

Social accountability

Nunavut perspective

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A couple of years ago I was invited to attend the College of Family Physicians of Canada's (CFPC's) annual Leaders' Forum. The key focus at this meeting was social accountability.¹ Participants included CFPC board members, College staff, and other invited guests; the meeting room was full of highly motivated and socially engaged people. There were presentations on work in Haiti and in low-income areas in some of our cities; there was a board game designed to encourage cooperation and structured to demonstrate social inequities. The meeting also included discussions about the challenges facing aboriginal people in Canada.

My discussion in this article is part of a commitment to social accountability, which is mandated in medical schools across Canada and has been taken up by all the main medical associations.²⁻⁴ For example, the newest medical school in Canada, the Northern Ontario School of Medicine in Sudbury and Thunder Bay, has a commitment to social accountability included in its charter, and Memorial University of Newfoundland in St John's has always had a mandate to train physicians for the rural, underserved parts of the province.

But what is *social accountability*? The medical literature provides various explanations for this concept.⁵⁻⁷ I think that all explanations of social accountability involve an initiative to bridge the social, psychological, and cultural distance that exists between privileged middle-class physicians and underserved, marginalized populations requiring care.

From the discussions at that CFPC session I attended, it was evident that social accountability is part of a broader initiative in the medical community around the world. Although the conversations at the meeting were lively and passionate, I left feeling that there was something lacking in the discussions and the comfortable middle-class approach to this issue.

Allow me to explain how my perspective on social accountability has been shaped by my work.

Background

For more than 14 years I have lived in Nunavut, where I have worked as a physician, Medical Director, and, currently, Territorial Chief of Staff. Nunavut was created as

a territory in its own right in 1999. The political initiative that led to the creation of Nunavut was the settlement of a land claim between the Inuit of the Eastern Arctic and the Government of Canada. This settlement acknowledged Canada's right to sovereignty over these lands in exchange for money and rights to the land and its use by Inuit, which are spelled out in the agreement.

Nunavut was created as a public government in a mostly Inuit society. For example, I am enfranchised with a vote and can be an elected official, even the Premier in theory. The situation is quite unlike the reserve system in which many First Nations people live.

Nunavut resembles a developing country. It has very high rates of poverty, poor overall educational levels, crowded housing, and a variety of poor health statistics typical of a socioeconomically disadvantaged population. Its political development (its decolonization) has involved taking control of its own destiny, taking a place among the provinces and territories of Canada, and learning how to provide high-quality services and opportunities to its small, widely dispersed, mostly Inuit population. These are services and opportunities that Canadians expect wherever they live in the country.

There are a number of physicians who have come to Nunavut, made it their home, and provided excellent clinical care over the years. They have also, by virtue of their commitment, become part of the community and have contributed to the social and political development of Nunavut.

The medical work in Nunavut is demanding, fascinating, and exceptionally rewarding to a practitioner's professional life. Nonetheless, there are considerable challenges to living and working in a developing, marginalized society, even in our own country.

This work is not for everyone.

I believe that by their actions these physicians embody what it means to be socially accountable. They are accountable to their community: the people of Nunavut. They do not work for a third-party agency, like a southern university, an agency based in a large urban centre, or the federal government. They work for the people of Nunavut, through their agent, the Government of Nunavut.

While many Inuit lack education and the experience to be professional managers, many others have that education and expertise. For example, as Chief of Staff, my immediate supervisor, the Deputy Minister of Health, is *qallunak* (a non Inuk), but her boss, the Minister of

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Health, is an Inuk. Her boss, the Premier, is an Inuk. His “boss,” the Commissioner (analogous to a Lieutenant Governor), is an Inuk, and her “boss” is the Queen.

So these physicians who have moved “from the south” are deeply embedded in an Inuit-run system.

The physicians I put forward as examples of social accountability are not martyrs or missionaries. They are not new graduates on an adventure. They are normal people living busy lives in a normal fashion.

The point is, they embody social accountability by their very actions of living and working in a marginalized socioeconomically challenged society, by making their home here, by taking life partners here, by accepting their status as a minority group in a culturally different society. This is social accountability in action.

What the Nunavut experience teaches

So what does the Nunavut experience teach us about social accountability? When I reflect on the conversations that I have had about this important issue, as well as the concept of bridging the psychological distance among practising physicians, I think that Nunavut shows us that social accountability needs commitment, cultural humility, and partnerships.

Commitment. Physicians who live and work in Nunavut demonstrate real commitment to the community and the people. They are not part of an “expat” community living apart from the people they are serving. They are fully integrated into the community and their fortunes rise and fall with those of the community at large. They do not “bail out” when the going gets tough.

I think that acting in a socially accountable fashion requires a considerable commitment to the community and integration into the social and bureaucratic communities.

At a workshop on global health that I attended a couple of years ago, the presenter spoke proudly about sending junior physicians to underdeveloped countries for a few months at a time to provide service. One country’s organizers, however, announced to the program director in Canada that they did not want short-term inexperienced physicians and would rather take only long-term experienced physicians.

I fully agree with the host country’s organizers’ request for experienced physicians making a long-term commitment.

Apparently, the program director tried to get senior faculty members to provide this service but there were no takers. If senior staff members in such a global health program are unwilling to accept this type of challenge, then I suggest that they and their program directors reexamine their commitment to social accountability, which is an important factor in the global health agenda.

I contend that underserved populations can no longer be treated as “fodder” for inexperienced practitioners. Those populations, like the Nunavummiut, want and deserve continuity in care from experienced, committed physicians.

Cultural humility. For me, cultural humility entails not only the willingness to be respectful of another culture but also the willingness to submit to the mores and leadership of the host culture. I suppose that what I term *humility* is very similar to what is termed *cultural competence* in academic discussions of cross-cultural issues. However, I think that rather than having a set of skills (ie, competence), having the appropriate attitude toward one’s patients and colleagues is a more fundamental trait. If we approach this task with an attitude of humility and respect, we can acquire the knowledge about our patients and the skills necessary to navigate our way successfully. The physicians working in Nunavut model cultural humility because they are fully integrated into the Inuit-dominated health system.


Partnerships of equals. When sitting in a meeting room in Toronto, Ont, talking about marginalized and needy people, it is difficult to avoid falling into what I see as a vicious paradox of (often unconscious) cultural superiority that distances us from the people we wish to serve. Then we attempt to bridge this “distance” by way of an overwhelming sense of guilt about our own favourable economic status and comfortable lives versus the endless challenges facing marginalized and poor populations in our own country and around the world. Instilling guilt in someone or some social group can be an effective consciousness-raising strategy, but it is not a sound basis for a healthy and productive working relationship. When our response to another group’s situation is to tell the group members how to fix their problems or for us to feel so guilty that we cannot respond to them as equals then we cannot bridge this “distance” in a genuine, respectful fashion.

When social accountability is framed in these terms I think it is doomed to fail. On the other hand, partnerships of equals can be very effective because they take us beyond the “superiority-guilt” dichotomy and move us onto another plane of social transactions.

For example, in Nunavut we are short of skilled practitioners and administrators. However, we understand our health challenges and have ideas on how to address them. We need (and have) out-of-territory academic and health system partners to provide us with the expertise to address our priorities. The partners involved are invited by us on our terms to assist in what we identify as our needs. I see these partnerships as a model for outside agencies providing assistance anywhere in the world.

Conclusion

So where does this leave us? I think that social accountability is a by-product of commitment, integration, humility, and a respectful egalitarian approach to our patients and service partners. There are real limits on how much can be done from the boardroom in Toronto, as long as we are comfortably ensconced in our lives and jobs in the privileged areas of our country.

I invite all my colleagues to work together to advance the social accountability mandate and to bridge both the geographic and psychological distances between the boardroom in Toronto and the practice in Nunavut in a meaningful, effective, and practical fashion. 

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Competing interests

None declared

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References

1. College of Family Physicians of Canada [website]. *CFPC board meeting highlights. May 30–June 1, 2014*. Mississauga, ON: College of Family Physicians of Canada; 2014. Available from: www.cfpc.ca/uploadedFiles/Publications/News_Releases/News_Items/oldNews/Information%20Release%20re%20Board%20Meeting%20Highlights%20June%202014.pdf. Accessed 2016 Mar 23.
2. Health Canada. *Social accountability. A vision for Canadian medical schools*. Ottawa, ON: Health Canada; 2001. Available from: www.afmc.ca/pdf/sa_vision_canadian_medical_schools_en.pdf. Accessed 2016 Mar 24.
3. *Global Consensus for Social Accountability of Medical Schools* [website]. San Francisco, CA: WordPress; 2010. Available from: healthsocialaccountability.org. Accessed 2016 Mar 24.
4. Strasser RP, Lanphear JH, McCready WG, Topps MH, Hunt DD, Matte MC. Canada's new medical school: the Northern Ontario School of Medicine: social accountability through distributed community engaged learning. *Acad Med* 2009;84(10):1459-64.
5. Rourke J. Social accountability in theory and practice. *Ann Fam Med* 2006;4(Suppl 1):S45-8.
6. Meili R, Buchman S. Social accountability: at the heart of family medicine. *Can Fam Physician* 2013;59:335-6 (Eng), 344-5 (Fr).
7. Meili R, Ganem-Cuenca A, Leung JW, Zaleschuk D. The CARE Model of social accountability: promoting cultural change. *Acad Med* 2011;86(9):1114-9.

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