

Social Accountability: Moving Beyond the Rhetoric

Plenary Session of the Annual Meeting
Association of Canadian Medical Colleges
Canadian Association for Medical Education

Québec, QC
April 28, 2003

Proceedings



Association of Canadian Medical Colleges
Association des facultés de médecine du Canada

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Program

Introduction

On Monday, April 28, 2003, the Plenary Session of the Annual Meeting of the Association of Canadian Medical Colleges and the Canadian Association for Medical Education was dedicated to the topic of social accountability in medical education. *Social Accountability: Moving Beyond the Rhetoric* provided an opportunity to explore the meaning of social accountability for medical academies and to plan concrete steps to move forward through a combination of plenary speakers and workshop sessions.

The objectives of the session were to:

- Enhance understanding of international trends in expressing and measuring the social accountability of medical schools;
- Reflect on the current state of social accountability in medical schools in education, research and service;
- Identify opportunities for action in enhancing the social accountability of medical schools; and
- Task the Working Group on Social Accountability (ACMC) whose role is to support the coordination and impact of medical schools on the health of their communities.

The **Agenda** for the day was organized as follows:

Opening Remarks: Plenary Chair

Robert Woollard, Royal Canadian Legion Professor and Head, Department of Family Medicine, University of British Columbia

Social Accountability: The Next Frontier?

Charles Boelen, International Consultant (health system and personnel); Former coordinator of the World Health Organization Program for Human Resources in Health

Social Accountability in Biomedical and Health Research

Alan Bernstein, President, Canadian Institutes of Health Research

Social Accountability in Public Health Care Policy

Thomas Ward, Deputy Minister of Health, Nova Scotia

Small Group Sessions

How Does the Academy Express its Social Accountability?

Facilitator: Carol Herbert, Dean, Faculty of Medicine and Dentistry, University of Western Ontario

Scribe: Sarita Verma, Associate Dean, PGME, Queen's University

Presenters: Paul Grand'Maison, Vice-Dean, UGME and Vice-Dean to the Community, Université de Sherbrooke; Phillip Berger, Associate Professor, University of Toronto

How Does the Academy Foster Social Accountability?

Facilitator: Kendall Ho, Associate Dean and Director, CME, University of British Columbia

Scribe: Jason Kur, Representative, Canadian Association of Internes and Residents

Presenters: Noni M^{ac}Donald, Dean, Faculty of Medicine, Dalhousie University; Irfan Dhalla, Final Year Medical Student, University of Toronto

How Does the Academy Teach its Social Accountability?

Facilitator: Brian Hennen, Dean, Faculty of Medicine, University of Manitoba

Scribe: Carl Whiteside, Associate Professor, Department of Family Practice, University of British Columbia

Presenters: Jeffrey Turnbull, Chairman, Department of Medicine, University of Ottawa; Dave Davis, Associate Dean, Continuing Education, University of Toronto

How Does the Academy Measure its Social Accountability?

Facilitator: David Hawkins, Executive Director, Association of Canadian Medical Colleges

Scribe: Jean Parboosingh, Consultant, Working Group on Social Accountability

Presenters: Charles Boelen, International Consultant (health system and personnel); Former coordinator of the World Health Organization Program for Human Resources in Health

Each of the four groups worked with the following **objectives**:

- To identify two exemplary actions in their relevant area.
- To identify factors that predispose, enable and reward social accountability in medical schools.
- To identify challenges to social accountability.
- To advise specific tasks (and time frames) for academic medicine, the working group on social accountability of medical schools or government(s).

Groups Report Back

Concluding Remarks

Robert Woollard, Royal Canadian Legion Professor and Head, Department of Family Medicine, University of British Columbia

Opening Remarks

Plenary Chair: **Robert Woollard**

Royal Canadian Legion Professor and Head, Department of Family Medicine, University of British Columbia

Dr. Woollard chairs the ACMC's Task Group on Social Accountability. He describes it as "a remarkably creative and delightful task group, that has been charged by Canada's deans of Medicine with first developing and now implementing an ACMC strategic approach to the concept of social accountability – an action oriented approach and hence the title of today's plenary Beyond the Rhetoric."

Dr. Woollard explained that the plenary was styled as a workshop in order to extract and organize participants' experience and wisdom as the group collectively considered the role of the Academy in focusing its considerable talents on some of the most complex and heretofore intractable problems in health care that confront Canadian society.

He remarked that the room represented a remarkable wealth of activity – a broad range of expertise addressing enduring questions on the broad issues of human affairs from cradle to grave, from the molecule to the masses. Therefore the task was not to passively accept new knowledge but rather to actively share that which exists, to attempt to do so in an organized fashion that by day's end would produce a platform upon which could be built an organized network. The purpose of this network is to demonstrate both the utility and the commitment of academic medicine in Canada to contribute to resolving, or at least mitigating, the priority health care needs of Canadians.

That, after all, is the definition of social accountability of medical schools according to WHO and as quoted in the joint vision paper of ACMC and Health Canada "Social Accountability: A Vision for Canadian Medical Schools".

...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

That Vision Paper was held up by Roy Romanow at the last ACMC/CAME Annual Meeting in Calgary when he described it as among the best Canadian academic medicine has to offer and challenged participants to make it live.

Dr. Woollard remarked that the Plenary and the week's activities, including the National Symposium: "Envisioning Solutions: Creative Partnerships for the Future of Health Care in Canada" are a considered response to that challenge.

These meetings are intended to go beyond the rhetoric to reflect on the numerous relevant activities already taking place under the broad umbrella of Canadian academic health sciences. But to reflect with the purpose of acting more effectively through better identifying, better supporting and better focusing those activities most directly relevant to the priority health needs of society.

Medical schools, through their centuries long association with and participation within universities have carried a dual responsibility – to uncover new knowledge (and occasionally new truths) through research and to transmit that knowledge through generations of physicians to the better service of those in society who are ill – who are suffering – in short, “patients”. A relative academic independence has been a necessary and valuable feature of medical schools for centuries which needs to endure.

But, in the ACMC/HC Vision Paper, quoted by Roy Romanow from the podium one year ago in Calgary and re-iterated in the paper by Jean Parboosingh and the working group in the April 1st CMAJ (Vol. 168, pages 852-3):

“Society provides medical schools and the medical profession with certain privileges and resources; these are justified only insofar as they are placed unambiguously in the service of those in need and their community”.

Dr. Woollard pointed out that the Plenary’s speakers, presenters, workshop facilitators and rapporteurs come from the wide spectra and many axes on which those privileges and resources and that unambiguous commitment to service exist.

They come from the halls of the World Health Organization to the front lines of the marginalized of the inner city streets. They come from the most demanding roles of the public service to the leadership of the research that can support evidence-based public policy in our increasingly complex world. They come from the dean’s office to the front lines of today’s medical students – students whose complex world makes his own student days look like a walk in the park. And they cover leadership of the education of professionals across the entire continuum of life-long learning.

Social Accountability: The Next Frontier?

Charles Boelen

International Consultant (health system and personnel); Former coordinator of the World Health Organization Program for Human Resources in Health

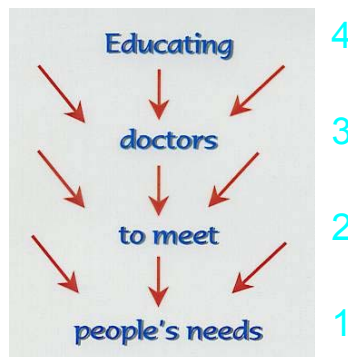
The social accountability of institutions by its very nature is a collective of activity – and like all successful collective activities it must have effective leadership. If the concept and its expression may be said to have a major international champion and leader, that person would be Dr. Charles Boelen. Former coordinator of the WHO Program for Human Resources in Health, his research and field practice have focused on three intertwined areas:

- *The social accountability of universities.*
- *The fostering of family medicine as a key asset for primary health care systems.*
- *The development of the international strategy “Toward Unity for Health” of which many Canadians are institutional (e.g., Université de Sherbrooke) or individual (e.g., Dr. Carl Whiteside) participants.*

Dr. Boelen is tireless in supporting these issues at a global level – most recently at the World Federation on Medical Education in Copenhagen where representatives from 74 nations wrestled with how to promote social accountability through the accreditation systems. He joined the Plenary Session to share his experience and wisdom.

Robert Woollard, Plenary Chair

Dr. Boelen began his presentation by reminding the audience of the business of the Academy – “We are in the business of educating doctors to meet people’s needs. That sounds simple.”



However, he warned that it is not simple – and that it is critical to break this mandate into its four distinct parts and reverse the order – so that we ask the following questions:

- Are we aware of people’s needs?
- What kind of health system will meet those needs?
- What kinds of doctors will work in that system?
- How do we educate them?

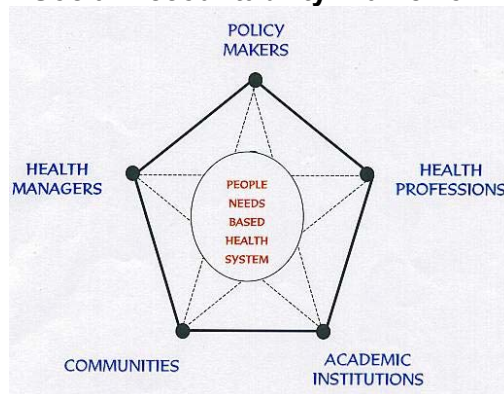
Therefore, we first identify people’s needs – then find ways to meet them. *“If we are not preparing doctors to work in the future environment where they will be working, we will not meet people’s needs”*. He warned that it is erroneous to make implicit assumptions that if we are good at education we will have good doctors and a good health system – this is not the case. It is critical to start with people’s needs

Next, Dr. Boelen advised participants to consider the context and the content of medical education – and to ensure that they interrelate. Historically medical schools have *“been shy about the context”*. Dr. Boelen asserts that medical education has lacked role models. If the content of medical education is not based on the context of society – of people’s needs – it will not be socially accountable.

C O N T E X T C O N T E N T

Dr. Boelen presented a framework of social accountability. He emphasized the three elements of the framework – what is in the circle, what is on the tips of the pentagram, and the relationships between them.

Social Accountability Framework



The pentagram demonstrates that central to all activities are health services based on people’s needs – represented in the circle. The points of the pentagram represent the partners which provide those health services and attend to society’s needs – the medical school is just one important partner among many of the different stakeholders.

Dr. Boelen presented three challenges in this model.

- The first challenge relates to the organization of the health care system. The system and its services should be centred on the needs of individuals and the population – the circle in the middle. The system is currently not conducive to providing services in that fashion because it is fragmented.
- The second challenge is institutional change – each of the five partners needs to be organized to serve the centre.
- The third challenge relates to sustainable partnerships.

Adequately addressing these challenges will require that medical schools be open to society. They will have to do three things:

- Listen and hear what is happening in society;
- Work with others – collaborate; and
- Act on the health system.

A medical school has three important functions: education, research, and service. In order to be socially accountable, all of these functions must address four core social values: quality, equity, relevance, and cost-effectiveness.

| Social Values | Functions of a Medical School | | |
|--------------------|-------------------------------|----------|---------|
| | Education | Research | Service |
| Quality | | | |
| Equity | | | |
| Relevance | | | |
| Cost-effectiveness | | | |

Dr. Boelen left participants with the question *“Is social accountability the next frontier?”* He asserted that in the 1950s we spent a great deal of time on process in medical education. Beginning in the 1970s and through to the present, we have had greater concern for relevance – asking ourselves the question *“Is this fitting local needs?”* As we move through the millennium, it is critical to ask the question *“Does what we are doing make a difference?”* – therefore, considering the impact of medical education. Whatever we do, we must consider how it will enrich the individual person, our community, and society at large.

“Canada is considered a world leader—now it has the opportunity to be a leader in social accountability in medical education.”

Boelen C, *Towards unity for health . Challenges and opportunities for partnership in health development*, 84 pages, World Health Organization, Geneva, Switzerland, 2000. Also available on the website of the organization "The Network Towards Unity for Health" www.the-networktufh.org.

Defining and Measuring the Social Accountability of Medical Schools. Division of Development of Human Resources for Health. World Health Organization, Geneva, Switzerland, 1995.

Social Accountability in Biomedical and Health Research

Alan Bernstein

President, Canadian Institutes of Health Research

The research community in Canada has in recent years seen a significant increase in funding and a remarkable experiment in focusing its considerable talents through the Canadian Institutes of Health Research. To a significant measure the CIHR itself, by its very existence, is an expression of our nation's desire to focus and facilitate research of relevance for public priorities. Dr. Alan Bernstein – the inaugural President of the CIHR – is internationally known as a researcher and scientific leader with his pioneering research in the areas of cancer, hematopoiesis and gene therapy. This suits him well to his present pioneering stewardship of the Institutes.

Robert Woollard, Plenary Chair

Dr. Bernstein began his address by articulating that we find ourselves in a unique moment in time – as we begin a new century, there is a revolution in health research. This revolution is characterized by the convergence of mathematics, the physical sciences, social sciences and humanities, together with biological, behavioural and clinical approaches to answer important questions in health and disease. Scientists have mapped the complete sequence of all three billion bases of DNA belonging to the human genome. This phenomenal step will lead towards the understanding a variety of diseases; and the development of novel treatments. *“One day, researchers will be able to understand the molecular bases of life and human biology.”* The revolution is characterized by speed, significant impact, and the need for multidisciplinary approaches. The CIHR's vision is to help position Canada as a world leader in health research and its application, to improve the health of Canadians and people everywhere.

CIHR was launched through an act of parliament in June, 2000. The mandate through this Act was that CIHR be Canada's major federal funding agency for health research. Its objective is to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into:

- improved health for Canadians,
- more effective health services and products, and
- a strengthened Canadian health care system.

The CIHR involves a multidisciplinary approach, organized through thirteen virtual institutes – each one dedicated to a specific area of focus, linking and supporting researchers pursuing common goals. CIHR's Institutes are not centralized bricks and mortar facilities. Instead, these virtual organizations support and link researchers located in universities, hospitals and other research centres across Canada. The institutes embrace four pillars of research – biomedical, clinical science, health systems and services, and the social, cultural and other factors that affect the health of populations.

The CIHR model embraces the concepts of social accountability. The Institutes are constructed to respond to society's needs, and to translate knowledge for the use of society. All of the Institutes' programs are multidisciplinary and bring the community into research involvement. Each Institute has an Advisory Board with voluntary members representing all walks of life. They are health stakeholders, members from the voluntary sector, professional caregivers, philanthropists and lay people. They help to bridge the gap between the scientific and voluntary communities and enable researchers, voluntary health organizations, government and other partners to work together to shape the Canadian research agenda and translate research findings into practice within Canada's health system.

Dr. Bernstein declared that there is not a tension between excellence in research and the social accountability agenda – and in fact, the CIHR is a firm indication of that. *“I don't believe there is a tension between excellence and research and the tremendous opportunity to build on what the public wants us to do. We should not look at either/or, we have social accountability based on excellence – the creation of the CIHR is a manifestation through Parliament of the desire of the people of Canada for just that.”*

The biggest challenge facing the CIHR is to bridge research on practice, policy-making and people's everyday decision-making. This reflects the mandate of not only excelling in new knowledge – but translating it into better health for Canadians. Dr. Bernstein asserted that in responding to this broad mandate, it will be necessary for CIHR to strengthen relationships among health researchers and users of health knowledge, enhance capacity for knowledge uptake, and accelerate the flow of knowledge into beneficial health applications. While new technologies make this more possible – there is a need to set priorities.

One of these priorities is to provide leadership in building capacity within Canada's health research community through the training and development of researchers, and to foster the development and ongoing support of the scientific careers of women and men in health research. To accomplish this, the CIHR is establishing training centres. Together with partners in government, voluntary and private sectors, CIHR encourages multidisciplinary, integrative health research through the training of the next generation of researchers, and to increase the capacity of Canada's health research enterprise to address important research questions in all areas of health research, including biomedical research, clinical research, research respecting health systems, health services, the health of populations, societal and cultural dimensions of health and environmental influences on health.

“I believe that we are in a unique moment in time. There is a revolution going on in health research – driven by fantastic developments in science – driven by multidisciplinary work. There are tremendous opportunities. We need to build a research enterprise that is responsive, based on excellence, allowed to bring multidisciplinary approaches, and engages the Canadian public.”

Social Accountability in Public Health Care Policy

Thomas Ward

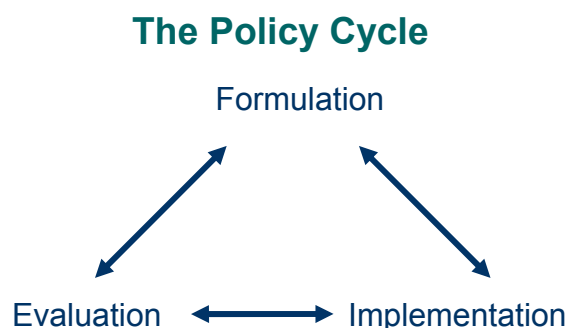
Deputy Minister of Health, Nova Scotia

The social institutions of government, the social institutions of education and research, together with the social institutions representing professionals, all, in their best expressions, have a common purpose – the services of others – be those ‘others’ the citizenry, the learners, the questers after knowledge or the afflicted and most vulnerable members of society. Each of our institutions has unique mandates and responsibilities, but today’s work is predicated on the idea that if we work in partnerships – respecting our differences but acknowledging our common aims – those that support our privileged positions will be better served. It is therefore essential that we seek to better understand the meaning of social accountability in public health care policy. We are fortunate to have Dr. Thomas Ward to address this topic. Dr. Ward has moved between the sometimes solitudes of government, the Academy and clinical practice – being a paediatrician by training, a medical administrator by education, and a policy maker at a time when the health care system is undergoing unprecedented change.

Robert Woollard, Plenary Chair

Dr. Ward began by pointing out that according to the definition of social accountability – “priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public” – governments must be engaged in the process. However, he also asserted that this is a challenge. Since they are the managers of the system, how do we begin to engage governments?

Dr. Ward went on to explore the concepts relating to public policy in relation to social accountability. Public policy covers a wide range of fields. Policies are the instruments of government to accomplish the goals of government or as Thomas Dye defined policy – “they are whatever governments choose to do or not to do”. There is a fundamental shift in public policy in Canada today – we cannot have a conversation about public policy if we are not discussing both economic and social policy. “Part of the conundrum for government is to balance those two piece”.



The policy cycle involves formulation, implementation and evaluation. Over the last few years, the lines between these three components have blurred. However, the common thread across all of them remains the bureaucracy – the bureaucracy greatly influences all three. There are challenges facing the bureaucracy. Times have changed, but the bureaucracy, rather its function, has not. Historically its role has usually been that of “*protector of the status quo*” and master of incremental change. Therefore, there is a problem of policy stasis.

Dr. Ward stressed that this plenary session was looking at a fundamental reassessment in the underlying values of the policies. He voiced the challenge “*How do you engage the bureaucracy in this fundamental reassessment?*” There are a number of problems. There is a rapid turnover in bureaucrats and in politicians. And, there is policy stasis.

Dr. Ward described policy stasis as an issue of social rights stasis – where the belief of a social right reinforces the current structures and makes any significant alteration a difficult task for any government. Medicare provides an example. Forty years since the inception of Medicare it has become an entitlement. The Kirby and Romanow reports are witness to this concept. They supported the continuance of this model. They did not recommend any fundamental review. Dr. Ward asserts that the only reason we have been able to have Medicare is because of our economy. Now, how are we going to make the public and governments comfortable with change? To overcome this stasis will require a new approach – a paradigm shift – the ‘*new universalism*’ described by the WHO.

This paradigm shift will involve moving from a medical model to a population health model that is based on and recognizes the determinants of health. It will involve moving from autocracy to partnership – and it is often difficult for physicians to make this move. It will involve moving to partnerships that are based on shared values and trust between partners. It will involve moving to a model that includes both individual education combined with team education of professionals. It will involve an increasing focus on outcomes. It will involve a new role for Deputy Ministers – one that involves knowledge navigation – moving from data to information to knowledge.

“Social accountability is a system (societal) process. It needs a new approach. It is about conversation, communication and partnership. It is about a shared vision for the future. It is about hope”.

Fundamental to social accountability is working in true partnerships. Dr. Ward reminded participants that there are four basic requirements to real partnerships:

- Exchange of purpose
- The right to say no
- Joint accountability
- Absolute honesty

In a real partnership, abdication is not an option, and no one partner is in charge.

“I share anxiety for the future. We are concerned that we are floundering. But I share the excitement that together there is a better way to approach it. Fundamentally it is the most important thing I can do.”

How Does the Academy Express its Social Accountability?

Facilitator: *Carol Herbert*, Dean, Faculty of Medicine and Dentistry, University of Western Ontario

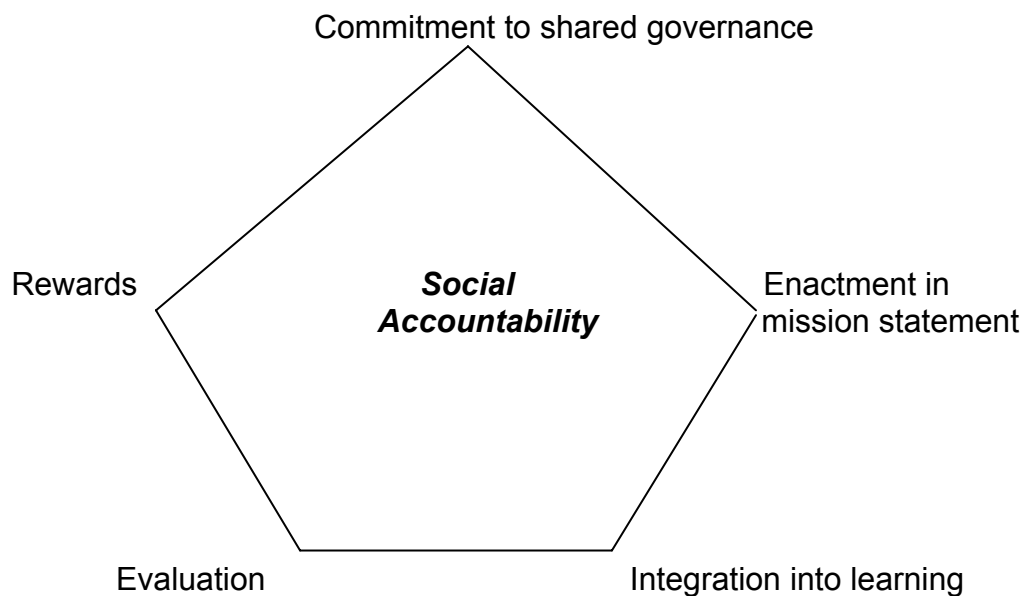
Scribe: *Sarita Verma*, Associate Dean, PGME, Queen's University

Presenters: *Paul Grand'Maison*, Vice-Dean, UGME and Vice-Dean to the Community, Université de Sherbrooke;
Phillip Berger, Associate Professor, University of Toronto

• **Introduction**

This workgroup began by defining the word “express” as “how we delineate, depict or represent in words or deeds the action in terms of the social accountability framework”. They saw expression as “observable actions”.

The workgroup used the pentagram diagram to describe how the Academy expresses its social accountability.



The five points – or pillars – of expression were:

- Commitment to shared governance – with the need to listen and ‘give up’ control.
- Rewards for faculty – promotions and tenure.
- An enactment of social accountability in the mission statement of the Academy.
- Evaluation through accreditation – based on the CanMEDS and the four principles of family medicine.
- Integration into learning – developing specific program-based goals based on social accountability.

Examples:

Two examples were presented by this workgroup.

The Faculty of Medicine at the Université de Sherbrooke explicitly expresses a commitment to social accountability in their motto and their mission statement.

- Motto: A faculty of medicine serving a society in movement.
- Mission: Education, research, clinical service, social commitment.

The faculty has also made administrative changes to embrace social accountability – they have created the position of Vice-Dean to the Community. There are a number of examples as to how the faculty has expressed social accountability:

- Learning is tied to the problems of the community.
- Population and individual health issues are integrated throughout the continuum of the curriculum.
- There is an extended network of health care settings for clinical education.
- The concepts of humanism and professionalism are integrated throughout the continuum of the curriculum.
- There is a commitment towards CanMEDS roles.

The Faculty of Medicine of the University of Toronto has partnered with the St. Michael's Hospital in Toronto to explicitly base service and education on the needs of their community – particularly supporting people who are poor. There are many important components within this partnership. The ethics guide states that preferential options are provided for the poor. The partnership is explicitly stated in many arenas – including the signage on the buildings. All clinical services, training and research are based on the values of equity and social justice – particularly focusing on people who are poor. Taking political action and advocating on behalf of patients is an important and expected duty of the clinical faculty.

Enabling Factors

The group identified a number of factors that will enable the Academy to express social accountability.

- The institutional commitment of the Academy is an essential enabler.
- Learning about and embracing the concepts of the determinants of health.
- People must be rewarded and credited for this work and not denigrated. Teachers must be well recognized, well paid and have access to awards.
- The truest sign of social commitment is a presence. *“Be less centripetal and more centrifugal”*. The Academy must lead by modeling.
- Today's burgeoning technology can enhance communication and access.

Challenges

The group identified a number of challenges facing the Academy when expressing social accountability.

- Faculties of medicine need to recognize the value of learning from and working with communities. They need to recognize the value of working in partnership with public health and community health.

- Addressing the needs of the MOST marginalized members of society is very difficult – especially when they are the least able to advocate for themselves. It is critical to respond to the needs of the community in an equitable fashion for all groups – for example, the elderly, the poor, children, Aboriginal people, and refugees. It is important to remember that speaking on their behalf is not the answer.
- The values of society can pose challenges. *“How do we respond to a society which values specialization, technology, ‘dot.coms’ over ‘feeding’?”*
- The basic values and culture of the Academy pose a challenge. *“How do we affect a paradigm shift within the Academy?”*

Moving Ahead

The group laid out the next steps in order to move forward on expressing social accountability within the Academy.

- Develop a model of shared governance. This is a major task. It will require engaging with those with whom we must partner. It is important to bring in all partners very early in the process – so that the main stakeholders can help define their own needs.
- There must be a visible, expressed commitment – internally and externally. Therefore, social accountability must be expressed in the mission and vision statement of the Academy.
- Rewards must be implemented – e.g., promotion and tenure for disseminated faculty.
- Invite government to participate in the process up front.
- Revise the accreditation standards so as to reflect principles and components of social accountability. These standards should be based on CanMEDS roles (which are based on society’s needs) and the four principles of family medicine. These can be applied to all learners.

How Does the Academy Foster Social Accountability?

- Facilitator:** *Kendall Ho*, Associate Dean and Director, CME, University of British Columbia
- Scribe:** *Jason Kur*, Representative, Canadian Association of Internes and Residents
- Presenters:** *Noni M^{ac}Donald*, Dean, Faculty of Medicine, Dalhousie University; *Irfan Dhalla*, Final Year Medical Student, University of Toronto

Introduction

This workgroup answered the question ‘*How does the Academy foster social accountability?*’ They saw the fundamental components of fostering as ‘*becoming a WE*’. The concept of partnership was central. “*Accountability will not occur without greater public involvement in the accreditation process and more reporting from the faculties to the public.*” In the final analysis, the group concluded that actions speak louder than words. “*Judge a person by what he does, not by what he says*”.

Examples:

Two examples were shared by this workgroup.

The Faculty of Medicine at Dalhousie University worked with the Capital Health Authority to make a difference around health issues with multiple stake holders. One of the results – “*Our Life – A Community Health Status Report*” – examined the needs of the community. Research, teaching and clinical service decisions could then develop out of these identified needs. This process fostered the communication needed to address the community’s issues.

The Affirmative Action Training Program for Aboriginal Students is a provincial partnership between the University of Alberta and the provincial government. The program began in response to a disproportionate number of Aboriginal health care workers. There are 14 students in the program currently – 28 already graduated – 13 currently work in Aboriginal communities. There are three to six positions available for the program – and there have been 30 applications this year alone. It is an affirmative action program – i.e., the average GPA for Aboriginal students is 7.5 versus 8.1 for the rest of the class.

Enabling Factors

A number of enabling factors were identified that were specific to the two examples that could be applied in general when fostering social accountability within the Academy.

- The public and students tend to understand the issues of social accountability more so than do academics and clinicians. This support should be garnered and utilized.
- Valuing social accountability by the leadership of the Academy is essential. Changing the culture requires leadership within the medical school.

- Champions for the implementation of social accountability are crucial. *“In the Alberta program, the key feature is the dedication of an individual who helps run the program”.*
- Financial commitment to the programs is essential.

Challenges

The group identified a number of barriers and challenges to fostering social accountability.

- Faculty members themselves are a challenge. They are often more difficult to convince about the merits of social accountability because of competing influences.
- The admissions procedures to medical schools can be a barrier. The intense competition to get in fosters the wrong attitudes toward social accountability. *“The process is often the opposite of what we are trying to foster”.*
- Tuition increases will de-foster social accountability. Students will be more concerned with paying off debts as opposed to social responsibilities. This is already happening with respect to the changing demographics at the medical student level.
- There is a lack of objective measures about the importance and impact of social accountability within the Academy.
- Involving the public is often a challenge. Usually public representatives on committees are not representative of the public at large – they are often retired politicians, etc.
- Communication can be a challenge – within the Academy, between professionals, and with other stakeholders.

Moving Ahead

This workgroup identified a number of next steps which will be critical in fostering social accountability within the Academy.

- Engage public involvement. Meaningful partnerships must be formed and meaningful dialogue must develop. This will involve active listening; mutual education; and a bias towards action. Multiple approaches to community/public engagement must be utilized. Members of the public should be more involved in selection of medical students and hiring policies.
- Engage in Academy training. This will involve identifying leadership and champions for the issue of social accountability. Interdisciplinary and team approaches must be utilized. Faculty and trainees must be valued in concrete ways. There must be a very visible presence in the community.
- Set standards and measure accountability. Implement systems of continuous quality improvements.
- Bridge the gap between the hidden and formal curriculum within medical schools.
- Integrate social accountability into the formal curriculum at the earliest point.
- Do more to address transparency and objective measurements. This involves laying the foundation at the medical schools and explaining why this is important.
- Develop alternative funding payment plans (AFPs) for physicians – this is one way to address some socially accountable issues.

How Does the Academy Teach its Social Accountability?

Facilitator: *Brian Hennen*, Dean, Faculty of Medicine, University of Manitoba
Scribe: *Carl Whiteside*, Associate Professor, Dept. of Family Practice, University of British Columbia
Presenters: *Jeff Turnbull*, Chairman, Dept. of Medicine, University of Ottawa;
Dave Davis, Associate Dean, Continuing Education, University of Toronto

Introduction

This group addressed the question “*How does the Academy teach its social accountability?*” They first concluded that “*teaching = changing behaviours*”. Therefore, any success in teaching social accountability within medical schools will involve changes in behaviour – on the part of both the learner and the teacher. The group also stressed that it is important to differentiate between good deeds and social accountability – doing “*good*” may not equal social accountability.

Examples:

The group considered four excellent Canadian programs exemplifying the teaching of social accountability.

- Ottawa: Inner City
- Dalhousie: Aboriginal Projects
- Queen’s: Primary, Secondary and Tertiary Services to the North
- Northern Ontario Medical School has a mandate in Social Accountability

Enabling Factors

The group identified a number of issues that have (and will) enable the teaching objectives related to social accountability to move ahead. The Academy will be able to move ahead with this challenge when a number of conditions are in place.

- There is effective collaboration between community, health services and health professional educators.
- There is effective intraprofessional and interprofessional/multiprofessional communication and understanding of the principles of social accountability.
- All faculty leaders and members understand the principles and are supportive of teaching social accountability.
- There is effective faculty development in place to prepare teachers to achieve the goals.
- Social accountability is clearly stated in the mission statement of the Academy and supported by committed deans of medicine and other health profession training program leaders.
- Social accountability is clearly stated in the medical students’ oath.
- Selection policies and processes are focused on identifying high profile students who are likely to incorporate the principles of social accountability into their practices upon graduation.
- Evaluation of students involves assessment of their acquisition of knowledge/skills and attitudes of the principles of social accountability.

- There is academic recognition of those contributing – i.e., there are rewards and compensation for becoming involved in teaching social accountability.
- Funding is available to facilitate this paradigm shift.

Challenges

The group outlined the most critical challenges that need to be overcome.

- First and foremost the ‘talk must match the walk’. It is far too easy to talk about teaching social accountability, to embrace the rhetoric – but not to actually do the hard work of putting words into action.
- Relationships must be developed with many partners – other professional groups, the community, governments, and administrators. And then the partners will need to work together cooperatively in a sustainable fashion.
- There needs to be agreement on the paradigm shift and pedagogic change that reflects this shift.
- Support needs to be garnered across the faculty and with others who are involved in the education of health professionals.
- Work must be done with the community in order for them to identify their priority needs. The Academy needs to listen to communities in an effective way.
- Collaboration must begin between public health and teaching of the principles of population based medicine.
- Selection of leaders for institutions involved in health education should be based on an understanding and commitment to teaching the principles of social accountability.
- The principles of community-based teaching strategies are to be incorporated into models of training (service/learning models).
- All administrative processes must be put in place to support the integration of social accountability into teaching.

Moving Ahead

The group identified what needs to happen next in order to move on the teaching component of social accountability within the Academy.

- Integrate the teaching of social accountability into the mandates and missions of the medical schools.
- Develop and implement principles of leadership selection that identify those committed to this agenda.
- Develop and implement principles for promotion and tenure that reflect the social accountability agenda.
- Develop and implement a selection process that will identify students most likely to implement the principles into their practices upon graduation.
- Implement accreditation expectations that facilitate the movement of health institutions towards social accountability.
- Cultivate mentors – implement faculty development opportunities.
- Foster communication between community, health services and other educators of health professionals and associations.
- Document and share social accountability experiences/initiatives so that medical schools can learn from each other.
- Establish end-point outcome evaluation strategies.

How Does the Academy Measure its Social Accountability?

Facilitator: *David Hawkins*, Executive Director, Association of Canadian Medical Colleges

Scribe: *Jean Parboosingh*, Consultant, Working Group on Social Accountability

Presenters: *Charles Boelen*, International Consultant (health system and personnel); Former coordinator of the World Health Organization Program for Human Resources in Health;
Thomas Ward, Deputy Minister of Health, Nova Scotia

Introduction

David Hawkins opened this workgroup session with an acknowledgement that the mission statements of medical schools reflect the concepts of social accountability but are often not explicit in articulating their commitment. The task of this group was to discuss how do we know when we have achieved our goals.

Charles Boelen gave an example of the differences between a “*titanic*” medical school and one that is socially accountable.

| “Titanic” medical school | Socially accountable medical school |
|---------------------------------|--|
| Disease management focus | Holistic/disease prevention/health promotion focus |
| Specialty-driven | Comprehensive (incl. family medicine) |
| Process oriented | Outcome-oriented |
| Reactive | Proactive |
| Accountable to peers | Accountable to society |

He then reminded the group of the WHO definition of social accountability:

“...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”.

He reflected that the word “obligation” in the definition means that it is not an option and that the transition to social accountability should be self-directed and not imposed.

Dr. Thomas Ward referred the group back to Dr. Boelen’s “*titanic*” model and specifically referred to the Federal/Provincial/Territorial Accord of 2000. One action that came out of the Accord was an agreement on governments reporting to the public. Some have done this in their own jurisdictions, others have reported nationally. The 2003 Accord states that accountability should be based on outcomes of a broad comprehensive approach to health care – more than just process and inputs. The establishment of a Health Council has the potential to lead to national standards or expectations with input from the medical leaders.

Examples:

Many examples were identified by this workgroup. Two were highlighted at the opening session.

The first related to professionalism. The Professionalism project that Drs. Richard and Sylvia Cruess have been spearheading nationally and internationally has generated an enormous amount of activity but outcomes have not yet been measured. The project to date has encompassed the definition of professionalism, how to teach it, how to encourage its adoption and how to evaluate it. It was suggested that knowledge and behaviours can be measured, although change in attitudes are more difficult to measure. Licensing authorities and certifying/recertifying bodies are looking at ways of measuring professionalism. So far, process measures are used, not outcome measures.

A number of examples related to rural health were shared.

- At Université Laval, students are sent to remote areas. The measure of success is the number of graduates working in rural areas.
- The University of Western Ontario has not yet evaluated its rural program for students and residents, but has found that small numbers of physicians are going into rural practice.
- The University of Manitoba has a rural/northern summer experience of 10 weeks duration – 42% of the students have gone into family medicine over the past six years. Also, the Manitoba Centre for Health Policy reviewed the health of the First Nations population and has knowledge of the needs of the Aboriginal population as well as the number of Aboriginal professionals. An access program at the high school level has been established to encourage Aboriginal students into the health professions.

Enabling Factors

The workgroup identified a number of factors that enable the measuring of social accountability.

- Partnerships with health service researchers to develop outcome measures will be useful.
- Linkages to large datasets, such as the census, are possible and can aid in measurement of outcomes.
- Identifying outcome measures can be a tangible way of making links with the community. Surrogate measures can be used in the interim as outcome measures are identified.

Challenges

A number of challenges were identified which make measuring social accountability difficult.

- Rewards for individuals, namely promotion and tenure, are usually achieved through research, teaching and other scholarly activities. Medical schools do not know how to recognize and reward social accountability.
- Outcomes are difficult to measure over the short term. For instance, it is only recently that evidence-based prescribing has become established, but evaluation is necessary to prevent wasting time and money.
- It is difficult to identify evidence-based outcomes.

- Some outcomes are outside the control of the medical schools. For instance, good doctor-patient relationships are related to time factors. Short consultations are a hindrance. Others need to be involved in solving these problems and achieving good outcomes.
- The marketplace does not necessarily facilitate the expression of professionalism. This is more obvious in the U.S. than in Canada.
- We do not understand the reasons for resistance to change.

Moving Ahead

The workgroup identified a number of next steps for moving ahead on measuring social accountability.

- Partnerships
 - There is a need to engage the community. Communication with the community and other professionals is key and should be measured.
 - There is a need for a careful approach to teaching and measuring communication skills.
 - There is a need to have others outside of medicine decide on outcomes measures – this requires reaching out to the community. Therefore, there should be societal rather than peer benchmarking.
- Indicators: moving from process to outcome
 - There is a need to develop outcome measures in addition to process measures.
- Recognition
 - There is a need to develop a system for medical schools to recognize and reward individuals who demonstrate social accountability. This must include scientific rigor, rewards and promotion.
- Organizational change
 - There is a need for organizational change – specifically relating to working conditions.

Concluding Remarks

Robert Woollard

Royal Canadian Legion Professor and Head, Department of Family Medicine,
University of British Columbia

Dr. Woollard commended all – speakers, participants, facilitators and scribes – on their contribution to the day. He urged that the dialogue that exists between the partners must last forever. The understanding of what the partners can bring must be shared indefinitely. The Academy, governments, communities, and health managers must acknowledge that they are responsible for what happens next. *“Most of the most important actions will be carried out by ‘you’ – in the leadership you show, the work that you do.”*

“We do have a privileged existence. We have been given by society a privileged position. We have to do the kinds of things that were talked about here – foster, express, teach, measure. Thank you for what you have all contributed today. However, we all know that good intentions are not enough. We must now move beyond the rhetoric!”