The aims of higher education have been debated since the inception of the modern university. However, in a time of growing economic disparity, we must critically examine what the aims of higher education in society should be, and how they are or are not being achieved. Using medical education as an exemplar, this paper will argue that the aim of higher education in general, and medical education specifically, should be the achievement of social justice. First, a historical understanding of the role of medical education within higher education will be illustrated, drawing from the work of key educational theorists. Subsequently, I will examine how medical education is and is not achieving social justice in two key domains. First, I will outline the inward approach that educational institutions have used to achieve fairness or inclusion, namely through altering admissions processes. Second, I will highlight who is served by medical education in clinical, research, and broader societal contexts. Finally, I will touch upon the means by which the aim of social justice can be furthered within medical education.

**Social Justice: contextual definitions**

The term social justice is often used imprecisely, encompassing concepts like human rights, social equality, and distributive justice (Burris and Anderson 2010). Much of our current framing of social justice draws from the Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948 in the aftermath of the Second World War (United Nations 1948). Practically, Zajda, Majhanovich, and Rust
provide a useful definition: “Social justice as a construct is an attempt to answer the following question: How can we contribute to the creation of a more equitable, respectful, and just society for everyone?” When focusing specifically on social justice in education, White and Talbert (2005: 59) emphasize that rather than focusing on vocational training, a social justice approach calls for traditional education models to become transformative and empowering pedagogies. This is reminiscent of the emancipatory work of Paolo Freire, where social justice is achieved in part through a shift from a banking model of education where information is deposited into previously ‘empty’ students, to one where students, as co-creators of knowledge, work towards addressing the oppressive structures perpetuating societal inequity (Freire 1993).

It is also important to consider other related terms often utilized in medical education literature. The terms “social responsibility” and “social accountability” are often used interchangeably though they have important discursive differences. Social responsibility can be considered the act of working towards societal welfare or the ‘common good,’ stemming primarily from the core values that underpin a physician’s role in society rather than from legislative mandate (Dharamsi et al. 2011). Social accountability lauds similar goals but implies that physicians (and the institutions that educate them) must be held accountable to society to ensure that societal needs are being met through research, education, and service provision (Dharamsi et al. 2011; Boelen and Woollard 2011; Woollard 2006). The precision, broader applicability to higher education, and emancipatory implications of the concept of social justice make it the most accurate term for the purposes of this paper.
Situating Medicine within Higher Education

Medicine has been a part of the modern university since the 11th century. It has occupied a unique position within the academy. Cardinal Newman emphasized the aim of the university as the creation of intellect or knowledge for knowledge’s sake, but had to acknowledge that medicine was neither trade nor art, but something in between (Newman 1873/1976). He states:

“...in ancient times the practitioners in medicine were commonly slaves, yet it was an art as intellectual in its nature...And so in like manner, we contrast a liberal education with a commercial education or a professional; yet no one can deny that commerce and the professions afford scope for the highest and most diversified powers of mind. There is then a great variety of intellectual exercises, which are not technically called “liberal.” (1873/1976: 81)

Abraham Flexner countered the view of ‘knowledge for its own sake’ in The Idea of a Modern University (Flexner 1930/1968). Like Newman, however, Flexner highlights the unique position of medicine within the academy, describing it as a “learned profession” (contrasted to “unlearned professions” or vocations), with its “roots deep in cultural and idealistic soil” (1930/1968: 29).

The achievement of social justice did not fit with Flexner’s understanding of the aims of the modern university. He urged universities to take an objective stance to social, political, and economic phenomena while refraining from interfering in policy matters or community mobilization (1930/1968: 15). In a fascinating medical analogy, he calls on the professor of medicine to be

“thoroughly humane, realizing fully that he is dealing with, and in that sense responsible for, human life. But the professor of medicine is primarily a student of problems and a trainer of men. He has not the slightest obligation to look after as many sick people as he can; on the
contrary, the moment he regards his task as that of caring for more and more of the sick, he will cease to discharge his duty to the university” (1930/1968: 16).

In 1910 Flexner wrote an instrumental report, *Medical Education in the United States and Canada* (Flexner 1910). He established the university model as the ‘gold standard’ for medical training and his emphasis on research excellence had a transformative impact on the trajectory of academic institutions in the century since (Ludmerer 2010). Notably, Flexner strongly opposed the commercialization of higher education institutions, where owners’ interests could take priority over those of the greater public (Ludmerer 2010). In this way, he elevated “medical education from an unfettered commercial enterprise to a regulated professional degree [and] strengthened the overall health of Americans” (Steinecke and Terrell 2010: 237). However, in his call for “fewer and better physicians,” he ultimately recommended the closure of all but 31 of 155 schools visited (Flexner 1910).

Steinecke and Terrell (2010) ask “progress for whose future?” highlighting how this implementation of the Flexner Report resulted in immediate and long-lasting obstruction of opportunities for African Americans to pursue medical education. The financial and regulatory benchmarks that Flexner advocated resulted in the disproportionate closure of medical schools training and serving rural and African American populations (Steinecke and Terrell 2010). Similarly, his work resulted in the marginalization of midwifery practices and the delegitimization and devaluation of healthcare provided by women, for women (Ehrenreich and English 2005). The increased support and strengthening of higher education institutions that met these
stringent requirements, primarily attended by economically privileged white men, furthered the disparities among students and communities along race, class, and gender lines. Importantly, Steinecke and Terrell (2010: 242) emphasize the role of organizational culture by noting “the historical consequences of reform cannot and should not be laid at the feet of Abraham Flexner; instead, they result from medical schools, universities, and teaching hospitals implementing standards informed by overt and covert social norms shaped over centuries.” These norms include the commercialization of research endeavours, the devaluation of clinical teaching excellence in favour of research throughput, and an ongoing focus on scientific inquiry as the primary basis for medical knowledge “to the exclusion of social and humanistic aspects” (Cooke et al. 2006: 1341). Flexner himself recognized the role of physician as “social instrument” (Flexner 1910; Beck 2004).

**Looking inwards: Achieving diversity within the academy**

Persistent social inequities in North America result in differential access to postsecondary education at all levels, for a myriad of reasons that include unequal opportunities to social and cultural capital that can facilitate entry into higher education and rising tuition fees. Marginson (2011) makes a useful differentiation between the notion of advancing *fairness* by changing the demographic makeup of participation and making it more socially representative, and that of advancing *inclusion* by broadening access and completion of underrepresented populations. He highlights that both understandings of equity may be employed in programs aiming to improve equity and
diversity in higher education, but that they have different implications for efficacy and agency. He notes “inclusion policies and strategies typically move beyond changing the terms of social competition (the objective of fairness policies) to focus on strengthening the human agency of persons hitherto excluded” (Marginson 2011: 27). Marginson advocates that the traditionally marginalized

“must become included not just at a small number of structural portals, but at all points and in all zones where agency and the capacity for higher education are formed: schools and other education institutions; communities, families and the public debate; policy on student financial support; all the potential routes whereby student enter or can enter and move through higher education” (2011: 30).

The chief diversity officer of the Association of American Medical Colleges discusses the “moral imperative” of fairness at the heart of diversity work, “framing diversity in health care as a means to increase access to care for underserved populations, reduce health disparities, shape a more inclusive biomedical research agenda, and enhance the cultural competence of providers” (Nivet 2012: 1458). He calls for the broadening of the evidence base around diversity initiatives to better understand successes and failures in order to create a “roadmap for success” aligning on-the-ground diversity practitioners, institutional leaders, and policy influencers. To develop this evidence base, higher education institutions may need to rely on critical methods that ‘make strange’ and bring to light underlying assumptions and discourses. A Foucauldian analysis of Canadian policy documents pertaining to medical student selection did just that (Razack et al. 2014). They uncovered a push to include ‘social accountability’ in definitions of institutional excellence, but this term was reified as an
“all-encompassing solution to most issues of representation” with little questioning of power relations and distributions within these institutions. By focusing on where power lies and how it moves, the authors suggest the potential for “greater inclusiveness in policy development processes” and participatory roles for marginalized groups (2014: 179).

The demographic makeup of Canadian medical schools makes evident the work remaining in achieving social justice within the academy. Particular groups, including those who are black or Aboriginal, from a rural area, or of lower socioeconomic status, remain underrepresented in the medical academy (Dhalla et al. 2002). Strikingly, 39.0% of fathers and 19.4% of mothers of first year Canadian medical students had master’s or doctoral degrees, compared to 6.6% and 3.0% of the general Canadian population aged 45-64 (Dhalla et al. 2002). With rising tuition fees has come a rise in socioeconomic status of medical trainees, a “weeding out” of those unable to afford steep fees and significant debt (Kwong et al. 2002). This has major class- and race-based implications for the demographic makeup of the medical academy. Furthermore, students who are already in medical school are more likely to get into residency programs at the same institution with evidence suggesting the presence of ‘in-house bias’ (Bass et al. 2013). In an American example, deShazo and colleagues (deShazo, Smith, and Skipworth 2014a) use a historical approach to highlight the forces for and against civil rights for black communities (including physicians) in the American South, emphasizing that historical colonial forces and continued structural racism have contributed to continued low numbers of physicians serving low-income black communities and black physicians.
Attempts to achieve diversity among students in higher education are complicated by the very metrics used to evaluate trainees and institutions. National rankings of medical schools, for instance, focus heavily on grade point average (GPA) and Medical College Admissions Test (MCAT) score. Increases in average GPA and MCAT scores from 2005-2009 were paralleled by a decline in percentage of traditionally underrepresented students within the academy (Heller et al. 2014). This finding alludes to some of the challenges in the increasing focus on rankings, including what they leave unexamined. Heller and colleagues (2014) suggest a reduction in GPA and MCAT weighting in the ranking scoring system as well as the inclusion of a diversity score as a means of achieving increased diversity among the medical student body. The fifth comprehensive review of the MCAT (Davis et al. 2013) aimed to evaluate whether MCAT results differed between white, black, and Latino populations, and whether it acted as a discriminatory barrier to medical school admission. Black and Latino groups’ mean MCAT scores were statistically lower than those of white examinees, though the examination did not appear biased in and of itself. Davis and colleagues (2013) highlight the plethora of social, environmental and educational (from elementary through secondary education) factors that explain these differential results. They conclude that given similar acceptance rates among racially diverse applicants, the MCAT should not represent a major barrier to admission for underrepresented groups. However, the fact that there were over 23,000 white applicants and only approximately 3000 black and 3000 Latino applicants is critical, again reflecting ‘baseline privilege’ and perhaps
differential understanding of the “conditions for possibility” based on race and social class (Foucault 1972).

**The aims of medical training: Who is being served?**

Speaking of higher education more broadly, Kingwell (2011) asks “what's an education for?” He argues that its primary role is to make us “better and more engaged citizens,” for “democracy depends on engaged critical thinkers who have humane knowledge of history, politics, culture, economics, science, who are citizens and not consumers and who can see that there exist shared interests beyond their own desires” (2011: 10). The idea of “physician as citizen” is notably absent from the CanMEDS framework outlined by the Royal College of Physicians and Surgeons of Canada, which has been critiqued for its reductive potential (Whitehead, Austin, and Hodges 2011; Whitehead et al. 2014). This competency-based framework describes the knowledge, skills and abilities that physicians should possess to meet patient care needs, and has been implemented with little modification on an international scale (Royal College of Physicians and Surgeons of Canada 2005; Royal College of Physicians and Surgeons of Canada 2014). Martin and Whitehead (2013) draw attention to the critical need for engaged “physician-citizens” to achieve improved health outcomes for all members of society in an increasingly complex healthcare context. The role of higher education, in their view, is to train a societally appropriate mix of generalists and specialists to work in both rural and urban environments, who are well-versed in the social determinants on
health an in domains beyond just biomedical expertise.

It is important to recognize that factors affecting admissions have a direct impact on how well we can train “physician-citizens” by this definition. High tuition fees and the resulting financial debt and stress have major implications for choice and location of practice for physicians, as primary care practice is less well remunerated than other specialties (Kwong et al. 2002). Yet, meeting the primary care needs for members of society, particularly racially and geographically marginalized groups, is essential if we are to achieve any semblance social justice in health. Similarly, the training of members of underrepresented groups increases the potential for graduates to subsequently serve their communities upon matriculation (deShazo, Smith, and Skipworth 2014b; Davis et al. 2013; Nivet 2012; Steinecke and Terrell 2010).

In addition to service provision, it is important to recognize the ways in which the research apparatus of higher education institutions can compete with social justice endeavors, and how it may be utilized to better achieve justice-oriented goals. Marginson (2011) highlights that intellectual discovery, rather than being a universal good, is episodic and localized with the ‘highest quality’ knowledge production occurring in certain centres of excellence. Achieving fairness would involve some decentralization of the research effort, with adverse implications for research institutions in our current global knowledge economy (Marginson 2011). Brennan and Naidoo (2008) argue that research is one of the ways in which higher education can benefit even those not directly participating in it, through new technologies, local industry development, public scholarship and improved citizenship. They note the tensions between the different
functions of a research institution, “particularly between higher education as a site of disinterested scholarly activity and the call for academics to act in the role of public activists” (Brennan and Naidoo 2008: 296).

Looking forward: a movement towards social justice

Using medical education as an exemplar, this paper critically examined the role of higher education in achieving or obstructing social justice. While educational theorists have argued both for and against this as the aim of higher education, I argue that in the context of widening global and economic disparities, a justice-oriented mission is imperative for institutions of higher education generally, and medical education specifically.

Achieving social justice in medical education requires changes in admissions procedures, but also necessitates major shifts in institutional culture and structure. Steinecke and Terrell (2010: 242) make five recommendations for success in this regard: consistent funding, exacting data collection and innovative research, constitutional mission-based diversity policies, community engagement, and daring leadership. Zajda and colleagues call us to look beyond higher education altogether, warning that the creation of a just society,

“will remain unfulfilled unless we debate more vigorously social inequality in the global culture...We need to critique vigorously the status quo of stratified school systems. We need to focus our debate on the
‘dialectic of the global and the local and the unequal distribution of socially valued commodities’ (Zajda, Majhanovich, and Rust 2006: 15).

Curricular changes have a role to play in shifting culture in medical education, and the work of Paulo Freire has powerful implications for a transformative, emancipatory shift in medical education (Kumagai and Lypson 2009; DasGupta et al. 2006). Such curricular change cannot rely on “familiar, reductionistic, add-a-lecture- test-for-knowledge curricular response[s]” (Wear 2003: 550). Rather, it must involve a bigger overhaul and deeper reorientation of curriculum altogether. Kumagai and Lypson (2009: 783) describe this as critical consciousness, a “reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships.” However, even curricular change alone is insufficient, for institutional structures must be altered, and power and privilege interrogated (Whitehead, Kuper, and Webster 2012; Wear 2003). Institutions must grapple with uncomfortable questions about their historical and contemporary participation in the maintenance of the status quo. Only then can true social justice can even be understood and ultimately achieved.
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