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# Social Accountability as a Framework for The Moral Obligations of a Health Institution

**Dr. Alex Anawati**
**B.Sc., MD., CCFP-EM**
**ER Physician HSN & WNGH**
**Assistant Professor NOSM**
**Global Health Coordinator NOSM**
**Board of Directors NOSM**
**CCFP Social Accountability Working Group**

## Social Accountability as a Framework for The Moral Obligations of a Health Institution - Summary Page for Health Sciences North's Strategic Plan 2019-2024 Steering Committee

There is a call from within Canada and internationally for the principles of social accountability, social justice and health equity to transfer beyond academic schools and into health institutions like Health Sciences North (HSN). Medical schools graduate class after class of physicians trained and grounded in the principles of social accountability - it is only a matter of time that the health workforce will call on health institutions, like HSN, to implement social accountability as a foundational pillar. As a graduate from NOSM's charter class I am asking HSN to commit to the principles of social accountability in medical education, as laid out by the World Health Organization, and transfer those principles to help direct our health institution to truly honor its contract with society.

The WHO defines social accountability as "the obligation to direct education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. Priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public." Priority health concerns are further articulated in terms of relevance, quality, equity and cost effectiveness. The stakeholders that must be committed to this process are - health institutions, health professionals, policy makers, academic institutions and communities -communities must be give an equal seat at the table (Boelen & Heck, 1995; Boelen, 2000).

***Relevance*** refers to "the degree to which the most important health problems are tackled first" and "to direct efforts to people and groups in greatest need." ***Quality*** is the use of "evidence-based…comprehensive health care to individuals and populations, taking into account their social and cultural expectations." ***Cost effectiveness*** is having "the greatest impact on the health of a society while making the best use of its resources" - prevention rather than expensive diagnosis and treatment. ***Equity*** dictates that "getting the best health services cannot be the privilege of a few, but the right of everyone…[with] the goal to reduce any form of discrimination based on race, sex, religion, ethnic group, socioeconomic status or age…[and that] we should be prepared to mobilize in solidarity to help all those at risk of losing their social rights, including the right to health." ***Equity is the cornerstone of social accountability.*** (Boelen & Heck, 1995; Boelen, 2000).

I am asking the following:

1. **Ascribe to social accountability.** Declare a commitment to and an understanding of the principles of social accountability and health equity. Create a social accountability mandate. Translate social accountability knowledge into practice for all staff and the organization.

2. **True, meaningful and empowered community engagement.** Equitable inclusion of all community members and populations. Remove the barriers that exclude participation from marginalized groups – with a special focus on those who suffer most. Re-balance the distribution of power into the hands of the community.

3. **Synergistic partnerships built on social accountability.** Advocate for all partners to ascribe to the principles of social accountability. Utilize the WHO's partnership pentagram as a guide.

4. **Constant evaluation and evolution of the organization's social accountability.** Create clear and specific indicators or metrics, tied to social accountability, that can be evaluated to demonstrate the impact on priority health concerns and the health outcomes of our people. Create meaningful feedback loops that allow the community to hold the institution accountable.

**When I look out into the world, I can't help but see something wrong.**

With all our knowledge, our science, our technology and our wealth … we still can't find the solution to people's suffering. But, it's not for a lack of resources, more a reflection of a lack of human will. Now, imagine if that was not the case. Imagine a world where we, together, believed in something more. Where we forgot our differences and focused on something else. Imagine if we realized we are united in our humanity; driven to reduce inequity. If only we believed in the true idea of compassion and community. Imagine the possibilities from the positivity that acknowledges our inescapable network of mutuality tied to our single garment of destiny.

**When I step out into the world, I go to work in the ED. I witness repeated assaults on our humanity that keep me up at night.**

Indigenous patients tell me stories … "it took everything for me to walk through the door and ask for help." As an MD, and a person, I try to understand that fear. I understand it to a degree because I've taken the time to learn and imagine how colonialism, residential schools and how my own ethnocentrism work against trust with Indigenous patients. "I'm sorry, but your son did not survive that car accident." Far too often, I pick up the pieces of preventable tragedies. The aftermath of that car accident was caused by a drunk driver. I know that alcohol consumption rates in Sudbury and Northeastern Ontario are very high (Sudbury & District Health Unit, 2018); and I wonder, if we reduced those rates - how many lives we would save without assembling a trauma team. I'm also tired of discharging patients from the ED, that I know live on the streets, without the means to elevate themselves out of poverty. I know that I will see these patients again and again and again as low socioeconomic status is the #1 indicator for use of the ED (Ohle et al., 2017). Now, the Sudbury and District Health Unit have a poverty reduction initiative, but there is no coordination with the front line where I work - where the effects of poverty walk right in through the front door. Once, I saw forty patients over two-night shifts. Sixteen of them in the throes of opioid addiction. Three of them just kids under the age of sixteen. The youngest being thirteen – all three from the same youth shelter - using intravenous drugs and sharing needles. Those three kids, will battle addictions their whole lives. There is a good chance I will watch them die in their 20's, through their repeated visits to the ED, from the complications of their drug use that we let them start in their teens. What's so sad about that is that I know Sudbury's student led clinic 'RAZ' identified homeless, women and youth shelters as lacking health care services through a community health needs assessment (Mavin, 2007). I also know that these students want to deliver health services to these people but cannot find an MD to supervise them. Who is going to solve that problem?

I am kept up at night because there are obvious solutions to these problems, but there lacks the vision and there is a critical lack of human will to act. When you think about our lack of human will to change, keep in mind, that the way we treat the most vulnerable people of society, is a reflection of society itself – it is a reflection of who we are.

I wish I could bring you with me when I step out into the world. I wish you could see what our community is really like. I wish you could see the relevance of our priority health concerns as they sit down in front of us over and over and over and over again. And, when we are done - I wish you could explain to me why we lack that human will to change.

**I realize that my place in the world reflects one of many, different and equally valid worldviews and we stand to gain from a deeper understanding of the worldviews we are unfamiliar with.**

We all exercise moral judgment. We all decide where we draw our line in the sand and we all decide on which side of that line we choose to stand on. We decide with our words or our silence. We decide with our actions or inactions; and we can decide with our apathy. Whatever means of expression we choose, we all define, in explicit terms – where our moral judgment stands. From that moral judgment we build ideas, we build values, we build principles, we build our lives and we affect other people's lives. Now consider this: what if your moral judgment was blind to the realities, for example, of people from different cultures or different socioeconomic classes or even just different walks of life?

**As a steering committee, you cannot argue against Health Sciences North's social obligations.**

By now, I hope I've managed to capture your interest. Maybe I've pushed you too far and you're defensive because you disagree with what I've said. If that's true, I invite you to come and see it first hand with me in the ED. In such a diverse environment as Health Sciences North (HSN), the morality of everything we do as a health institution needs to be guided by something bigger than who we are as individuals. The strategic plan needs to accept that it is very difficult for a health institution not to be accountable to society. It is very difficult for a health institution to argue against its implicit moral obligations to truly take care of its people. When you, as the steering committee for HSN's strategic plan, consider our place in the world - please realize that HSN is at the centre of that human will we need for change. Realize, that HSN's strategic plan must show a commitment to its social accountability as the foundation for everything it does…that is, if we are ever going to find our will for change.

Social accountability is actually a World Health Organization's (WHO) concept that guides medical schools and medical education – but its principles are easily transferrable to a health institution. Social accountability shares common ideas and themes with social responsibility, social responsiveness, social obligation, social justice and health equity. It is heavily inspired by the Alma-Atta of the USSR in 1978 when the right to health was declared a human right and when the movement towards equitable health for all was born. The idea has been formalized and endorsed by the WHO in 1995 and its application has grown tremendously, particularly in Canada because of its positive impacts on population health outcomes (Strasser, 2016).

Our medical school, the Northern Ontario School of Medicine (NOSM), is a world leader in social accountability. Medical schools have accepted social accountability as an obligation (Boelen & Heck, 1995; Boelen, 2000); as should health institutions. Several documents

demonstrate this explicit commitment in Canadian medical education (AFMC, 2015; AFMC, 2010; NOSM, 2009; Health Canada, 2001). As well, medical schools have integrated social accountability into their vision, mission and strategic plans and it permeates throughout their curriculums (University of Saskatchewan, 2017; UBC, 2016; University of Manitoba, 2016; University of Calgary, 2015; NOSM, 2015; NOSM, 2009).

The social accountability of medical schools can reach beyond academic institutions and into the institutions that are responsible for the delivery of the health care system (Wilson et al. 2017; Goel et al., 2016; Woolard et al., 2016; Meili et al., 2016). If medical schools are graduating class after class of future physicians built on these principles, it is only a matter of time that the health workforce will call on a health institution, like HSN, to implement social accountability as a foundational pillar. So, it stands to reason that health institutions should be a partner that carries a social accountability mandate forward.

Not convinced? Well, I am not alone in seeing the connection of social accountability to a health institution like HSN. The Canadian College of Family Physicians argues for the application of social accountability at the patient level (Goel et al., 2016), the community level (Woolard et al., 2016) and also at the policy development level (Meili et al., 2016). The Royal College of Physicians & Surgeons of Canada include social accountability in their updated versions of the CanMEDS framework (RCPS, 2015) and the Canadian Nurse's Association discuss this topic as social justice (Canadian Nurses Association, 2010). A social accountability lens (Wilson et al. 2017) should be considered as a moral obligation for any health institution.

**So, what is Social Accountability?**

The WHO defines social accountability as "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. Priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public" (Boelen & Heck, 1995). Priority health concerns are further articulated in terms of relevance, quality, equity and cost effectiveness (Boelen & Heck, 1995). The stakeholders that must be committed to this process are defined by the WHO's partnership pentagram and include - communities, health institutions, health professionals, policy makers and academic institutions (Boelen, 2000).

The idea of ***relevance*** is "the degree to which the most important health problems are tackled first" (Boelen & Heck, 1995) and "to direct efforts to people and groups in greatest need" (Boelen, 2000). ***Quality*** is the use of "evidence-based data and appropriate technology to deliver comprehensive health care to individuals and populations, taking into account their social and cultural expectations" (Boelen & Heck, 1995, p6). ***Cost effectiveness*** is having "the greatest impact on the health of a society while making the best use of its resources" (Boelen & Heck, 1995); it would be more effective to engage in prevention rather than expensive diagnosis and treatment. Finally, ***equity*** dictates that "getting the best health services cannot be the privilege of a few, but the right of everyone…[with] the goal to reduce any form of

discrimination based on race, sex, religion, ethnic group, socioeconomic status or age…[and that] we should be prepared to mobilize in solidarity to help all those at risk of losing their social rights, including the right to health" (Boelen, 2000). ***Equity, not equality, is the cornerstone of social accountability.***

**Social Accountability is a mind set**

Being socially accountable is more than following the definition set out by the WHO. There are certain pre-conditions to a socially accountable way of thinking that this definition inspires. It challenges the very basis of the knowledge we use to make decisions (Boelen, 1995; Harding, 2003). Social accountability requires us to redefine the conditions for the gathering and the interpretation of information that we use to make decisions on how to create 'the best' health care system. The questions we ask and the answers we accept as valid create un-intended consequences for our diverse populations. These are consequences that we may be unaware of because we asked the wrong question, to the wrong people and in the wrong way in the first place.

We have to acknowledge and ***access socially constructed knowledge*** from the worldviews of our people, our populations, our community and our region. Every individual person achieves a ***standpoint*** in life from which they create their worldviews (Harding, 2003). This is based on their lived experiences and because of the social pressures they are under. Those standpoints are unique to an individual; they can be shared across groups of people under similar social pressures; and tend to focus what we are aware and unaware of in society. Some perspectives are not visible to others. We would be blind to social injustices and inequity if we did not take the time to access the wealth of knowledge from the day-to-day struggles of our people.

We need to ***resolve dual realities*** that arise from different achieved, individual standpoints and worldviews. Very real differences can be observed in our interpretation of what the world is really like. A person who has never been touched by addiction and enjoys the comfort of upper class socioeconomic status may be reluctant to embrace the idea of a safe injection site for heroin users. I've heard from a lot of people that believe it would encourage intravenous drug use, drug addiction and all the social ripple effects that go with it. They may not understand why a heroin user cannot just make the decision to quit and they might think that it is a simple choice or matter of will not to use heroin. I've never met a drug addict that wakes up in the morning and says "wow, I'm so happy that I'm addicted to drugs!" Instead, I've heard how heroin users paint a reality of living with opioid addictions, living in poverty and losing everything they ever cared about. I've heard them describe the fear of getting HIV or Hepatitis C and the desire to quit, but the inability to shake their dependence. So, who's perspective is most valid? Equating one with the other allows for a deeper understanding of what is happening and why it is happening (Harding, 2003).

We need to realize that ***the most objective view of the world lies with those at the margins of society.*** Those who suffer the most, those with the least privilege and those who are the most disadvantaged paint the most objective view of the world (Harding, 2003). They have the most

to gain from understanding the perspectives of those who make decisions that affect their lives. There exists an implicit motivation for an individual with the least privilege to understand how someone is 'ruling over them,' but not vice versa. People who have the most power, also have the power to define others (Harding, 2003).

We need to get creative, ***empower those who are powerless*** and save table spaces for their social graces. "Significant progress remains to be made to ensure quality in the interaction between patients and providers and full empowerment of citizens in the protection of their own health" (Boelen, 2000). For a health institution, we can assume that power is consolidated with policy makers, health administrators, academic institutions and health professionals as they are the stakeholders who control the resources. The world constituted by those with power, stands over the world constituted by those who are oppressed and they do not stand in equal relation (Harding, 2003). These four stakeholders impose their ideas on the people we are supposed to serve. They impose their will because of the imbalance of power between them and the community. For example, it's a socially accountable step in the right direction to have a patient advocate; but is it truly a step in the right direction if the contributions from that patient advocate are dwarfed by health administrators, policy makers and health professionals? Without re-balancing the power differential between traditional decision makers and the patient advocates it would be a failure to be socially accountable. It is also a dangerous decision path for a health institution because, with all our privilege and power, we would risk perpetuating marginalization and reinforcing stereotypes.

***Social accountability is dynamic***. The 'situatedness' of socially accountable information changes. It is dependent on the stakeholders. It depends on the populations, community and the social pressures they face. It reflects a specific point in time. It is dependent on the geographic location of the community or population that is served. It is in constant evolution and we must be ready to identify that evolution and adapt (Boelen, 2000).

In the end, there are critical factors to consider for a 'socially accountable way of thinking.' The idea of socially constructed knowledge or a standpoint, resolving dual realities, that the most objective view of the world lies with those at the margins of society, to empower the powerless and the dynamic nature of social accountability are important considerations that force us to shift our way of thinking. We must strive to define the elements from the WHO's definition, but we must do it in a socially accountable context or it will be a colossal failure. This would require a seismic shift in thinking and culture, which I fear may be too difficult for a health institution to digest without the committed leadership to galvanize the human will needed for change.

**HSN's strategic plan is the starting point for a socially accountable health institution**

I choose to be an optimist and I hold onto the hope that together we can achieve something beyond our differences. I believe we are united in our humanity and in our drive to reduce inequity. It is after all the basic premise of why we do what we do – to help others. "Optimism is a moral choice. But, if you choose to go through the world with cynicism and negativity, then you will have to endure living out your very low ambitions." That's a quote from Dr. Jim Young

Kim, a founder of Partner's in Health. Dr. Jim Young Kim showed the world that you can create unique health care systems for the poorest people and successfully treat multi-drug resistant tuberculosis, HIV/AIDS and malaria. If you're interested you can look up the Declaration of Cange (Haiti) where the very patients dying from treatable HIV pled the premise that "the right to health, is the right to life [and] everyone has a right to live" (Partners In Health, 2013). And, if you agree with that, you should ask yourself: With all our knowledge, our science, our technology and our wealth … why can we not find the solutions to people's suffering? Why are we falling short on human will?

Medical schools took up the challenge to imbed social accountability as a pillar of their existence. Health institutions can follow suit and take similar steps to shift to a socially accountable mindset and culture and help to galvanize that human will for change. The strategic plan could direct the entire organization to take up the cause. Here are 4 overarching themes that prevailed in medical education and that could transform HSN (Boelen & Woolard, 2011):

1. **Ascribe to social accountability.**
    a. Declare an explicit commitment to and an understanding of the common, core values and principles of social accountability.
    b. Create a social accountability mandate.
    c. Translate social accountability knowledge into practice for all staff and across the organization itself.

2. **True, meaningful and empowered community engagement.**
    a. Inclusive of all community members and populations.
    b. Remove the barriers that traditionally exclude meaningful participation from marginalized and oppressed groups – with a special focus on those who suffer most.
    c. Re-balance the distribution of power into the hands of the community.

3. **Synergistic partnerships built on social accountability.**
    a. Advocate for all partners to ascribe to the principles of social accountability.
    b. Utilize the WHO's partnership pentagram as a guide.

4. **Constant evaluation and evolution of the organization's social accountability.**
    a. Create clear and specific indicators, tied to social accountability, that can be evaluated to demonstrate the impact on the priority health concerns and population health outcomes of our people.
    b. Create meaningful feedback loops that allow the community to hold the institution accountable.

**Item #1 – Ascribe to social accountability**

The WHO definition sets out the necessary elements that define the principles of social accountability. HSN would be required to understand 1) the communities, populations regions

and/or nation that it serves and through that understanding discover and address 2) priority health concerns explored in terms of relevance, quality, cost effectiveness and equity as previously described. It also requires all the aforementioned to be identified by a 3) range of stakeholders, with ***the community truly being an equal partner in the process*** (Boelen, 2000). That information is then integrated to direct 4) education, research and service activities (Boelen & Woolard, 2011; Boelen, 2000; Boelen & Heck, 1995).

Social accountability attempts to reduce the mismatch between a community's priorities and the current health care system. In turn, this impacts the bigger picture – measurable improvements on population health outcomes (Boelen & Woolard, 2011). It should lend to better health care access, more efficient utilization and cost reductions (Montori et al, 2017; Ku et al, 2017). Just imagine the impact we could have with a dedicated response to the upstream causes of the downstream effects we see walk in the front door of the ED. We currently have a coordinated response for our elderly patients, but why don't we have the same coordinated response to other upstream issues? Why don't we coordinate around poverty or intravenous drug use or alcoholism or social stigmas or institutional discrimination or whatever it is that is identified as a priority health concern by our community and our populations? Why don't we creatively find ways to impact the social determinants of health? If we did, then maybe I won't have to assemble a trauma team as often in response to drunk driving or admit patients for heart valve replacement surgery as a complication of their intravenous drug use.

**Item #2 – True, meaningful and empowered community engagement**

We need to re-think true, meaningful and empowered community engagement along the lines inspired by social accountability. The absence of meaningful community engagement is an existential threat to being socially accountable. The Excellent Care for All Act (2010) requires hospitals to establish a patient relations process to address and improve the patient experience. Our community engagement must go beyond the patient experience, must address the needs of the community and improve the overall health of our populations.

What are the processes that we use for community engagement? Are we an ad hoc tokenistic type community engagement or do we utilize an 'advisory panel?' Ad hoc processes de-value community input and are usually feeble attempts at satisfying an accreditation standard. How do we know that we are engaged with a valid and representative group from the community? If 10% of the population of Sudbury is Indigenous (Statistics Canada, 2016) do we have similar representation in our community engagements? Don't we need a stronger Indigenous presence so that we can begin to understand why Indigenous people suffer with the greatest burden of disease of any population in Canada? The very selection criteria and requirements to be a patient advocate or sit on an advisory panel runs the risk of perpetuating marginalization and stereotypes. If we are going to understand the health effects of poverty, then we need to save some table spaces for the social graces of the people who live in poverty. Will they be able to participate in an advisory panel that takes them away from generating income or attend meetings if they do not own a car or answer emails if they don't own a phone or a computer?

How are we making sure that those different, and equally valid worldviews are equitably represented and not imposed on others?

The community needs an equal voice at the table and it cannot be underestimated just how far the power balance has to shift to truly accomplish this. There are resources out there that suggest that a ratio of 2 or 3 community members to 'other powerful stakeholders' is needed to truly allow the community's voices to be heard and acted on. There are examples of this already being done at St-Micheal's Hospital in Toronto with a community advisory panel that has two thirds of its membership from the community, with special focus on vulnerable populations and the social determinants of health (St-Micheal's, 2006). It is critical to have valid community engagement because it will change the priority setting for HSN. For example, when MDs set priorities for managing chronic illnesses the focus is usually on the technical medical management of the disease. When MDs and patients get together, it changes the priority setting and incorporates primary care needs, the desire for self-management and the need for more patient involvement in decision making (Boivin et al., 2014). What a disconnect!

**Item #3 – Synergistic partnerships built on social accountability**

Earlier, I gave the example of the Sudbury and District Health Unit's poverty reduction initiative and lamented how there was no coordination with the ED where we see the effects of poverty walk right in through the front door. This is one example of the type of partnership that we need in order to create health care systems that go to where the need is. It is a sad, unfortunate and missed opportunity for positive change. The WHO's partnership pentagram identifies 5 key players– health institutions, academic institutions, the community, health professionals and policy makers – as a guideline for who we need to partner with (Boelen, 2000). Our academic institution, NOSM, is already ascribed to social accountability and is a world leader. HSN could be the second of the 5-partners to embrace this ideology and it would also position us as world leaders and game changers.

**Item #4 – Constant evaluation and evolution of HSN's social accountability**

Measurable improvements in population health can only be achieved if we create, from the perspective of our people, clear and specific indicators on the priority health concerns of our people. A community health needs assessment, inspired by the principles of social accountability is needed. There are multiple sources of information that already exist that we could draw on, however, we should not be tempted to brush away the most valuable source which is socially constructed knowledge. Qualitative data that can be sourced from our community is needed to inspire and guide the selection and quantification of these indicators. These indicators should reflect priority health concerns and population health outcomes. Other consideration for indicators could be cost-reductions in the delivery of care or higher quality care that takes into account social and cultural context as demonstrated by improved patient or community relations.

We have to accept that our community needs to hold us to account. They must be empowered to constantly evaluate and review our initiatives, our processes and our movement towards being socially accountable. They must also be allowed to evolve our social accountability. They must be seen as partners that can help us achieve equitable health for all.

When it comes to evaluating the social accountability of an institution there are a few tools that we can borrow from medical schools. The more robust tools out there include a conceptualization, production and utilization model (Boelen & Woolard, 2009), as well as theNET framework (Training for Health Equity Network, 2011) and the WHO's social accountability grid (Boelen, 1995). There is also an international ASPIRE for excellence program through the Association of Medical Education of Europe that recognizes and awards membership to institutions that have committed to excellence in social accountability (AMEE, 2015). Whatever the model we choose to evaluate our efforts, it should be squarely focused on very real changes in our population's priority health concerns.

In summary, it would be a travesty for HSN's strategic plan not to ascribe to the ideas and language that reflect social accountability, social justice, social responsibility, social responsiveness and health equity. It is very very difficult for a health institution not to accept its moral obligations. We have struggled to find our human will to act when there exist obvious and attainable solutions to people's suffering. A health institution can galvanize the human will we need. Do not let this opportunity slide, if we do, it will be a very long 5-years before we have another opportunity to explicitly define our morality, to reduce inequity by uniting in our humanity and to realize that we are mutually tied to a single garment of destiny. We need to accept our social accountability.

Sincerely,

Dr. Alex Anawati
B.Sc., CCFP-EM
ER Physician HSN & WNGH
Assistant Professor NOSM
Global Health Coordinator NOSM
Board of Directors NOSM
CCFP Social Accountability Working Group

fb – Alex Anawati
twitter - @aanawati
Instagram - alexanawati

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