

Demonstrating social accountability in medical education

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Abstract

THE AUTHOR CONSIDERS THE UNIVERSITY OF TORONTO'S Health, Illness and the Community course for undergraduate medical students, described in this issue by Wasylenki and associates (see pages 379 to 383). Social accountability in medical education demands a community orientation and hence an emphasis on outreach. Medical schools should expand their clinical service to the community, provide community-based residency placements and offer continuing medical education in rural and regional centres. Accountability also requires community involvement in planning and implementing research projects. Placing students in a community setting as part of the curriculum is praiseworthy, but it is not sufficient to ensure social accountability. What is needed now is a more comprehensive acceptance by faculties of medicine of the mandate of community-centred learning, together with well-targeted funding for education and research initiatives.

Résumé

L'AUTEUR SE PENCHE SUR LE COURS INTITULÉ La santé, la maladie et la communauté, qui s'adresse aux étudiants en médecine de premier cycle de l'Université de Toronto et que Wasylenki et ses collaborateurs décrivent dans le présent numéro (voir pages 379 à 383). L'imputabilité sociale en éducation médicale passe par une orientation communautaire et met donc l'accent sur l'intervention communautaire. Les facultés de médecine devraient étendre leur service clinique à la communauté, fournir des stages de résidence dans la communauté et offrir de l'éducation médicale continue dans les centres ruraux et régionaux. L'imputabilité passe aussi par la participation de la communauté à la planification et à la mise en oeuvre de projets de recherche. Il est louable de placer les étudiants en contexte communautaire dans le cadre du programme d'études, mais cela ne suffit pas pour assurer l'imputabilité sociale. Il faut maintenant que les facultés de médecine acceptent de façon plus complète le mandat de l'apprentissage communautaire, ainsi que le financement bien ciblé d'initiatives d'éducation et de recherche.

A heightened emphasis on social accountability is an important challenge facing medical schools today. The Health, Illness and the Community course required of first- and second-year medical students at the University of Toronto and described by Dr. Donald A. Wasylenki and associates in this issue (see pages 379 to 383) is one response to this challenge. Such initiatives should be considered against the background of recent thinking on social accountability in medical education. What constitutes an acceptable comprehensive strategy for accountability? What does it mean for a medical school to be "community oriented"? Does adding community-based learning experiences to the curriculum adequately answer the challenge of social accountability?

Definitions

The social accountability of medical schools has been defined as their "obligation to direct . . . education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve."¹ For medical faculty, such a community orientation means



Editorial

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practising medicine, teaching and conducting research outside the institutional setting of hospital and classroom and involving the public in planning, implementing and reviewing these activities.

Community-based education has been advanced by the Health Professions Schools in Service to the Nation (a program of the Pew Health Professions Commission and the US National Fund for Medical Education) with the concept of "service learning," by which students experience rigorously planned and evaluated learning activities while providing direct community service.²

Expectations

What society expects of medical schools is determined by the public at large as well as by governments, health professionals and educators. In 1988 participants at the World Conference on Medical Education adopted 12 resolutions for medical education reform. One of these was to "enlarge the range of settings in which educational programmes are conducted, to include all health resources of the community, not hospitals alone." Another was "to encourage and facilitate cooperation between the ministries of health, ministries of education, community health services and other relevant bodies in joint policy development, programme planning, implementation and review."³

In 1980 the College of Family Physicians of Canada (CFPC) task force on curriculum presented 4 principles as the basis of family medicine. The second and third of these were: "Family medicine is a community based discipline," and "The family physician is a resource to a defined practice population."⁴ These principles are now imbedded in the accreditation guidelines of the CFPC.⁵

In 1990 the Educating Future Physicians for Ontario (EFPO) program conducted a comprehensive public review to determine what society expects of physicians. Six key roles were identified: communicator, collaborator, expert clinician, advocate, gatekeeper and learner. EFPO then began to develop programs for faculty development and student assessment based on these roles.⁶ In 1995 the Royal College of Physicians and Surgeons of Canada established the CanMEDS 2000 project to tailor the roles identified by EFPO to a specialist membership. In the section of its report that dealt with residency, the Royal College's working group on societal needs stated: "If a skill or competency will ultimately be utilized in a community setting it should be learned in that setting."⁷

Research bodies have also recently reviewed their public accountability. The Medical Research Council of Canada's task force on health research recommended in 1994 that the council "support the participation of communities in all phases of research, as appropriate to the

questions under study."⁸ Recently, the Kahnawake Schools Diabetes Prevention Project (a partnership of the Kahnawake Mohawk community, community-based researchers of the Kateri Memorial Hospital Centre and the Kahnawake Education System, and academic researchers from McGill University and the Université de Montréal) developed a code of research ethics that expects continuous consultation and collaboration with the community, the employment of community researchers and staff, agreement of all research partners, including the community, before the project begins and involvement by all partners in decisions about reporting and publishing results.⁹

The clinical services of medical schools have historically been provided mainly through their affiliated hospitals to populations situated nearby. Prompted by necessity and the evident social benefits of wider service, medical schools have begun to extend their outreach activities in clinical service and continuing professional education through regional and rural centres. A successful example of this trend is the University of Western Ontario's Perinatal Outreach Program.

Academic outcomes

What outcomes should be used to measure a medical school's accountability to society? I would suggest 4: accreditation by the Royal College or the CFPC; successful completion by residents of the Royal College and CFPC examinations; appropriate numbers and distribution of family physicians and specialists; and evidence that most clinical disciplines in each school have research programs in which community partners are fully involved. The first of these measures reflects the recognition of the Royal College and the CFPC that community learning sites should be available in any accredited program. The second still requires development: examinations that seriously assess a candidate's sense of social accountability and ability to practice well outside of an academic setting are not well developed.

The third measure — appropriate numbers and distribution of physicians — continues to challenge medical faculties. Medical schools cannot be held responsible for the failure of government and professional organizations to negotiate and arrange reasonable environments and rewards for physicians to practise where they are needed. For the most part, graduates are entering the full range of practice sites available across the country. But they do not stay because they are not supported by the necessary resources.

Finally, the need for research that invites the participation of the community concerned has been acknowledged. Here, the challenge is to find sufficient funding without encroaching on basic science research funds, to cultivate



the necessary research skills in the academy and the community, and to ensure that ethical standards are met.

The rigour of community-based education and research must equal that traditionally expected in an academic setting. Although methodologic standards may need to be adjusted to fit a community context, applying *different* standards does not mean applying *lower* ones. If, for example, a qualitative analysis is used to assess patients' experiences of the transition from hospital to ambulatory care, the standards established by peer review in that methodology must be met. Methods of student assessment may also need modification; for example, residents assigned to remote sites could be examined via electronic media, but such examinations would have to be equivalent to those given at the home institution.

A comprehensive strategy

Simply placing students in a community setting as part of the curriculum is not a sufficient response to the challenge of social accountability in medical education. A comprehensive strategy would include education, clinical service and research. The education component would include a continuum of community-related activities throughout undergraduate education and residency. The services component would include clinical outreach activities as well as a commitment to producing the appropriate mix of generalists and specialists to serve the whole community. Finally, the research component would involve university faculty, members of the community and program funders in addressing research questions formulated in consultation with the community.

The University of Toronto's Health, Illness and the Community course leads the way in demonstrating commitment to the community. It deserves to be studied and

emulated. But it is not enough. A community focus in medical education must be sustained into residency and practice. It must be accompanied by research activity in which the community is a partner. Most of the supports necessary to implement a comprehensive strategy are in place: community groups, accreditation bodies and research organizations. What is needed now is full acceptance by faculties of medicine of the mandate of community-centred learning, together with well-targeted funding for education and research initiatives.

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