

Introducing a Collaborative E2 (Evaluation & Enhancement) Social Accountability Framework for Medical Schools

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Abstract

Medical schools recognize that they have an important social mandate beyond their primary role to educate future physicians. The instantiation of social accountability (SA) within faculties of medicine requires intentional, effective partnering with diverse internal and external stakeholders. Despite early, promising academic work in the field of SA in medical education, there remains a lack of conceptual clarity about what SA could and should entail, and a lack of practical direction regarding how it could be implemented. The paper describes the development of an innovative SA framework that incorporates both pragmatic-evaluation and collaborative-enhancement components. The framework consists of five distinct phases, uses a deliberative engagement methodology, and is meaningfully informed by a set of four SA Lenses: Diversity, Inclusion and Cultural Responsiveness; Equity; Community / Stakeholder Engagement and Partnering; and Justice-Fairness and Sustainability. In addition to using the framework to evaluate and enhance the social accountability statuses of a variety of the medical school's operational components, Dalhousie Faculty of Medicine leaders are committed to applying the framework's SA Lenses to important decision-making processes, such as the revision of the medical school's strategic directions and the allocation of limited resources to address important, emerging medical education issues and challenges.

Keywords: Social accountability framework, Faculty of medicine, Evaluation and enhancement components, Collaborative decision making, Deliberative engagement, Partnering

1. Introduction

Most modern medical schools have come to accept that they have an important social mandate beyond their primary role to educate future physicians (Parboosingh, 2003). Referencing the mid-1990s definitional language of the World Health Organization (WHO), these faculties of medicine recognize that they have a social accountability (SA) commitment "to direct their education, research and service activities toward addressing the priority health concerns of the community, region and/or nation they have a mandate to serve" (Boelen & Heck, 1995). Many administrative and academic leaders appreciate that the actualization of this obligation requires intentional, effective partnering with diverse internal and external stakeholders (Murray, Larkins, Russell, Ewen, & Prideaux, 2012). Up until recently, this partnering has been mostly limited to the creation of service learning opportunities within the undergraduate curriculum whereby arrangements are made for medical students to spend time in local and/or international settings where the clinical focus is on the delivery of healthcare to members of historically-marginalized or otherwise disadvantaged social groups (Hennen, 1997). Review of the literature regarding SA in medical education reveals that some limited, academic attention has been paid to such topics as: lack of optimal diversity among students, faculty members, administrators and staff (Hung et al., 2007); equity concerns regarding the uneven matching of healthcare provider resources to demonstrated population needs (Jamieson, Snadden, Dobson, Frost & Voyer, 2011); crucial health-outcomes roles played by socioeconomic, political and environmental determinants of health (Cappon & Watson, 1999); and recognition of the value of community-based, participatory research (Ramsden, McKay, & Crowe, 2010).

Despite early promising academic work in the field of SA within faculties of medicine, there remains a lack of conceptual clarity about what SA could and should entail, and a lack of practical direction regarding how it can be pragmatically implemented (Dogra, Reitmanova, & Carter-Pokras, 2010). The WHO's exclusive, focus on addressing priority health concerns/needs and its specification of a limited range of SA partners, has tended to

constrain discussion about the potential social mandate of medical schools, and to give the false impression that all meaningful SA agency requires explicit, macro-level partnering. In addition, the few existing models of social accountability that were developed for use in the medical education domain, including the Boelen-Woollard Conceptualization-Production-Usability Model (Boelen & Woollard, 2009), the THEnet's Evaluation Framework (The Training for Health Equity Network, 2011), and the University of Saskatchewan's CARE Model (Meili, Ganem-Cuenca, & Leung, 2011) have not been widely adopted. As such, they currently provide limited, practical guidance to faculties of medicine who are endeavouring to evaluate and enhance their SA statuses in innovative and strategic ways.

2. Framework Methodology

With these considerations and challenges in mind, members of the Social Accountability Committee of the Dalhousie University Faculty of Medicine established a working group in 2014 to develop and pilot an accessible SA framework for medical schools which incorporates both pragmatic-evaluation and collaborative-enhancement components. The resultant Collaborative E2 (Evaluation & Enhancement) Social Accountability Framework is designed for collective use by the medical school's internal and external stakeholders. It employs a deliberative engagement methodology, i.e., the use of a facilitated, dialogical process in which participants engage in a power-leveled, reflective space using pre-established terms of engagement (Kirby & Simpson, 2012; Cohen, 1989). The framework is meaningfully informed by a set of substantive values and principles that act as interpretative lenses and criteria for decision making (Alberti, Bonham, & Kirch, 2013; Kaur, 2012). These values and principles are instantiated in the framework in the following four SA Lenses: 1) Diversity, Inclusion and Cultural Responsiveness, 2) Equity, 3) Community / Stakeholder Engagement and Partnering, and 4) Justice-Fairness and Sustainability (Dalhousie University Faculty of Medicine Social Accountability Statement, 2014).

1. Diversity, Inclusion and Cultural Responsiveness Lens

Diversity is valued and demonstrated within the Faculty of Medicine when a wide breadth of difference in people, ideas, perspectives and experiences is respected, affirmed and actively supported. The inclusion of individuals, social groups and communities who identify with one or more dimensions of 'difference' enriches medical school environments and enables an appreciation of, and respect for, the complexity of the lived experiences of societal members. Relevant elements/dimensions of diversity include: age, race, ethnicity, gender, sexual orientation/identity/expression, ability-disability, income, health literacy, religion/spirituality, geographical location and language. The Faculty of Medicine responds in culturally competent, safe and constructive ways to the self-identified challenges of individuals, groups and communities with whom it engages in various capacities.

2. Equity Lens

The Faculty of Medicine is committed to identifying and playing a constructive role in addressing and reducing unfair disparities among individuals, social groups and communities in their health outcomes and access to quality healthcare, education and employment. Inequities typically result from unjust structural and systems factors within societies including the historical marginalization of particular social groups and their related experience of differing impacts of the socioeconomic, political and environmental determinants of health. Development of the capacity to recognize and critically reflect on one's own values, beliefs, attitudes and 'social group advantage' assists leaders, faculty, staff and learners to collaboratively identify and address equity-related concerns and issues.

3. Community / Stakeholder Engagement and Partnering Lens

The meaningful participation of its stakeholders, i.e., affected individuals, social groups, communities and collaborative partners, enhances and legitimizes the decisions made, actions taken, and policies developed by the Faculty of Medicine. In this context, 'communities' are not strictly defined by geography or political considerations but, rather, are broadly interpreted as collectives of persons who are bound together in interdependent relationships by shared experiences, interests and goals. Connections with stakeholders and communities occur across a broad spectrum – from observation of community-based service learning activities to robust, reciprocal partnering where the Faculty and its multi-level partners identify and work closely together to achieve mutual education, patient care, population health, research and policy goals. Dynamic interprofessional collaboration across a broad range of health and social science disciplines is an integral feature of this engagement. Effective partnering with communities/stakeholders is fostered by good

governance and the use of transparent processes to guide deliberations, promote trust, and help justify decision making outcomes.

4. Justice-Fairness and Sustainability Lens

The Faculty of Medicine accepts and embraces its responsibility to treat individuals, social groups and communities fairly and, in so doing, to meaningfully attend to differentials in power and context. The anticipated benefits and burdens of decision making are distributed in a fair manner, and differential treatment is justified by the transparent demonstration of relevant differences among individuals and groups in their legitimate needs/interests and opportunities. In the making of challenging allocation decisions, competing obligations to meet currently prioritized mandates and to prevent future depletion of limited educational, research and clinical resources are identified and carefully balanced. Those working within the Faculty of Medicine demonstrate that their deliberations take the perspectives and interests of local, historically marginalized and otherwise disadvantaged social groups into account. The Faculty's leadership in, and commitment to, the promotion of justice is comprehensive and multifaceted, extending from its internal community and organizational structures to communities and populations with which it is engaged across the globe.

The framework is intended for practical use in the evaluation and enhancement of the social accountability of a wide variety of operational components within faculties of medicine, including clinical and basic science departments, medical education divisions, research offices and healthcare delivery programs. It has also been designed for use by medical schools as-a-whole. As the following description of the framework's five phases illustrates, participants from various organizational levels of the involved operational component are directly engaged from the beginning to the end. This consistent, dynamic involvement of internal stakeholders encourages buy-in and reassures participants that they will not be critically judged by 'social accountability experts' who have little or no awareness of the challenges that the operational component faces on a day-to-day basis.

3. Five Distinct Framework Phases

Phase 1. SA Self-Study

In this first phase, a group of internal stakeholders from 'top-to-bottom' organizational levels of the involved operational component meets to perform a SA Self-Study. After reviewing an educational module about SA in medical education, this group collectively applies the four SA lenses to the operational component's circumstances and responds to a set of prompting questions for each lens in a sequential fashion. The responses of participants are captured by a designated Phase 1 recorder who completes a self-study template during the meeting. The self-study report consists of the recorder's synopsis of key discussion points and relevant ideas/insights that emerge during the meeting.

Phase 2. Review of the Self-Study Report by the SA Committee

SA Committee members and the relevant organizational sponsor for the framework's use review the generated self-study report during a regular committee meeting. Choices regarding who will be involved in Phase 3 are influenced by the nature of the operational component and any opportunities and/or challenges that are anticipated in the analysis of its current SA status and/or in the determination of its potential for SA enhancement. Phase 3 participants include several of the operational component's internal stakeholders, several members of the SA Committee with relevant knowledge and experience, and several persons who are members of the operational component's identified core, external stakeholder groups. The SA Committee identifies whether there is a need for information-gathering prior to Phase 3, e.g., relevant literature searches, review of the existing practices of similar operational components in other faculties of medicine, and/or targeted interviewing of key resource persons.

Phase 3. SA Evaluation and Enhancement through Deliberative Engagement

The aforementioned methodology, which is described in detail in the referenced paper by Kirby & Simpson (2012), is used for this phase of the framework. Two of the participating SA Committee members function as Phase 3 co-facilitators. Another SA Committee member participates as the Phase 3 recorder to document the outcomes of the deliberations and to, subsequently, in Phase 4, prepare a Report with Recommendations. The Faculty of Medicine's Social Accountability Statement (with its four incorporated SA Lenses) and the framework's terms of deliberative engagement are collectively reviewed prior to the dialogue.

Phase 3 (a) – Participants work-through the following four steps in their sequential, collaborative consideration of each of the framework's four SA lenses:

- Step 1. Identify the operational unit's existing SA strengths (of relevance to this lens)
- Step 2. Identify and discuss relevant constraints and challenges
- Step 3. Uncover and explore SA enhancement opportunities
- Step 4. Develop lens-specific recommendations

Phase 3 (b) – Participating members engage in a facilitated dialogue with the goal of dynamic synthesis of the outcomes of the four separate analyses achieved in Phase 3 (a). In doing so, identified, competing interests and obligations that emerge from consideration of the SA lenses are carefully balanced by the deliberators. This dialogue provides the basis for a comprehensive assessment of the operational unit's existing SA status. Subsequently, short and long term recommendations for future enhancement of SA within the operational unit are developed and ranked according to priority. Each of these recommendations is: 1) explicitly linked to relevant SA-related accreditation standards and the strategic directions of the Faculty of Medicine, and 2) coupled with an assessment of the anticipated resource (financial, personnel, space, communications, etc.) implications of implementation of the recommendation.

Phase 4. Preparation and Submission of a Report with Recommendations

The Phase 3 recorder prepares a draft Report with Recommendations which is shared electronically with all the deliberators. Suggestions for revision are solicited and, during a subsequent meeting, content-revisions that are collectively considered to address substantive omissions and/or to add-value to the report are incorporated. The SA Committee submits the final Report with Recommendations to the Dean of Medicine and Faculty Council for their consideration and potential approval as per normal administrative processes. Ideally, this is associated with an in-person presentation of the report by three members of the working group, i.e., an internal stakeholder, a SA Committee member and an external stakeholder.

Phase 5. Formal Review of SA Progress

One year later, the Lead of the operational component, e.g., the head/chair of a relevant department within the medical school, submits a written SA Progress Report to the SA Committee, Dean of Medicine and Faculty Council that describes the progress made to date in the implementation of the report's SA recommendations. An opportunity is provided for the Lead to meet in-person with the SA Committee to discuss the content of the progress report and to develop strategies for mitigating any unanticipated barriers to implementation of the recommendations.

4. Initial Evaluation Results and Discussion

The Collaborative E2 Social Accountability Framework was piloted in the winter of 2015 in a longitudinal integrated clerkship (LIC) program located in a combined rural and small-urban community setting that is known for its rich diversity of patient populations, language and culture. Internal and external stakeholders of the clerkship program and SA Committee members were engaged during Framework Phases 1 to 4 in the manner described above. The stakeholders involved in Phases 1 and 3 included the LIC site director (the physician-educator-lead), the site coordinator, a local clinical preceptor, two Dalhousie University Med III students who were actively engaged in the LIC, and two participants from the Eel Ground First Nation Health Centre. Three members of the Faculty of Medicine's Social Accountability Committee, including an academic healthcare ethicist in the Department of Bioethics and the director of Global Health, were engaged in Phases 1 and 3.

The choice of a diverse, rural-based longitudinal integrated clerkship setting for the framework's pilot posed certain challenges. The significant geographical distance between the LIC site and the main campus of the medical school created difficulties in terms of arranging and populating meeting sessions in Phases 1 and 3, as the involved global health director and healthcare ethicist thought it imperative that they be present in-person at the LIC site for Phases 1 and 3 of the framework's use. Fortunately, the LIC's physician-educator-lead was able to actively participate in the Phase 4 presentation to the Dean of Medicine and Faculty Council through the use of the medical school's distributed-education (enhanced videoconference) system. In addition to the geographical challenges, the framework's four SA Lenses were developed with the medical school as-a-whole and a wide variety of sub-operational units in mind. As a result, not all of the intentional elements of the SA Lenses were optimally applicable to the specific context of rural LIC operations.

A generic evaluation instrument was completed by those who participated in the use of the framework. The SA Working Group subsequently reconvened to review and analyse the feedback provided by 86% of the participants. On the basis of the evaluative findings, a number of revisions were made to the SA framework by the working group including: inclusion of a preliminary Phase 0 educational session on SA in the medical school context for the

self-study group participants; addition of a framework-facilitator from the SA Committee to the Phase 1 process; enhancement of the structured time designated for discussion during Phase 2 meetings of the SA Committee; and incorporation of a Spectrum of Engagement and Partnering Matrix developed by the working group into the analysis of the relevant lens during Phase 3. In addition, a strategic decision was made to relocate the primary presentation of the Report with Recommendations to the administrative committee or entity within the faculty of medicine that is most responsible for approving the recommendations and finding the resources necessary to have them effectively implemented.

5. Interim Conclusion and Next Steps

It can be (minimally) concluded that an innovative, collaborative social accountability framework with combined evaluation and enhancement components was developed and piloted in the Dalhousie University Faculty of Medicine. The long term, intended outcomes of multiple uses of the framework in a particular medical school are that the number, quality and variety of meaningful instantiations of social accountability within that faculty of medicine will be enhanced and optimized. Although, the recently-obtained results of (the-year-later) phase 5 of the pilot suggest that intended outcomes were largely achieved in the piloted operational unit of Dalhousie University Medical School, it is too early to perform a comprehensive evaluation of the framework and the outcomes of its various uses. An important piece of this assessment phase will be the development and validation of an appropriate, formal evaluation instrument, as such an assessment mechanism does not currently exist in the medical school SA domain.

Following completion of the pilot in late 2015, the framework has been, and is currently being, used in 2016 to evaluate and enhance the social accountability of two other dynamic components of the Dalhousie University Faculty of Medicine, i.e., the Family Medicine Undergraduate Medical Education Program and the medical school's Continuing Professional Development Division. In addition, members of the SA Committee has been working closely with the Dean of Medicine, Faculty Council and other senior faculty leaders to find appropriate opportunities to apply the framework's four SA Lenses to important, decision-making processes within the medical school, such as the revision of the Faculty of Medicine's strategic directions and the allocation of presently limited resources to address important, emerging medical education issues and challenges.

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