Social accountability of medical schools: Do accreditation standards help promote the concept?

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ABSTRACT

The social accountability of medical schools is an emerging concept in medical education. This issue calls for the consideration of societal needs in all aspects of medical programmes, including the values of relevance, quality, cost-effectiveness and equity. Most importantly, these needs must be defined collaboratively with peoplethemselves.

Social accountability should be considered in the accreditation of medical education, a process implemented with the aim of ensuring quality in medical education. This process may be voluntary or mandatory and varies from one country to another.

The objective of this study is to analyse current accreditation standards in relation to the concept of social accountability.

The standards of the World Federation for Medical Education (WFME), the Liaison Committee on Medical Education (LCME) and the Australian Medical Council standards (AMC) were classified into process standards, content standards or outcome standards. The three sets of standards were plotted against the social accountability grid suggested by Boelen and Heck.

Most of the standards are process standards. Content standards are addressed less frequently than process standards, and very few standards address the outcomes of the medical school. When considering standards that address social accountability, the focus is on education more than the service and research functions of the medical school.

Standards should consider all aspects of the medical school's functions to promote the concept of social accountability.

Keywords: Social Accountability, Medical Schools, Accreditation, Standards

INTRODUCTION

To reach the goal of "health for all" suggested by the WHO, both health systems and medical schools must undergo major reforms [1, 2]. Reforms in medical schools should aim to promote health through three basic functions: education, research and service [3]. The consideration of social needs should be the mission of medical schools and the cornerstone for the achievement of these functions.

Medical education should aim to produce doctors who are prepared to provide care and who understand their role in the context of the community and society [4-6]. Research should address relevant areas of community health and should aim to improve the health of the community. Service should include both clinical and preventive aspects and should consider the health concerns of the relevant community.

Medical schools can be labelled socially responsible, socially responsive or socially accountable based on their response to societal needs [7].

A medical school that is socially responsible is aware of its duties regarding the health of society. Such educational programmes may be oriented towards common health problems, and objectives will be defined from within the school itself. A medical school that is socially responsive responds to the health needs of society by including community-based activities in its educational programmes. A medical school is considered socially accountable when it anticipates the identification of society's health needs through its contributions of society. This anticipation should be reflected in all functions and stages of the medical education programme [7].

The social accountability of medical schools is defined by the WHO as the, "obligation of the medical schools 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 organisations health professionals and the public" [8]. Thus, the major difference between these three concepts is that social accountability guides an institution's entire scope of activities [8] .

In considering the social accountability of medical schools, there are many concepts that parallel the public accountability of the health system [3]. These parallels may be seen in the context of the four values of the health system [8]: relevance, quality, cost-effectiveness and equity. These four values must be considered in the planning of the three components of a medical school programme (education, research and service), in the implementation of the programme and in assessments of the impact of the school's programme on the community, graduates and health services [8, 9] .

Accreditation of Medical Schools and Social Accountability

Accreditation in medical education is defined as "a voluntary peer-review process designed to test the educational quality of new and established medical programmes" [10]. The accreditation process is implemented with the aim of ensuring quality in medical education and ensuring that educational programmes produce competent doctors who are able to serve their communities. The process may be voluntary or mandatory and varies from one country to another [10].

The need for changes in the accreditation of medical education programmes arises in response to the accelerating changes in medical practices and health care delivery systems to meet the changing health needs of society, globalisation and the cross-border movement of health professionals [11-15].

Recent advances in establishing standards for the accreditation of medical schools are reflected in the work led by the World Federation of Medical Education (WFME) in collaboration with the World Health Organization (WHO). This work aims to provide a general quality assurance instrument for medical education to be used worldwide on a voluntary basis [16]. This work has resulted in the publication of the document "Basic Medical Education: WFME Global Standards for Quality Improvement" [17]. These global standards are intended to be used mainly as a tool for the development of medical programmes and to facilitate the international accreditation and recognition of medical schools [18] while addressing the issue of addressing national problems and challenges [12]. The standards are now widely used by many countries worldwide.

Many countries have developed their own standards and processes for accreditation. The Liaison Committee on Medical Education (LCME) is responsible for the accreditation of medical schools in the United States and Canada. In the document titled "Functions and Structure of a Medical School" [11, 19], the Committee issued standards for the accreditation of medical education programmes leading to the M.D. degree.

The Australian Medical Council (AMC) is the responsible body for the accreditation of medical schools in both Australia and New Zealand [11, 20-22]. The standards set by the AMC are divided into eight areas, which are further divided into sub-areas with standards within each sub-area.

The WFME, LCME and AMC are used as the basis for the development of accreditation systems in many countries around the world [11, 14, 23-25].

Accreditation standards play a significant role in promotion of change in medical schools and are considered one of the most important factors in promoting social accountability in medical schools, as indicated in the Global Consensus for the Social Accountability of Medical Schools [27].

The objective of this work is to analyse the accreditation standards of the WFME, LCME and AMC to determine how these standards are related to the concept of social accountability in medical schools.

METHODS

The standards of the three accreditation systems—the Liaison Committee on Medical Education (LCME), the World Federation for Medical Education (WFME) and the Australian Medical Council Standards (AMC)—can be classified as process standards, content standards or outcome standards. Process standards refer to standards that are related to a medical school's preparation for performing its functions and the execution of these functions. Content standards are standards that relate to the composition of a programme, and outcome standards are related to the results of a programme arising from the three main functions of education, research and service.

The Social Accountability Grid [8] has been used to analyse the standards of these three systems. In plotting these standards on the Social Accountability Grid, the researcher read each

standard at least three times and assigned each standard to the appropriate class in the social accountability grid.

The classification and plotting of the standards in the grid was performed through the following steps.

- A description was provided for each cell of the grid by summarising the definitions of the values by Boelen and Heck [8], as in table (1)
- The expected outcome for each standard in the WFME, LCME and AMC sets of standards is defined and placed in the appropriate cell of the grid. The process is shown below in table (2) with two standards for each set.
- When more than one classification can be obtained for the standard, the more relevant one was chosen.
- Consultations with experts in medical education were made with respect to some of the confusing standards (see acknowledgement) and experts from the Education Development Centre at the Faculty of Medicine-University of Gezira (EDC-Gezira) in Sudan.
- The process was repeated after a one-month interval, and the results of each step were compared.

Because there was a difference in the two standard plots, an expert opinion was sought. After the process was completed, the end product was sent to three external experts in medical education for revision and comments.

RESULTS

The World Federation for Medical Education (WFME), in its document titled Basic Medical Education WFME Global Standards for Quality Improvement, suggested nine areas for the accreditation of medical schools with 36 standards. Twenty-six (72.2%) of them are process standards, 8 (22.2%) are content standards, and only 2 (5.6%) are outcome standards, as shown in table (3) .

Twelve (33.3%) of the standards address social accountability issues, 7 (19.4%) address areas of education relevance, 3 (8.3%) address educational quality, and 1 (2.8%) are related to each of the two areas of research relevance and research quality, as shown in table 4.

The Liaison Committee on Medical Education (LCME) conducts the accreditation of medical schools in the US using 131 standards that are distributed in five main areas, which are divided into 17 subareas. Of these standards, 103 (78.6%) are process standards, 19 (14.5%) are content standards, and 9 (6.9%) are outcome standards, as shown in table 5.

Twenty-one (16%) of the standards address social accountability issues, 7 (5.3%) can be classified as education-relevant standards, 7 (5.3%) can be classified as education quality standards, 5 (3.8%) are related to education equity, and 1 (0.8%) standard is related to each of the two areas of research quality and service relevance, as shown in table 6.

The Australian Medical Council (AMC) has established eight areas for accreditation standards. There are 35 of these standards: 27 (77.1%) are process standards, 6 (17.1%) are content standards, and 2 (5.8%) are outcome standards, as shown in table 7.

Eleven (31.4%) of the standards address social accountability issues. Of these, 4 (11.4%) can be classified as education-relevant standards, and the same number are related to

education quality standards. Two (5.7%) address education equity issues, and one (2.9%) is related to research relevance, as shown in table 8. Tables 9 and 10 summarise comparison of the WFME, AMC and LCME standards when classified and plotted on the social accountability grid

DISCUSSION

It is evident that there are many initiatives for quality assurance in medical education, both nationally and internationally, through the development and application of standards [25]. Standards are the criteria or "yardstick" by which decisions and judgments can be made [13]. The functions of standards are to direct the design of educational programmes, lead the evaluation of these programmes, help in assessing consistency between the programmes and help students understand what is required of them [13, 28].

The results in this research illustrate that the existing accreditation standards of the AMC, the LCME and the WFME are process standards with little emphasis on content and outcomes. The focus on process standards is somewhat contrary to the movement towards competency-based education, which concentrates on the outcome of the education process and not the process itself [29]. The contribution of a good process to the outcomes is not clear [30]. The outcome-based movement seeks to address the optimal outcomes for patients and society based on the educational process, which usually begins with this expected end in mind [31].

The major emphasis of the standards is on the function of education, which may affect the impact on medical schools of improvements to the health status of the community.

Definitions of standards to address social accountability should consider three principles. First, the social goals should be defined through public discussion. Second, the goals should be specific. Third, the standards should be based on evidence that links them to the social objectives [32]

The literature suggests that given the funds and support that medical school graduates receive from society, these graduates should be evaluated for their social utility [32]. Thus, the assessment of social accountability should be a major component of accreditation standards and processes [27, 33].

The accreditation system can be a powerful force for change [34] and can lead to a consideration of the *impact* of educational programmes rather than the process of delivering these programmes [35]. Previous studies have shown that social aspects are considered in evaluations of medical school graduates if schools receive funds and support from society [32]. For this reason, the measurement of social responsiveness should be a major component of accreditation standards and processes [33, 36].

According to the definition of social accountability, medical schools should consider research and the provision of service as part of education. Thus, these areas should also be considered in accreditation standards [8, 37]. Medical schools are encouraged to actively provide health services in accordance with the community's health needs, as indicated by the WHO's definition of the social accountability of medical schools [8]. Both research and service are important for social accountability standards because medical schools are among the most important stakeholders of communal health.

A focus on education at the expense of the research and service functions of medical schools reflects the focus on the immediate role of the doctor rather than a consideration of the role of medical schools themselves [22].

The cost effectiveness of the functions of medical schools is not addressed in the three sets of accreditation standards. This may be because this area has only recently attracted attention.

Both the AMC and the LCME address equity in education. This focus may reflect the importance of considering the culture of the community in accreditation standards.

CONCLUSIONS

Accreditation standards should consider the changing health needs of the society. As the education process in medicine moves towards an outcome-based approach, accreditation standards should follow the same process of development. The social accountability of medical schools should be considered in future accreditation standards as a means of improving the outcomes of medical education.

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APPENDIX

Table 1: Description of the cells of the social accountability grid

Value	Domains and Values		
	Education	Research	Service
Relevance	The educational programme reflects major health issues	Research planning and conduct address major health problems	Service is directed towards important health problems
Quality	The educational programme addresses the production of graduates with necessary competencies to deliver quality service within the context of the society	Research planning and conduct address health problems using available high-quality methods	Service delivered is based on evidence and high technology
Cost effectiveness	The educational programme emphasises cost-effective personal and social health services	Research planning and conduct have the greatest impact on health with optimum use of available resources	Services delivered have the greatest impact on health with optimum use of available resources
Equity	The educational programme exposes students to problems in all categories in the society, and the programme can accept students from all of these categories	Research planning and conduct are directed towards problems in all categories of society	Services provided are available to all people

Table 2: Expected outcomes of the standards

Standard type	Standard number and text	Expected outcome	Classification
WFME	1-1 Basic The medical school must define its mission and objectives and make them known to its constituency. The mission statements and objectives must describe the educational process resulting in a medical doctor who is competent at a basic level with an appropriate foundation for further training in any branch of medicine and in keeping with the roles of doctors in the health care system.	The medical school must have a mission addressing society. The curriculum must be related to the mission. The objective must be as relevant as possible to the society to produce competent doctors to work a specific society	Education Relevance Process
	2-3 Basic The medical school must identify and incorporate into the curriculum the contributions of the basic biomedical sciences to create understanding of the scientific knowledge, concepts and methods fundamental to acquiring and applying clinical science.	The curriculum must have basic science components that increase the understanding of the rest of the curriculum; this should contribute to the production of quality doctors	Education Quality Content
LCME	IS-14-A Medical schools should make available sufficient opportunities for medical students to participate in service-learning activities and should encourage and support student participation.	Service to the community will provide learning opportunities to students and will be related to the curriculum	Service Relevance Content
	ED-1-A The objectives of the educational programme must be stated in outcome-based terms that allow the assessment of student progress in developing the competencies that the profession and the public expect of a physician.	The graduate's competencies and curriculum outcomes and assessment are related to society's expectations.	Education Relevance Outcome
AMC	1.6 The medical school has constructive partnerships with relevant health departments and government, non-government and community health agencies to promote mutual interests in the education and training of medical graduates skilled in clinical care and professional practice.	The medical school has partnerships with a health system that ensures the graduation of skilled doctors.	Education Relevance Process
	1.7 The medical course is set in the context of an active research programme within the school.	The research in the medical school is directly related to the educational programme.	Research Relevance Content

Table 3: Classification of the WFME standards

Process Standards	Content Standards	Outcome Standards
1-1,1-2,1-3,2-1,2 7 ,3-1,3-2,4-1,4-2,4-3,4-4,5-1,5-2,6-3,6-5,6-6,7-1,7-2,7-3,7-4,8-1,8-2,8-3,8-4,8-5,9-1	2-2,2-3,2-4,2-5,2-6 ,2-8,6-1,6-4	1-4,6-1
26 (72.2%)	8 (22.2%)	2 (5.6%)

Key: Number of area and number of standard in the particular area are present in the cells; e.g., 1-1 is area 1-standard no. 1.

Table 4: The distribution of the WFME standards on the social accountability grid

Value	Domains and Values		
	Education	Research	Service
Relevance	1-1 1-2 2-2 2-4 2-8 6-2 7-1 (7=19.4%)	6-4 (1=2.8%)	
Quality	1-4 2-3 2-5 (3=8.3%)	6-4 (1=2.8%)	
Cost-effectiveness			
Equity			

Key: Number of area and number of standard in the particular area are present in the cells; e.g., 1-1 is area 1-standard no. 1.

Table 5: Classification of the LCME standards

Process Standards	Content Standards	Outcome Standards
IS-1,IS-2,IS-3,IS-4,IS-5,IS-6,IS-7,IS-8,IS-9,IS-10,IS-11,IS-12,IS-12A,IS-13,IS-15,IS-16,ED-3,ED-4,ED-8,ED-9,ED-16,ED-24,ED-25,ED-26,ED-27,ED-28,ED-29,ED-30,ED-31,ED-32,ED-33,ED-34,ED-35,ED-36,ED37,ED-38,ED-39,ED-40,ED-41,ED-42,ED-43,ED-44,MS-1,MS-3,MS-4,MS-5,MS-6,MS-7,MS-8,MS-9,M2-10,MS-11,MS-12,MS-13,MS-15,MS-16,MS-17,MS-18,MS-19,MS-20,MS-21,MS-22,MS-23,MS-24,MS-25,MS-26,MS-27,MS-27A,MS-28,MS-29,MS-30,MS-31,MS-32,MS-33,MS-34,MS-35,MS-36,MS-37,FA-2,FA-3,FA-4,FA-5,FA-6,FA-7,FA-8,FA-9,FA-10,FA-11,FA-12,FA-13,FA-14,ER-1,ER-2,ER-3,ER-4,ER-5,ER-6,ER-7,ER-8,ER-9,ER-10,ER-11,ER-12	IS-14,IS-14A,ED-1,ED-5,ED-5-A,ED-6,ED-7,ED-10,ED-11,ED-12,ED-13,ED-14,ED-15,ED-17,ED-17-A,ED-18,ED-23,MS-2,MS-14	ED-1-A,ED-2,ED-19,ED-20,ED-21,ED-22,ED-46,ED-47,MS-31-A
103 (78.6%)	19 (14.5%)	9 (6.9%)

Key: Symbols represent the number of standards as in the LCME document

Table 6: The distribution of the LCME standards on the social accountability grid

Value	Domains and Values		
	Education	Research	Service
Relevance	ED-1-A ED-7 ED-10 ED-14 ED-15 ED-16 ED-20 7 (5.3%)		IS-14-A 1 (0.8%)
Quality	ED-5-A ED-6 ED-17 ED-19 ED-23 ED-37 MS-31-A 7 (5.3%)	IS-14 1 (0.8%)	
Cost-effectiveness			
Equity	IS-16 ED-21 ED-22 MS-7 MS-8 5 (3.8%)		

Key: Symbols represent the number of standards as in the LCME document

Table 7: Classification of the AMC standards

Process Standards	Content Standards	Outcome Standards
1-1,1-2,1-3,1-4,1-5,1-6,1-8,1-9,1-10,2-1,3-6,4-1,5-1,5-2,5-3,5-4,6-1,6-3,6-4,7-1,7-2,7-3,7-4,7-5,8-1,8-2,8-3	1-7,3-1,3-2,3-3,3-4,3-5	2-2,6-2
27 77.1%	6 17.1%	2 5.8%

Key: Number of area and number of standard in the particular area are presented in the cells; e.g., 1-1 is area 1-standard no. 1

Table 8: The distribution of the AMC standards on the social accountability grid

Value	Domains and Values		
	Education	Research	Service
Relevance	1-6 2-1 3-2 6-1 4 (11.4%)	1-7 1 (2.9%)	
Quality	4-1 6-1 6-2 8-3 4 (11.4%)		
Cost-effectiveness			
Equity	7-1 8-3 2 (5.7%)		

Key: Number of area and number of standard in the particular area are presented in the cells; e.g., 1-1 is area 1-standard no. 1

Table (9) A comparison between the WFME, AMC, and LCME standards

	Process Standards %	Content Standards %	Outcome Standards %
WFME Standards	72.2	22.2	5.6
AMC Standards	77.1	17.1	5.8
LCME Standards	78.6	14.5	6.9

Table (10) A comparison between the standards when plotted on the social accountability grid

	Domains and values											
	Education				Research				Service			
	Relevance %	Quality %	Cost-effectiveness %	Equity %	Relevance %	Quality %	Cost-effectiveness %	Equity %	Relevance %	Quality %	Cost-effectiveness %	Equity %
WFME	19.4	8.3	-	-	2.8	2.8	-	-	-	-	-	-
AMC	11.4	11.4	-	5.7	2.9	-	-	-	-	-	-	-
LCME	5.3	5.3	-	3.8	-	0.8	-	-	0.8	-	-	-