (AFMC 2006; RCPSC 2001, 2006, 2009a, b) and; (4) documents making recommendations for specific medical education programs (CFPC 2007, 2009) Table 1.

To manage the data, we used Atlas.ti (v.6, ATLAS.ti Scientific Software Development GmbH©, 2009), a qualitative analysis software, to organize three consecutive readings of all the selected documents. The first reading mainly consisted of identifying the sections of the documents in which selection and admission of medical students were mentioned or discussed. During a second reading, Lessard identified and commented on how the documents defined and discussed the key concepts of excellence, diversity, and equity. During the third reading, Lessard generated distinctive *statements of truth contained within the texts*. We interpreted these statements of truth in their respective contexts in order to see how arguments about the selection and admission of medical students are elements of an internally coherent whole (i.e. the documents), and if they imply specific relations of power and organizational hierarchies.

Table 1 Inventory of selected documents, and discarded documents, for each professional organization

Professional organization	Included documents	Considered documents that did not meet a priori inclusion criteria
AFMC	AFMC (2001). *Social Accountability: A Vision for Canadian Medical Schools* AFMC (2003). *Social accountability: moving beyond the rhetoric—proceedings.* Plenary Session of the Annual Meeting held in Quebec, April 28, 2003 AFMC (2006). *Enhancing the health of the population: The role of Canadian Faculties of Medicine* AFMC and INDIGENOUS PHYSICIANS ASSOCIATION OF CANADA. 2007. *Best practices to recruit mature aboriginal students to medicine* AFMC (2010). *The future of medical education in Canada* AFMC (2011). *Equity and Diversity Audit Tool for Canadian Medical Schools*	AFMC. *Young Leaders' Forum synthesis report: Connecting with the health care leaders of 2027.* July 2007 AFMC. *Rapport de synthèse de la réunion du groupe d'experts tenue en 2008.* April 2008 Boudreau, Donald. *Physicianship: A framework for a Renewed Undergraduate Medical Curriculum.* Presentation to the Resource Committee on Professionalism, AFMC annual meeting, May 2008. Hawkins, David. *Social accountability of Canadian Medical Schools: The factor of complexity.* Information pamphlet Hutchison, Tom, McNamara, Helen, Mount, Bal and Eileen Lavery. *Teaching physicians the healer role: The McGill Approach*.Presentation, McGill Programs in Whole Person Care, May 3, 2008. Lovato, Chris. *2007 Conference in medical education: Fully Distributed Medical Education Undergraduate Programs in Regional Campuses*. Post Conference Workshop Report, Victoria. 2007
CFPC	CFPC (2004). *Admission of rural origin students to medical school: recommended strategies* CFPC (2007). *Rethinking undergraduate medical education—A view from family medicine* CFPC (2009). *CanMEDS-FMU: Undergraduate competencies from a family medicine perspective*	CFPC. *Defining Competence for the Purposes of certification by the college of family physicians of Canada: The evaluation objectives in family medicine.* 2010. CFPC. *General Guidelines for the Accreditation of Postgraduate Training* CFPC. *Recommandations du groupe de travail du CMFC sur la formation prédoctorale.* 15 mai 2002. CFPC. *Critères pour l'agrément des programmes de residence en médecine familiale, médecine d'urgence, compétences avancées et soins palliatif.* 2006 CFPC. *Cursus Triple C axé sur le développementt des compétences: Rapport du Groupe de travail sur la revision du cursus postdoctoral—partie 1.* 2011. CFPC. *Repenser l'éducation médicale prédoctorale: Perspective de la médecine familiale* (2007)
MCC	MCC. *Registration to practice medicine in Canada.* Link updated in 2012.	MCC. *Finding opportunities in collaboration: 2010 Annual Report.* 2010.

Table 1 continued

Professional organization	Included documents	Considered documents that did not meet a priori inclusion criteria
RCPSC	PHYSICIAN HUMAN RESOURCE STRATEGY FOR CANADA TASK FORCE TWO (2006a). *A Physician Human Resource Strategy for Canada: Final Report* RCPSC (2006). *RCPSC Statement on appropriate physician resource for Canada: toward achieving responsible self-sufficiency* RCPSC (2009a). *Health human resources: an essential part of a sustainable, accessible and responsive health care system* RCPSC (2009b). *One step forward—two steps back? a discussion paper on physician mobility in Canada.* Office of Health Policy and Governance Support RCPSC (2011). *Addressing societal health needs*	RCPSC. *The CanMEDS Program Overview—2011* RCPSC. *Safeguarding the quality of the educational continuum and medical workforce in Canada's complex health care system.* July 2008 RCPSC and the CFPC. *Conjoint Discussion Paper: Family Physicians and Other Specialists: Working and Learning Together*. August 2006 RCPSC and the CFPC. *Family physicians and other specialists: A joint initiative to enhance collegial relationships*. March 2007
CMA		

Results

We have organized the identified *énoncés* identified in the next sections:

"Important changes are required to mirror societal diversity"

Institutional policy documents often argue for a specific change or imply that current practice is no longer ideal, because the world is about to change or there has been a change, or discontinuity (Revel 2004). The Foucauldian concept of "discontinuity" can help understanding situations in which discursive objects are no longer perceived, described, or classified the same way from one epoch to the other (Foucault 1972). Interestingly, sometimes careful historical and textual research reveal that recommendations for changes or discontinuities—such as the ones entailed in the policy documents—are rhetorical constructions. Arguments about discontinuities may be at variance from what are in fact continuous, seemingly silent discourses existing in parallel with more dominant discourses (Foucault 1971).

In their discussion of ongoing changes currently affecting Canadian medical schools, Eskander et al. (2013) advance the notion that the current shift aims at enhancing *equity* in admission policies and curriculum content, in order to generate a profession more representative of the social diversity existing in the population at large. The documents we reviewed focus mostly on the diversity aspect, and pay less attention to equity and excellence. They suggest that changes in the way diversity is understood is a shift currently occurring to society. However, we assume that this shift is not a discontinuity in the Foucauldian definition (i.e. a change in what is 'true' or 'legitimate'). No information is given about actual changes occurring to the composition of society. What we note is more a *rhetorical construction* that there has been a change, used to suggest urgency and push

forward specific policies. According to this new understanding, changes happening within medical education should reflect the diversity of the Canadian population at large, and diversity should be the object of inclusion or access policies. Regulatory bodies all interpreted this discontinuity in terms of a pressing need for medical education and the health system to mirror and adapt to a pluralistic Canadian society. Documents mention an emerging awareness of a diversity of health problems with respect to medical specialities (AFMC 2001, 2003, 2006; CFPC 2007, 2009; RCPSC 2006; PHRSC-TFT 2006); socio-economic disparities (AFMC 2003; RCPSC 2011); marginality (CFPC 2009); movements and migration (AFMC 2003, 2010; RCPSC 2009b); gender (AFMC 2011); and ethnic diversity (AFMC 2003, 2011). Documents also mention other "transforming realities." For instance, it is argued that contemporary awareness should change the way certain facets of diversity are conceptualized. Notably, the situations of aboriginal (AFMC and IPAC 2007; RCPSC 2011) and rural people (CFPC 2004) are presented as necessitating quantifiable and qualitative transformations of the medical education system, given the access crisis to health care within these communities.

"Diversity: a desirable feature"

This discursive statement suggests that diversity is observable, quantifiable, and, in most cases, valuable, if not profitable. Noteworthy is this valorization of diversity because it often became dominant and was presented as self-evident (i.e. reified). For example, CFPC produced two documents (2007, 2009) arguing for an improvement of medical schools' and of the health system's ability to assess communities' needs and to handle diversity. CFPC also produced one document (2004) emphasizing the need for more rural representation in medical faculties. A RCPSC document also mentions the need to enhance these abilities, but highlights the case of Aboriginal peoples as a specific example of diversity (2011). All AFMC documents mention this statement, and this regulatory body discussed it in great detail. The *Audit Tool* (AFMC 2011) is certainly the document that does so in the most explicit way, in that it specifically mentions ethnic, socioeconomic, and gender-related forms of diversity, but does not mention other dimensions of diversity such as religion, language or social classes.

"Leadership in social accountability as a path to international recognition"

This discursive statement is closely related to the reification of diversity. It advances the notion that Canadian faculties of medicine should take advantage of their present emphasis on social accountability. In the last decade, national and international institutions have considered initiatives to enhance equity and diversity under the conceptual umbrella of social accountability. The World Health Organization defines social accountability as:

> 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. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.
>
> (WHO 1995: 3)

WHO estimates that more than equity, social accountability ought to improve the relevance, quality, and cost-effectiveness of medical cares and medical education (WHO 1995). Leinster (2011) hence considers social accountability as a way to improve the excellence and quality of the medical system. Social accountability is presented as a way

for Canadian faculties of medicine to seek recognition at the international level. The documents often refer to the implications of WHO's definition of social accountability on the Canadian health system; WHO is often used as an authority or a justification for the placing of emphasis on social accountability. Documents produced by the AFMC and RCPSC often mention WHO as a source of definitions of terms, (e.g. AFMC 2001, 2006, 2010, 2011), to justify a certain moral or ethical orientation (AFMC 2006; RCPSC 2011), or to make the case for change (AFMC 2003).

Excellence refers to the set of qualities that an institution or an applicant requires to be considered as desirable. Its relationship with social accountability is complex. As mentioned earlier, documents bring a more prominent focus on social accountability than on equity or excellence. In fact, AFMC often invokes social accountability to demonstrate the excellence of medical education in Canada. For example, it is stated in a document that "Canada is considered a world leader—now it has the opportunity to be a leader in social accountability in medical education" (AFMC 2003: 7). Regulatory bodies invoke excellence to qualify almost anything done in medical education. Documents—especially those produced by AFMC—associate excellence with sets of progressive diversity policies allowing claiming for international recognition.

"Equity as a way to improve medical education and the quality of the health care system"

This discursive statement proposes that making medical education and the health system more equitable or socially accountable can improve the health of the population. In many cases, documents mention social accountability as an important element that has been neglected in the past. In the same line, they represent equity as a way to address specific concerns that have affected Canadian society for a long time, such as differential access to health care among aboriginal populations and for those in rural areas. AFMC documents suggest that addressing equity implies an improvement in access to health care for marginalized populations, either by discussing the current challenges faced by the health system (2003), by acknowledging the commitments some bodies have already taken regarding equity and social accountability (2006), or by mentioning future orientation that should be taken by actors of the health system and of medical education (2001). CFPC documents also deal with these three types of discourses in the specific case of rural origin students (2004) and by addressing the need to democratize medical knowledge and the way in which health issues are dealt with (2009). RCPSC documents address the positive implications of increasing the number of admission in medicine and the number of available physicians (RCPSC 2006, 2011; PHRSC-TFT 2006), which could also justify an increased acceptance of IMGs (2009a, b).

"Social accountability as a discontinuity with detractors"

Documents mention perceived obstacles to the achieving of greater social accountability for the regulatory bodies or for medical schools, and often emphasize institutional resistance to change and the "hidden curriculum" or "implicit agenda." These concepts refer to the potential existence of an alternative set of principles, values, and actions embedded within medical education, which go against the stated principles, objectives, and processes that the collectivities representing medical education concerns have explicitly defined. Documents generally describe the implicit agenda, or hidden curriculum, as something that must be acted upon in order to value and assert social accountability, notably because it

emphasizes competition, hierarchy, barriers to medical education, and the specialization of physicians. All AFMC documents mention the hidden curriculum or other obstacles to social accountability. However, CFPC (2007) analyses this phenomenon and mentions its content, positive aspects, the obstacles to change, and strategies to act upon it for all of the players within the medical education and health systems.

Table 2 shows a few examples upon which we based the elaboration of the *énoncés* identified.

Foucauldian analysis

In undertaking this Foucauldian analysis, we considered these questions:

- What are the subject positions that one can occupy to participate in this discourse?
- Whose legitimacy is affected by power imbalances?
- What objects are created by the discourse?
- What key concepts are embodied in each discursive statement?

Foucault wrote: "The question posed by language analysis of some discursive fact or other is always: according to what rules has a particular statement been made, and consequently according to what rules could other similar statements be made? The description of the events of discourse poses a quiet different question: how is it that one particular statement appeared rather than another" (Foucault 1972: 27). All the documents analyzed share two important characteristics. Firstly, they are persuasive in nature and seek to make the case for specific change by identifying some temporal discontinuity or an abrupt reframing of perception. We could summarize such discontinuities by the phrase *we see things differently now and we need to change*. In terms of secondary appeals, we see the values-imbued notion of aspiring for the creation of a "better" profession, one that is more responsive to societal needs. This attempt to respond to societal needs is generally characterized under the rubric of increasing social accountability. A second characteristic the documents share is that they are inherently prescriptive in nature, promoting change frequently through the use of the modal verb "should" within the elaborated policies Table 3.

Discontinuity as a rhetorical strategy to promote practice change

Documents frequently imply that demographic shifts in society have made changes to medical admissions urgent. For example, some documents mention that crises in Canadian rural and Aboriginal communities are long standing. We hence wonder what exactly prompted the assertion of discontinuity as a rhetorical strategy for change and what professional organizations' orientations and possibilities can be when addressing such issues that led them to the current valorization of social accountability and its intertwinement with the concepts of excellence, diversity, and equity. Could reframing these situations as "new concerns" potentially obscure or even reproduce the dynamics of exclusion that are contributing to the lack of access to care in peripheral areas in the first place, such as in rural Canada and within Aboriginal communities? For example, Strong-Boag (1981) show that nearly seven decades passed between the era when medical education organizations ceased to use overtly discriminatory language about women in medicine and when a meaningful change in admissions and other policies that led to parity of women and men entering medical schools (Strong-Boag 1981).

Table 2 Statements of truth and examples from the policy documents

Statements of truth	Examples
"Important change are required to mirror society"	"Societal changes—such as increasing socioeconomic disparity, urbanization, diversity, and global mobility and connectivity—contribute significantly to the shaping of medical education. […] Emerging issues around the safety, quality, and efficiency of health care also influence the skill sets required of contemporary Canadian practitioners." (AFMC 2010, p.9) "Although the primary need is to alleviate and often cure disease and disability the needs of communities and society change and evolve over time and latterly have encompassed greater emphasis on health and wellness." (RCPSC 2011, p. 1)
"Diversity: A desirable feature"	"Diversity, in the context of equity, acknowledges that power differences exist between people based on factors such as race, ethnicity, class, gender, sexual orientation (dis)ability, etc. Diversity also acknowledges that, within any given group, there are significant differences between individuals themselves. Accounting for difference is an important task of organizations that embrace an ethic of equity." (AFMC 2011, p. 4) "All admission committees should apply a "rural lens" to the admissions process. This should include examining what is looked for at every stage: screening, scoring, essay questions and interviews to ensure there are no unintentional barriers to rural origin students. In fact, "rural" could be regarded as one of the positive or desirable candidate attributes to be considered in the selection process." (CFPC 2004, pp. 11–12)
"Equity as a way to improve medical education and the quality of the health care system"	"Despite the complexities of its health care system, Canada is a global leader in medical education innovation. Examples abound, from McMaster University's system of problem-based learning, designed to help students keep pace with the continually expanding knowledge base, to the new Northern Ontario School of Medicine, created specially to serve rural, remote, and Indigenous communities. Focused and innovative curricular changes in medical education are being directed by the Educating Future Physicians for Ontario (EFPO) and CanMEDS projects, including the development of new assessment and evaluation strategies, and through Canadian faculties creating competency-based curricula." (AFMC 2010, p. 10)
"Leadership in social accountability as a path to international recognition"	"Health Canada, in a 2001 monograph cited the WHO (World Health Organization) 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/or nation that have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public." (RCPSC 2011, p. 1) "Equity at its most basic level is about fairness, and it is premised upon a sense of justice. Equity is not the same as equality. Equality implies sameness. Equity on the other hand, assumes difference and takes difference into account—to ensure a fair process and ultimately, a fair (or equitable) outcome. Used in World Health Organization (WHO) documents, inequity refers to differences which are not only unnecessary and avoidable, but also unfair and unjust." (AFMC 2011, p. 3)

Table 2 continued

Statements of truth	Examples
"Social accountability as a discontinuity with detractors"	*"A commitment to diversity and equity starts at the top—reflected in the faces of leadership, in the allocation of resources, and in positions and roles designated to further diversity as well as equity. Clear statements from the Medical school's leadership of the institutional commitment to equity and diversity are essential if those goals are to be fully realized. It is at the strategic level where departments and administrative units can establish sustainable change efforts—through earmarked resources and visible champions."* ~L. Charvat "Exemplary Practices in Equity and Diversity Programming". UBC-Vancouver, May 2009. (AFMC 2011, p. 5) "The hidden curriculum encompasses what students learn outside the formal curriculum. It is pervasive and complex and can be deeply instilled in institutional cultures. […] There are elements of the hidden curriculum that are positive in nature; however, many others have been identified as having a counterproductive effect on learning. The hidden curriculum often supports hierarchies of clinical domains or gives one group advantages over another. It sometimes reinforces the negative elements of existing reward and recognition systems and deters students from pursuing certain careers in medicine, such as family medicine. For these reasons, revealing and clarifying the hidden curriculum will be a challenging yet critical move forward for Canada's Faculties of Medicine." (AFMC 2010, p. 23) "Equity means striving to make quality health care available to all people; medical schools can assist by defining populations at risk through well-designed research, identifying methods of removing barriers to access and educating students in environments in which they are exposed to those in need. These values are implicit in the Canadian health care system and are recognized by the Canadian population at large, which is, today, better informed and more demanding of better access and quality for the health care system." (AFMC 2001, p. 2)

Policy documents often invoke contingent situations, sometimes implied to be recent or new, as a justification for the recommendations for change (Roe 1994). This strategy has a long history in medical education policy development. Whitehead et al. (2012) analyzed an historical archive of policy documents in medical education and note that many have argued, throughout the twentieth century, for novelty and improvement in the training of physicians. Each generation identified "new" problems (for example, the "explosion of medical knowledge," repeated roughly every decade since 1910), with appeals for their urgent attention. We found similar repetitive discourses of novelty in the policy documents we analyzed. Specifically, organizations recurrently argue for the selection of medical students to be chosen not only on assessments of simple biomedical knowledge, but, as well, on assessments of humanistic characteristics. Another pressing but apparently recurring imperative was the appropriate balance between over-specialization and generalism, seen as having implications for student selection in terms of diversity and equity concerns.

Documents mention "temporal shifts" as a major persuasive argument in favor of change. However, mentions of these shifts and the need for policy change do not fully reveal institutions' actual roles in change or the ways in which they use their power. The

Table 3 Foucaldian analysis

Discursive statement	Whose legitimacy is affected?	Created objects	Key concepts
"Important change are required to mirror society"	Medical schools gain control over professional organizations in composing the features of the professions (AFMC 2001) Rural or Aboriginal community leaders (as well as those of other minority or marginalized communities), who people in position of representing them (CFPC 2004) Specialities, such as palliative cares, family medicine, public health, infectious or chronic diseases can gain or lose powers depending on circumstances (RCPSC 2009b)	Health crises (*E. Coli*, SARS, etc.) (AFMC 2006) Opportunities for qualitative and quantitative research on Canadian society (RCSPC 2011) Committees, meetings and conferences involving community leaders (CFPC 2004; AFMC 2001, 2003) Physician social, cultural and geographical mobility (RCPSC 2009b) Special funds for Aboriginal, Inuit and Métis (RCPSC 2009a)	Commitment to community and to patients (CFPC 2009) Societal Needs (RCPSC 2011) Aboriginality, Rurality, Marginality (CFPC 2004) Change and Discontinuity (RCPSC 2011; AFMC 2010) Differential access to care and workforce shortages (RCPSC, 2006) Emerging needs (AFMC 2001) Public interest (RCPSC 2011)
"Diversity: A desirable feature"	Family medicine, as a first line directly dealing with communities, gains power (CFPC 2009) Institutional leadership gains power in defining diversity and having the responsibility to commit to it (AFMC 2011) Programs "exemplifying" social accountability (AFMC 2003)	Diversity-enhancing recruitment programs and committees (AFMC 2011) Programs to prepare Aboriginal students to have the appropriate skills for medical education (RCPSC 2011, 2009a; CFPC 2004) Measures and policies taken by institutional leadership to enhance diversity (AFMC 2011) Financial support programs for Aboriginals (AFMC and IPAC 2007) Registration guidelines (MCC 2012)	Diversity- based Determinants of health (AFMC 2001) Acknowledgment and recognition (AFMC 2011) Institutional commitment (AFMC 2011) Knowledge, skills and attitudes adapted to diverse communities (CFPC 2009) Programs that exemplify social accountability (AFMC, 2003) Under-representation (AFMC 2010)

Table 3 continued

Discursive statement	Whose legitimacy is affected?	Created objects	Key concepts
"Equity as a way to improve medical education and the quality of the health care system"	Physicians come to play new roles in society (AFMC 2001) Physicians gain an increasing power in determining patients' needs and identifying vulnerable populations (CFPC 2009) Family medicine seemingly gains prestige and power (CFPC 2009) Council of Deans gains power, as they are the one who defined nationally the concept of social accountability (AFMC 2006)	Establishment of innovative practice patterns and participation to the shaping of the health system (AFMC 2001) Assessment and management of patients using patient-centred clinical methods (CFPC 2009) Strategy to enhance medical institutions and medical education in rural and Aboriginal communities (CFPC 2004)	Balanced integration of service and education (AFMC 2001) Fair and equitable distribution of the workforce (CFPC 2004) Focus on population needs (AFMC 2006) Patients' safety and access to care (RCPSC 2006)
"Leadership in social accountability as a path to international recognition"	Governments, health organizations and professional, and public leaders gain power, as they participate in defining community needs (AFMC 2001) Consultants in social accountability (AFMC 2003) Canadian organizations, by being referred to by the WHO, gain international recognition (RCPSC 2011)	Task groups and education, research and service activities to address community needs (AFMC 2001) Inter-faculty, national and international committees (AFMC 2003) Health promotion campaigns (AFMC 2006)	The four values of social accountability: relevance, quality, cost effectiveness and equity (AFMC 2001) WHO's authoritative definition of equity and social accountability (AFMC 2011)

Table 3 continued

Discursive statement	Whose legitimacy is affected?	Created objects	Key concepts
"Social accountability as a discontinuity with detractors"	Positivist science, biomedicine and corporations gain power through the hidden curriculum; unveiling this process may make visible its dominance and reduce its power (CFPC 2007) Administrations and leadership are those who have the responsibility and can act upon it (CFPC 2007; AFMC 2010)	Programs to bring students into community or family medicine (AFMC 2006) Task groups to define and work on the hidden curriculum (AFMC 2006) Engage faculty, student body and administration in creating safe ways, mentorship programs, and places for discussion (AFMC 2010) Mandatory clerkship in family medicine for all medical students (CFPC 2007)	History of reforms without change, slight transformations with no real results, addressing the issues relative to the hidden curriculum (CFPC 2007) Implicit rules to survive and take advantage of the system (CFPC 2007) Challenges to equity and social accountability (AFMC 2003)

juxtaposition of the idea of a societal shift with a call for change, but little observed change in the larger macrosocietal context, raises questions about the relations of power between medical education institutions and society. This paradox is evident in this excerpt from the introduction of a document on social accountability:

> At the beginning of the new millennium, the expectation of the public is that governments and the professions work collaboratively to ensure that the highly valued Canadian health care system continues to provide the necessary access and quality to meet the needs of the population. Medical schools have an important role to play in this endeavour. […] Canadian medical schools, along with their partners, have a major role to play in influencing the changes in the health care system that are necessary to ensure an effective, efficient, accessible, equitable and sustainable system in the 21st century.
>
> (AFMC 2001)

Transforming public expectations regarding health offers opportunities for medical education and health institutions to perpetuate the claim over the central role that they are already playing in defining such policies. Thus, they protect the status quo, which has over the past century conferred a great deal of reproductive power and status on the medical profession. In *The Social Transformation of American Medicine* Starr argues that, "The dream of reason did not take power into consideration… the history of medicine has been written as an epic of progress, but it is also a tale of social and economic conflict over the emergence of new hierarchies of power and authority, new markets and new conditions of belief and experience." (Starr 1982: 3–4).

Social accountability as an all-encompassing term:

The concept of equity lacked clarity of definition in the documents. For example, at times it meant the selection of more individuals from rural and Aboriginal (i.e. under-represented) communities within medical education, which was presented as a way to bring improved services to these communities (AFMC 2007). At other times, equity implies the improvement of physicians' mobility across the country, thus bringing the privilege of access to health care to all national communities (CFPC 2004; RCPSC 2006). Rather, as previously mentioned, a number of recommendations from documents make the case for changes under the concept of "social accountability." However, social accountability, as any overused term, can be problematized. In the documents that we analyzed, "social accountability" is defined and put forward by corporate organizations that, on the one hand, are limited in their scope and extent of actions and that, on the other hand, have their own interests as well.

WHO's definition places social accountability as an obligation on the part of medical schools to address individuals' and communities' health concerns. Yet, the documents in fact invoke this concept to address issues that are much more specific and actually contingent on highly contextual factors in order to be properly addressed. They treat it as a "solution" to problematized realities that are emerging in the context of changes affecting contemporary Canadian society and communities. These changes are associated with concerns relative to a growing social, linguistic, socioeconomic, ethnic, cultural, etc. diversity, and an increasingly necessitated sense of equity.

Documents often reduce diversity to a few key features viewed as characterizing contemporary Canadian society (e.g. Aboriginality, rurality, cultural or ethnic diversity,

etc.), constructed as "emerging" problems that now require institutions' attention. For example:

> The Society of Rural Physicians of Canada (SRPC) recognizes the importance of educating doctors for rural practice. Part of this includes ensuring the admission of a fair and equitable number of students of rural origin as they are the most likely to ultimately choose rural practice as a career. In 2002 national data was published that revealed that rural origin students are seriously under-represented in Canadian medical schools.
>
> (CFPC 2004, p. 4)

And also:

> The impact of social, economic and behavioural determinants of health is now quite well known to governments and health organizations. Unfortunately, a key problem lies in turning this understanding into concrete actions that have a positive impact on communities and individuals. Faculties of Medicine have a critical role to play in this shift.
>
> (AFMC 2006, p. 1)

Viewed in this manner, diversity affects people's physical, social and economic environment, as well as their characteristics and daily comportments, and has implications on a multitude of features that can be considered as "determinants of health," such as one's income, level of education, genetics, networks, gender, etc. Equity comes here as the capacity to integrate these various determinants into the medical profession, medical education, and the health system. The previous quotes suggest that this integration can be accomplished by breaking diversity down into a set of potentially problematic objects (social determinants, causes of inequalities, foci, issues, quantitative needs, etc.). These different elements can be assessed quantitatively and qualitatively and allow institutions to act upon individuals, groups, and communities:

> Meeting societal health needs also requires responsiveness to the social determinants of health, which address the root causes of inequalities in health status and also focus on health promotion and disease prevention. There are unique issues with respect to HHR planning for each specialty, and therefore a coordinated, but flexible approach is required to adequately address quantitative needs.
>
> (RCPSC 2011, p. 1)

The fact that groups can be excluded or treated differently for being "different" is discussed as a novelty, something that was apparently recently "discovered" in the Canadian social setting. Representing the link between difference and exclusion as something that was acknowledged recently may potentially render invisible or difficult to perceive the processes by which these groups have been systematically excluded or dominated in the Canadian geopolitical context over long periods of time. Regulatory bodies may even play (if perhaps inadvertently) a role in perpetuating these inequities and differences.

Creating dialogues

The documents generally promote social accountability or equity in the form of "dialogue," by involving other institutions and actors such as community leaders, stakeholders, and representatives of under-represented groups, through the creation of committees and

task forces, and by making use of funding opportunities. Our Foucauldian analysis showed how these recommended interactions center on given key-objects, which then synergize to provide new roles to institutions as illustrated in these excerpts:

> While recognizing the role of governments and others in providing funding for health care services and for research and education, medical schools can play a leadership role in helping to contribute, in partnership with a wide variety of other parties and agencies.
>
> (AFMC 2001, p. 2)

> Adequately addressing these challenges [affecting health needs and the requirements for partnerships] will require that medical schools be open to society. They will have to do three things: • Listen and hear what is happening in society; • Work with others—collaborate; and • Act on the health system.
>
> (AFMC 2003, p. 7)

> Every medical school in Canada serves a large population which includes rural communities. This should necessitate the inclusion of rural physicians and community members to help shape the admissions policy and process.
>
> (CFPC 2004, p. 11)

Recommendations thus contribute to the national and international prestige of institutions involved, as they present themselves as the initiators of policies aimed at correcting the wrongs of the past and looking forward to meet the needs of an increasingly diverse and inequitable society. While there is recognition of the need to seek partnerships with other agents in society, the position of less empowered groups is already enunciated and defined in the texts. Such groups are to be consulted, and their preoccupations and needs should be taken care of by the professional organizations themselves.

Conclusions

This Foucauldian analysis raises challenges in defining the concepts of equity, excellence, and diversity, and how these words may have specific meanings for different individuals and/or groups depending on their particular or local histories. Designing health policies with respect to medical education, including the selection of students, is ultimately an act of power, with both positive and negative, intended and unintended consequences for the institutions involved. One detrimental effect of rhetorical constructions—such as the one presenting the present situation as a *new* crisis—is that they may divert attention from the root causes of a given situation. Our analysis in fact suggests that deeper structural changes, beyond the regulatory bodies considered here, are required to address these problems. To contribute constructively to the situation, we query how best to incorporate marginalized viewpoints within the design and development of policy, and have a new appreciation of how texts about underserved or underrepresented groups might actually serve to continue to unintentionally exclude these groups from positions of power relative to health and the medical system. Our research highlights how ways of writing and speaking influence practices, and gives us a glimpse of how the way one writes or speaks impacts social justice. For example dealing with questions of equity and diversity should explicitly take into account the historical disempowerment of certain communities and deal directly with redistribution of power relationships, through critical reflection on the inclusiveness of the process of policy development.

What if the documents were inclusive of diverse populations' concerns and of marginalized perspectives? What are the implications for future policy development with respect to addressing social accountability concerns in medical education? All policy documents analyzed state the aspiration for an improved and more societally responsive health care system through student selection practices aimed at greater inclusivity and attention to marginalized groups. Our analysis of the discourses embedded within these documents showed a more complex situation, in which institutional power and prestige may continue to be reproduced through the very processes that seek to empower other players and stakeholders within society. Whether these policies may unwittingly contribute to the further disempowerment of groups whose marginalization they seek to address is worth questioning. The methodology of explicitly seeking to situate policy development within relevant social, historical, and political contexts was useful in understanding how we might change our practices with respect to policy development for greater inclusiveness and decreased marginalization. Ultimately, policy developers in medical education need to focus attention on the imbalances of power in the actual process of policy development. Reframing the discourse will go a long way towards the creation of inclusive spaces where marginalized voices can be heard and accorded their due recognition.

Acknowledgments This study was funded by Social Sciences and Humanities Research Council of Canada Grant # 410-2010-1355.

References

Addams, A. N., Beer-Bletzinger, R., Sondheimer, H. R., White, S. E., & Johnson, L. M. (2010). *Roadmap to diversity: Integrating holistic review practices into medical school admission processes*. Washington: Association of American Medical Colleges.

Association of Faculties of Medicine of Canada. (2001). Social accountability: A vision for Canadian Medical Schools [PDF]. Retrieved 15 Feb 2012, from http://www.afmc.ca/pdf/pdf_sa_vision_canadian_medical_schools_en.pdf.

Association of Faculties of Medicine of Canada. (2003). Social accountability: Moving beyond the rhetoric—Proceedings. Plenary session of the Annual Meeting held in Quebec, April 28, 2003[PDF]. Retrieved 15 Feb 2012, from http://www.afmc.ca/pdf/Apr28_Social%20Accountability.pdf.

Association of Faculties of Medicine of Canada. (2006). Enhancing the health of the population: The role of Canadian faculties of medicine [PDF]. Retrieved 15 Feb 2012, from http://www.afmc.ca/pdf/2006_april_afmc_public_health_vison_paper.pdf.

Association of Faculties of Medicine of Canada. (2010). The future of medical education in Canada [PDF]. Retrieved 15 Feb 2012 from http://www.afmc.ca/future-of-medical-education-in-canada/medical-doctor-project/index.php.

Association of Faculties of Medicine of Canada. (2011). Equity and diversity audit tool for Canadian medical schools [PDF]. Retrieved 15 Feb 2012 from http://www.afmc.ca/pdf/committees/AFMC_Equity_and_Diversity_Audit_Tool_10MAY2011.pdf.

Association of Faculties of Medicine of Canada. Indigenous Physicians Association of Canada (2007). Best practices to recruit mature aboriginal students to medicine [PDF]. Retrieved 15 Feb 2012 from http://www.afmc.ca/pdf/IPAC-AFMC_Recruitment_of_Mature_Aboriginal_Students_Eng.pdf.

College of Family Physicians of Canada. (2004). Admission of rural origin students to medical school: Recommended strategies [PDF]. Retrieved 15 Feb 2012, from http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Health_Professionals/AdmissionRuralOrigin.pdf.

College of Family Physicians of Canada. (2007). Rethinking undergraduate medical education—a view from family medicine [PDF]. Retrieved 15 Feb 2012, from http://www.cfpc.ca/projectassets/templates/resource.aspx?id=1124&langType=4105.

College of Family Physicians of Canada. (2009). CanMEDS-FMU: Undergraduate competencies from a family medicine perspective [PDF]. Retrieved 15 Feb 2012, from http://www.cfpc.ca/uploadedfiles/education/canmeds-fmu_Feb2010_final_formatted.pdf.

Eskander, A., Shandling, M., & Hanson, M. D. (2013). Should the MCAT exam be used for medical school admissions in Canada? *Academic Medicine: Journal of the Association of American Medical Colleges., 88*(5), 572–580.

Foucault, M. (1971). *L'Ordre du Discours: leçon inaugurale au Collège de France présentée le 2 décembre 1970*. Paris:Gallimard.

Foucault, M. (1972). *The archaeology of knowledge*. New York: Pantheon Books.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. New York: Pantheon Books.

General Medical Council. (2009). *Tomorrow's doctors education: Outcomes and standards for undergraduate medical education*. London: General Medical Council.

Gutting, G. (2005). *Foucault: A very short introduction*. Oxford: Oxford University Press.

Hodder, I. (1994). The Interpretation of Documents and Material Culture. In N. K. Denzin & Y.S. Lincoln (Eds.), *The Handbook of qualitative research* (pp. 393–402). Thousand Oaks: Sage Publications.

Hodges, B.D., Kuper, A., & Reeves, S. (2008). Discourse analysis. *British Medical Journal, 337*, a879.

Leinster, S. (2011). Evaluation and assessment of social accountability in medical schools. *Medical Teacher, 33*(8), 673–676.

McHoul, A., & Grace, W. (1993). *A foucault primer: Discourse, power and the subject*. New York: New York University Press.

Medical Council of Canada. (2012). Registration to practice medicine in Canada. Link updated in 2012 [PDF]. Retrieved 15 Feb 2012, from http://www.mcc.ca/pdf/Registration_Chart_en.pdf.

Mills, S. (1997). *Discourses*. New York: Routledge.

Nietzsche, F.W. (1994). *On the genealogy of morality*. New York: Cambridge University Press.

Pennycook, A. (2001). *Critical applied linguistics: A critical introduction*. Mahwah: Laurence Erlbaum.

Physician Human Resource Strategy for Canada Task Force Two. (2006). A physician human resource strategy for Canada: Final Report [PDF]. Retrieved 15 Feb 2012, from http://www.cha.ca/documents/pa/TF2FinalStrategicReport-e.pdf.

Razack, S., Maguire, M., Hodges, B., & Steinert, Y. (2012). What might we be saying to potential applicants to medical school? Discourses of excellence, equity, and diversity on the web sites of Canada 17 medical schools. *Academic Medicine, 87*(10), 1–7.

Revel, J. 2004. « Michel Foucault : discontinuité de la pensée ou pensée du discontinu? », *Le Portique*, 13-14 [HTML]. Retrieved Febrary 15, 2012 from http://leportique.revues.org/index635.html.

Roe, E. (1994). *Narrative policy analysis: Theory and practice*. Durham: Duke University Press.

Royal College of Physicians and Surgeons of Canada. (2006). RCPSC statement on appropriate physician resource for Canada: Toward achieving responsible self-sufficiency [PDF]. Retrieved 15 Feb 2012, from http://www.royalcollege.ca/shared/documents/advocacy/workforce_self_sufficiency_e.pdf.

Royal College of Physicians and Surgeons of Canada. (2009a). Health human resources: An essential part of a sustainable, accessible and responsive health care system [PDF]. Retrieved 15 Feb 2012 from http://rcpsc.medical.org/publicpolicy/brief_hoc_april09_e.pdf.

Royal College of Physicians and Surgeons of Canada. (2009b). One step forward—two steps back? A discussion paper on physician mobility in Canada. Office of Health Policy and Governance Support [PDF]. Retrieved 15 Feb 2012, from http://www.royalcollege.ca/shared/documents/advocacy/physician_mobility_e.pdf.

Royal College of Physicians and Surgeons of Canada. (2011). Addressing societal health needs [PDF]. Retrieved 15 Feb 2012 from http://www.royalcollege.ca/shared/documents/fmec/societal_health_needs.pdf.

Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.

Strong-Boag V. (1981). Canada's women doctors: Feminism constrained. In S. Sed (Ed.) *Medicine in Canadian Society: Historical Perspectives*. Montreal: McGill-Queen's University Press.

Visker, R. (1995). *Michel Foucault: Genealoty as Critique*. New York: Version.

Whitehead, C.R., Hodges, B.D., & Austin, Z. (2012). Captive on a carousel: Discourses of 'New' in medical education 1910–1920. *Advance in Health Science Education, 17*(4). doi:10.1007/s10459-012-9414-8.

World Health Organization. (1995). *Defining and measuring the social accountability of medical schools*. Geneva: World Health Organization.

Young, M.E., Razack, S., Hanson, M.D., Slade, S., Varpio, L., Dore, K.L., & McKight, D. (2012). Calling for a broader conceptualization of diversity: Surface and deep diversity in four Canadian medical schools. *Academic Medicine 87*(11), 1501–1510.