Social accountability and accreditation: a new frontier for educational institutions

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CONTEXT An association with *excellence* should be reserved for educational institutions which verify that their actions make a difference to people's well-being. The graduates they produce should not only *possess* all of the competencies desirable to improve the health of citizens and society, but should also *use* them in their professional practice. Four principles enunciated by the World Health Organization refer to the type of health care to which people have a right, from both an individual and a collective standpoint: *quality, equity, relevance* and *effectiveness.* Therefore, social, economic, cultural and environmental determinants of health must guide the strategic development of an educational institution.

DISCUSSION Social responsibility implies accountability to society for actions intended to serve it. In the health field, social accountability involves a commitment to respond as best as possible to the priority health needs of citizens and society. An educational institution should verify its impact on society by following basic principles of quality, equity, relevance and effectiveness, and by active participation in health system development. Its social accountability should be measured in three interdependent domains concerning health personnel: conceptualisation, production and utilisability. An educational institution that fully assumes the position of a responsible partner in the health care system and is dedicated to the public interest deserves a label of excellence.

CONCLUSIONS As globalisation is reassessed for its social impact, societies will seek to justify their investments with more solid evidence of their impact on the public good. Medical schools should be prepared to be judged accordingly. There is an urgent need to foster the adaptation of accreditation standards and norms that reflect social accountability. Only then can educational institutions be measured and rewarded for their real capacity to meet the pressing health care needs of society.

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INTRODUCTION

An educational institution that aspires to *excellence* in the production of health care professionals should be granted that status not only when its graduates possess all of the competencies desirable to improve the health of citizens and society, but when they are able to use them in their professional practice. Although medical schools are not presently held to account for the ways in which their graduates are used, and serve, their societies, such an accounting may be required in the future. Educational institutions are increasingly requested to be more explicit about their outputs of professional practitioners and the impact of their presence on social well-being. We may expect policies in higher education and health care to foster such an approach, providing there is political will to improve coordination between the identification of people's health needs, health care system management and educational strategies. In return, educational institutions must use their autonomy and resources to make the best use of their innovative potential to meet these challenges.

Over the last half-century, the quality of education of health care professionals has progressively improved through a series of educational advances.[1] These have included among other things: planning of educational programmes by objectives; problem-based learning; training in multi-professional teams; early immersion in the community and first-line health care services; the adoption of a 'learner-centred' approach; faculty development; educational research, and, more recently, extensive use of informatics and the Internet. Moreover, in many instances norms used for the evaluation and accreditation of educational institutions take these developments into account.

Although these are all very useful, these innovations have not materially contributed to correcting the global crisis affecting human resources development in the health care sector.[2] This crisis is exemplified by an appalling inventory of contributory factors, which include: a quantitative lack of health care staff; inadequate proportions of specialties with respect to priority health care needs; a chronic dearth of primary health care staff; the migration of health professionals to more socially and financially attractive working environments; the underserving of rural areas; a general deficit of effective action towards disease prevention and health promotion; little mobilisation of citizens to assume responsibility for protecting their own health; poor incentives to work in partnership with the social sector for a more effective impact on the social determinants of health; a drifting towards the merchandising of services at the expense of professional ideals; lessening trust in health professionals by administration and the public, and the de-motivation of health care professionals. If we add the professional migration patterns aggravating the already inequitable distribution of health care human resources, we present a context of severe global challenge for medical schools.

How can they cope with such a crisis? To what extent can an educational institution help mitigate the crisis through its education, research and service missions? It is imperative that the design, implementation and follow-up of educational programmes be established in a manner that ensures they are relevant to the needs of citizens and society as a whole and are closely related to the process of national health development. Because health policy has an influence on the spectrum of competencies that health care professionals need to possess, the institution must have an interest in such policy. This proactive posture of the institution should be clearly enunciated in its mission statement and institutional objectives. Moreover, its strategic development plan should be formulated with due regard to evolutionary trends in the health care system and the projected needs of health care personnel, in both qualitative and quantitative terms. Educational programmes should be adjusted accordingly.

There is an expectation that the other partners in social accountability (policy makers, health service managers, health professionals and the public) are equally committed to anticipation, adaptation and quality assurance.

WHAT SOCIAL ACCOUNTABILITY IMPLIES

The World Health Organization (WHO) defines the social accountability of medical schools as representing: 'the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, 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.'[3] From this, two features of social accountability emerge: altruism and integration. Altruism focuses primarily on society's well-being and integration is an integral part of the social canvas.

Two groups of principles may serve as frames of reference: humanistic principles, which are relative to people's protection, and systemic principles, which are relative to the relationship of the institution with the health care system.

Humanistic principles

Four principles, enunciated by WHO, refer to the type of health care to which people have a right, from both an individual and a collective standpoint: *quality, equity, relevance* and *effectiveness.* The principle of quality seeks to provide the citizen with the best possible measures to protect, restore and promote a state of physical, mental and social well-being. The principle of equity tries to ensure that every citizen has full access to health care services and does not face any form of discrimination. The principle of relevance seeks a response to priority health care needs and the provision of special attention to the most vulnerable individuals or groups in society. The principle of effectiveness refers to the utilisation of health care resources, both human and material, in a manner that serves the public interest in the most effective and efficient way.

Systemic principles

These principles relate to the understanding of the complexity of a health care system and to the capacity to find a most useful place in it. The institution is likely to improve its effectiveness if it works in partnership with other stakeholders in the system, namely, policy makers, health system managers, health care professionals and civil society. In order to implement the humanistic principles outlined above, each of these stakeholders has a coordinated role to play. For instance, the policy maker should frame a long-term vision of a health care system which is coherent and integrated; the health system manager should ensure an allocation of resources that is consistent with this vision; the health care professional should acquire competences to deliver the appropriate range of services, and the citizen should assume greater responsibility in protecting his or her own health and that of the community. All partners should adapt their roles and act in synergy to strengthen the system and its human resources for health.[4]

To be fully socially accountable, an institution needs to claim the right to question whether its 'products' (graduates, service models or research findings) are being used in the best interest of the public. Social accountability entails a duty to venture into a field over which the institution has no formal authority, namely, the functioning of the health care system. We suggest that, taking humanistic and systemic principles as references, a label of excellence should be reserved exclusively for institutions which are designed to make an impact on society.

EXCELLENCE IN IMPACT

By questioning its raison d'être and the final impact of its work, such an institution undertakes a higher order of social accountability. Achieving such an undertaking requires the institution to address a number of interconnected issues: the prioritisation of needs; the system characteristics necessary to facilitate the greatest impact of its graduates; health promotion; required competences; career supports, and impact analysis, etc. These issues need to be addressed by the institution in order to establish and orient its mission. The institution in isolation cannot find all the answers. As a 'producer' of professionals, it must enter into a series of relationships with the social institutions that will utilise its output. At the same time, it must realise that needs are in constant evolution and thus its curriculum and goals must be in a state of constant adjustment. The series of relationships, information gathering, feedback loops and effectors of change needed for this require that the institution recognise principles of complexity in its plans and actions.[5–7] Thus linear relationships of cause and effect need to be replaced by the creation of explicit, adaptable processes that define desired outputs and measure actual outputs while adjusting to the needs of the system their graduates are entering. This is no small task.

Achieving the desired impact requires an initial definition of the type of graduates desired. Desirable profiles, with their spectra of competencies, have been described in models suggested by the WHO (i.e. the 'Five-Star Doctor'), the UK General Medical Council (i.e. 'Tomorrow's Doctor'), the Royal College of Physicians and Surgeons of Canada (i.e. in CanMEDS), and by promoters of the concept of 'professionalism'.[8–11] However, even if such graduates are achieved, if their competencies are not formally recognised and fairly rewarded by the health care system, their desired impact will not be achieved. The graduates will either be underemployed or will revert to the kinds of practices that *are* incentivised. The educational institution must therefore initiate a frank conversation between those who design health policies, those who organise health care services and

those who create job opportunities and support services requiring the acquired competencies.

Partnership is productive within an institution if common interest prevails over private interests. The threat is real if the members of one partner focus on their own interests and ignore the wider social perspective. Within medical education the focus on acquiring biomedical information and technology skills often directs students away from developing the skills and attitudes required to understand and address the true determinants of health in their patients. It should not come as a surprise that most of the creativeness in medical education concentrates on curriculum content and learning methods rather than on the social purpose and moral obligations of the curriculum. In brief, a lot of emphasis is placed on processes and not enough on impact.

This disappointment is not new! At the beginning of last century, Abraham Flexner was mandated by the Carnegie Foundation to undertake a review of the quality of North American medical schools. Aware of lack of equity in the US health care system, he recommended that Afro-American students should benefit from excellent medical education in order to contribute to raising the health status of their communities. Flexner dared to make a correlation between good medical education and population health. Achieving a positive impact on the health of citizens through improved medical education was indeed the prime motive for the exercise. Unfortunately this expectation fell short as the reform of medical schools conducted by his successors consisted of strengthening the scientific nature of the curriculum but little else.[12] History has demonstrated the result: blocks of education in the basic sciences became a compulsory passage before students were allowed any contact with patients and the social environment; the introduction of the social sciences and humanities is limited and late; disciplines and departments guard their autonomy jealously; vertical teaching is enhanced at the expense of the integrated teaching best suited to address complex health issues, and the public health sciences have been marginalised. These were unintended consequences of good intentions. The lack of assessment of the impact of graduates and the evolving needs of society have tended to isolate the institution from the living environment. This model has remained distressingly~prevalent worldwide for over a century and continues to inspire parameters for the accreditation of medical schools. This represents an historical missed opportunity for the academe to set as its raison d'être its impact on social well-being.[13]

EXPRESSIONS OF SOCIAL ACCOUNTABILITY

Social accountability requires that the actions of a medical school begin and be grounded in the identification of societal needs. The meeting of those needs is the desired end. We suggest that the beginning and end of this complex process are connected through a cascade of three specific, although interdependent, domains concerning the health professionals they produce: conceptualisation, production and usability (Fig. 1).

The domain of *conceptualisation* involves the collaborative design of the kind of professional needed and the system that will utilise his or her skills. The domain of *production* involves the main components of training and learning. The domain of *usability* involves initiatives taken by the institution to ensure that its trained professionals are put to their highest and best use.

The term 'usability' is preferred to the terms 'utilisation' or 'usefulness'. Graduates may indeed be utilised and useful as soon as they are employed in any health care structure, even if they only partially apply the spectrum of competencies in which they have been trained. By contrast, the notion of usability refers to the degree of concordance between their acquired competencies and their opportunities to practise them. Therefore, the domain of usability should reflect processes initiated by the institution to ensure that the profile of a health professional on which the training was based is properly valued in the future working environment.

There may be a mismatch between an institution applying this conceptualisation–production–usability (CPU) model and the health system if there are not enough job opportunities for health professionals educated to respond to the public interest. A sustainable series of partnerships is necessary if feedback loops of CPU activities are to be built. Social accountability cannot be entirely fulfilled if all of the
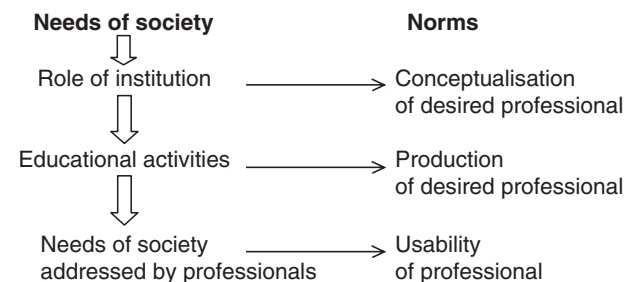

Figure 1 Needs of society and norms

main actors do not share a common set of values and an effective, although complex, system through which to express those common values.

Table 1 presents a general framework from which specific norms, indicators and criteria can be drawn to orient an educational institution towards greater social relevance. It covers three domains and 11 sections for a total of 31 items. A certain degree of redundancy among items is unavoidable because of the inherent structure of the model.

One of the major concerns in the design of the CPU model is to ensure consistency among the three domains of conceptualisation, production and usability. Here are some illustrations:

- the value of equity mentioned at item 1.1, which the institution declares is one of the founding principles, is referred to in items of section 5 (Educational programme) and in items 10.1 and 10.2 of section 10 (Employment);
- there is a link between item 1.3 (Health system), advocating that an educational institution should be an integral part of a health system (provided it is oriented to meet the needs of citizens and society), and an engagement with health management in a given geographical area in partnership with other actors (items 2.2 and 2.3), and between the utilisation of this area for field operations in education, research and service delivery (section 4), and, finally, the verification of effects (items 11.1 and 11.2), and
- the same concern for consistency is demonstrated when the institution undertakes to train a certain type of health professional (items 1.4 and 2.4), designs an educational programme (item 5.1), evaluates the acquisition of competencies (item 6.3) and verifies the effects on practice (item 10.3).

An illustration of how the CPU model could be used concretely, with examples relative to the different items, will be addressed in another paper.

RELATING TO CURRENT EVALUATION AND ACCREDITATION SYSTEMS

Since the introduction of norms for evaluating and accrediting medical schools in North America by the Liaison Committee on Medical Education (LCME), through the different national initiatives inspired by these and until the more recent publication of international standards by the World Federation of

Medical Education (WFME), the main emphasis has been put on the domain of production, and only minor interest shown in the domains of conceptualisation and usability[14–16] (Table 2).

In 1995, the WHO, in its advocacy role for socially responsive health policies, recommended that principles of social accountability be taken into account in the quality assurance of medical education. The WHO did not make concrete proposals regarding norms and nor did it explicitly encourage countries to avail themselves of revised accreditation systems.[17,18]

Recently, international groups such as the Network towards Unity for Health, via a task force on 'social accountability and accreditation',[19] the Conférence Internationale des Doyens des Facultés de Médecine d'Expression Française (International Organisation of Deans of Francophone Medical Schools, CIDMEF), via its council for evaluation,[20] and the Société Internationale Francophone d'Education Médicale (International Francophone Society of Medical Education, SIFEM), through its working group for 'society and health',[21] have began to support this direction for action. Similarly, the Foundation for the Advancement of International Medical Education and Research (FAIMER), the mandate of which is to develop medical education expertise worldwide, stresses the need for medical education to demonstrate tangible effects for the improvement of the health of populations.[22] Moreover, national health policy analysts, specialised groups in the development of human resources for health, and the United Nations, through Millennium Development Goals, add their support for such a reorientation.[23,24]

Many national and regional efforts are underway to establish accreditation systems. There is a pressing need to launch an initiative that embraces standards based on social accountability before institutions and countries become too firmly engaged in adopting accreditation approaches that do not optimally reflect obligations to society.

TRENDS AND OPPORTUNITIES

As globalisation is reassessed for its social impact, societies will seek to justify their investments with more solid evidence of the impact of these investments on the public good. Medical schools should be prepared to be judged accordingly. Arguments in favour of the CPU model based on ethical, democratic, economic and political issues are presented below.

Table 1   The conceptualisation–production–usability model

Conceptualisation
  1 References
    1.1 Values: explicit reference to values (i.e. quality, equity, relevance, effectiveness)
    1.2 Population: reference to population features and priority health needs
    1.3 Health system: reference to health system development for greater coherence and integration
    1.4 Health personnel: reference to qualitative and quantitative needs (see 1.1, 1.2, 1.3)
  2 Engagements
    2.1 Mandate: mission and institutional objectives consistent with References
    2.2 Field: involvement in health management of a territory and given population
    2.3 Partnership: institutionalised partnership with key stakeholders, locally and nationally
    2.4 Expected outcome: definition/justification of profile (list of competencies) (see References above)
  3 Governance
    3.1 Strategic planning: engagements incorporated in a widely accepted development plan
    3.2 Management: validation, co-ordination and evaluation of implementation of plan
    3.3 Resources: mobilisation of internal and external resources consistent with Engagements (see 2)

Production
  4 Field operations: education, research and services activities consistent with Engagements (see 2)
  5 Educational programme
    5.1 Objectives and content: consistent with profile of health professional (see 2.4)
    5.2 Curriculum structure: early and longitudinal exposure to priority health issues in the community
    5.3 Learning process: solving complex health problems, both for individuals and communities
    5.4 Practicals: sites prioritising primary health care and linkage with other levels of health service
  6 Students
    6.1 Recruitment: equal opportunity and priority to students from underserved communities
    6.2 Career: orientation and assistance to access jobs related to priority health issues
    6.3 Evaluation: reference to the entire spectrum of competencies (see 2.4)
  7 Teachers
    7.1 Source: involvement of a variety of teachers from the health and social sectors
    7.2 Abilities: teachers serving as role models, in reference to the profile (see 2.4)
    7.3 Support: training and incentives to improve abilities in public health and medical education
  8 Research: related to health system management (see References, section 1, and Usability, sections 10, 11)
  9 Service: excellence in primary health care services (see Usability, sections 10, 11)

Usability
  10 Employment
    10.1 Job opportunities: advocacy and partnership for emergence of priority health professions
    10.2 Settlement: retention and distribution of graduates according to needs (see 1.1, 1.2)
    10.3 Quality of services: maintenance of competences of graduates (see 2.4)
    10.4 Practice: improving working conditions at primary health care level (see sections 4, 9, 10)
  11 Impact
    11.1 Partnership: relationship with stakeholders for improved management of health system
    11.2 Effects on health: risk reduction and health promotion in the field (see 2.2, 2.3, 4)
    11.3 Promotion: dispatching results on usability to decision-making bodies, both local and national

Table 2 Societal needs and medical education norms

	Conceptualisation	Production	Usability
Current norms	+	+++	+
Desired norms	+++	+++	+++

Ethical issues: causes and consequences

The aim to minimise risks (first, do not harm) in human endeavours that affect people's health is older than the legacy of Hippocrates. Society demands this cautionary principle of its practitioners and, increasingly, of the institutions that produce them. Further, society demands that a relationship be established between decisions for actions and the long-term effects of those actions. Although a direct correlation between educational strategies and population health is not easily demonstrable, proxies exist. We can differentiate a socially accountable institution from one that is not.[1,3] We should also provide evidence that the educational programmes of socially accountable institutions result in the education of health professionals who are responsive to society's priority health care needs.

Democratic issues: openness and transparency

Areas that used to be reserved for experts are increasingly accessible to the public. Wide access to information and the more critical attention of citizens lead to questioning of the management of any institution. The explicit recognition of a socially accountable institution will reassure both its students and the wider public.

Economic issues: results and support

Greater transparency will induce comparisons among institutions. Accreditation norms based on principles of social accountability will enable public authorities, funding agencies and civil society to more knowledgably support those institutions with the capacity for a higher social impact.

Political issues: system approach and enhanced synergies

Good governance of institutions will be defined increasingly by these institutions' capacity to take into account the complexity of the socio-political environment and to take advantage of opportunities to build sustainable partnerships with other institutions with similar or complementary missions. We may anticipate that political authorities will attribute excellence and provide resources preferentially to institutions that show an aptitude to create synergies that induce greater coherence and performance of the health care system.

CONCLUSIONS

Accreditation systems, properly designed and mandated, can be powerful forces for quality and change in any complex system. This is particularly true of the institutions of medical education. Accreditation can support countries in their regulatory obligation to institutionalise quality assurance approaches and guide individual institutions in their development. Therefore, it is very important to pay close attention to developments in this area. There is an urgent need to foster the adaptation of accreditation standards and norms that reflect social accountability. Only then can educational institutions be measured and rewarded for their real capacity to meet the pressing health care needs of society.

REFERENCES

1 Woollard R. Caring for a common future: medical schools' social accountability. *Med Educ* 2006;**40**:301–11.
2 Joint Learning Initiative. *Human Resources for Health: Overcoming the Crisis.* Cambridge, MA: President and Fellows of Harvard College 2004.
3 Boelen C, Heck J. *Defining and measuring the social accountability of medical schools.* Geneva: World Health Organization 1995. http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7_fre.pdf. [Accessed 15 November 2008.]
4 Boelen C. *Towards unity for health: challenges and opportunities for partnership in health development.* Geneva: World Health Organization 2000. http://whqlibdoc.who.int/hq/2000/WHO_EIP_OSD_2000.9.pdf. [Accessed 15 November 2008.]
5 Waldrop M. *Complexity: the Emerging Science at the Edge of Order and Chaos.* New York, NY: Simon & Schuster 1992.

6   Mennin S. Small-group problem-based learning as a complex adaptive system. *Teach Teacher Educ* 2007;**23**:303–13.

7   Glouberman S, Zimmerman B. Complicated and complex systems: what would successful reform of Medicare look like? *Commission on the Future of Health Care in Canada* Discussion Paper No. 8, Government of Canada, July 2002.

8   World Health Organization. *Doctors for Health. Doctors for Health. A WHO global strategy for reorienting medical education and medical practice for Health for All.* Geneva: WHO 1996 (WHO/HRH/96.1).

9   General Medical Council. *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education.* London: GMC 2003. http://www.gmc-uk.org/education/undergraduate/tomdoc.pdf. [Accessed 15 November 2008.]

10 Frank JR, ed. *The CanMEDS 2005 Physician Competency Framework. Better Physicians. Better Care.* Ottawa, ON: Royal College of Physicians and Surgeons of Canada 2005. http://crmcc.medical.org/canmeds/canMEDS2005/index.php. [Accessed 15 November 2008.]

11 American Board of Internal Medicine Foundation, American College of Physicians Foundation, European Federation of Internal Medicine. Medical Professionalism in the New Millennium. A Physician Charter. *Ann Intern Med* 2002;**163**:243–6.

12 Flexner A. *Medical education in the United States and Canada. A report to the Carnegie Foundation for the Advancement of Teaching.* New York, NY: Carnegie Foundation (Bulletin No. 4) 1910.

13 Boelen C. A new paradigm for medical schools a century after Flexner's report. *Bull World Health Organ* 2002;**80**:592–3.

14 Liaison Committee on Medical Education. *Functions and structure of a medical school. Standards for accreditation of medical education programmes leading to the MD degree.* 2008. http://www.lcme.org/functions2008jun.pdf. [Accessed 15 November 2008.]

15 World Federation for Medical Education. *Basic Medical Education Standards. WFME global standards for quality improvement.* Copenhagen: WFME 2003. http://www.wfme.com. [Accessed 15 November 2008.]

16 Karle H. International recognition of basic medical education programmes. *Med Educ* 2008;**42**:12–7.

17 Boelen C, Bandanarayake R, Bouhuijs PAJ, Page GG, Rothman AI. *Towards the assessment of quality in medical education.* Geneva: World Health Organization 1992 (WHO/HRH/92.7).

18 Gastel B, Wilson MP, Boelen C, eds. Toward a global consensus on the quality of medical education: serving the needs of populations and individuals. Proceedings of the 1994 WHO/Educational Commission for Foreign Medical Graduates Invitational Conference, Geneva, 3–4 October 1994. *Acad Med* 1995;**70** (Suppl 7):1–90.

19 World Health Organization Network towards Unity for Health. The Network towards Unity for Health. http://www.the-networktufh.org. [Accessed 15 November 2008.]

20 Conférence Internationale des Doyens de Facultés de Médecine d'Expression Française. *Politique et méthodologie d'évaluation des facultés de médecine et des programmes d'études médicales.* Bordeaux: CIDMEF 2006. http://www.cidmef.u-bordeaux2.fr. [Accessed 15 November 2008.]

21 Société Internationale Francophone d'Education Médicale. *Facultés de médecine et besoins de santé. Vers de nouvelles normes d'évaluation/accréditation.* Grenoble, France: SIFEM 2007. http://www.sifem.net/SanteSociete.php. [Accessed 15 November 2008.]

22 Foundation for the Advancement of International Medical Education and Research. *Improving world health through education.* Philadelphia, USA: FAIMER. http://www.faimer.org. [Accessed 15 November 2008.]

23 World Health Organization. *Global Health Workforce Alliance. Strategic Plan.* Geneva: WHO 2006. http://www.who.int/workforcealliance. [Accessed 15 November 2008.]

24 United Nations. *Millennium Development Goals.* http://www.un.org/milleniumgoals/index.shtml. [Accessed 15 November 2008.]