Chapter 1.1.3

FROM THE VILLAGE TO THE GLOBE: THE SOCIAL ACCOUNTABILITY OF RURAL HEALTH PRACTITIONERS

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Introduction

Throughout the world people in rural areas have fewer health professionals available and lead shorter lives on average than those living in urban environments. This inequitable state of affairs has persisted for decades but only in recent years has the world's attention, and that of the medical profession, been drawn to address it. The global gradient of inequitable distribution of health professionals between urban and rural areas, together with the associated gradient of population health status, has been well established by the World Health Organisation (WHO) and others (1, 2). At issue is the question of what can be done about it and what might the roles of existing and future rural practitioners be in addressing the issue?

This chapter seeks to explore the social responsibilities and social accountability of rural practitioners in addressing this challenge — both in their local villages and in the global commons.

Social accountability (3,4) is a concept that has gained increasing currency around the world as health professionals and health systems wrestle with obvious and increasing divergence between health resources (both human and fiscal) and the peoples' needs for those resources. The chapter outlines how social accountability is defined and how rural practitioners and communities are particularly suited to animating and studying the concept in the real world of front line health services. It goes on to point out the educational and professional development contributions that rural practice can make to the development of future professionals and their work well beyond the rural domain.

What is special about rural?

The practice of medicine in rural areas of the world presents a loom on which to explore and express the major themes of life, health and healing. Indeed, perhaps it is at the scale of the village, the town, the valley that we are best able to see the threads of lives that weave the tapestry of our understanding of health, illness, suffering and healing. This is true at the close scale of the lives and families of the people we are privileged to treat. The lessons taught and learned in the thousands of rural villages are also applicable at the global scale in which all of our lives are embedded.

In rural areas the factors that influence health (the social determinants of health) become evident in ways that statistics and demographic maps such as the World Health Report can only crudely represent. At the same time, the relationships required to negotiate the pathway back to health by individuals who have fallen prey to illness are more evident and often more susceptible to influence by physicians[1] and other health professionals than can be evident from the perspective of a large urban institution. The necessity for all health workers in the community to communicate and link their activities with the real and immediate lives of those in their care fosters the kind of interdisciplinary and patient-focused action that is the theme of all reports and policies attempting to address the hoped for renaissance of primary health care(5,6,7). This is not to say that it is universally done well but, of necessity, it is at least attempted on a regular basis.

Why does rural matter?

Yet, in spite of these factors there is a world-wide difference between the health status of citizens in urban centres and those in rural areas. This gap, in such crude indicators as life expectancy, is variable in its immediate causes and extent but in no country is it less than two years and in some it exceeds two decades. Probably only a modest amount is due to availability of health services. Much of it is due to factors well beyond the traditional view of the formal health system and specific health policies. Nonetheless, rural physicians are regularly turned to by their communities

[1] A 'physician' here (in North America more broadly) is another term for 'doctor' or general practitioner, while in countries like South Africa and Australia, a 'physician' is a specialist in Internal Medicine.

to assist in responding to perceived threats to the local populations. These threats may relate to environmental concerns, traffic accident prevention, recreational and cultural developments, social inequities, addiction services and a host of other issues that may arise in a particular community at a particular point in its history.

This is the nexus where primary care and population health meet, where care for the individual patient can inform and be informed by the factors that influence, not only the health of that patient, but the health of the community. It is also the place where policies and activities of the health system must similarly inform and be informed by the policies in the many other social realms that have an influence on the health of the populations. These cross influences are well known and the importance of the interdependence between the health and educational systems in particular are well articulated in the report of the Global Commission on Health Professionals for a New Century (8). Translation of the *intent* of co-ordination and collaboration into *action* is much slower to achieve at anything like a universal scale. At the level of rural health such practices are not only seen but can inform policy 'up the food chain' by the insights gained and the examples given of effective achievement. A good example is co-ordinated community level actions of health and education workers to create 'dry grads' as alternatives to the drinking, driving and youthful deaths that contribute inordinately to the shorter life spans of rural citizens.

What can rural practitioners do?

This is where rural practitioners and their organisations can make a powerful difference. Whether it is with the local council, provincial policy, the Society of Rural Physicians of Canada or the Wonca World Rural Health Conference; the perspective rural practitioners bring, grounded in place and daily practice, provides an essential element of any hoped-for solution.

Why is this so? Because rural practice is ground zero in the socially responsive practice of medicine (9,10). It is the place where actions and their consequences, where causes and their impacts are most readily seen and where interventions are often possible - interventions that have an impact on the lived lives of patients and the communities that foster or challenge their health. Rural practitioners are drawn into responding to matters that affect their patients' health. This can range from lobbying for appropriate equipment and services, through leading development initiatives and on to community animation to protect the environment and its influence on health. Needs are more clearly perceived at this scale and the

responses are often more evident. Hope for a positive impact is also less likely to be overtaken by the seemingly overwhelming paralysis by analysis that is often a feature of larger, more complex environments.

However, social responsiveness is only one step along the pathway to social accountability. It is helpful to think of the social obligations of a profession along a continuum — from social responsiveness through social responsibility to social accountability. The WHO has defined the social accountability of medical schools as having:

> '…the obligation to direct their education, research, and service activities towards addressing the priority health concerns of the community, the region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organisations, health professionals and the public' (4).

As we shall see, this definition has been expanded through a Global Consensus for the Social Accountability of Medical Schools (GCSA)(11) but for our purposes it is sufficient to make the distinction outlined by Boelen and Woollard (12), in part because it shows the rich possibilities for rural practitioners to contribute to the profession's search for its very soul — its ethos of service to those in need of its work.

> 'The term social **responsibility** of an educational institution implies awareness of duties regarding society and the term social **responsiveness** the engagement in a course of actions responding to social needs. The term social **accountability** adds a documented justification for the scope of undertaken actions and a verification that anticipated outcomes and results have been attained' (12).

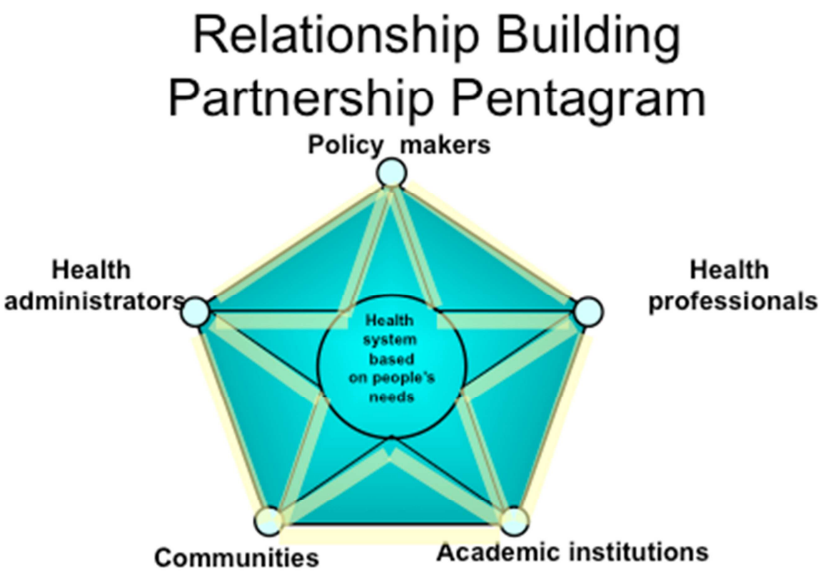
This refers to the medical school and, in concert with the GCSA referenced above, calls for a serious re-examination of the current state of most medical schools in North America and elsewhere.

As they turn to this task, the faculties have a precious, often unrecognised and certainly under-utilised resource at their disposal. This is the increasing number of rural practitioners and practices that are becoming faculty[2] as Canadian medical education becomes an increasingly distributed enterprise. More undergraduate and postgraduate training is being conducted in rural areas than ever before. This is often characterised as an attempt to acquit the schools' social obligations to help

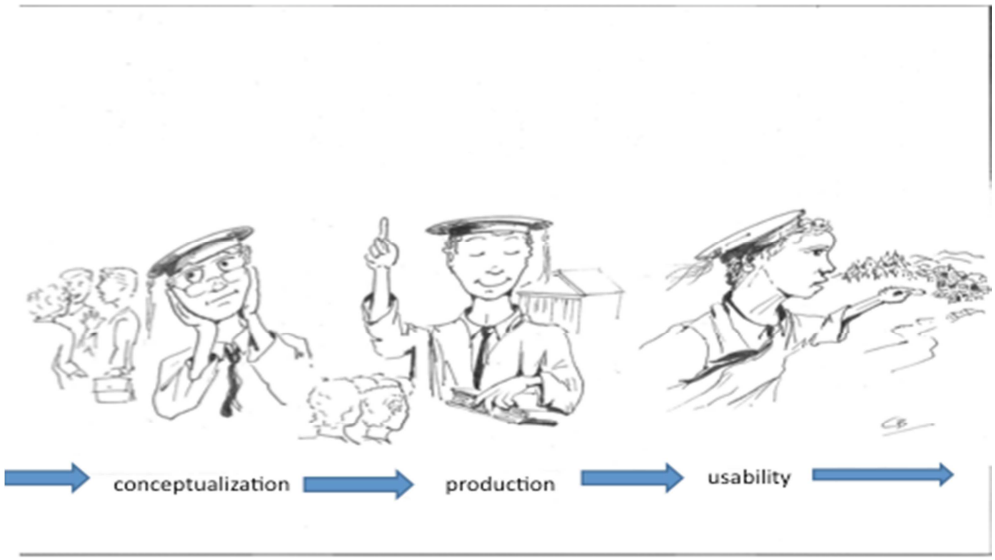
[2] Here, 'faculty' refers to a member of academic staff.

mitigate the maldistribution of their graduates — disproportionately choosing urban and specialised careers in spite of the acknowledged need for rural generalists. There is, indeed, evidence that this is working since graduates trained in rural and Northern programmes are far more likely to choose careers in similar areas.

However, even in explicitly distributed programmes such as that at the University of British Columbia (UBC), the numbers are small compared to the needs. The vast preponderance of graduates from other parts of the programme are not obviously committed to serving in areas of need. In common with most schools in Canada, UBC does not behave as if it is taking responsibility for what its graduates do after they have been licensed. There are increasing calls (12,13) for medical schools to move beyond simply producing doctors in traditional ways and to conceive of their responsibility and accountability for participating with society in *conceptualising (C)* the kind of physicians society needs, *producing (P)* such physicians and then following through to ensure their graduates are *usable (U)* in addressing the priority health needs determined by a five way partnership including the academy, health professionals (of many kinds), policy makers, health managers and, above all, the communities themselves.



This ***CPU*** model will be much aided and achieved by and with the increasing numbers of rural faculty teaching students where the connections are both demonstrable and palpable. Success achieved here can then be translated into the more complex and often confusing urban scale where connections between practice and impact are generally less evident.



(Credit: Charles Boelen)

Why be socially accountable?

Why should physicians hold themselves accountable in this way? And why should rural physicians in particular have an especially acute sense of this obligation? The reason arises directly from the 'social contract' that professions have with society.

For over a decade, the profession on both sides of the Atlantic has been wrestling with the issue of professionalism as it pertains to physicians: a clear articulation of this is given in *Medical Professionalism in the New Millennium. A Physician Charter* (14).

> 'The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle

> ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.'

These three principles are

- principle of primacy of patient welfare
- principle of patient autonomy
- principle of social justice.

The complicated and complex environment in which the profession must work is no simpler in the rural environment. However, the manner in which the principles are made manifest and the '...political, legal, and market forces..' that influence our work are often more immediate and sometimes more tractable than in an urban environment.

While often feeling beleaguered in the face of time and complexity, physicians have been given inordinate privileges by being able to do important and remarkably satisfying work, as well as being compensated rather well in both material and social measures. These privileges are particularly true in rural practice where we daily confront the results of our work - both our triumphs and our tragedies. These rather immediate feedback loops carry within themselves the capacity to teach us both the technical skills that are refined during practice in rural communities; and our understanding of the true meaning of healing. By allowing us to see the causes and manner by which our patients become ill, they provide a window whereby we can see the potential for upstream interventions that will mitigate or even prevent the illness the next time or with the next patient. No lives are more replete with 'teachable moments' than those of rural practitioners. Their capacity to marshal these moments on behalf of both their patients and their communities is a mark of their learned capacities as healers.

The pleasure of this repeating experience of doing things that matter and seeing the results thereof in the lived lives shared with patients and in community is so rewarding that it should not be churlish to say that some 'tuition' is due! Notwithstanding the 'sweat equity' of frequent call, persistent availability, family strains and high tension practices; perhaps society might reasonably expect that the wisdom derived from this experience be shared at a scale where it can build a different world than the one that brought illness to patients and community in the first place. As Rudolf Virchow said in the 19th Century:

> 'It is the curse of humanity that it learns to tolerate even the most horrible situations by habituation. Physicians are the natural attorneys of the poor, and the social problems should largely be solved by them' (15).

And in this century others have somewhat plaintively asked:

> 'What good does it do to treat people's illness and then send them back to the *conditions* that made them sick?'

This will inevitably call upon us to work with people, sectors and policies beyond the formal health system and our local communities. This commitment to collaborative and positive social change lies at the core of social accountability.

Why does the scale of our work matter?

Social accountability exists at a range of scales - from the individual practitioner through local partnerships to professional organisations, the schools where physicians are trained and continues up to the scale of global citizenship. At each level it is informed by the responsibilities that accrue to physicians by virtue of the social contract for the privileges granted.

At the local level it is reflected in the sometimes onerous call schedules and the collective responsibilities rural practitioners frequently show in gaining special skills (anaesthesia, surgery, obstetrical, etc.) that become necessary in their particular communities in order or preserve the services that are required. It is frequently exemplified by exhausted practitioners continuing to serve beyond reason simply because there is no one to hand off to.

Indeed, it is often such practitioners that are willing to invest their efforts in teaching the next generation of physicians - often with the hope (but without the guarantee!) that long-term support will be found through recruitment of those they teach. There is growing evidence that programmes grounded in such teaching *do* produce more graduates willing to serve in rural and underserved areas of practice. This is a high order example of social responsibility and, if it is achieved through working in conjunction with health authorities and educational institutions, is a clear and commendable expression of social accountability. It should not go unnoticed that the capacity of rural practitioners to fulfill these tasks is grounded in their daily practice of social responsiveness.

It is these lessons learned through being responsive, observant and useful that can be brought to the table in regional collaborations. Students can participate in learning these lessons in a way that is frequently denied by their experience in large urban institutions. The increasing presence of rural educational experience, often in interdisciplinary settings, is not only acquainting students with highly skilled clinicians. It also provides unique lessons in collaborative practice, communication skills, clinical decision making and professionalism. While the teaching resource is not inexhaustible, it represents a palpable example of social accountability and the cross-sectoral work that is embodied in social accountability. A case can be made that many aspects of the students growing professional identity can be best taught at the scale of the rural community and its more personal relationships. This growing identity can then be applied in the more impersonal milieu of urban society — to the enjoyment of the developing practitioner and the benefit of patients.

For the practitioner who stays in rural community practice these insights, readily grasped by the observant student during rural rotations, are constantly refined and applied across the range of practice and community issues; issues that can profoundly affect the health of patients and the health of the community as a whole. Whether these insights relate to environmental hazards, local economic development, the adverse effects of inequities, social discrimination or cultural development; they frequently provide a scaffold on which to influence relevant policy well beyond the village. Presentations and engaged social and political action can have remarkable influence at the municipal, provincial, national and even international levels. The work of Jenner and Pasteur arose from the villages of Britain and France respectively to develop the systems of mass immunisations that have had dramatic impact on the lives of millions — even to the virtual elimination of smallpox and the near eradication of polio.

How do we link the scales from the village to the globe?

Clearly Jenner and Pasteur did not set out with plans to conquer disease all over the world. Nor did they have the tools of modern communication and transportation that allow rapid dissemination of innovation — both for good and for ill. Indeed, the lad who received the first successful rabies vaccine travelled some distance by horse and wagon to see Pasteur, saved by the long, slow incubation period of the virus.

But most areas of the world now have remarkable connections for communication and even transport compared to previous generations of practitioners. Combined with the growing effectiveness of telemedicine, the professional and personal isolation once a feature of rural practice is somewhat less onerous. Such connectedness can be a mixed blessing if not supported by ongoing and mutually respectful human relationships, the kind of relationships that are often a feature of rural practitioners and patients.

The disparity of numbers of health practitioners of all types in rural areas of the world has proven to be an intractable problem. Some advances are being made through educational and policy interventions. Ultimately success is likely to be achieved by the use of a career cycle model that attracts practitioners, not necessarily for their whole career but for increasing portions of their and their family's lives.

Social accountability is being, and likely to continue being, a similar career/life cycle phenomenon. There is a strong axis of connection between students, young and late career professionals who do rural practice and international service. This may take place at different ages and stages of a given professional's career and may be reflective of a high order ethos of service in those who serve in these two areas. The rich connections so forged weave the tapestry of healing and social accountability from the village to the globe — and back again.

Conclusion

Social accountability is a central part of the social contract that health professionals have with the communities and societies within which they serve. In return for the privileges and enjoyment that comes with the practice of medicine, society reasonably expects that our skills, knowledge and acquired wisdom be dedicated to the good of others. The professional code of ethics (16) carries in its fundamental principles this expectation at two levels:

1. consider first the wellbeing of the patient;
2. consider the wellbeing of society in matters affecting health.

This obligation exists across a range of scales from interactions with individual patients and their families through societies at the level of the village to the interactions of the profession as a whole with global population. It calls upon our educational institutions to similarly dedicate their efforts in teaching, research and service to similarly devote their efforts (11).

At no scale is this principle more obvious, practical and enjoyable than at the level of the rural practitioner. Here, we can both see and influence some of the many factors, policies and institutions that contribute to both the health and the suffering of our patients. As dedicated healers, this can place us in a position to not only deal with the immediate problems of our patients but to learn from those many interactions and provide insight and influence over the social and political forces that determine health. The principles and practice of social accountability call upon us to use that influence to create a future marked by mutual caring and constructive change, one that builds health rather than compromising it — in social, environmental and economic terms. This becomes increasingly so as rural practitioners become progressively engaged in the education of future health practitioners.

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