OPINION ARTICLE

Exploring possibilities of harmonising social justice with medical education through the use of CanMeds and AfriMeds when engaging in discipline integration [version 1; peer review: awaiting peer review]

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Abstract

Medical curricula are largely content heavy and grossly overloaded but focus primarily on medical and biomedical sciences. It has been argued by authors such as Gukas and Filies that well-balanced professionals are seldom produced by such content heavy curricula. The incorporation of social justice principles in medical curricula is vital in promoting the production of well-balanced and competent healthcare professionals, as called for in the CanMeds/AfriMeds frameworks. However, the World Federation for Medical Education issued a consensus statement asserting that medical students in the USA and Canada receive little to no formal training and teachings as far as social justice is concerned. In this paper it is asserted that medical students in South Africa are no exception to such consensus. It is further asserted in this paper that if one begins to examine principles of CanMeds/AfriMeds, entry points for the insertion of social justice principles becomes a possibility without having to further overload an overloaded curriculum. In essence, adopting and promoting roles of CanMeds/AfriMeds such as professional, collaborator and scholar enhance a non-hierarchical style and environment of teaching medical students. This new style and environment of learning are shown in this paper to enable an insertion of social justice principles in a medical curriculum in instances where such insertion may otherwise have been impossible.

Keywords

Medical Education, Social Justice, Medical Curriculum, Doctor-Patient Relationships, Mentoring, Transformation of Learning Spaces
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Introduction
The purpose of this paper was to determine how one may through the use of CanMeds/AfriMeds better promote the harmonisation of social justice with medical education.

This paper therefore focussed on how one might find ways to harmonise principles of social justice with medical education whilst using CanMeds/AfriMeds as entry points for the insertion of social justice principles. In essence, this paper begins to explore ways in which medical educators may assist social justice principles in taking their place alongside traditional foci in medical education such as biomedicine and biomedical sciences etc.

The research question
How might one through the use of CanMeds/AfriMeds (as entry points for principles of social justice) better promote the harmonisation of social justice with medical education?

Background
Medical education is education which purports to prepare one to be a medical practitioner (Mann et al., 2009). Medical practitioners, according to Mann et al. (2009) are ideally well rounded, unbiased and non-prejudicial professionals. But what if said medical education carries with it gaps in knowledge and as asserted in this paper, both gaps in knowledge, and the promotion of social justice principles. I refer here to a sort of medical education which ought to prepare students to not only take on the roles referred to in CanMeds and AfriMeds, but also to be professionals who appreciate the importance of social justice in healthcare. CanMeds and AfriMeds are frameworks used to describe the abilities healthcare practitioners ought to have in order to effectively meet the needs of the people whom they serve (Hefler & Rammanan, 2017). In both, they list the following roles as essential in developing well rounded medical practitioners: Manager, Health Advocate, Scholar, Professional, Communicator and Collaborator. Indeed programmes, such as mentoring exist within some medical education curricula to aid in producing the desired well-rounded healthcare professionals (Ramani et al., 2006). In fact, mentoring within medical education curricula, Ramani et al. (2006) argue, is often identified as a crucial step in achieving career success.

However, despite the importance of mentoring and other programmes within medical education, not all medical trainees or educators recognize the value of the relationship between student and educator when attempting to develop students fully (Ramani et al., 2006). For instance, from a social justice perspective issues of unequal power relations inevitably abound in student-educator relationships. The result of unequal relations is often weak, timid and unquestioning students unable to engage in critical thought (Freire, 1996). In addition, when matters of social justice are included in curricula outside of social justice itself they are more often than not covered in a somewhat superficial manner (Datnow, 2020). Thus, however well-meaning programmes within medical education may be, medical education still remains riddled with challenges.

Identifying and then addressing these challenges is therefore essential if one is to have any hope of developing competent, well-rounded and socially just medical graduates.

Highlighting how a social justice consciousness can be used to address problems related to unequal power relations, stereotypes and assumptions in curricular within medical education, inserting such principles in the said curriculum becomes all the more relevant. It is therefore contended that once the identified problems are addressed and feasible solutions are explored the path towards equipping medical students to not only fulfil the roles stipulated in CanMeds/AfriMeds will be paved, but in addition, the path towards developing socially just practitioners can be paved. In essence, a direct relationship between the implementation of CanMeds/AfriMeds and principles of social justice seems apparent. Thus, integrating social justice in medical education with the aid of CanMeds/AfriMeds is indeed a possibility, I will therefore discuss medical education in greater detail under the next heading, which will then be followed by a discussion around social justice so as to make the relationship between the two somewhat more apparent to readers.

Medical education
Under this heading, in addition to literature surrounding medical education in general, the core competencies of healthcare professionals as stated in CanMeds and AfriMeds will also be alluded to. A reason for this is that much of the literature surrounding medical education included in this paper makes reference to CanMeds/AfriMeds. According to Filies (2017) the core competencies for healthcare professionals, as listed in CanMeds/AfriMeds have increased in importance as years have progressed. This, Filies (2017) argues, is largely due to the fact that medical education has a history in which reform occurs, but with little change. In addition, Lempp & Seale (2004) earlier postulated that during the 1990s despite changes in respect of content covered within medical education, very little attention was paid to the hidden curriculum.

For too long many principles and policies which fall outside the scope of biomedicine and medical sciences were superficially incorporated into medical training, to the extent that they were not given the value that they deserve (Kumagai & Lypson, 2009). Thus, the contradiction of reform without change, in my view applies. Lempp & Seale (2004) have argued that medical education programmes and curricular should set students up for career success by ultimately equipping them to become competent clinicians. In order to do so, factors falling outside of the medical education curriculum would have to be considered. In essence, the core competencies of healthcare professionals, as listed in CanMeds/AfriMeds must be considered. Thus, having medical trainers or educators who are capable of nurturing and even developing these core competencies in students is a need that ought not to be ignored.

While mentoring is often identified as a crucial step in achieving career success, not all medical trainees or educators recognize the value of a mentoring relationship (Ramani et al., 2006).
In essence, a mentoring relationship, according to Koehler & Sturm (2018) should be one in which ongoing learning on the part of both mentor and mentee is promoted. Koehler & Sturm (2018) have asserted that this has not always been the case within medical education. As such, changes in pedagogical practices which have long since been used by mentors are often necessitated.

The necessity to alter pedagogical practices within medical education so as to better equip students to be successful in their careers is therefore but another aspect which I feel deserves some attention. A reason for this, further to the above, is that Ramani et al. (2006) have asserted that medical educators rarely receive training on how to teach, and as a result they know medicine well, but are often ill equipped to face challenges when taking on major teaching responsibilities. In addition, Patterson & Krouse (2015) identified four areas which require address in improving medical education curricular, and they are 1) personal encouragement, 2) haphazard teaching, 3) the importance of hierarchy, and 4) getting ahead by being competitive.

Patterson & Krouse (2015) have asserted that often medical students are profoundly demotivated by their perception that many medical educators have a low level of commitment to teaching, and this leads to a repetitive cycle of non-attendance by students and educators alike. In addition, one of the primary ways in which students learned about medicine in wards was through humiliation. Perhaps, pedagogical changes as far as commitment and the use of humiliation are concerned may be necessitated, especially if one is to adequately foster the core competencies of healthcare professionals. As I fail to see how the competencies of professional and scholar can be fostered in settings in which levels of commitment are low and instances of humiliation are high. In addition, humiliation in settings of teaching and learning are made all the more possible by unequal power relations between students and educators. Certainly, such an occurrence flies in the face of principles of social justice, which at the very least demand a non-hierarchical relationship between those being taught and those doing the teaching (Freire, 1996).

Further to the above, Patterson & Krouse (2015) proffered that humiliation was often used to teach students the importance of hierarchy in medicine, thus contrary to principles of social justice while suggesting that areas 3 (hierarchy) and 1 (encouragement) are indeed related. Nevertheless, haphazard teaching (area 2) appeared to go hand in hand with the lack of commitment mentioned in area 1, thus a link amongst areas 1, 2 and 3 is apparent (Patterson & Krouse, 2015). Accordingly, from a social justice perspective I am inclined to argue that should area 3, the importance of hierarchy, be addressed, areas 1 and 2 may benefit as well. The importance of incorporating principles of social justice within medical education thus becomes apparent. Finally, according to Patterson & Krouse (2015) many medical students have reported that competition rather than cooperation is the defining characteristic of medicine. Accordingly, very little community building exists. Social justice as a discipline, frowns upon the exclusion of a group or groups of individuals merely for the benefitting of an elitist few (Young, 2000). Thus, the lack of the incorporation of social justice within medical education results in the roles of collaborator, communicator and scholar being inadequately fostered. Again, the necessity for the harmonising of social justice within medical education seems apparent. This is especially apparent, in light of the shift in thinking which favours placing a greater value on CBE and the development of a well-rounded healthcare professional than had previously been the case. Based on the paragraphs above, it is evident that principles of social justice are vital in promoting the roles of healthcare professionals as stipulated in CanMeds/AfriMeds. I will thus turn my attention towards social justice itself under my next heading.

**Social justice**

The discipline of Social Justice although having its roots in religious circles can be linked to any academic discipline (Burke & Collier, 2017). The incorporation of social justice in other disciplines is certainly not a new idea (Freire, 1996). However, how successfully scholars have drawn links between social justice and other areas of study remains contentious (Burke & Collier, 2017). Thus, medicine, and in particular medical education is no exception. Social justice was initially a very neutral concept, aiming to accommodate all; but in the later 20th century became deliberately political and firmly positioned in the critical theory paradigm (Burke & Collier, 2017). Seen, presently as a process and a goal, social justices is in essence an ideal to which any individual and/or discipline believing in fairness and equality should aspire (Adams & Bell, 2016; Bell, 1997). Medical practitioners are at the fore when dealing with people from all structural social groups, thus promoting both fairness and equality in everyday healthcare practices ought to come as merely part of the job (Harris, 2011). For this reason, amongst others, finding ways to harmonise principles of social justice with medical education is, in my view, of great significance.

Hofmeyr & Nyoka (2013) have argued that increasingly value systems in society are at odds with the temptation of material gain. Marshall & Harrison (2005) have contended that many physicians enter the profession largely due to the prestige that accompanies it. As a result of focusing rather on material gain than simply improving the lives of others value systems are likely ignored. When this happens, according to Hofmeyr & Nyoka (2013) the socially marginalised become more exposed to exploitative practices propagated by those in power. The exploitation of marginalised beings flies in the face of social justice principles, as contended by Young (2000) who identified both marginalisation and exploitation as two of the five faces of oppression. Powerlessness, cultural imperialism and violence constitute the other three faces of oppression (Young, 2000). Nevertheless, with societal value systems being at odds, healthcare is no exception to the occurrence of marginalised individuals being most prejudiced. Jansen (2017) has postulated that a lack of willingness to share power with patients in their treatment is evidenced especially when alternatives to western medicine are suggested by patients. Accordingly then, western medicine and conventional medical sciences take precedence not only at university level but extend to the practice of medicine (Jansen, 2017). The harmonisation
of medical education with social justice is, in this way, dealt yet another blow as issues of social justice are marginalised for the benefit of biomedical sciences. However, bearing in mind the CanMeds/AfriMeds principles of scholar and communicator, the need for clinicians to be prepared to learn from patients, be open-minded and communicate, possibly in a negotiated fashion, a feasible treatment plan is indeed highlighted. Thus, a principle of social justice which calls once again for a non-hierarchical relationship is necessitated.

In practice, however, the ideas and opinions of patients, especially those from disadvantaged socio-economic backgrounds, are often marginalised (Jansen, 2017). When individuals are deprived of access to basic human rights, simply due to the structural social group to which they belong, according to Young (2000), oppression abounds. Young (2000) goes as far as asserting that if such deprivation occurs to the extent that individuals in a specific group are excluded from benefits that many others in society enjoy, marginalisation of such individuals is said to have occurred. Accordingly, individuals who find it difficult to access basic healthcare simply due to material deprivation are indeed marginalised beings who have been pushed to the outskirts of society. In addition, individuals whose preferences concerning treatments are ignored due to a knowledge hierarchy can be deemed marginalised as well (Jansen, 2017). Merely practicing medicine while turning a blind eye to the marginalisation of the very individuals whom one is supposed to be serving is indeed a social injustice. Kumagai & Lypson (2009) thus assert that medical education cannot be devoid of social justice principles.

However, merely including social justice principles in a medical education curriculum does little if such principles are not well received by students, the very people who will constitute future healthcare professionals and therefore be in a position to effect change which promotes greater fairness and equality within medicine and healthcare. Accordingly, the need to shape and re-shape the perceptions of medical students as mentioned by Tunstall-Pedoe et al. (2003) is highlighted. One is also then reminded of the interconnectedness between the need to incorporate social justice in medical education and the need to produce well-rounded healthcare professionals as highlighted in both CanMeds and AfriMeds. Using the desired roles of a healthcare practitioner as described in CanMeds/AfriMeds as an entry point for the incorporation of social justice principles in medical education seems the all the more logical when one considers the interconnectedness of social justice with well-rounded professionals, as mentioned above. In reality many students experience medical education in socially unjust spaces (Kumagai & Lypson, 2009). In such instances, in keeping with Freire’s (1996) calls for structural transformation, a way forward would then be to transform the space in which students learn so as to ensure the promotion of social justice. This approach stands in opposition to one which integrates students into a medical education curriculum which has historically and continues to ignore principles of social justice; or at the very least presents them as a mere “add-on.”

Social justice is of significance in education, and for the purposes of this paper, medical education due to its strong stance against instances of oppression. Oftentimes oppression and indoctrination go hand in hand (Freire, 1970). In an article on the action of “knowing” Freire (1970) postulated that repetition serves to aid indoctrination in educational settings. In this paper, the educational settings relevant to medical students is of significance. Freire (1970) asserted that once repetition is employed to the extent that the action being repeated is eventually largely accepted and taken as the norm, indeed indoctrination can be claimed to have taken effect. Relating this postulation to Deleuze’s (1994) claim that repetition allows for the lines between multiple realities to be blurred, despite how differing such realities may be, it becomes apparent that if medical students are repeatedly exposed to a socially unjust way of practicing medicine, despite possible initial reservations on their parts, eventually unjust practices will be taken as the norm.

Medical students, in my view, are indeed indoctrinated to such an extent that many become complacent with the gross inequalities and general lack of social justice prevalent within the medical field and indeed medical education. Following Freire’s (1996) call for structural transformation, as well as the stark reminders of inequality within healthcare which have been brought to the fore by coronavirus disease 2019 (COVID-19) (The disproportionate effects on ethnic minorities, (Kirby, 2020)); it seems logical then that transformation is required within the medical education curriculum if one is to tackle instances of social injustice within the medical field. This assertion is made in view of Freire’s (1996) contention that through raising awareness about inequality, one’s practices inevitably change. Accordingly, finding ways in which to harmonise principles of social justice with medical education becomes imperative in tackling instances of social injustice prevalent within the medical field and more specifically, medical education itself.

One possible way of promoting the harmonisation of social justice with medical education is through using the roles of a well-rounded medical practitioner as described in CanMeds/ AfriMeds as entry points for the insertion of social justice principles. Lockyer et al. (2018) have contended that the roles described in CanMeds are inextricably related to a complex web in which a well-balanced healthcare professional is entangled. Certainly, within this complex web issues of social justice abound as Freire (1996) has postulated that social justice is an ideal to which we must strive as it cannot be excluded from any aspect of humanity. I accordingly focus now on entry points for the insertion of social justice under the next heading.

**Entry points for social justice in medical curricula**

Moodley, Van Aswegen & Smit (2021) have asserted that the role of Communicator despite being stipulated as essential in AfriMeds remains largely a self-taught role for many South African medical practitioners. Relating this assertion to Jansen’s (2017) claim that often times treatments proposed by patients that do not align with western medicine are often simply dismissed, it becomes apparent that should healthcare
professionals improve their communication skills and practices with patients, by for instance, simply listening to suggestions rather than merely dismissing them, perhaps a more equal practitioner-patient relationship would emerge. Indeed, the hierarchy positioning those in power as elevated in respect of the disempowered would come under attack (Freire, 1996). Certainly then, as a profession; healthcare practitioners would move closer to a sort of practice that incorporates in it a basic principle of social justice, being that of equality.

Focussing on competencies related to that of “scholar” as set out by CanMeds/AfriMeds attention must now be shifted to the works of Maart et al. (2021) who through their use of curriculum mapping identified points in a healthcare curriculum at which they assert the role of “scholar” comes into play. Maart et al. (2021) proffer that when a practitioner is required to interpret data in order to determine exactly how a disease may be affecting a community such practitioner is indeed exercising their role as a scholar. It is, however, my contention that if one is to truly understand the impact of any disease on a particular community, then certainly understanding the social dynamics and engaging with such community becomes paramount.

Young (2000) has identified cultural imperialism as but one face of oppression which serves to marginalize, and exclude. Cultural imperialism is the taking, and accepting of a dominant group’s beliefs and practices as the norm (Young, 2000). Thus, if a practitioner is required to engage with, and gain some deeper understanding of, a community and how a particular disease affects such a community, then indeed fulfilling the role of “scholar” opens a door for the rejection of cultural imperialism in the practice of healthcare. I accordingly assert that to fulfill the role of “scholar” in this manner provides yet another entry point in a medical curriculum for a principle of social justice (rejection of cultural imperialism) to be inserted and given due regard.

Humiliation and unequal power relations, according to Patterson & Krouse (2015), are a common occurrence in the pedagogical approaches employed by many medical educators. Taking into consideration the roles of both professional and that of collaborator it is apparent that such practices fly in the face of these two roles. Thus, using basic principles of social justice such as that of equal power relations would negate such a practice, and so result in an easier fulfillment of the roles of professional and collaborator as listed in CanMeds/AfriMeds. Accordingly, rejecting humiliation and unequal power relations when teaching medical students will not only aid in the fulfillment of the roles of professional and collaborator but such rejection too, opens an avenue in medical education for the insertion of principles of social justice.

Tunstall-Pedoe et al. (2003) have suggested that students usually start their undergraduate training with prior labels of their own professional identity and stereotypes of others. Accordingly, the role of scholar is needed so as to promote an openness to move away from preconceived notions (Sharma et al., 2018).

Thus, a clear link to the social justice principle of reluctance to simply accept a dominant belief without interrogation is evident and indeed required to ensure the fulfilment of this role.

Patterson & Krouse (2015) have asserted that many medical students have reported that competition rather than cooperation is the defining characteristic of medicine. Accordingly, very little community building exists. Social justice as a discipline, frowns upon the exclusion of a group or groups of individuals merely for the benefitting of an elitist few (Young, 2000).

Hence, the promotion of collaboration, which is one of the roles set out in CanMeds/AfriMeds would indeed find support in the work of Young (2000). Thus, yet another opportunity for one to insert a principle of social justice within medical education exists.

Literature seems to suggest that difficulties in harmonising social justice with medical education exist in the hierarchical structure which defines the relationships between medical educators and students (Dasgupta et al., 2006; Gukas, 2007). In addition, when physicians practice medicine they practice in a way that reflects how they, themselves were taught. That is to say, as an all-knowing entity completely devoid of the voices of the very people whom they are treating. Such challenges have existed for decades and will likely continue to exist as medical education is supposedly a curriculum of reform without change as contended by Lempp & Seale (2004). One may therefore better promote the harmonisation of social justice with medical education by using CanMeds/AfriMeds principles as entry points for the insertion of social justice as suggested above.

For instance, simply promoting the skill of communication amongst healthcare practitioners invariably awakens the possibility for them to become better listeners and so begin to take into consideration the unique beliefs and desires of their patients as opposed to practicing medicine in a fashion which follows the same hierarchical relationship of superior and inferior to which they are often exposed in medical school (Gukas, 2007). It is indeed hoped that this paper will induce further investigation and considerations concerning how the harmonisation of social justice with medical education may be achieved without overloading an already overloaded curriculum. It is therefore hoped that the recommendations, on which I will focus under the next heading, can serve as a point of departure and foundation upon which to base further investigations into how one may best harmonise social justice with medical education.

Recommendations
The recommendations of this paper spans four areas; i.e. 1) Mentoring of medical students, 2) Pedagogical changes, 3) Doctor-Patient relationships, and 4) Transformation of Learning Spaces. I shall elaborate on each area in turn. With respect to mentoring, as highlighted above, mentoring to a large extent does not take place on equal grounds. Such is the case as mentors assume a somewhat superior position to mentees often subjecting the mentees to instances of humiliation and belittlement. Social justice, as a discipline promotes the existence of equal power relations, even in teaching and learning
environments (Freire, 1996). It is thus recommended that mentors be made aware of both the lasting adverse impacts of humiliation on their mentees as well as the ineffectiveness of one’s inability to accept that a position of life-long learner has proved ultimately beneficial to both teacher and student (Morrow, 2007). Accordingly, mentors are encouraged to refrain from engaging in humiliating and belittling medical students. This can ultimately be promoted if mentors take the CanMeds/AfriMeds roles of professional, communicator and collaborator more seriously. In essence, taking these roles more seriously opens the door for the social justice principle of equal power relations to enter the realm of medical education.

Secondly, if mentors are to change their approaches to mentoring medical students, as suggested in the previous paragraph, indeed pedagogical changes are necessitated. Pedagogical changes are recommended as far as encouragement, haphazard teaching, the establishment and maintaining of hierarchical relationships, as well as the promotion of competitiveness are concerned. Relying on the evocation of the CanMeds/AfriMeds roles of professional and scholar, aspects of encouragement and haphazard teaching can be addressed so as to aid in pedagogical changes. It is thus recommended that medical educators embrace the role of professional to the extent that teaching in a haphazard manner becomes a thing of the past. In addition, if the role of scholar is fully embraced medical educators may become more encouraging towards students as being a scholar makes one more open to considering the diverse needs of one’s students and so becoming more accommodating to such (Freire, 1996).

It is further recommended that in recognising the need to be open to learning from one’s students, the hierarchical relationships between medical educators and students be minimised so as to encourage the CanMeds/AfriMeds role of communicator amongst both medical educators and students. Finally, as far as pedagogical changes are concerned, it is recommended that competitiveness amongst medical students be discouraged in everyday teaching so as to improve collegiality and promote the growth of communities of cooperation amongst the medical practitioners of the future. This can be achieved by assigning a greater amount of group work assessments in which a diverse array of strengths is required in order for a group to excel at such task or assessment.

With respect to Doctor-Patient relationships, indeed the norms set for these are established in medical school (Gukas, 2007). Again, if the CanMeds/AfriMeds role of scholar is brought to the fore, medical students who will likely become newly qualified doctors will accept that they are not an all-knowing entity unto themselves and accordingly view patients as equal partners in their treatments of ailments. Thus, a negotiated and non-hierarchical role and relationship between doctors and patients will be established. It is accordingly recommended that the social justice principle of non-hierarchy in relationships be embraced and allowed to enter into the realm of medical education through the CanMeds/AfriMeds role of scholar in this instance.

Finally, concerning the transformation of learning spaces for medical students; as established above, the harmonisation of social justice with medical education is challenging due to the hierarchical structures which exist within medical schools (Dasgupta et al., 2006). As Dasgupta et al. (2006) have asserted such structures become so commonplace within medical schools that students are indoctrinated into the belief that the existence of these structures are the norm. Common amongst the three areas of recommendation listed above was the assertion that non-hierarchy must be promoted. It is therefore recommended that when teaching and mentoring medical students, medical educators do so in a manner that promotes equality, not just amongst students, but also equality between the educators and the students themselves. This can be achieved through avoiding humiliation of students during mentoring, engaging students in curriculum design and remaining cognisant of student diversity during teaching. If all of this is done, then dealing with people in a non-hierarchical manner will indeed filter down to how students deal with patients in a Doctor-Patient relationship (Gukas, 2007).

Conclusion
The answer to the research question of how one might harmonise two disciplines that at first glance may seem worlds apart is to simply use CanMeds/AfriMeds as entry points for principles of Social Justice such that one cannot achieve the framework requirements without at least being open to accepting some principles of social justice along with them. Thus, it is my assertion that medical education whilst welcoming of CanMeds/AfriMeds cannot extend such a welcoming without also allowing social justice principles to take their space alongside what has previously been a very elitist, medical science orientated curriculum.

Finally, it is my view that this paper is of significance because increasing the output of competent healthcare professionals in a developing country like South Africa is imperative in improving the living conditions of its citizens. Alternatively, increasing the output of competent healthcare professionals in a developed country like Canada will help sustain a public healthcare system envied by many countries. This paper thus hopes to assist in this regard by commencing a new line of thought amongst medical education curriculum developers which will ultimately lead to producing a new breed of healthcare professionals.

The desired professionals alluded to in this paper will be educated in a manner and in environments devoid of the hierarchical relationships that foster both inequality and social injustices. Attaching principles of social justice to the roles of CanMeds/AfriMeds is indeed a feasible way of harmonising social justice with medical education. As demonstrated in this paper, this can be achieved through using the CanMeds/AfriMeds frameworks and their roles as entry points for social justice principles.

Data availability
No data are associated with this article.
References


