

Inaugural Meeting of Partners' Forum on Social Accountability of Canadian Medical Schools

Halifax, Nova Scotia
April 27 & 28, 2004

Proceedings

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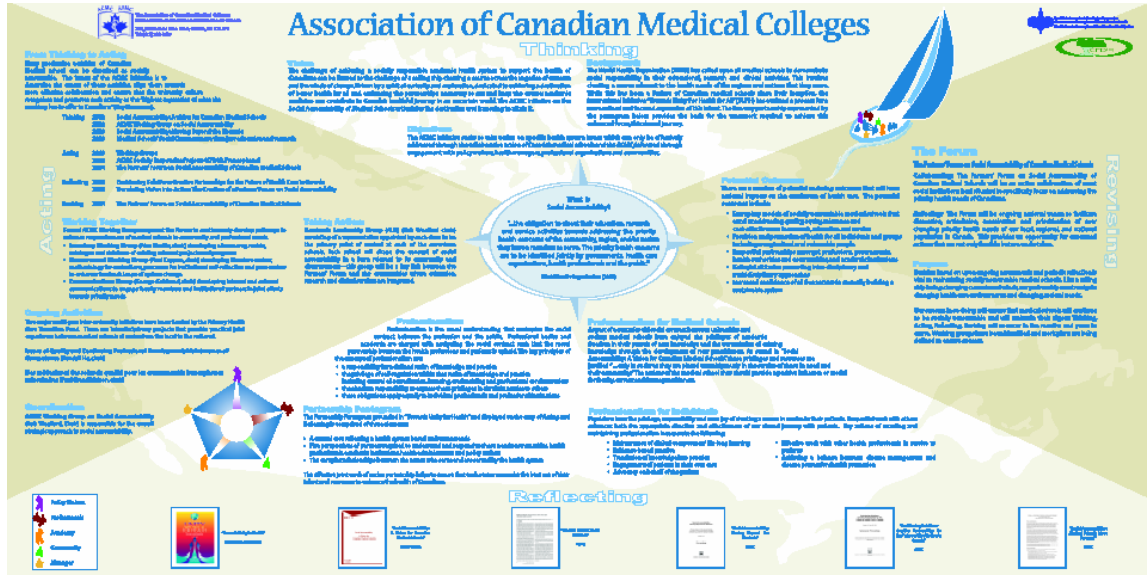
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Introduction and Background

The Association of Faculties of Medicine of Canada (AFMC) has been focusing on the theme of the *Social Accountability of Medical Schools* – encouraging a broad focus on the expectations of society and strategies to meet them. Over the past two years the AFMC has conducted background work and worked actively to build partnerships. This work is depicted in Figure 1, and relevant background documents are listed in Appendix 1.



The AFMC believes that the future of health care in Canada can and must be shaped by the concerted action of many people and groups. They recognize that no single social institution bears full responsibility for design, development and maintenance of this most fundamental of Canadian values. Preparing for fundamental change, the best outcome is likely to result when all interested parties can work together to define their individual roles and their collective responsibilities. Academic medicine in Canada wishes to foster and participate in a process that involves an enduring collaboration with communities and governments in response to the needs of the society.

As a result of the work accomplished to date a new Partners' Forum is being established to address the Social Accountability of Canadian medical schools. Through this Forum the AFMC and its members can engage directly with key stakeholders – policymakers, health managers, professional organizations, and communities – to identify priorities, and jointly undertake action to address those priorities. The inaugural meeting of the Partners' Forum took place in Halifax on April 27th and 28th, 2004.

Extensive work led up to the meeting of the *Partners' Forum*. A planning session with key partners affirmed that:

- The Forum represents the beginning of an **enduring** process and relationship – not an ad hoc or informal initiative.
- The Forum is a **national** expression of relationships that must be fostered at the provincial and regional levels with each of the medical schools.
- The Forum should address the four domains of medical school accountability: **education, research, translation** of new knowledge into practice, and **service**.
- The Forum will focus on the social accountability of medical schools recognizing that, while vital, it is not sufficient. It must also include **practicing physicians, other health professional colleagues**, and the **systems** in which they serve.
- The Forum must develop objectives which are **action oriented** and specific enough to be **measured**.
- The Forum must develop sustaining resources to ensure its enduring **effectiveness**.
- The Forum must effectively **communicate** its activities to its wider audience through publication of proceedings, web sites, etc.

The planning session empowered a Forum Organizing Committee to prepare for the inaugural meeting of the Partners' Forum in the early spring of 2004. The Organizing Committee recruited participants and conducted an initial survey of them to identify priority issues for the work of the Forum. The Agenda of the inaugural meeting was based on this survey. These proceedings reflect the deliberations of this inaugural meeting of the Partners' Forum.

Tuesday, April 27, 2004

Welcome

Dr. Carol Herbert, President, The Association of Faculties of Medicine of Canada

Dr. Herbert welcomed all Partner's Forum participants and commented that she has had the pleasure of meeting with many of them in a number of different venues – all committed to improving the health of Canadians. She reflected that there have been many activities underway in Canada, and that many of the Forum participants have been committed to trying to make a difference.

“If I could find one phrase to describe the people in this room it is that we are all gathered here tonight because we want to make a difference. We want to leave behind in our Canada something better than we have been working with over the last many years. Wonderful as the changes have been in the last 50 years in health and health care, we want to leave it behind better for the fact that we have been present.”

Dr. Herbert gave an overview of the sectors represented at the Partner's Forum: representatives from all levels of government – from federal, provincial and municipal governments; medical schools; academic institutions; national medical associations; national community-based organizations; nursing associations and faculties; other national health care organizations; and advocacy groups. She stressed that the social accountability initiative to date has been a process which has been building background, knowledge and skills, but most importantly a sense of trust and mutual respect amongst people from a disparate range of sectors – which are represented at the Forum.

Dr. Herbert made promises to the Forum participants. She assured them as President that AFMC is in this process *“seriously and for the long haul.”* She promised that medical faculties mean to do business differently, and want to know how best to enact the kind of vision of social accountability that has been articulated in the background documents. *“We are trying to now move from thinking to action in our individual settings through reflecting into planning to act in a way that will be measurable in terms of outcomes.”*

Dr. Herbert urged participants to aim to agree on a direction – to choose one or more entities that really resonate for the group. She stressed that the organizers want the Forum to identify concrete actions – that all partners will be prepared to work on together – *“because for medical schools to be different we need a lot of help from our friends”*.

“Whatever I can tell you about the commitment of our faculty, when it comes to thinking about our students, we owe it to our students to leave them able to do their work differently in the next 25, 30 or 50 years. We

have to make it possible for people to work differently. These are students who are extraordinary. We need to ensure that they have the ability and the structures in place that will allow them to provide the kind of care that we need in this country. We need to be leaders by being a healthy country, and by being healthy individuals and healthy organizations.”

Dr. Herbert commented that the opening session provides an opportunity for visioning. She introduced Rob McLean, futurist and co-author of *The Canada We Want* to lead that visioning. *“I hope that Rob will stretch our imaginations.”*

The Canada We Want

Rob McLean

Rob began by expressing his pleasure at being part of this significant meeting. He proposed to do the following with Forum participants:

- Talk about National Projects.
- Share a perspective on National Projects – particularly the public health system in Canada.
- Talk about transformative change.
- Talk about transformative change and the social accountability of medical schools.

Rob asked participants to share the various perspectives that they bring to the discussion – professional and personal, interests, where they live, where they were born, what languages they speak, cultural, religious, political and life experiences – to name a few. He observed that this is part of what the Partners’ Forum is about – understanding how things look from different perspectives.

He described his book – *The Canada We Want* – co-authored with John Godfrey. *The Canada We Want* is a look at the last 50 years in Canada and a look forward to the next 25 years. Rob and John found the last 50 years of Canadian life fell into two parts. During the first 20 to 25 years there were six great National Projects.

- The Social Safety Net – unemployment insurance was topped up; the Canada Pension Plan was born, and there were various social welfare interventions.
- Public Health Insurance
- Education – the education system was developed to accommodate the baby boom – public schools in the 1950s; secondary schools in the 1960s; and universities in the 1970s.
- Canadian Culture – the Massey Commission Report on the Arts and Sciences was released in 1950. This Report addressed coping with

the new medium called 'television'. It dealt with Canadian culture, funding mechanisms and Canadian content. It also dealt with research.

- Human Rights – the Bill of Rights; the Charter; the Royal Commission on the Status of Women; funding for Aboriginal groups and communities to develop leadership.
- Infrastructure – the St. Lawrence Seaway; the Trans Canada Pipeline; The Trans Canada Highway; airports, and microwave towers.

Rob observed that while Canada was not the only country in the world developing its infrastructure, not everyone else developed a social safety net, health care, education, and an emphasis on culture.

The book then identified the National Projects from the 1980s and 1990s – the GST, free trade, failed constitutional negotiations, and deficit reduction.

In *The Canada We Want*, Rob and John concluded that Canada needs more National Projects that look like the first group, not the second. As a result, they asked themselves, what would new National Projects be? They came up with the following list.

- *Developmental health*. This would involve acting on what we know about the determinants of health – crafting and implementing the necessary policies to support them.
- *Healthy child development*. Now that we know how the brain gets wired and when it gets wired, this would involve taking action to make the circumstances for early child development optimum.
- *New energy systems*. Burning hydrocarbons is contributing to global climate change. Canada has the hydrogen technology that could be leading in the world if developed.
- *Multimedia educational software*. The world is moving towards an era whereby high speed networks will be the source of all information. This will create a new cultural paradigm. How, therefore, will we enforce Canadian content? They proposed through the use of technology in education.

Rob provided a strategist's perspective on one of the National Projects – health care insurance. He observed that markets are highly efficient at generating *differentiation*. Canada's health system, like that of the U.S. and most other countries includes both *private sector* and *public sector* components. The system design issue at the margin is *health insurance or access to care*. Canada made an explicit moral choice, through the National Project on Public Health Insurance, to create a single-tier, *undifferentiated* approach to health care. "We basically said markets are great – but we don't like them when it comes to access to health care."

He observed that we all know that our health system is facing important challenges, there are a number of things that we should *not* do.

- We should *not* adopt strategies that reduce the cost of health care to *government* but increase the cost to *society*
- We should *not* adopt strategies that reduce the ability of governments to manage at a *systemic level*
- We should *not* adopt strategies that make administration of the health system less efficient
- We should *not* adopt strategies that would impede our ability to manage toward better health outcomes
- We should *not* undermine our economic comparative advantage
- We should *not* move toward a differentiated system that undermines the moral choice behind public health insurance

The Partners' Forum: A National Project and Transformative Change

Rob observed that the Partners' Forum and their future work has potential to be a significant National Project. He provided the audience with a number of characteristics that define National Projects. They:

- Are major undertakings that affect the lives of all Canadians.
- Are *national*, not *federal*. *"This is not Ottawa, it is the country. It involves the federal government – but also a lot of other players – provincial and municipal governments, the private sector, public and not-for-profit institutions, and communities."*
- Typically evolve over about two decades.
- Have social *and* economic benefits for Canadian society.
- Traditionally are above partisan politics.

Furthermore, he observed that the Partners' Forum is on the verge of transformative change. In an interactive fashion, Rob posed three strategic questions to the Partners' Forum – and here is what Forum participants thought:

1. Do you agree that we need "transformative change" in Canada's health system?
Forum participants agreed – they felt that it is clear that we do. There are problems with access, primary care, provider resources – and just providing more money will not solve these problems.
2. How would we recognize "transformative change" in Canada's health system if we saw it?
Participants suggested that we would change the fundamental operation of the system. We would change outcomes. We would experience fundamental changes in the dynamics of the system and how people interact with it. We would have a system of health care that provides access to primary care on a timely basis.
3. What is the role of medical schools in health system "transformative change"?

“If we can’t lead, and can’t follow, at least have the decency to get out of the way.”

Participants felt that it is critical to become more strategic, less disciplinary focused and broader in thinking about the solutions. This will require making partnerships with different groups. *“Find friends in places we have not looked for them before.” “We have become preoccupied with interventionist, illness models. We have to become allied with others in addressing the other determinants of health.”*

Transformative Change and the Social Accountability of Medical Schools

Rob observed that the Partners’ Forum has a definition for Social Accountability.

The definition of social accountability of medical schools is the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.

WHO, 1995

He also observed that the Forum has a framework – there has been a clear process of moving social accountability in medical education forward.

He raised a number of questions to provide the backdrop for the Forum’s discussions and action.

1. How can we recognize the difference between a medical school that is socially accountable (or accountable to society), and one that is not?
Participants responded that it would:
 - Have a visible presence in the community from the community’s perspective.
 - Be representative of the communities it serves. The faculty would be representative of a large variety of stakeholders, ideologies, participants and communities.
 - Honestly listen to its community in terms of what they see as their problems and how the medical school can address them.
 - Show visible results of its work.
 - Possess a value system that is pervasive – that would influence how the institution operates at a fundamental level, how it sees its role, and the impact it has on the communities in which it operates.

2. Is there a difference between accountability to society of individual medical schools, and accountability to society of Canada’s medical schools as a collective?
Rob stated that while an individual medical school could be doing a good job in its community that not good enough. The reason the

Forum is gathering is because there is a collective responsibility which is different than what people are doing in their specific communities. Participants need to ask themselves questions at both levels: what do we need to do as individual medical schools within our own constituency and what do we need to do collectively?

3. What is the dynamic between collective action and the actions of individual institutions in a transformative change process?

Rob observed that collective action is not easy – it involves persuading a lot of people to take action together. Getting change in individual institutions is also not easy. In transformational change it is important to think about the dynamics between an individual action and collective action.

Moving forward

Rob challenged participants with the question: *What do we need to accomplish in the next 24 hours to get the Partners' Forum process launched in the right direction?*

The answers were:

- Make a commitment to act.
- Come to consensus on priorities.
- Agree on a process with regard to next steps.
- Identify deliverables, who is responsible and timelines.

He warned that given the nature of what transformational change is all about – that it is based on a powerful idea, a destination – all the details of an action plan will not be arrived upon quickly. Complete consensus on all of the details of the plan will take time – part of the Partners' Forum's immediate work will be to become comfortable with the idea that the plan will not have everything in it. It will be more important to have figured out a priority, have commitment, and some first steps.

In summary, Rob identified that the Partners' Forum has an important opportunity:

*“... a Prime Minister who “gets” National Projects and is publicly committed to transformative change in health ...
... a commitment to additional resources for health within a framework of reform...
... an imminent process of substantive negotiations between the federal government and the provinces ...
...we have leaders in this room who recognize the need for medical schools to move beyond the status quo ...*

...a diverse group of stakeholders who have been invited, in the best traditions of Canada's successful National Projects, to make a difference ...time set aside to explore what collective and individual actions we need to take, and how to organize ourselves to make progress in both the short and longer-term ...

Our history of successful National Projects demonstrates what we can accomplish together. It's up to us to get it done."

Wednesday, April 28, 2004

Objectives and Format of the Day

Dr. Robert Woollard

Bob welcomed Symposium participants and charged them with their tasks for the day. He outlined a number of assumptions which were fundamental to the day's activities:

- The health care system contributes to the general welfare of Canadians. While considered to be among the best in the world, there are many questions regarding its sustainability and quality.
- Change is needed to improve the system – and it is evolutionary or even revolutionary change. It can only be achieved through effective inter-sectoral collaboration and cooperation.
- Academic medicine and health science has a modest but not trivial contribution to make to such collaborative efforts. That contribution would benefit from more effective focus, better integration and more thoughtful prioritization
- This better focus, coordination and prioritization can best be achieved under the rubric of *The Social Accountability of Medical Schools*.
- The Partners' Forum on the Social Accountability of Canadian Medical Schools is a venue to achieve these ends.

Dr. Woollard reminded participants of the overall goal of the Partners' Forum – to focus the activities of medical schools – in the realms of research, education and clinical service – on the priority health needs of Canadians and in alignment with the mutual priorities of partners in the other sectors. *"This will be achieved by the respectful engagement of the academic medical communities in a process of cultural change"*.

Dr. Woollard set the task before the Forum

"...to roll up our sleeves; get dirt under our finger nails; wrestle with particular issues while recognizing general changes, relationships, and processes that will help us to ensure a more enduring and thoughtful process of change not only within the halls of academic medicine but in

Canadian society as a whole. This is not a small task. National Projects have never succeeded when the thinking was small or contingent. Each of us in this room has a significant opportunity for leadership and a remarkable demonstrated capacity for achieving it. Thus, if this group can't embark upon a successful National Project, it is not clear to me who can."

Morning Small Group Session

To begin their work, the Forum was divided into four smaller groups to address the priority issues which had been revealed through the pre-meeting survey of participants:

1. The function, supply and distribution of physicians (two groups)
2. Professionalism and cultural competence of physicians
3. Enhancing the health status of marginalized populations

Each group was asked to address the following questions:

1. With respect to your group's issue, what outcomes or results at a national or community level would strengthen Canada's health system and demonstrate the Social Accountability of Medical Schools?
2. What collective and/or collaborative actions could be taken by members of the Partners' Forum at a national or community level in support of those outcomes or results?
3. What individual actions could be taken by institutions that are members of the Partners' Forum in support of those outcomes or results?
4. What personal actions could be taken by us as individuals in our various institutional roles in support of the outcomes or results that the Partners' Forum aspires to accomplish?

Group 1

Function, Supply and Distribution of Physicians

Facilitator: Dr. Jean Parboosingh

Rapporteur: Dr. Peter Vaughan

Group 1 identified two desired outcomes – implementing a population health approach and improving quality of care. In order to implement a population health focus the group recommended a number of approaches, including focusing on the determinants of health; engaging and empowering the population; and educating them regarding health maintenance and wellness. The group stressed that it will be critical to develop research that provides the evidence-base for best practices to address the determinants of health; and then use the skills of evidence-based medicine to evaluate outcomes. Improving quality of care would involve improving access, collaborating with other

disciplines – that is, stressing the concept of team care with an emphasis on interdisciplinarity – and developing standards for healthy and improved environments for caregivers.

The group identified a number of issues that are influencing the function, supply and distribution of physicians that need addressing. These are:

- The need for the public to be better informed on health and the role of a variety of health care providers;
- The identification of the right number of health care providers;
- The preparation of generalists versus the preparation of specialists;
- Accessibility to medical education – particularly related to tuition costs and rising debts; and
- The role of health services research in identifying and implementing best practices and in providing the evidence base for health care practices.

Group 1 stressed the need for a shift in thinking from what they described as our current ‘industrial’ model – or production model – to a communication or information-based model. This shift would involve grounding the medical school in the community it serves – and therefore engaging the community in meaningful ways – as well as collaborating with many partners.

Connection to the community was seen as one of the most critical elements of social accountability. The group emphasized that if professionals are educated and trained in that practice model, when they go into practice they will be part of a team that provides a broad panacea of approaches to the community and a better connection to the community. *“We are trying to connect the education and practice to the community as part of the interdisciplinary model that involves multiple partners working together for the better good of the community.”*

To achieve this, Group 1 saw that significant behaviour change is required – both within and outside of the medical academy. They stressed that interprofessional education is needed at all levels. *“Medical schools can take a leadership approach – but it is critical that they collaborate in education with many disciplines”*. It was recognized that there will be practical issues that need to be addressed – such as timing and scheduling – however, they felt that it is critical that the team approach to care be addressed by experiential education opportunities. They also saw a need for teaching hospitals to show leadership in collaboration to facilitate interdisciplinary education.

The overwhelming theme throughout the group’s discussion was *“a different way of thinking”*. The group had a number of specific suggestions as to how this could be manifested:

- The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians, and hospitals can help shift the paradigm from one of 'silos' to interdisciplinary cooperation.
- Connections must be built with the community to avoid the isolation of medical schools. *"Coming out of that medieval closet environment into the 21st Century"*.
- The health care system should be decentralized – away from the emphasis on institutional based resources to community-based resources.
- Decision-making, management and power should be shared among many partners.
- Provincial governments as funders should promote efficiencies and reduce the use of ineffective practices.

Group 2

Function, Supply and Distribution of Physicians

Facilitator: Dr. Alan Neville

Rapporteur: Dr. Jasun Kur

Group 2 began their discussion by reframing their question – while the function supply and distribution of physicians remained the goal of their discussion, they stressed that this has to be viewed in the context of other health care professionals and it has to be addressed in the context of developing future educational learning environments.

They identified a number of challenges in addressing this question:

- The 'turf wars' that are commonly experienced when people try to work together. *"Getting people together is great, but you have to move forward as an interdisciplinary/interprofessional team."*
- The perception that physicians are 'outside' the system compared to other health care workers.
- The fear of change.
- Engaging all physicians in the change process – particularly those on the front line.
- Securing buy-in at the academic level.
- Physician workload – the fact that most physicians are in undersupply and are overworked.
- The evolving expectations of the public.

Group 2 felt it will be critical to address the issue of managing the expectations of students when they enter medicine – with regard to what careers are available and the needs in the country. In other words *"balancing personal career choice and societal need"*.

Furthermore they felt that the cost of medical education is a significant barrier – the cost is increasing so much that the students who attend medical school no longer represent the patients they are serving – they come from a privileged background. Therefore, social accountability includes striving to educate physicians who come from varied life experiences.

Moving to actions, Group 2 felt that the first step will be to agree on common principles. Then it will be important to build on work done by groups such as the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Canadian Medical Association and Task Force 2. Finally, they identified a number of actions that could have impact:

- Involve and interact with the community – getting professionals out into the community and having the community involved in all aspects of the process. Engaging the community in a meaningful way was seen as critical.
- Learn from the experience of other jurisdictions
- Promote accountability broadly – not only among medical leaders but with other groups, governments and communities.
- Support the recognition that working in teams is not an option – it is a requirement.
- Ensure that new physicians have the skills to work in interdisciplinary/interprofessional, team models.
- Support role models.
- Change behaviors amongst physicians themselves – for example, looking at language used.
- Deliver the message that a pan-Canadian National Health Human Resource Initiative is important and that it is necessary to do it with all sectors at the table. These issues are beyond federal/provincial/territorial politics.
- Address enrollment issues. Share admission policies and processes. (This was seen as only a stop gap measure – it is also important to look at the bigger picture.)
- Introduce the realities of the health care system to students earlier in their student experience. Students often say they want more exposure early on so they know what they are getting into.
- Provide clear messages regarding expectations – in the social accountability agenda – to balance the needs of society with the individual needs and desires of professionals.
- Provide rewards for ‘un-differentiation’ and for ‘having a wide view of the world’. *“Do not provide rewards for people who have decided to do something from a very early point on in their education.”*

The group stressed that it will be important to have the freedom to try new ideas, and to recognize that not everything is going to work – *“there are no cookie cutter*

solutions to these problems. We are going to have to try new models in different regions of the country, they may fail but we need to have the freedom to try.”

Group 2 recommended that an interdisciplinary/interprofessional, community-based approach to providing care is the way to proceed. This will help ensure that professionals – including physicians – practice where there is need. However, they felt that further discussion is needed about what kinds of clinical learning environments and experiences will prepare physicians to practice in this way. It will be important to clearly articulate the long-term benefits of these clinical learning environments so that they can be promoted to the players involved. According to Group 2, medical schools have a role as leaders in this process. For example, they can bring together health and education ministries – they should strive to make the linkages and get them communicating.

Group 3

Professionalism and Cultural Competence

Facilitator: Dr. John Toews
Rapporteur: Ms. Joan Sayer

Group 3 outlined the following framework that guided their discussion. The importance of:

- Transformational change.
- Being aware of what medical schools give society – doctors, research and service.
- Defining professionalism – including the concept of social contract—whereby there is a shared responsibility to patients and to society.
- Making professionalism an overt part of the curriculum. To this end, role modeling is very important.

The group recommended that it would be helpful if medical schools not only recognized, but verbalized and addressed issues of morale. Students are not necessarily aware of morale issues at school – however, when they become practitioners morale becomes an issue.

The group expanded the definition of cultural competency to include sensitivity. They felt that it was important for practitioners to be aware of their own values – where they are coming from. This would assist in appreciating a patient’s background. The notion of ‘physician know thyself’ was seen as very important.

Group 3 identified a very concrete outcome – that by the year 2010 the number of Aboriginal health care professionals in medical schools should be proportional to the numbers in the population. Some group members stressed the importance of recognizing that in Canada there are several minorities – therefore it would also be necessary to extrapolate some of the ideas to all marginalized

populations. They articulated a need for socioeconomic diversity – since the cost of medical education has escalated; primarily privileged students are accessing medical schools.

Moving to actions, the group recommended:

- The development of model curricula to be shared across medical schools. This should allow for common evaluation with the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the Medical Council of Canada.
- The development of diversity standards for medical school classes.
- Collaboration with the education sector.
- The development of model services specific to local communities. This would involve identifying the specific needs of the local community. Medical schools should engage the community when assessing need – asking them what their needs are, addressing those needs and evaluating outcomes.
- Collaboration between medical schools and regional health authorities to more accurately and effectively assess community needs.
- The inclusion of funds in support of community responsiveness in alternate funding plans.
- The inclusion of public members as key players on medical school committees. Public participation on committees should be part of accreditation of medical schools.
- Providing international medical graduates with the opportunity to maximize their potential – providing the supports necessary – *“not as an add-on, but part and parcel of the mainstream”*.

Finally, Group 3 stressed that it is important to incorporate the role of public health. Public health personnel are very skilled in health promotion, and furthermore, public health professionals can play a key role in facilitating behavioural change.

Group 4

Health Care of Marginalized Populations

Facilitator: Dr. Paul Grand'Maison
Rapporteur: Dr. Todd Watkins

Group 4 began their discussions by expressing the view that ‘marginalized’ has a negative connotation. *“Our goal is to bring people in from the margins – rather than expanding the margins.”* In that context the group changed the language – rather than marginalized they used diverse. They then defined this population as a group of people who are underserved by the health care system and are not receiving the care that they need.

The group identified six specific outcomes related to the health care of diverse populations:

- A collective strategy.
- Awareness of, education in, and accessibility to diverse populations.
- Meaningful involvement and integration of diverse populations into the discussions and into the strategy development at all stages, both globally and locally.
- Integration of social accountability in student evaluations and school accreditation.
- Cultural and systemic change – this change needs to happen over time. It involves changes in attitudes, commitments and principles with respect to ways of working.
- Diversity in medical schools – including socioeconomic diversity. Currently there are groups of individuals who do not have access to medical school because of the cost.

The theme of cultural shift was paramount to the group's discussion. They stressed that social accountability is not an 'add on'. *"It is not a program built into the curriculum as a distinct entity – but needs to be thought of in everything that is done – it needs to be integrated. That is necessary for a cultural shift. Social accountability needs to be the back drop to everything done in medical schools."* To enable this, the group stressed that faculty will have to be better recognized for the work they do in social accountability.

The group also adopted the theme 'think globally, act locally'. They identified that there is a local responsibility – and therefore a local dialogue needs to take place. While it is critical to have a global strategy – a broad vision – it must fit the community served.

Group 4 stressed that the community's input needs to be broadened and expanded.

There needs to be formal standing and recognition within communities for diverse populations' participation in planning, governance and management structures of health services and education.

Group 4 recommended that all Partners' Forum members need to be personal champions for social accountability. Social accountability should be the back drop of what each individual does. *"Everyone has different roles and responsibilities but can still be personal champions for social accountability."* There will be a need to promote individual dialogue – to engage others who know about these issues and involve them in the process – and thus share the workload. Communication was seen as key. *"This is a two-way street. It is important to bring the local programs to the national table and to share with people at the local level national activities and strategies."*

Discussion

During the discussion following the small group reports, two main themes emerged – terminology and human resources.

Participants discussed and debated the use of terminology – particularly that of social ‘accountability’ versus ‘responsibility’. Some saw responsibility as being able to respond and move forward, while accountability as being accountable and doing the minimum. *“We want to go further than that. Schools should be able to respond – not just be able to give an account of what they have done.”* Some participants stressed that in the medical profession there is a social contract with society – society has given physicians the right to be a self-regulating profession, and therefore they are accountable for what they do as health care providers to the people for whom they provide education, service, etc. There was a caution against confusing concepts of social responsibility and social responsiveness. *“I don’t think we want to be responsive – we see ourselves as having a leadership role.”*

Others identified confusion between some aspects of transparency and social accountability. They identified that the administrative literature is dealing with the concept of accountability – mostly looking at reporting back on how responsibility is assumed. Transparency allows other people to see what is going on. Accountability can encourage engagement – during the process of reporting back to the community at large they become engaged in the process. Participants concluded that *“I think we are all talking about the same concepts – but we need to be cautious with our language.”* They recognized that the words accountability, responsibility, responsiveness can have nuanced differences for different groups and were saying that it is important to understand that language is used differently, but the basic values are shared.

A number of participants commented on concerns regarding human resources issues.

One participant identified that students in medical school are looking not at becoming physicians, but a great proportion are looking very early on at becoming sub-specialists. If things do not unfold in that direction for them there is incredible disappointment and disillusionment in terms of their careers. Therefore the goals of the medical schools should be clear when students apply – affecting the admissions process, the strategy in undergraduate curriculum, in career counseling and the planning of postgraduate training. *“Students entering medical school should be very prepared and excited about the fact that they could be a generalist physician in our society and have a prestigious, fulfilling, meaningful role serving Canadians.”*

One participant saw the issue as generational. *“The generation that is going through medical school right now comes from a group that tends to be very*

career driven, very self-centred when it comes to public service. Medical students today don't have any sense of professional identity. Everyone comes with a different idea of what a physician is and does not develop that sense of professional identity or service to the community. The focus is on basic science but not much on the community served."

Other participants articulated one of the biggest challenges facing medical schools is that they are now training physicians for 2010, but need to be planning on how to train physicians for 2020. In order to accomplish this, a national framework of health human resources is needed – not only addressing the numbers of physicians required but how they are going to function, in what kinds of teams and what kinds of structures. To do that effectively it will be critical to respond to the needs of the population and to bringing together all of the players to plan a road map that is *"not narrow but a broad pathway"*.

Rob McLean summed up the morning's deliberations. He commented, *"If the meeting was over and we were all going home would we have done our job?"* And he answered *"No."*

Rob therefore challenged the groups for the afternoon to identify two or three flagship initiatives that the Partners' Forum could undertake. He identified that the seeds of those ideas were planted by the small groups:

- Modeling various aspects of the future;
- Determining how to do interdisciplinary/interprofessional education differently,
- Shifting the model from an industrialized model to something else,
- Playing a significant role in terms of the future design of the health care system and developing the education system needed to support that future design; and
- Impacting on the human resource issues – particularly relating to diverse communities.

Luncheon Speaker

Potential Linkage to National Health Council

Dr. Robert McMurtry

Dr. McMurtry began his presentation with a video describing the newly formed Health Council of Canada. The mandate of the Health Council is to monitor and make annual public reports on the implementation of the First Ministers' Accord on Health Care Renewal, particularly its accountability and transparency provisions. The Health Council reports publicly through federal/provincial/territorial Ministers of Health and includes representatives of both orders of government, experts and the public. To fulfill its mandate, the Council draws upon consultations and relevant reports, including governments'

reports, the work of the Federal/Provincial/Territorial Advisory Committee on Governance and Accountability and the Canadian Institute of Health Information (CIHI). The Council held its first meeting in January of 2004.

The characteristics of the Council include that it:

- Is independent and objective.
- Is accountable and transparent.
- Has representation from a cross-section of perspectives, including academic, scientific and professional communities, and reflects in reasonable manner Canada's diversity, including linguistic and Aboriginal representation.

The membership is 25 people from 12 of the 14 jurisdictions. (Quebec will cooperate with their own council. Alberta is not participating.) The Council has eight work groups:

- Home Care and Catastrophic Drug Coverage
- Primary Care
- Wait Times
- Health Human Resources
- Tools and Technologies
- Healthy Canadians
- Monitoring System Performance
- Finance and Audit

Dr. McMurtry identified that *“There is an obvious connect with the Partners’ Forum. There is a significant continuity between the Council, the Vision as articulated in Social Accountability A Vision for Canadian Medical Schools and the WHO definition of social accountability. The emphasis on professionalism, monitoring community needs and research and evidence reflect the shared values.”*

The Romanow commission – which recommended the formation of the Council – was based on democratic mobilization – it was an unprecedented consultation that made it clear how Canadians feel. Mr. Romanow was deeply impressed by the social accountability work and highly supportive of it.

Dr. McMurtry challenged the forum in the words of Mr. Romanow that *“the time for action is now”*. He supported the concept of our “young and brightest” – the students of today – to provide us with a 2024 vision. He agreed that the Work Groups of the Council would be grateful for the input from the Partners’ Forum and invited their input *“That would be a good mission to commence that engagement”*.

Afternoon Small Group Session

To continue their work, the Forum returned to their small groups and they were charged to identify two flagship projects – short term and long term – and to address the following questions:

1. What should these projects be?
2. What processes should be initiated immediately following this meeting in order to make progress?
3. Who should take responsibility for initiating these actions?

Group 1

Function, Supply and Distribution of Physicians

Facilitator: Dr. Jean Parboosingh

Rapporteur: Dr. Peter Vaughan

Group 1 recommended that two project areas should be initiated:

- *Creation of a vision* which would include a definition of resources (human, information technology etc.), the educational and health system needs and policy issues. The group recommended that this be done from the perspective of each of the partners and then be compiled.
- *Flagship projects* – a number of tangible projects were suggested:
 - Public health – the development of a model to include interprofessional education.
 - Primary health care – patient-centred, community-based, collaborative and interdisciplinary/interprofessional. The development of a collaborative curriculum for continuing education could be a short term goal, followed by evaluation, research and development and teaching. The advantage of this project is that it would take place out of the hospital setting.
 - Aboriginal health – the strategies developed here could also be applied to other underserved populations.

Group 1 recommended that The Association of Faculties of Medicine of Canada (AFMC) and the medical schools should set priorities and then approach the partners as to how to meet the goals and get commitment for support. They suggested that there be a Steering Committee from the medical schools with partners co-opted and in an advisory capacity. The accrediting bodies can develop indicators and criteria to compel groups to move in the desired directions.

They recommended that planning for the development of a vision for the future (2010 or 2020/24) should be tasked to the Steering Committee of the Partners'

Forum. Two different strategies were suggested: scenarios- based planning – how to get there and “what-ifs”; and solutions-based planning – design the functions and resources needed. These could be done on a two to three year timeline with implementation being the long term task. The Royal College would be willing to accept this vision and play an effective role in making it happen.

Group 1 recommended that AFMC and all the faculties of medicine play a leadership role and provide direction for developing a plan for the desired future – which would include primary care organizations within an integrated system providing seamless access to referrals when necessary.

Group 2

Function, Supply and Distribution of Physicians

Facilitator: Dr. Alan Neville

Rapporteur: Dr. Jasun Kur

Group 2 identified Aboriginal health as the predominant theme for a shorter term project. They felt that Aboriginal health is uniquely suited because it overlaps so many areas – undergraduate training, postgraduate training, research and population health. Academic institutions can play a leadership role. The initiative would have to involve a number of components: education, curricula, research, public initiatives and evaluation. The group discussed admissions policies and concluded that while increasing numbers is an important part of this, more systemic change is necessary as well. Curricular objectives need to change in undergraduate and postgraduate medical education, and very importantly in continuing medical education, as well as in specific community projects. The group stressed that this initiative could be used as a template for other “diverse” groups and other larger population issues.

The group was not interested in re-creating the wheel. *“It will be important to work with groups who already do this and try to expand that. At the same time, it will be important to liaise with the community of need and find out what their specific needs are.”*

The group suggested commissioning the AFMC Secretariat to oversee this work. During the first stage they recommended surveying schools with expertise, since there are very good projects going on across the country with curricular change in Aboriginal medicine as well as the implementation of admissions policies. They recommended surveying Aboriginal communities – since Aboriginal communities have identified needs. The group felt that it would be important to examine where medicine fits into these needs. Some of them are clearly not best addressed by medicine – thus identifying the need for an interdisciplinary/interprofessional team. The group stressed that it will be critical to focus on consultation with communities of interest whereby the communities identify their own needs – and to avoid a top-down, ‘ivory tower’ approach.

Group 2 felt that there are clear objectives of health care benefit of doing this and they should be articulated. For example, this initiative would result in an increased understanding among health care professionals of the needs of Aboriginal people and communities. There would be a leadership benefit within the Aboriginal community – the project would help develop leadership within the community and also enable the Aboriginal leadership to expand in new areas.

Finally the group felt that there needed to be appropriate measures of success integrated into the process. For example: a report card, accreditation, public satisfaction, and government interest.

Group 3

Professionalism and Cultural Competence

Facilitator: Dr. John Toews
Rapporteur: Ms. Joan Sayer

Group 3 spent time thinking about their broad vision in the year 2024. They:

- Are interested in knowing that the health status of the population has been improved.
- Want to see more of an emphasis on health promotion and disease prevention.
- Want to see medical graduates who are committed and competent in needs based health planning.

They had two flagship projects. The first related to Aboriginal Health. Their goal was to see 224 Aboriginal entrants per year in medical schools – Group 3 felt that this would force change. They recommended that the recruitment of students involve: appropriate admission policies; suitable support systems; faculty role models; community involvement; collaboration with educational bodies; and collaboration with Aboriginal communities.

In order to accomplish this they recommended that a Standing Committee on Aboriginal Issues be formed. Consultations and involvement with the Association of Aboriginal Physicians in Canada and Aboriginal leaders in medicine would be important. They stressed the need to build a national consensus – and saw that the role of The Association of Faculties of Medicine of Canada would be to build this national consensus. They recommended that funding be sought conjointly.

The second longer term flagship project was a social contract of medical schools. The reference document, *Social Accountability: Vision for Canadian Medical Schools*, refers to the social contract – and stresses that it is necessary to bring together the participants around the pentagram to provide the vision for the future. Again, the group felt that The Association of Faculties of Medicine of Canada would be in the best position to facilitate this process and these partnerships.

Group 4
Health Care of Marginalized Populations
Facilitator: Dr. Paul Grand'Maison
Rapporteur: Ms. Bernice Downey

Group 4 reported that they were challenged to achieve some balance between process and a concrete project. There was a sense from those group members who had already been involved with the social accountability initiative to move forward, get going, and identify something concrete. That moved into a discussion of what could be worked on – there seemed to be a sense of urgency.

There was recognition that there are best practice models at the local/regional level that could be used as models or templates to draw from. The group felt that the development of the social accountability process over the next year was in and of itself a flagship project – it would provide the opportunity to scan the environment and see what existed. Some of the potential ideas were: public health, fellowships initiatives and Aboriginal health human resources. The group discussed the idea of how parallel projects – long term/short term, process/concrete could happen. They stressed that it will be important to make decisions in the context of the funding environment.

The group identified the development of a health human resources strategy as critical – particularly, increasing the number and mix of physicians to better reflect the communities served. This seemed to provide the opportunity to address a broader number of groups. The group wrestled with the question, *“How to accommodate and be inclusive of other interests and yet choose something concrete?”* They suggested beginning with Aboriginal interests – feeling that it could accommodate both short and long term goals. They recommended looking at curriculum development; cultural competencies development; and increasing the numbers of Aboriginal graduates – this initiative could then lead into a continuum of activities, going from short to long term. Ultimately, the human resources initiative could become broader and more inclusive.

AFMC was seen as facilitating this, but the group felt that there are others who could come to the table and contribute to this process. For example, if the interest was in public health or in women’s health, that would indicate who would be invited to the table. There would be a diversity of participants and roles.

The group concluded by stating that *“we would end up with the human health resources strategy in terms of increasing the number of physicians that we want”*.

“THE HHR STRATEGY → THE MD’s THAT WE WANT.”

Discussion

Dr. Robert Woollard

In summary, Dr. Woollard commented on the groups' deliberations and observed that:

- They consistently looked at both short and long term projects.
- They tried to encapsulate the urgent, "let's get our feet on the ground and move forward with something concrete", while at the same time thinking of the long term.
- Several groups mentioned the concept of an inventory of best practice. Dr. Woollard observed that the AFMC has an inventory group that is in the process of gathering such data – it can be of service to and integrated with the flagship project. In six months it is hoped that there will be a list of practices.
- While there was a lot of emphasis on the AFMC – the broader partnership is critical to the project. AFMC could provide infrastructure that will help to give the group confidence to move forward.

Dr. Woollard stressed the importance of taking concrete action and moving along to the next steps. The Royal College of Physicians and Surgeons of Canada offered to host a meeting in six months time. All groups identified Aboriginal Health as an important project – therefore it was suggested that a working group should carry this forward. It was stressed that it would be important to secure funding for a Director/Secretariat/Staff to actually do the work.

The participants agreed that the Partners' Forum Organizing Committee propose a workplan for the Aboriginal health project. There could be further input as a result of that. In addition a template could be developed for the long-term project. Since the Organizing Committee is not here for the long term, it was recommended that in addition to the workplan, the Organizing Committee come back with suggestions for a structure and steering committee that would take the initiative to the next phase.

It was agreed that the proceedings of the Partners' Forum be sent to all participants, along with an outline of the workplans for reflection and reaction. A follow-up meeting will be held in six months.

In Closing: Rob McLean's Reflections

In closing Rob McLean reflected that he saw the Partners' Forum as a process in motion, *"which has been gestated over a few years of hard work by people to try and do something different."* He stressed that this is not easy and urged people to remain with the process, *"because it is leading you to places where you would otherwise not have gotten to"*.

Rob stressed that the group has just started – and that it is important to carry on with the dialogue. It is also important to build some momentum – *"and meeting in six months is a good idea to get the process going. That does not mean that you will be meeting that often in the long term. However, you are still in a formation process and I don't think you can do that with a once a year conversation."*

Rob summarized that the Forum reached consensus in favour of two kinds of flagship projects – a shorter term flagship project that is responsive to particular need – Aboriginal health. He reflected that it offers tremendous opportunity for all of the medical schools in the country to collaborate at a national level, in addition to what they are doing in their individual activities communities. *"That would be a powerful statement, just by the fact of doing it."*

He also identified that there was interest for a longer term project – however there was more uncertainty surrounding that. He recommended that the Forum give the organizing committee – the people who have shepherded this process so far – some time and room to take the input from this meeting to examine what can be done in terms of the longer term contribution.

"If arising out of this meeting those two things were to happen and you were to meet again in six or nine months, that would be a great outcome and stage along the process of moving forward. The best National Projects take time – we are trying to do something different, something new, it is not going to happen quickly. What has been accomplished in such a short time frame is impressive. Thank-you again for the opportunity to participate. When invited I truly believed that there is something quite special going on in this process, which is why I agreed to come. I wasn't wrong."

Appendix 1: Background Documents

Executive Summary of Social Accountability A Vision for Canadian Medical Schools.

Social Accountability A Vision for Canadian Medical Schools. http://www.hc-sc.gc.ca/hppb/healthcare/pubs/social_accountability/index.html or access through http://www.afmc.ca/pages/articles_social_accountability.html

E. Jean Parboosingh, for the Association of Canadian Medical Colleges' Working Group on Social Accountability Medical schools' social contract: more than just education and research. CMAJ • APR. 1, 2003; 168 (7): 852-3.

Robert Woollard. Social Accountability: Medical Schools Move Forward. ACMC Forum, March 2004; 37(1): 10-12.

Social Accountability: Moving Beyond the Rhetoric, Plenary Proceedings, http://www.afmc.ca/pages/articles_social_accountability.html.

Envisioning Solutions: Creative Partnerships for the Future of Health Care in Canada, Symposium Proceedings, (http://www.afmc.ca/pages/articles_social_accountability.html).

Charles Boelen. Towards Unity for Health: challenges and opportunities for partnership in health development: A working paper. 2000. World Health Organization, Geneva, Switzerland. (<http://www.the-networktufh.org/abouttufh.asp>, accessed April 5, 2004).

Other material can be accessed through www.afmc.ca

Appendix 2: Participants

Dr. William Albritton
University of Saskatchewan

Ms. Jan Benedict
Canadian Federation of Medical Students

Dr. Ian Bowmer
Health Canada

Dr. Michel Brazeau
Royal College of Physicians and Surgeons of Canada

Mr. Glenn Brimacombe
Association of Canadian Academic Health Organizations

Mr. Frank Cesa
Health Canada

Dr. Guillaume Charbonneau
FAEMQ

Ms. Janet Davies
Canadian Nurses Association

Ms. Bernice Downey
National Aboriginal Health Organization

Dr. George Goldsand
University of Alberta

Dr. Paul Grand'Maison
Université de Sherbrooke

Dr. Calvin Gutkin
The College of Family Physicians of Canada

Ms. Louise Hanvey
The Association of Faculties of Medicine of Canada

Dr. David Hawkins
The Association of Faculties of Medicine of Canada

Dr. Brian K.E. Hennen
University of Manitoba

Dr. Carol Herbert
University of Western Ontario

Dr. Dan Hunt
Northern Ontario Medical School

Dr. Jason Kur
Canadian Association of Interns and Residents

Ms. Penelope Marrett
Canadian Mental Health Association

Ms. Susan Maskill
The Association of Faculties of Medicine of Canada

Ms. Diane McArthur
Ontario Ministry of Health

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Royal College of Physicians & Surgeons of Canada

Mr. Rob McLean
Futurist and Author

Dr. T. Jock Murray
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Mr. Robert Shearer
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