The CARE Model of Social Accountability: Promoting Cultural Change

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Abstract

On the 10th anniversary of Health Canada and the Association of Faculties of Medicine of Canada's publication in 2001 of *Social Accountability: A Vision for Canadian Medical Schools*, the authors review the progress at one Canadian medical school, the College of Medicine at the University of Saskatchewan, in developing a culture of social accountability. They review the changes that have made the medical school more socially accountable and the steps taken to make those changes possible. In response to calls for socially accountable medical schools, the College of Medicine created a Social Accountability Committee to oversee the integration of these principles into the college. The committee developed the CARE model (Clinical activity, Advocacy, Research, Education and training) as a guiding tool for social accountability initiatives toward priority health concerns and as a means of evaluation. Diverse faculty and student committees have emerged as a result and have had far-reaching impacts on the college and communities: from changes in curricula and admissions to community programming and international educational experiences. Although a systematic assessment of the CARE model is needed, early evidence shows that the most significant effects can be found in the cultural shift in the college, most notably among students. The CARE model may serve as an important example for other educational institutions in the development of health practitioners and research that is responsive to the needs of their communities.

Social accountability is a concept that arose as a reaction to gradual changes in medical education that emphasized specialization and technical competency while doing little to improve the overall health of populations.[1] These changes may have improved medical education, but they also contributed to a human resources crisis in the health care sector, as manifested in inequitably distributed health professionals (to the disadvantage of rural and poor areas), a persistent shortage of primary care staff, and an inability of the health sector, the social sector, and policy makers to jointly address multiple dimensions of health.[2,3] Priorities, however, have evolved, as demonstrated by the World Health Organization's (WHO's) call for Health for All[3,4] and an end to growing health disparities. Societies want to ensure that investments in the health care sector improve the community's health,[3,5] and medical schools are key actors in advancing this change.[3]

In 1995, the WHO formally defined social accountability as it relates to medical schools, outlining the obligation of educational institutions to serve the health of their surrounding communities and calling on them to collaborate with governments, health care organizations, and the public in identifying, prioritizing, and responding to health issues.[3] A sustainable and responsive model for delivering health services, according to the WHO, requires the active participation of five principal partners: policy makers, health managers, health professionals, academic institutions, and communities.[6]

Social Accountability in Canada

Health Canada and the Association of Faculties of Medicine of Canada (AFMC) have since adopted the principle of social accountability. Their 2001 report, *Social Accountability: A Vision for Canadian Medical Schools*, states that the "primary goal of medical education is to prepare graduates to practice effectively in reducing the burden of illness and improving the health of their communities."[7] The specific recommendations of the report include addressing the needs of diverse individuals and communities in Canada and globally, integrating competencies in prevention and the social determinants of health in medical curricula, and providing students with firsthand experience in community settings and among distinct populations to broaden the learning context.[6] The principles of social accountability are not limited to Canada's borders; the concepts of partnership, collaboration, and equity direct Canada's role in improving health globally as well. An examination of medical education by the AFMC in 2007 identified key issues that continue to require attention in order to enhance social accountability: the health needs of rural communities, the paucity of Aboriginal students in medicine, and the increasing burden of chronic diseases, among others.[8]

A debate exists among Canadian medical school leaders over the best approach for meeting the goals set forth by the AFMC, with some calling for the creation of dedicated committees, and others

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recommending that an emphasis on social accountability be integrated into the curriculum across all departments. Those who advocate for the integrative approach argue that it would validate social accountability as a necessary aspect of the entire medical profession; relegating the responsibility for ensuring social accountability to a specialized committee could marginalize it as something done "elsewhere, by others." Those on the other side of the debate, while recognizing that integration into all departments is the optimal goal, believe that change requires "sustained, multifaceted interventions over time"[1] and that dedicated committees are needed to guide the implementation and ensure the sustainability of social accountability.

Social Accountability at the University of Saskatchewan

The College of Medicine at the University of Saskatchewan decided that in its local context a dedicated committee was necessary, and so, in 2004, the dean established the Social Accountability Committee, charging it with incorporating social accountability into all of the educational, research, and service activities of the college. This work was to take the form of engagement, communication, and advocacy related to social accountability, support for specific curricular and extracurricular projects, and the development of community partnerships to identify and address unmet health needs. The volunteer membership of the committee included faculty from various departments, members of the educational administration, students, community representatives, and practicing physicians. The dean was the original chair, followed by a faculty member from the Department of Academic Family Medicine. Membership was loosely defined to encourage maximum participation and thus varied from meeting to meeting, growing as the initiative developed. Interest grew within the College of Medicine, resulting in projects and subcommittees working to address health disparities in the city of Saskatoon, its surrounding communities, and around the world. Emerging areas of interest included Aboriginal health, primary health care in urban and rural underserved areas, gender equity, immigrant health, global health, and eco-health, with the promotion of greater health equity as an overarching goal.

The quarterly committee meetings evolved over time, reflecting changes in the initiative. In the original phase, meetings focused on establishing the initiative and assessing existing social accountability activities within the College of Medicine. As subcommittees were formed and projects begun, the meetings shifted to focus on reports of the emerging activities. When interest in purely report-based meetings waned, guest speakers were brought in to supplement logistical discussions with background discussions on key topics. The current format combines presentations and reports on existing and new activities, and opportunities for the committee members to network and solve problems.

As interests expanded and activities diversified, the initiative grew beyond the capacity of a volunteer committee. A full-time social accountability coordinator, hired in 2007, reports to the committee chair and supports existing initiatives and development of new activities. That same year, the role of the chair was restructured as a quarter-time faculty position with the primary responsibility of leading the committee. The committee undertook strategic planning to set goals for further developing a culture of social accountability at the College of Medicine. Social accountability was referenced prominently throughout the College of Medicine's Integrated Plan for 2008 to 2012.[9] In 2009, the Social Accountability Committee was formalized as a standing committee of the College of Medicine's faculty council, which meant that the council had to formally approve the committee's members and chair. In 2010, the council approved the establishment of a Division of Social Accountability, to be hosted by the Department of Community Health and Epidemiology. Changing the initiative from an "at-pleasure" satellite of the current administration to a more permanent institutional component not only increased its capacity in terms of clerical support and office space but further legitimized the effort to give social accountability a central role in the college. A strategic planning workshop in early 2011 has set future directions for the division and the committee, which will remain the body that directs the college's social accountability activities. These future directions include enhanced initiatives related to Aboriginal health and a greater emphasis on evaluation and research as a means to better understand the impact of the initiative and advance scholarship in the field of social accountability.

The CARE model

One of the committee's early steps was meeting with departments throughout the College of Medicine to identify and understand existing activities that could be described as socially accountable. Shortly after the committee chair became a paid position, the new chair met individually with department heads and also presented interactive "grand rounds" sessions to each department to further explore understandings of social accountability and the current activities in the area. From these discussions, the chair and committee identified four key areas of activity within a medical school: *Clinical activity*, *Advocacy*, *Research*, and *Education and training* (giving the acronym CARE). Socially accountable *clinical activity* addresses priority problems and responds to changing community needs, including overcoming barriers to access. Socially accountable *advocacy* includes speaking out on behalf of underserved populations or neglected conditions and working with partners and policy makers to translate a vision of a patient-centered health care system. Socially accountable *research* is curiosity based, is conducted in response to real needs, and leads to evidence-based practice and quality care. Socially accountable *education and training* models and teaches professionalism and community-responsiveness, provides opportunities for service–learning, and incorporates social accountability into practical training and continuing education throughout the life of a physician's practice.

Beyond clever wordplay, CARE is a useful tool for identifying the priority health concerns of local, regional, national, and international communities, while making health systems more responsive and socially accountable. The Social Accountability Committee works through subcommittees that focus on key issues relevant to the communities served by the College of Medicine (Figure 1). The subcommittees use the CARE model as a guide to assess how their work

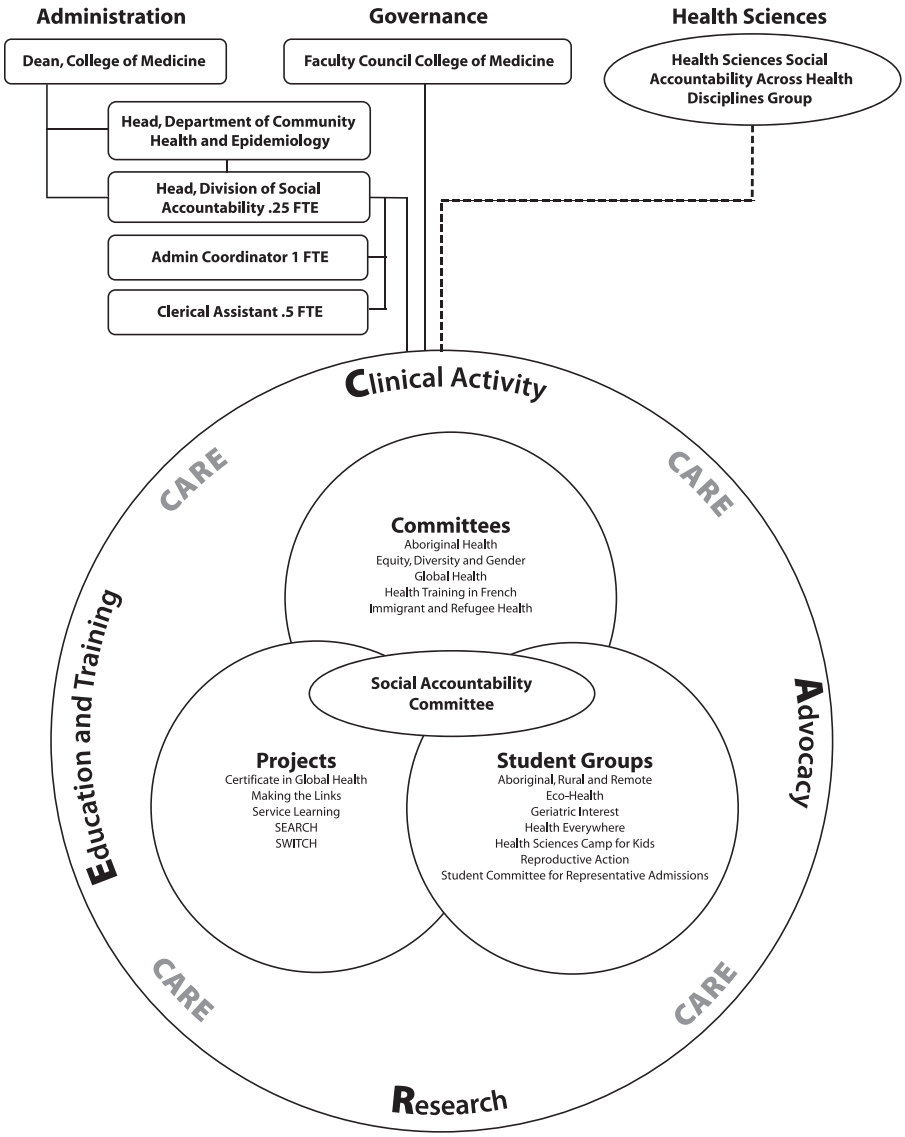

Figure 1 This organogram describes the relationship of the Social Accountability Committee to its partner committees, projects, and student groups at the College of Medicine at the University of Saskatchewan. The Division of Social Accountability offers practical support to each of these activities. The figure also describes the staffing of the division and the reporting relationships of that staff, as well as the reporting relationship of the committee to the faculty council. The dotted line represents a developing structure for interprofessional collaboration in social accountability at the level of the Council of Health Sciences Deans. SEARCH indicates Student Energy in Action for Regina Community Health; SWITCH, Student Wellness Initiative Toward Community Health.

addresses each of the four categories of activity. After a subcommittee has scanned its area of interest for social accountability activities, both curricular and extracurricular, it designs projects to address gaps. These projects might include new course content, an independent speaker series, a service–learning program for students, sending faculty and students to relevant conferences, or initiating collaborative work to introduce a new clinical service. These activities are then reported back to the larger committee, which again applies the CARE model to evaluate the initiative's success and guide future activities. The four areas of the CARE model serve as a guide for the subcommittees and departments and allow for an assessment, albeit imperfect, of whether social accountability is truly being integrated into all of the college's activities. For example, if the Immigrant and Refugee Health Subcommittee had an education project with elements of advocacy, the Social Accountability Committee might suggest ways of expanding into areas of clinical activity and research that build on existing connections. Table 1 presents a list of the goals and activities of various subcommittees within the Social Accountability Committee.

Special projects: SWITCH and Making the Links

In addition to the Social Accountability Committee and its subcommittees, social accountability finds expression through unique projects. The Student Wellness Initiative Toward Community Health (SWITCH)[10] and Student Energy in Action for Regina Community Health (SEARCH) are student-run interdisciplinary clinics serving inner-city neighborhoods in Saskatoon and Regina, respectively. These clinical experiences are open to all medical students, who work alongside students from nursing, pharmacy, nutrition, social work, physical therapy, kinesiology, clinical psychology, and other disciplines. The students offer, under appropriate supervision, after-hours clinical services and health programming to underserved communities. In Making the Links,[11] a multisite longitudinal service–learning experience, 10 medical students (approximately 10% of the student body) are selected to spend the summer after their first year of study in northern Saskatchewan (in the communities of Ile a-la-Crosse or Pinehouse, or on reserve at Buffalo River Dene Nation). Those students then work at SWITCH during the school year and spend six weeks of the following summer in rural Mozambique. Between these three experiences, the students participate in all aspects of the CARE model: clinical care at SWITCH and the Massinga Rural Hospital (Mozambique), advocacy in community development projects in northern Saskatchewan and Mozambique, participatory research in malaria and HIV in the rural community of Tevele (Mozambique), and community service–learning supplemented by theoretical education in global health. Through these CARE experiences, the students understand the commonalities and differences in three diverse, low-resource settings: remote Aboriginal communities, inner-city neighborhoods, and rural Sub-Saharan Africa. Above all, students gain experiential understanding of the crucial importance of the social determinants of health. These experiences provide a fundamental

Table 1

Goals and Activities of Subcommittees of the Social Accountability Committee at the University of Saskatchewan College of Medicine, 2011

Subcommittee	Goals	Activities
Aboriginal Health Committee	• To strengthen culturally based linkages between indigenous world views and the medical community • To create and develop knowledge and skills specific to the discipline of Aboriginal health and healing	• Recruit and retain Aboriginal students and faculty • Develop a modular curriculum in Aboriginal health and healing • Run the Aboriginal Student Mentorship Program for Aboriginal students interested in medicine • Support the student-led Aboriginal, Rural and Remote Health Group
Equity, Diversity, and Gender Group	• To advocate, support, and promote equity and diversity within the College of Medicine • To support and encourage an awareness of equity, diversity, and gender in curriculum, research, and service undertakings • To serve as a resource and help answer questions and concerns of faculty, students, and staff at the College of Medicine	• Assess current undergraduate and postgraduate curriculum to further enhance diversity in the curriculum • Develop initiatives that support international medical graduates • Support the student-led Reproductive Action Group • Establish a mentoring program for women in academic medicine
Global Health Committee	• To oversee the College of Medicine's global health initiatives, which are guided by the social transformation model[9] • To advance the college's efforts in global health education, research, and development	• Provide travel awards to medical students, faculty, residents, and graduate students for research and/or learning experiences in developing countries • Coordinate predeparture orientation and debriefing sessions for students participating in international study/service learning/research experiences • Plan the annual Global Health Speaker Series • Support the student-led group, Health Everywhere
Health Training in French/Formation Santé en Français	• To provide students, residents, and current practitioners the skills and connections to provide health services in French, an official Canadian language • To improve the quality of health services offered to the Francophone population of Saskatchewan	• Offer workshops in medical terminology and networking sessions among students and professionals in medicine and other health sciences • Work in collaboration with French-speaking community agencies to better serve immigrant health
Immigrant and Refugee Health Committee	• To define the College of Medicine's role in immigrant and refugee health within the greater community and to explore and address immigrant health from a socially accountable perspective	• Expand immigrant health content in curriculum • Run a community service-learning project that matches medical students with immigrant families • Support medical student participation in obtaining learning opportunities in immigrant and refugee health

element of social accountability: the "powerful opportunity for mutual change … in the learner, his or her teachers and the community themselves."[1]

Deepening interest in fostering a culture of social accountability

The existence of these projects and subcommittees suggests, at the very least, a deepening awareness of and interest in social accountability at the College of Medicine in Saskatchewan. The projects involve numerous faculty, staff, and students (SWITCH, in particular, is attended by over 50% of medical students). Evidence of this cultural change can be found among the students who, over the past 10 years, have not only participated in but have also been frequent innovators of social accountability activities. SWITCH and Making the Links arose from student initiatives, and students have long clamored for more service–learning experiences and for meaningful interaction and education regarding health issues of the underserved.

In the last two years, interest from students in social accountability has continued to flourish. Existing groups like Health Everywhere, a global health advocacy group, SWITCH, and SEARCH continue to grow in membership and activity. Multiple new groups have arisen: (1) the Reproductive Action Group educates students and communities on sexual health, (2) the Geriatric Interest Group focuses on underaddressed issues in care of the elderly, (3) the Aboriginal, Rural, and Remote Health Group both hosts speakers and carries out community tours to deepen student understanding of health in Aboriginal and rural communities, (4) the Political Action Committee trains students in lobbying government for health advocacy, (5) Community Health for Community Change focuses on promoting the principles of community health and bridging the University of Saskatchewan and its surrounding community, (6) the Student Committee for Representative Admission seeks to ensure that students from underrepresented groups are welcomed into the College of Medicine through proper preparation and admissions policies, (7) the Global Health Research Interest Group is a cross-campus research and advocacy group for equity in marginalized populations globally, and (8) the Health Science Camps for Kids teaches

elementary and junior high school students in urban and remote communities about careers in the health sciences.

The plethora of initiatives demonstrates the diversity of areas, interests, and multidisciplinary collaboration that social accountability encompasses. The recent expansion of these groups reflects a culture of "civic professionalism" among medical students, where their scope of medicine has broadened beyond the individual obligation to the patient to the collective obligation to local and global communities.[7] Students in medicine and a wide array of health disciplines have been the leaders of this culture shift at the University of Saskatchewan. Students informally interviewed about the proliferation of student activity suggested that revised admissions processes and grading policies that emphasize life experience and communication skills have changed the makeup of the student body. They also referred to a perception that advocating for social accountability has become not only acceptable but expected. The level of energy, enthusiasm, and passion in undertaking social accountability initiatives embodies the need to "remind ourselves that medical education is fun—and we should avoid taking ourselves overly seriously if we want to effect practical change."[1] Former Making the Links participant Dr. Breanna Davis adds:

> Reflecting on my educational experience at the College of Medicine, Making the Links was by far the most influential, challenging and rewarding experience of medical school. The importance of serving the underserved, community engagement and development, and service–learning, reinforced by the [Making the Links] program, guided me into a rural family medicine residency and on to a practice in Northern Saskatchewan with a continued interest in global health. It is important to me to stay interested, engaged and excited in this career and I am so grateful to have observed successful teachers, with such strong community ties, who exemplify the rewards of social accountability in practice.

Accounting for social accountability

Although the CARE model serves to assess ongoing activities, a more comprehensive assessment is needed to formally evaluate where and to what extent cultural change is occurring. The extensive literature on cultural change in organizations (for a comprehensive review, see Jung et al[12]) provides a range of potential tools in the form of quantitative instruments and qualitative methodologies, and recent initiatives to measure and evaluate cultural change in universities[13,14] are important resources. Empirical evaluations of cultural shift could determine the effectiveness of the Social Accountability Committee and the CARE model on the development of a culture of social accountability at this medical school.

It would also be useful to compare our experiences with those of an institution that took a different approach to integrating social accountability into its activities. An assessment of the culture at our institution led to the choice of a dedicated committee approach. And although the existence of a hub for social accountability activity, complete with support staff, has certainly led to success in some areas, some departments do not engage with the committee in any meaningful fashion. Whether the supportive structures established by the committees represent barriers to some members of the college community or result in a perception that social accountability is something to be taken care of by others are important questions that we have not yet formally explored. Certainly, frequent communication and open avenues for dialogue with the Division of Social Accountability will be key to mitigating any potential isolation.

Overall, however, the concentrated approach and the CARE model seem to have served the College of Medicine at the University of Saskatchewan quite well. Many faculty members and the great majority of students are involved in some aspect of the official social accountability activities, while the continued support from the administration has kept the committees and their activities visible and valued. The CARE model was featured in a plenary session on social accountability at the May 2011 Canadian Conference on Medical Education in Toronto, giving us the opportunity to engage more formally with other faculties of medicine in comparing approaches to social accountability and in advancing the vision outlined in *Social Accountability: A Vision for Canadian Medical Schools*.[7]

Developing a Culture of Social Accountability

The experience at the College of Medicine at the University of Saskatchewan presents one model for promoting a culture of social accountability. The CARE model offers a new way to envision the work of a medical school and, if further developed, to evaluate success in developing a health system based on people's needs. The combination of the two offers an excellent starting point for other faculties interested in furthering the social accountability of their institutions and the profession as a whole.

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Teaching and Learning Moments

Learning to Be Helpful

"What can I do to help?" As a medical student new to the wards, I have often struggled for ways to be more than an enthusiastic bystander. If life in the hospital were adapted for the theater, I would surely be typecast as "Eager Short White Coat"—energetic and easily occupied, yet, in the context of the classic "see one, do one, teach one" triptych, perpetually stuck at seeing. Opportunities to be helpful, however, sometimes emerge unexpectedly. The last day of my anesthesiology rotation, I followed my team to the labor and delivery operating rooms, where we found Mrs. Z., a 28-year-old woman whose slender figure was barely discernible under her gown.

"G1P0 here by herself, you know the drill," announced the anesthesiologist, and the resident hurried into action. I dashed out of his way around the table and discovered that the patient looked rather like me, ethnically speaking, which was rare at this hospital. I introduced myself and extended my right hand; she winced as a cold cleansing sponge was applied to her back.

"You're going to feel some pressure," the resident said. Mrs. Z. remained motionless.

"She doesn't really speak English," a nurse hollered across the operating room.

Retreating to the other side, I tried to focus on the spinal needle and the resident's meticulous technique, but I was distracted by our patient's soft cries and the loneliness reflected in her eyes; perhaps it was the other way around. As the catheter was threaded, my attending turned to face me.

"Any questions?"

Medical students live for this moment—the chance to ask one startlingly excellent question that can at once challenge and impress. I usually pause during such moments to craft the perfect inquiry, but this time, there was no hesitation.

"Just one for the patient," I replied, circling back to Mrs. Z. and again offering my hand, this time palm up. "*Nin shuo guoyu ma*?" Do you speak Mandarin?

Awaiting a response, I suddenly panicked, fearing I had insulted my attending or assumed too much about my patient. But Mrs. Z. smiled in surprise, and then she exhaled, fast and freely, her breath carrying away the heavy burden of unfamiliarity and isolation. As the sterile drapes were unfurled over her, she shared with me her anxiety that this C-section would prove she was unfit, physically and spiritually, to be a mother. Grasping her hand reassuringly, I realized how I, too, had been plagued by a gnawing uncertainty about belonging on the wards, and how Mrs. Z. and I had found common ground, first through language, and then by the respective new roles in our lives.

Mrs. Z. delivered a healthy baby girl, whom I had the privilege to hold as the anesthesiologist put an encouraging hand on my shoulder. "That was the best thing you could have done today," he told me, "because you helped her do her job so that we could do ours." Being helpful, I thought as I lay the baby in her mother's arms for the first time, is not always about finishing prerounds before the morning meeting or having an extra pair of gloves in my pocket. Rather, it is a thoughtful recognition of the kind of clinical care my colleagues would want to give and my patients to receive, and an honest awareness of my own instincts and abilities that I am, on occasion, uniquely able to employ in order to support both. With time, I know I will get to perform bedside procedures and manage complex illnesses; but, for now, while still an eager short white coat, I am learning to measure helpfulness not merely by what I can do for others but by what I can give of myself.

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