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Essay

The Toxic Mix of Multiculturalism and Medicine: The Credentialing and Professional-Entry Experience for Persons of African Descent

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Abstract: This essay is based on a case study of international medical graduates (IMGs) in Canada who migrated from sub-Saharan Africa. The chapter examines how narratives of race are situated and deployed in the field of medicine and can produce some aversive social–psychological landscapes in the credentialing and the professional-entry process as it relates to persons of African descent. It will show that, often without predetermination or intent, professionals of African descent in Canada are highly susceptible to implicit racial associations and implicit racial stereotyping in relation to evaluations of character, credentials, and culture. The article exposes some of the critical intersections of common experience, such as: (a) cultural deficit bias—Whiteness as an institutionalized cultural capital attribute; (b) confirmation bias—reaching a negative conclusion and working backwards to find evidence to support it; (c) repurposed sub-Saharan Blackness stereotypes—binary forms of techno-scamming and fraud; and (d) biased deception judgement—where the accuracy of deception judgements deteriorates when made across cultures. These social psychological phenomena result in significantly disproportionate returns on their foreign education and labour market experience for Black medical professionals that require decisive efforts in changing the narratives.

Keywords: implicit associations; racial stereotyping; systemic racism; multiculturalism; foreign credentials

1. Introduction

The annual immigration numbers in Canada for 2023 amounted to around 500,000 new immigrants, one of the highest rates per population of any country in the world (Statistics Canada 2024)[1]. However, in contrast to the increasingly dynamic immigration flows driven by efforts to ease labour shortages in key sectors of the economy, the health sector has seen a baffling exclusion of internationally trained physicians. Despite the logical role foreign physicians could play in resource planning in this country in the face of a chronic doctor shortage and an exasperating patient wait time crisis (Dangerfield 2023), they still face numerous challenges and subtle barriers in attempting to enter the supply of practicing physicians (Foster 2008). Correspondingly, researchers have found that credentials devaluation of racialized foreign-trained doctors is one of the common barriers to obtaining work in the self-regulated medical profession (Jeannotte 2008).

This essay takes the position that the incongruous underutilization of racialized internationally trained physicians must be reframed not as the default choice, but as an active choice that perpetuates preventable disparities. Foreign credentials devaluation is not a generic workplace malfunction; it is a political act that defies multicultural ideology and symbolizes how people of colour are living in the interstices of White cultural hegemony. Hence, the medical profession is culturally regulated to the disadvantage of foreign-born and foreign-trained and predominantly non-European and non-White immigrant practitioners, a major impediment to advancing a non-discriminatory and sustainable medical labour force in Canada.

1.1. Theoretical Framework

The theoretical framework for this analysis falls within the field of academic study on the social psychology of bias (Fiske et al. 2010; Greenwald and Banaji 1995; Dovidio and Gaertner 1986). An important area of research engagement for social psychology of bias research is the unquantifiable prejudice against people of colour that can and does occur outside our conscious awareness. This is called 'implicit bias' (Fiske and North 2014; Nosek et al. 2011; Greenwald and Banaji 1995—also see Table 1). Implicit bias science has determined—through voluminous research on this topic—that racial bias today is less likely to manifest as explicit (or conscious) bias and more likely to manifest as implicit (or unconscious) bias. Implicit racial bias research has definitively shown that while 'old-fashioned', blatant, or overt discrimination is on the wane in contemporary society, implicit, unconscious, and covert bias is a persistent issue (Greenwald and Banaji 1995). Therefore, current measures of racial discrimination are less direct and more ambiguous than earlier ones. The guiding idea here is that in the contemporary Western world, prejudice has been 'driven underground', that is, into the realm of 'implicit cognition' (see Table 1) and out of conscious awareness (Dovidio and Gaertner 1986).

Table 1. Key Dimensions of Cognitive Bias Research.

Implicit cognition	Implicit cognition constitutes the majority of mental activity, which occurs outside conscious awareness or conscious control. This includes domains such as learning, perception, or memory which may influence a person's behavior without their conscious awareness of those influences. Studies indicate that the brain is capable of processing approximately 11 million bits of information every second, but our conscious mind can handle only 40–50 of those bits. This leaves the bulk of our mental processing to the unconscious level (see: Reingold and Ray 2006; Nosek et al. 2011; Greenwald et al. 2009; Staats 2015).
Unconscious mind	The unconscious mind refers to the refers to subjective maps of reality that drive our behaviors. It comprises a reservoir of feelings, thoughts, urges, and memories that are outside of our general awareness, but affect our conscious thoughts and behavior. According to experts in the field of social psychology, the unconscious mind refers to subjective maps of reality that drive our behaviors (see: Westen 1999; Corsini and Wedding 2011).
Explicit bias	Explicit bias refers to the attitudes and beliefs we have about a person or group on a conscious level which occur as a result of deliberate thought (see: Gaertner and Dovidio 1986; Greenwald and Banaji 1995; Daumeyer et al. 2019).
Implicit associations	Implicit associations refer to the automatic associations we have with a social object that also influence our attitudes and behavior about that social object. The associations we harbor in our subconscious cause us to have reflexive feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance. Because implicit associations arise outside of conscious awareness, these associations do not necessarily align with individuals' openly held beliefs or even reflect stances one would explicitly endorse. Once an implicit association is activated, it is difficult to inhibit (see: Greenwald and Banaji 1995; Graham and Lowery 2004; Reskin 2005; Dasgupta 2013; Staats 2015).
Implicit bias	Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner and are activated involuntarily and without an individual's awareness or intentional control. Implicit bias does not mean that people are hiding their racial prejudices. They literally do not know they have them. Implicit bias occurs when someone consciously rejects 'stereotypes' and supports equality efforts in hiring but also holds negative associations in his/her mind unconsciously (see: Gaertner and Dovidio 1986; Greenwald and Banaji 1995; Nosek et al. 2011; Staats 2015; Mullainathan 2015).
Stereotyping	Stereotyping refers to a widely held, but fixed and oversimplified, image or idea of a particular type of person or thing. They are based on biased judgements that are irrational and rigid insofar as they are supported by little or no evidence and result in distorted perceptions that do not comport with reality. An 'implicit stereotype' is the unconscious attribution of particular qualities to a member of a certain social group. Implicit stereotypes may be associated with one event that we may have seen in the past, but the source of these associations may be misidentified, or even unknown, by the individual who holds them, and can persist even when an individual rejects the stereotype explicitly (see: Greenwald and Banaji 1995; Fiske et al. 2002).

Table 1. *Cont.*

Rebounding Effects	Rebound effects refer to a paradoxical increase in stereotypic thoughts and responses following stereotype suppression attempts (see: Follenfant and Ric 2010).
Modern racial bias	Modern racial bias is less likely to manifest as conscious or 'explicit bias' and more likely to manifest as unconscious or 'implicit bias'—i.e., more automatic, ambivalent, and ambiguous than old-fashioned biases such as social dominance orientations and right-wing authoritarianism, which overtly expressed intergroup hostility (see: Greenwald et al. 2002; Fiske and North 2014, p. 2).
Cultural capital	Cultural capital refers to forms of knowledge; skill; education; and any advantages a person has which give them a higher status in society, including high expectations. In terms of professional practice, cultural capital relates to the ability of a group to define knowledge and enforce its version of reality. Racial stereotypes are rooted in the collective consciousness of society as a 'cultural capital' attribute of Whiteness, or White hegemony (see: Bourdieu 1986; Bauder 2003; Reiter 2009).
Microaggression	A microaggression is the casual degradation of any marginalized group. The term was coined in the USA in the 1970s to describe the off-the-cuff insults and dismissals researchers regularly witnessed inflicted on people of African descent. Studies suggest that microaggressions can lead people of colour to fear, distrust, and avoid relationships with White people. On the other hand, some people report that microaggressions have made them more resilient. Scholars have suggested that, although microaggressions 'might seem minor', they are 'so numerous that trying to function in such a setting is 'like lifting a ton of feathers.'" (see: Sue et al. 2008; Evans 2009; Timpf 2015).
Aversive racism	Aversive racism is a term first coined in the 1970s that has subsequently developed into a body of research studying the conduct of individuals who rationalize their aversion to a particular group by appeal to rules or stereotypes, and thus deny racially motivated behavior. People who behave in an aversively racist way may profess egalitarian beliefs; nevertheless, they may change their behavior when dealing with a member of a racialized minority group (Dovidio and Gaertner 2000; Crisp and Turner 2007; Rawls and Duck 2020b).
Debiasing	Debiasing refers to the reduction in bias, particularly with respect to judgment and decision making. The consensus of all serious observers is that implicit racial biases are both intransigent and intolerable if we simply wait and hope that the barriers they create will disappear with time (Galinsky and Moskowitz 2000; Welch 2007). According to recent research literature, there are three general approaches to debiasing judgment and decision making, as well as the costly errors with which biased judgment and decision making are associated: changing incentives, nudging, and training. Each approach has strengths and weaknesses. A 'best practice' to debias is to openly acknowledge biases and then directly challenge or refute them (Morewedge et al. 2015; Byrd 2021).

An important identifying feature of the social psychology of bias is that 'racial stereotyping' (see Table 1) is an implicit mode of knowledge in our society that is experienced as an element of social structure and not an irregularity in it. Therefore, unconscious bias against sub-Saharan Africans who are medical practitioners is not an 'optional feature' of Canadian life, but rather, it is embedded in the normative order. Unconscious racial stereotypes are a hidden grammar in society's repertoire of meaning that influences judgment in a fashion not introspectively known by the actor. Moreover, implicit stereotyping is consistent with recent findings of discrimination by people who explicitly disavow prejudice. In other words, people who do not consider themselves biased behave in a biased and discriminatory manner unintentionally and unbeknownst to themselves (Graham and Lowery 2004; Reskin 2005). Biased informed actions and decision making are not only perpetrated by 'bad people', as if 'good people' are not predisposed to implicit devaluation of their fellow human beings. Indeed, since implicit bias distorts consciousness unintentionally, it has become like a second nature in our society and often appears to be neutral. The consensus of all serious observers is that implicit racial biases are both intransigent and intolerable if we simply wait and hope that the barriers they create will disappear with time (Galinsky and Moskowitz 2000; Welch 2007). In the context of professional workplace practice, implicit bias research has now clearly established that racial stereotypes are obstacles to fair competition and equity that are so formidable and self-perpetuating that they *cannot* be overcome without deliberate and self-reflective intervention (Morewedge et al. 2015).

This has presented a major challenge in Canada. While the complexity of racial suffering has been identified in other jurisdictions, it is often overlooked amongst Canadian society (Williams et al. 2022). Meanwhile, the politicization of multiculturalism has permitted many in Canada to deny claims of racial bias and racism (Foster 1998; Nelson 2010). Canada is lauded as a successful multicultural nation and is widely considered as a model to be emulated by other Western industrialized nations (Cheatham 2020; Ugland 2018). This phenomenon is otherwise known as Canadian 'exceptionalism' in the context of cultural diversity and immigration policymaking (Triadafilopoulos 2021). The formal inclusion associated with the ideology of multiculturalism masks the continuing and deepening exclusionary barriers to equitable citizenship for marginalized sectors of Canadian society (Foster and Jacobs 2012).

1.2. Cognitive Blind Spot in Race Relations in Canada

Constance Backhouse (1999) wrote in *Colour-Coded: A Legal History of Racism in Canada* that relegating what is racist to historical and faraway practices whitewashes Canada and portrays it as a raceless nation. In her assessment, Canadian legal history is characterized by an 'ideology of racelessness', and this is a 'hallmark of Canadian historical tradition' that is in keeping with a 'national mythology that Canada is not a racist country' (Backhouse 1999, p. 14). This made-in-Canada myth contributes to a cognitive blind spot regarding race relations in the Canadian collective conscience, where issues of race and racism are typically covered over in institutional life and not fully accepted as a priority area of scholarly research or public policy. The upshot is that Canadian multicultural ideology tends to symbolize a race-neutral and colour-blind regime that, for the most part, has been and remains uncontested and, therefore, largely misconstrued.

The historical basis of the established institutions of Canadian settler colonialism has been built upon an entangled triad structure of settler–native–slave (Tuck and Yang 2012). This has resulted in irrefutable systemic and systematic barriers for Black and Indigenous and other people of colour (Williams et al. 2022). Yet, racism is so deeply enmeshed in the fabric of society's social order that it often appears both natural and normal. It is only the more crude and conspicuous forms of racism, on the wane, that are seen by most people as problematic. The majority of modern racism remains hidden beneath a veneer of normality. Here, the subtle and covert racial inequities experienced by Black and racialized foreign physicians remain unproblematic. This erasure of harms makes it difficult to raise the issue of racial inequities and any associated adverse impacts within the context of public sector institutions, including a self-regulating medical profession. In addition, the lack of attention to issues of racial inequity regarding the quality of life and the well-being of Black medical professionals and others of colour is also part of a larger societal transformation, which is characterized by forms of unrecognized racial bias reinforcing a veneer of Canada as a raceless or 'post-racial society' (Kaplan 2011).

The challenge of implicit bias studies is to make the invisible visible. Recent research into the complexities of bias and racial; suggests that in North American, European, and colonial zeitgeist societies, Black, Indigenous, and people of colour (BIPOC) experience racial stereotyping and associated 'microaggressions' (see Table 1) on a repetitive, constant, inevitable, and cumulative basis (Cénat 2023). Scholars note that while microaggressions—or the casual degradations of marginalized groups—might seem minor, they are so numerous that trying to function in such a setting is 'like lifting a ton of feathers'. (Timpf 2015). The resultant racial trauma is distinguished by the consistency of racist victimization beyond childhood and the internalized racism that contributes to ruptures in the Black psyche—including ego depletion; flattened confidence; distorted communications; a tendency toward Black self-censorship in professional performance areas; and inauthentic presentations of self (Inzlicht et al. 2006; Foster 2015a). Quite apart from the musings of 'Canadian exceptionalism', racial trauma can surround the victims' life course and produce harmful consequences to their physical and mental health, be-

haviour, cognition, relationships with others, self-concept, and social and economic life (Williams and Mohammed 2013; Hope et al. 2021).

These linkages between implicit bias, racial microaggressions, and racial trauma are virtually missing from contemporary trauma literature (Helms et al. 2012). Observers seem not to view covert types of racism and ethnoviolence as life-threatening (e.g., vicarious experiences, exposure to racial microaggressions in the workplace) because the historical roots of the trauma are invisible. However, for many in the Black community, particularly those with foreign skills training, the workplace is experienced as part of a cumulative round of microassaults, microinsults, and microinvalidations that belittle their experience and devalue their credentials (Bertrand and Mullainathan 2004). These racial microaggressions are recognized by social psychological researchers to contribute to ongoing and often progressive race-based traumatic stress (Butts 2002). Accordingly, a key priority for advancing the study of implicit racial bias includes more systematic attention to 'stress-proliferation processes' at the multiple intersections of racial microaggressions, institutional/systemic racism, and intergenerational trauma (Williams et al. 2012; Williams et al. 2018; Comas-Díaz et al. 2019).

2. Method

It is the contention of this essay that the current professional discourse on Black doctors with foreign credentials is limited by the lack of an adequate contextual framework to grasp the invisibility of racial harms in the Canadian medical workplace. This limitation is addressed here through two related methods or approaches.

First, the essay is organized around a case study of the common intersections in the professional experience of two sub-Saharan IMGs attempting to enter the Canadian medical workplace. The essay exemplifies how evaluation processes can be based on 'aversive racism' (Dovidio and Gaertner 2000; see Table 1), where individuals rationalize their aversion to a particular group by appealing to rules or stereotypes and thus deny racially motivated behavior.

Secondly, this article is situated within a cultural studies framework that positions cognitive bias within the contexts of ideology, power, and institutions (Hall 1980, 1996). The primary goal here is to show how 'implicit racial stereotyping' and 'repurposed sub-Saharan tropes' are combined with 'cultural deficiency' modelling, 'confirmation bias', and 'deception judgement bias' to create an inhospitable professional landscape and poisoned environment for sub-Saharan IMGs. This can result in debilitating effects on Black African doctors' physical, social, mental, and professional well-being (Bauder 2003; Foster 2008, 2009, 2011).

The Foundations of Cognitive Bias and Prejudice

One possibility for combatting the power asymmetries and trauma of modern racism is to begin looking at the cognitive foundation of bias and prejudice. There is extensive literature on the 'cognitive bias codex' for at least 188 cognitive biases found to impact various domains—including, for example, decision-making biases, social biases, and memory errors (Morewedge et al. 2015; Gonzalez 2017). However, the focus here is to isolate the research literature and explanatory tools that provide the most purchase for understanding the 'deep structure' of the devaluation crisis of Black African IMG credentials.

It is the position here that the determinative cognitive biases, as they relate to Black professionals and particularly foreign-trained professionals of African descent, can be enumerated as follows:

(a) Cultural Deficit Bias—Whiteness as an institutionalized cultural capital attribute;
(b) Confirmation Bias—reaching a negative conclusion and working backwards to find evidence to support it;
(c) Repurposed Sub-Saharan Stereotypes—binary forms of techno-scamming and fraud;
(d) Biased Deception Judgement—the accuracy of deception judgements deteriorates when made across cultures.

These four codices are operationalized by some key dimensions of the social psychology of race and cognitive bias research provided in Table 1.

3. Diminished by Assumptions: The Case Study of Race in the Medical Profession

A case study approach can be a platform for an in-depth, multi-faceted understanding of complex issues (Crowe et al. 2011), which can be helpful in addressing the role that racism can play in the ecosphere of a self-regulated profession. This case study involves an analysis at the intersections of two discredited internationally trained medical doctors from sub-Saharan Africa.[2] In this regard, it can be particularly useful to obtain a more 'lived experience' appreciation of how narratives of race are situated and deployed in the medical profession and in Canada more widely. This affords the opportunity for a real-world, real-time perspective on racialized workplace problems that are otherwise opaque, and a chance to develop an integrated approach to effective policy solutions and improved equity outcomes.

3.1. Dr. Ujima

Dr. Ujima is a Nigerian-born and -trained physician. English is not his first language, although he is fluent. Dr. Ujima acquired an unrestricted license to practice medicine in Saskatchewan and Alberta in the 2010s, when he left the country in which he was educated and socialized. Three years later, he applied for a College of Physicians and Surgeons of Ontario (CPSO) license using the pathway available to individuals who hold an unrestricted license in another Canadian jurisdiction.

Following the application to the CPSO, a letter with information the Registrar determined to be relevant to Dr. Ujima's licensure from a Health Region in Saskatchewan indicated that an emergency suspension of Dr. Ujima's privileges was issued, as there were concerns about his performance and disruptive attitude. A week following the emergency suspension in Saskatchewan, an alternate agreement was reached, and the suspension was rescinded. Under the original the terms of the agreement, Dr. Ujima was not permitted to see patients at the Health Region in Saskatchewan, except in the context of mentored practice, for a period lasting up to three months.

In their decision letter, the CPSO Registration Committee in Ontario expressed concern about the mentorship Dr. Ujima had undertaken in Saskatchewan to address deficiencies in his competence, as well as behavior they saw as an act of withholding relevant information. After a series of submissions to the Registration Committee, an Order was made directing the Registrar to refuse Dr. Ujima's application for a certificate of registration to practise in Ontario.

It was Dr. Ujima's contention he was a victim of marginalization in Saskatchewan. Dr. Ujima maintained that the complaints, coming primarily from one colleague, were unfounded and eventually resolved in his favour, and that he eventually remained in good standing in Saskatchewan at the time of his planned departure. It was Dr. Ujima's position that it was shown beyond any reasonable doubt that he was a good physician, and the suspension of his privileges was rescinded nunc pro tunc, meaning rescinded and regarded as though it never happened. Hence, he had failed to disclose the earlier suspension of privileges in Saskatchewan because he considered it a non-event.

Following an appeal, the Registration Committee stated that, after careful consideration of the information before it, the refusal of Dr. Ujima's application was warranted to protect the public interest because of his prior history of complaint proceedings and the concealment of that history, which related to his conduct and character. In addition, the Committee confirmed that the non-exemptible Section 2 of Ontario Regulation 865/93 was also engaged, since Dr. Ujima's past and present conduct did not afford reasonable grounds to believe that Dr. Ujima:

- Would practice medicine with decency, integrity, and honesty and in accordance with the law; [and]
- Could communicate effectively and would display an appropriately professional attitude.

3.2. Dr. Ujamaa

Dr. Ujamaa is an international medical graduate physician who undertook residency training at a prominent Canadian university in a specialist program. Dr. Ujamaa was born in Cameroon, which is home to at least 250 languages, with some accounts reporting around 600. French and English are the official languages, a representation of the heritage of Cameroon's colonial past as a protectorate of both France and the United Kingdom from 1916 to 1961. Dr. Ujamaa is fluent in both official languages of Cameroon, although neither is his first language. Dr. Ujamaa was also born with attention deficit hyperactivity disorder (ADHD).

Dr. Ujamaa was first made aware of the allegedly fraudulent Entrustable Professional Activities (EPAs) submission at the same time he received the report requesting his dismissal from the program. EPAs are discrete, observable, assessable tasks that, together, attempt to define professional duties. The framework for his medical residency is based on EPAs, chosen because they offer a practical approach to assessing competence in real-world settings and impact both learners and patients. Introduced in graduate medical education (GME) in 2005, EPAs are intended to aid supervisors in making determinations about residents' competence.

Dr. Ujamaa's clinical performance as a medical resident was never disputed, nor was it part of the rationale for his dismissal. His dismissal was based on what was identified as 'professionalism' concerns. The Committee's recommendation to dismiss Dr. Ujamaa was predominantly based on his submission of two EPAs without the consent of the alleged assessors and Dr. Ujamaa's failure to adequately communicate with a number of program representatives in a number of varied circumstances. The Board of Examiners raised a variety of issues related to Dr. Ujamaa's communication with the program and his repeated failure to inform colleagues of absences. The Faculty Council Appeals Committee's position was that this, along with the two allegedly fraudulent EPAs, warranted his dismissal from the residency program.

In support of Dr. Ujamaa's argument that he did not intend to submit the two EPAs at issue, he indicated to the Committee that he submitted 45 EPAs prior to the 2 submitted without the assessors' consent. It is for this reason that the Committee found it difficult to believe the claim he was saving the August 19th EPAs as drafts when he submitted them. The Committee also believed that a medical resident, having accidentally submitted an evaluation that was meant to be saved as a draft, should have reached out to someone (the assessor, the Program Director, or administrators from the Program or PGME) to report the error. According to the Committee, his claim that the EPA was submitted inadvertently due to his ADHD did not account for his failure to report the error when he received confirmation emails that the EPAs had been submitted.

The Committee determined that neither Dr. Ujamaa's previous clinical performance nor his non-fraudulent EPAs led to the inference that the August 19 submissions were not intentional. Dr. Smith reported to the Committee why someone with Dr Ujamaa's clinical performance and without a history of fraudulent submissions would choose to take this action. Dr. Smith informed the Committee that August 19 was Dr. Ujamaa's last day on the obstetrics rotation as he was going on vacation on August 20. The fraudulent EPAs were submitted late in the afternoon of his final shift and were required for him to pass the rotation. Based on this evidence, the Committee believed the August 19 EPAs were intentionally submitted.

It was Dr. Ujamaa's contention that the program assumed he had committed fraud without considering less nefarious scenarios. He expressed the believe that, as a person with a disability, a person of colour, and an immigrant of African origin, that he was subjected to several unreasonable expectations. Dr. Ujamaa alleged he was required to be able to communicate with the program even when ill and without access to a means to communicate. He also believed that the program expected him to attend shifts scheduled in violation of his accommodation plan and did not respect the plan. It was his position that these alleged professionalism breaches were innocent administrative errors linked

to his ADHD. Dr. Ujamaa maintained that there was no evidence of any professionalism breaches on his behalf and that the program actively worked to have him removed from training and demonstrated bias against him.

The Committee denied that there was any basis to the allegations that the program ignored his disability or that Dr. Ujamaa's disability was responsible for the alleged breaches of professionalism. The Committee indicated that the program had been extremely supportive of him and had worked to ensure that his accommodations were implemented in accordance with his reintegration plan. It was the Committee's position that Dr. Ujamaa's claim of simply committing some innocent administrative errors due to his ADHD was factually incorrect. The Committee asserted that Dr. Ujamaa was subjected to the same expectations as someone without a disability, but with the support of an accommodation plan designed to remove disability-related barriers to achievement. Further, Dr. Ujamaa's discrimination claims as they related to being a person of colour and an African immigrant were disregarded for being presented without evidence.

It was the finding of the Committee that Dr. Ujamaa's appeal could not be allowed on any of the grounds outlined in the Faculty Guidelines for Appeal. Therefore, the decision of the Board of Examiners was upheld. Dr. Ujamaa was removed from the residency program on the following grounds:

- Significant professionalism issues;
- The submission of two fraudulent Entrustable Professional Activities (EPAs).

4. Cultural Deficit Bias—Whiteness as an Institutionalized Cultural Capital Attribute

Dr. Ujima and Dr. Ujamaa, as sub-Saharan IMGs, feel that they were victims of discrimination. Indeed, in the submission of Dr. Ujamaa, he stated, 'there are unconscious biases and/or a reasonable apprehension of bias against foreign trained physicians, particularly those of African descent, in the credentialing process', while the official Appeals Committees feel that there is no evidence of such discrimination. Indeed, in the response to Dr. Ujamaa, the committee stated that 'discrimination claims as they relate to being a person of colour and an African immigrant are disregarded for being presented without evidence'.

In the context of implicit bias science as outlined above, the idea of a racialized victim producing clear-cut 'evidence' of discrimination is counterintuitive. Modern racial discrimination is more likely to be associated with 'implicit racial stereotypes' (see Table 1) that are rooted in the collective unconsciousness of society as a 'cultural capital' attribute of Whiteness, or White hegemony (See: Bourdieu 1986; Bauder 2003; Reiter 2009). Michael Morris (2016) calls this pervasive phenomenon Standard White—referring to the notion that Whiteness is the normal and standard racial identity, which confers the implicit ability for Whites to create and reinforce standards and norms against which others are evaluated. By focusing on the operation of White normativity, he explores (exposes) the pernicious effects of privileging a particular racial group, even in the absence of overt discrimination or racial animus.

This is indicated by Dr. Ujima's and Dr. Ujamaa's lived experience of accreditation blockage, where there was clearly no direct challenge to their competencies or clinical performance and no racial animus registered by their Appeals Committees. A more likely explanation for their fate is linked to the machinations of the unconscious mind creating another hurdle for 'racialized others' to professional entry and to top jobs. For example, two processes associated with 'us–them' categorization pose problems for advancement of the 'racialized other'. First, having categorized someone as like or unlike us, we extrapolate other characteristics, assuming that ingroup members generally resemble us and outgroup members differ. Second, we automatically favor ingroup members. We trust them more than other persons, attribute positive traits to them while ignoring their negative characteristics, prefer to cooperate rather than to compete with them, evaluate them more positively than others, cut them more slack when their performance falls short, and favor them when distributing rewards (Reskin 2005, p. 34). In Canada, where this

cognitive process is overlaid by racial power dynamics, 'foreign-ness' and 'other-ness' relate to the economic disenfranchisement and the social discontent of our more recent racialized newcomer cohorts (Fang et al. 2012).

Since 'implicit associations' (see Table 1) are automatic, ambivalent, and ambiguous, they are much more dangerous than the old-fashioned prejudices and discrimination because they go undetected but have an equally destructive impact on people's lives. Standard White also draws attention to the adaptability of bias. By claiming the center for Whites, White normativity allows the pressing concerns of minority groups to be unheard and marginalized, even while it may simultaneously acknowledge their competence or achievements.

Ghassan Hage's interpretation and use of Bourdieu's (1986) theory of 'cultural capital' to explore multiculturalism and race relations in Australia is instructive here. In the book White Nation, Hage (1998, p. 19) defines the term 'White' as standing for people of European origin, while the term 'Third World-looking' denotes most of the rest. For Hage, nationality in Australia is played out as in a White fantasy, a fantasy of belongingness as well as control over a territorial space that is identified as an extension of selfhood. I not only belong to the place, but the place belongs to me. The content of this place is its Whiteness, White in the sense of White culture, a culture of (northern) European origins but clearly related to Southern Europe as well. The emphasis on 'the look' is important in tracking Whiteness as an organizing principle that controls and positions 'ethnics' within the Australian social space. Hage argues that 'White' is not a stable, biologically determined trait, but a 'shifting set of social practices' (Dolby 2000, p. 49). In this respect, the nation (of Australia) represents a circular field, with the hierarchy moving from the powerful center (composed of 'White' Australians) to the less powerful periphery (composed of the 'others'). The 'others', however, are not simply dominated, but are forced to compete with each other for a place closer to the center.

The professionalization of medicine in Canada can similarly be characterized as a circular field where Whiteness is centered as an institutionalized cultural capital attribute and constitutive feature of the normative order. The normalization of White privilege manifests itself when all members of a society, as well as potential newcomers, are judged against the characteristics or attributes of those who are privileged. Typically, this is seen as a neutral process: the standard is typically invisible to those who do the judging and deeply embedded in every institutional sphere, as well as immigration policy. Society's members and potential newcomers are subject to the embedded cultural rules and unconscious procedures of Whiteness that inadvertently distort the process of recruitment, entry, treatment, promotion, and/or reward allocation as well as performance evaluation in favour of one group rather than another. In this system, when people, usually the most privileged, succeed, it is seen as the result of individual effort or merit, not due to privilege (Wildman and Davis 2002). This has been called 'internalizing dominance', i.e., all the ways that White people learn they are normal, feel included, and do not think of themselves as 'other' or 'different' (Sawyer 1989). White people, particularly males, always carry this privilege around with them everywhere they go and are generally unaware of it.

Quite apart from Canadian multicultural ideology, Whiteness remains an extremely desirable characteristic that is normalized and naturalized, and a strong indicator for inclusion (Reiter 2009). Whiteness functions as an important capital in the construction of social status because it overdetermines those able to claim it and indicates an elevated position in the existing social hierarchies (Reiter 2009). Hence, Whiteness remains a cultural category signifying superiority and well-deserved privilege.

In the self-regulated professions, this is linked to the creation of what the classic sociologist Max Weber (1978, p. 638) called a 'social closure' or holding a monopoly over the exclusive right to perform a particular kind of work in the marketplace, thereby creating a 'labour market shelter' (Freidson 1970, 2001). Accordingly, those who hold a valued position may have an interest, conscious or unconscious, in defining it in such a way that it cannot be occupied by anyone other than the possessors of properties identical to their

own ([Bourdieu 1986](#), p. 151; [Bauder 2003](#), p. 702). The difficulties immigrant professionals of colour encounter in the recognition of their foreign credentialed knowledge can be understood as a systemic process of labour market exclusion, facilitating the reproduction and maintenance of a whitestream political economy of professional practice. Thus, in the medical ecosphere, the multicultural diversity narrative reinforces the invisibility of the race-based asymmetrical power structure that is rooted in unconscious bias, the defense of White privilege, and a lack of inclusive representation.

Foreign credentials devaluation and accreditation blockage in the medical profession is not a generic phenomenon, but rather has a disproportionate impact on people of colour. Thus, for instance, while Canada's liberal medical establishment will no longer abide overt racism or colour-barriers in the licensing and accreditation process, the tacit normalization of Whiteness culturally regulates the disadvantage of foreign-born and foreign-trained physicians of colour ([Bauder 2003](#); [Foster 2008](#), [2009](#), [2011](#); [Fleras 2015](#)). In this respect, various interests and perspectives on credentials devaluation and accreditation blockage in our society must be understood in the context of a political economy where Whiteness is institutionalized as a form of cultural capital.

Here, multicultural diversity in the workplace is primarily limited to seeing an increase in numbers or a demographically diverse workforce as an endgame rather than seeing the value of bringing a diversity of perspectives to a power-sharing table where a range of different viewpoints, experiences, and cultural backgrounds can enrich the whole. In the Canadian context, White women have been the primary beneficiaries of multiculturalism and attendant employment equity policies, which has prompted critics to define it as the 'diversification of Whiteness' ([Aarts 2023](#)). This narrow approach to diversity has had the effect of quelling the ethical dilemma of racism while preserving the dominance of White subjectivities that continue to reflexively produce 'cultural cloning' or the social reproduction of sameness ([Essed and Goldberg 2002](#)), as well as 'White normativity' or unconscious and invisible ideas and practices that make Whiteness appear natural and right ([Lopez 2006](#)). Together, these concepts confer the implicit ability for Whites to create and reinforce standards and norms against which others are evaluated.

In the end, embracing the principle of diversity without fully embracing its necessary systemic challenges acts to preserve the status quo balance of White power and privilege while having a chilling effect on the career prospects and satisfaction levels of Black and racialized medical professionals ([Bauder 2003](#); [Foster 2008](#), [2009](#), [2011](#)).

5. Confirmation Bias

The professional evaluations of Drs. Ujima and Ujamma both intersect around negative decisions where the presentation of new information about their alleged transgressions was resisted or ignored to preserve the original verdict and condemnation of their lack of 'decency, integrity, honesty (Dr. Ujima) and/or professionalism' (Dr. Ujamaa) in the practice of medicine.

Strikingly, in the matter of Dr. Ujima, the earlier suspension of his practice privileges in Saskatchewan was rescinded nunc pro tunc, meaning the suspension was to be regarded as though it never happened. Since the Saskatchewan suspension was a primary reason for the denial of a license to practice in Ontario, this new or corrected information might logically be factored into a re-determination of the original decision. However, in the decision statement, it appears that the presentation of the new information was itself interpreted as problematic by the Appeals Committee. Rather than regarding the Saskatchewan suspension as though it never happened based on the new information, the Ontario medical authorities determined that Dr. Ujima's disclosure of new information was also a negative reflection on his character (i.e., showing 'a prior history of complaint proceedings and the concealment of that history'). What Dr. Ujima explained as a non-event the Appeals Committee interpreted as an attempt at deceit, further reflecting on his lack of decency, integrity, and honesty and justifying the registration refusal.

In the matter of Dr. Ujamma, as a Black person with a disability (born with Attention Deficit Hyperactivity Disorder—ADHD), he offered the previously ill-considered explanation that his alleged professionalism breaches were innocent or less nefarious administrative errors linked to his ADHD. The theory of 'intersectionality' postulates the need for greater sensitivity to overlapping or intersecting social identities such as race and disability that can expose an individual to multiple systems of oppression, domination, or discrimination and increase their vulnerability (Courtney-Long et al. 2017). In addition, human rights law also requires organizational accommodation for protected groups, including persons with disabilities to 'the point of undue hardship', i.e., to the point of significantly onerous conditions for an employer (OHRC (Ontario Human Right Commission) 2000). However, there is no indication that the Appeals Committee seriously approached the increased vulnerability of Dr. Ujamaa's as a person of colour and a person with a disability with a commensurate increased sensitivity. It is also arguable that the decision makers did not adequately consider legal standards of human rights when considering whether Dr. Ujamaa's disability was a contributing factor in his situation. There is no indication that the Appeals Committee considered a review of the appropriateness of Dr. Ujamaa's accommodation plan or suggested that further accommodation considerations would create an onerous condition for the employer. Instead, the Appeals Committee upheld the removal of Dr. Ujamaa from the residency program and implied that his presentation of new information was a continuation of his pattern of fraudulent behaviour.

In both matters, the Appeals Committee not only rejected new information, but redoubled a commitment to the original decision. In implicit bias studies, this is consistent with a 'rebound effect' (see Table 1). Rebound effects refer to paradoxical increases in stereotypic thoughts and responses following attempts to suppress stereotypes (Follenfant and Ric 2010).

5.1. Rebound Effects

Some research indicates that once individuals activate an implicit association (see Table 1), it is difficult to inhibit it (Dasgupta 2013). These individuals are susceptible to confirmation bias or belief perseverance, where they pay more attention to information that confirms their pre-existing beliefs.

The rebound effects in the case of Drs. Ujami and Ujamaa can be interpreted as modified episodes of confirmation bias. Due to rebound effects, suppressing these automatic associations does not reduce them and may amplify them by making them hyper-accessible (Galinsky and Moskowitz 2000, 2007; Macrae et al. 1994). Despite what may feel like a natural inclination, attempts to 'debias' (see Table 1) everyday life or a toxic workplace by repressing biased thoughts are ineffective. Thus, when a decision maker's deepest convictions are challenged by contradictory evidence, these beliefs can grow stronger. In the context of the regulated professions, for instance, confirmation bias as it relates to professional credibility is associated with the tendency to search for, interpret, favor, and recall information in a way that confirms one's preexisting beliefs or hypotheses while giving disproportionately less consideration to alternative possibilities (Nickerson 1998). Here, rather than altering a stereotyped perspective, the challenge of new evidence can backfire by deepening the original conviction and intensifying the racial caricature injuries through selective attention to evidence or facts, misrepresentation, distortion, falsification, or ideological misperceptions (Nyhan and Reifler 2006).

5.2. Tendencies toward Groupthink and Gaslighting

Shenelle N. Wilson (2022) offers an autoethnographic analysis of the selective attention risks of confirmation bias regarding Black medical residents like Dr. Ujamaa. In Wilson's analysis of her own professional experience, once one attending begins to criticize the Black trainee, tendencies toward groupthink act to support selective attention and reinforce the initial belief, and dissenting faculty do not rise to the trainee's defense in favor of maintaining solidarity. The resident may try to defend herself to faculty, asking them to

consider whether implicit bias and racism play a role in her negative evaluations. These questions garner responses that trivialize or divert her feelings, which perpetuates the cycle. This insidiously happens at both the micro and systemic levels, making it difficult to recognize and the cycle even more difficult to link to the implicit racial bias that initiated and perpetuated it.

Yet, the 'implicit cognition' (see Table 1) is made visible through patterns of racial trauma (Kirkinis et al. 2021). For instance, many Black trainees can experience the traumatic effects of a years-long cycle of 'gaslighting' (Wilson 2022). The term gaslighting has been used to refer to a variety of techniques that invalidate a person's experiences. For Black physicians, this abuse has the potential to prey on insecurities such as impostor syndrome and stereotype threat, where they are or feel themselves to be at risk of conforming to stereotypes about their social group (Steele and Aronson 1995; Steele 1997). Gaslighting techniques include trivializing, where a person is led to believe that their feelings are not important, and diverting, where the abuser changes the subject by focusing on the person's emotions or reactions. Examples include dismissing concerns about biased treatment and questioning one's experience with inequity. In the workplace, gaslighting tactics may result in someone being unfairly penalized or fired.

According to Wilson, this begins when a Black resident makes a mistake in medical knowledge or patient care. Her mistake is publicized among other trainees, faculty, and even ancillary health care team members. She is then more closely observed and scrutinized by her superiors, and unsurprisingly, this leads to the identification of more errors. The rate of these errors is seemingly higher than that of her peers, but few raise concern or even consider that this may be due to selective attention bias. This is an instance in which the error rate may be similar among all residents but appears higher in those who are more closely observed (Wilson 2022).

These mistakes are used to justify negative evaluations, and the resident is informed by program leadership that there is concern regarding her capacity to be a good physician. With her career at stake, she becomes terrified about making another mistake and goes to great lengths to recheck her work. Inevitably, this causes the appearance of uncertainty, inefficiency, and lack of autonomy. In surgical training, the stress of this environment may limit the trainee's ability to demonstrate surgical skills and therefore further inhibit their progress to independent practice (Wilson 2022).

There is now substantial empirical support for the claim most people—even those who sincerely declare egalitarian views—hold implicit biases against Blacks and other marginalized groups. This is true even of members of the 'targeted' group (Crisp and Turner 2007). Implicit and indirect forms of race-based bias can act to distort the consciousness of both the perpetrator (through externalized narrow-mindedness) and the target (through internalized stigma/inferiority).

Erving Goffman (1963) first used the term 'spoiled identity' to refer to the experience of moving through life with an attribute that is deeply discrediting. This attribute divides people into those who are normal and those who are not, thereby making those who are not less worthy. Contemporary research indicates that the spoiled identity attributes are worrisome when they are ascribed by others to people of African descent to enforce a second-class citizenship. But they become even more worrisome in the move from outside to inside through the internalization of Black stigmas, where the negative beliefs can become a part of who that person is. In turn, this has linkages to the widening gaps in Black and White well-being. Black stigmas impact wages, unemployment rates, income and wealth levels, ability test scores, physical and mental health, mortality statistics, as well as prison enrollment and crime victimization rates. These persistent and substantial racial disparities require that we understand and study the extent to which an inherited racial stigma, even today, inhibits the ability of Black people to realize their full human potential (Loury 2002). For thus, our exploration of the 'foreign credentials gap' serves as a microcosm.

6. Re-Purposing Sub-Saharan Stereotypes

6.1. Implicit Racial Stereotypes

Stereotypes are an implicit mode of existing knowledge. The relationship between implicit stereotyping and implicit evaluation is typically associated with the link to culturally defined stereotype content (Blair et al. 2001). For example, the long-standing racist trope of synonymizing Blackness with criminality has long been widespread in Canada. Indeed, researchers have found that Black boys as young as 10 are more likely to be viewed as older and less innocent than Whites, and to face police violence if accused of a crime (Goff et al. 2014). Other researchers have found that Black men in general tend to be stereotyped as threatening and perceived to be larger than they are. As a result, they may be disproportionately targeted by police even when unarmed (Wilson et al. 2017). These formidability bias judgements appear to integrate multiple pieces of information to ultimately conclude that young Black boys and older Black men are more physically threatening than young and older White men, and that they must, therefore, be controlled using more aggressive measures (Wilson et al. 2017). Thus, police 'use of force' research conducted in Canada has consistently found highly disproportionate incident numbers among Black males across jurisdictions (see: Foster and Jacobs 2022a, 2022b).

Implicit bias studies have asserted that, because of pervasive, culturally embedded associations combined with words and images that strengthen these unconscious associations, people of African descent are regularly viewed with suspicion and as criminals. Further, when used continually, a neural pathway becomes entrenched and provides an efficient, smooth path for messages to reach an individual's consciousness, which makes racially coded categories quickly and sometimes instantly transmitted.

These categories, as implicit bias research notes, cause stereotypes to become hardwired, and the brain further favors quick conclusions over reasoned deliberation (Jewel 2017). Many people explicitly repudiate the Black-crime stereotype, but it is pervasive in dominant White culture, so we are all aware of it. Our unconscious is not good at distinguishing between associations that we approve of and those we do not, so merely having the two concepts (Black and crime) associated in our memories causes one to be automatically activated in our thoughts when the other is presented (Glaser 2014).

Links between race and stigma can be traced to cultural narratives that go back to the master–slave mythology of European colonialism and the basic colonial projection of the "slave figure" as simultaneously unpredictable and capable of "turning nasty" (Hall 1996, p. 21). Stuart Hall (1996) guided us in a precise reading of this colonial grammar of race. The primitive nature of Black people means they are cheating, cunning, savage, and barbarian (Hall 1996). The notion of the intrinsic primitivism supports the idea of their suitability to their servile positions; the fear of their unpredictability provides justification for maintaining control over them, while the image of the civilized White man 'confronting his Destiny' makes the exercise of this imperial control not only acceptable, but also respectable (Hall 1996). Meanwhile, the stigmatization of Blackness is still deeply embedded in White hegemony and cannot be separated from the context of ideology, institutions, and power (Hall 1990, 1996).

In the context of evaluative methods of professional practice, research has shown that the negative valence of Black stereotyping has consequences in regulated professions, like medicine, for fair competition. For instance, while the immigration system has been guided by a 'cream of the crop' entry model that is based human capital criteria related to acquired skills and credentials, the Canadian workplace has been dominated by a 'cultural deficiency' model based on negative assumptions about the merits of education and training in non-White, racialized societies. The holding of these two contradictory values or positions at the same time unfairly influences employment outcomes and is a primary source of dissatisfaction among immigrants of colour (Foster 2015b, 2015c).

6.2. Sub-Saharan Blackness Stereotypes

With the contemporary global influx of Black migrants from sub-Saharan Africa and around the world, racial stigmas have become transnational as well, and anti-Black

discourses have multiplied and tended to be highly negative, framing Black/African Diaspora communities as a "problem group"—unintelligent, hostile, poor, lazy, crime-prone, and dishonest (Devine and Elliot 1995). Africa and sub-Saharan Africans symbolize poverty, AIDS, hunger, and political instability, and are viewed as uncivilized, savage, duplicitous, and incapable of governing themselves (Offeh-Gyimah 2000).

Adding to the longstanding racial tropes and stigmas, sub-Saharan Blackness brings with it new and repurposed 'spoiled identity barriers', including internet scams, cyber-crime, and computer fraud. These new virtual-realm stereotypes distinctively pinpoint and sharpen the characteristics of 'dishonesty, fraud and deceit' as a central image and conceptualization of the lived experiences of Black people globally, which all other negative valences revolve around (Bischoff 2023).

The combination of Blackness and African-ness produces an even more distinctive race archetype. A Western social construct of a Black sub-Saharan African can conjure a racial stereotypical stigma that sharpens the characteristic of 'dishonesty' as a central image of Black people-ness which all other negative valences revolve around. The activation of the central stereotype typically activates a constellation of Black African stereotypes that fall within a range from the buffoon to the brute (Devine 2001; Lepore and Brown 1997).

Some of the historical stereotypes of Black people in a Western context are the Sambo, Golliwog, and Pickaninny (happy, usually laughing, lazy, irresponsible, or carefree); the Mammy (Black woman completely dedicated to the White family); the Mandingo (Black male subservient to the sexual instinct); the Sapphire (angry Black woman); the Jezebel (sexually promiscuous); and the Tragic Mulatta (light-skinned woman 'passing').

Modern Black stereotypes on the buffoon–brute continuum (and leaning more to the brutish) include The crack victim, the drug dealer; the watermelon stereotype; the fried chicken stereotype; the welfare queen; the radical crank (for assertive Black leaders); and more.

Today, most people of even moderate media exposure are also aware of the 'Nigerian Internet Scammer' (Bischoff 2023). The word Nigeria has become a Western cautionary tale psychically framed to some extent by fantasies of colour and deceit. Even though most Canadians may not have any personal experience with a specific internet dodge and swindle perpetrated by Nigerians, the image of cyber-fraud has come to be so associated with Nigeria, and Sub-Saharan Africans more diffusely, that it is now a generic concept and a part of a silent vocabulary in our everyday grammar of deceit.

Indeed, in Western popular culture, cyber-fraud is nominally dubbed the 'Nigerian 419' because the first wave of these swindles came from Nigeria. The '419' part of the name comes from the section of Nigeria's Criminal Code which outlaws the practice. However, despite the impression fostered that Africans, and specifically Nigerians, are the world's major perpetrators of online fraud, official statistics reveal a very different picture. Financial internet frauds are not exclusive to Nigeria or other countries in Africa. Internet Crime Complaint Center (IC3) statistics showed that 66.1% of reported cases of Internet fraud were from the United States, with other countries such as the UK, Canada, China, and South Africa among other top global perpetrators (Bischoff 2023).

It is important to understand that in the context of global migration, African stereotypes 'otherize' Blackness in ways that ignore national boundaries and differences. Therefore, distinction between Nigerians and Cameroonians and other Sub-Saharan Africans is typically lost in Western perception and translation. Here, quite apart from the proximal closeness of Nigeria and Cameroon as geographic neighbours and Drs. Ujima and Ujamaa's countries of origin, they also share the binary forms of techno-terrorism and fraud in Western thinking and imagery of the 'Dark Continent'.

The Dark Continent stands for a place that stretches beyond the civilized world. As the proxy, African migration can conjure unspoken thoughts of duplicity, and there is a strong susceptibility and social conditioning among the dominant White culture for 'framing' Sub-Saharan Africans broadly as potentially dishonest and deceitful scammers. Thus, the African presence in a Canadian context can lead to a heightened awareness, scrutiny, and

vigilance on the part of those in the dominant White culture in their inter-racial interactions. In this regard, the caricature of the Black African, crystalized by the 'stigma of deception', is commonly used as a key unspoken indicator to benchmark character and performance expectations in everyday life and the workplace, informing the actions of others.

7. Biased Deception Judgments

7.1. Unconscious Distortions Leading to Hyper-Surveillance

It is notable that both Dr. Ujima's and Dr. Ujamaa's clinical performances as a licensed practitioner and a medical resident, respectively, were never at the center of the accreditation disputes and were not used as rationale for either of their dismissals. Indeed, it is fair to say that the primary rationale for their discreditation and dismissals surrounded the interpretation of deceptive behaviors.

In the matter of Dr. Ujima, the Appeals Committee denied him the right to practice medicine in Ontario to 'protect the public interest because of his prior history of complaint proceedings and the concealment of that history'.

In the matter of Dr. Ujamaa, the Faculty Council Appeals Committee determined the allegedly fraudulent behavior in question was 'the submission of forty-five (2 of 45) professional activity reports'.

Several decades of research on deception have found that people are scarcely better than chance at telling whether someone is lying to them. Moreover, when trying to tell if someone from another culture is deceptive, the rate of accuracy goes down to below chance (Bond and DePaulo 2006). Since the accuracy of deception judgements deteriorates when made across cultures, assessors (and everyone else) 'should' become less confident in their ability to make appropriate inferences from an individual's behaviour.

For sub-Saharan IMGs who seek to be doctors in Canada and aspire to customarily White male positions, this is especially problematic. Racial stereotypes for Blacks are inconsistent with stereotypes about the ideal physician. As a result, predominantly White medical settings put Blacks with foreign training and degrees in a double-bind. First, societal stereotypes and stigmas about how Black people behave, and the quality of their characters, prevents them from fitting easily into the stereotype of the ideal medical doctor. Traits that define professionalism in general relate to culture-conditioned characteristics that normalize Whiteness. This means that envisioning Black people in settings where White people hold the top positions is beyond the limits of the White imagination and rendered a non-sequitur. Secondly, in the precipitous state of entering or upon assuming an entry role, Black doctors, and particularly Black male doctors, butt up against the pervasive stereotype that perceives Black men as threats and symptoms of danger and criminality (Russell 1998).

Danger, deceit, and deception are pre-existing thresholds of the Black interaction equation, including for Black professionals and doctors. This is linked to a 'hyper-surveillance' based on unconscious distortions where Black medical doctors and residents like Drs. Ujima and Ujamma are constantly subject to the White gaze and, therefore, are more susceptible to career risks.

This kind of hyper-scrutiny can also have profound personal impacts. It has a harmful effect on dignity. Victims may also lose their sense of being safe and secure. It can affect their sense of liberty and their connection with their families and communities and can have serious health consequences.

It is perhaps in this regard that 'burnout' has long been recognized as being particularly acute among Black medical professionals (Wingfield and Chavez 2020; Dyrbye et al. 2019; Post and Weddington 2000). Burnout is a syndrome characterized by feelings of energy exhaustion; cynicism related to one's job; a decrease in professionalism, productivity, and quality of medical care; and an increase in medical mistakes and intent to leave (Dyrbye et al. 2019). It has negative effects on both work and personal life. Emotional impacts of toxic workplace burnout can be a sense of failure and self-doubt; feeling helpless, trapped, and defeated; detachment and feeling alone in the world; loss of motivation; and an increasingly negative outlook. Additionally, there are serious personal

consequences to burnout, including relationship issues, alcohol dependence, and suicidal ideation (Lawrence et al. 2022). Distinctive coping strategies involve spirituality, kinship, and the development of strength and perseverance in the face of adversity.

7.2. Racial Perspective of Honesty

Research in the United States by Rawls and Duck (2020a) regarding race-based worldviews on 'honesty' also has implications for understanding the racial dissonance in the contemporary workplace. These researchers found that Blacks and Whites tend to be oriented toward different conceptions of self and community—one individualistic, the other egalitarian—in a way that affects their perspectives on honesty in interactional practice. For African Americans, honesty is not only about telling the truth. It involves a commitment to completely and accurately express how one feels in the moment—with a particular focus on expressing feelings about trouble—combined with a commitment to sticking with an interactional problem until the problem is fixed. White Americans find the Black American practice of honesty both intimidating and puzzling. Black Americans find the White American version of honesty, which involves being 'diplomatic' and withholding anything that would be problematic, to be dishonest: 'plastic'. The White ideal places the highest value on the independence and self-interest of the individual, while the White interaction order reproduces a hierarchy of categories (race, gender, status) that are consistent with self-interested individuals. By contrast, Black Americans adopt a form of practice that resists hierarchy, emphasizing civility, respect for uncategorized personhood, and submission to mutual responsibility (Turowetz 2020, pp. 129–61). When Black Americans do withhold in an interaction, it is because trust relations have broken and they are either taking self-protective action or have given up on an interaction completely. The Black American focus on creating a space for equal personhood here and now leads to an expectation that the feelings of participants in the moment should be expressed. In an inversion of what White Americans consider personal—Black American interactional expectations treat a person's feelings as part of the immediate public situation in which they occur—the information about job status and social category that White Americans consider public is treated as private (Rawls and Duck 2020a, pp. 81–104).

7.3. Unpacking White Privilege

In a time when racial prejudice is generally taboo and decision makers, including officials in the medical profession, strenuously disavow the use of group-based stereotypes to make judgments that affect others, one might expect discriminatory outcomes to be unusual. However, research repeatedly indicates that systemic racism reinforces the implicit bias that Black people are less trustworthy or less skilled, making it more difficult for Black people to establish a foothold in the profession or the credibility and authority necessary to have their opinions held in high regard in the workplace (Anderson and Bolt 2016; Moore 2007).

On the other hand, our medical system is structured to individually and systemically favor White physicians and patients in ways that White people are trained to ignore. Most White doctors do not think race affects them or their clinical decisions and are taught to ignore their own racial privilege in favor of a meritocratic social myth.

White privilege is built upon Whiteness and is a legacy of racism and bias that has created unearned benefits and advantages for White people. White privilege does not imply that White people have not endured their own personal struggles, but instead acknowledges the systemic benefits they enjoy because of our social structure. White privilege allows White people to walk through the world with the assumption that their needs will be readily met and that they will be given the benefit of the doubt (Autry 2020).

Medical professionals are increasingly aware of how social determinants of health lead to important health disparities; however, White physicians seldom ask how their own racial privilege reinforces a hegemonic White culture and what effects this may have on colleagues and patients' health.

Although systems of racial oppression take generations to dismantle, the task begins with an awareness of the problem. White physicians and decision makers have an opportunity to acknowledge the unearned racial privilege that benefits their careers and actively work to dismantle the systems that propagate racism in medicine. The challenge for White physicians and the directing minds in the profession is to take the first step by unpacking their White privilege. The path of self-realization is the first active interventions to address the racial disparities in healthcare and in wider society. This can begin by speaking out against the racism that they have all benefited from to work towards racial justice in the medical system for their colleagues and their patients. A 'best practice' to debias race relations is to openly acknowledge biases and then directly challenge or refute them (Morewedge et al. 2015; Byrd 2021).

8. Closing Thoughts

A major cause of bias in physician entry and assessment processes is likely the implicit racial biases that operate outside of conscious awareness and control, but nevertheless influence behaviors. This can include cultural deficit bias, confirmation bias, re-purposed racial stereotypes, and bias deception judgements that are determinative sources of invisible harms against foreign-trained physicians of African descent that both shape and confirm negative evaluations of character, credentials, and culture. These implicit biases influence trends towards foreign credentials gaps, devaluation, and accreditation blockage of internationally trained Black medical doctors through processes that can lead to misattribution and disambiguation. Although the social psychology of race and race relations gives us good insight into the causes of racially biased medical workplaces, there are no known, straightforward, and effective anti-racism policies or program interventions yet.

The lived experiences of Drs. Ujima and Ujamaa offers a platform to explore how subtle forms of discrimination can produce biased perceptions of professional integrity and credibility that lead to career nullification and can only be detected after looking at all the circumstances to determine whether a pattern of behaviour exists. Individual acts themselves may be ambiguous or explained away, but when viewed as part of a larger picture, they can lead to the inference that subtle or aversive racism is a factor in the treatment a person receives.

Meanwhile, many medical schools espouse the goals of diversity, equity, inclusion, and accessibility (Shin et al. 2023). In Canada, authorities in the medical field have expressed commitment to addressing current societal needs, and those expected moving forward including the Black Physician's Association's proposals to dismantle anti-Black racism in medical education, as well as the recommendations of the Truth and Reconciliation Commission (Moffatt-Bruce 2020). However, these institutional commitments are more likely to be successful if they incorporate the understanding that bias in the profession occurs in the absence of explicitly 'racist' thoughts because of well-documented, pernicious, trauma-inducing stereotypes that operate largely outside of conscious awareness and control.

This begins with the recognition that we need to make the unconscious conscious and make the invisible visible. This chapter conjoins the social psychology of race and race relations research, which has now clearly established that implicit racial bias and implicit racial stereotypes are obstacles to workplace equity for racialized workers that are so formidable and self-perpetuating that they cannot be overcome without deliberate and self-reflective intervention. Bringing immigrant and Canadian-born workers of all racial and ethnic backgrounds to the point of fair competition requires institutions and professions that are attentive to the modern challenge of subtle and systemic race bias and are determined to oppose it head-on. The moment we acknowledge that we are operating under unconscious bias, we are then empowered to change it.

Data Availability Statement: The original contributions presented in the study are included in the article further inquiries can be directed to the corresponding author.

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Notes

[1]   In 2023, 471,771 permanent immigrants made Canada their home, which was within the target range of Immigration, Refugees and Citizenship Canada (IRCC). Permanent immigration was up compared with one year earlier in every province and territory except Nova Scotia and Quebec.

[2]   The real names of the physicians who were the subjects of our case study have been altered for research anonymity and de-identification purposes; however, information about disciplinary cases is routinely made publicly available by the Ontario Physicians and Surgeons Discipline Tribunal.

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