

Social accountability at the meso level

Into the community

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What good does it do to treat people's illness and then send them back to the conditions that made them sick?¹

This is the third article in a series about the social accountability of family medicine. Previous commentaries have described the scope of social accountability² and the clinical (micro) level at which social accountability can be enacted by family physicians for individual patients.³ In this article we move up the scale to the meso level: the broader community and geographic context in which clinical and academic medical work are situated. This includes community engagement and education, training, and continuing professional development.

The fourth and final article in this series will address the policy and population (macro) level, where family physicians must act as advocates in Canada's complex political environment to accomplish the best health outcomes for all Canadians.

Between that broad macro level and our micro-level work with individual patients and families rests the place where communities of physicians are called upon to serve communities of patients—the meso level.

Relationships: doctor-patient, doctor-community, doctor-society

Medicine has a tradition of calling on its practitioners to develop and attend to the doctor-patient relationship. This is where family physicians feel most comfortable and competent. However, this has become difficult in increasingly fragmented and subspecialized health systems marked by episodic and technical care. Because family medicine is a community-based discipline,⁴ we are required to contextualize and respond to the factors that make our patients healthy or not. This enlargement of the scope of our relationships carries us beyond our individual patients to the causes of ill health that work on a broader scale.

In the 1996 William Pickles Lecture, Ian McWhinney identified 4 ways in which generalist physicians differed from specialist physicians.⁵ One of these was that generalists view their patients in an organismic, rather than a mechanistic, way—that is, as a complex being interacting with and enmeshed in their families, communities, and society as a whole, all of which influence

their health. As organismic practitioners, it follows that we should not limit ourselves to thinking about health and illness as only an individual entity and responsibility, nor should we limit our role to acting at the individual level alone. As generalist physicians we have the power, the influence, the professional responsibility, the ethical framework, and, therefore, the obligation to consider and to act to influence the broader determinants of health that affect not only individuals, but also communities and society as a whole—and there is strong scientific evidence that this makes a difference.⁶

We are obliged as communities of physicians to act together to serve our partner communities of patients, health system managers, policy makers, teachers, and researchers. While essential, it is insufficient to simply deal with the patients who walk through our doors without *thinking* about what influences bring them to us and *acting* to ensure the existence of the local and regional resources that represent the highest and best expressions of our communities caring for one another.

The previous micro-level article called on us to connect our patients to community resources for income support, housing, education, prescription coverage, and clinical and social supports and services.² In each of these domains, family physicians can affect the quality, availability, and effectiveness of these important influences on the health and well-being of our patients in our particular communities.

How can we be effective advocates at the meso level? Should family physicians, for example, engage in the medical school admissions process at our local medical schools to admit students more likely to respond to the needs of our communities (geographic, cultural, socioeconomic, etc)? Should we better engage in the development of more just and equitable collective behaviour in our communities (assessing community capacity and assets, leveraging existing resources and local skill sets, participating in local advocacy groups, etc)?⁷ Family physicians will invariably see health patterns and trends in their communities. Should we at least bear witness and call our communities' attention to local issues that are making our patients sick (sources of contamination, lack of recreation programs, needed school social and nutritional programs, etc)?

These questions can generate an intimidating list of calls upon our all-too-precious time. They can cause an overwhelming mix of frustration, helplessness, and guilt

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if we let them. But 2 factors can mitigate this. First, at the meso level, the determinants of health are context specific, and if our eyes are open we can readily assess those that might be amenable to intervention. Second, our professional status as physicians opens doors and provides influence denied other citizens. What we do can have real effects on our patients' health and well-being. Further, it can in fact make elements of micro-level care—and thus our own work—easier.

The core of family physicians' work at the meso level is the joint commitment to health systems based on people's needs. The building blocks of those systems are in our hands at the community level. While we cannot expect ourselves to be engaged in all of the issues in our communities, we are in a position to look upstream at the proximal causes of our patients' ill health. It is well known that these upstream determinants have a greater effect on the health of our patients than does our clinical care of individual patients, no matter how well delivered.⁸ As sentinels of the health of people in our local communities, we have both an opportunity and an obligation to influence some of these upstream determinants.

Our 40-year-old patient, Diana, who has multiple medical conditions and was recently diagnosed with cervical cancer, has been connected with local resources.² It is one thing to understand her poverty and illiteracy and how they isolate her, but it is another to enable the community to be part of the solution that addresses the underlying causes of her multiple morbidities and contributes to her recovery. Looking beyond her individual case, you consider what you, as an influential physician-citizen, might do to make the community a better partner in her care and build a better, more caring community.

Helping Diana

You might consider some of the following strategies to help Diana and patients like her:

- develop a local outreach program, housed in your clinic, for regular Papanicolaou tests among marginalized citizens;
- present to the local school board representative the idea of an adult literacy program;
- ask the family medicine resident in your practice to research and write a paper on the community needs and the community strengths that Diana's case demonstrates;
- call a meeting or create a social network of health professionals in the town to consider what might be done to develop support groups, health education resources, and other local initiatives in keeping with the resident's findings;
- reconsider your earlier reluctance to have undergraduate learners in your busy practice and instead work with the local pharmacist, social workers, nurses, and

teachers to develop a multidisciplinary teaching site in conjunction with the various health education and residency programs; and

- respond positively to the local high school's request to present on health topics (eg, sex education), but suggest topics be expanded to discussions about social justice and what makes people (and communities) healthy or not.

Learning from Diana's case you realize that, busy as you are, looking upstream for ways to help her and others like her in the community provides a deep professional satisfaction, as revealed in Niebuhr's hope for "the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference."⁹ Pragmatically, these investments in community engagement have the potential to contribute to improved patient outcomes, efficiencies, and benefits at the micro level of patient care. As a physician engaged fully in your community, the scope of things that you can change is expanded—to the betterment of your patients, your family, and yourself.

Adaptive communities

As true generalist practitioners, family physicians have a social accountability to their communities, which is why McWhinney said that family physicians should live among the communities they serve.⁵ Communities of varying sizes and with variable needs require physicians who are individually and collectively able to adapt to meet those needs. In rural areas, services that might in other circumstances be supplied by high-volume specialists (eg, surgical intervention, interventional obstetrics, anesthesia) rely on rural generalist practitioners with focused skills that allow optimal care through the safe delivery of such needed services—safer and healthier than would be the case in their absence. Acquiring such skills is a meso-level response to community need.

A community can change over time, however, and the skill sets of the collective practitioners must similarly evolve. For example, the resource-based community hospital where one of the authors (R.W.) practised for 16 years at one time had more than 100 deliveries per year, but now provides no elective deliveries because of dramatic changes in the demographic profile of the community. Even in large cities, neighbourhoods, technologies, diseases, and health status undergo changes, and a cohort of well trained generalists is essential if the changing needs are to be met—which is the essence of social accountability. At the meso level, specialist and generalist physicians, even in a complex urban environment, must work together to intentionally adapt their collective institutions and capacities to the health priorities of their communities—from the most challenged of neighbourhoods to the civic functions of the cities and towns as a whole.

The obvious implication of this is that the education and health systems must continuously produce the required number and balance of generalists and specialists to provide the right care, and our engagement in the education and training of future physicians is valuable.


Beyond our offices

The call to socially accountable action demands that we see beyond the world of our offices and into the communities of which they are a part. It requires us to care for our individual patients by embracing our obligations to look “upstream” and to grapple with and respond to the broader social determinants contributing to our patients’ illnesses. Beyond that, it calls on family doctors to engage in addressing those local determinants in a way that will influence the health of all patients and, on a macro level, society itself.

Healing has different features at each of the micro, meso, and macro levels, but the common threads of our obligations and approaches bridge these levels. Our point of entry—an individual patient’s illness—allows us to trace the various possible causes and guides our therapeutic interventions beyond just the traditional individual (micro) level of care.

Conclusion

Through our enduring relationships with patients, family physicians are privileged to have a front-row seat for the pageant of human life. Our ongoing commitment to serving patients as individuals is a necessary, but not sufficient, description of our task. Bearing witness to illness and suffering and our understanding of its causes—from the molecular to the individual to the whole community—should motivate us to use our privileged position, with the power it provides, to act to help our patients at all 3 levels. If we are to have our most reliably positive effect on the health of both patients and populations, we must engage, as opportunities arise, with the many communities that directly affect that health—communities of institutional management, teaching and research, professional governance, and cultural and economic development. Our guiding principle

is that of social justice, as the single greatest determinant of health is the inequity embedded in the society we serve.¹⁰ The community level of social accountability is where this plays out most potently. It is also the level at which knowledgeable and committed family physicians can have their most effective and satisfying influence. 

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Competing interests

None declared

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