How do Educational Staff and Students in a Medical School Perceive Social Accountability? A Multi-Perspective Qualitative Interview Study

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Abstract

Background: The majority of medical education is currently biomedical, while the concept of social accountability is not always systematically integrated. Education on social accountability equips students with the knowledge and skills to be socially accountable health professionals. However, the existing definitions of social accountability are not consistently applied, and the perspectives of important stakeholders are lacking. This study explores the perceptions of medical students and educational staff members on the construct of social accountability. **Methods:** This study uses an exploratory qualitative design in which online semi-structured interviews were conducted with 28 educational staff members and 16 students at a medical school in the Netherlands. Participants were recruited using purposeful sampling and snowballing techniques. The interviews were qualitatively analyzed according to the grounded theory approach. **Results and Conclusion:** Amongst the participants, there was unfamiliarity with the term, social accountability. Participants mentioned the impact on society, institutional responsibility, and context-dependency as all features of social accountability. In line with previous studies, participants identified community-based learning and working, patient-centeredness, and diversity as sub-aspects of social accountability. Further aspects identified by the participants are sustainability, moral issues, and interprofessional collaboration. This study provided more insight into the construct of social accountability from the perspectives of educational staff and students at a medical school.

Keywords: social accountability, medical education, integration, multi-perspective, definition

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Background

Better integration of social accountability into the medical curriculum will ensure students master social accountability competencies during medical training, in addition to (pre)clinical knowledge and abilities. Students should continue to develop these competencies throughout their professional careers. At their graduation, medical students take the Hippocratic Oath and swear to uphold their ethical standards during their career: "*I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.*" [1, p5] This oath reflects physicians' obligations to patients, the profession, and to society. Social accountability includes these obligations towards society. Social accountability is represented in the CanMEDS framework. This is a common medical educational

framework in which the role of a health advocate, (which includes understanding patients' social needs, improving health through preventive medicine, increasing health equity, and creating change in the medical system), is one of the domains.[2]

Social accountability includes the integration of social themes that affect health (like poverty and migration), into the curriculum, and the involvement of the community in identifying the needs concerning healthcare. However, social accountability is often not systematically integrated as a concept in medical education, resulting in students developing insufficient knowledge and skills to respond to social themes and to involve the community in education, research, and service activities.[3] Furthermore, minority groups are insufficiently involved in the development of the construct of social accountability, and as a result, in medical education. These gaps lead to inefficient and inequitable healthcare, because the priority healthcare needs of society will be less efficiently addressed as a result of the underrepresentation of minority groups in education, research, and service activities.[3]

The World Health Organization (WHO) calls on the social obligation of medical schools to fulfil their social contract by integrating social accountability in their institutional approach and the content of medical curricula.[4] Medical literature has issued many calls for social accountability.[5,6] Boelen and Heck[4] were the first to urge medical schools to formulate a common vision of social accountability. They proposed the following definition: *The obligation of medical schools to direct their education, research, and service activities towards addressing the priority health needs of the community, region and/or nation they have a mandate to serve. The priority health needs are to be identified jointly by governments, healthcare organizations, health professionals and the public.* [4, p3] It is of significant importance that medical schools develop a common vision of social accountability to enhance the integration of social accountability into the medical curriculum.[7,8]

In recent years, the attention to social accountability in medical education has increased. Six dimensions of social accountability were distinguished based on a survey amongst medical students, preceptors, and community members: a service to the community in which people explain or take responsibility for their actions; answer for one's actions; show good character by being honest and transparent, and treating people with respect; ensure community health well-being; work for social justice; and participate in shared decision-making.[9] The criteria of the ASPIRE to Excellence award distinguished four domains of social accountability: 1) organization and function of the school; 2) education of doctors; 3) research activities; and 4) contribution to health services and health service partnerships for the community/region.[8] A different study showed that meeting the population's health needs and being connected, responsive to, and accountable to the community's needs and context were considered as aspects of social accountability.[10]

Although the literature provides many definitions of social accountability and its various domains, the perspectives of important stakeholders, such as educational staff and students, are underrepresented.[9] The construct has not yet been sufficiently investigated in depth by means of multi-perspective interviews with different stakeholders related to specific contexts. The inclusion of the perspectives of key stakeholders would enhance the applicability and tangibility of the definition of social accountability. This study explores the perceptions of medical students and educational staff members on the construct of social accountability. The following research question was posed: How do medical school educational staff and students perceive social accountability?

Method

Design

This study employed an exploratory qualitative design to investigate the participants' perspective of the construct of social accountability through inductive analysis of the data gathered from individual semi-structured interviews. This design enabled a more in-depth investigation of the participants´ perspectives on social accountability. The study took place at a faculty of medicine in the Netherlands, where the integration of social accountability is in its starting phase, and where the aim is to integrate social accountability in its medical curriculum. Three subgroups were distinguished in the study sample: 1) educational staff; 2) undergraduate students; and 3) graduate students. We defined "educational staff" as coordinators, policy advisors, medical and executive board members, educational designers, principal educators, and teachers. Principal

educators are teachers who improve the quality of the faculty by developing new courses and strengthening faculty development.

Ethics

Ethical approval for this study was obtained from the Dutch Society for Medical Education (NVMO) (Case Number 2020.8.6). We can confirm that all methods were performed in accordance with the relevant guidelines and regulations. The participants received an information letter via email before the interview, and signed informed consent. The pseudonymization of the data guaranteed privacy. The abbreviation ES is used for educational staff and the abbreviation S is used for students.

Sampling and recruitment

Purposeful sampling and snowballing were used to recruit the participants. The educational staff members and students were invited to participate in this study in March 2021. A list of educational staff members was obtained from the secretary, who were invited by e-mail. Students were invited by means of a message posted on an electronic learning platform and an announcement in the faculty's newsletter. For the educational staff members and students who agreed to participate, convenient dates and times were arranged by e-mail.

Participant demographics

Twenty-eight educational staff members and 16 students participated in this study. Six principal educators, four members of the board, 15 coordinators, four policy advisors, and two teachers participated. Several participants had more than one function; for instance, several individuals were coordinator *and* principal educator. Six graduate students and 10 undergraduate students participated. The recruited participants were a heterogeneous group, based on age, years of experience or study, and whether or not they were first-generation students. The demographics of the participants are presented in *Table 1*.

Table 1: Participant Demographics

	Educational Staff (N = 28)	**Students (N = 16)**
Male/Female	**12/16**	**10/6**
	Educational Staff (N = 20)	**Students (N = 11)**
Age	**52.6 (33-66)**	**23 (17-26)**
Years of working experience	**15.5 (1-40)**	
Year of study		**3.7 (2-6)**
First-generation student	**Yes 10** **No 10**	**Yes 5** **No 6**
Country of birth	**Germany 1** **Netherlands 19**	**Netherlands 11**
	Educational Staff (N = 17)	**Students (N = 11)**
Country of birth parents	**Netherlands 30** **Indonesia 2** **Germany 2**	**Netherlands 17** **Germany 1** **Egypt 2** **Turkey 2**

Data collection

Procedure

We conducted semi-structured interviews until saturation was reached from May to June 2021. Because of COVID-19 measures, the interviews were conducted by videoconference or phone, which are good alternatives for face-to-face interviews.[11, 12] The interviews took between 30–60 minutes and were conducted by the main researcher (JO). A second researcher (JS) also attended several interviews to enhance consistency. We recorded the interviews and two student assistants transcribed the interviews, verbatim. To increase credibility, our research team, consisting of two educational scientists, a principal educator, a vice-dean of the faculty, and two students discussed findings. To increase credibility, we present quotes from the participants. We asked clarification questions to the participants to ensure we interpreted the information correctly, and to increase the confirmability. To increase the confirmability, we discussed the analysis within the team; and to increase the dependability, we conducted interviews until saturation was reached. To increase transferability, we have described the participants, methods, and procedures in as much detail as possible. Saturation was reached when new interviews did not produce new information, compared to the previous interviews.

Materials

An interview guide was created to create consistency between the interviews. The interview guide consisted of: (1) a question about how the participants would define social accountability themselves (e.g., *What are the first things that come into your mind when you think of the construct of social accountability in the context of a medical school?);* (2) a question to reflect upon the definition provided by us (e.g., *What do you think of the definition we provide of social accountability?);* (3) a question to reflect upon the distinguished aspects of social accountability provided by us (e.g., *To which extent do you think the constructs we mentioned are logical or illogical to consider as social accountability, would you consider these constructs also as social accountability and do you think of other constructs?).*

Due to the relative unfamiliarity of the construct, we anticipated that the participants would experience difficulties formulating their own definition. Therefore, we first asked openly about social accountability, and then we provided a definition based on the often-used definition by Boelen and Heck[4] and the domains distinguished by the ASPIRE award. "*The obligation of medical schools to focus their education, research, and healthcare on the priority health needs of the population, region, and country they serve. Subdomains of social accountability are diversity, interprofessional collaboration, community-based learning and research, patient-centered care, and sustainability*" [4, p3, 8]

Data analysis

The analysis of the data was conducted according to the grounded theory method described by Boeije. [13] We chose this method because it enables a detailed analysis and is often used for the construction of an understanding. The analysis consisted of two steps: segmenting and reassembling. Segmenting consists of open and axial coding. Open coding is the fragmentation of text, the labelling of fragments with codes; and axial coding is the establishment of relations between codes, the clustering of codes, and the defining of codes. In the last step of the analysis, reassembling, the main theme is determined, to which all the other categories can be related. By segmenting and reassembling, main and sub-themes will be generated, creating a new understanding of a construct.[13] Some interviews (11%) were analyzed by two researchers (JO and JS), and the remaining interviews were analyzed by JO. The differences between these analyses and the findings of all interviews were discussed until a consensus was reached. The program MaxQDA was used for coding the transcripts. During the analysis, memos were created to write down ideas that arose during coding. The emerging themes were discussed in the research group.

Results

The interview transcripts' qualitative analysis revealed several main and sub-themes. Features are defined in this study as characteristics that define social accountability and sub-aspects as skills and knowledge domains that can be distinguished in social accountability. Table 2 presents the main themes, sub-themes, and main findings.

Table 2: Main themes and sub-themes and main findings

Main themes	Sub-themes	Main findings
Level of familiarity with the term (1)	Unfamiliarity with the term (1a) Associations with the term (1b)	-The term is unfamiliar to most of the educational actors and to all students. -Several educational actors and students provided a definition by literally translating or analysing the term. -The term is considered as abstract. -Social accountability is associated with the role of health advocate by the CanMEDS.
Features of social accountability (2)	Societal impact (2a)	-A main feature of social accountability is the impact on society. -The impact on society is considered as contributing to solving social problems.
	Institutional responsibility (2b)	-A main feature of social accountability is institutional responsibility. -Institutional responsibility includes the reciprocal relationship between a student and the society and the medical institution. -Institutional responsibility is considered as ensuring that the student population is a representation of the serving population, being student-centered, and connecting with society.
	Context-dependency (2c)	-A main feature of social accountability is institutional responsibility. -Institutional responsibility includes the reciprocal relationship between a student and the society and the medical institution. -Institutional responsibility is considered as ensuring that the student population is a representation of the serving population, being student-centered, and connecting with society.
	Context-dependency (2c)	A mean feature of social accountability is context-dependency. -Social accountability is considered as a multifactorial construct which has a different meaning in different contexts. -The proposed definition is considered as a logical and complete definition and is especially focused on education.
Sub-aspects of social accountability (3)	Community-based learning and working (3a)	-Community-based learning and working is considered as a sub aspect of social accountability. -Community-based learning and working is seen as using knowledge and skills to benefit the community; investigating the needs of society; involving the community in education and research; teaching social issues; using education and research to improve healthcare policies; volunteering.
	Patient-centeredness (3b)	-Patient-centeredness is considered as a sub aspect of social accountability. -Patient-centeredness is seen as putting the individual patient at the center of focus and dealing with more assertive patients.
	Diversity (3c)	-Diversity is considered as a sub aspect of social accountability. -Diversity is seen as being sensitive to and having respect for differences; acquiring knowledge about the relationship between social-economic-status and diseases; having a broad view; being aware of bias; creating an inclusive environment; counteracting colonization in education.

	Sustainability (3d)	**-Sustainability is considered as a sub aspect of social accountability.** **-Preventive medicine, planetary health, and efficiency are seen as sub aspects of sustainability.** **-Students should be educated about their own ecological footprint and how to limit this.**
	Moral issues (3e)	**-Moral issues are considered as a sub-aspect of social accountability.** **-Moral issues are seen as ethical issues and dilemmas.**
	Interprofessional collaboration (3f)	**-Interprofessional collaboration is by some participants seen as a sub aspect of social accountability, other participants see interprofessional collaboration as a way to achieve social accountability.** **-Interprofessional collaboration is considered as collaborating between professionals/students of different disciplines; treating others equally; having respect for others.**

Main and Sub-Themes

Level of familiarity with the term (1)

Unfamiliarity with the term (1a)

Most of the educational staff and students explicitly stated that they experienced difficulties explaining the meaning of social accountability. Furthermore, several educational staff and students defined social accountability by translating or analyzing the term. "Social" relates to the relationship between a physician, student, medical school, or hospital, and society; and "accountability" relates to the obligation the aforementioned entity has towards society. This difficulty explaining the term, and the fact that participants analyzed or translated the term, reflects the unfamiliarity of the construct amongst educational staff and students.

Associations with the term (1b)

Several educational staff associated social accountability with the role of health advocate, as described by the CanMEDS (Royal College of Surgeons and Physicians of Canada, 2021). These participants seemed more familiar with the term "health advocate" than social accountability. Participants also considered the term abstract: "*I think you need to try to make it tangible by using several main aspects*" (ES1).

Features of social accountability (2)

Social impact (2a)

The educational staff and students considered social accountability to be the responsibility of a doctor, an organization, or a medical school towards society, to contribute to the solutions of social problems such as homelessness, and health problems caused by living circumstances.

Institutional responsibility (2b)

Some participants also perceived social accountability as the responsibility a medical school has towards the student and society, which includes, for instance, ensuring that the medical student population represents the population they will serve: "*Because the extent in which we as a medical school take our responsibility to take account of diversity or other social issues like using our resources in an environment-friendly way is different from educating our students about these issues*" (ES10). Several of the educational staff believed that social accountability is a reciprocal relationship between society and the medical school. The medical school is funded by society; in return, the medical school and hospital provide education to future health professionals, and contribute to society by providing good healthcare, and ensuring everyone has access to medical care. Social accountability involves thus a commitment to and connection with society.

Context-dependency (2c)

Participants mentioned that social accountability is a multi-factorial construct that is context-dependent: the context of research (e.g. involving the community in research), education (e.g. teaching social accountability knowledge and skills and creating equitable changes), organization (e.g. reducing the emissions of the hospital), student, society, individual (e.g. paying respect to patients and colleagues of different backgrounds) and collective. According to the participants, our definition was specifically focused on education, instead of on the context of research or organization, especially the constructs of community-based learning and interprofessional learning. "*And then you mentioned several constructs which are all very education-related*" (ES9).

Sub-aspects of social accountability (3)

Community-based learning and working (3a)

According to the participants, social accountability is about community-based learning and working, which means using knowledge and skills in a way that benefits and involves the local community. For instance, in developing educational material or formulating research questions. Community-based learning and work also teach students about the issues that are considered important by society, and how to investigate social needs: "*The worst thing you can do is to build your medical school like an ivory tower with only a service entrance for employees*" (ES11). Community-based learning further included using education and research to improve healthcare policies, which means learning about healthcare policies in relation to social needs and demographics to adjust those policies. Students need to learn where and when healthcare and society do not fit each other, how the society is constructed, and the social problems that exist.

Another aspect of community-based learning and working was volunteering and providing help in developing regions or countries. For instance, Doctors without Borders or the Kruispost, a Dutch health care center that provides free medical and psychosocial care to people who cannot find help in the regular healthcare system. e.g., uninsured, homeless, or asylum-seeking people: "*You get a feeling about what can be improved in society as a beginning doctor or student*" (S33).

Patient-centeredness (3b)

Patient-centeredness was considered to be: teaching students to take social aspects of the patient into account, to align the knowledge and course of action with the needs of the patient, and to deal with patients who are now more assertive than patients used to be: "*To learn to deal with patients who take matters in their own hands with regard to diagnosing*" (S26).

Diversity (3c)

Participants approached diversity as being sensitive to, and having respect for, differences in culture, ethnicity, gender, age, living circumstances, migration background, sexual preference, living environment, and educational level. Participants considered it important that students acquire knowledge about socioeconomic backgrounds in relation to diseases, and that they learn to have a broad view and to be aware of bias: "*They (the students) think that they know how everything in the world works, but actually they are looking at their own prejudices*" (ES8). Diversity was also about creating a diverse and inclusive learning and working environment, for instance by counteracting colonization and avoiding stereotypes in clinical cases: "*I think it is the responsibility as a medical institution to be aware of the fact that we base our cases often too much on stereotypes*" (ES10).

Sustainability (3d)

Sustainability was considered an essential part of social accountability of which several aspects are distinguished. Firstly, efficiency: "*Efficiency is for me also (a part of) social accountability because we have a system with restricted human resources and funding in which we have to make sure that everyone has access to a minimum of healthcare"* (ES7). Secondly, preventive medicine, which was about creating a society in which there are as few diseases as a result of environmental circumstances as possible. Thirdly, planetary health, which included teaching students about their own ecological footprint as a student, as a professional, and that of the healthcare sector; to learn what the impact of their footprint is on the environment and ways to minimize this impact: "*This way they can get perspectives for action to reduce their own impact*" (ES12). To improve sustainability, it was of great importance to recognize the connection between ecosystems, sustainability, and health.

Moral issues (3e)

Another aspect of social accountability was moral issues; for instance, the dilemma of whether or not to work in a private clinic: "*Students have to think about whether or not they want to work in a private clinic. We have our main point of focus on educating doctors who treat all patients equally. That means that we educate doctors who generally consider working in a private clinic, where only a select group of people can be treated, morally disapproving*" (ES10). Another dilemma: "*Is it ethical that we send a patient back into a society that causes diseases, after their treatment in the hospital?*" (S35). The participants stressed that a lot of diseases can be prevented by taking social factors into account.

Interprofessional collaboration (3f)

Another aspect was interprofessional collaboration, which entails the collaboration between professionals or students of different disciplines, and includes treating other professionals equally and respecting their competencies and professionalism. However, some participants experienced interprofessional collaboration in order

to achieve social accountability, rather than a sub-aspect of social accountability: "*I see social accountability like a mission, a purpose. If you make it big, your own life purpose, you can fulfil this mission in several ways. Interprofessional education is one of the ways in which you can operationalize it*" (ES10).

Discussion

Main findings

This study explores the perceptions of medical students and educational staff members regarding the construct of social accountability. The qualitative analysis revealed that participants experienced difficulties explaining the term, and analyzed or translated the term literally, which reflected unfamiliarity with the construct of social accountability. Participants mentioned the impact on society, institutional responsibility, and context-dependency as features of social accountability. Identified sub-aspects of social accountability are community-based learning and working, patient-centeredness, diversity, sustainability, moral issues, and interprofessional collaboration.

Findings related to prior literature

This study further explores the understanding of the construct of social accountability by including the perspectives of medical students and educational staff. Previous literature showed unfamiliarity with the construct of social accountability among medical teachers, and being sensitive to social needs as a significant aspect of social accountability.[14] Among the participants of our study, we also found unfamiliarity with the construct of social accountability. This unfamiliarity is congruent with the faculty's early phase of integration of social accountability. Existing research showed diversity, patient-centeredness, and community-based learning and working as sub-aspects of social accountability.[15] These aspects are also defined as sub-aspects of social accountability by the participants of our study. Furthermore, previous research showed meeting social needs, addressing social issues in the curriculum, and forming community memberships as aspects of social accountability.[16] These aspects are represented in the sub-aspect community-based learning and working distinguished by our participants and in the feature of societal impact. Other dimensions of social accountability revealed in the previous literature are: a service to the community in which people explain or take responsibility for their actions, answer for one's actions, show good character by being honest and transparent, and treating people with respect, ensure community health well-being; work for social justice, and participate in shared decision-making.[9] The dimension, work for social justice, is related to advocacy, which is a dimension that is underexposed by our participants. The other dimensions are represented in the sub-aspects and features distinguished by our participants.

In accordance with our findings, a previous study has shown context-dependency as a feature of social accountability, which means that social accountability is dependent on contextual features, such as specialism and region.[17] The participants of our study did not consider social accountability only an individual responsibility—but an institutional responsibility. Moral issues are an aspect that is identified by the participants, and has not yet been explicitly included in existing literature.

Strengths and limitations

The research team consisted of people with various educational functions: a board member, an educational scientist, a policy advisor, and a principal educator. This facilitated different perspectives coming together in this study, and enabled the interpretation of the results from different viewpoints. Another strength of this study is the heterogeneity of the study population in terms of age, years of experience or year of study, and status as a first-generation student.

One of the limitations of this study is that we had already used the term "social accountability" in the invitation letter, and announced our aim as a medical school to implement social accountability in our curriculum. This information could have biased participants, because it may be the case that participants had already searched for this term online, and were biased by the information they found beforehand. Moreover, the participants could have focused their definitions of educational constructs under the influence of the context we mentioned. The definition we provided to the participants during the interview may have biased the participants in their answers. In addition, the term social accountability had never been discussed in depth with the students and educational staff, because the implementation of this construct at the medical faculty is still in an early stage. This might be the cause of the participants' unfamiliarity with the term. Furthermore, the participants were all related to the same medical institution, which could

Recommendations for further research

The current study has explored the perceptions of medical students and educational staff members regarding the construct of social accountability. Future research can dive deeper into this construct by investigating how social accountability is currently implemented, how it would *ideally* be implemented, and the experienced barriers and facilitators regarding the implementation of social accountability. Furthermore, future research can also incorporate patient and community perspectives on defining social accountability in medical education.

Conclusion

This study provided insight into the understanding of the construct of social accountability. We used the findings of this study to formulate a definition of social accountability based on three factors: the differences between the definition we proposed and the definitions the participants proposed; the similarities between these definitions; and the participants' reflections upon our proposed definition. We have made a start in formulating a tangible and applicable definition of social accountability in medical education: *A global obligation of medical schools to respond to the priority health needs of the population to be served to deliver equitable healthcare. This obligation involves a reciprocal relationship between medical schools and society. This relationship is expressed in directing education, research and service activities towards current and significant social factors such as diversity, sustainability, and moral issues. Learning objectives, learning activities, and evaluation tools are co-constructed to measure the impact of each other's actions.* This definition can be further developed by including the perspective of patients. If medical schools adopt social accountability, and integrate social accountability into their curriculum, students will be better prepared with the knowledge and skills required to be socially accountable healthcare professionals.

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