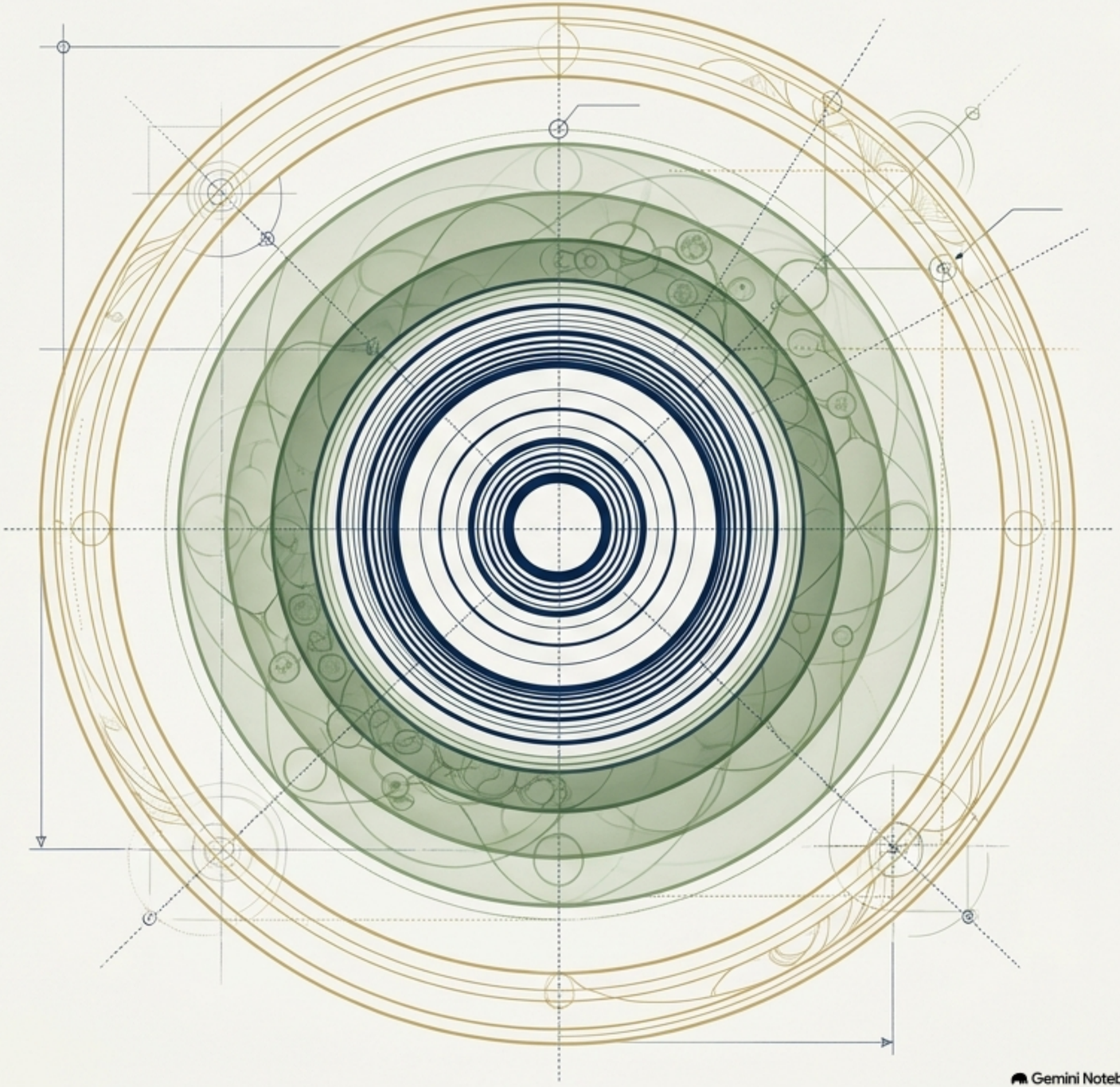
Competence is Necessary, but Not Sufficient

A life-grounded framework for enabling conditions and distributed accountability after CanMEDS 2026.

> Treat what threatens life.
> Prevent what repeatedly harms it.
> Enable the conditions through which it can thrive.



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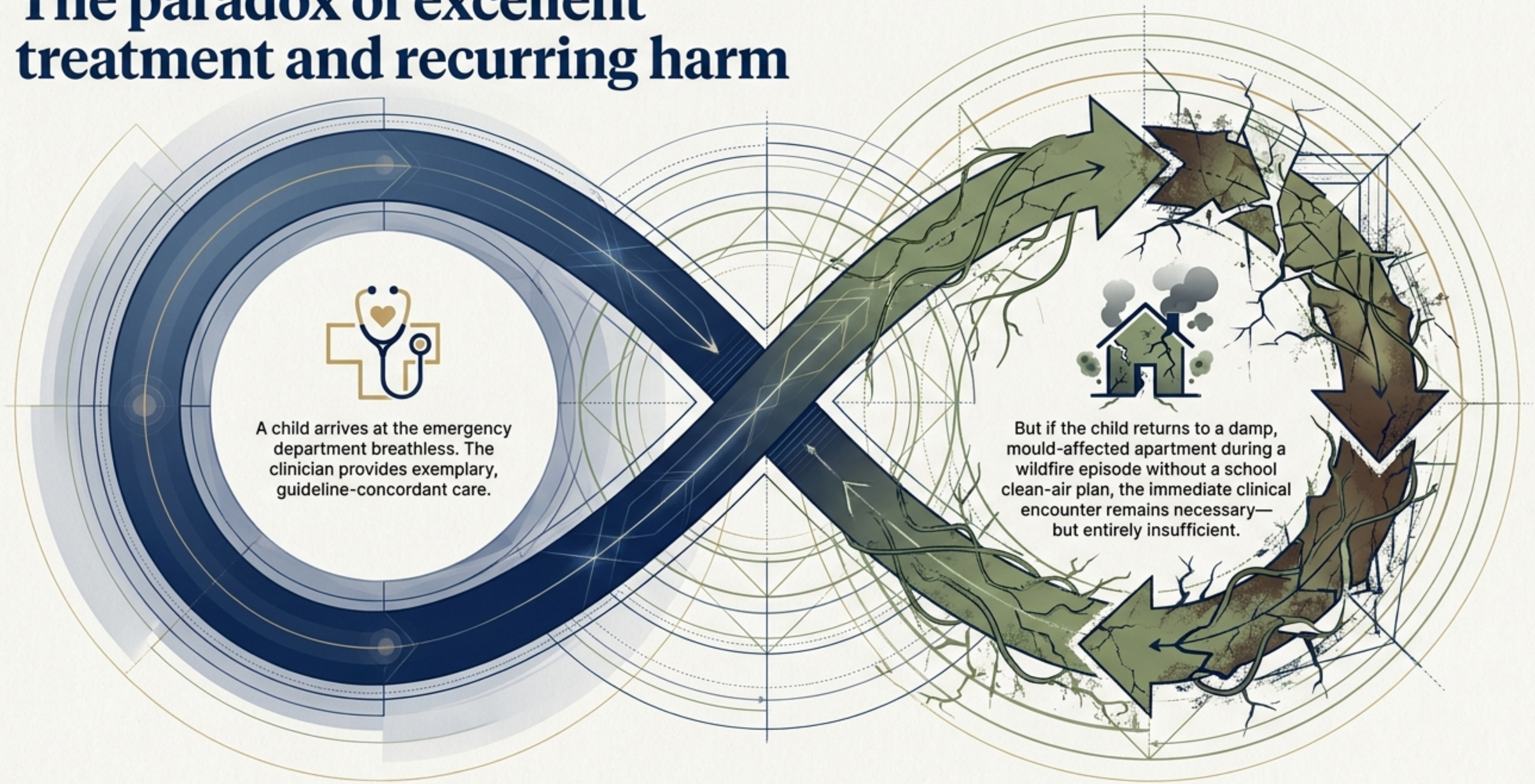
The paradox of excellent treatment and recurring harm



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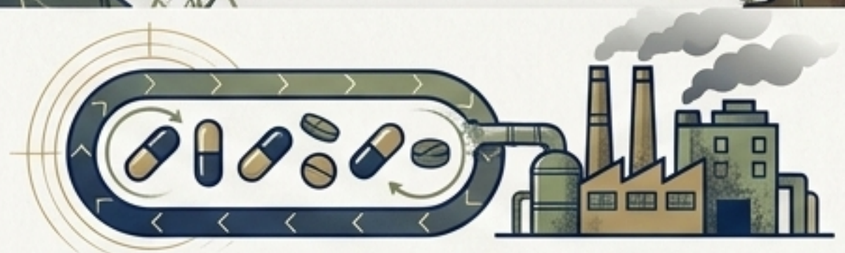
The Competency Sufficiency Error creates impossible expectations

The Definition: Treating a necessary condition for good practice (clinical competence) as if it were sufficient for healthy people, trustworthy institutions, or sustainable systems.

Knowledge for Capability: Naming a determinant (like food insecurity) is mistaken for changing it.

Individual Responsibility for Institutional Duty: Trainees are expected to compensate for missing staff, time, or referral pathways.

Advocacy for Public Authority: Exhorting a doctor to speak up is treated as a mechanism for legal enforcement.



Downstream Service for Health Creation: Recurrent intervention is recorded as system performance without asking why preventable demand persists.

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Drawing a hard line around what competence cannot fix

The Contribution	What Competence Cannot Fix
Clinical competence & professional formation: Safe treatment, judgment, ethical orientation.	A correct prescription cannot repair unsafe housing.
Institutional capability: Staffing, workflows, partnerships.	A screening form cannot supply an unfunded referral service.
Governance & jurisdiction: Legitimate authority, enforcement, rights.	An advocacy reflection cannot exercise a housing inspector's legal powers.
Enabling conditions of living: Air, shelter, food, income, land.	Medical education cannot substitute for a material condition that does not exist.

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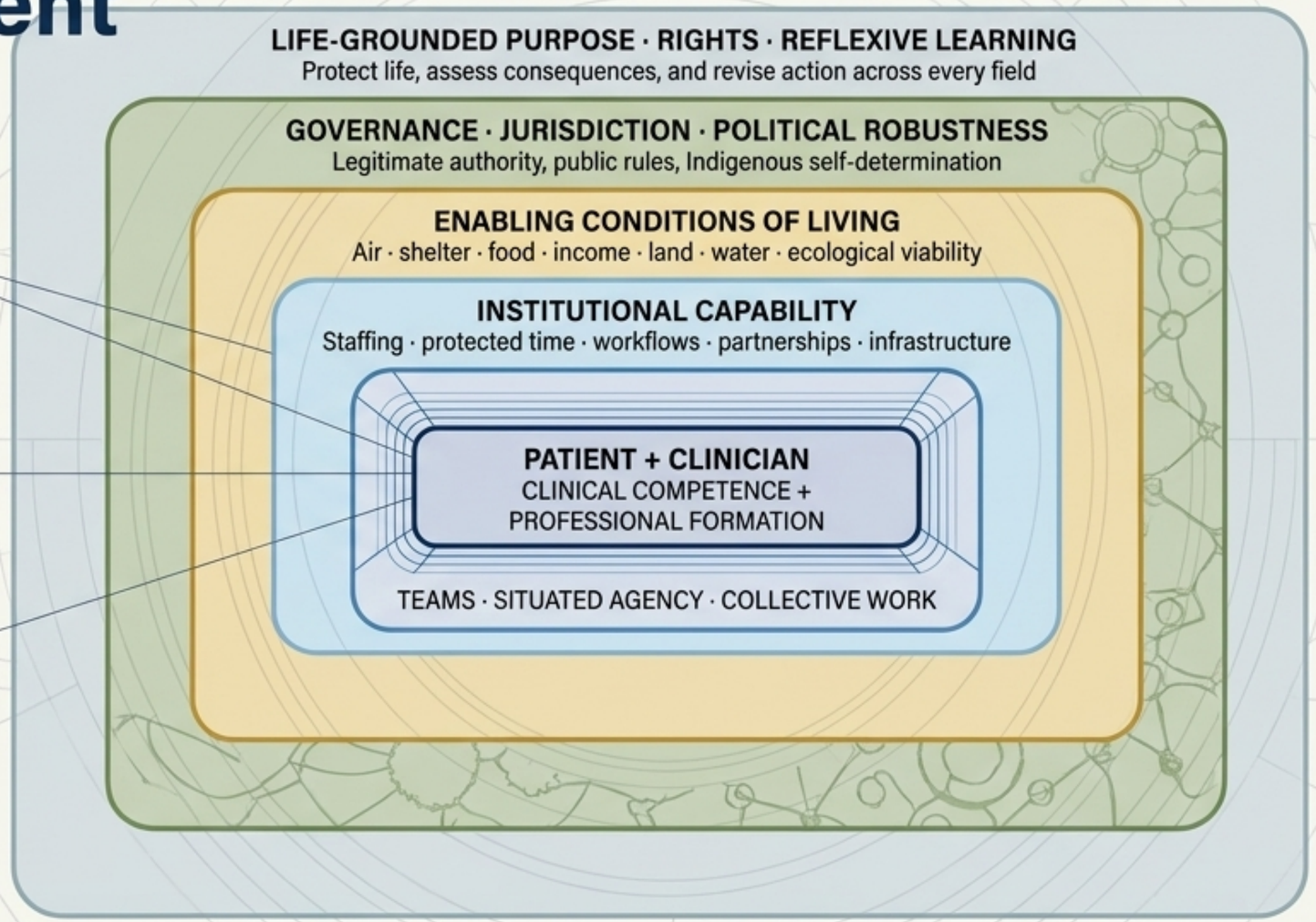
A nested architecture of health enablement

Clinical competence and professional formation remain essential, but they operate within a larger causal architecture.

Not a pipeline, but an ecosystem: These domains coexist and continuously influence one another.

A change in public policy can immediately alter clinical options, and a frontline case can reveal a structural failure.



These domains coexist and influence one another; they are not sequential stages. Feedback reshapes practice, institutions, living conditions, and governance.

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Distributed accountability matches responsibility to practical power

The Proportionality Principle: Accountability must be proportionate to an actor's power, authority, resources, and ability to change the relevant condition. Avoid overburdening clinicians and allowing powerful organizations to hide.

Treat

Protect life when immediate danger is present (Clinical).

Prevent

Intervene when recurrent harm pathways can be changed (Institutional).

Enable

Foster conditions through which communities sustain health (Governance/Ecological).

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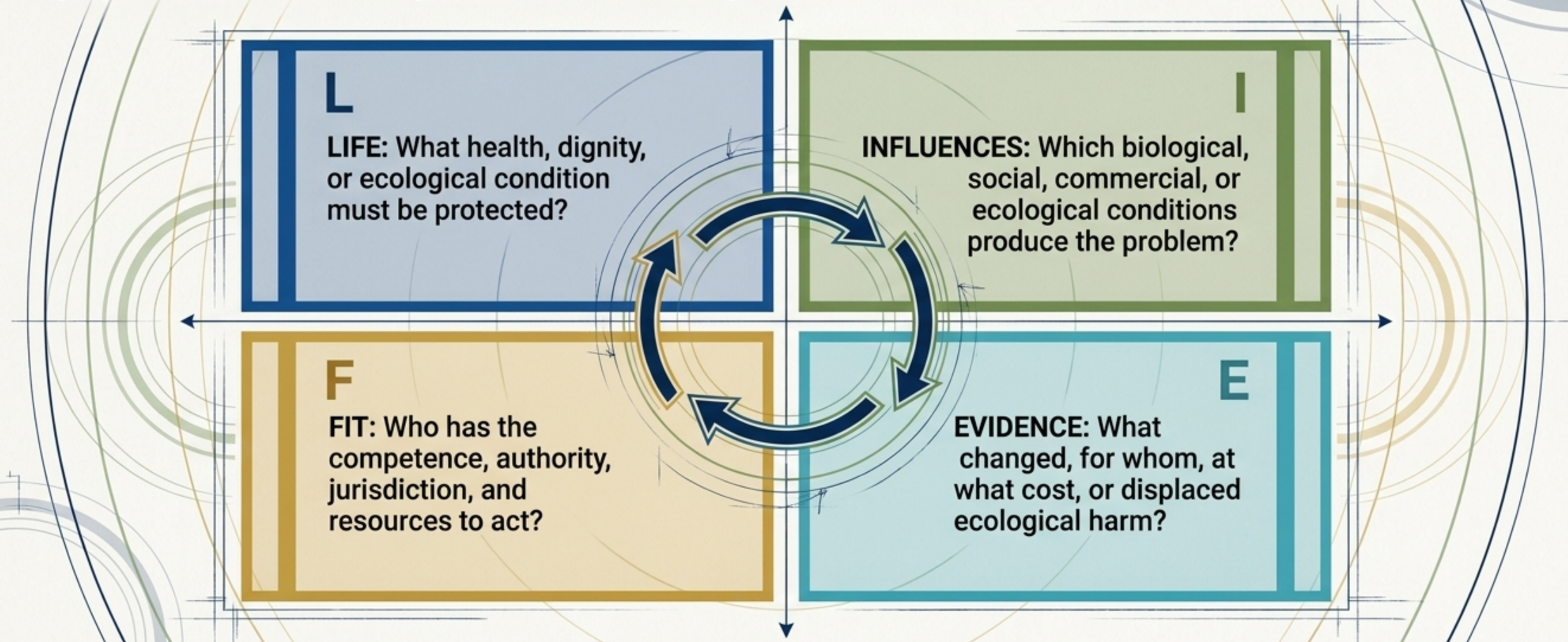
LIFE: A four-part operational grammar

A diagnostic tool to keep complexity actionable without expanding physicians' duties beyond their authority.



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Protecting CanMEDS roles from systemic overreach

Boundary: Clinical expertise does not confer housing or regulatory jurisdiction.

Boundary: Communication cannot replace material access to resources.

Boundary: Collaboration cannot presume authority over another profession.

Boundary: Leadership does not excuse institutions from providing staff and infrastructure.

Boundary: Advocacy is not equivalent to enforcement or public policy.

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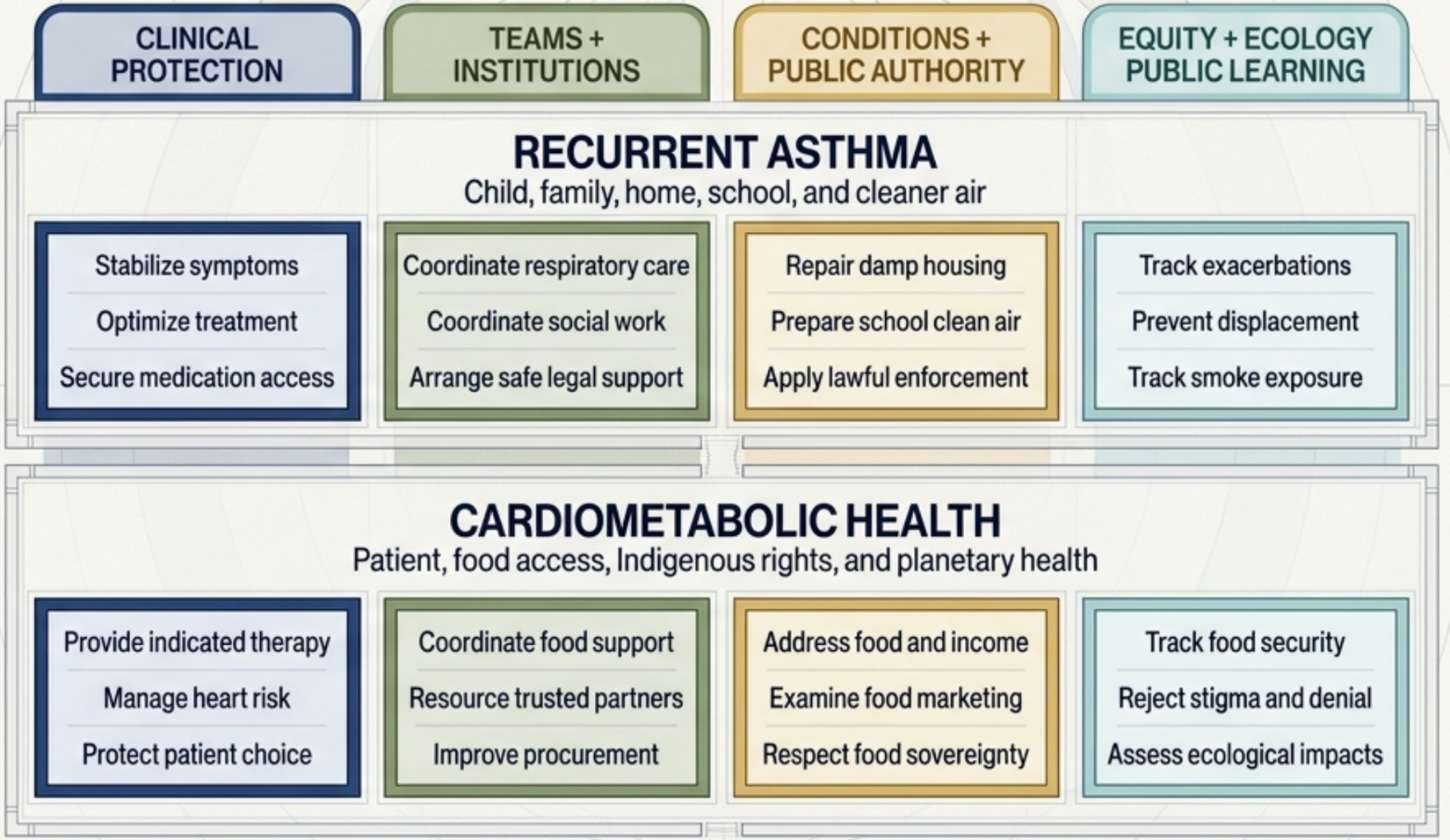
Pressure-testing the framework across two clinical realities

Both cases begin with appropriate care, require authority beyond the clinic, and must measure if lives are protected without shifting harm elsewhere.

Asthma reveals a tractable path between clinical care, housing, and public authority.

Cardiometabolic health exposes a harder stress test involving commercial determinants, ecological metrics, and food sovereignty.



Accountability follows legitimate authority, jurisdiction, resources, and practical power. Actions are coordinated and recursive—not a sequence that delays needed clinical care.

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Commercial determinants require public authority, not just clinical advice

Food insecurity is not a knowledge deficit:
Recommending unaffordable, healthier foods to a shift-worker without income support is medically sound but materially impossible.

Produce prescriptions are limited:
While useful as short-term referral bridges, they risk medicalizing food insecurity and rely on precarious charity without addressing underlying supply chains.

Planetary health must avoid carbon-only reductionism:
A generic planetary diet that ignores affordability, nutritional adequacy, and cultural food traditions is not life-enabling.

Effective treatment (e.g., GLP-1 agonists for cardiovascular risk) must be protected, but treating successful medication as proof that the commercial production of disease is solved is a fatal error.

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Indigenous sovereignty requires legitimate jurisdiction, not just consultation

Indigenous health cannot be reduced to an additional social determinant or a generalized claim about traditional diets.

Consultation

Jurisdiction

Inuit Nunangat: The Food Security Strategy frames food access strictly through self-determination and the conditions of life, rejecting externally imposed dietary templates.

First Nations OCAP®: Data quality is inseparable from decision-making authority. A dashboard extracting community data without Ownership, Control, Access, and Possession is invalid.

Kahnawà:ke: Community-led diabetes prevention is essential, but structural institutional support must back it up—communities overcome commercial food environments entirely alone.

The standard: Who has the authority to shape, decline, or lead decisions affecting their knowledge and land?

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Five stress tests to **prevent superficial implementation**

	Challenge	Superficial Substitute	**Life-Grounded Correction**
	Rescue vs. Upstream	Choose medication OR structural reform.	Protect indicated care AND address changeable causal conditions.
	Complexity vs. Usability	Require clinicians to analyze everything.	Identify the few influential conditions and match to responsible actors.
	Prevention vs. Certainty	Promise universal cost savings.	Evaluate outcomes, distribution, and opportunity cost openly.
	Environment vs. Equity	Optimize carbon alone.	Evaluate nutrition, rights, affordability, and ecology together.
	Participation vs. Authority	Treat consultation as consent.	Specify legitimate jurisdiction, decision rights, and data governance.

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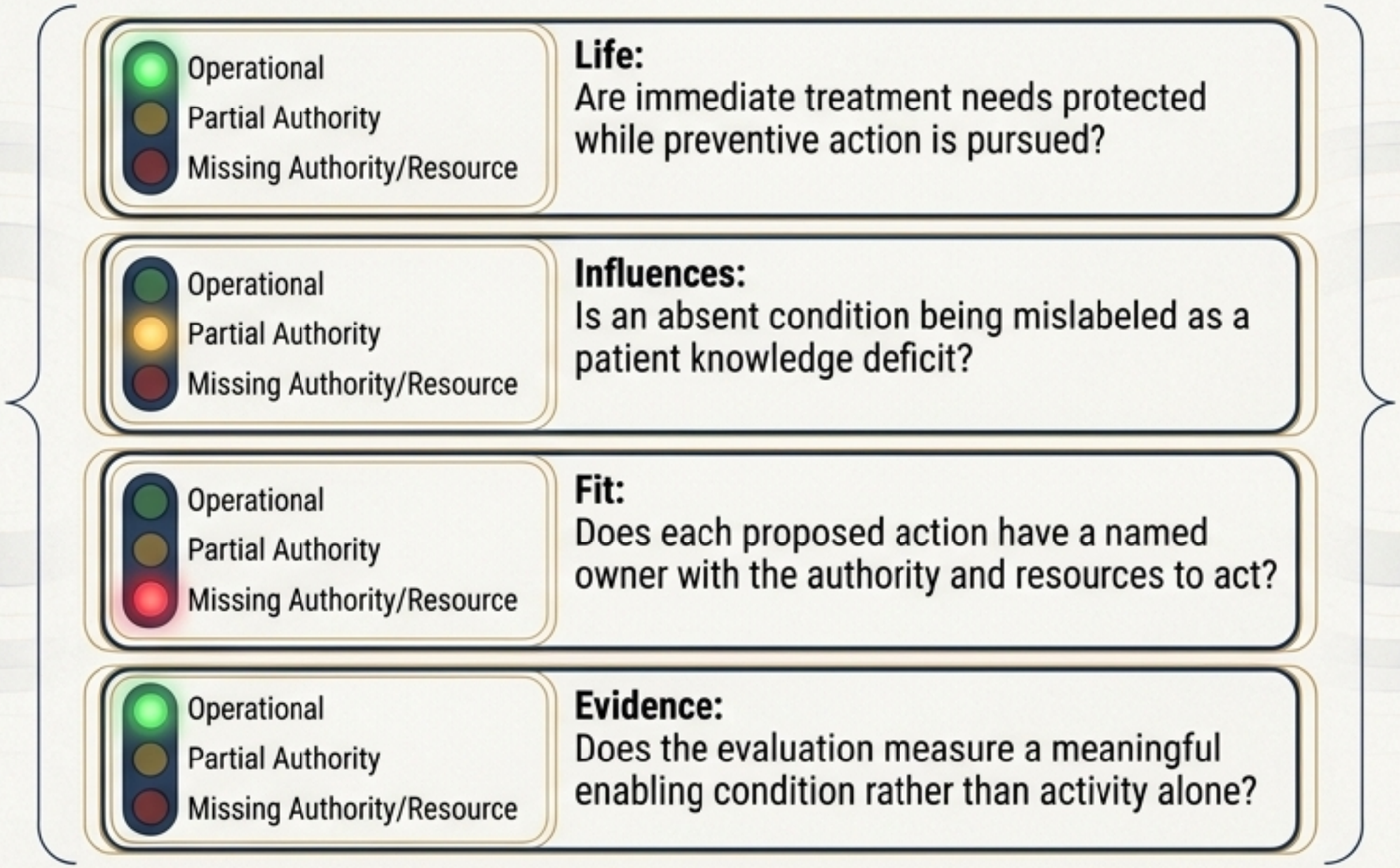
The Institutional Constraints Audit & Premortem

A tool to ensure institutional promises have material support, avoiding unfunded moral delegation.



The Premortem Question: If this work fails in six months, what missing condition, misassigned responsibility, unresourced partnership, or unintended harm will most plausibly explain the failure?

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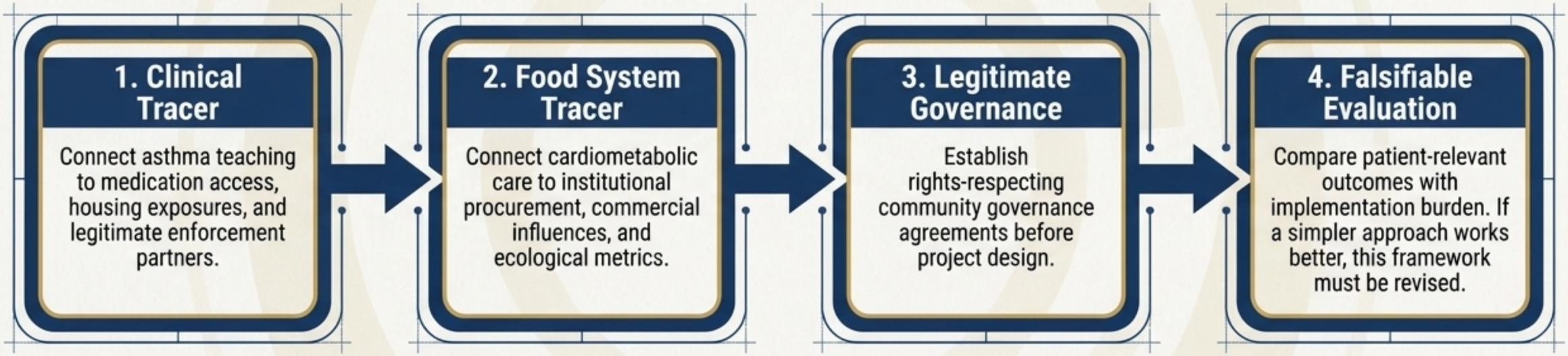
A pragmatic path forward: The Ottawa Demonstration

The Ottawa Charter's 40th anniversary and CanMEDS 2026 launch present a unique opportunity for a bounded, four-part demonstration.



What comes after CanMEDS 2026 is an architecture of action, not an endless list of competencies.

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