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Letter to Editor

Realms of social accountability in medical education: the Indian conundrum

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Dear Editor,

The mission statement of most medical schools often addresses the obligation to direct their education, research, and service activities toward addressing priority health concerns of the community; they have a mandate "to serve".[1] On a broader spectrum, *social accountability* can be defined as addressing the competencies that enable medical graduates to develop community oriented goals, re-orienting medical education to launch high-value, community oriented primary care interventions, to develop the interest of students to serve marginalized areas, and to accredit/analyse the systemic impact of the interventions. But in the era of "globalized healthcare" and "specialties inclination," we cannot deny the existing challenges towards inculcating social responsibility among medical students. In fact, institutions find it difficult to balance financial compartmentalization for advanced technologies on one hand and commitments to address social determinants of the community on the other hand. In this article, we intend to address the roadblocks in achieving socially accountable medical education in the Indian context.

India has witnessed a dramatic increase in the number of its medical colleges, reflecting an increase in the doctor-population ratio.[2] Considering the fact that the major share towards this increase is due to a surge in the number of private medical colleges and the majority of these colleges are concentrated in economically better-off provinces, this increase in the number of doctors is not equitably distributed. The socially excluded population in vulnerable geographical areas face differences in the rate of illness, which depends upon the *"social gradient of health"* determined by an array of factors affecting the conditions of life; together these are referred to as *"social determinants of health."*[3] Change in professional cultures are needed to ensure a holistic approach to these issues and to reduce inequalities. Community based participatory research (CBPR), which involves patient and community engagement in research design[4] and early involvement of students as integral members of the healthcare team, is a feasible strategy to help medical students become aware of the social determinants of health. However, there are barriers to achieving this goal.

The existing system of medical education seldom promotes non-academic attributes such as social cohesion and equity. Beginning with undergraduate eligibility examinations all the way through to postgraduate selection examinations, students are made to be competition oriented, yet the knowledge they gain from coaching centres, while paying hefty fees, never enhances the cutting-edge societal skills required of graduates to effect equitable improvements in the health system.[5] Furthermore, private medical colleges, despite being non-profit organizations, have to collect enough fees from students to stay in operation. This leaves such students with soaring amounts of debt at the time of course completion. A study[6] showed that high debt levels lead students to consider practicing in underserved areas. This commercial nexus in graduate medical education which has become established over recent years is gradually discouraging students from economically disadvantaged backgrounds to enter the medical profession. This, in the long term, might lead to physician emigration and/or to a preference for highly profitable avenues, ultimately

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divesting the larger community of socially accountable medical education.

According to *MCI Vision 2015*,[7] the cardinal objective of undergraduate medical education is to produce an Indian medical graduate who can serve in the community as a physician of first contact and provide necessary preventive and curative services. Leaving the initial steps taken towards materialising competency-based medical education in India out of the discussion for the moment, the dire need for graduates to specialise in their field of choice itself shrinks the possibility that they will pursue community outreach activities. A study [8] showed that students generally choose their specialties based on financial rewards and secure employment as well as number of job opportunities. Students who enter medical school with altruistic interests for serving underserved populations later develop an inclination towards specialization during their medical education. In recent years it has been observed that students rarely prefer to choose basic sciences and laboratory sciences as a specialty and rather wait, at times for years, to enter the high-yielding clinical specialty of their choice. This trend suppresses the number of doctors available to serve the community for a stipulated amount of time.

In fact, the trend of corporate downsizing followed in some private sectors is said to negatively influence teachers' professional attitudes and make them more concerned about their institution's competitive advantage than about doing what is ethically responsible.[9] As per the World Health Organisation's definition,[10] social accountability is "the obligation of all stakeholders to direct their education, research and service activities towards addressing the priority health concerns of the community they have a mandate to serve." Indian medical graduates, rather than focusing on being an intellectual or an astute professional, need to appreciate the non-medical expertise of being a health advocate, communicator, collaborator and leader.[11] This requires willingness to be immersed in the community and to become self-aware. Paradoxically, the current medical education system keeps medical students in a "phantom zone," devoid of social network relationships.

To conclude, to make medical education fully socially accountable, every institution should re-examine the question of whether its products and pursuits are designed to make an impact on society. Policy makers and administrative officials should consider the current socio-political zeitgeist and seek to establish partnerships of common interest. Students should be redirected from the sole notion of acquiring biomedical knowledge and clinical skills for specialities and specialization and be encouraged to develop attitudes and skills for augmenting the true social determinants of health. Curriculum developers, particularly those belonging to medical schools in developing countries, should be encouraged to place the potential for social and moral obligations higher than other mandates.

Ethical approval

Not applicable.

Competing interests

None.

References

1. Boelen C, Pearson D, Kaufman A, Rourke J, Woollard R, Marsh DC, et al. Producing a socially accountable medical school: AMEE Guide No. 109. Med Teach. 2016;38(11):1078-91. doi: 10.1080/0142159x.2016.1219029.
2. Solanki A, Kashyap S. Medical education in India: current challenges and the way forward. Med Teach. 2014;36(12):1027-31. doi: 10.3109/0142159x.2014.927574.
3. Marmot M, Friel S, Bell R, Houweling TA, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. Lancet. 2008;372(9650):1661-9. doi: 10.1016/s0140-6736(08)61690-6.
4. Pinto AD, Bloch G. Framework for building primary care capacity to address the social determinants of health. Can Fam Physician. 2017;63(11):e476-e82.
5. Dehury RK, Samal J. "Exit exams" for medical graduates: a guarantee of quality? Indian J Med Ethics. 2017;2(3):190-3. doi: 10.20529/ijme.2017.037.
6. Rosenthal MP, Diamond JJ, Rabinowitz HK, Bauer LC, Jones RL, Kearl GW, et al. Influence of income, hours worked, and loan repayment on medical students' decision to pursue a primary care career. JAMA. 1994;271(12):914-7.
7. Medical Council of India MCI Vision 2015. Available from: https://old.mciindia.org/tools/announcement/MCI_booklet.pdf. Accessed July 7, 2018.
8. Bland CJ, Meurer LN, Maldonado G. Determinants of primary care specialty choice: a non-statistical meta-analysis of the literature. Acad Med. 1995;70(7):620-41.
9. Persell CH. Teachers and privatization. In: Levin HM, ed. Privatizing Education: Can the Marketplace Deliver Choice, Efficiency, Equity, and Social Cohesion? Boulder, Colo: Westview Press; 2001. p. 279-300.
10. Boelen C, Heck JE. Defining and measuring the social accountability of medical schools. Geneva: World Health Organization; 1995. Available from: http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7.pdf. Accessed June 8, 2018.
11. Whitehead CR, Kuper A, Hodges B, Ellaway R. Conceptual and practical challenges in the assessment of physician competencies. Med Teach. 2015;37(3):245-51. doi: 10.3109/0142159x.2014.993599.