Title

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Journal

Advances in Health Sciences Education, 23(4)

ISSN

1382-4996

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Publication Date

2018-10-01

DOI

10.1007/s10459-017-9792-z

Adv in Health Sci Educ (2018) 23:853–862
https://doi.org/10.1007/s10459-017-9792-z

REFLECTIONS

Time for action: key considerations for implementing social accountability in the education of health professionals

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Received: 3 October 2016 / Accepted: 17 August 2017 / Published online: 12 September 2017

Abstract Within health professional education around the world, there exists a growing awareness of the professional duty to be *socially responsible*, being attentive to the needs of all members of communities, regions, and nations, especially those who disproportionately suffer from the adverse influence of social determinants. However, much work still remains to progress beyond such good intentions. Moving from contemplation to action means embracing *social accountability* as a key guiding principle for change. Social accountability means that health institutions attend to improving the performance of individual practitioners and health systems by directing educational and practice interventions to promote the health of all the public and assessing the systemic effects of these interventions. In this Reflection, the authors (1) review the reasons why health professional schools and their governing bodies should codify, in both curricular and accreditation standards, norms of excellence in social accountability, (2) present four considerations crucial to successfully implementing this codification, and (3) discuss the challenges such changes might entail. The authors conclude by noting that in adopting socially accountable criteria, schools will need to expand their philosophical scope to recognize social accountability as a vitally important part of their institutional professional identity.

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Keywords Global health · Health equity · Health professional education · Humans · Interprofessional relations · Social accountability · Social responsibility

Introduction

Social determinants substantially influence the health and illness of all people (Braveman et al. 2010; Woolf and Braveman 2011). Although recognizing these determinants has long been a topic on the academic agenda (Porter 2006; Schroeder et al. 1989; Showstack et al. 1992), few educational institutions have fully embraced the charge of integrating them in their curricula for training health professionals. They have yet to assume the "obligation to direct their education, research, and service activities toward addressing the priority health concerns of the community, the region, or the nation they have a mandate to serve" (Boelen and Heck 1995, p. 3).

There clearly exists a growing awareness of the professional duty to be *socially responsible*, meaning being attentive to the needs of everyone, including those who disproportionately experience illness as an adverse effect of social determinants. However, much work still remains to move beyond such good intentions. The progression from contemplation to action means embracing *social accountability* as a guiding principle of education and practice. Social accountability implies that health professional schools attend to (1) improving the performance of individual practitioners and health systems through interventions that promote the health of all the public, including those living on the margins of society, and (2) assessing the systemic impact of these interventions (Boelen and Woollard 2011).

In light of these considerations, we ask: *Is it time for academic health professional institutions and their governing bodies to codify in their professional curricula and accreditation standards norms for excellence in social accountability?*

Current realities

Many health professional schools have expressed in their mission statements interest in attending to community needs, especially as they relate to people living in medically underserved areas (Mullan et al. 2010; Morley et al. 2015). Various educationally-focused organizations have similarly articulated their agreement with such sentiments (Adler et al. 2016; Frank et al. 2015; Robert Wood Johnson Foundation 2016; National Academies of Sciences, Engineering, and Medicine 2016). Over the years, several academic institutions have sponsored programs dedicated to training small groups of health professionals in the principles and practice of social medicine and community health (Ho et al. 2008; Strelnick et al. 2008; Zink et al. 2008; Dharamsi et al. 2011; Haq et al. 2013; Kaye et al. 2010), particularly with an eye toward educating students about the effects of social determinants (O'Brien et al. 2014; Meurer et al. 2011). Although progress is underway in select settings (Strasser et al. 2015), there still remains a huge gap between the expressed goals of these bodies and initiatives and the institutional response of the greater academic community (Fleet et al. 2008; Tyer-Viola et al. 2009; Puschel et al. 2014; Armstrong and Rispel 2015).

Recently, interest in learning and teaching about the social determinants of health and their effects has blossomed (Bezruchka 2012; Braveman and Gottlieb 2014). Much scholarly attention has been given to upstream causes and downstream consequences of such factors as income inequity, food insecurity, and racism (Stringhini et al. 2010; Weiler et al. 2015; Paradies et al. 2015) As well, the popularity of global health as a topic for scholarly discourse (Haq et al. 2000; Panosian and Coates 2006; Ventres 2017), the attraction of participating on short-term international service-

learning trips (Parsi and List 2008; Ventres and Wilson 2015), the implementation of South–South academic exchanges (Quintana et al. 2012; Flinkenflögel et al. 2015), and various efforts by interdisciplinary leaders in the majority world (Papp et al. 2013; Michaels et al. 2014) have heightened interest in understanding how social determinants affect health outcomes around the world (Ventres and Fort 2014; Kasper et al. 2016). Nonetheless, regardless of location, these activities have fallen short of creating a critical consciousness around social accountability as a means of addressing health inequities (Kumagai and Lypson 2009). The gap between well-informed intention and sustained commitment to change remains wide (Sharma et al. 2017).

The reality of these gaps reflects common cultural ideologies that have deep roots in education and practice (Bloom 1989; Eisenberg 1995; Engel 1988). As well, it strongly suggests that current approaches are not sufficient to improve the health of all (Starfield 2006). Collecting evidence documenting how the health of vulnerable people unduly suffers in relation to that of those who are well off has not been enough to change systems of education and practice (Pickett and Wilkinson 2014), and the knowledge that addressing inequities can reduce health disparities has not resulted in improved health outcomes across populations (Bloom 1990; Marmot 2005). Consequently, the question remains: How do we move toward rectifying these gaps and reducing these disparities?

Bridging the gaps

We believe the answer to this question rests in the execution of two parallel strategies. First, we concur with others who have recently called for major cultural transformations within health professional education, aimed toward inculcating among faculty members and students a commitment to health equity and incorporating such values as generosity, solidarity, and social interdependency when teaching how social determinants affect health (Frank 2004; Dawson and Jennings 2012; Sharma et al. 2017; Ventres et al. 2016). Second, in order to ameliorate the burdens these determinants have on health inequities, we assert that principles of social accountability must guide changes in the structure and outcomes of medical education and practice. As well, resultant socially accountable interventions must be implemented and their effects assessed. This second strategy is our focus here.

In order to move from intention to action, we suggest that academic administrators, affiliated hospital and health plan executives, and members of governing bodies of accrediting professional associations commit to social accountability through leadership development, organizational capacity building, and programmatic governance. We encourage these institutional authorities to address social determinants by (1) re-orienting their standards for education, concentrating on high-value, community-based, health-promoting primary-care interventions, and (2) targeting these interventions toward economically poor and socially marginalized people in their surrounding communities. We urge these academic, corporate, and administrative leaders to make social accountability central to the work of training health professionals for, and providing medical services to, all people in the communities they serve.

Key considerations

Much information supporting this move to social accountability already exists. This includes specific frameworks that model social accountability in action (Boelen and Woollard 2009; Leinster 2011; Ventres and Dharamsi 2015; Boelen et al. 2016),

declarations of policy from international institutions and organizations (Pan American Health Organization 2007; Training for Health Equity Network 2011; Murray et al. 2012; Larkins et al. 2013; Reddy et al. 2013), and tactical statements such as the Global Consensus for Social Accountability of Medical Schools (2010). As well, various articles describe how socially accountable principles have informed particular curricular and service activities (Meili et al. 2011; Kaprielian et al. 2013; Strasser et al. 2015), some even suggesting how to apply them at the level of patient interaction (Ventres and Haq 2014; Buchman et al. 2016; Goel et al. 2016; Woollard et al. 2016).

Based on our review of these sources and our own experience leading ventures in social accountability, we submit that academic administrators, affiliated hospital and health plan executives, and members of governing bodies of accrediting professional associations consider four critical factors as they work to implement socially accountable goals. Although not unique to social accountability, they are vital components of any activity or planned intervention that purports to be socially accountable. These four considerations, each accompanied by corresponding task-oriented concerns that require examination (Table 1), include:

1. *Partnerships* Recognizing how social determinants influence health outcomes is not something that any member of any health profession can accomplish in isolation.

Table 1 Implementing social accountability in health professional education—key factors, considerations, and actions

Critical factor	Key considerations	Task-oriented actions (representative examples/rationales)
Partnerships	Identify key stakeholders	Assess community health resources/needs (US Centers for Disease Control and Prevention 2013)
	Nurture strategic/collaborative relationships	Develop community-based/participatory strategies (South and Phillips 2014)
	Develop targets for implementation/assessment	Set communally-established equitable goals (Eichbaum 2017)
Accreditation	Link targets to socially accountable goals	Review exemplar SA programs/current site specific activities (Hosny et al. 2015)
	Explore social/environmental perspectives	List and compare current/prospective SA standards (Frank et al. 2015)
	Emphasize long-term service/stewardship needs	Incorporate a test/revise/re-test plan to develop standards (Boelen et al. 2012)
Competencies	Integrate SDOH in planning/implementation	Identify interdisciplinary individual/institutional objectives (Frenk et al. 2010)
	Focus on underserved/marginalized areas	Include community-oriented development goals (Strasser et al. 2013)
	Reference population health measures	Re-orient measures of evaluation toward community outcomes (The Training for Health Equity Network 2011)
Leadership	Build appropriate human/institutional resources	Identify influential program participants (Shaw et al. 2012)
	Create/refine inventive assessment tools	Select key areas for assessment (engagement, responsiveness) (Lodenstein et al. 2017)
	Nurture SA orientations/intentions/ethics	Revise vision/mission statements to reflect SA plans (Morley et al. 2015)

Becoming more socially accountable means identifying key stakeholders in healthcare and social systems, those who provide services as well as those who receive them. It means developing strategic and collaborative partnerships with these stakeholders. It means, as well, engaging with these stakeholders, across institutional and cultural boundaries, to promote best practices, systematic assessments, and programmatic results that are mutually beneficial and sustainable over time.

2. *Accreditation* Integrating social accountability into curricular and service endeavors means that standards for implementation and evaluation must address systemic issues such as access to health-care, equity, continuity, and relational engagement, inclusive of all societal members. It is important that these standards address institutional and individual capabilities in light of such concerns as social context, history, culture, geographical place, service needs, and financial stewardship.
3. *Competencies* Moving toward social accountability in health professional education means training and evaluating learners as to how knowledge, skills, attitudes, intentions, and relationships interact in the promotion of health as well as the treatment of disease. While such abilities are only part of the equation that adds up to producing the right health care professionals to offer the right care "with the right partners at the right time in the right place" (Boelen and Woollard 2011, p. 615), those promoting social accountability include, among others: understanding social determinants and upstream approaches to care; attending to underserved, marginalized, and vulnerable people and communities; applying skills in health advocacy, teamwork, and cross-cultural communication; and, employing evaluation and administrative tools in public and population health.
4. *Leadership* Growing social accountability implies focusing human and financial resources on specific objectives. This means (1) expanding appropriate training strategies and assessment methods, and (2) aligning financial incentives to support socially accountable goals. It means supporting the strategic, advocacy, and research roles of schools as they apply to medically underserved areas close to and far away from where they are located. It means developing and validating tools to assess the short- and long-term impacts of educationally-, scholarly-, and practice-based interventions aimed at improving the health of the public. Ultimately, it means welcoming a philosophical shift in educational ideology, one that begins with a willingness to accept institutional social accountability and may require capacity-building assistance, at the highest organizational levels, to guide the way.

Further considerations

We are well aware that many educators, administrators, and executives may be wary of these suggestions. Some may argue that attending to social accountability lies well outside the traditional domain of health professional education, or that adding another area of required focus will decrease time allotted for other concerns in already crowded curricula. Others may note that the responsibility for social determinants and their influence on health and illness lies with other professionals, especially those working in politics, social services, and even public health—physicians, nurses, and other clinicians should stick to the diagnosis and treatment of disease (especially given how current systems of remuneration preferentially support these pursuits). Still others may aver that the future of health care, and hence the education of its professionals, lies in the potential of high-tech diagnostics,

gene-based therapies, and population-derived "big data", rather than in interventions traditionally associated with social accountability, including participatory public engagement, interprofessional collaboration, and the integration of high-quality primary care in communities of need.

We recognize that addressing social accountability, through the incorporation of partnerships, revision of accreditation standards, elaboration of appropriate competencies, and enhancement of leadership potential, signifies a change away from of the conventional wisdom that currently steers the course of health professional education (Cooke et al. 2010). We agree with those who see this change as a necessary adaptation, and not a rejection, of tenets that have guided education worldwide for over a century (Maeshiro et al. 2010). We also see this integration less as a burden and more as an opportunity for academic institutions: socially accountable schools need not give up all that they do well today as they become key actors in community assessment, civic engagement, and documentation of outcomes. In order to achieve success, however, they will need to expand their philosophical scope to recognize community as a vitally important part of their institutional professional identities—social accountability does not end with curricular reforms and cannot be left as a task for others (Vanderbilt et al. 2016).

Conclusion

We applaud the admirable efforts that many health educators around the world already have made to instill in their colleagues and students a sense of social responsibility. Now, however, given (1) the mounting evidence that social determinants affect all people's health, and (2) the inconsistent institutional commitment to systematically addressing these determinants in current medical education and practice, it is time for administrators and the governing bodies of health professional schools to become socially accountable by explicitly attending to the four factors we outline above. Educators and other stakeholders can no longer assume that the health of the public is others' responsibility and does not pertain to their interests. It is time to lead and take action: it is time to make social accountability a core value and an institutional duty. We look forward to seeing social accountability become a driving force behind progressive changes in health professional curricula, the enactment of new accreditation standards, and a positive influence on the health of all people in communities worldwide.

Acknowledgements Dr. Ventres thanks the Brocher Foundation, Geneva, Switzerland; the Faculty of Health Sciences, Nelson Mandela Metropolitan University, Port Elizabeth, South Africa; and the Institute for the Medical Humanities, University of Texas Medical Branch, Galveston, Texas, for supporting him with residential fellowships during which this essay was designed, written, and revised.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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