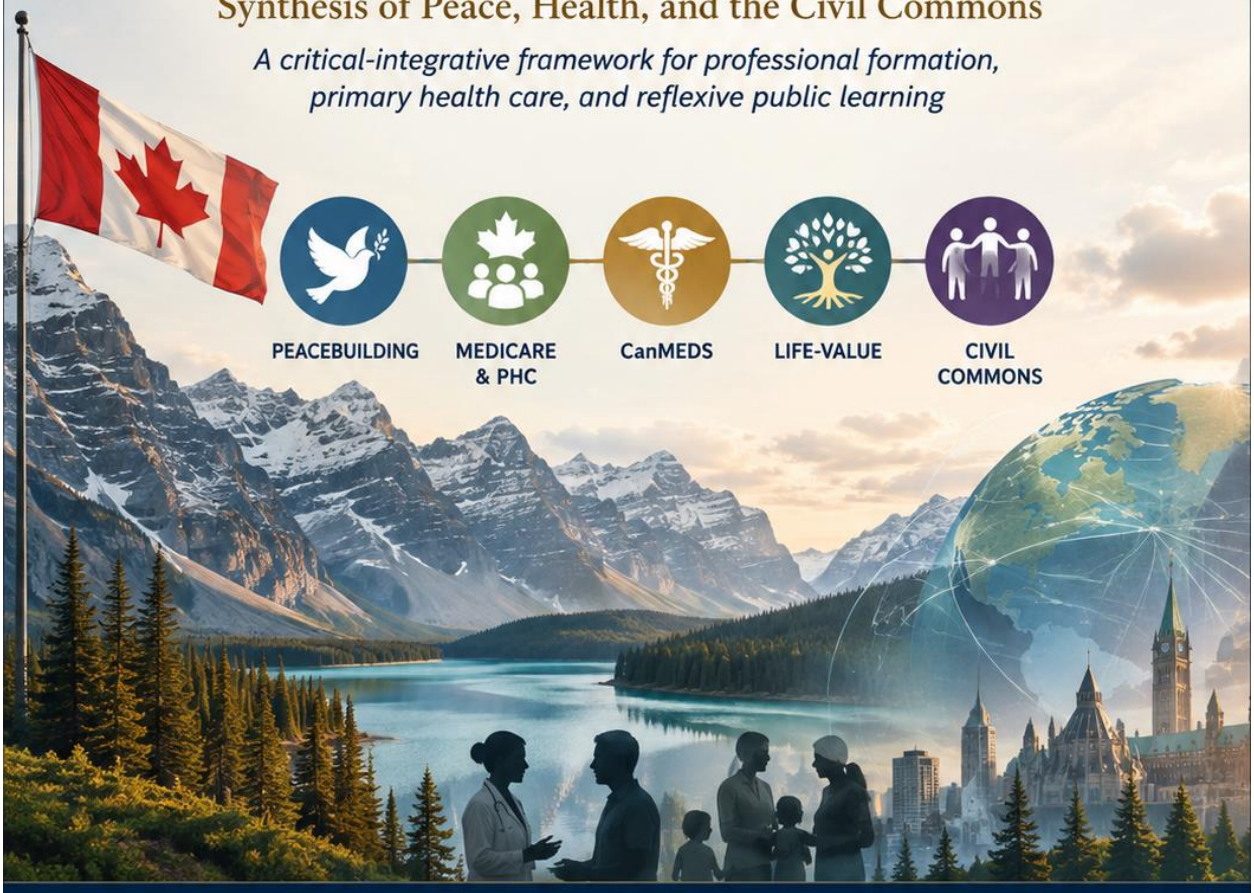
ACADEMIC WHITE PAPER

CONCEPTUAL ANALYSIS

Life-Grounding CanMEDS

Reorienting Medical Competence within Canada's Unfinished Synthesis of Peace, Health, and the Civil Commons

A critical-integrative framework for professional formation, primary health care, and reflexive public learning



LIFE-GROUNDED PHYSICIANS • LIFE-COHERENT INSTITUTIONS • LIFE-FLOURISHING COMMUNITIES

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Physician, systems thinker, and interdisciplinary scholar-practitioner

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Abstract

CanMEDS offers an influential answer to the question of what physicians should be able to do. It is less explicit about a prior normative question: what should those capacities ultimately serve? This paper argues that a life-ground lens can provide an orienting and corrigible answer without becoming an eighth CanMEDS role, subordinating rights or Indigenous jurisdiction, or weakening Medical Expert. The argument is developed through a critical-integrative reading of six Canadian strands: peacebuilding, Medicare, the Lalonde and Ottawa Charter health-promotion tradition, primary health care, CanMEDS, and Life-Value Onto-Axiology and the civil commons. Across these strands, a recurrent pattern appears. Public responsibility is normatively enlarged from isolated events and individuals toward relationships, structures, communities, ecosystems, and future generations, while operational systems of jurisdiction, finance, incentives, metrics, and assessment remain narrower. This purpose-implementation gap is termed operational contraction; under sustained pressure it can produce institutional inversion, in which means such as throughput, organizational survival, fiscal targets, or market value displace the life-serving ends institutions were created to support. Life-grounding makes that displacement visible by asking whether policies, institutions, and professional practices protect, restore, or enlarge life-capacities under conditions of rights, dignity, evidence, nonviolence, ecological integrity, legitimate authority, and public correction. Life-coherence is therefore defined not as stability or uniformity, but as the sustained capacity for materially grounded, relationally viable, dignity-preserving, nonviolent coexistence under changing conditions. CanMEDS is positioned as a strategic hinge because its seven roles connect clinical knowledge to communication, collaboration, leadership, advocacy, scholarship, and professionalism. Yet professional formation cannot compensate for life-disabling institutions. The paper therefore proposes a broader Canadian programme linking a Life-Ground CanMEDS Implementation Lab to community-governed primary health care, Health-Peace and Life-Impact Assessment, a Life-Coherence Dashboard, civil-commons investment, and protected institutional capacity for learning and moral agency. The July 2026 approval and October 2026 launch of CanMEDS 2026 create a timely institutional opening for testing this synthesis rather than presuming it.

Keywords: CanMEDS; competency-based medical education; civil commons; health promotion; life-coherence; life-ground; Life-Value Onto-Axiology; peacebuilding; positive peace; primary health care; professional formation; social accountability; structural competency; structural violence; Canada

> **Scope note.** This is a critical-integrative conceptual analysis, not an empirical effectiveness study or a claim that Canadian institutions form a linear story of progress. Policy and access claims are current to 21 August 2026. The proposed framework is a testable and corrigible public programme, not a comprehensive doctrine or substitute for Indigenous jurisdiction, democratic contestation, clinical evidence, professional role boundaries, or rights.

1. Introduction: From Competence to Purpose and Life-Coherent Public Capacity

CanMEDS begins with a practical educational question: what capacities should a physician possess and demonstrate? Life-grounding begins one step earlier, with a normative question that competency frameworks cannot answer by enumeration alone: what are those capacities for? A physician may be diagnostically excellent, communicatively skilled, collaborative, efficient, scholarly, and professionally reliable while working inside arrangements that systematically disable health, displace harm, or narrow the conditions of recovery. The issue is therefore not whether competence matters, but what should orient its exercise when biological mechanisms, relationships, institutions, political economy, and ecological conditions interact.

Canada occupies an unusual place in the modern history of collective care. Its international identity has been associated with peacekeeping and multilateral problem-solving; its domestic political identity with universal Medicare; its public-health legacy with the 1974 Lalonde Report and the 1986 Ottawa Charter; and its medical-education influence with CanMEDS, first approved in 1996 and now used internationally (Health Canada, 1974; Royal College of Physicians and Surgeons of Canada [Royal College], 2026a; World Health Organization [WHO], 1986). These are neither identical achievements nor unqualified successes. They emerged from different sectors, political struggles, constitutional arrangements, and historical exclusions. Yet together they reveal a distinctive institutional possibility: society can assume responsibility not only for crisis response, but for the conditions that make life, health, participation, and peace possible.

The connecting movement is an enlargement of the relevant unit of concern. Peacebuilding moves beyond defeating an enemy toward transforming relations and conditions that reproduce violence. Medicare moves beyond private purchasing power toward pooled social responsibility. Health promotion moves beyond the clinic toward income, housing, education, environment, participation, and peace. Primary health care moves beyond episodic physician contact toward comprehensive, community-oriented, multisectoral care. CanMEDS moves beyond technical expertise toward communication, collaboration, leadership, scholarship, advocacy, and professionalism. Each enlarges responsibility without abolishing the valid core of the narrower practice.

The puzzle is not whether Canada has generated integrative ideas. It has. The puzzle is why their implications have not been institutionally joined. Health spending remains downstream even though Canada helped articulate an upstream determinants-of-health paradigm. Primary health care remains fragmented despite commitments to teams and community participation. Health advocacy is formally central to professional formation, yet learners and physicians often lack the time, authority, partners, and organizational protection required to act. Peace is rhetorically valued while preventable structural and ecological violence is normalized. Indigenous health inequities expose the deepest contradiction:

universalist institutions can distribute selected benefits while preserving colonial relations that disable life and deny jurisdiction.

> **Core thesis. Across the Canadian strands examined here, public responsibility is repeatedly enlarged toward the conditions that make life, health, participation, and peace possible, while the operating machinery of jurisdiction, finance, professional formation, measurement, and authority remains narrower. The unfinished task is to make that purpose-implementation gap visible and corrigible through an explicit life-ground criterion bounded by rights, evidence, plural democratic authority, and Indigenous jurisdiction.**

The question whether CanMEDS can be life-grounded is therefore nested within a larger one: can Canada align the institutional purposes it already affirms with the biological, social, relational, and ecological conditions its systems actually produce? CanMEDS matters because professional formation links knowledge, identity, clinical reality, institutional culture, and public trust. It is a strategic hinge, but it cannot carry the transition alone. A life-grounded physician in a life-disabling institution will experience contradiction rather than transformation.

The paper makes four contributions. First, it reconstructs six Canadian strands as instances of normative enlargement rather than as disconnected national achievements. Second, it identifies operational contraction and institutional inversion as the common explanation for their incomplete integration. Third, it develops Life-Value Onto-Axiology (LVOA), positive peace, relational epistemology, systems thinking, and commons governance into a life-coherence framework. Fourth, it translates that framework into a Life-Ground Lens for CanMEDS and a modular, testable Canadian programme for primary health care, public policy, professional education, and democratic learning.

2. Method, Sources, and Epistemic Commitments

This paper uses critical-integrative conceptual analysis. It brings five literatures into structured dialogue: Canadian institutional history and public policy; primary health care and health-professions education; peace, structural violence, and commercial determinants; life-value philosophy and civil-commons theory; and systems, commons, and learning-health-system scholarship. Official Canadian and WHO documents establish policy history and current institutional conditions. Peer-reviewed sources support health-systems, educational, and structural claims. Foundational work by Galtung, Maturana and Varela, McMurtry, Meadows, and Ostrom supplies distinct analytical functions. The method is abductive: it asks what common pattern best explains both the convergence and persistent separation of the Canadian strands, then derives propositions that can be challenged through implementation and research.

Three epistemic commitments govern the synthesis. First, domain distinctions are preserved. A philosophical value criterion is not an empirical result; a clinical mechanism is not a social policy; a systems

analogy is not evidence of causal identity. Second, claims are graded by evidence rather than made true by conceptual resonance. Third, the observer is included. Following Maturana, professional categories and institutional measures are distinctions made by embodied observers in social practices; objectivity therefore requires transparent methods, comparison, and correction rather than the fiction that values and categories are absent (Maturana, 1988; Maturana & Varela, 1987). This reflexivity remains compatible with realism about suffering, physiology, material deprivation, and ecological limits.

> **Epistemic guardrail: Coherence is not proof. A framework may connect many observations elegantly and still be incomplete, biased, or wrong. Its value depends on domain discipline, discriminating evidence, protected dissent, and readiness to revise.**

The analysis treats Indigenous knowledge, law, and governance as sovereign sources of authority, not as material to be absorbed into a settler framework. First Nations, Inuit, and Métis peoples are heterogeneous, and no single relational worldview can represent that diversity. Where the paper identifies resonances among relational health, ecological interdependence, and life-ground thinking, these are invitations to ethical dialogue, jurisdictional respect, restitution, and co-governance — not claims of equivalence or conceptual ownership.

3. A Recurrent Pattern Across Six Canadian Strands

The six strands can be read as overlapping enlargements of the system for which institutions accept responsibility. The pattern is conceptual rather than triumphalist. Each tradition recognizes that harms once treated as private, local, or technical arise within wider relationships and structures, and therefore require wider forms of responsibility. Table 1 summarizes the enlargement and the operational limit that prevents each strand from realizing its own stated purpose.

Table 1. Canadian strands in the enlargement of collective responsibility

Strand	Canadian articulation	Normative enlargement	Unresolved operational limit
Peacebuilding	Pearson-era peacekeeping; later peacebuilding, Women, Peace and Security, civilian protection	Security moves from defeating enemies toward limiting direct violence and building conditions for positive peace	National mythology can obscure interests, structural violence, harms within missions, and the weak integration of peace with domestic policy
Medicare	Saskatchewan hospital insurance (1947) and medical services (1962); federal statutes; Canada Health Act (1984)	Illness risk becomes a shared public responsibility; need rather than purchasing power governs insured access	Coverage remains centred on hospital and physician services; timely access, medicines, dental, long-term, and community care remain uneven
Health promotion	Lalonde Report (1974); Ottawa Charter (1986); later Health in All Policies	Health moves beyond medical care to social, economic, political, commercial, and ecological conditions	Lifestyle programmes are easier to fund than structural redistribution or regulation; intersectoral authority remains weak

Strand	Canadian articulation	Normative enlargement	Unresolved operational limit
Primary health care	Alma-Ata commitments; transition funds; team-based and community models	Care becomes comprehensive, participatory, preventive, and linked to the conditions of everyday life	Primary health care is narrowed to first-contact services; provincial models, incentives, information, and governance remain fragmented
CanMEDS	Seven-role physician competency framework (1996, 2005, 2015, 2026)	Competence widens from technical performance to relationships, systems, advocacy, leadership, learning, and social purpose	Assessment favours individual and observable acts; workplace culture and professional identity are incompletely aligned with the framework
Life-Value Onto-Axiology	McMurtry's Canadian life-value philosophy and civil-commons analysis	Evaluation moves from money, preference, or institutional success to the enabling of universal life-needs and capacities	The framework remains marginal to mainstream policy, medical education, public measurement, and institutional authority

Note. **The table identifies a recurrent conceptual direction, not a linear national progression. Every strand contains exclusions, countercurrents, and reversals.**

3.1 Peacekeeping and the Move from Negative to Positive Peace

Canada's peacekeeping tradition is both historical achievement and national mythology. Canadian personnel have participated in peace-support operations since the 1950s, and Canada continues to contribute finance, airlift, training, civilian protection, and Women, Peace and Security initiatives. In 2025, the federal government committed more than $40 million to UN peace operations and peacebuilding and reported that Canada was the eighth-largest assessed financial donor (Global Affairs Canada, 2025). Yet personnel contributions have declined markedly from earlier decades, and scholarship shows how the peacekeeper identity can romanticize Canadian altruism, conceal geopolitical interests, and obscure harms within missions (McCullough, 2016).

Galtung's distinction clarifies the unfinished movement. Negative peace is the absence or containment of direct violence; positive peace requires social conditions that reduce structural and cultural violence (Galtung, 1969, 1990, 1996). Structural violence occurs when political and economic arrangements systematically prevent people from meeting avoidable needs or realizing attainable capacities. This connects foreign policy to domestic institutions. Food insecurity, unsafe housing, discriminatory care, ecological destruction, and preventable barriers to health are not identical to armed conflict, but they distribute injury and premature death through arrangements rather than singular assailants (Farmer, 2004). A life-grounded peace policy must therefore connect conflict prevention abroad with the civil conditions that make nonviolent and dignified life possible at home.

3.2 Medicare as a Civil Commons

Canadian Medicare is a paradigmatic civil commons. Saskatchewan introduced universal public hospital insurance in 1947 and physician-services coverage in 1962; federal cost-sharing supported national diffusion, and physician services were covered in every province and territory by 1972. The Canada Health

Act of 1984 consolidated public administration, comprehensiveness, universality, portability, and accessibility for insured hospital and physician services (Health Canada, 2026). Its deepest principle is not administrative technique but social solidarity: people pool resources while well so that illness does not become a market test at the moment of vulnerability.

Yet Medicare universalized a bounded basket. Medicines outside hospitals, dental care, psychotherapy, home care, long-term care, and many community supports remain variably covered. Even nominal entitlement does not ensure timely entry. In 2024, 83% of people in Canada reported a regular health-care provider, leaving an estimated 5.7 million adults and 765,000 children without one; only 27% of adults with a provider obtained same- or next-day access for a non-urgent need (Canadian Institute for Health Information [CIHI], 2025a, 2025b). The civil-commons achievement is real but incomplete: financial access to selected services has not become reliable access to the continuum of capacities required for health.

3.3 From the Lalonde Report to the Ottawa Charter

The 1974 Lalonde Report broke with a health-system imaginary centred almost exclusively on medical care. Its health-field concept distinguished human biology, environment, lifestyle, and health-care organization (Health Canada, 1974). The move made causal fields beyond the clinic visible. Implementation, however, often privileged lifestyle because behaviour programmes were administratively tractable and less disruptive than income redistribution, housing reform, labour protection, or regulation of harmful commercial practices. Structurally constrained choices could thus be redescribed as personal failure. Contemporary commercial-determinants research reinforces the need to examine the systems, practices, and pathways through which market actors shape exposures, policy, knowledge, and consumption (Gilmore et al., 2023).

The Ottawa Charter corrected and extended the upstream movement. It named peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity as prerequisites for health, and called for healthy public policy, supportive environments, community action, personal skills, and reoriented services (WHO, 1986). The Commission on Social Determinants of Health and the Helsinki Health in All Policies framework later reinforced the need for coordinated action across government (WHO, 2008, 2014). Yet the Charter's breadth exceeded the authority, budgets, and accountability of health ministries, while inequality and ecological disruption intensified (Labonté, 2016). Canada helped articulate an upstream paradigm without redesigning the institutional machinery around it.

3.4 Primary Health Care: Whole-of-Society Vision, First-Contact Reality

Primary health care (PHC) is often confused with primary care. The latter generally denotes first-contact clinical services; the former is a whole-of-society approach integrating services, multisectoral action on determinants, and empowered people and communities (WHO, 1978, n.d.). Canada has funded

interdisciplinary teams and introduced diverse payment and governance models, but reforms remain incremental and provincially uneven. Analyses repeatedly identify the absence of a pan-Canadian vision, physician-centred financing, regulatory variation, unclear team roles, and weak common accountability as barriers (Hutchison et al., 2011; Suter et al., 2017).

The access crisis is not only a labour shortage; it is a systems-design signal (Flood & McGibbon, 2023). Emergency departments absorb conditions that accessible primary care could often address, and CIHI estimates that about 15% of emergency visits are for conditions potentially manageable in primary care (CIHI, 2025c). Clinician supply matters, but supply without attachment, continuity, team infrastructure, community governance, and action on living conditions reproduces the narrow model. A life-grounded PHC system would ask not only whether an appointment occurred, but whether the care network restored the capacity to live, relate, work, learn, and participate under sustainable conditions.

3.5 CanMEDS and the Social Formation of the Physician

CanMEDS is one of Canada's most influential professional exports. Its seven integrated roles — Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional — make a consequential claim: expertise is insufficient unless it is relationally and socially enacted (Frank et al., 2015). The framework was revised in 2005 and 2015, and CanMEDS 2026 was approved on 15 July 2026 for official launch at the International Conference on Residency Education in October 2026 (Royal College, 2026b). The revision retains Medical Expert as the integrative role while strengthening attention to contemporary domains including social determinants and disparities.

Competency frameworks nevertheless face a structural tension. What can be observed in bounded encounters tends to dominate what develops through identity, moral formation, organizational culture, and collective action. Sternszus et al. (2023) distinguish what learners are doing from who they are becoming. The global commission on health-professions education similarly argued for transformative and interdependent learning linked to health-system needs (Frenk et al., 2010), while structural competency asks clinicians to recognize and respond to forces operating above the individual encounter (Metzl & Hansen, 2014). Without aligned workplaces and authority, Health Advocate can shrink to referral, Leader to throughput management, and Professional to compliance.

3.6 Life-Value Onto-Axiology and the Civil Commons

LVOA begins from the life-ground: the universal conditions without which living beings and societies cannot reproduce or develop. These include breathable air, potable water, nourishing food, shelter, care, knowledge, meaningful relation, ecological integrity, and institutions that protect access to them. Life-value is objective in a limited but important sense: deprivation of these conditions predictably damages or extinguishes life-capacity, even though cultures legitimately interpret flourishing in diverse ways. A policy has positive life-value insofar as it enables more coherent ranges of sensing, feeling, thinking,

acting, relating, and participating without degrading the grounds on which those capacities depend (McMurtry, 1998, 2011).

The civil commons names the institutional form of this value: cooperative social constructs that provide life goods according to need and protect them across generations. Public health, Medicare, safe water systems, education, libraries, ecological regulation, labour protections, and peace institutions can function as civil commons. The concept exposes a recurrent category error: GDP, revenue, throughput, rankings, and efficiency are treated as ends even when their growth disables the life systems they were meant to serve (McMurtry, 2013). LVOA does not eliminate conflict or trade-offs. It requires decision-makers to identify whose capacities expand, whose contract, what grounds are consumed, and what future options remain.

4. The Integration Failure: Operational Contraction and Institutional Inversion

The absence of integration is not chiefly an intellectual failure. Canada has long possessed the relevant concepts. It is an institutional-selection problem: prevailing rules reward actors for producing sectoral outputs while displacing costs across ministries, communities, ecosystems, and time. Normative purpose expands, but operational responsibility contracts to what a bounded organization can fund, count, control, and attribute. Eight reinforcing mechanisms sustain the gap.

1. **Jurisdictional fragmentation.** Health delivery is primarily provincial and territorial, while income security, housing, environment, Indigenous services, professional regulation, education, and foreign policy are divided across governments and agencies. Responsibility is distributed more readily than accountability.
2. **A downstream financing architecture.** The Canada Health Act protects hospital and physician services, a major achievement that also stabilizes the fiscal centre of gravity around treatment. Upstream action competes for discretionary funding and often yields benefits outside the paying ministry's time horizon.
3. **Professional and organizational silos.** Peacebuilding, public health, clinical care, education, social services, and ecology maintain distinct vocabularies, evidence traditions, budgets, regulation, and career ladders. Boundary-spanning work is praised but weakly resourced.
4. **The assessability bias.** Institutions prefer countable and attributable outputs: visits, procedures, competencies, deployments, and quarterly performance. Trust, prevention, structural change, ecological regeneration, and professional identity develop slowly and resist single-agent attribution.
5. **Normative avoidance.** Institutions often seek neutrality among conceptions of the good. In practice, market price, organizational survival, and political feasibility become default value systems. The question 'What enables life?' is replaced by 'What is funded, billable, or measurable?'
6. **Political economy and concentrated power.** Upstream action can threaten profitable arrangements in food, housing, labour, pharmaceuticals, fossil energy, digital platforms, and finance. Commercial actors

can shape policy, knowledge, and public narratives while externalizing health and ecological costs (Gilmore et al., 2023).

7. **The colonial contradiction.** Universalist national narratives have coexisted with dispossession, jurisdictional ambiguity, racism, and suppression of Indigenous health systems. The Public Health Agency of Canada (2021) acknowledges that public-health history cannot be separated from colonial history. Integration without self-determination reproduces the problem it claims to solve.
8. **Narratives without transition mechanisms.** Peace, health promotion, collaboration, reconciliation, and social accountability remain slogans unless attached to authority, financing, professional formation, community governance, enforceable rights, feedback, and correction.

Under sustained pressure, operational contraction can produce institutional inversion — what may be called a Great Inversion — when institutions created as means to protect and enlarge life begin to treat their own reproduction, throughput, fiscal targets, and market-valued outputs as ends. People become cases, consumers, labour units, risk scores, or costs; communities become delivery sites; ecosystems become externalities; and professional judgment becomes an instrument of organizational flow. The problem is not that efficiency, budgets, or measurement are unnecessary. It is that subordinate means can become de facto governing criteria.

> **Across these strands, the recurrent pattern is enlargement in principle, contraction in practice, and inversion under pressure: peace can become pacification, health promotion behaviour management, primary health care episodic access, advocacy brokerage, leadership throughput management, and professionalism compliance.**

Table 2. Distinctions that prevent false integration

Distinction	False completion	Life-ground test
Peace / pacification	Silence, managed disorder, or absence of overt conflict while avoidable deprivation and domination persist	Do direct, structural, cultural, and ecological violence decline, and do the material conditions of dignified coexistence improve?
Coherence / coercion	Uniformity, compliance, or centralized control presented as harmony	Can dissent, plural knowledge, rights, and local authority alter decisions without retaliation?
Universality / bounded insurance	Equal entitlement to a restricted basket despite delayed entry and uncovered necessities	Can people obtain timely, continuous access to the goods and services required for health according to need?
PHC / first contact	More appointments without population responsibility, prevention, teams, participation, or action on determinants	Does the local care ecology restore capacity and reduce recurring need, not merely process encounters?
Advocacy / brokerage	Referring individuals around unchanged barriers and counting the referral as structural action	Are recurring barriers documented, escalated, collectively addressed, and reduced at their source?
Prosperity / extraction	Rising revenue, GDP, asset value, or volume while household, workforce, community, or ecological capacity contracts	Are gains achieved without disabling the life-ground, transferring harms, or consuming future options?
Adaptation / betrayal	An organization survives by normalizing unsafe work, inequity, exclusion, ecological damage, or moral injury	Does adaptation preserve the wider conditions of life and dignity rather than merely organizational fitness?

Distinction	False completion	Life-ground test
Legitimacy / capture	Formal consultation, metrics, or expert language conceal whose interests set the agenda and define evidence	Are power, conflicts of interest, uncertainty, affected knowledge, and routes of correction publicly visible?

5. The Missing Grammar: From Life-Value to Life-Coherent Governance

The Canadian strands need more than coordination; coordination can efficiently align institutions around the wrong end. They require a shared but contestable grammar for distinguishing life-serving success from organized life-disvalue. LVOA supplies the normative centre, while positive-peace analysis, rights, Indigenous sovereignty, systems inquiry, and democratic procedure constrain how that centre may be interpreted and used.

5.1 Life-Ground, Life-Capacity, and Civil Commons

Life-ground names the material, ecological, relational, and cultural conditions required for life to continue and develop. Life-capacity names what living persons and communities can actually do and be: sense, move, feel, think, communicate, care, create, work, learn, participate, and form meaningful relationships. Life-value concerns the enabling of these capacities; life-disvalue concerns their avoidable disablement. This shifts evaluation from institutional output alone to the effects of output on lived and future capability.

Civil commons are not identical with the state, public ownership, or any single service model. They are socially organized capacities that secure universal access to life goods through cooperative rules. A public programme can cease to function as a civil commons when captured, inaccessible, degrading, or organized around extraction. Conversely, community, Indigenous, municipal, cooperative, or hybrid institutions can perform civil-commons functions when they protect access, dignity, ecological continuity, and democratic accountability.

5.2 Life-Coherence Is Not Mere Stability

Life-coherence is the sustained capacity for life-serving, nonviolent, dignity-preserving, materially grounded, and relationally viable coexistence under changing conditions. It is not the absence of disagreement, the internal consistency of a model, or the stability of an organization. Exploitative systems can be stable, efficient, and internally coordinated. Life-coherence asks whether their coordination preserves the conditions of wider life and whether their rules remain open to those who bear the consequences.

This definition preserves conflict and plurality. Needs can compete; interventions can help one group while harming another; urgent care can consume resources needed for prevention; and ecological

constraints can limit legitimate preferences. Coherence does not dissolve such tensions. It requires that they be made visible, adjudicated without domination, and revisited in light of outcomes. The framework therefore distinguishes coherence from coercion, peace from pacification, prosperity from extraction, legitimacy from ideological capture, and adaptation from betrayal of the life-ground.

> **Life-Coherence discipline. Ask three questions repeatedly: Does this protect, restore, or enlarge life? What evidence would change our judgment? And can we remain committed enough to act without ever loving coherence more than reality?**

5.3 A Public Life-Coherence Test

A practical Life-Coherence Test can structure deliberation without pretending to calculate one final social score. For any policy, curriculum, technology, institution, or clinical pathway, decision-makers should make seven fields explicit.

- **Life need and capacity —** Which universal need or attainable capacity is protected, restored, enlarged, or disabled?
- **Violence and harm —** What direct, structural, cultural, ecological, or iatrogenic harms are created, prevented, hidden, or displaced?
- **Distribution and power —** Who receives benefits, who bears costs, whose knowledge defines the problem, and who can alter the decision?
- **Life-ground effects —** What happens to air, water, food, shelter, care, knowledge, relation, ecological integrity, and access to them?
- **Viability and options —** Which constraints and reserve margins matter, and what meaningful future choices are preserved or foreclosed?
- **Rights and authority —** Are consent, dignity, disability justice, treaty relations, Indigenous jurisdiction, and community decision rights protected?
- **Evidence and correction —** What is known, uncertain, or unmeasured; what would disconfirm the theory of change; and when must the decision be reviewed?

The test does not yield an automatic answer. Its purpose is to prevent one domain's proxy — cost, volume, satisfaction, test score, or organizational survival — from silently becoming the value of all values. It makes assumptions contestable and connects ethical purpose to feedback, authority, and revision.

6. An Architecture of Reflexive Public Learning

A public system learns reflexively when it can perceive the conditions and pressures its institutions create; evaluate them by their effects on life-needs, capacities, rights, and ecological grounds; redesign rules cooperatively; monitor unequal consequences; and revise error. 'Reflexive' means that observers, institutions, metrics, incentives, and power relations are included within the field of inquiry. 'Public

learning' means that shared commitments are connected to institutional memory, experiment, feedback, democratic and Indigenous authority, and correction.

This formulation is deliberately institutional. Awareness without authority cannot alter rules; authority without participation can become coercive; measurement without a value criterion can optimize harm; and values without feedback can become ideology. The task is to join normative orientation, distributed governance, practical capacity, and error correction.

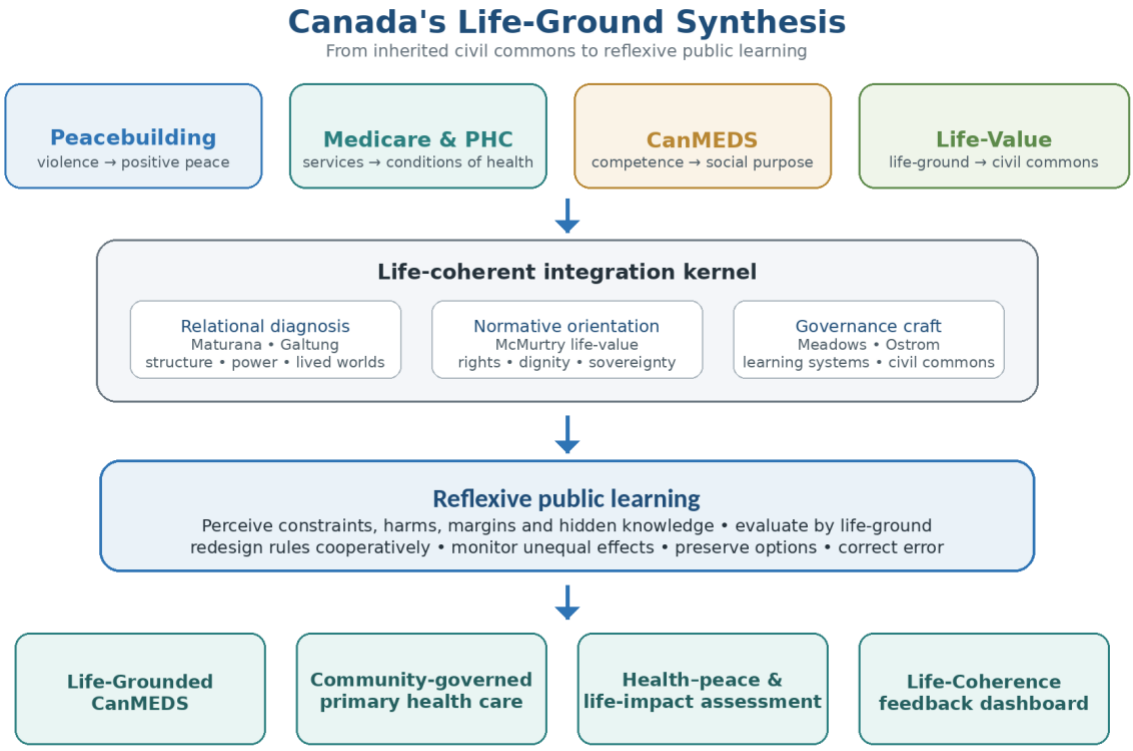

Figure 1. An integrative architecture for Canada's unfinished life-ground synthesis.

Note. **Arrows express an argument and feedback design, not a linear national progression. Indigenous law, knowledge, and governance enter through sovereign partnership across the architecture, not as a component owned by the framework.**

6.1 The Sevenfold Viability Grammar

The framework uses a sevenfold viability grammar to move from value language to diagnostic inquiry. It can operate at the scale of a patient, family, care team, community, institution, health system, or ecosystem, provided mechanisms are not confused across levels.

- **Constraint —** What limits are inviolable or currently binding: physiology, time, safety, law, rights, ecological thresholds, or material resources?
- **Margin —** What reserve or buffer remains before failure: clinical reserve, household income, workforce slack, trust, biodiversity, or fiscal room?

- **State —** What is the present pattern of functioning, distribution, and capacity — not merely the average output?
- **Disturbance —** What acute shocks or chronic pressures are acting, through which mechanisms, and how are they distributed?
- **Perception —** What signals can be detected, whose knowledge counts, what incentives distort attention, and what remains invisible?
- **Regulation —** What feedback, repair, coordination, rights, authority, and governance mechanisms can respond?
- **Options —** What meaningful future choices remain or are created for affected persons, communities, species, and generations?

The grammar corrects two symmetrical errors. It prevents aspirational discourse from bypassing present danger and material constraint, and it prevents crisis management from treating short-term survival as sufficient. A person may be medically stabilized while losing housing, livelihood, cultural safety, or future options. A health system may increase throughput while exhausting its workforce. A nation may increase GDP while crossing ecological thresholds. Viability must therefore include present state, reserve margin, regulatory capacity, and preserved options.

6.2 Maturana, Galtung, and McMurtry as Complementary Disciplines

Three traditions organize the critical core. Maturana and Varela contribute an epistemology of living systems, structural coupling, and observer responsibility: professional categories and institutional worlds are enacted through embodied histories of interaction rather than simply read from a neutral reality (Maturana & Varela, 1980, 1987). Galtung contributes the diagnostic distinction among direct, structural, and cultural violence, preventing non-crisis from being mistaken for peace. McMurtry contributes the evaluative criterion: institutions should be judged by whether they enable or disable life-capacities through access to universal life goods.

Their functions must remain distinct. Maturana does not independently determine justice or policy priority; Galtung diagnoses violence but does not supply a complete clinical or governance method; McMurtry supplies a value criterion but not an automatic measure. Together they support a disciplined sequence: observe how a problem and world are being enacted; diagnose avoidable harm, exclusion, and power; evaluate effects on life-capacity; intervene at appropriate leverage points; and learn from consequences.

6.3 Meadows, Ostrom, and Learning Systems

Meadows distinguishes shallow interventions in parameters from deeper interventions in information flows, rules, goals, and paradigms (Meadows, 1999, 2008). This explains why adding a competency or pilot fund rarely transforms the system that selects behaviour. Ostrom shows that durable commons require rules fitted to local conditions, participation in rule-making, monitoring, graduated responses, accessible

conflict resolution, and nested governance (Ostrom, 1990). These principles protect life-grounding from both centralized abstraction and unaccountable localism.

Learning-health-system scholarship provides a contemporary implementation bridge. Menear et al. (2019) describe value-creating learning systems as integrating science, informatics, incentives, and culture around continuous improvement with patients and stakeholders. A life-ground framework adds an explicit question that 'value' alone can leave open: value for whom, through which capacities, under what ecological and distributional conditions, and with what preserved options? The aim is not merely faster learning, but learning constrained by life-value, rights, positive peace, and public correction.

> **A life-coherent institution joins four capacities: a defensible direction, the power to act, plural perception of consequences, and rules for correction. Remove any one and the project becomes aspiration, coercion, blindness, or drift.**

7. Life-Grounding CanMEDS: A Strategic Hinge

Can CanMEDS be life-grounded? Yes — but the more consequential claim is that professional formation can become a hinge between clinical truth and public responsibility. The seven roles already contain the necessary action domains. The problem is not categorical absence; it is the absence of a common evaluative centre and the misalignment of curriculum, assessment, workplace conditions, payment, community authority, and public accountability. A Life-Ground Lens should therefore operate across the roles rather than become an eighth role.

> **Purpose proposition. CanMEDS asks what physicians should be able to do. A Life-Ground Lens asks what those capacities are for: to protect, restore, and, where possible, enlarge life-capacity while avoiding preventable harm and respecting rights, evidence, professional role limits, legitimate community authority, and Indigenous jurisdiction. It is therefore an orienting criterion for the direction and proportionality of competent action, not a new competency domain.**

Across every role, the lens asks: What life need or capacity is at stake? What conditions enable or disable it? What direct, structural, cultural, ecological, or iatrogenic harms are present? Who bears the harms and benefits? Whose knowledge and authority matter? What evidence distinguishes mechanism from metaphor? What action is proportionate to the physician's role and power? What effects follow for communities, ecosystems, and future options?

Medical Expert should remain foundational and integrative. Life-grounding does not dilute biomedical competence. It situates disease mechanisms within the conditions shaping exposure, access, recovery, adherence, and recurrence, while preserving diagnostic accuracy and limits. Physicians are not trained or authorized to solve every social problem. Their responsibilities are to recognize relevant structures, avoid

compounding harm, mobilize appropriate partners, use institutional voice responsibly, and contribute evidence from clinical reality to collective learning.

Table 3. A Life-Ground Lens across the seven CanMEDS roles

CanMEDS role	Life-ground reframing	Illustrative observable performance
Medical Expert	Integrate biological, psychological, social, ecological, structural, and iatrogenic mechanisms around restoration of life-capacity	Formulates immediate danger and disease while identifying material constraints on recovery; distinguishes established evidence, uncertainty, and analogy; selects proportionate intervention
Communicator	Treat meaning, language, power, trauma, culture, and relationship as conditions of safe and dignified care	Elicits the patient's account and goals; checks whose voice is missing; communicates uncertainty without blame; supports informed and culturally safe choice
Collaborator	Link the clinical team with community, public-health, social, and ecological capacities where relevant	Builds shared plans with patients and appropriate partners; clarifies accountability; reduces harmful hand-offs; values non-physician and community knowledge
Leader	Steward resources by life-need, equity, workforce and system capacity, ecological consequence, and future options — not throughput alone	Uses data to identify displaced harms; protects continuity and workforce margins; tests whether efficiencies contract access or resilience; supports learning systems
Health Advocate	Move from isolated referral toward proportionate action on structural, commercial, colonial, and ecological determinants	Documents patterns; connects people to resources; supports community-led priorities; and escalates recurring failures through legitimate channels with attention to power and limits
Scholar	Join rigorous evidence appraisal to reflexivity, systems inquiry, plural knowledge, and public learning	Grades claims by evidence; separates causation from analogy; includes affected communities in question design; respects Indigenous data sovereignty; publishes negative findings
Professional	Understand the social contract as a covenant with patients, communities, the life-ground, and future generations	Maintains competence, integrity, boundaries, and accountability; resists patient blame and conflicts of interest; names unsafe institutional norms; accepts correction

The reframing connects competency to professional identity formation and structural competency. The aim is not only that a learner can perform a life-ground analysis on command, but that the physician habitually perceives relevant conditions, recognizes limits, and acts with epistemic humility and institutional courage. Because identity is shaped by the hidden curriculum, teaching equity and stewardship while rewarding speed, volume, silence, and self-sacrifice will reproduce moral contradiction. Professional formation must therefore include the formation of the workplace.

8. Why 2026 Is an Institutional Opening

An institutional opening is not a prophecy of progress. It is a convergence of pressures and decision points in which path dependence may be altered. Five features make 2026 consequential. First, CanMEDS 2026 was approved on 15 July 2026 and is scheduled for official launch in October, creating a rare opportunity to connect professional competence with social determinants, Indigenous health, planetary health, artificial intelligence, and identity formation. Second, primary-care access failures have become visible

enough to challenge incremental reform. Third, the post-pandemic public-health agenda explicitly calls for equity, community resilience, intersectoral governance, and attention to structural and ecological emergencies (Public Health Agency of Canada [PHAC], 2021, 2023).

Fourth, the colonial contradiction is empirically, legally, and morally undeniable. In 2024, only 54.3% of Inuit adults reported a regular provider compared with 85.7% of non-Indigenous adults; many Indigenous people travelled extraordinary distances for care, and substantial proportions reported racism or discrimination from health professionals (Statistics Canada, 2025). The Truth and Reconciliation Commission's Calls to Action and the United Nations Declaration on the Rights of Indigenous Peoples Act require movement beyond consultation toward rights, jurisdiction, and cooperation (Government of Canada, 2021; Truth and Reconciliation Commission of Canada, 2015). PHAC identifies self-determination as a determinant of health.

Fifth, planetary disruption, toxic-drug deaths, antimicrobial resistance, workforce distress, geopolitical instability, and rapidly deployed digital and artificial-intelligence systems reveal that health, peace, technology, labour, and ecology cannot be governed as separate externalities. Planetary-health scholarship documents the dependence of human health on intact natural systems and the inequitable distribution of ecological harm (Whitmee et al., 2015). The Helsinki Health in All Policies framework already offers a vocabulary for intersectoral responsibility; what remains missing is a shared evaluative centre, operational authority, and public feedback.

There are concrete institutional openings. The Canada Health Act Services Policy took effect on 1 April 2026, clarifying that patients should not be charged for physician-equivalent medically necessary services when delivered by other regulated health professionals (Health Canada, 2026). The Royal College has linked contemporary medical expertise to social determinants and disparities, and Canadian learning-health-system initiatives offer infrastructure for continuous improvement. None of these developments guarantees integration. Each could become another theme, pilot, dashboard, or reporting silo. The pivotal choice is whether they are oriented through a common life-ground purpose and matched with authority to act.

9. An Operational Canadian Programme

Reflexive public learning becomes meaningful only through institutions. The following programme is modular: each component can be piloted, compared, revised, or rejected. The unit of change is not the physician alone, but the coupled system of public policy, education, care delivery, community and Indigenous governance, material infrastructure, and feedback.

9.1 Establish a Canadian Life-Ground Collaborative

A Canadian Life-Ground Collaborative could convene Indigenous governments and health authorities, federal–provincial–territorial partners, patients and communities, public health, professional colleges, health professions schools, peace and social-policy expertise, municipalities, and civil-society organizations. Its purpose would not be to centralize control or impose a national score. It would develop shared methods for life-impact analysis, support locally governed pilots, compare results, and identify legal, financial, and organizational barriers that no sector can solve alone.

A Life-Ground CanMEDS Implementation Lab should operate as one stream within this broader collaborative. It could develop role-specific cases, entrustable behaviours, faculty-development practices, community feedback methods, and organizational standards aligned with CanMEDS 2026. Candidate practices include longitudinal community diagnosis; Life-Ground Rounds linking clinical cases to housing, work, ecology, and institutional design; structured reflection on identity and moral distress; and quality-improvement projects that trace displaced harms beyond the clinic. Biomedical performance must be monitored to prevent integrative training from crowding out core expertise.

9.2 Rebuild Primary Health Care as a Community Civil Commons

Primary health care should be funded and governed as durable local infrastructure rather than a collection of episodic transactions. Every person should be attached to an accountable team or network with timely access, continuity, comprehensive care, navigation, and links to public health and community resources. Team composition should respond to local needs and may include nursing, pharmacy, social work, rehabilitation, mental health, midwifery, community health workers, and Indigenous healers and knowledge holders where communities choose. Payment should support population responsibility, access, complexity, prevention, and collaboration rather than volume alone.

Community governance is essential. Advisory structures without authority can legitimate predetermined decisions. Local and Indigenous governing bodies should participate in priority-setting, data stewardship, evaluation, and resource allocation, with protected funding and decision rights. For First Nations, Inuit, and Métis communities, models must be nation- and community-specific and grounded in self-determination. Life-grounding is not a rationale for benevolent central control; it is a reason to place knowledge and authority closer to those living the consequences.

9.3 Institutionalize Health–Peace and Life-Impact Assessment

Major federal, provincial, territorial, and municipal policies could be subject to a Health–Peace and Life-Impact Assessment. The process would identify effects on universal life goods, direct and structural harms, cultural legitimation of exclusion, trust and social cohesion, ecological integrity, distribution across populations, reserve margins, and future options. It would publish uncertainty, conflicts of interest,

affected knowledge, and the theory of change. It would not label every disagreement as violence; its purpose would be to reveal preventable injury and displaced costs before they are normalized.

Internationally, Canada's peacebuilding contribution could emphasize health systems, local public-health capacity, water and food security, gender justice, climate resilience, and protection of health workers and infrastructure. Domestically, the same positive-peace logic would treat overdose prevention, safe housing, food security, anti-racism, accessible care, and ecological protection as peace infrastructures. Applying one life-value test to external and internal policy would reduce the gap between national identity and material practice.

9.4 Create a Life-Coherence Dashboard and Public Learning Cycle

A dashboard should not compress life into one score. It should display a small and interpretable set of indicators across mutually constraining domains: essential life goods; health and functional capacity; equity and freedom from structural violence; ecological integrity; relational trust and democratic participation; workforce and institutional capacity; and meaningful future options. Every aggregate should be disaggregated where ethically and statistically appropriate, with Indigenous data governed under relevant sovereignty principles.

The dashboard's function is deliberative feedback, not technocratic command. Decision-makers would publish anticipated benefits, harms, distributional effects, uncertainty, and review dates. Communities and independent evaluators would test whether promised gains occurred and whether harms were displaced. Policies would include revision, escalation, or sunset rules tied to evidence. This extends the learning-health-system cycle beyond clinical performance to the life-ground that health systems and other sectors jointly produce (Menear et al., 2019).

9.5 Protect Time, Authority, and Moral Agency

No curriculum can produce life-grounded practice in institutions that exhaust workers and punish boundary-spanning action. Implementation requires protected time for team learning and community work; access to cross-sector partners and information; psychologically safe escalation of recurring harms; and leadership accountability for workforce reserve and continuity. Moral distress should be read not only as an individual wellness problem, but as information about constraints between professional commitments and institutional rules. Advocacy without authority and protection becomes an unfunded moral demand.

10. A Testable Research Agenda

The framework should advance only through discriminating evaluation. Early studies should ask whether life-grounding adds explanatory and practical value beyond established equity, social-accountability,

structural-competency, planetary-health, quality-improvement, and systems curricula. Mixed-method, comparative, participatory, and realist designs are appropriate because effects depend on context and implementation. Four linked pilots are proposed in Table 4.

Table 4. Illustrative pilots and falsifiable propositions

Pilot	Primary proposition	Measures	Disconfirming result
Life-Ground CanMEDS	A cross-role lens improves structural reasoning and proportionate action without reducing biomedical competence	Clinical reasoning; observed role integration; patient/community ratings; standard examinations; learner well-being and agency	No added value over existing curricula, lower biomedical performance, performative advocacy, or greater moral distress without agency
Community PHC	Community-governed team funding improves attachment, continuity, and resolution of life-need barriers	Attachment and timely access; continuity; avoidable ED use; patient-reported capacity; equity gaps; workforce retention; cost	Access or equity does not improve, administrative burden rises, workforce reserve falls, or governance lacks real influence
Life-impact assessment	Tracing structural violence and displaced harms improves policy design and prevention	Changes to policy options; distribution of benefits and harms; ecological effects; trust; crisis incidence; implementation fidelity	The process merely relabels existing analysis, politicizes without clarifying, systematically delays action, or is ignored
Life-Coherence dashboard	Multi-domain feedback identifies deterioration and trade-offs earlier than throughput and expenditure metrics alone	Detection of access, workforce, ecological, trust, and equity deterioration; policy revision; public comprehension	Indicator overload, gaming, false precision, no effect on decisions, or systematic exclusion of marginalized knowledge

Research governance must match the framework's claims. Affected communities should co-design questions and valued outcomes; Indigenous partners must exercise data sovereignty and control over interpretation and use; conflicts of interest must be public; and negative or null results should be published. Economic evaluation should include displaced costs and benefits outside the health budget, while ecological assessment should include material and carbon effects. Long follow-up is necessary for prevention and identity formation, but intermediate mechanisms — perception, collaboration, authority, rule change, reserve margin, and preserved options — can be measured earlier.

11. Ethical and Scientific Guardrails

A framework that claims to connect life, professional practice, and public institutions carries serious risks. Its credibility depends less on conceptual reach than on the disciplines that prevent it from becoming another totalizing ideology.

- **No patient blame.** Life-ground analysis recognizes agency without treating illness or constrained behaviour as evidence of moral, motivational, or cognitive failure. Structural exposure, biology, chance, infection, disability, trauma, and limits remain real.
- **No coercive coherence.** Dissent, conflict, grief, disability, cultural difference, and refusal are not system errors to be eliminated. Coherence concerns life-serving relations and capacity, not uniformity or enforced harmony.

- **No authoritarian optimization of life.** Governments and professions may not define one preferred human type or sacrifice persons to aggregate capacity. Rights, consent, dignity, disability justice, plural ways of living, and procedural safeguards constrain the framework.
- **No cross-domain overreach.** Philosophy, systems models, clinical evidence, Indigenous law, lived experience, and policy analysis contribute different kinds of knowledge. Analogy does not establish causal identity or jurisdiction.
- **No appropriation of Indigenous knowledge.** Relational resonance does not erase sovereignty, treaty relations, or the distinct authority of First Nations, Inuit, and Métis peoples. Integration must mean cooperation, restitution, and jurisdictional respect — not extraction.
- **No reduction of life to a dashboard.** Indicators aid perception; they do not replace narrative, experience, judgment, rights, or democratic contestation. What is unmeasured may still be decisive.
- **No erosion of medical expertise.** A broadened causal and ethical horizon must strengthen diagnostic accuracy, evidence-based treatment, procedural skill, and timely response to danger.
- **No unfunded moral mandate.** Individuals should not be held accountable for structural outcomes without time, authority, partners, protection, and institutional responsibility.
- **No immunity from critique.** Life-coherence can itself become ideology. Conflicts among needs, scales, and time horizons must be named, and independent evaluation and dissent must be institutionally protected.

> **A life-grounded system is not one that claims perfect coherence. It is one that can perceive when its own rules disable life, hear those who bear the harm, and change course before failure becomes irreversible.**

12. Discussion

12.1 Theoretical Contribution

The connecting pattern among peacebuilding, Medicare, health promotion, PHC, CanMEDS, and LVOA is a recurrent widening of the object of care and horizon of responsibility. The principal theoretical contribution is the paired concept of normative enlargement and operational contraction. Each Canadian innovation widened moral and causal concern while retaining an implementation architecture optimized for a narrower unit: peacekeeping contained violence without consistently transforming its structures; Medicare socialized selected costs without universalizing the conditions of care; health promotion named determinants without commanding the sectors that produce them; PHC invoked community while financing transactions; and CanMEDS expanded roles while assessment and workplace culture favoured individual performance.

Institutional inversion names what can happen when this contradiction persists: institutions do not simply fail to achieve their ends; their means become substitute ends. Life-grounding therefore requires more than adding values language to existing structures. It changes the public question from whether an organization met its own output target to whether its rules protected life-needs, expanded capacities,

reduced violence, preserved ecological and workforce margins, and kept future options open. LVOA supplies one explicit evaluative centre, while Galtung, Maturana, Meadows, Ostrom, rights, democratic procedure, and Indigenous jurisdiction provide indispensable diagnostic, epistemic, operational, and political disciplines.

Integration does not mean centralization or conceptual homogenization. A shared life-ground orientation can coexist with distributed authority, methodological pluralism, federal diversity, and Indigenous jurisdiction. What must be common is not one programme, metric, or worldview, but the requirement that institutions disclose the life effects of their decisions, include affected authority and knowledge, and correct preventable harm.

12.2 CanMEDS and the Scale of Change

CanMEDS is a strategic leverage point because professional formation connects scientific knowledge, moral identity, clinical encounters, organizational norms, and public trust. Physicians see where structural conditions enter bodies, where policy fails at points of care, and where technical rescue cannot substitute for conditions of recovery. Yet professional education alone cannot carry a system-wide mandate. It must be coupled to PHC teams, community and Indigenous authority, civil-commons investment, positive-peace policy, and learning infrastructure. Otherwise, the Health Advocate becomes responsible for harms the institution continues to produce while withholding the power to change them.

The Life-Ground Lens is therefore not an eighth role, a new ideology, or a claim that physicians should become universal social engineers. It is an orienting discipline for deciding what competent action means when biology, structure, relationship, ecology, and institutional power interact. Its success should be judged by whether it improves clinical reasoning and proportionate action while strengthening — not weakening — expertise, humility, collaboration, and accountability.

12.3 Limitations

This paper is conceptual and selective. It does not provide a complete institutional history of Canada, an effectiveness evaluation of the proposed programme, or a comprehensive account of every relevant tradition. The recurrent pattern proposed here is interpretive and may understate conflict among the strands. LVOA itself is contestable; terms such as life-ground and life-coherence require operational refinement and may be misused. The viability grammar and dashboard are measurement proposals, not validated instruments. Canadian federalism, professional regulation, Indigenous jurisdiction, and local diversity limit the transferability of any national architecture. These are reasons for participatory pilots and disconfirming tests, not for declaring the synthesis complete.

13. Conclusion

Can CanMEDS be life-grounded? Yes — but the question becomes more precise when framed as purpose. CanMEDS specifies capacities for competent medical practice; life-grounding asks what should orient those capacities when clinical, institutional, structural, and ecological consequences interact. The answer proposed here is not that medicine should absorb every social responsibility. It is that competent action should be directed toward protecting, restoring, and enlarging life-capacity within evidence, rights, professional limits, legitimate authority, and conditions of public correction.

Canada's relevant institutional traditions form neither a completed model nor a collection of unrelated achievements. Positive peace names social conditions that reduce violence; Medicare demonstrates solidarity through pooled access; health promotion and PHC identify determinants and community systems of health; CanMEDS widens professional responsibility; and LVOA offers an explicit criterion for asking whether the whole enables or disables life. The synthesis remains unfinished because purposes have widened while authority, finance, metrics, assessment, and power have often remained narrow.

The practical task is therefore not another declaration but alignment: fund upstream and community capacity; protect professional and workforce margins; recognize Indigenous jurisdiction; assess structural, ecological, and displaced harms; measure without reducing; and build public cycles of learning and correction. The 2026 CanMEDS transition creates an institutional opening, not a guaranteed breakthrough. Its value will be tested by whether renewed professional formation improves clinical reasoning and proportionate action while helping institutions become more accountable to the conditions that make life and health possible.

Author's Note

This manuscript was developed in dialogue with ChatGPT, used as an analytical and drafting companion to organize sources, test distinctions, and prepare the document. The author retains responsibility for the argument, interpretation, source selection, and final text. The conceptual framework is offered as a research and policy proposal, not as clinical guidance or a substitute for diagnosis, treatment, democratic deliberation, or community-specific governance.

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