Editorial

Improving medical education through the paradigm of social accountability

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The World Health Organization (WHO) defined medical schools social accountability as: "the obligation to direct their education, research, and service activities toward addressing the priority health concerns of the community, the region, 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"[1]. More recently the Global Consensus for Social Accountability of Medical Schools (GCSA) defines a socially accountable medical school as one that: "responds to current and future health needs and challenges in society, reorientates its education, research and service priorities accordingly, strengthens governance and partnerships with other stakeholders and uses evaluation and accreditation to assess their performance and impact"[2]. These definitions are very important to foster a broader discussion on social accountability and health education for the future we want our students and next generations to have.

Medical schools concerned with their social impact is a concept that is moving forward as a central preoccupation in education on the health sciences. The biggest issue though would be to accomplish real change of attitude towards a less excluding medical education within academe,

firstly among professors and administration. And this is a challenge for the 21th century for the medical schools: to bring education, government sponsored healthcare provisions to communities in need and research on the direction of the priority health care needs of the community: in other words, social impact[3].

The social accountability concept is helpful as it aims to plan, implement and evaluate medical education programs. It promotes excellence in medical education, more precisely it increases the notion of making the greatest possible difference on people's health by a more purposeful use of resources and more active collaboration with constituencies that are supposed to benefit from undergraduates. To understand the impact of a medical education program on people's health we should try and answer two fundamental questions: "Are there medical education programs that have a greater impact on people's health?" and "Can social accountability be measured?". Satisfactory answers to those questions would reassure seekers of excellence in medical education.

If we want to come up with social impact assessment parameters to comply with, we must consider policies for avoiding high dropping out rates from undergraduates from disadvantaged

areas, to promote the education of primary care practitioners, and to foster practice opportunities in multi-professional transdisciplinary teams. So far, few medical schools have been able to impact on the peoples' health as prescribed by these indicators, both in the Northern and Southern hemispheres[4,5].

The administrative bodies of medical schools need to surmise how to contribute in increasing density and fair geographical distribution of health workforce keeping in mind the aforementioned issues. Other concern that must be tackled is how to foster the progress toward universal healthcare coverage and the interdisciplinary approach for person-centered care, particularly where chronic diseases are prevalent, which do require transdisciplinary approaches with greater costs both to government and to the community it most frequently affects.

Medical schools are part of the health system and integrated to the economic activities of the community within which it functions, acting in the tertiary sector, the service sector. They prepare future health professionals to work in society, and these professionals have to be prepared to understand and to provide the service with quality and discernment.

The assessment of the quality of medical education, for a long time now, has been following a traditional way of evaluation such as the ones proposed by the LCME (Liaison Committee of Medical Education) in North America and the WFME (World Federation for Medical Education). The main emphasis were on processes, compared to inputs, outcomes, and impact of medical education programs6,7. Now, evaluation instruments of social accountability are beginning to emerge such as the CPU model, an acronym for "Conceptualisation-Production-Usability", made up of a sequence of parameters exploring more comprehensively the school commitments in planning actions, in implementing those actions and in ensuring actions produced the anticipated effects on society. All these parameters could be analyzed by asking if the medical schools syllabuses promote the ideal set of competences for a health professional to fit in an equitable and efficient health system?, or how they are training the students to acquire identified competences?, and if the work of graduates improve health system performance and people's health status?8. A number of initiatives inspired from the CPU model are being developed, by THEnet, AMEE and the AFMC

(Association of Medical Schools in Canada) and the concerned professor should look into those[9,10,11,12].

Sustainable excellence in medical education requires efficient partnerships from the medical school with the different main health sector actors: health care policy-making bodies, health service organizations, health insurance schemes, professional associations, other health professional schools and community representatives.

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