Medical schools' social contract: more than just education and research

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Medical schools and their students and faculty have always been involved in extracurricular activities in their communities. However, although students and residents, and some of their teachers, have initiated programs in recognition of the broader social role of their schools, and deans' offices have instituted programs to respond to community needs, there has been a failure to make these efforts explicit to their many publics, namely, potential students and residents, health care professionals and their organizations, governments and the general public. But this is changing. The medical schools of the future will need to formally address not only their roles in education and research but also their social roles in the community.[1]

There are many examples of student-initiated and medical school–initiated activities across the country at local, national and international levels, only a few of which can be included here. What began as a class project by 2 students at the University of British Columbia is now a student-run, evening-and-weekend medical clinic under the supervision of faculty members in the Downtown Eastside of Vancouver (www.chius.ubc.ca). At a national and international level, medical student groups work collaboratively with governmental and non-governmental organizations to promote international health and development, advocate for social change, improve educational capacity, that is, increase the international health content in Canadian medical schools as well as improve education (both basic and medical) in other countries, and facilitate information exchange between university students in Canada and abroad.[2]

Examples of medical school initiatives include the Southwestern Ontario Rural Regional Medicine Unit (www.sworm.on.ca), which was designed to develop, integrate and coordinate rural medicine at the University of Western Ontario and improve rural health care through medical education and research and development, and the joint University of British Columbia and University of Northern British Columbia Northern Medical Program (www.unbc.ca/nmp), which is intended to develop a community-based model of medical education.

Society provides medical schools and the medical profession with certain privileges and resources; these are justified only insofar as they are placed unambiguously in the service of those in need and their community. The public and patients expect that governments and the health care professions will work collaboratively to ensure that the Canadian health care system continues to provide the necessary access and quality to meet the needs of the population. By identifying and responding to the health needs of the community and by ensuring that individual graduating physicians understand their role in society, Canadian medical schools along with their partners, such as academic health care centres, governments, communities and other relevant professional organizations, have a major role to play in influencing the changes in the health care system that are necessary to ensure an effective, efficient, accessible, equitable and sustainable system.

For students to understand and adopt the values of professionalism at the bedside, they need to see it demonstrated by their faculty and peers. To understand their broader social roles, they need to see them demonstrated by their medical schools and deans and by their universities. Medical schools need to be socially accountable.

The World Health Organization has defined the social accountability of medical schools as

> the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.[3]

Medical schools should ensure that individual physicians graduate with the recognition that the profession of medicine is one of constant change and, thus, they need to be cognizant of the need for lifelong learning. Graduates need to be prepared to demonstrate their competence in an ever-changing environment, to ensure that their practice is based on evidence and to respond to the changing environment in which they practise. This includes recognition of the roles of other health care professionals and of the patient in the patient–physician interaction, advocacy on behalf of the patient and the willingness to work in a variety of settings where the need exists for medical services.

Medical schools must meet the challenge of changing their research agenda to include areas that have not been of paramount interest to academic researchers, while maintaining a leadership role in the traditional research arena. Their goal must be to be responsive to the current and emerging needs of their individual communities, within the larger context of national and international trends, by continually profiling the health status and health care needs of the community.

Provision of tertiary and quaternary care to the community is almost exclusively within the purview of those health care organizations that are inextricably linked to a medical school, the two forming the academic health sciences centre. A balanced integration of service and education, regardless of which sector of the health care system it takes place in, is essential to ensure the well-being of trainees and that the appropriate educational outcomes are achieved.

The explicit incorporation of social accountability within the fabric of medical faculties will provide the basis for the development of respectful partnerships for health with government, health authorities, communities and business. These partnerships will facilitate and encourage shared work on health planning, problem solving, health service delivery, health service evaluation and health policy development. The development of an effective social accountability model for medical schools will also provide a pattern for other professions and partners in health to follow as they develop similar social accountability frameworks.

We recognize that this is a long-term endeavour that requires the input of all partners. Each medical school has its own niche in the medical community and health care system and will have to define its own role in meeting the needs of its communities. In order for the concept of social accountability to become incorporated into the everyday life of medical schools, an iterative process is required. It is expected that there will be a range of time frames for the adoption of this concept, depending on the willingness of senior members of the academic community to commit publicly to explicitly acknowledging this role.

The benefits to individuals in the medical profession and to medical schools of explicitly incorporating the principles of social accountability into their daily activities range from greater personal job satisfaction to increased collegiality and collaboration among partners, including governments, in meeting the health needs of all Canadians. Through engaging in discussions of social accountability and professionalism, not only will society understand and appreciate what the medical profession has to offer but the profession will also reach a better understanding of itself.

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References

1. *Social accountability: a vision for Canadian medical schools*. Ottawa: Health Canada; 2001. Cat no H39-602/2002. Available: www.hc-sc.gc.ca/hppb/healthcare/pdf/socialaccountability.pdf (accessed 2003 Feb 12).
2. Hanlon J, Gupta S, Wires S, Kiran T, Tan D. Thinking globally: international health in medical education. *Univ Tor Med J* 2002;79(2):166-8.
3. Boelen C, Heck JE. *Defining and measuring the social accountability of medical schools*. Geneva: Division of Development of Human Resources for Health, World Health Organization; 1995. Document WHO/HRH/95.5.

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