How do Contextual Issues

Influence Socially Accountable Medical Schools?

Thesis submitted by

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Nature of Assistance	Contribution	Names, Affiliations of Co-Contributors
Intellectual support	Research Collaboration	My supervisors, Adjunct Associate Professor Judy Taylor (first supervisor), Associate Professor Sarah Larkins and Dr Jenni Judd crossed checked my data analysis for consistency of themes. The Training for Health Equity Network (THEnet) contacts at each school assisted with initial participant recruitment and local ethical protocols. Two colleagues from Ateneo de Zamboanga School of Medicine (ADZU SOM) acted as interview interpreters and assisted with field trip logistics. (Their names are not included as they were also participants).
	Transcription	A transcription Service transcribed 26 interviews.
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Statement on Ethics

This research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research, 2007. The proposed research study received human research ethics approval from the JCU Human Research Ethics Committee Approval Number #H4245.

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This thesis is dedicated to students, staff and communities of the University of the Philippines, Manila School of Health Sciences, Palo, Leyte.

Abstract

Socially accountable medical schools deem themselves responsible for the health needs of the communities that they serve. They orientate their education, research and service to the health needs of the population. As a theoretical concept, socially accountable medical schools developed out of attempts for the transformation of medical education. During the 1910s to 1980s there were key reforms in medical education and broader public health from the Flexner review to "Health for All". Developments included decolonisation in less financially resourced countries which led to the need for new health roles. During the 1980s to 2000s Dr Charles Boelen and other colleagues at the World Health Organization developed the theory of socially accountable medical education and socially accountable medical schools. Influential conceptual frameworks developed included the social accountability grid, then the conceptualization, production and utilization grid, the values of social accountability (relevance, equity, cost-effectiveness and quality) and the Towards Unity for Health partnership's model. From the 2000s to 2010s medical schools and global institutions refocused on socially accountability and there was re-interest in measuring and evaluating socially accountable medical schools. A number of initiatives at individual schools and collectively, operationalised social accountability. In the 2010s initiatives included the Lancet's Independent Commission on Health Professional Education for the 21st century and the call for socially accountable medical education to be aligned with accreditation systems. Some of the challenges to implementing social accountability at medical schools included the perceived lack of power of the medical profession and medical schools to address wider systems issues.

From my professional experience I observed that many medical schools aspiring to be socially accountable had developed independently from the theoretical concepts of socially accountable medical education. Therefore contextual factors, or external and internal conditions, must have influenced schools to aspire to be socially accountable. From this analysis of the historical and conceptual development of socially accountable schools I hypothesised that there were three key contextual factors that have influenced socially accountable medical schools:

- Profile of the local health workforce
- Partnerships with the local, state and national health system; and
- Partnerships between the medical school and its 'community'.

Using a multiple case study approach I explored how contextual issues have influenced social accountability at four medical schools in Australia and the Philippines. I theorised that workforce, health sector partnerships and communities would be strong contextual influences. I interviewed 75 participants including staff, students, health sector representatives and community members. I undertook fieldwork and documentary analysis.

I needed to understand how social accountability was interpreted at the schools to appreciate the contextual factors that influenced social accountability at that school. Social accountability was understood in different ways at each school, but there were three common understandings. Firstly, socially accountable medical education was about meeting workforce, community and health needs. Secondly, social accountability was determined by the type of programs the school implemented or, the way the school operated. Thirdly, social accountability was deemed a personal responsibility or value. Nevertheless there are differences between understandings at each school. There was an

assumption that social accountability in the context of medical schools and medical education was known and universally understood, yet the term is still open to contention and debate.

There were internal and external factors that influenced the activities and outputs of socially accountable medical schools. At Flinders University School of Medicine (FUSOM) the influential contextual factors were: workforce; government policy and funding; Flinders School of Medicine's community engagement policy; the Flinders University remit for difference; The Training for Health Equity and leadership and individual champions. At James Cook University School of Medicine (JCUSOM) there were five contextual factors that had influenced social accountability: the difference of the geographic place and the unique needs of the population of the north of Australia (connected with the participants' understanding of community); the local workforce situation; the impact of government policy; community support for the school; and the shared values and experiences of people, including staff and leaders at both the school and the health sector. There were seven overarching influences, both external and internal factors at Ateneo de Zamboanga School of Medicine (ADZU SOM): regional health; workforce and community needs; placement communities; local officials and politics and peace and order in the face of a regional conflict; religion; limited resources and the values and experiences of a leader. Social accountability at the University of the Philippines, Manila, School of Health Sciences (UPMSHS) was influenced by four contextual factors: the regional workforce and health needs; local politicians and politics; the community and limited resources.

In the cross case analysis I found ten contextual factors that influenced social accountability. The strongest contextual factor was the local workforce and health

situation which led to innovative educational programs and a research focus on local health issues. Communities may not have comprehended their own influence; however, they were fundamental for socially accountable practices including student placements. Government policy and funding supported socially accountable programs such as rural health initiatives in Australia. While in the Philippines, due to the decentralisation of the health system, the local government and local politicians influenced student placements and graduate employment. The wider institutional environment of their universities affected the culture and the resourcing of programs. In some contexts, resources were required to fund programs and in some contexts lack of resources has spurred innovation. The values and professional experiences of leaders and individuals influenced whether a school's organisational culture was conducive to social accountability. Membership of a coalition of socially accountable medical schools, The Training for Health Equity Network (THEnet) created a community of learning and legitimised local practice.

There were two contextual factors that emerged from the cross case analysis and require further investigation: the idea of resisting dominant paradigms of medical education and the health system. All schools also had a culture of resistance to mainstream models of medical education. The resistance or rebellion against dominant paradigms fostered the need for alternative models of medical education that develop the theory of socially accountable medical schools. The health sector, a contextual factor I identified in the literature, was not a direct influence. However the health sector was connected with other contextual factors: individual champions; the workforce situation and resources.

A conceptual framework illustrates the seven building blocks for socially accountable medical schools. Practical guidelines based on these building blocks are provided for

medical schools. Topics for further research include applying the conceptual framework to medical schools not part of THEnet and developing understandings of how communities would like to work with medical schools. There needs to be further exploration on how medical schools aspiring to be socially accountable are perceived, both internally and externally as "the other" and are challenging dominant paradigms of medical education. This research will assist the medical education community to learn from the experiences of the four case study schools, and will contribute to the development of the theory and practice of socially accountable medical schools.

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List of Abbreviations and Acronyms

ACCHS:	Aboriginal Community Controlled Health Services
AFMC	Association of Faculties of Medicine of Canada
ADZU SOM:	Ateneo de Zamboanga University School of Medicine
AMC:	Australian Medical Council
ARMM	Autonomous Region of Muslim Mindanao
AMEE:	Association for Medical Education in Europe
BHS	Barangay Health Station
BHW	Barangay Health Worker
CPU:	Conceptualization-Production-Usability (CPU)
DOH:	Department of Health
DTTB	The Doctors to the Barrios
CPU	Continuing Professional Development
FU	Flinders University
FUSOM:	Flinders University School of Medicine
GCSA:	Global Consensus for Social Accountability
GHWA:	Global Health Workforce Alliance
GP:	General Practitioner
HFA:	Health for All
HMO:	Hospital Medical Officers
HREC:	Human Research Ethics Committees
HRH:	Human Resources for Health
IMG:	International Medical Graduate
JCU:	James Cook University
JCUSOM:	James Cook University School of Medicine
LGU:	Local Government Unit

MILF	Moro Islamic Liberation Front
MNLF	Moro National Liberation Front
MHO:	Municipal Health Officer
NGO:	Non-government Organisation
NTCS	Northern Territory Clinical School
NTMP	The Northern Territory Medical Program
OCEP	Onkaparinga Clinical Education Experience (
PBL	Problem Based Learning
PHC:	Primary Health Care
PRCC	Parallel Rural Community Curriculum
QH:	Queensland Health
RCS:	Rural Clinical Schools
SPHTMRS:	School of Public Health, Tropical Medicine and Rehabilitation Sciences
THEnet:	Training for Health Equity Network
The Network:	Network of Community orientated Educational Institutions for Health Sciences or The Network: Towards Unity for Health
TUFH:	Towards Unity for Health
UDRH:	University Departments of Rural Health
UPMSHS:	University of the Philippines Manila, School of Health Sciences, Palo, Leyte
UPM:	University of the Philippines, Manila
WFME:	The World Federation for Medical Education
WHA:	World Health Assembly
WHO:	The World Health Organization
WONCA:	World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. WONCA's short name is The World Organisation of Family Doctors

Glossary

Barangay: Village or small community in the Philippines

Community-based medical education: Student teaching occurs in the community – at the primary health care level - and focuses on the population health needs of the wider community.

Indigenous: I chose to use the term Indigenous in this thesis to describe Aboriginal and Torres Strait Islander peoples of Australia. I acknowledge that these two groups of people have separate cultural identities. I use the separate terms Aboriginal peoples or Torres Strait Islander peoples when discussing these individual groups.

Mal-distribution: The differences between the distribution of medical professional workforce between different areas such as cities and rural areas.

Reference population: The community or population that a school aspiring to be socially accountable wishes to serve.

School: Medical school or discrete department that focuses on teaching graduate or undergraduate medicine, research and service.

Social Accountability: "Social accountability is the obligation to orient education, research and service activities towards priority health concerns of the local communities, the region and/or nation schools have a mandate to serve. These priorities are jointly defined by government, health service organisations, the public and especially the underserved" (The Training for Health Equity Network, 2008) with reference to (Boelen & Heck, 1995).

Socially accountable medical school/medical school aspiring to be socially accountable: A medical school explicitly[1] aspiring to be socially accountable.

Socially accountable medical education: The education focus of socially accountable medical schools. This incorporates community based education that centres on the health needs of the community or reference population.

Standard medical school: A medical school that does not explicitly aspire to be socially accountable[2]. .

[1] By explicitly, I mean schools that have an explicit agenda to be more socially accountable as defined by the World Health Organization.

[2] Using 'standard' rather than "schools not ascribing to the philosophy/theory/approach of socially accountable medical schools ascribed the WHO" was based on pragmatic reasons (word count) rather than a philosophical belief. However it is simplistic to assume a polarity between being a school that aspires to be socially accountable and one that does not aspire to be socially accountable. I also believe that aspiring to be socially accountable is a critically reflexive process that will never be fully achieved. A polarised understanding is flawed as medical schools are complex organisations and comprise many different people, departments and teams with differing values and professional roles. Therefore most contemporary medical schools have units (often Family Medicine or rural health) and individuals (often Family practitioners or public health physicians) who aspire for their school (or team or unit) to be socially accountable.

Peer Reviewed Publication and Presentations

I have presented the following peer reviewed conference presentations as part of this project.

Preston R, Larkins S, Judd J, Taylor J,. The role and influence of communities upon socially accountable medical schools. Oral poster presentation at the Melbourne Social Equity Institute Inaugural Conference; 2014 28 February - 1 March 2014; Melbourne Cricket Ground (MCG), Melbourne, Victoria: Melbourne Social Equity Institute, The University of Melbourne; 2014.

Preston, R, Taylor, J, Larkins, S & Judd, J (2012) How do community partnerships influence socially accountable medical education, Oral paper presentation at the Rendez-Vous 2012 Conference, 9 October 2012, Northern Ontario School of Medicine, Thunder Bay, Canada.

Preston, R, (2012) How do contextual factors influence socially accountable medical education?, Oral paper presentation at the Faculty of Medicine, Health and Molecular Sciences 3 minute thesis competition, 3 September, James Cook University, Townsville.

Preston, R, (2012) Power to the People! How Communities influence Medical Schools, Oral paper presentation at the *So you think you can research* competition, North Queensland Festival of Life Sciences, 29 October, James Cook University, Townsville.

Preston, R, Taylor, J., Larkins, S., & Judd, J. (2011, 1 July 2011). How do contextual issues influence social accountability in medical education? Oral paper presented at the LOCAL? GLOBAL? Health Professional Education for Social Accountability Alice Springs Convention Centre, Alice Springs, Australia.

Preston, R., Taylor, J., Larkins, S., & Judd, J. (2011). How do contextual issues influence social accountability in medical education? Peer-reviewed poster presented at the 2011 Primary Health Care Research Conference: Program & Abstracts Brisbane Convention Centre, Brisbane, Australia. www.phcris.org.au/conference/browse.php?id=7198

Above poster also presented at: North Queensland Festival of Life Sciences (JCU FMHMS) 29 September 2011 and The Townsville Hospital and School of Medicine and Dentistry Research Symposium 14 October 2011.

The following papers are in preparation:

Peer reviewed Conference Presentation

Preston R, Larkins S, Judd J, Taylor J. How do contextual issues influence socially accountable medical schools? The Global Community Engaged Medical Education Muster October 27-30, 2014; Voyages Ayers Rock Resort, Uluru Northern Territory, Australia 2014.

Papers

Preston, R; Ross, S; Larkins, S; Taylor, J; Judd, J; and Palsdottir, B The Historical and Conceptual development of socially accountable medical schools, Education for Health (Literature Review paper: based on chapter 2).

Preston, R; Larkins, S; Taylor, J; Judd, J, Lindemann, I; Ross, R; Tandinco, F; Samson, Context counts: What has influenced social accountability at four medical schools" Medical Teacher, In preparation (Based on discussion chapter 6).

Preston, R, Larkins, S, Taylor, J and Judd, J, Lindemann, I; Ross, R; Tandinco, F; Samson, R "From personal to global: Understandings of socially accountability at medical schools", Medical Teacher, In preparation (Based on discussion chapter 6).

Preston, R; Ross, S, Palsdottir, B Larkins, S; Taylor, J; Judd, J, Enhancing socially accountable medical schools through a community of practice: The Training for Health Equity Network. Academic Medicine, In preparation (Based on discussion chapter 6)

Preston, R; Larkins, S; Taylor, J; Judd, J, Lindemann, I; Ross, R; Tandinco, F; Samson, Context counts: What has influenced social accountability at four medical schools" Medical Teacher, In preparation (Based on discussion chapter 6).

Preston, R and Taylor, J "Developing guidelines for communities to work with medical schools" Education for Health, In preparation.

Preston, R and Taylor, J How partner with with medical schools: a guide for communities and community organisations. Community report or monograph, In preparation.

Chapter 1 Introduction

1.1 Preface: The global crisis in medical workforce

The global medical workforce is in crisis. Many communities and countries do not have access to appropriately trained medical professionals (Bhutta et al., 2010; Boelen, 2009). In less financially resourced countries[3] such as the Philippines some people will never see a health professional in their lifetimes (Dovlo, 2005; Kwizera & Iputo, 2011; Raghuram, 2009). In more financially resourced countries, such as Australia, the geographic mal-distribution of the health workforce is well documented (Cristobal & Worley, 2011; Joyce, McNeil, & Stoelwinder, 2006; Murray & Wronski, 2006). Australian major cities had 372 doctors per 100,000 people in 2009, while in outer regional areas (or small country towns) the ratio was 188 per 100,000 (Australia. Department of Health, 2012, p. 19). A consequence of the crisis is the "brain drain" of highly skilled health professionals from countries like the Philippines to fill the medical workforce gap in countries like Australia. In the Philippines some health professional schools are dedicated to producing "health workers for export", compromising this country's already overburdened health system and contributing to workforce shortages (Institute of Health Policy and Development Studies, 2006; Kanchanachitra et al., 2011; Labarda, 2011).

[3] The term less financially resourced countries and more financially resourced countries will be used to describe "developing countries" and "developed countries". Although there are other terms used in the international development literature such as "the global south", this term means nothing to Australians.

Solving this crisis is complex and involves inter-sectoral collaboration among international organisations, governments, communities and educational institutions. As trainers of the future physician workforce, medical schools have important roles in this process. However, traditionally medical schools have been based in metropolitan cities within tertiary hospitals far from rural and other underserved populations. Their graduates are ill-equipped to serve where they are most needed, in population health and primary care. (L. A. Green, Fryer, Yawn, Lanier, & Dovey, 2001; White, Williams, & Greenberg, 1961). Yet increasingly medical schools want to focus on the *outcomes* of medical education and deem themselves responsible for the health of their communities. These schools are aspiring to social accountability.

1.2 A tale of four medical students

Jess is heading to a quiz night after working at the emergency room. She has been in a rural South Australian town for 6 months as a third year graduate medical student from Flinders University School of Medicine (FUSOM). Jess is attached to a General Practitioner (GP); Dr Robert, an overseas trained medical graduate who has worked in this small rural town for 15 years. She undertakes two sessions a week with GPs and also works nights in the emergency ward. Once a week Jess goes to tutorials at the rural clinical school of FUSOM in the nearby main town centre, 15 kilometres away. However it is through joining in the weekly quiz night and other community events with her fellow students and colleagues from the hospital and clinical school that she has gained a better insight into rural life. Although she grew up in the metropolitan centre of Adelaide she is keen to work in rural areas.

Quang is a sixth year undergraduate medical student from James Cook University (JCU) in northern Queensland, with a bit of a sore head after a graduation party; he is

attending “the last lecture”. Two popular lecturers have been voted by students to give the final lecture to his cohort. “Give until it hurts” states a senior consultant from the hospital who describes how working in less financially resourced countries should be more about the needs of people than professional egos. Throughout his education Quang has learnt about the tropics, Indigenous communities and rural and remote health. Like many of his 200 classmates Quang will go on to work in regional or rural towns. He did an international placement in Vietnam at a small rural hospital.

Gloria lies down on her mattress amongst her sleeping fellow students. She is exhausted after spending the day working with local villagers; filling plastic soft drink bottles with sand. These bottles will build a lying in centre for pregnant women. Gloria is a third year medical student at Ateneo de Zamboanga School of Medicine (ADZU SOM). It is the third year that she and her eight classmates have lived in this barangay or village; and the lying in centre has been an accumulation of collaborative work with the local community over these years. About 25 minutes away from the barangay along a rough dirt track her supervisor manages the municipal health centre. Dr Rosa is a graduate of ADZU SOM and although supervising the students is yet another task in her busy day, she is grateful for the extra services that they can provide to some of the 12,733 people that her centre serves.

In a small clinic attached to the University of the Philippines, Manila, School of Health Sciences (UPMSHS) John examines a young woman in the first stages of labour. John is a medical student but working with pregnant women is not new to him. Like the midwife educating him, he had previously trained at UPMSHS, first as a midwife (community health worker) and then as a nurse, always returning to undertake service in his own community in the rural province of Samar. The community selected John when

he was a fresh faced high school graduate keen to travel to Palo, Leyte and attend UPMSHS. The local Mayor text messaged John yesterday, asking him how his studies are going and, as usual, implied that the community cannot wait for him to return. John's community has not had a doctor in at their health centre for over 20 years, they are eagerly preparing for his return when he graduates next month.

1.2.1 What are socially accountable medical schools?

These students[4] are involved in programs that may seem like small aspects of their medical education. However, these activities are not small, nor insignificant; the students are undertaking innovative medical education and are becoming "transformative healthcare professionals" (Bhutta et al., 2010; Frenk et al., 2010a).

The terms socially accountable medical school and socially accountable medical education were first conceptualised in the early 1990s by Dr Charles Boelen and colleagues at the World Health Organization. Socially accountable medical schools have:

> *"...the obligation to direct their education, research and service activities towards addressing the priority health concerns of communities, region and /or nation they have a mandate to serve"*
>
> (Boelen & Heck, 1995, p. 3).

It is important to recognise that while the term "social accountability" in health professional education was new; some institutions had practiced the principles of social accountability for many years. Since the 1960s innovative health professional schools,

[4] Although these medical students are fictional these vignettes are based on my fieldwork.

particularly in low resourced countries, have strived to become more responsive to their communities and health systems. These schools trained their students in medically underserved communities with a focus on primary health care. Their graduates were well-trained health professionals suited to the areas in which they would practice. However, social accountability was not heeded by the majority of health professional schools and principally medical education continued to focus on a biomedical model, favouring training in large tertiary hospitals rather than in communities or disciplines with workforce shortages (Fulop & Roemer, 1982; Kantrowitz, Kaufman, Mennin, Fulop, & Guilbert, 1987).

1.2.2 Definitions used in this thesis

Social accountability: I use the Training for Health Equity's definition of social accountability:

> *Socially accountable medical schools hold themselves responsible for producing outcomes aligned with health workforce, priority health, and health system needs of their communities…*
>
> (The Training for Health Equity Network, 2011) with reference to Boelen & Heck (1995)

When I use the term social accountability it is short hand for the phrase "social accountability in medical schools". Many companies use 'social accountability' to define corporate responsibility or 'the triple bottom line'. However in this thesis social accountability refers to the context of medical schools.

Socially accountable medical school refers to an institution aspiring to be socially accountable. Originally, I thought I would explore socially accountable medical education; and my initial research question was "How do contextual issues influence social accountability in medical education?" However, I changed the question's wording to "How do contextual issues influence socially accountable medical schools. This change was more about semantics than a change in research direction as I had always set out to explore all activities of the case study schools as an institution, including research, teaching and service.

1.3 Study rationale: What has influenced socially accountable schools?

I have been involved in medical education since 2005 when I was appointed as an academic at the James Cook University School of Medicine and Dentistry (JCUSOM). Since 2009 I have been the JCUSOM School representation on the evaluation group of The Health Equity Network (THEnet), an international grouping of eleven health professional schools with strong social accountability mandates. This collaboration developed a common evaluation framework to measure social accountability across a variety of contexts (Larkins et al., 2013; The Training for Health Equity Network, 2011).

As I will discuss in chapter two, the conceptualisation of social accountability developed by Boelen and the World Health Organization (WHO) has had some influence upon medical education. Some new institutions, including James Cook University, were established with a clear social accountability mandate (Hays, Stokes, & Veitch, 2003; R. P. Strasser & Lanphear, 2008) either following WHO guidelines or

very close to the principles of social accountability. However, from my own professional experience and discussions with colleagues, these theoretical perspectives have not been very significant in shaping social accountability at many of The Training for Health Equity Network (THEnet) schools, particularly those in less financially resourced countries. A common revelation of staff and leaders of these schools was: "*we did not know that what we were doing was social accountability; but when we learnt more about what social accountability encompasses; we realised that this was what we were doing. It made sense*!"

Schools had not developed programs or missions to fit "the theory" of social accountability. Rather schools had developed in isolation of this theory. Indeed the schools themselves, including members of the Network-Towards Unity for Health may have had more impact upon the conceptual development of social accountability.

I became interested in what had influenced the development of socially accountable medical schools in diverse contexts in less financially resourced and more financially resourced countries. I hypothesised that there would be contextual factors or the external and internal conditions that have influenced schools to aspire to be socially accountable. There is a dearth of material about the relationship between social accountability and the contextual factors that affect socially accountable medical schools and my thesis aims to provide information that will contribute to this area.

Figure 1.1 explains the development of the research question. While the there is a theory or conceptualisation of social accountability (1), this may not have much influence on the schools that I knew were aspiring to the socially accountable (2). Indeed these schools may have influenced the development of the theory of social accountability from their practical experiences in the 1950s to the 2010s (3). . As further

discussed in Chapter 3: Methodology, and section 1.4; there must be other contextual factors or internal and external influences that have affected socially accountable medical schools(4, 5-5d).

Furthermore, there is no scale and polarity of “socially accountable medical schools” and “non-socially accountable” schools as from the 2000-2010s both the theory and conceptualisation of social accountable (1) and schools aspiring to be socially accountable (2) began to influence (6) the policies and practices of global medical education (7) and the wider medical school community (9). Medical schools are also influenced by global medical education (8), so the concept of socially accountable medical education filtered through. .

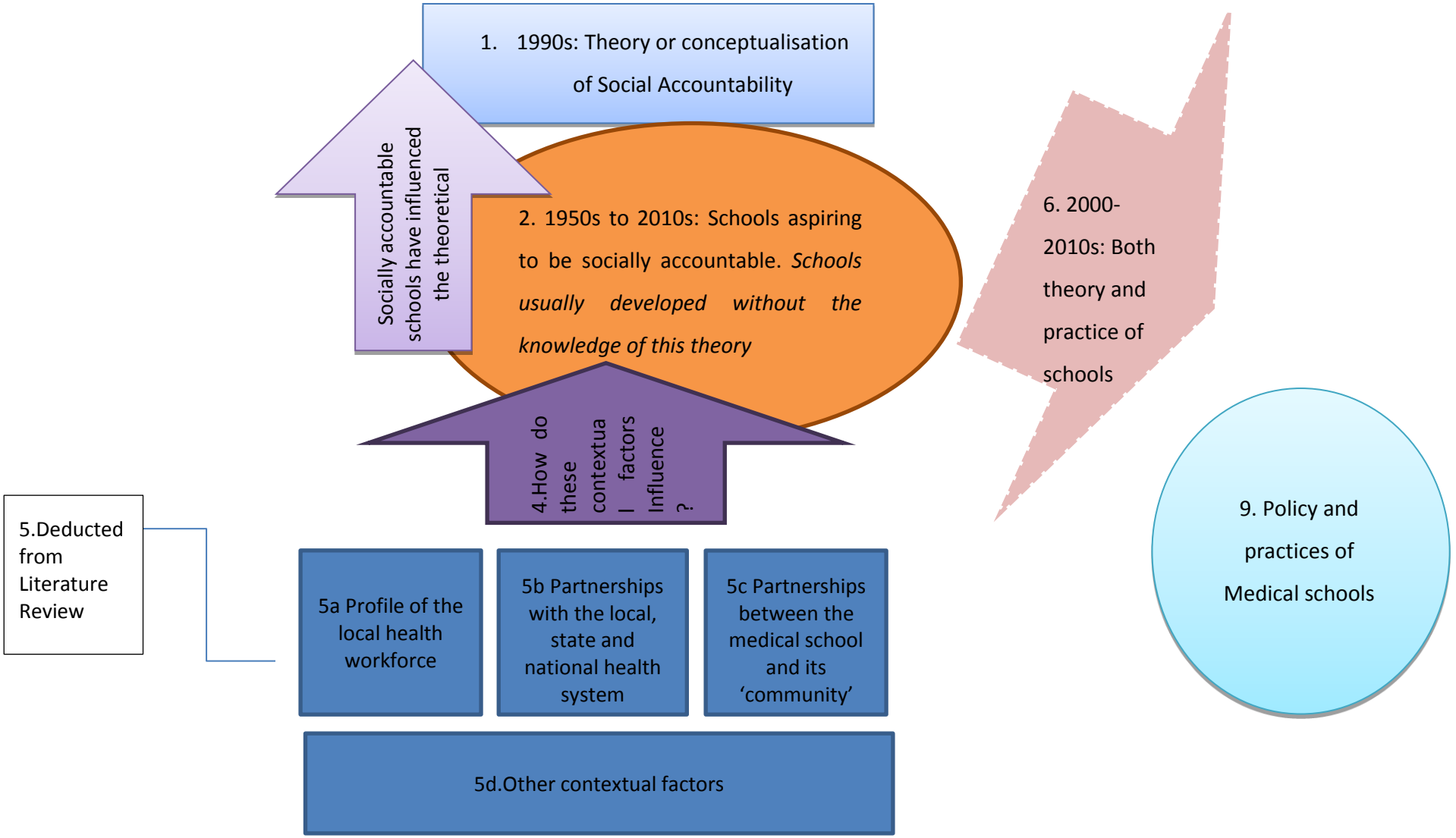

Figure 1.1 Development of question from the literature

1.4 The importance of context

This research study is explored through an in-depth analysis of contextual factors, and the ways in which these influence the planning, implementation and outcomes of socially accountable medical schools within and between four medical Schools in two countries.

1.4.1 Definition of contextual factors

From the 2000s to 2010s, health system and health policy researchers became increasingly interested in how contextual factors impact upon interventions, policies and programs; including health workforce training (English et al., 2009; L Gilson, 2010; L Gilson, 2012; K. Lee, Lush, Walt, & Cleland, 1998; Mbindyo, Gilson, Blaauw, & English, 2009; Mills, 2011; Ssengooba et al., 2007; Victoria et al., 2005; Wrede et al., 2006; Wyss, 2004). Understanding contextual factors that influence phenomena is important when trying to explain why interventions or programs succeed or fail (Mbindyo et al., 2009). In her presentation to the First Global Symposium on Health Systems Research in 2010, Gilson (2010) called for research that investigated: "What features of context need to be consider by HSR [Health Services Research]?; How can these contextual features be considered?; and How can policy lessons be drawn from HSR" (n.p). Good case study design that considers contextual issues and context can inform health policy research, particularly in the area of human resources for health (L Gilson, 2010).

A working definition of 'context' in my study was conceptualised through Bronfenbrenner's (1979) ecological approach (Figure 1.3) as described by Thomas (Thomas, 2011). Bronfenbrenner (1979) defined levels of systems including Macro-

systems, Meso-systems and Micro-systems and their influence on a human individual's development. However, these terms are now part of western culture and language.

The meanings ascribed to micro, meso and macro levels are generally understood to represent different levels or layers. In the beginning of my study, these concepts were applied to the School of Medicine as an organisation. The working conceptual model identifies that there are 'layers' or 'levels' of contextual factors that may influence social accountability in medical education. Possible contextual factors to be explored were identified from the literature and at a workshop at the 2011 Australian and New Zealand Health Professional Educators' conference (Preston, Taylor, Larkins, & Judd, 2011b).

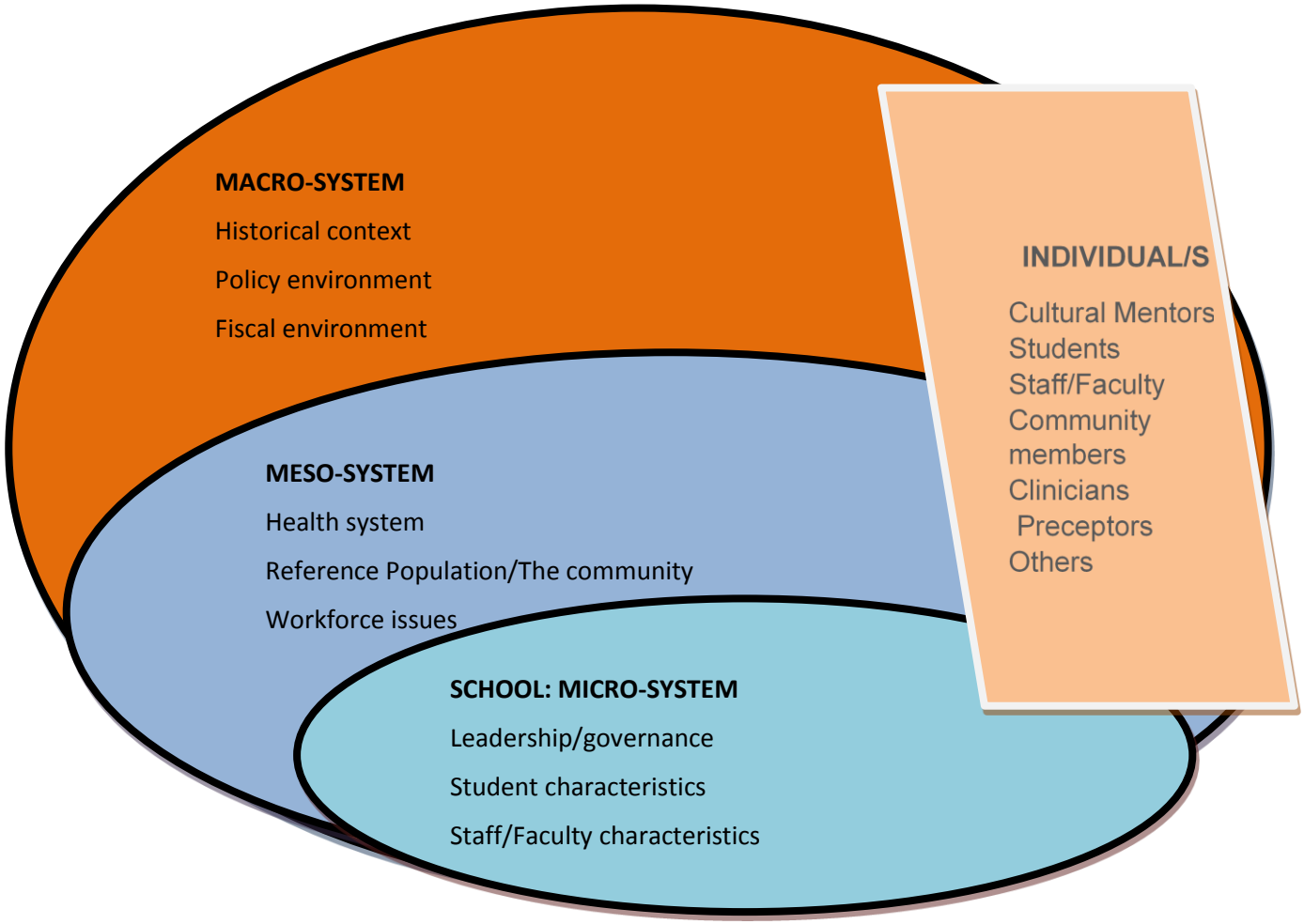

Figure 1.2 Initial conceptualisation of contextual factors that may influence socially accountable medical schools

Adapted from: Bronfenbrenner (1979) and Thomas (2011).

1.4.2 Definitions of three key contextual issues

Socially accountable medical schools aim to address the workforce issues of their community and health systems. I therefore hypothesised that there were three key contextual factors that have influenced socially accountable medical schools:

- Profile of the local health workforce
- Partnerships with the local, state and national health system; and
- Partnerships between the medical school and its 'community'

(See Figure 1.1: shapes 5, 5a, 5b, 5c and 5d). The decision to focus on these three was made on the basis of:

- Analysis of the historical and conceptual development of socially accountable schools: Material about contextual factors was sourced from the literature review search; in addition the terms "medical education" and "community partnerships" and medical schools and community engagement and "health sector" partnerships were searched. Papers on the workforce and health system connections were sourced from Human Resources for Health (HRH) databases;
- The weight of literature about the topic;
- Relevance to all four cases and internationally;
- These contextual factors were able to be studied empirically in situ; and
- My professional experience and knowledge about socially accountable medical schools.

These three factors are always inter-related. For example, the local health workforce may influence the school's connections with the health system. Partnerships with the community may also be influenced by connections/partnerships with the Health System.

Furthermore, the definition of these contextual factors may vary across contexts. How I conceptualised the influence of these contextual factors is outlined in Table 1.2.

Table 1.2 Developing Conceptual Framework: How Contextual Issues Influence Socially Accountable Medical Schools

Contextual Issue	Issue to Address	Importance in Social Accountability/ "outcome"	Features of schools aspiring to be socially accountable "action"	Issues
Profile of the local health workforce	Mal-distribution of doctors in underserved areas: geographic (rural, remote, outer urban or inner urban areas) and cultural (minority groups).	Graduates retained in areas of need. No workforce issues.	Recruitment/selection of students from underserved areas (as they are more likely to return to their communities). Placements in underserved areas. Curriculum includes analysis of workforce issues.	Assumption that there is a defined local area of workforce need.

Contextual Issue	**Issue to Address**	**Importance in Social Accountability/ "outcome"**	**Features of schools aspiring to be socially accountable "action"**	**Issues**
Partnerships with the local, state and national health system s	Graduates ill-equipped to serve the current health system and address priority health and social needs.	Graduates can work effectively within health systems. Health improvements.	Partnership projects in education, research and service. Joint positions (teaching/research/service). Long term placements in areas of need. Curriculum focuses on social and health needs of the population. Health sector "preceptors" are teachers.	Health system might not be conductive to practice or values of schools. There are many other factors that contribute to health improvements.

Contextual Issue	**Issue to Address**	**Importance in Social Accountability/ "outcome"**	**Features of schools aspiring to be socially accountable "action"**	**Issues**
Partnerships between the medical school and it's 'community'.	Graduates ill-equipped to work with communities and address priority health and social needs.	Graduates can effectively serve reference population/communities. Health improvements.	Curriculum focuses on social and health needs of community (broadly defined), with input from community. Community involvement with recruitment of students. Student placements in communities of need. Community involved in teaching, service and research. Graduate profile reflects the community.	Who is the community? There are many other factors that contribute to health improvements. Assumption that communities would like to participate in the medical school.

(Boelen & Heck, 1995; The Training for Health Equity Network, 2011, 2013b)

1.4.3 Contextual Factor 1: Profile of local health workforce

The profile of the local health workforce including shortages of health professionals and the distribution of health workers, with a focus on medical professionals, is a key contextual factor. The medical school defines its local area of influence. The recognition that there is a global health workforce crisis has led to global polices and strategies; including the need to address the brain drain in developing countries and the mal-distribution of the workforce in both less financially resourced and well financially resourced countries. Furthermore, the need to reassess the type of workforce most appropriate to health needs has led to a realignment of skillsets and professions. This may have a profound impact on the role of the doctor, including their power and influence. The profile of the local health workforce would therefore have an influence on socially accountable medical schools through the need to train a workforce with knowledge, attitudes and skills to meet priority health needs of underserved populations. The local workforce may exert significant influence on the development of the social accountability of a school. The contextual factor of the workforce may influence the profile and types of health workers that medical schools train. It may also influence training places, student admissions and the curriculum. There must be an appropriately trained and skilled workforce to contribute to teaching and to be preceptors. Workforce issues may have been the reason the school was established or expanded, for example James Cook University School of Medicine (Hays et al., 2003) and Northern Ontario School of Medicine (Matte, Lanphear, & Strasser, 2010; R. P. Strasser & Lanphear, 2008; R. P. Strasser et al., 2009; S. Strasser & Strasser, 2007).

1.4.4 Contextual Factor 2: Partnerships with the local, state and national health system

This contextual factor comprises the nature of the connections between the medical school and the broader health system either at a local, regional or national level. Schools aspiring to be socially accountable recognise that they need to anticipate the health needs of their communities and therefore should have a role in the health system. In isolation, medical schools cannot address workforce needs or health outcomes. However, strong partnerships between medical schools and the health sector will ensure that the teaching, research and service activities of medical schools can meet the further health care needs of communities. Graduates will be well equipped to work in a health system (i.e. have appropriate knowledge, skills and attitudes). Furthermore, the health system, including existing health staff and leaders, will share the values and culture of social accountability. Medical schools need to work in partnership with health sector to effect change in health system performance and improve health of all in their region. There are also different levels of health systems according to country contexts. In most countries there is complexity dealing with more than one health system, as there are different levels of government responsibility (national/federal; state/provincial and local/community). Medical schools have different levels of involvement with the health system; from inputs into high-level policy to local level initiatives such as student placements at community health facilities.

The need for coordination between the education sector (universities) and the health sector is a key issue for reorienting medical education and for socially accountability (Fulop & Roemer, 1982; Katz & Fulop, 1978, 1980; Walton, 1993; World Health Organization, 1981, 1991). Walton (1993) outlines that there is a need for more interaction between the education system and the health care system due to the rapid changes in the medical profession. The lack of coordination could have serious

consequences for health care (Walton, 1993, p. 394). Wider issues effect the distribution of doctors and socially accountable medical schools should be involved in the resolution of factors that influence the impact of good practice of their graduates and on the health of communities. Boelen (2004a) described some of these issues as "...career choices of graduates, attractiveness of the most needed health careers, incentives and rewards for primary health care, fair geographical distribution of the health workforce..." (p. 224). There is a need for a redefinition of partnerships between the education and health system with joint planning of curriculum, workforce planning and distribution or a link between supply and demand (Omaswa, 2011).

1.4.5 Contextual Factor Three: Partnerships with the community

Schools aspiring to be socially accountable aim for improved health in their communities or 'reference populations', defined as "…the populations that the school serves and the communities within this" (The Training for Health Equity Network, 2011). Communities are therefore the main beneficiaries of socially accountable medical schools. Partnerships with the community are an essential part of socially accountable medical education. Communities should help define the type of doctor who will best meet their health care needs; be part of the training and recruitment of students; and help define and develop the curriculum. Partnership initiatives include health or clinics in poor or underserved areas (Cappon & Watson, 1999); public health projects and research (Parboosingh, 2003) and electives or placements with underserved communities locally or internationally (Meili, Fuller, & Lydiate, 2011; Murdoch-Eaton & Green, 2011). Community engagement or collaboration with institutions, including medical schools and universities is complex. There are different levels of partnerships that can change over time or through different activities. Discussing partnerships between hospitals and community, Poland (2005) argued that few studies look at

collaborations that may be "…relatively informal, ad hoc, hastily invented and rapidly changing the nature of the vast majority of collaborations…" (p. 126). For the purposes of my thesis, I have defined partnerships as collaborations between communities and medical schools for education, research and service. As outlined in the Towards Unity for Health model, there may be tensions in approaches to community participation and partnerships between the health profession and communities (Boelen, 2000b). Issues of power and empowerment are intertwined within these partnerships; and may involve the medical school and medical professional giving up power.

There is contention regarding the definition of community. "The community" is also an intangible entity that is hard to define or "measure". There are also power issues around who defines community: community members themselves or external 'experts'. Usually outsiders set the boundaries for community membership and therefore who can participate in initiatives or partnerships (Rifkin, Lewando-Hundt, & Draper, 2000). There should also be recognition that the community is not homogenous (Rifkin, 1986). In socially accountable medical schools, community is understood as the "reference population" defined jointly by the school and the communities (The Training for Health Equity Network, 2011). This defined population includes the underserved. However, defining 'their community' for medical schools is an innovative concept and social accountability offers no real guidelines for how or who should define communities. Indeed the use of the term "our" community is contentious, as it assumes the school has ownership of the community or communities (S. Berry, personal communication, 6 February 2014). It is therefore an important part of my research to establish understanding of communities at each case study school.

1.5 An introduction to the thesis

This thesis describes how contextual issues influence socially accountable medical schools through case studies of four medical schools; two in Australia and two in the Philippines. There are seven chapters, the first three chapters describe the background, literature and the methodology (chapters 1 to 3). There are two results chapters: chapter 4 focuses on the two Australian schools; and chapter 5 outlines results for the two Filipino schools. Chapter 6 is the cross case analysis and discussion. The concluding chapter, chapter 7, outlines recommendations for policy, practice and further research

In *Chapter 2 (Literature review: Historical and Conceptual Development of Socially Accountable Medical Schools*) I outline how the concept of social accountability developed in medical education. This includes a critical review of its theoretical development and highlights the gaps in the practical application of social accountability principles at medical schools. I outline reforms to medical education since Abraham Flexner's seminal review in 1910 (Flexner, 1910). I draw upon the grey literature and peer reviewed literature on innovative medical schools and medical education reform as well as wider changes in global health policy; namely the prioritisation of primary health care.

In the third Chapter (*Chapter 3: Methodology*) I discuss my choice of methodology and theoretical framework, including my epistemological position of social justice and how constructivism and critical theory have influenced this research. I define my case studies and outline my sampling strategy, ethical issues and limitations to the study. I describe my data collection methods including semi-structured interviews, fieldwork and documentary review. I explain how I conducted within case analysis and cross case

analysis using NVivo 10 (QSR International, 2012). I also outline the methodological limitations of the research.

There are two results chapters, where I outline the four case study schools. In each chapter I describe the background of the two case studies and the within case analysis (results) including:

- How socially accountable medical education and socially accountable medical schools are understood in each case; and
- What contextual factors have influenced socially accountability in each case.

Chapter 4: Australian Cases has three sections, the first section gives an introduction to the Australian health and medical education systems to give context to the two Australian chapters. There is a focus on innovative rural medical education programs. The next section outlines the results for Case 1: Flinders University School of Medicine (FUSOM) and Case 2: JCUSOM. *Chapter 5: The Filipino Cases* also has three sections, the first section gives context to the Filipino health system and medical education system. I have focused on two issued: decentralisation of the health system and medical migration or the brain drain of health professionals to more financially developed countries. The next section presents the results for Case 3: Ateneo de Zamboanga School of Medicine. I discuss the results of Case 4: University of the Philippines, Manila School of Health Sciences in the last section.

In *Chapter 6: Cross Case Discussion* I outline the results of the across case analysis. First, I discuss the similar and different understandings of socially accountable medical schools at the four case study schools and compare these interpretations with the literature. I then examine what contextual factors have influenced socially accountable

medical schools; and how these differ across cases. I illustrate how contextual factors influenced the four case study schools in a diagram. Finally, in the concluding chapter (*Chapter 7: Conclusion*) I illustrate the 'building blocks for socially accountable medical schools' in a conceptual framework that could assist other schools. I summarise my findings and highlight the implications of the findings for future research. I also outline recommendations for medical schools.

1.6 Summary

In the context of the crisis in health workforce, during the late 2000s to the early 2010s there was a reinvigoration of academic and professional interest in both the theory of and practical applicability of socially accountable medical education and medical schools (Frenk & Chen, 2011; Frenk et al., 2010a; Global Consensus for Social Accountability of Medical Schools, 2010; Sales & Schlaff, 2010; R. P. Strasser, 2010; The Network: Towards Unity for Health, 2010; Woollard, 2010). While much research has described the social accountability agendas and practices of individual schools as well as set out theoretical perspectives; little is known about how contextual factors influence socially accountable medical schools. Understanding the contextual factors that promote social accountability in education, research and service activities of medical schools will help determine how academic institutions can best contribute to the health care needs of the communities they serve.

Chapter 2 Literature Review: Historical and Conceptual Development of Socially Accountable Medical Schools

2.1 Introduction

This chapter investigates the historical and conceptual development of socially accountable medical education and socially accountable medical schools[5]. As outlined in Figure 2.1, this chapter begins with the methodology of the literature review (section 2.2) and a summary of the conceptual and historical development of socially accountable medical education and medical schools (section 2.3). Section 2.4, *1910s to 1980s: Influential medical education and health reforms*, describes reforms to medical education drawing on grey literature and peer reviewed literature on innovative medical schools and medical education reform as well as wider changes in global health policy; namely the prioritisation of primary health care. Section 2.5, *1980s to 2000s: Theoretical development of socially accountable medical schools* outlines the influence of the work of The World Health Organization and Dr Charles Boelen and colleagues on the conceptual development of six key theoretical concepts of socially accountable medical schools. How these theoretical models have been applied at the medical school, national and network levels are described in section 2.6: *1990s to 2010s: From theory to practice: the local and global implementation of socially accountable medical education and medical schools*. From 2000s to 2010s there was a re-kindling of interest in social accountability, complemented by global interest in Human Resources for

[5] Following standard thesis conventions both literature review chapters are written in the third person. I have written the rest of my thesis in first person (L. Tynan, personal communication, 4 November 2012).

Health. There was recognition that global health targets, such as the health-related Millennium Development Goals (MDGs), would not be reached without an appropriately trained and resourced health workforce. The section 2.7, *2000s to 2010s: Human Resources for Health and the "revitalisation" of the theory and practice of socially accountable medical schools* describes this era.

Section 2.2: Concept/logic map of the literature and methodology of the literature review

Section 2.3: Summary of Conceptual and historical development of "Socially Accountable Medical Education" and "Socially Accountable Medical Schools

Section 2.4: 1910s to 1980s: From Flexner to "Health for All": Influential medical education and health reforms

Section 2.5: 1980s to 2000s: Theoretical development of socially accountable medical schools: The World Health Organization and Dr Charles Boelen

Section 2.6: 1990s to 2010s: From theory to practice: the local and global implementation of socially accountable medical education and medical schools

Section 2.7: 2000s to 2010s: Human Resources for Health and the "revitalisation" of the theory and practice of socially accountable medical schools

Figure 2.1 Outline of Chapters 2 and 3 (Literature Review and Literature Synthesis)

2.2 Concept/logic map of the literature and methodology of the literature review

This section outlines a conceptual or logic map of the literature and the methodology for finding, selecting and analysing the literature.

2.2.1 Logic map of the literature

The development of socially accountable medical schools and medical education was iterative, they cannot be separated. However, relevant grey and peer reviewed literature around this phenomenon is from diverse disciplines including: primary health care; human resources for health; global health, health policy; medical sociology; medical

anthropology; and development studies. Figure 2.2 outlines the key disciplines and topics about socially accountable medical schools and how they are logically interrelated. This concept map has guided this literature review. For example, the focus of socially accountable medical schools is to provide an appropriate health workforce to address the health needs of their communities, especially under-served populations. Therefore, relevant literature includes global policies on human resources for health as well as local health issues. Some topics such as rural and remote health and primary health care cut across the broader topics. Depending on the discipline, the literature discusses topics using different perspectives (globally or locally specific).

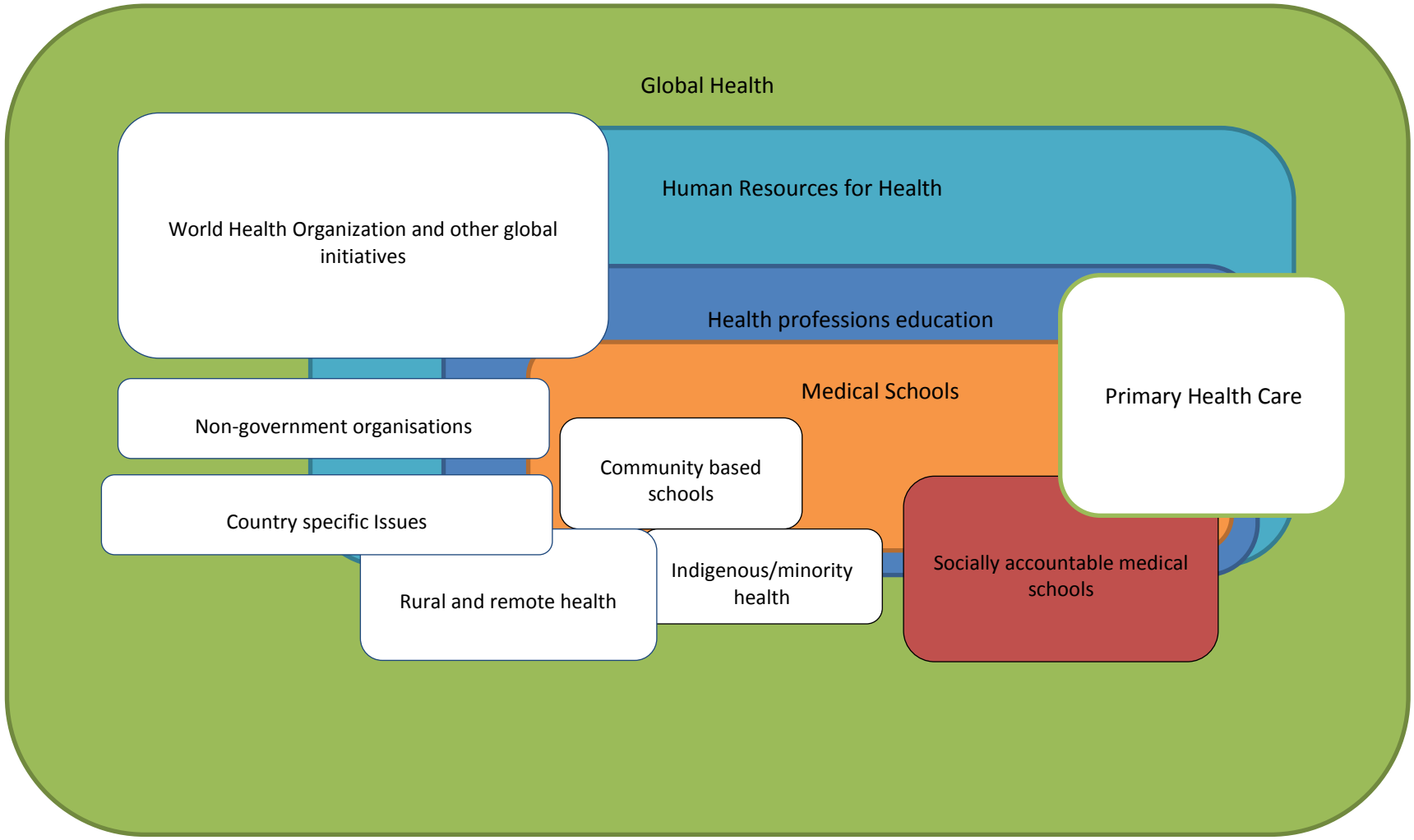

Figure 2.2 Logic map of the literature

2.2.2 Methodology of literature review[6]

A narrative literature review was conducted in March 2011, the methodology is summarised in Table 2.1. A systematic search strategy was constructed to review international peer reviewed published literature on social accountability, combining the terms social accountability and medical education and medical schools in various combinations and including variants on these terms. The strategy was tailored to each database, including OVID, CINAHL, and INFORMIT (see Table 2.2). Due to the World Health Organization's (WHO's) influence in Human Resources for Health (HRH), the WHO publications database was searched. Grey literature was also ascertained from databases of non-government organisations. Citation searches were conducted for selected articles, and current issues of relevant health professional education and health journals were hand searched. Databases were also searched for publications in English published until 2011. As the literature review aimed to outline the historical development of socially accountable medical education, in the initial search there was no limitation on the age of articles. However due to the wealth of literature, articles were subsequently identified from 1970. Seminal articles from before 1970 found in reference or citation searches were included in this review.

Searches were repeated at intervals from April 2011 to December 2013 to identify new publications. Many of the literature sources, including conference papers, policy documents and reports were located from academic journal alert lists; from colleagues and from conferences and reports. Bibliographies were hand searched. Relevant grey

[6] Documentary evidence (peer reviewed and grey literature) was also used as part of the data source. The methodology for searching for this data will be discussed in chapter 4 (Methodology).

literature (reports) and peer reviewed papers were found on electronic databases. These other sources (including the websites of key organisations) are clarified in Table 2.3 below. Finally, in December 2013 and January 2014, a repeated search of all databases and key sources was undertaken to identify any gaps in the initial search.

Table 2.1
Summary of literature review methodology including data sources and process timeline

Timeline	Mar – June 2011	April 2011 to Nov 2013	Dec 2013 to Jan 2014
Data Source			
Professional knowledge and networks (conferences, suggested papers, reports & other grey literature)		On-going	
Data Base search: OVIDSP, Informit	First Search		Second search
Citation Tracking			
Journal alerts and hand searching		On-going	
Books			
E-mail lists			
Analysis			
Synthesis		On-going	
Writing			

Table 2.2
Databases search strategies (repeated search December 2013)

Database & description	Years	Search terms and strategies used	Results		
OVIDSP	1970 – 19/12/13	“social* account* AND “medicine” OR “medical school” or “medical education” or “medical student”	317 articles	152 relevant	91 relevant included in the review
	1970 –19/12/13)	"socially accountable medical school*".	7articles	3 same/repeated 1 irrelevant	3 relevant included in the review
	1970 – Current (19/12/13	“health profession* education” AND social* account*	9 articles	1 repeat 1 irrelevant	7 relevant (2 by author) included in the review
	1970-Current	“health profession* education” AND “social* account*”	13 articles	8 repeated	3 relevant included in the review
Informit	1970-2013	(("medical schools") OR ("medical students")) AND (("socially accountable") OR ("socially responsible"))	4 articles	4 repeated articles	1 relevant article included in review
	1970-2013 All databases Arts, Education, Indigenous, Medicine, Social Sciences	(("health system") OR ("medical schools") OR ("medical students") OR ("health professional education") OR ("health profession* education") OR ("medical education") OR ("medical school*")) AND (("socially accountable") OR ("socially responsible"))	8 articles	4 repeated 1 sourced from previous search	2 relevant included in review

Table 2.3
Literature sources and search strategies used: Other sources of literature

Literature Source	Methodology
Databases	
Cochrane Review	Hand searched for relevant terms: education, workforce, "Health manpower"
World Health Organization (WHO) http://apps.who.int/iris	"socially accountable" and "medical schools"
	"social accountability"
	"Medical education"
	"social accountability" AND "medical education"
Annual reviews: www.annualreviews.org	Searched for "medical education" and "social accountability"
Journals	
Education for Health	Searched to 2011
	Contents alerts received from 3/2011 to 12/2013
Rural and Remote Health	Contents alerts received from 3/2011 to 12/2013
BMC Medical Education	Contents alerts received from 3/2011 to 12/2013
Social Science and Medicine	Search "social account*"
	Contents alerts received from 3/2011 to 12/2013
Academic Medicine	"social account*"
	Contents alerts received from 3/2011 to 12/2013
The Lancet	Contents alerts received from 3/2011 to 12/2013
Medical Teacher	"social account*"
	Contents alerts received from 3/2011 to 12/2013
Educación Médica	Hand searched 3/2011 to 12/2013
Focus on Health Professional Education: A Multi-	Hard copy received from

Literature Source	Methodology
Disciplinary Journal	3/2011 to 12/2013; hand searched
Internet Journal of Medical Education http://www.ispub.com/journal/the_internet_journal_of_medical_education/archive/last.html	Hand searched (12/2013)
International Journal of Medical Education http://www.ijme.net/archive/	Hand searched (12/2013)
Australian Medical Students Journal	Hand searched (12/2013)
Email Lists	
HIFA2015: Healthcare Information For All by 2015: http://www.hifa2015.org	Subscribed to email list March 2011
Capacity Plus http://www.capacityplus.org/	Publications searched E-Newsletter (2011 to 2014)
Primary Health Care Research Information Service http://www.phcris.org.au	E-newsletter
Websites	
World Health Organisation (WHO) Human Resources for Health http://www.who.int/hrh/en/	"hand searched" documents (second search: 14/01/2014)
Education Resources Information Centre http://eric.ed.gov	"medical education"
Human Resources for Health www.hrhresourcecenter.org/sg_overview	Hand searched
The Network Towards Unity for Health http://www.the-networktufh.org/publications_resources/furtherreading.asp	Publications searched
Global Consensus for Social Accountability of Medical Schools http://healthsocialaccountability.org	Publications searched
THEnet (The Health Equity Network) www.thenetcommunity.org)	Publications searched
LIME network www.limenetwork.net.au	Search resources
Institute for Healthcare improvement http://www.ihi.org/ihi	Searched resources

Literature Source	Methodology
Institute for International Medical Education http://www.iime.org/gmer.htm	Searched resources
Sub-Sahara Africa Medical Schools Study www.samss.org	Searched resources
Education of Health Professionals for the 21st Century: A Global Independent Commission	Searched resources
Intrahealth http://www.intrahealth.org/page/health-systems-and-hrh	Searched resources
The Asia Pacific Action Alliance on Human Resources for Health (AAAH) http://www.aaahrh.org/aaah.php	Searched resources
Health Systems Action Network http://www.hsanet.org	Searched resources
Carnegie Foundation www.carnegiefoundation.org	Searched publications
The Alliance for Health Policy and Systems Research http://www.who.int/alliance-hpsr/en/	Searched resources

2.3 Conceptual and historical development of "Socially Accountable Medical Education" and "Socially Accountable Medical Schools"

The four main historical eras that lead to the conceptual development of socially accountable medical education and socially accountable medical schools, are summarised in Table 2.4.

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Table 2.4
Conceptual and historical development of "Socially Accountable Medical Education" and "Socially Accountable Medical Schools"

Date	World Health Policy /Directives	Medical Education	Individual schools or networks of schools	Global events
1910s			Flexner Report : USA	
1920s				
1930s				
1940s				
1950s				"De-colonisation" in less resourced countries: new health roles
1960s	Alma Ata and "Health for All" implementation of			
1970s		Towards Unity for Health: Innovative Schools (The Network-TUFH) (since 1960s		
1980s				
1990s	World Health Organization: Five Star Doctor Social Accountability Framework (Charles Boelen)		Individual Schools: establishing or recognising own socially accountability	
2000s	Millennium Development Goals Boelen and Woollard's Conceptualisation - Production - Utilizations (CPU) Model		Training for Health Equity Network (THEnet): Health Professions	

Date	World Health Policy /Directives	Medical Education	Individual schools or networks of schools	Global events
2010s	WHO: Human Resources for Health: Task shifting, new health roles Global Consensus Conference for Social Accountability (2010); Health Professions Independent Commission on Transforming Health Professional Training for the 21st Century (The Lancet) (2010); Partnerships between less resourced and more resourced countries ASPIRE and AMEE (An International Association for Medical Education)			

2.4 1910s to 1980s: From Flexner to "Health for All": Influential medical education and health reforms

The first key historical era for socially accountable medical education was from the 1910s to 1980s when key reforms in medical education and broader public health from the Flexner review to "Health for All".

2.4.1 The Flexner Report and early medical education reforms

Although not defined at the time, many of the concepts and foundations of socially accountable medical schools were first explored in Abraham Flexner's 1910 report to the Carnegie Foundation on restructuring doctor training in the United States of America (Boelen, 2002; Flexner, 1910; Frenk et al., 2010a). There was concern about the lack of professionalism in medical training and the "apprentice" model of training. The review advocated that medicine should be taught in universities and should be focused on public service rather than commercial gain (Flexner, 1910). Furthermore, the importance of the behavioural and social sciences in medical curricula was recognised (Benbassat, Baumal, Borkan, & Ber, 2003; Boudreau, Cassell, & Fuks, 2007; Dornan & Bundy, 2004; Hernandez-Peña et al., 2013) as was the need for fair geographical distribution of doctors (Boelen, 2002). General accountability to the public was also noted (Boelen, 2002); it was recommended that the public be able to scrutinise qualifications (Boyer, 2008). "The physician's responsibility to the community was defined" (Boyer, 2008, p. 647). Flexner also made the connection between good medical education and population health outcomes (Boelen & Woollard, 2009). Flexner's recommendations and academic administrative changes influenced modern medical schools including "...courses for entrance, standardized curriculum and

institutional and governmental certification of proficiency" (Boyer, 2008, p. 647) and continue to exert broad influence.

While the Flexner report instituted educational and institutional reforms (Frenk et al., 2010a), there was an "…emphasis placed on a biomedical approach to education, at the expense of a more comprehensive understanding of social and community health problems" (World Health Organization, 2013d, p. 23). Training remained in tertiary or academic hospitals and medical schools focused on academic excellence with little consideration of their impact upon health systems and the population health needs beyond student graduation (Boelen, 2009). Due to the persistence of the traditional model of medical training, in the 1950s, two problems of medical education were established. One issue was the lack of medical professionals in geographic areas of need such as rural areas and in disciplines or professional areas of need such as primary health care. The second problem was that medical training in a tertiary hospital setting did not reflect where graduates would work in terms of both facilities and types of conditions treated (Fulop & Roemer, 1982; Schmidt, Neufeld, Nooman, & Ogunbode, 1991). Due to their training, many students were ill-prepared for the reality of medical practice.

2.4.2 The development of community orientated schools and The Network

In response to these two problems, from the late 1950s the WHO and individual schools fostered the establishment of departments of community medicine in medical schools. Yet these departments of community medicine had low status in academic schools and students had limited exposure to community problems compared with other curriculum. For example, they had little or no opportunity to gain skills in health promotion and prevention. While there were some successes, it was accepted that to be influential a

whole of school approach to community medicine would be required. Whereby the whole school would need to reorient its activities around community medicine principles in order for this to be effective (Schmidt et al., 1991).

The World Health Organization published case studies of innovation in medical schools in the late 1970s and early 1980s. The case studies highlighted community oriented schools, most of which had been in existence since the 1950s (Blumenthal & Boelen, 2001; J. Guilbert, 1984; Kantrowitz et al., 1987; Katz & Fulop, 1978, 1980; Richards & Fulop, 1987; World Health Organization, 1987). Student learning took places in the community rather than primarily in hospital based settings and curriculum and training was based on community health problems (Blumenthal & Boelen, 2001; Boelen & Boyer, 2001; J. Guilbert, 1984; Kantrowitz et al., 1987; Katz & Fulop, 1978, 1980; Richards & Fulop, 1987; World Health Organization, 1981, 1985). This type of medical education was an alternative to hospital based training that might fail to adequately prepare students for service in communities. Community Based Training or training focused on Primary Health Care (PHC) is an important feature of socially accountable medical schools (Katz & Fulop, 1978, 1980; Neufeld, 1991; Richards & Fulop, 1987; World Health Organization, 1987). Schools accepted as sharing similar characteristics implemented alternatives: training health personnel willing to service the community by providing health care; ensuring training programs are relevant to present and future community needs; learning based on community problems; integration; active or experiential learning and the use of appropriate technology (Katz & Fulop, 1978). Some schools with more conventional programs developed ‘alternative tracks’ that were community based (Kantrowitz et al., 1987). A less threatening way of introducing innovation was having ‘alternative’ that sat beside the more traditional programs (Katz & Fulop, 1978, 1980).

Many innovative schools were members of 'The Network of Community–Orientated Education Institutions for Health Sciences' (The Network)[7] "...a global network of individual, institutions and organisations committed to improving the health of the people and their communities" (A Kaufman et al., 2004, pp. 1212-1213). The Network formed in 1979 when nineteen medical schools were bought together in Kingston, Jamaica by the WHO (Schmidt et al., 1991). These schools had key elements of socially accountable medical schools: they emphasised real health problems and independent learning; community health issues were at the centre of the curriculum that was taught through Problem Based Learning (PBL) and they were involved with local health care systems. The World Health Organization envisaged that the Network would influence medical education reforms at other schools (A Kaufman et al., 2004, p. 1215). The scope of this organisation broadened to include expertise in medical education, health systems, service development and policy development (A Kaufman et al., 2004; Schmidt et al., 1991). The group's other key achievement was the steady growth and diversity of membership. Most members, including institutions, organisations and individuals, were from less financially resourced countries (A Kaufman et al., 2004). This diversity ensured a more global appreciation of health professional and health system issues including the unique challenges and achievements of less-financially resources countries.

[7] In 1999, the organisation was renamed 'The Network: Community Partnerships for Health through Innovative Education, Service, and Research' (The Network) (Schmidt et al., 1991). In 2002 The Network incorporated the Towards Unity for Health (TUFH) Initiative; further discussed in the next section.

2.4.3 (De)-colonisation[8] and challenges for less-financially resourced countries

Another key influence on changes to medical and health professional education was (de)-colonisation in less financially resourced countries during the 1950s to 1970s. As skilled professionals from the colonial powers left these nations, there were gaps in the workforce. Locally devised workforce solutions developed for appropriate health systems. Innovative health programs and health professional roles were progressed as health roles other than doctors were seen as more appropriate in some settings, particularly primary health care (Fulop & Roemer, 1982). Alternative programs of the 1960s and 1970s included the Mexican health worker program, the Jamkhed program in India and community health movements in Latin America (Baum, 2007). Furthermore, from the 1970s the potential of traditional birth attendants (including up-skilling to become skilled birth attendants) and community based health workers were being accepted in developing countries (Fulop & Roemer, 1982). China became a member of the WHO in 1972 and the success of their "barefoot doctors" program was globally influential. In the 1970s "a million "barefoot doctors" or semi-skilled health professionals were providing health care and health education to the 500 million rural Chinese" (Rifkin, 1978, p. 34). With the increase in health costs, in more financially resourced countries, other health professional roles such as nurse practitioners and physicians' assistants were explored (Fulop & Roemer, 1982). The development of these new roles challenged the traditional role of the doctor as leader of the health team. Newly independent countries also influenced a global acknowledgment of the health

[8] The term "de-colonisation" assumes that the effects of colonisation are no longer played out, however, as argued by Indigenous academics Muller (L. Muller, personal communication, 3 September 2012) and Baker (2012). As Australian and other nations are still colonised, (de)-colonisation preferred term.

inequities between countries and the need for a new international economic order and the transfer of resources, including appropriate aid for health system reform.

2.4.4 Primary health care and "Health for All"

The reforms to medical education were strengthened by changes to health systems, especially through the move to focus on primary health care as an essential part of the health system. The shift to a broader notion of health care required a differently trained workforce. In 1977 the World Health Assembly (WHA) declared that the social target of governments and the WHO should be the attainment of health for all people of the world by year 2000 that would lead to a socially and economically productive life (World Health Organization, 1981). The Declaration of Alma Ata, endorsed in 1978 at a conference in Alma Ata, USSR was attended by "…134 member states, 67 international organisations and dozens of NGOs" (World Health Organization, 2008a, p. 746). This Declaration placed primary health care (PHC) as an essential part of the health care system (World Health Organization, 1978). The definition of health was expanded to include 'health as a human right' and the responsibility of governments to ensure community participation, access, and equity was emphasised. There was also recognition that health was influenced by factors outside the health sector requiring greater inter-sectoral collaboration. Health for All by the Year 2000 (HFA) was a global strategy developed in 1981 based on the Alma Ata declaration (World Health Organization, 1981).

The Alma-Ata conference and Declaration demonstrated "(t)he most profound reorientation and redefinition of the work of the WHO..."(Reid, 1985, p. 58). The Declaration itself signalled a change for WHO from "…its earlier reliance on a 'top-down' transfer of professional medical authority to solve the world's health problems"

(Baum, 2007, p. 35) and towards a broader more inclusive definition of health and health care. The Alma Ata Declaration outlines the type of health professionals and health professional training required and has influenced education, training and workforce policy developments globally and at national and local levels. One example of Alma Ata's influence is the call for training and education of health professionals to be conducted in Primary Health Care (PHC) rather than in tertiary or specialist teaching hospitals. The declaration called for a health workforce suited to community needs (including in the informal sector); multi-disciplinary team work; training in social as well as technical issues; and appropriate referral levels. It also brought about interest in different types of health workers and their educational needs; no one health worker is identified as more important or influential than another. Furthermore, communities were deemed part of the health workforce and were to be given power and influence in their own health.

For medical education, Health for All (HFA) signalled a shift in WHO policy from focusing on the 'quantity' of health professionals to the relevance of health professionals (Kantrowitz et al., 1987). Inequities in health 'manpower[9]' and the unequal distribution of medical professionals were distinguished as important issues. Inappropriate training was also discussed as an important cause of the mal-distribution of human resources for health. Reforms to medical education were outlined as a key strategy to solve these issues. As part of their training, health professionals should have been "...imbued with the philosophy of health development" as defined in the Alma Ata Declaration (World Health Organization, 1981, p. 45). Health workers should also be

[9] Later termed "Human Resources for Health", this term was used to describe "manpower" and is more gender neutral.

socially motivated to serve communities and they should be re-orientated and retrained to take an active role in communities. The 1985 report '*Health manpower requirements for the achievement of health for all by the year 2000 through primary health care'* outlined how to achieve the human resources for health requirements for operationalising the Health for All strategy (World Health Organization, 1985). Recommendations included: community involvement and control; the re-orientation of medical education for health services and community needs; including problem based learning; focusing of community and public health problems; service; and changes to student selection to take into account student attitudes and attributes. All these proposals were foundations to the conceptualisation of socially accountable medical schools.

2.4.4.1 The influence of the Health for All strategy on medical education

The majority of reports on medical education and socially accountable medical schools cite the influence of the Health for All strategy (Blumenthal & Boelen, 2001; Boelen, 1992, 1997a, 2000b; Boelen, Des Marchais, Dohner, & Kantrowitz, 1992; Boelen & Heck, 1995; J. Guilbert, 1984; Kantrowitz et al., 1987; Katz & Fulop, 1980; Richards & Fulop, 1987; World Health Organization, 1985, 1987, 1991, 1995, 1996, 2008b). For example, Resolution WHA37.31 of the World Health Assembly (WHA) and the report "Universities and Health for All" called for member states to support universities "...in orientating the education and training of workers in health and related fields towards the attainment of Health for All" (Tarimo & Webster, 1994, p. 74; "The universities and health for all," 1988). Graduates needed to meet the health needs of the communities that they would serve. Universities and governments needed to work together to ensure the most appropriate use of technology as well as equity in the health system. In 2001 a conference, "Universities and the Health of the Disadvantaged"(Blumenthal & Boelen, 2001) recognised that universities needed collaboration across the facility as health was

not just an issue for medicine but the whole university. However, the focus returns to solely medical schools in subsequent reports. The World Health Organization (The WHO) attempted to disseminate information about reorientated health professional schools. It created the bulletin "*Changing medical education and medical practice"* and revised a WHO guide for teachers of PHC staff (Tarimo & Webster, 1994). While the WHO and other global organisations continued to advocate for health reform based on the Health for All strategy, even after the year 2000, there were challenges in implementing these reforms.

2.4.4.2 The Challenges to implementing Health for All and reforms to medical education

While the Health for All (HFA) strategy and the need for primary health care (PHC) are cited by many reports, recommendations supporting this were not implemented at medical schools, nor included in medical education and training. Some authors contend that this failure was because there was no strategy to mobilise stakeholders to bring about the required change (Boelen, 2004a; Woollard, 2006). Key factors required to achieve HFA at a health systems level included political will, funding, human resources and community support. The challenges of implementing a PHC focused medical education system are significant, particularly due to issues surrounding professional power and influence. There was an identification of the need for different roles and levels of training to implement HFA policies (World Health Organization, 1985). This may have been seen as a threat by medical professionals. Green (1994) has outlined how medical professional conservatism and the interest of elites "…ensured the failure of Health for All and supported the choice of selective strategies with a framework better suited to the medical profession's interests" (Koivusalo & Ollila, 1997, p. 125). David Werner, who established a village health program in Mexico and wrote the text

"Where there is no Doctor", acknowledged "the threat which arises once the medical professional and other local elites realise that the community health worker is not beholden to these traditional power blocs"(Rifkin, 1978, p. 34). Indeed, Rifkin outlines how barefoot doctors were a political creation rather than technological creation (Rifkin, 1978).[10] Mburu (1989), writing about non-government organisations in Africa, described a culture clash between Ministries of Health and non-government organisations (NGOs) in supporting PHC. Some Ministries believed that PHC was not "medical" and they feared a move away from "standards" of medical care in hospitals to second rate medical practice in communities. Furthermore, as under the philosophy of PHC all health workers could be perceived as experts, not just doctors, the 'health for all' movement could be seen as socialist infiltration (Mburu, 1989). This was particularly notable in the historic context of the cold war, when Mburu's paper was published. So while the *ideals* or *values* of PHC were influential and accepted; the actual operation or change to the health system to PHC was unrealistic and incomplete, including in medical education. There was little resourcing for implementation of these changes and limited motivation to challenge existing power structures in the health and political system. However, the philosophy of the Alma-Ata declaration, Health for Health and PHC continue to influence socially accountable medical schools and is "still the declared basis for the policy of most governments" (A. Green, 2007, p. 55).

[10] China had closed its medical schools, doctors were sent out to the country side and community workers were trained to take on roles of doctors. These workers were deemed as having authority as they were nominated by the community; not because they had technical skills or were endorsed by the medical professional (Rifkin, 1978). "...(T)he village health worker was the institutionalisation of people's participation in decisions which affect and improve their own health care" (Rifkin, 1978, p. 34)

2.5 1980s to 2000s: Theoretical development of socially accountable medical schools: The World Health Organization and Dr Charles Boelen

Influenced by both the gap in human resources for health (HRH) and the need for medical school reform, Charles Boelen[11], a medical professional who worked in health professional education initiatives at the World Health Organization in the early 1990s, has pioneered and led the theoretical development of the socially accountable medical education (Westberg, 2008). The next section outlines six key concepts in the theory of socially accountable medical schools referencing peer reviewed and grey literature by Dr Boelen and colleagues.

2.5.1 The development of socially accountable medical education: Key reports and papers

While there is no clear definition of socially accountable medical schools in early reports and papers; there are the early stages of the key concepts of social accountability.

The conceptualisation of socially accountable medical education was developed in the early 1990s to 2000s as Dr Boelen[12] and colleagues chaired meetings with relevant

[11] Dr Boelen's email signature states his credentials as: International consultant in health system and personnel. He is the former coordinator of the WHO program (Geneva) of human resources for health (Boelen, 2014).

[12] Although there are no references, much of the presentation (published in a 1994 edition of "Medical Education") is based on past WHO reports authored by Boelen. Certainly much of Boelen's later work, even in the peer-reviewed literature, can be assessed as opinion pieces or "rehashed" version of earlier research. However, rather than be seen of an indication of poor research or poor peer review, this indicates that, one, Boelen was *the* eminent author on social accountability in medical education and socially accountable medical schools until the resurgence of the concept in the late 2000s; and, two, Boelen persisted in advocating for socially accountable medical schools throughout the 1990s and early 2000s. Indeed his perseverance in persuading the global medical education community to accept social accountable medical education was achieved in the 2010s (in the context of other developments discussed in section four of this review).

national and regional bodies that focused on reforming medical practice and education, consulted medical education experts and schools and wrote peer reviewed papers (Ayres, Boelen, & Gary, 1999; Blumenthal & Boelen, 2001; Boelen, 1990, 1992, 1993a, 1993b, 1994a, 1994b; Boelen, 1995; Boelen, 1997a, 1997b; Boelen, 1999; Boelen, 2000a, 2000b, 2002, 2004a, 2004b, 2005, 2008a, 2008b, 2009; Boelen, Bandaranayake, Bouhuijs, Page, & Rothman, 1991; Boelen & Boyer, 2001; Boelen et al., 1992; Boelen & Heck, 1995; Boelen & Woollard, 2009; Bryant, Boelen, & Salafsky, 2001). At a plenary session of the World Summit on Medical Education in 1994 Boelen (1994b) stated that the idea of a socially accountable medical schools meant focusing on the outcomes of medical education:

> *The concept of social accountability of an educational institution requires that it share responsibility for the fate of the end-product - its graduates – far beyond the mere transmission of new knowledge skills and attitudes…*
>
> (p. 83).

In their influential 1995 report "Defining and measuring the social accountability of medical schools", Boelen and Heck (1995) outlined the first clear conceptualisation of social accountability in the context of medical education:

> *[Social accountability is]…(t)he 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.*
>
> (p. 3).

These priority health concerns were to be identified jointly by governments, health care organisations, professionals and the public[13]. Boelen and Heck (1995) also developed the social accountability grid, a model for assessing the social accountability of medical schools. In their 2009 paper *Social accountability and accreditation: a new frontier for educational institutions*, Boelen and Woollard (2009) further developed the social accountability grid (Boelen & Heck, 1995) into the Conceptualization-Production-Usability (CPU) model. During this period five influential ideas developed:

- the five star doctor;
- the role or mission of the medical school;
- the values of social accountability;
- the need for inter-sectoral collaboration or partnerships beyond medical education; and
- assessment and evaluation of social accountability (through frameworks to measure a school's progress towards social accountable practice).

2.5.2 A new type of doctor: The five star doctor

The "five star doctor" is a predecessor or foundation to socially accountable medical education as it captured some of the key features of socially accountable medical schools; with a focus on community and an expanded physician role[14].

[13] In the same year the World Health Assembly WHA48.8 "Reorientating medical education and medical practice for health for all" was released.

[14] The five star concept has been adapted by medical education authors and a "sixth star" of educator or teacher incorporated (P. Lee, 1994) (Morales Suárez, Sacasas, & García, 2008). In 2004 the World Organisation of Family Doctors (WONCA) initiated a 'five star doctor' award to accredit doctors who demonstrate the five star qualities (Westberg, 2008).

A "new doctor" was required to work effectively in a reformed health system to serve people's needs (Boelen, 1990, 1992; Boelen et al., 1992). The "Five Star Doctor" had five essential roles: care giver; manager; decision maker; communicator; and community leader (Boelen, 1993b, 1994a). The "five star doctor" was instigated from a range of meetings, reports and consultations that included The Edinburgh Declaration (1988) and the ministerial consultation for Medical Education in Europe (1988)[15] (Boelen, 1990; Westberg, 2008; World Health Organization, 1991). It was envisaged that the "Five Star Doctor" would be a reference point for medical education and that the reforms for creating a "Five Star Doctor" in medical schools would flow on to medical practice. (Boelen, 1994a, 2000b; Boelen & Boyer, 2001; Boelen et al., 1992; World Health Organization, 1996). However the implementation and practicalities were not outlined. Given the individualistic way that many doctors and health system worked and similar to the implementation of PHC, there were a lot of barriers to the introduction and reorientation of health services.

[15]Developments in medical education and social accountability are iterative and cannot be separated but it is beyond the scope of this review to analysis all developments in medical education. There has been a continued emphasis on medical education reform by WHO and others international organizations including the United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Children's Fund (UNICEF) and the United Nations Development Program (UNDP) which culminated in the Edinburgh Declaration in 1988. This developed from the World Conference on Medical Education held in Edinburgh in August 1988 (Boelen et al., 1991; Metcalfe, 1989). Statements from this conference echoed previous calls that medical education must meet the needs of society, especially the vulnerable (Metcalfe, 1989). The eight strategies included expanding training beyond hospitals to different settings. There was a call for community-based learning; curricula reflecting national health priorities; including appropriate student selection, and increased emphasis on health promotion and disease prevention (Kwizera & Iputo, 2011). Following from this, in August 1993 a Summit was held with the support of WHO, other international organisations, governments and NGOs to decide on a global strategy for change to reorientate medical education (Walton, 1993) It aimed for on-going, sustained international mechanisms for implementing and managing reform (Walton, 1993).

2.5.3 From responsive to accountable: The changing mandate of medical schools

Socially accountable medical schools should be accountable to the current and future health needs of society (Boelen, 1994b; Boelen et al., 1991; Boelen et al., 1992; World Health Organization, 1991). This was a development from early calls for medical schools to be socially responsible through their teaching research and service (Brandt, 1989; Bruhn, 1971; Greene, 1947; Hirsch, 1969). Schools should focus on "influencing the environment in which the graduates will work to the greatest satisfaction of the health consumers, the health authorities and the graduates themselves" (Boelen, 1994b, p. 83). Boelen (1999) differentiated between schools that were neutral, reactive or proactive to improving the health system

> *A socially responsible medical school perceives the needs of society and reacts accordingly, and a socially accountable school also consults society about priorities and provides evidence of impact of its deeds.*
>
> (p. S11).

Medical schools needed to be also to be proactive and to anticipate and influence the environment or health system for their graduates. Woollard (2006) differentiated between the social accountability of individual graduates and institutions and felt that it was the responsibility of institutions to foster an ethos of service and address the priority health needs of communities The features of a socially accountable medical school included:

- "Explicit attention to societal needs in the policies and structure of the faculty/staff;
- A faculty (staff) reward, recognition and promotion system that supports relevant scholarship;

- Robust engagement with the health sector;
- A mechanism to fully engage the faculty/staff communities;
- Community 'service learning' opportunities for all students;
- Interdisciplinary or inter-professional training opportunities for all students; and
- An explicit commitment on the part of each school to define, develop and assess the professional development of its students' (Woollard, 2006, p. 309).

This new role for the medical school was influenced by wider health workforce issues. Boelen and Woollard (2009) described a crisis in human resources for health despite educational advances in health professional education. This link between education and workforce is critical; and an example of a contextual factor that influences socially accountable medical education. Their paper focuses on health professionals, not just doctors, and was the first time that the idea of social accountability was applied outside medicine. There is, however, no explanation on why there was a change in focus (Boelen & Woollard, 2009).

2.5.4 Values of socially accountable medical schools: Relevance, cost effectiveness, quality and equity

The principles or values of relevance, quality, effectiveness and equity have underpinned socially accountable medical schools and were first highlighted as values that would guide the "Five Star Doctor" (Boelen et al., 1992). The social accountability grid, a framework by which medical schools could gauge their progress towards social accountability, gave clear definitions of the four values of socially accountable medical education. Boelen and Heck (1995) stated that these values would give clear guidelines for medical schools interested in being more socially accountable:

- Relevance: The health issues that the medical school addresses through teaching, research and service should be relevant to the community. These prioritised health issues should be updated regularly though consultation with the community. Graduates should be trained in health services where they can effectively learn about these health priorities. Furthermore medical schools should be involved in planning to ensure the workforce is relevant to the community.
- Quality: High-quality health services are defined as not only technically appropriate but meet cultural and social issues and consumer expectations. These expectations would vary across context, but services should encompass primary health care, hospital care and disease prevention.
- Cost-Effectiveness: "Cost-effective health care systems are those that have the greatest impact on the health of a society while making the best use of its resources" (Boelen & Heck, 1995, p. 7). Health systems that prioritise health promotion, primary health care and disease prevention are more cost-effective. However, the medical school curriculum needs to promote the cost effectiveness of individual and public interventions. Furthermore schools need to undertake collaborative research and evaluation on cost-effectiveness.
- Equity in health care: link with Health for All; high quality health care should be available for all; research; student exposure to models of care for underserved (Boelen & Heck, 1995, pp. 5-8).

By the late 2000s, the value of cost effectiveness was changed to effectiveness and defined as "...the utilisation of health care resources, both human and material , in a

manner that serves the public interest in the most effective and efficient way" (Boelen & Woollard, 2009, p. 889).

2.5.5 Partnerships and inter-sectoral collaboration: The Towards Unity for Health project

Another key foundation of the concept of social accountable medical schools was the need for collaborative and inter-sectoral partnerships with other health and social institutions including the community, governments and health care systems (Boelen et al., 1992). Partnerships were also embedded in the definition of socially accountable medical education (Woollard, 2006). The leadership of a Dean, or head of a medical school, with a clear understanding of the "Five Star Doctor" combined with initiative and drive to create partnerships with the health sector was also cited as essential. There needed to be a network of relationships between health care, medical practice and medical education. Changes at all three areas needed to be coordinated, for example the practice of patient centred care must be supported by reference to strategies to achieve this in medical education curricula. These strategies were supported by The World Health Assembly's resolution (WHA48.8), "*Reorientating medical education and medical practice for health for all"*, made in 1995 (World Health Organization, 1995). Medical schools were one of the institutions that needed to rethink or reposition themselves in the health system.

The Towards Unity for Health (TUFH) project was launched by the WHO in 1999 (Boelen, 2000b, 2004a) and aimed to address health needs and ensure appropriate health services through unifying partnership between medicine and public health or individual and community health. Figure 2.3 summarises the key concepts of this project. The outcome would be a reduction in "... fragmentation in the health system" (Boelen, 2004a, p. 31) and "unity' in health. The TUFH Partnership Pentagon (see Figure 2.4)

was another theoretical framework developed by Boelen (2000b) to illustrate the range of possible interactions between policy makers; health professionals; academic institutions; communities and health managers within a health system. Twelve field projects were chosen in 2001 to pilot this approach and socially accountable medical education was highlighted as one element or part of TUFH project (Bryant et al., 2001). Conceptual models, including the Towards Unity for Health Pentagon, can guide the nature of partnerships different levels of the health sector and the benefits, and challenges of working across sectors (Boelen, 2000b).

Aim: Service based on people's needs
Values: Quality, equity, relevance, cost-effectiveness
Objective: To reduce fragmentation in health systems and create unity
Starting point: Integration of medicine and public health
Technical needs: reference population; organisational model; health information management
Partnerships: policy makers, health managers, health professionals, academic institutions, communities "

Figure 2.3 TUFH summary of document and project

(Source: Boelen, 2000b, p. 69)

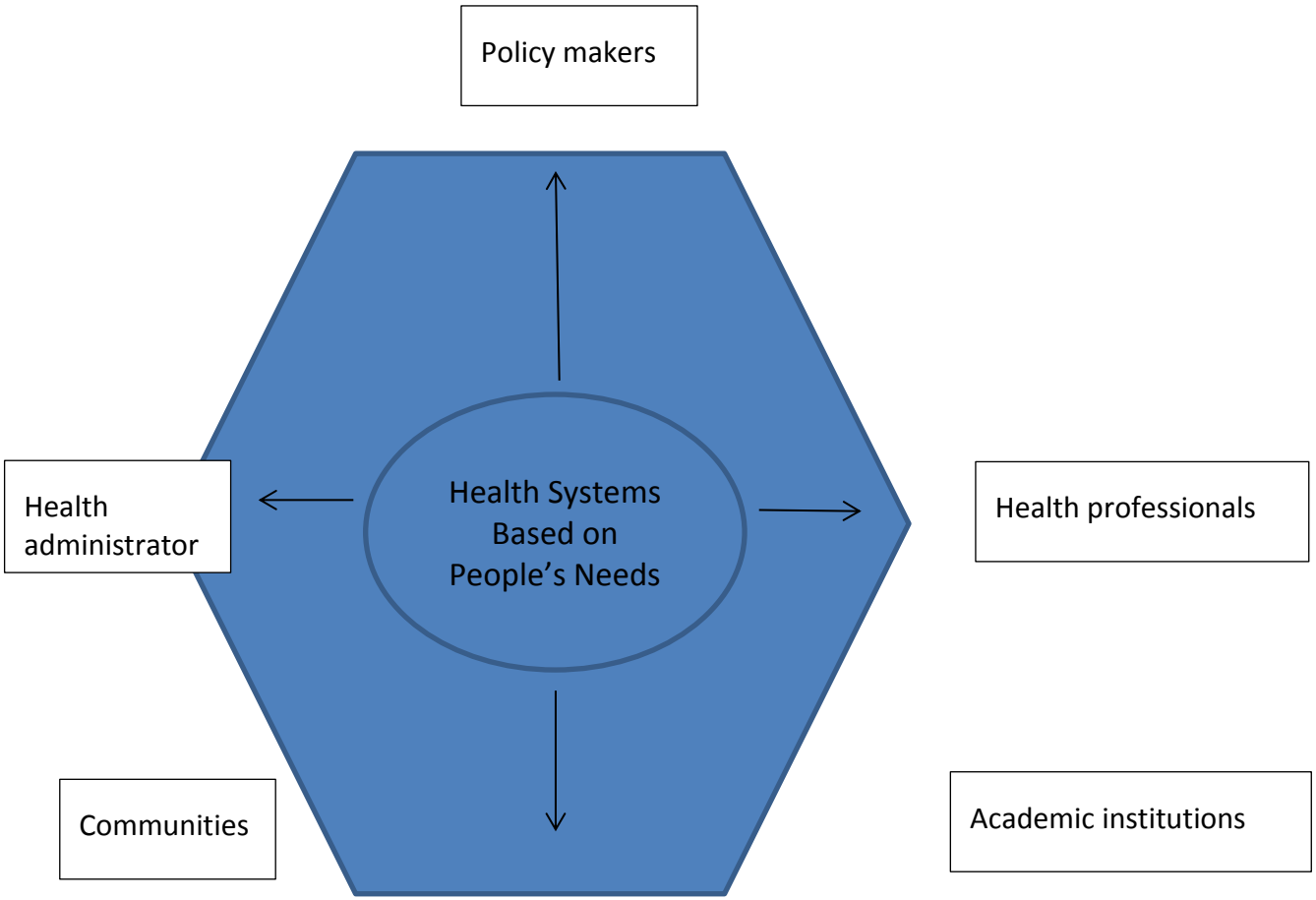

Figure 2.4 Towards Unity for Health Pentagon

Adapted from (Boelen, 2000b)

The Towards Unity for Health model has also influenced the conceptual development of socially accountable medical schools. Boelen (2004a) discussed the challenges and opportunities of TUFH projects and advised how individuals and actors can work more effectively through:

- principles (there were the values of social accountability);
- populations (a defined population);
- partnerships (collaboration);
- integration (building a coherent and comprehensive health delivery system);
- information (sharing of health information);
- impact (a shared framework of assessment against the values/principles); and
- institutionalisation (making sustainable changes at the organisational level).

The pentagon included how to get started with medical education reform; steps for the development and early implementation and steps for later adoption with a goal and task for each step. There was a need for assessment and accreditation and longitudinal studies and comparisons between schools that were using different strategies. There was also need to evaluate the mission of a school against outcomes.

2.5.6 Assessment, evaluation and steps to accreditation models

From the mid-1990s the focus of social accountable medical schools had shifted to how it could be measured and assessed. This was a precursor to the Global Consensus in Social Accountability developed in 2010, and acceptance

by the wider medical education community. The social accountability grid was a tool for medical schools to assess how their functions of education; research and service met the four values of social accountability at the planning (inception of medical school); the doing (actual activities) and the impacting stages of a medical school (Boelen & Heck, 1995). The impacting stage went outside the usual outcomes of medical schools (graduates and research papers) to include influencing the health of the community. The goal of schools should be to produce graduates that not only can practice in a reformed health care system but also can influence and reform the system. The social accountability grid included an annex with a guide to each value and each domain at each stage. It illustrated what schools should be doing to meet social accountability obligations[16]. This grid could be adapted according to the context of different schools. While one use of the grid could be for external evaluation or accreditation, the aim was not to rank schools but for individual institutions to measure progress and stimulate action towards social accountability.

The Australian rural health academic Max Kamien presented the grid at a teaching conference in Australia in 1999 (Kamien, 1999). He gave a practical example of how a medical school could evaluate its education mandate with the grid framework. This was one of the first times the Social Accountability Grid was disseminated by someone other than its author. In addition, the

[16] For example at the planning stage in the domain of service under the value of relevance:

"There is institutional commitment to contributing towards meeting the priority health needs of the community, region and/or nation"

(Boelen & Heck, 1995, p. 28).

Chulalongkorn Medical School in Thailand applied the social accountability grid to the school (Sirisup, 1999). The school determined health care priorities focusing on health system development, public health and the needs of the poor.

2.6 1990s to 2010s: From theory to practice: The local and global implementation of socially accountable medical education and medical schools

From the 1990s health professional schools and national and international networks applied the theoretical models of socially accountability. Section 2.6 outlines how individual schools have interpreted the theory of social accountability, including community engagement, partnerships with communities, placements and research. There are two case studies: a national application of social accountability (Canada) and an international network of health professional schools aspiring to be socially accountable (The Training for Health Equity Network).

2.6.1 Individual schools aspiring to be socially accountable

Arguably the first to demonstrate the operationalization of social accountability were the Network of Community Orientated Education Institutions for Health (the Network/TUFH institutions) discussed in section 2.2 (Gadon & Glasser, 2006; Kamien, 1999). Since the late 1990s new institutions were established with a clear social accountability mandate, including James Cook University in Australia (Hays et al., 2003), the Northern Ontario School of Medicine in Canada (S. Strasser & Strasser, 2007) and Patan School of Health Sciences in Nepal (The Training for Health Equity Network, 2013b). Other schools have

analysed how their own values or principles aligned with the theory of socially accountability well before this theory was conceptualised. For example the Faculty of Health Sciences of Walter Sisulu University in South Africa, which was first established in 1985 as part of University of Transkei (Kwizera & Iputo, 2011). The University of New Mexico Health Sciences Center, established in 1994, had a clear mandate of social responsiveness, including changing the health system (A Kaufman, 1999). The Faculty of Medicine at Suez Canal University established in 1978 undertook a long-term partnership initiated by the surrounding rural community and therefore "the School was already addressing…the issue of the Social Accountability of a Medical School before the topic had been fully and extensively described in the medical literature" (Talaat & El-Wazir, 2012).

Some institutions have 'self-defined' how they operationalised the theoretical concepts of social accountability and much of the literature from individual medical schools has been opinion pieces with little empirical evidence or external evaluation. Most authors have outlined a 'socially accountable' element of their medical school's activities (such as teaching or research) or even as part of a single course (such as a placement with an underserved community or a subject). Other aspects are outlined as "...courses, curricula, community relations and the ethos of schools themselves" (Woollard, 2006, p. 305). Community-based curricula that focused on the underserved; rural health; Indigenous health, or global health are also cited as examples of socially accountable practice (Galukande, Nakasujja, & Sewankambo, 2012; Jarvis-Selinger et al., 2008; Talaat & El-Wazir, 2012; Wasylenki, Byrne, & McRobb, 1997). Placements, research or curricula on global health are cited

demonstrations of social accountability (Murdoch-Eaton & Green, 2011; Murdoch-Eaton, Redmond, & Bax, 2011; Parboosingh, 2003). Schools validated their social accountability through how students were selected and retained (Cappon & Watson, 1999) and access to medical school by underserved groups (Kamien, 1996).

2.6.2 Case study of partnerships: Northern Ontario School of Medicine approaches

The Northern Ontario School of Medicine (NOSM) was established with a clear social accountability mandate to address the medical workforce needs of Northern Ontario, Canada (R. P. Strasser, 2010; R. P. Strasser et al., 2009). Community engagement has been an important part of the school's program. The model of medical education is the distributed community engaged learning in 70 rural and remote communities across Northern Ontario (R. P. Strasser, 2010). The community were involved in a curriculum workshop prior to the establishment of the school and are involved in student selection, as standardized patients and hosting students (R. P. Strasser, 2010). The benefits of partnerships are emphasised:

> *Community engagement for NOSM is consistent with its social accountability mandate and has a particular focus on collaborative relationships with Aboriginal communities and organizations, Francophone communities and organizations, and rural and remote communities as well as the larger urban centres of Northern Ontario.*
>
> (R. P. Strasser, 2010, p. 3).

There are local NOSM groups, reference groups and formal memorandums of understandings. The school needed to demonstrate that they are serious about a real partnership by "empowering the community to be a genuine contributor to all aspects of the medical school" (R. P. Strasser, 2010, p. 4). The formal agreements facilitate this through local steering committees. There is a genuine feeling that the medical school is part of the community and that the community is part of the medical school. Ezzat (1995) writes about this belief:

> *Health profession institutions must pervade the health care system just as the health care system pervades the community. As such, the institution is not a self-contained isolated set of buildings and laboratories but an institution without walls embedded in community values and is continually assessing its relevance to its culture and health status.*
>
> (p. 47).

2.6.3 A National approach to socially accountable medical education: Canada

At a national level Canada provided an interesting example of how socially accountable medical education has been operationalised not only at the medical schools but also in Continuing Professional Development (CPD) of health professionals (Association of Canadian Medical Colleges, 2003; Cappon & Watson, 1999; Fleet et al., 2008; Goldman, Reeves, Novak Lauscher, Jarvis-Selinger, & Silver, 2008; Health Canada, 2001; Ho et al., 2008; Thompson & Davis, 2008). A steering committee that focused on social accountability was founded by the Association of Faculties of Medicine of Canada (AFMC). This

initiative was made up of diverse partnerships and aligned with wider changes in the Canadian Health System, instituted by Health Canada in 2000 (Cappon & Watson, 1999; Fleet et al., 2008) The program was based on the Towards Unity for Health model (Boelen, 2000b; Ho et al., 2008). There is a hierarchy of five-way partnerships from local to regional, provincial and to the national level. An example is that the AFMC interacts at the national level (Woollard, 2006).

Under this initiative all 17 of Canada's medical schools have partnered to focus on social accountability and CPD. The approaches to CPD were both inter- and intra-professional. Each project included external partners beyond the medical professionals. Projects were diverse but had two main foci: professional collaboration and learning, and community partnerships in action (Ho et al., 2008). For example, University of Saskatchewan and University of British Columbia had specific divisions and initiatives on social accountability including dedicated staff (Dharamsi, Ho, Spadafora, & Woollard, 2011). The University of Saskatchewan developed the CARE model (Clinical activity, Advocacy, Research, Education and Training) to guide an institution-wide approach to social accountability (Meili, Ganem-Cuenca, Leung, & Zaleschuk, 2011). The approach promoted a cultural change over 10 years at the school with most students and staff involved in social accountability activities. Other Canadian initiatives include: an Association of Canadian Medical Colleges' Working Group on Social Accountability (Association of Canadian Medical Colleges, 2003; Parboosingh, 2003); national meetings (Ho et al., 2008) and a database of activities (Meili, Ganem-Cuenca, et al., 2011).

2.6.4 A Network approach: The Training for Health Equity Network (THEnet)

The Training for Health Equity Network (THEnet) is a collaboration of health professional schools aspiring towards social accountability (Neusy & Pálsdóttir, 2008, 2011; Pálsdóttir & Neusy, 2010; Pálsdóttir & Neusy, 2011; Pálsdóttir et al., 2008; R. P. Strasser & Neusy, 2010). This project was founded in 2008 by two experts in global health who recognized the gap in medical schools practically addressing the Human Resources crisis (B. Pálsdóttir, personal communication, 8 October, 2011). An initial assessment and literature review was undertaken on the feasibility of developing a collaborative evaluation framework for socially accountable medical schools (Pálsdóttir et al., 2008). It was acknowledged that the initial work of the WHO, led by Dr Charles Boelen, formed a solid theoretical basis for measuring social accountability in medical schools. However, no schools that had implemented this framework could be found. Eight medical schools with a clear commitment to social accountability - assessed through publically available documents and school visits - were invited to join the international THEnet collaboration and four new members of THEnet were formalised in 2011 (see Table 2.5). Most members have formal or informal linkages with the Network TUFH and have a community based approach to medical education (Larkins et al., 2013; Ross et al., 2014). Despite their diverse contexts, common principles and missions are shared (see Table 1.1 in chapter one). The group jointly developed an evaluation framework for measuring social accountability based on these key principles (discussed in section 2.5). The Training for Health Equity Network has also an advocacy role, helping initiate the global consensus conference on social accountability

and representation at global and national meetings on socially accountable medical education.

Table 2.5
THEnet Members

THEnet Foundation members
Flinders University, Australia*
James Cook University, Australia*
The Northern Ontario School of Medicine, Canada*
Ateneo de Zamboanga University, The Philippines*
The Medical School of Walter Sisulu University, South Africa*
University of the Philippines, Leyte*
ELAM, Cuba and Barrio Adendro Programo Nacional Universitario de Entrenamiento, Venezuela#.
THEnet 2011 members
Gezira University Faculty of Medicine, Sudan
Ghent University Faculty of Medicine and Health Sciences, Belgium
Patan Academy of Health Sciences in Nepal
The University of New Mexico, School of Medicine, United States.

*Involved in testing the Evaluation Framework

#no longer a member in (2012)

2.7 2000s to 2010s: Human Resources For Health and the "revitalisation" of the theory and practice of socially accountable medical schools

There was a revitalisation of social accountability in medical schools during the late 2000s to mid-2010s. This resurgence was part of a wider focus on Human

Resources for Health (HRH) in the context of global health issues such as the Millennium Development Goals (MDGs). Section 2.7 outlines how recognition of the need for an appropriately trained workforce was one requirement for achieving the health goals of the MDGs that led to a range of global and regional initiatives focused on Human Resources for Health (HRH). This section briefly outlines some of the global issues and WHO policies surrounding the health workforce. Three key activities during this period will be discussed: the Global Independent Commission on Educating Health Professionals for the 21st Century; the Global Consensus for Social Accountability; and calls for accreditation and evaluation incorporating social accountability.

2.7.1 Global Human Resources for Health

Contemporary initiatives and reports on the global health workforce and Human Resources for Health (HRH) have influenced national and local workforce policy and also the implementation of workforce strategies, including training and education initiatives. The Millennium Development Goals (MDGs) equals with Alma Ata in its scale, significance and influence internationally. There has been recognition that countries do not have the health workforce to achieve the MDGs and other health targets (Global Health Workforce Alliance & World Health Organization, 2009a; UN Millennium Project, 2005; World Health Organization, 2006, 2009a, 2009b, 2010a, 2011c; World Health Organization & Global Health Workforce Alliance, 2008). The MDGs are eight quantifiable targets adopted by world leaders in 2000 to address extreme poverty with the aim to be achieved by 2015. They provided a coordinated focus for governments, non-government organisations and donor

governments (United Nations Development Program, 2010). The 'health related' goals are Goal 4: Reduce Child Mortality; Goal 5: Improve maternal health and Goal 6: Combat HIV/AIDS, malaria and other diseases. Meeting these goals would require well trained and adequate numbers of health professionals (UN Millennium Project, 2005).

In 2004 World Health Assembly (WHA) resolution 57.19 on the international migration of health personnel encouraged "...member states to develop strategies to mitigate the adverse effects of migration of health personnel and minimise its negative impact on health systems" (Watt, Brikci, Bereearley, & Rawe, 2011, p. 31). In 2006 The 57th WHA's resolution 59.23 "*Rapid Scaling up of health workforce production*":

> *...urge(d) member states to affirm their commitment to the training of more health workers"... by "... mitigating health worker migration; promoting training in accreditation institutions; encouraging financial support of training institutions by donors; promoting training partnerships between schools in less developed and more developed countries; promoting workforce plans across sectors; using innovative teaching and training programs through new technologies.*
>
> (World Health Assembly, 2006, pp. 1-2).

In the same year the World Health Report, "*Working Together for Health"*, focused on workforce development and active planning and management to address the "urgent crisis in human resources" (World Health Organization, 2006, p. xx). The report called for action in the fifty-seven countries that had a

health worker to population density below the crucial threshold of 2.3 per 1000 population (M. Dayrit, Dolea, & Dreesch, 2011).

From the 2010s there were a myriad of initiatives within and outside of the WHO system focusing on Human Resources for Health (HRH) in less financially resourced countries. Health professional education and health professional institutions were a focus of these initiatives. There was a focus on "scaling up" the production of adequate health workforce, particularly in Africa (Capacity Plus, 2011; Global Health Workforce Alliance & World Health Organization, 2009a, 2009b, 2011a, 2011b; O'Brien & Gostin, 2011; Pacqué-Margolis, Ng, & Kauffman, 2011; The Capacity Project, 2009; Watt et al., 2011; World Health Organization & Global Health Workforce Alliance, 2008). Interestingly initiatives for HRH were in some ways similar to "Health for All" in 1978. For example, one 'solution' for the HRH crisis includes the immediate scaling up of training community-based and mid-level health professionals. The cost of training doctors and the logic of changing the mix of staff and training is outlined by many authors (Dussault & Franceschini, 2006). The focus changed from medical education alone to encompass health professional education and there was an influence on the concept of social accountability.

2.7.2 Education of health professional for the 21st century: A global independent commission

In 2010, on the 100 year anniversary of the Flexner report, the medical journal The Lancet commissioned a global independent commission of experts to review health professional education. In the report, *"Transforming Health Professional Training for the 21st Century"*, socially accountable medical

education was put forward as one strategy to radically change the training of health professionals (Frenk et al., 2010b). The major findings were:

- There is insufficient funding: There is a global crisis in the education of health professionals because there is insufficient funding to train the kind of health professionals that complex health systems demand today. In addition, there is little value for the money that is invested.
- There is a mismatch between health needs of populations and supply of health professionals: There is no correlation between the burden of disease of a population and number of medical schools, nursing schools and public health programs. The poorest parts of the world often lack any capacity to train health professionals (Frenk et al., 2010a).

Key recommendations of the Commission were for a broad reform movement, encompassing instructional and institutional design:

- Instructional design: the approach should be competency-based and inter-professional, bringing together health professionals to work as a cohesive team. It should use new technologies to empower health professional during training and in the field.
- Institutional design: much tighter coordination is needed between education and health sector to ensure that the type of health professionals trained matches health needs in every country. In addition, global coalitions, associations and networks are needed to better leverage educational resources from around the world

through a systems based approach (Bhutta et al., 2010; Frenk et al., 2010a).

Furthermore, the population should be the driver of the education or health care system. The vision of new health professional schools is a global outlook and global sharing of resources that are both population and patient centred. There would be interdependence, from isolated education schools to align with health systems; and from standalone institutions to networks. Major reforms to the way students learn to be 'transformative' that fosters a culture of critical learning and lifelong learning; as well as socially accountable (Cohen, 2012).

The Commission was influential in that it brought the issue of inadequate health professional training to prominence in "mainstream" health professional education. The Commission brought ideas that had been enacted by community based schools, including members of THEnet and The Network, to mainstream health professional schools. It is also evident that socially accountable medical schools had influenced the Commission. Much of what the Commission had suggested was repetition from "Health for All" and the WHO's initial calls for social accountability of medical schools. Pursuit of these reforms would encounter many barriers and required mobilization, financing, policies and incentives. Indeed the Commission recommended four immediate to long-term enabling actions to create an environment that is conducive to specific reforms:

- Mobilize leadership
- Enhance investments
- Align accreditation
- Strengthen global learning (Frenk et al., 2010a).

While the Commission has stimulated discussion at more global conferences; actual action was occurring simultaneously with the Global Consensus for Social Accountability of Medical Schools.

2.7.3 The global consensus for social accountability of medical schools

The movement for global consensus on social accountability of medical schools was formalised in 2007 but had been debated for many years (Gastel, 1995; Global Consensus for Social Accountability of Medical Schools, 2010; The Network: Towards Unity for Health, 2009). As discussed in section 2.5 of this chapter, the early work of Charles Boelen outlined the need for an international consensus on accreditation for social accountability:

> *A global consensus is desirable and possible on the essential features of a medical school, on essential functions of physicians to be trained and essential principles and methods in education, research and service activities that any medical school should promote and apply.*
>
> (Boelen, 2000b, p. 49).

Boelen (2000b) argued that although the focus on evaluation was on the 'introspection' of institutions or self-assessment; accreditation systems and national systems should include social accountability. He highlighted the dearth of any form of global accreditation or assessment that focused on social accountability should not lose the local context.

In 2010, 130 global representatives from organisations and individuals with responsibility for health education, professional regulation and policymaking

participated in the Global Consensus for Social Accountability (Global Consensus for Social Accountability of Medical Schools, 2010; Woollard, 2011). The focus of the group was initially medical schools. There were three rounds of questionnaires using Delphi methodology followed by a consensus development conference. The three questions were:

- "*How should a medical school improve its capacity to respond to future health challenges in society?*
- *How could this capacity be enhanced, including the use of accreditation systems for self-assessment and peer review?*
- *How should progress towards this end be assessed?*"

(Global Consensus for Social Accountability of Medical Schools, 2010, p. 2).

Context and the importance of contextual issues are recognized. The list of 10 areas (see Figure 2.5) reflects a logical sequence, starting with an understanding of the social context, an identification of health challenges and needs, and the creation of relationships to act efficiently (areas 1 and 2). Among the spectrum of required health workforce to address health needs, the anticipated role and competences of the doctor are described (area 3) serving as a guide to the education strategy (area 4), which the medical school, along with consistent research and service strategies, is called to implement (area 5). Standards are required to steer the institution towards a high level of excellence (areas 6 and 7), which national authorities need to recognize (area 8). While social accountability is a universal value (area 9), local societies will be the ultimate appraisers of achievements (area 10) (Global Consensus for Social

Accountability of Medical Schools, 2010, p. 10). Similar to the call of Boelen (2000b), there was recognition of balance between global and local needs:

> *At the heart of the consensus lies the principle that social accountability in medicine should strengthen the link between production of graduates and their working environment and ensure that global principles can accommodate context specificity.*
>
> (World Health Organization, 2010b, p. 8).

Area 1:	Anticipating society's health needs
Area 2:	Partnering with the health system and other stakeholders
Area 3:	Adapting to the evolving roles of doctors and other health professionals
Area 4:	Fostering outcome-based education
Area 5:	Creating responsive and responsible governance of the medical school
Area 6:	Refining the scope of standards for education, research and service delivery
Area 7:	Supporting continuous quality improvement in education, research and service delivery
Area 8:	Establishing mandated mechanisms for accreditation
Area 9:	Balancing global principles with context specificity
Area 10:	Defining the role of society

Figure 2.5 Ten areas of the Global Consensus for Social Accountability

2.7.4 Accreditation, evaluation and social accountability: Developments and tensions

From its inception there has been interest in evaluating the social accountability of medical schools and developing global benchmarks or standards (Fulop & Roemer, 1982). In his early writing, Boelen advocated for tools and

methodologies for assessment but did not promote a global curricular or standards for accreditation. However, he noted that social accountability should also be promoted as a mark of academic excellence (Boelen, 2008b). Relevance to community need can be deemed the highest form of "excellence". Boelen emphasised that it is up to individual countries to determine the quality and licensure requirements of medical education according to their local context; but should include the social and health mission (Boelen, 2009, 2011). A 2001 survey of 895 medical schools found that few would be interested in being accredited for social accountability (Boelen & Boyer, 2001). However, there is an argument that if socially accountable medical education is to be taken seriously, then social accountability needs to be linked with medical school accreditation. Since the global consensus conference, from the 2010s, there was interest determining how social accountability could assessed within medical school accreditation systems and the development of global standards (Boelen & Woollard, 2009; Gibbs, 2011; Global Consensus for Social Accountability of Medical Schools, 2010; Lindgren & Karle, 2011; The Network: Towards Unity for Health, 2010).

Most countries have national accreditation for medical schools, such as the Australia Medical Council (AMC). The AMC differentiates between outcomes - for example, that graduates can practice anywhere in Australia - and the process of education - learning in the local context (Worley & Murray, 2011). Medical education accreditation is a requirement of the profession to ensure that doctors are meeting certain standards due to patient safety and professionalism. At the global level, accreditation and quality measurement are important developments for standardising medical education and the

capabilities of doctors (World Health Organization, 2010b, p. 7). Including social accountability in these system would require a fundamental change in culture of not only the medical schools but the representative and regulatory bodies (Gibbs & McLean, 2011). There are a number of initiatives in this area including the Global Consensus for Social Accountability (Woollard, 2010). The World Federation for Medical Education (WFME) developed global standards (Woollard, 2006). Lindgren and Karle (2011) claim that social accountability is embedded in these WFME global standards, however this has not been explicit, although is emphasised more in the most recent revision. Two examples of evaluation and assessment are Training for Health Equity Network (THEnet) Evaluation Framework (Larkins et al., 2013; Ross et al., 2014) and the ASPIRE-for-excellence, an initiative of the Association for Medical Education in Europe (AMEE) (AMEE, 2011).

2.7.4.1 The Training for Health Equity Network: Evaluation framework for socially accountable medical education

From 2010, six members of the Training for Health Equity Network (THEnet) implemented and tested THEnet evaluation framework for socially accountable medical education framework or "the framework" (Larkins et al., 2013; Ross et al., 2014). The framework includes a process, set of tools, and measures for assessing the progress of medical schools towards social accountability (Neusy & Pálsdóttir, 2011; R. P. Strasser & Neusy, 2010). Based on the Conceptualization, Production and Usability (CPU) model (Boelen & Woollard, 2009), the evaluation framework aimed to be flexible for all schools to apply in their contexts (Larkins et al., 2013; Ross et al., 2014). Rather than assign a score or 'tick sheet' the framework was aspirational; with a mixture of

quantitative and qualitative indicators. Becoming a socially accountable medical school was a critically reflective process, not an end point when a certificate could be framed and hung on a wall.

The framework proved to be a useful tool that demonstrated where schools had addressed social accountability and where they needed improvements (Larkins et al., 2013; Ross et al., 2014). All schools indicated that the framework takes dedicated time to complete, but that it is an effective tool to raise the profile of the social accountability agenda. The process of implementing the evaluation framework developed a comprehensive documentation of the school's commitment to social accountability, allowing each school to review their own mission, vision and goals in relation to social accountability and identify strengths, weaknesses and gaps. The evaluation framework provided evidence on aspirations for social accountability across the whole school including all school activities. There were shared outcomes among the schools but also some clear differences demonstrating that social accountability should also be assessed according to context (Ross et al., 2014). Members of the THEnet have also published in partnership or individually; demonstrating not only the process of socially accountable but the outcomes of these programs (Cristobal & Worley, 2011; Kwizera & Iputo, 2011; Larkins et al., 2013; Larkins, Sen Gupta, Evans, Murray, & Preston, 2011; Matte et al., 2010; Murray, Larkins, Russell, Ewen, & Prideaux, 2012; Ross et al., 2014; R. P. Strasser & Neusy, 2010; Worley & Murray, 2011).

2.7.4.2 ASPIRE-for-Excellence

ASPIRE-for-excellence is an initiative of the Association for Medical Education in Europe (AMEE) that recognises international excellence in education. This is quality assurance that goes beyond accreditation and will be assessed against standards or benchmarks (AMEE, 2011). There is professional peer review in three areas: assessment; student engagement and social responsibility and accountability. Assessments and guidelines were created by the working group and piloted in 2012. Three schools were given an ASPIRE award for social responsibility and accountability as a mission of the medical school in 2013:

- Southern Illinois University School of Medicine, the United States of America (who received awards in each of the three categories);
- Northern Ontario School of Medicine, Canada; and
- Hull York Medical School, the United Kingdom.

The schools were assessed on the organisation and function of the school; education of medical doctors; research activities; and impact on communities served. Schools must submit a report to an expert panel.

Marsh (2013) compared THEnet's Evaluation Framework with ASPIRE . There were similarities in the use of the World Health Organization definition of social accountability and Conceptualization-Production-Usability Framework of Boelen and therefore these share many similar criteria. Both could be used across different contexts. The main differences were that ASPIRE applies to medicine and is externally assessed against a criteria at a set point-in-time. The Training for Health Equity (THEnet) Framework is an internal critically

reflective process using criteria, aspirations, indicators and measure and many stakeholders.

2.7.4.3 Tensions in evaluating socially accountable medical schools

This call for evaluation and accreditation of socially accountable schools is not without controversy. This movement could be interpreted as fitting socially accountability within the global medical education focus on accreditation; standards and 'scales of excellence'. Furthermore, it is seen as a mark of excellence, more well-resourced schools may pursue social accountability for the 'reward' such as ASPIRE's mark of excellence. There is also tension around who should judge accreditations or awards of excellence: external experts or communities. Social accountability can be interpreted in different ways. For example, Lindgren and Karle (2011) agree that WFME global standards should take into account responding to society's needs; but have a broad understanding of this need, for example that in richer countries schools are socially accountable if they pursue high level research that will have a "public good" outcome

This is controversial; as there is a tension between internationally acceptable standards versus local relevance (World Health Organization, 1985). This debate is complicated by some innovative or community-based schools that are socially accountable being deemed "second rate" in comparison with more established schools. Achieving an appropriate balance between global excellence and local relevance is a challenge. In the past, some critics have argued that placing an emphasis on social accountability in medical education can undermine the technical excellence of graduates. Quests for academic

excellence in research and teaching (the focus of medical schools) have challenged and influenced the implementation of socially accountable medical education. For example, a United States study found that the top ranking medical schools - in terms of research funding and subjective assessment of school reputation - were lowest on the 'social mission' ranking in terms of graduate areas of practice (Mullan, Chen, Petterson, Kolsky, & Spagnola, 2010; James Rourke, 2013).

2.8 Summary

The theoretical development of socially accountable medical schools is aligned with health reforms and human resources for health. Early medical education reforms in the early twentieth century focused on modernising the training of doctors to be more scientific and professional. By the 1950s it was recognised that further reforms were required in both instructional design (towards problem-based and case-based learning) and institutional orientation (community-based rather than hospital-based training). The Alma Ata declaration and Health for All Strategy focused need to reform the health system to be more people orientated with an emphasis on primary health care. Medical education needed to change for doctors to work effectively in a changed system and to address issues such as mal-distribution of medical professionals. Medical schools were required to look beyond their role of producing graduates to their wider influence on both the health care needs of society and the need to reform the healthcare system. Innovative medical schools challenged the tradition of conducting medical training in tertiary

hospitals, far from the common health conditions and communities. These community-based schools focused on training in primary health care settings and on underserved communities. These medical schools provided lessons to the WHO and other more traditional schools. However, despite wide acceptance of the theoretical underpinnings of reform; the transformation to PHC required far-reaching and cross-sectional reforms and change in both health systems and medical education did not progress significantly.

Drawing on the experience of innovative and community based schools and the idea of a "five star doctor" Boelen and colleagues outlined values, assessment grid, evaluation guidelines and partnership/collaborative model on how to plan, implement and evaluate socially accountable medical schools. While these models form the recognised theoretical basis of social accountability, the "operationalisation" of these ideals into medical schools has varied. Rarely have these theoretical approaches been enacted as there has been little support or resources and some resistance.

The conceptualisation of socially accountable medical schools was still developing in the 2010s. From 2010 there was a reinvigoration and interest in human resources for health (HRH) and developments on socially accountable medical schools such as the Global Consensus for Social Accountability (GCSA) and the Independent Commission on Health Professional Education for the 21st century. This has led to interest in accreditation and the evaluation of socially accountable medical schools and the development of models of assessment from a critically reflexive process (The Training for health Equity Network) and review by external experts (ASPIRE).

In summary, in spite of a wealth of material about medical education generally, the literature is highly prescriptive and lacks critical perspectives, and few of the recommendations suggested in the reports about socially accountable medical schools or related areas, such as primary health care, have been implemented. Therefore there are considerable gaps in the literature around what contextual factors have influenced socially accountable medical schools. The next chapter includes an outline of the three contextual factors and how they may influence socially accountable medical schools.

Chapter 3 Methodology

3.1 Introduction to chapter

In the first section of this chapter I present a synthesis of the key concepts in socially accountable medical education and socially accountable medical schools. I also describe why this thesis focuses on the influence of contextual issues on socially accountable medical schools. I outline definitions for the key contextual factors explored in this thesis. I explain the development of the research question. I outline my choice of methodology and theoretical framework, including my epistemological position. I describe how I defined the "case" and how I selected my cases and I outline my data sources. I describe how I conducted within case analysis and cross case analysis with the assistance of NVIVO 10 (QSR International, 2012). I outline the sampling strategy, as well as the ethical issues and limitations to the study.

3.2 Identification of contextual factors

Socially accountable medical schools are influenced by contextual factors. In the literature, the main contextual factors that have influenced socially accountable medical schools are:

- Profile of the local health workforce
- Partnerships with the local, state and national health system; and
- Partnerships between the medical school and its 'community'.

These contextual factors are interlinked and complex. Socially accountable medical schools aim to address the workforce issues of their community and

health systems. Partnerships with communities and the health sector are conditions for socially accountable medical schools. The gaps and mal-distribution in the workforce appear to drive more appropriate medical training as advocated by the conceptualisation of socially accountable medical schools.

3.3 Research question

The aim of this research project is to:

- Analyse and compare key contextual factors that influence the planning, implementation and outcomes of socially accountable medical schools.

The specific questions are:

- How have the three contextual factors of profile of the local health workforce; partnerships with the local, state and national health system; and partnerships between the medical school; and its 'community' impacted upon progress towards socially accountability at these medical schools?
- What other contextual factors have influenced socially accountable medical schools and how do these differ across cases?
- In what ways could theory or conceptual frameworks be developed from this research that will be applicable to other settings?

The research outcomes are:

- A conceptual framework demonstrating the influence of key contextual factors on socially accountable medical schools; and
- Principles from which to derive practical guidelines for medical schools, global organisations, non-government organisations and Departments/ Ministries of Health to assess how contextual issues influence socially accountable medical schools.

3.4 Choice of methodology and theoretical framework

3.4.1 Epistemological position

My epistemological position or how I view the world and how I formulated this knowledge have influenced the theoretical perspective, methodology, and methods I selected for my study (Carter & Little, 2007; Lazar, 2004). Carter and Little (2007) outline the three main influences that epistemologies have upon the method of research:

- "… The relationship between the researcher and the participant" (p. 1321). For example, if participants are seen as active contributors or passive subjects.
- "…The way in which quality of methods is demonstrated" (p. 1321). For example, using a variety of methods to improve the rigour and trustworthiness of the research.

- "…Form, voice, and representation in the method" (p. 1321). For example, whether a researcher writes in their own voice, and how research outcomes are shared or reported to participants.

It is important that I am explicit about my position which helps to clarify my own perspective and the lens that I use to interpret the data. Consciously considering my own influence and bias also contributes to the validity and robustness of this study. This is essential as I am a member of staff at one of the case study schools. A social justice perspective, a critical theory framework and a constructivist approach influenced this research (Patton, 2002).

3.4.2 Social justice

I took a social justice perspective throughout this research as this perspective is linked with the phenomena of social accountability and my own epistemological position (Carter & Little, 2007; Patton, 2002). Underlying this thesis is the acceptance of socially accountable medical education as an appropriate aspiration for medical schools. My epistemological position was that the voices of all participants had to be heard and given equal weight in contributing to new knowledge. This was important in this research as it included cases from more financially and less financially resourced countries. In this study I have used the terms financially and less financially resourced rather than more developed and less developed countries or third world or first world. I believe that having less financial resources does not mean that countries were less developed socially or culturally.

Furthermore, the powerful profession of 'the medical doctor' was investigated. Issues of power and professionalism are played out between and within health

professionals (Wolinsky, 1988). One way in which socially accountable medical education has been defined and implemented is in the context of medical dominance and the changing role of 'the doctor' as a professional and 'leader' in the health world (Germov, 2002; Hafferty, 1988; Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010; B. Turner, 1995; Wartenberg, 1990; Wolinsky, 1988).

3.4.3 Constructivist approach

Utilising a constructivist approach I acknowledged that all participants have different perceptions, experiences and understandings of socially accountable medical education (Patton, 2002). I asked:

> *How have the people in this setting constructed reality? What are their reported perceptions, "truths", explanations, beliefs and worldview? What are the consequences of their constructions for their behaviours and for those with whom they interact?*
>
> (Patton, 2002, p. 132).

Constructivists deem knowledge as relative to a particular time and place. There is no one truth and phenomena are interpreted and described by people using their own constructs. Constructivism was suited to this study as research was conducted in two countries categorised as 'less financially resourced' and 'more financially resourced'. Differing worldviews must be appreciated and valued. Due to the nature of international development assistance historically, trans-national partnerships between institutions can be unequal (Bleakley, Brice, & Bligh, 2008; Crane, 2011). There can be an inferred and unspoken assumption that the knowledge and experiences of more financially resourced

schools are more valuable. Recent literature in medical education has criticised global medical school partnerships as post-colonialist or neo-imperialist enterprises, with imbalances in power relationships and benefits (Bleakley et al., 2008; Crane, 2011).

3.4.4 Critical theory

From a critical theory perspective, I have attempted to interpret different perspectives realistically in the context of informants' social worlds. Critical theory focuses on "how injustice and subjugation shape people's experiences and understandings of the world" (Patton, 2002, p. 130). This school of thought is critical of current power structures and aims to influence change in society (Kellner, 1990; Kincheloe & McLaren, 2005). Although founded as a reinterpretation and modification of the Marxist critique of political economy, critical theorists reject economic determinism; there is recognition of the importance of culture in comparison with the economy and of other conflicts and forms of oppression beyond class, including gender and race (Kellner, 1990; Kincheloe & McLaren, 2005). Reconceptualised critical theory argues that economic factors cannot be separated from these other forms of power (Kincheloe & McLaren, 2005). This is especially important to consider given the different financial resources in the different cases and my own position as someone from a resource rich school.

As a critical theorist I attempted to actively acknowledge and confront that research can reproduce or enforce existing power structures. I also attempted to be self-reflective and self-critical of the values and interest that underlie social theory (Kellner, 1990) and put my own "assumptions on the table" (Kincheloe

& McLaren, 2005, p. 305); acknowledging that my own values may be challenged through the research process. For example, I struggled being a "post-colonial" or neo-colonial researcher working within the hierarchical world of the health system. Particularly during fieldwork, I kept in mind that the way power is reproduced in the research process is complex and multi-faceted, especially in the context of "colonial privilege" (Kincheloe & McLaren, 2005, p. 306). I reflected on these concerns in my research diary (see appendix 1) [17].

I also aimed for my research to confront injustice in partnership with my participants and for my theories to address the disempowered (Kincheloe & McLaren, 2005). The 'Concept of Immanence' is essential in a reconceptualised critical theory and asks "who we are, how we go this way and where we might go from here" (Kincheloe & McLaren, 2005, p. 309). Research is not just about accepting the current situation and advocating for people to adapt, rather it is about generating "profound insights that lead to transformative action" (Kincheloe & McLaren, 2005). I have attempted to keep the Concept of Immanence in the frame when conducting this research so that it can be as transformative as possible. For example, I did not judge or evaluate the "social accountability" of participating cases, but accepted the assertion of schools that they are "aspiring for social accountability" as defined as relevant in their own context. My research enabled participants to see how they are aspiring for social accountability and what they might need to implement to

[17]See appendix 1 for a self-reflective discussion on how I grappled with the idea of being a "post-colonial" researcher.

further the development of social accountability at their school. Reciprocity was a key part of the project for all schools, and mutual learning and benefits were jointly developed. These included joint publications, (three in development) and conference presentations (Preston, Tandinco, et al., 2012) and assistance with gaining information on grants and other opportunities for mutual learning and support. See appendix 8 for further information about reciprocity.

3.5 Case study approach

A multiple case study approach was the most appropriate method for exploring my research aim, to investigate the contextual issues that have influenced social accountability in the dynamic social setting of medical schools (Baxter & Jack, 2008; Patton, 2002; Prior, Farmer, Godden, & Taylor, 2010; Stake, 1995; Thomas, 2011; Yin, 2003, 2009). The case study approach is useful when investigating complex real life situations holistically; where the case and its context is continually changing (Baxter & Jack, 2008; Grbich, 1999; Yin, 1999). Multiple case studies were required to fully explore the contextual factors and describe "…a rich picture with many kinds of insights coming from different angles, from different kinds of information" (Thomas, 2011, p. 21) and give "…powerful stories to illustrate particular social contexts" (Grbich, 1999, p. 190). This approach increases the likelihood that findings are subject, context and time specific. As a result the researcher can gain analytical insights through analytical generalisability (Thomas, 2011), making the evidence more compelling (Herriott & Firestone, 1983; Yin, 2009). Yin (2009) asserts that this is only true if each individual case is considered in its own context.

I developed conceptual or theoretical framework on how contextual issues have influenced socially accountable medical schools. The case study approach can generate concepts or theory given a sufficient weight of data about a particular element or recurring themes (Eisenhardt, 2002). The purpose is to explore the possibility of developing concepts or theory from this research that could be applied to other settings (Grbich, 1999).

3.5.1 Defining the unit of analysis: The case

> *Your case study is defined not so much by the methods that you are using to do the study, but the edges you put around your case – the direction and extent to which you want your case to go.*
>
> (Thomas, 2011, p. 21).

In case study design the boundaries of the case must be defined at the outset (Baxter & Jack, 2008; Creswell, 2007; Patton, 2002; Thomas, 2011; Yin, 2009). "The case study is a frame that offers a boundary to your research" (Thomas, 2011, p. 21). Researchers need to define the case in order to replicate data collection and conduct a sampling strategy. As outlined by Yin (1999) if cases are not clearly defined there can be two issues: "(1) the findings might not be about the presumed case, but some other situation; and (2) if multiple cases have been conducted, they might not be comparable in some fundamental way" (p. 1214). However, using a constructivist approach to case bounding, Stuart Wells, Hirshberg, Lipton, and Oakes (2002) co-constructed their cases in the field with their participants, based on the context of the case A true picture of cases could not emerge before data collection. Like Stuart Wells and colleagues

as I "…learned more about the context of each of (my) schools (I) continued to re-evaluate who (I) planned to interview…" (Stuart Wells et al., 2002, p. 344).

My case definition includes:

- Medical schools which includes sub-schools or departments, staff and students and recent graduates. Staff are defined as people employed at medical schools including Academic, Professional, Technical, tenured or casual employees, including clinicians, cultural mentors and preceptors.
- In addition to the schools, a specific rural site was purposively chosen based on staff availability accessibility, connections with health services and the community (for example the placement of students and connections with the health sector). Rural sites were defined as permanent teaching sites with staff or a preceptor. There were other sites, but for consistency and due to budget and time constraints, the main teaching campus and a site in a rural area were chosen for field work. In the Philippines they were chosen for logistical reasons including: security and safety; accessibility; availability of health staff and students; and the availability of interpreters.
- Former Deans or staff members who were closely associated with the development of the medical school.
- People employed in the health system who were closely associated and able to comment on its social accountability.

- Community people who were closely associated with the school and are able to comment on its social accountability.

3.5.2 Sampling strategy: Cases

I undertook purposeful theoretical sampling to maximise the likelihood of selecting cases demonstrating a range of contextual influences (Patton, 2002). The cases have also been pragmatically selected to fit within the resource (time and financial) constraints of the study (Eisenhardt, 2002). A summary of the inclusion and exclusion criteria I used to select cases is in Table 3.1.

Table 3.1
Inclusion and Exclusion Criteria

Inclusion Criteria
Medical schools that teach a medical course that enables graduates to register as qualified medical professionals with a national medical professional council or body.
Medical schools must be aspiring to be socially accountable by self-definition. They must have a clearly defined socially accountable medical education mandate. Socially Accountable Medical Schools have "...the obligation to direct their education, research and service activities towards addressing the priority health concerns of communities, region and /or nation they have a mandate to serve" (Boelen & Heck, 1995, p. 3)..
Members of THEnet to ensure: shared understanding of social accountability; data from THEnet evaluation framework and professional contacts for data collection
Piloted THEnet evaluation framework: to ensure sufficient numbers of school community would be aware of social accountability
Logistically possible
Dean agrees to participate
Exclusion Criteria
Travel for data collection would fit time and financial resources as well as travel advice/security

School not part of piloting the evaluation framework

School not able to participate fully in THEnet

I undertook five steps to identify schools, summarised in figure 3.1. Step one was a literature review that ascertained two formalised global networks of medical schools with socially accountability aspirations:

- The Network: Towards Unity for Health or The Network-TUFH (Boelen, 2000b, 2004a; Boyer, 2008; Cristobal, Engel, & Talati, 2009; A Kaufman et al., 2004; Schmidt et al., 1991; The Network: Towards Unity for Health, 2010); The Network: Towards Unity for Health have over 200 institutional, associate and individual members. This organisation focuses on community orientated health professional education.
- The Training for Health Equity Network or THEnet (Neusy & Pálsdóttir, 2008, 2011; Pálsdóttir & Neusy, 2010; Pálsdóttir & Neusy, 2011; Pálsdóttir et al., 2008).

In step two I chose to sample schools from THEnet as the group has a focus on socially accountable medical education, and was committed to piloting an evaluation framework that would assess schools' social accountability (Neusy & Pálsdóttir, 2011; The Training for Health Equity Network, 2008). I assumed that they might have had a shared understanding of social accountability (see Figure 3.1). A shared understanding of social accountability, in the context of health professional education, was a key inclusion criterion for the cases. If schools and their staff/faculty did not have a shared understanding of social

accountability the design flaw would have been "but what is social accountability?" The term could have meant anything and been interpreted in divergent ways (as the literature indicates). In order to sample schools that did not have a shared understanding, I would have had to develop a definition based on their characteristics and I would have had to judge whether selected cases were socially accountable against this criteria. This process would have gone against my epistemological position of critical theory and constructivism. By being members of THEnet schools, the institution had declared that they were aspiring to be socially accountable. Data collection was not distracted by philosophical discussions on what was social accountability and was the school aspiring to be socially accountable.

The other epistemological reason was that I made the assumption that different cultures, nations, histories, religious influences, political backgrounds might see social accountability differently and different contextual factors might be operating.

Furthermore, sampling from THEnet was appropriate for pragmatic reasons, as I am a member of THEnet and have professional contact will all the member schools and secretariat. The eight THEnet Foundation schools are outlined in figure 3.1. (Neusy & Pálsdóttir, 2008, 2011; Pálsdóttir et al., 2008). As I had been involved as a member of THEnet, I reflected on this relationship and the effect it might have on data analysis and interpretation in my researcher diary (see appendix 2).

- Health and social needs of targeted communities guide education, research and service programs. Students recruited from the communities with the greatest health care needs.
- Programs are located within or in close proximity to the communities they serve.
- Much of the learning takes place in the community instead of predominantly in university and tertiary hospital settings.
- Curriculum integrates basic and clinical sciences with population health and social sciences; and early clinical contact increases the relevance and value of theoretical learning.
- Pedagogical methodologies are: student, patient and population centred; service-based; and assisted by information communication technology.
- Community-based practitioners are recruited and trained as teachers and mentors.
- Embedded in the health system partnering with health system actors to produce locally relevant competencies.
- Faculty and programs emphasise and model commitment to public service.
- Whole school approach, across all departments, and commitment from the leadership. (Ross et al., 2014).

Figure 3.1 Descriptions of socially accountable medical education programs and their core principles

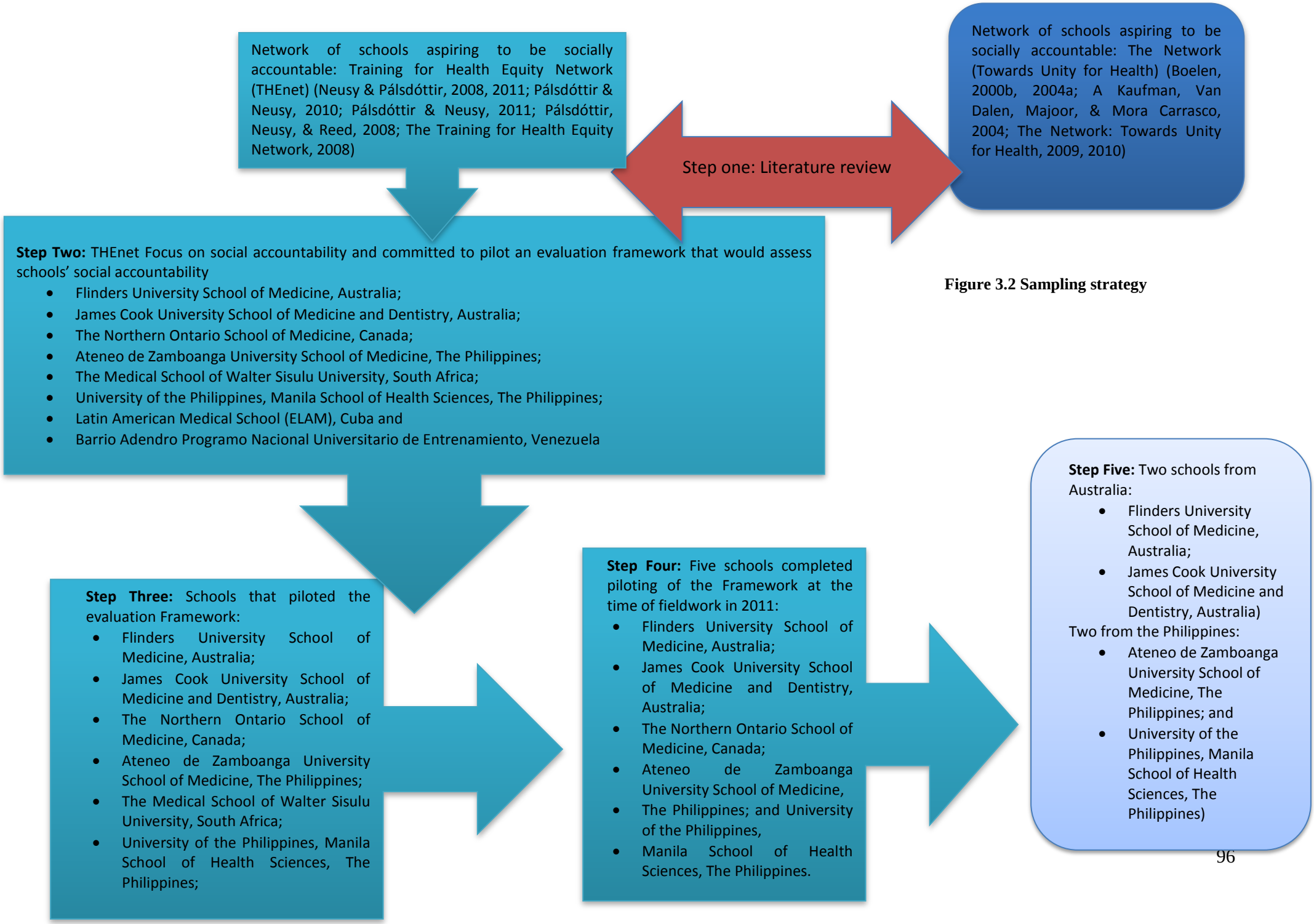

Figure 3.2 Sampling strategy

In step three I identified the six of THEnet member schools piloted the evaluation framework and were involved with most of the face to face and Skype meetings from 2009 to 2011 (see Figure 3.2). It was essential that schools had undertaken piloting as the evaluation framework report would provide a rich source of similar data sources[18] for each school; including critical self-reflection on the schools social accountability an ensure sufficient numbers of school community would be aware of social accountability. In step four I distinguished the five schools that completed piloting of the framework at the time of fieldwork in 2011 (see Figure 3.2).

In step five, I selected two schools from Australia (Flinders University School of Medicine, Australia and James Cook University School of Medicine, Australia) and two from the Philippines (Ateneo de Zamboanga University School of Medicine, The Philippines and University of the Philippines, Manila, School of Health Sciences, The Philippines). By selecting four schools in two different countries, I was able to investigate two national health systems and their broader socio-cultural contexts when undertaking intra-case and within case analysis. Furthermore selecting schools from low resourced and high resourced countries would give in-depth insight into different contextual factors. While I was studying the same phenomena of social accountability, I wanted to explore different contexts, so that in my cross case analysis I could gain analytical conclusions and "…generalise about the impact of different case contexts" (Stuart Wells et al., 2002, p. 334) Four cases were selected because of the likelihood of sufficient data to compare and if recurring themes to develop concepts (Yin, 2009). Pragmatically the four schools in two different countries would enable easier travel for

[18] I did not use the evaluation report as a data source as one school did not wish to release this information publically.

data collection (due to budgetary and time constraints). I contacted the Deans of all four schools and invited them to participate in the study. All agreed to participate (see ethics below).

The four case study schools are:

- School of Medicine, Flinders University, Adelaide, South Australia, Australia (FUSOM);
    - Town of Renmark and the Riverland area as a rural site;
- School of Medicine, James Cook University, Townsville, Queensland, Australia (JCUSOM);
    - Town of Atherton as a rural site;
- Ateneo de Zamboanga University School of Medicine, Zamboanga City and surrounding districts, Mindanao, the Philippines (ADZU SOM);
    - Mutia Municipal Centre as a rural site;
- University of the Philippines, Manila, School of Health Sciences, Palo, Leyte, the Philippines (UPMSHS);
    - The barangay of Canlingga, in the municipality of Dagami as a rural site.

3.6 Individual participants

I expected to interview up to 18 participants at each site, as outlined below:

- Leaders of the School of Medicine, that may include the Dean;
- The former leader or long-term staff members with knowledge of the history or establishment of the school;

- Up to eight current and former academic and professional staff from the participating institutions, including contact person on THEnet. I chose senior leaders and people with historical perspective of development of the school as well as "champions" at schools or those knowledgeable about social accountability and/or medical education. These included staff based at one rural site;
- Up to five current students enrolled in a medical degree at participating Institutions who were aged over 18. These included students in any year level who were interested in social accountability and, in Australia, students who were involved in the rural and/or international health student groups. I attempted to interview a balance of students from lower and higher years (clinical and preclinical) as well as students on placement at one rural site;
- Two to three community members involved in research, teaching or service at participating institutions, not necessarily on the campus. These included community members involved in teaching; in support roles at rural sites; on committees; or volunteers; and
- Up to five preceptors (health professionals who are paid on a sessional basis) or health professionals who work with the participating institutions (e.g. with students on placements) including a preceptor or someone from a hospital or the health department who has been involved with the school. These participants included health sector representatives who have had a close partnership with the school; graduates or alumni of the school; and those who hold executive positions in health centres or health departments. Finally participants included those with positions involved in policy or

medical education at a state, regional or provincial level that has had involvement in the school.

At three schools (FUSOM, ADZU SOM and UPMSHS) I worked with a school representative involved with THEnet to identify potential participants. I was also guided by the peer reviewed and grey literature on individual schools. Participants were initially contacted by email or face to face, and posted, hand delivered, or emailed an information sheet inviting them to take part in the study. Snowballing was undertaken whereby participants were asked in the interviews if they knew of any potential participants who could contribute to the study. I contacted these potential participants by email, text message, phone call or face to face on site visits. If participants indicated that they were interested in participation but did not give a specific time or did not return contact interviews were no longer pursued I explore individual sampling further in my results chapters. The final number of participants was dependent on data saturation or redundancy (Guba & Lincoln, 1985; Patton, 2002) as well as pragmatic reasons including availability and interest. For case three, a number of extra interviews were held as there was insufficient time to fully discuss selection criteria with THEnet contact person prior to interviews being arranged. As a result five interviews were not transcribed or used in analysis as participants did not meet the selection criteria. Table 3.5 describes the type and number of participants at each case.

Table 3.5:
Individual Participants

Type	Description	Participants				Total
		Case 1 FUSOM	Case 2 JCUSOM	Case 3 ADZU SOM	Case 4 UPMSHS	
Staff/Faculty	"Champions at schools" Any staff members who know about social accountability and/ or the history of the school, including leaders and former leaders	11	11	7 (including 2 former students)	9 (including 2 former students)	38
Students	Student at any year level who are interested in social accountability. In Australia, students who were involved in the rural and/or international health student groups.	4	4	5	4	17
Health Sector	A person holding a position involved in policy, medical education at a state, regional or provincial level, who also had involvement in the school. A preceptor or someone from a hospital or the health department, who has been involved with the school. At two schools (UPMSHS and ADZU SOM) this included graduates of the school who may also have a teaching or preceptor role.	2 (including 1 preceptor)	2 (including 1 joint JCU appointment with Department of Health)	6 (all had teaching roles and all were former students)	4 (including 3 former students; all involved in teaching students)	14
Community	"Champions at schools" Any community person involved in the school in teaching or research or at rural placement sites	1	1	2	2	6
Total		**18**	**18**	**20**	**19**	**75**

3.7 Ethics

A summary of the proposed research was circulated to the Deans' group of THEnet collaboration and I sought interest in participation. The Deans' group of THEnet collaboration approved this research at a joint meeting on 19 July 2011. The James Cook University (JCU) Human Research Ethics Committee (HREC) granted ethics approval at the meeting on 27 July 2011 (approval number H4245). Finally I forwarded the Deans' approval and JCU ethics approval to the human research ethics committees or relevant body of the three other institutions[19] (appendix 3).

3.7.1 Informed consent: Interviews

All participants were reassured that no information recorded in the interviews would in any way identify individuals. Potential participants were provided with a participant information sheet (appendix 4) which explained the aims of the project and information about their participation in the interviews. Participants completed a written consent

[19]Previous experience in the Philippines suggested that there are no central bodies for ethical approval, and rather this is best negotiated with partners at the local level. It is unusual for formal ethical approval to be sought for research. However, I forwarded JCU HREC's approval to both UPMSHS and ADZU and applied for University Level Ethics as appropriate. It should be noted that ADZU did not have an ethics board at their institution until they established one for THEnet pilot evaluation in 2010 (Samson, 2010) (personal communication Rex Samson, ADZU 8 October 2010). My THEnet contacts at ADZU and UPMSHS advised on other appropriate bodies to approach for ethical approval; however no official procedures were required. All health centre officials, Barangay captains and other officials were happy for me to conduct research with verbal approval and the consent forms and. A key ethical principle that I followed in the Philippines is reporting the research back to all participants. It was suggested by several participants that I return to the Philippines prior to my thesis submission to feedback my research. Unfortunately doe to security issues in Mindanao (ADZU SOM) and a major natural disaster (UPMSHS) I was unable to return.

(appendix 5) form prior to participation. Interviews were held at a time and in a place convenient for participants.

3.7.2 Photographs

Photographs were only taken with permission of appropriate authorities including community members, health care workers, school administration staff and students. In the spirit of reciprocity, copies of all photographs were made available to relevant participants and schools.

3.7.3 Data retention and storage

Following ethical protocols, all raw data (surveys and transcripts) were de-identified, and will be kept in a locked filing cabinet in a locked office in the School of Medicine and Dentistry, James Cook University for a period of at least 5 years following the completion of the study. Consent forms will be kept for 15 years. All computer files related to data analysis will contain only de-identified data and will be password protected.

3.8 Data collection

Consistent with the case study approach, data collection drew on multiple sources (Stake, 2005; Thomas, 2011; Yin, 2003, 2009):

- Semi-structured interviews with experts on the contextual factors likely to affect the school;
- Field notes taken during field visits and interviews at various sites at each school; and
- Documentary analysis of background grey and peer reviewed literature related to the school and its activities and the contextual factors including

published papers, documents, photographs, and archival records from schools and other institutions.

Triangulation, a metaphor from surveying, refers to using multiple data collection methods, researchers, theories and/or data sources in order to test for corroboration or contrasting perspectives (Hansen, 2006; Seale, 2007). In my study I have used different sources of data: interviews, field notes and documentary analysis. I compared interview data with what was available in documents about the program of the medical schools, and with my field notes. I noted where the same information was corroborated across the three sources and where there were discrepancies. Documents have primarily been used to triangulate interview data, for example when participants discussed different programs of the school or discussed the history of the school.

3.8.1 Fieldwork

Fieldwork enabled me to gain a richer understanding of the schools and their context. I collected data one case at a time and visited three case study sites for a period of up to eight days at the convenience of THEnet contact person and the school schedules. At FUSOM (case 1) I conducted fieldwork over two periods of time from the 27th to 28th of March 2012 in Adelaide and from the 19th to 24th of April 2012 in Adelaide and the Riverland region of South Australia. At ADZU SOM (case 3) I conducted fieldwork during one week from 13 to 17 July 2012. From 21 to 27 July 2012 I undertook fieldwork at the UPMSHS. I commenced with FUSOM for pragmatic reasons as it was easier to travel domestically and needed to undertake fieldwork in the Philippines during the dry season. I decided not to commence data collection at JCUSOM where I am based as I had more of an insider perspective. At JCUSOM, fieldwork commenced on 30 May 2012, and continued to the 10 July 2012. I attempted to conduct most of my

fieldwork within a two week period, similar to other cases. Although I had better access to potential participants and documentary evidence at JCUSOM, I tried to undertake all research within a similar time frame as the other schools to ensure consistency in the methodology. I conducted most interviews at JCUSOM over a period of two weeks and conducted a three day rural site visit.

3.8.2 Semi-structured interviews

Semi-structured interviews were conducted with staff, students, community representatives and health sector representatives. In semi-structured interviews question ordering, wording or inclusion are decided by interviewer as the interview progresses; allowing room to explore unknown factors and to be situational or context specific (Patton, 2002). This method was appropriate to elicit the participants' understanding of what contextual factors have influenced social accountability at the different medical schools.

The interview guide was piloted with four participants who met my selection criteria (Hansen, 2006; King & Horrocks, 2010; Liamputtong, 2009; Patton, 2002). For pragmatic reasons pilot interviews were held with people associated with JCU:

- A representative from the health sector who was a former employee of JCUSOM;
- A representative from the health sector who holds adjunct status;
- A former Associate Professor at the JCUSOM with adjunct status; and
- A community member who works near the JCUSOM and who has had a long association with staff and students.

I adapted interview questions and question order based upon pilot participants' feedback, my experience of piloting the interviews, and discussion with supervisors. For example, I added the definition of social accountability to read out to participants to ensure a shared understanding of the concept. I also rearranged the health sector questions to ask about the partnership activities with the health sector first.

Interview questions (appendix 6) focused upon the three contextual factors hypothesised to influence social accountability (workforce, health sector partnerships and community partnerships). Participants were also asked their own opinion of the contextual factors that have influenced socially accountable medical schools. While the interview guide ensured I covered the same questions at each site, semi-structured interviewing allowed me to be sensitive to situational issues (Grbich, 1999). Changes to the guides and questions were made throughout the interviews, and data analysis was conducted in tandem with data collection (Hansen, 2006; King & Horrocks, 2010; Liamputtong, 2009; Patton, 2002). I documented these changes in field notes. For example, after my first two interviews, I introduced a question about participants' role at the school and their professional history. This gave more context and background and made participants feel comfortable with the interviewing process (ice breaker questions). In the Philippines, local contacts were available to translate interviews into the local dialect if required (this occurred in one interview). Interviews were conducted at the school, in participants' homes, in their cars, at health centres, over the telephone and

through video conferencing. Due to logistical or cultural reasons, six interviews were conducted as joint interviews[20]. Table 3.2 summarises the type of interviews.

Table 3.2
Interview Type

Case	Type of Interview				
	Face to Face	**Telephone**	**Videoconference**	**Joint**	**Total**
FUSOM	14	2	1#	2	18
JCUSOM	16	2	0	0	18
ADZU SOM	19	0	0	2	20
UPMSHS	17	0	0	2	19
Total	66	4	1	6	75

#Also joint interview

[20] For example in case four I interviewed two male students in my very small hotel room as they were more comfortable being interviewed together. In cases three and four sometimes another person was present in the room during interviews. In case 1, the first joint interview was held as the participant was having a meeting, she seemed a bit put off that I just couldn't ask questions in front of the 3 other people in the room. As the interview progressed her fellow staff member started to answer questions and she was invited to sign a consent form and take part in the study. The second joint interview was a video conference in an office at a rural site due to time constraints.

3.8.3 Field notes

I took field notes during field work to supplement data and assist with methodological issues, including reflexivity, sampling other participants to interview and documents to collect. After each interview I recorded:

- The main issues or themes that struck me in this interview;
- Any issues with the interview;
- The setting, time and context;
- Follow up information on documents or other participants to interview; and
- Anything else that was interesting or important to the interview.

On field visits to sites I noted:

- The location of the school; and
- The community, including rural site community.

I also took notes at two meetings (FUSOM and JCUSOM) and three classes (ADZU SOM, JCUSOM, UPMSHS). Field notes informed the context and background of the cases.

It is often said that in qualitative research the investigator or researcher is the research instrument (Patton, 2002). Like all researchers, I have my own personal values and biases, prior assumptions and experiences. The act of reflexivity, a consciousness and attention to one's own effect on the research processes, is the feasible way to address bias in qualitative research (Hansen, 2006). For example, I found that I was affected by the poor state facilities at the schools in the Philippines compared with my own school.

I tried to manage this and not make assumptions about the effect of this resource gap on staff and students.

I theoretically sampled cases; and, due to my criterion, JCUSOM, where I have been employed since 2005, was a case. I acknowledged my thoughts and feelings in my researcher diary, especially surrounding the influence of being both a PhD student and academic staff member of one of the cases. Issues that I explored included:

- What are the implications of studying something I am a part of?
- What is the impact of existing personal and professional relationships?

Through my diary I was able to acknowledge how my role could influence the research. For example, at the other cases, I was always associated with JCUSOM; I acknowledged that this did have some effect on how participants discussed their school. My insider knowledge of JCUSOM was beneficial for data collection and analysis, but also a constraint. I found I wanted to present a positive picture of my own school and it's aspiration for social accountability. I also had to reflect on my role in THEnet's evaluation group as in the initial stages of this research I found myself wanting to evaluate or assess the progress of schools towards social accountability.

The other issue was my personal and professional relationships with some participants, including THEnet contact people. At case one I stayed with THEnet contact person in her home. I also socialised with those representatives and others during fieldwork. Furthermore, one of my supervisors was a participant in case two. These close personal and professional relationships assisted in arranging field work and interviews and there were opportunities during fieldwork and at supervisor meetings to discuss the research and sampling. However these discussions may have impacted upon their own interviews, which were usually held later in fieldwork. I counteracted this by

conducting these interviews the same as other interviews. Furthermore, as I was known to some participants and as THEnet contact people held high level academic positions some participants, particularly their students and colleagues, may have felt unduly pressured to participate. In my researcher diary I noted that many participants wanted to present a "good'" picture of "their school" and there may have been an underlying sense of competitiveness; about who was "more socially accountable". Furthermore, there was an ethical issue of the other schools' perception of my involvement with JCUSOM and the impact this has on anonymity and confidentiality. I tried to I separated myself from JCUSOM as much as I could during fieldwork and presented myself as a neutral PhD candidate rather than a representative of an institution. In the Philippines there were additional cultural issues that I explored in my researcher diary (appendix 2). These issues are further explored in section 3.10 (Limitations) and Appendix 7.

Visual methods were used with field notes. Photographs and visual records ('hand-drawn maps' and diagrams) supplemented field notes (Keller, Fleury, Perez, Ainsworth, & Vaughan, 2008; Thomas, 2011). Photographs of the environment including health facilities, the school, rural sites, student accommodation, town features, road conditions, and so on were taken. Permission was sought from staff, students and community members to take photographs when required and no photos were taken of clinical encounters or of patients. Photos were also used as an aide memoire for background on each case.

3.8.4 Documentary analysis

I analysed documents including published and grey literature from each of the schools, peer reviewed papers, meeting reports, websites and policies. The grey and peer reviewed literature were primarily used to triangulate information collected from

interviews (Yin, 1999), to supplement data, and for background information on the case. The common peer review and grey literature are outlined in Table 3.3.

Table 3.3
Common Sources of peer review and grey literature

Document type	JCU	Flinders	UP-SHS	ADZU
Academic papers	X	X	X	X
School Reports	JCU Faculty Review		History of the School (Publication)	
Accreditation Reports	Australian Medical Council (AMC) report	AMC Report		
School and University Websites	X	X	X	X
School and University Values	X	X	X	X
School and University Mission Statement	X	X	X	X
Student Handbooks	X	X	X	X
Criteria for Selecting Students	X	X	X	X
Student Placement/ Community guide	X	X	X	X

3.9 Data analysis

Data analysis was abductive and involved deductive and inductive iterative thematic analysis of qualitative data (Liamputtong, 2009), both within case and across case analyses (Stake, 1995). . Abductive coding best describes the combination of a

predefined deductive coding framework (set by the questions and contextual issues) and open coding that was inductive (Silver & Lewins, 2014).

3.9.1 Within case analysis

I transcribed 49 of the interviews verbatim and a transcribing service transcribed 26 interviews. I sent Australian participants their interview transcripts for respondent validation by mail, marked confidential. If no changes were necessary I asked participants to confirm this in an email. I gave a set time of four weeks for any changes, if participants did not respond after this time I assumed that they were happy with the transcript. Any changes were incorporated into the transcripts. Field notes, and notes from documentary analysis were transcribed. I used NVivo 10 to store, organise and analyse data (QSR International, 2012).

As outlined in Table 3.4, I undertook five steps to code and theme the data:

- I initially deductively coded data to eight codes (column two, Table 3.4) based on my questions (column one). I determined that there were two areas of interest in my research: firstly, participants' understanding of social accountability and, secondly, participants' understanding of what influenced social accountability in the case.
- I then developed deductive codes for each of these two areas (column three). For Understanding of social accountability there were five initial codes:
    - Social accountability in general;
    - What does social accountability look like at the school;
    - Response to definition of social accountability;
    - No or limited understanding of social accountability; and

- Comprehensive understanding of social accountability.

For contextual issues, I deductively coded data to the three contextual factors from the literature and then open/inductively coded themes to each case:

- Contextual issues: Workforce;
- Contextual issue: Health Sector;
- Contextual issues Community Partnerships; and
- Other Contextual issues (three to four codes for each case).

I then developed themes (column four) through the constant comparison method, drawing out amalgamated ideas from the codes:

- Understanding of social accountability: three to six themes for each case; and
- Contextual issues: seven to sixteen themes for each case.

I then finalised themes through constant comparison (column five):

- Understanding of social accountability: three to four themes for each case; and
- Contextual issues: five to seven themes for each case.

Table 3.4
Coding Frame: Within Case Analysis

Question 1	codes/nodes: First coding 2	Codes/Nodes: Second Coding 3	Themes: Third coding 4	Themes: Fourth coding 5
Could you tell me a bit about yourself and your involvement with (name of school)?	Background to school			
What's your understanding of socially accountability in medical education?	What is social accountability?	Social Accountability in general	How is social accountability understood:	How is social accountability understood:
What is your understanding of socially accountable medical education in (name of school)?		Understanding of social accountability at the school.	3-6 Themes for each case	3-4 themes for each case
Definition of Social Accountability:		Response to definition		
How do you respond to this?		No or limited understanding	No or limited understanding	No or limited understanding
		Comprehensive understanding	Comprehensive understanding	Comprehensive understanding

Question 1	codes/nodes: First coding 2	Codes/Nodes: Second Coding 3	Themes: Third coding 4	Themes: Fourth coding 5
Tell me the (name of school) story? Why was (name of school) established? What do you think are the key broad contextual factors that influence/influenced social accountability at (name of school)? What has influenced socially accountable medical education within the (name of school)? What has influenced socially accountable medical education from outside of (name of school)?	Contextual factors (other)	Themes: Other Contextual issues (3-4 themes)	Contextual issues: 7 - 16 Themes for each case	Contextual issues: 5-7 Themes for each case (some main themes for 3rd coding/analysis became sub themes)
What are the factors that could (name of school) further progress socially accountable medical education at (name of school)?	Barriers and Enablers for social accountability			

Question 1	codes/nodes: First coding 2	Codes/Nodes: Second Coding 3	Themes: Third coding 4	Themes: Fourth coding 5
What are some of the barriers? How do you perceive the current local medical workforce situation?				
What impact has the local medical workforce situation had, in your view, on (name of school)?	Contextual issues: Workforce	Contextual issues: Workforce		
What about at the national level?				
How does (name of school) work with the health system?	Contextual issues Health Sector linkages			
Has the health system influenced (name of school)? If so, in what ways? For example on (name of school) orientation or teaching? What about at other levels of the health system?	Barriers and enablers for health sector linkages	Contextual issue: Health Sector		

Question 1	codes/nodes: First coding 2	Codes/Nodes: Second Coding 3	Themes: Third coding 4	Themes: Fourth coding 5
What is your understanding of (name of school) relationship with the community?	Contextual issues Community Partnerships			
Who do you see as the community?		Contextual issues Community Partnerships		
How much influence do you feel the community has on (name of school)?	Barriers and enablers for community partnerships			
How do communities get influence?				

3.9.2 Across case analysis

Initial similar themes across cases were developed from data immersion. I read and re-read the within case analysis for each case. I focused on the two key questions: one, what is social accountability and two, what are the contextual factors that influence social accountability? Themes were refined and connections between themes mapped using site-order descriptive matrixes for each of these questions (Miles & Huberman, 1994). I developed three common themes concerning the understanding of social accountability. I undertook the following steps to develop the themes for contextual factors:

- I organised each contextual factor for each case in a table or site ordered matrix;
- I colour coded similar contextual factors;
- I noted that some contextual factors had two similar themes;
- I developed separate matrixes for each of the common themes describing what is the contextual issue that influences and how it influenced social accountability at each school; and
- I discussed why each factor may or may not be a contextual influence at other schools.

The analysis process was further confirmed through discussion with my supervisors. My supervisors had 'spot checked' some initial coding of the data in order to ensure that my coding reflected what people were saying (coder triangulation). They then checked some of the theming process to ascertain whether or not the themes I developed were consistent with what the data presented. Finally, I searched for negative instances that might challenge my assumptions about the understanding of socially accountable

medical education, and about the key contextual factors that might influence it (Seale, 2001, p. 334). In my analysis I investigated interesting outliers and questions. I also asked participants about data that I had found in the peer reviewed and grey literature and whether or not key points were consistent with their experience. During analysis, long discussions were held with the supervisors regarding my positions at JCUSOM and with THEnet. I ensured that my conclusions were drawn from the data. Two of my supervisors were from outside the School and the field, including an Adjunct who was my Principal Supervisor.

Additionally, I had consistently presented my research to others at conferences in order to ascertain whether or not my findings were credible (Preston, Larkins, Judd, & Taylor, 2014; Preston, Tandinco, et al., 2012; Preston, Taylor, Larkins, & Judd, 2011a; Preston et al., 2011b; Preston, Taylor, Larkins, & Judd, 2012a, 2012b, 2012c). I was able to reflect on comments and return to my data to re-examine my findings. Themes that emerged consistently across all data were categorised as core themes. Interesting outliers were noted. Concepts were then further developed in relation to the research questions and from the literature. There were consistent themes across all cases, regardless of the country or other factors. I then developed a conceptual framework that outlined how contextual factors influenced socially accountable medical schools.

3.10 Limitations of the research

This study has some methodological limitations surrounding research focus and participants. As outlined in chapter one, I changed focus from medical school to medical education post fieldwork. This meant that my questioned focused on medical education and not the boarder scope of the school. Perhaps I lost opportunities to gather

richer information. . However, participants did discuss a board range of activities of their schools including education, research and service.

In Australia there were no Aboriginal and Torres Strait Islander participants. This is an important omission given that the Australian schools have service to Aboriginal and Torres Strait Islander people within their ambit. I have no information as to what Aboriginal or Torres Strait islander people think about the socially accountable medical education that is practiced at the schools.

Another limitation was that as some details could have identified some participants some data was lost (for example the leaders of the school)My documentary analysis would have been enhanced if I could have accessed each of the results of applying the THEnet evaluation framework at each school as a data source. However, one case did not give permission for use and consequently I was unable to use it for the other three cases. There were translation and language difficulties with some community interviews in the Philippines. Due to security, budget and personal reasons I had to limit my fieldwork time. Therefore it was difficult to develop rapport. I was unable to include presenting results back to participants comments (member checking) in my methodology due to limitations to fieldwork and the security and emergency situation in the Philippines (insurgency in Zamboanga and Cyclone Hainan in the Philippines). However, I did send back interviews for participants to review.

Another limitation of this research is my emic/etic position in case 2. I was studying my own school and there was conflict due to this emic (insider faculty member and postgraduate student) and etic (outsider researcher). I have tacit knowledge of JCUSOM, this is knowledge that I could not have at other schools where I was an outsider researcher. Therefore this insider knowledge could not be part of the JCUSOM

case as it would make the case unique from the other cases. To illustrate this dual position and my emic knowledge, I have added appendix 7 from my research diary.

- Joe needs to see a doctor: my experience of the Australian Health System
- Racism 101 is about the community: who are they and do they hold the school's values?

The next three experiences: Racism 201: The Bystander; Racism 301: The bubble; Racism 401: Bad neighbours; Racism 501: Always nice to you; illustrate my experiences of being white in a colonised space. As I undertook fieldwork in my community I continually questioned my own white privilege and dual role of academic/researcher and community member. As I am part of this community I have continually asked "Is JCUSOM really part of the wider community?"

The next two vignettes are about the tacit knowledge that I hold at JCU:

- Sad not angry: the curriculum and the hidden curriculum that students really value.
- What ever happen to "I REAALLLY want to work in rural, Indigenous and tropical health?"

These vignette explore the hidden curriculum, what is valued by students and the tension of presenting a "face" of a school aspiring to be socially accountable and hiding the messy reality of differences in values and priorities. I have this knowledge of JCUSMD. What is this like at other schools? What "dirty secrets" did other schools hide?

The only way I could have gained insight at other schools would be through ethnographic studies at all sites, this was not feasible for a higher degree by research.

As well as being seen as a member of JCUSOM, I was also seen as a member of THEnet and had relationships with participants. It is interesting that not all participants mentioned THEnet in interviews and perhaps this was because they understood I also had tacit knowledge or assumed knowledge about THEnet and policies around social accountability that they did not need to discuss. This may also mean that some potential data were lost

3.11 Conclusion

In this chapter I defined the key contextual factors and described the study's aims and objectives. I outlined my project's methodology and how I undertook the research. A multiple case study approach was undertaken to answer the research question "How do contextual factors influence social accountability in medical education?" Data collection went as planned, with some changes as congruent with a qualitative approach. Critical theory, constructivism and a social justice approach have driven this research and consequently I have openly outlined my own assumptions and position as a researcher.

Chapter 4 Australia

4.1 Introduction: The Australian health system and medical education system

To give context to the first two cases, in this section I discuss the Australian health and medical education systems and focus on the roles of medical professionals. Health care in Australia is universally available, accessible and of good quality. Many doctors in regional centres are international medical graduates (IMGs). There are a range of federal government initiatives that support the health system, including the pharmaceutical benefits scheme and Medicare, the public health insurance system.

4.1.1 The demographic and health profile of Australia

Although known for its wide open spaces and natural beauty, most of Australia's 23 million people (89%) reside in urban centres (World Health Organization, 2013e). Indigenous Australians constitute 2.5% of the population (Australian Bureau of Statistics, 2012a). While in 2011, 26% of Australians were born overseas and a further (20%) had at least one overseas-born parent, most Australians are of British or European descent (Australian Bureau of Statistics, 2012b). There are three levels of government that have some responsibility for health: Federal or Commonwealth; six states and two territories; and local councils. Most Australians enjoy good health and relative wealth. In 2009, the life expectancy at birth was 80 for males and 84 for females, and the maternal mortality rate was 7 per 100,000 live births (World Health Organization, 2013e). The gross national product per person in 2012 was USD38,110. Most of the leading causes of death are lifestyle related: ischemic heart disease; cerebrovascular disease; dementia (including Alzheimer's disease); and cancer (World Health Organization, 2011a).

Australia has diverse, resourceful and dynamic Indigenous[21] communities however, the poor health of the country's First Peoples is a shameful legacy of brutal colonialism. Since 1788, European colonisers forced people off their land, divided families and conducted frontier wars that many non-Indigenous Australians still refuse to recognise (Reynolds, 2000). A formal policy of removing Indigenous children of "mixed descent" from their families was enacted until the 1970s (Australia. Parliament .Department of Parliamentary Services, 2008). The differences between the health of Indigenous and non-Indigenous Australians are well documented: Indigenous Australians live approximately 10 years[22] less than non-Indigenous Australians (Australia. Department of Families, Housing, Community Services and Indigenous Affairs., 2012); Indigenous babies are two times more likely to die before they are five;[23] and rates of chronic disease including diabetes and kidney disease are significantly higher among Indigenous peoples (Australian Institute of Health and Welfare, 2010; Close the Gap Steering Committee, 2014). Infectious diseases common in less resourced countries are also rife in remote communities where there is poor health infrastructure including housing and sanitation (Australia. Department of Families, Housing, Community Services and Indigenous Affairs, 2012; Australia. Department of the Prime Minister and Cabinet, 2014).

[21] I chose to use the term Indigenous in this thesis to describe Aboriginal and Torres Strait Islander peoples of Australia. I acknowledge that these two groups of people have separate cultural identities. I use the separate terms Aboriginal peoples or Torres Strait Islander peoples when discussing these individual groups.

[22] Approximately 11.5 years for males and 9.7 years for females (Australia. Department of Families, Housing, Community Services and Indigenous Affairs., 2012).

[23] "The mortality rate for Indigenous infants during 2003–2007 was 10.3 per 1,000 live births compared with 4.2 per 1,000 for non-Indigenous infants".(Australian Institute of Health and Welfare, 2010, pp. 234-235).

In reaction to government inaction, racism and culturally inappropriate care, Indigenous peoples have always had to take control of their own health care. From the 1970s communities developed Aboriginal Community Controlled Health Services (ACCHS) to deliver primary health care services (Eckerman et al., 2010). Yet in mainstream services many health professionals are inadequately trained to undertake culturally safe care, and upstream determinants of health including employment, housing and racial discrimination have not been addressed (Awofeso, 2011; Close the Gap Steering Committee, 2014; Osborne, Baum, & Brown, 2013). On 13 February 2008 Australia's then Prime Minister, Kevin Rudd, apologised to the Stolen Generation of First Australians on behalf of the Australian Parliament for the policy of removal of Indigenous children (Australia. Parliament .Department of Parliamentary Services, 2008). For many Australians this was a turning point in Indigenous and non-Indigenous relations (Eckerman et al., 2010). Most Australians now recognise "closing the gap" in health, education and social indicators requires a significant investment of resources across all levels of government and partnerships with Indigenous peoples (Australia. Department of the Prime Minister and Cabinet, 2014)

Other groups marginalised from the Australian health system and with poor health outcomes include refugees, people from culturally and linguistically diverse backgrounds, people with disabilities, people who live in rural and remote areas, and low socio-economic groups (Australian Institute of Health and Welfare, 2010). The ageing population, lifestyle diseases, including obesity and diabetes, and consumer expectations are contemporary challenges for the Australia's health system (World Health Organization, 2011a).

4.1.2 The organisation of the Australian health care system

The Australian health system is a complex combination of government and private services provided at different levels of government. Figure 4.1 gives a summary of the different levels and types of services. The Federal or Commonwealth government is responsible for setting national health priorities and targets and also subsidising state and private services (Duckett & Willcox, 2011) and funding primary health care services through Medicare.. The eight State and territory governments oversee health service delivery, including hospital services and population and community health (Healy & Dugdale, 2013). In 2011 the Council of Australian Governments (COAG) enacted a National Health Reform Agreement which gave more power to the Federal government to oversee the funding and governance of Primary Health Care (PHC) services and public hospitals (Healy & Dugdale, 2013). Local governments or councils undertake health infrastructure programs including garbage collection and insect control. They also provide community health services such as aged care in the home, however these services are not standardised across councils or states.

The primary health care system includes private medical practices that provide "first contact" (no referral) services including medical professionals (general practices) and allied health services. In 2011, 61 "Medicare Locals" were established across Australia with the roles of: coordinating PHC; supporting health professionals; improving access to PHC; and connecting PHC services with hospitals and social care (Bennett, 2013). The public can access hospitals through emergency departments but are referred to specialists by general practitioners. Non-government community health organisations provide a range of services across the whole health system from preventative health to palliative care. This sector includes large national organisations with budgets of millions of dollars, such as the Red Cross, to small support groups managed by

volunteers. Community health organisations receive funding from government grants and private donors.

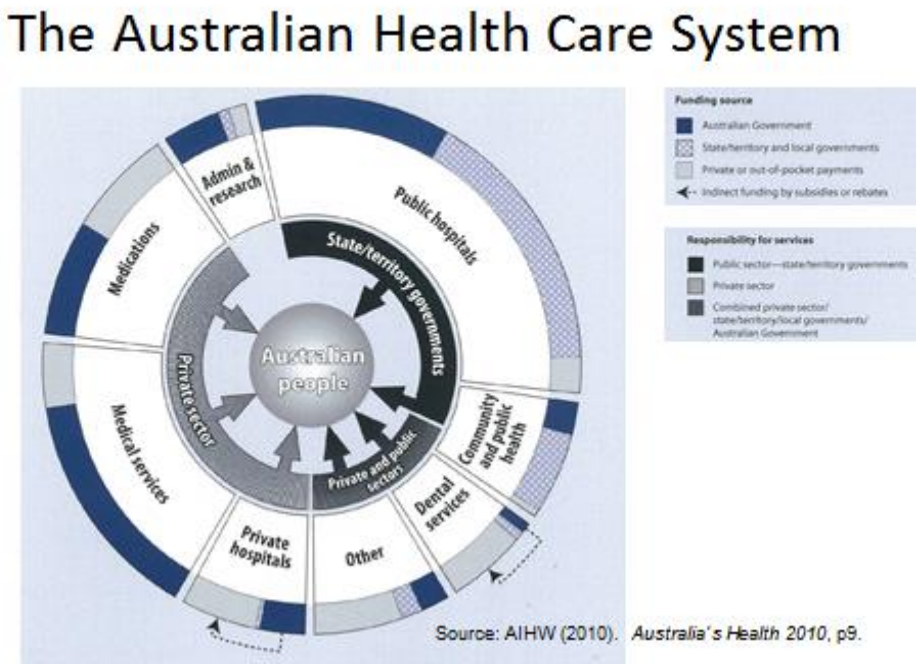

Figure 4.1 The Australian Health Care System (Australian Institute of Health and Welfare, 2010)

4.1.3 The financing of the Australian health care system

The Australian government funds around 70% of total health expenditure, of this the Federal government finances two thirds and the other third is supported by state, territory and local governments (Australian Institute of Health and Welfare, 2010). In 2010 to 2011 Australia spent 8.9 percent of its GDP on health care (Healy & Dugdale, 2013, p. 12). Medicare is Australia's public health insurance that provides universal health coverage; it is funded from the tax system, including a 1.5 per cent "Medicare levy" on taxable income (Healy & Dugdale, 2013). Medicare covers free or subsidised treatment by health professionals including doctors, specialists, and some allied health practitioners. There is a scheduled fee for GPs covered by Medicare. Medicare also

covers 85% of the schedule fee for other out-of-hospital services. Services that "bulk bill" only charge the schedule fee. If there is a gap between the schedule fee and the amount charged this is an 'out of pocket' expense covered by the patient or health insurance. Health professionals who bulk bill are paid an incentive by Medicare. Australia has a mix of public, private and non-for profit hospitals. Australians receive free treatment and accommodation as public (Medicare) patients in a public hospital. In private hospitals, Medicare covers 75% of the Medicare Schedule fee for services and procedures for private patients in public or private hospitals (Australia. Department of Human Services, 2013). There is a "safety net" for eligible low income earners and those who have higher health costs and once they meet a threshold of expenditure they no longer have to pay a gap fee.

Private health insurance is subsidised by the Australian Government (about 30%) and can cover hospital charges, inpatient services, allied health and aids and appliances such as spectacles (Australia. Department of Human Services, 2013). Private health insurance does not generally cover general practice fees. However, private practitioners, including GPs, determine what "rebatable services" they will offer. Through the Pharmaceutical Benefits Scheme (PBS), the Australian Government subsidises the cost of listed prescription medicine (Australia. Department of Human Services, 2013).

4.1.4 The Australian medical education system

There are 18 medical schools in Australia situated in every state and territory, 16 are public institutions and two are private. Twelve are based in capital cities and six in regional centres. There was rapid growth of schools in the last decade with eight schools established after 2000 (Medical Deans Australia and New Zealand Inc, 2013). Seven schools offer undergraduate courses of 4 years 8 months to 6 years duration, nine offer

postgraduate courses of 4 years for graduates and two offer both types of courses (Medical Deans Australia and New Zealand Inc & Australian Indigenous Doctors' Association, 2012). Recently there has been resurgence in regionally located medical schools, and the numbers of medical students attending them, to address the mal-distribution of the workforce. While the increase in medical students. a rise of 30% in 2001 to 2009; with an estimated 3,786 graduates in 2014 (Deloitte Access Economics, 2011), will have an effect on overall doctor supply there is a need for other educational and training initiatives to ensure adequate numbers will practice in rural areas.

There is a shortage of medical professionals in Australia due to past policies of limited medical school development. The health system is reliant upon International Medical Graduates (IMGs) particularly in rural areas with many from developing countries that can scarcely spare these health professionals. General Practitioners (GPs) have been permitted to migrate under Australia's permanent entry skilled migration visa categories as long as they can obtain general registration with the Australian Health Practitioner Regulation Authority. In addition, employers of GPs or Hospital Medical Officers (HMOs) can sponsor as many IMGs as they like on temporary entry visas. In September 2011, according to Australian registration statistics, there were 2,731 IMGs working on limited registration as GPs and 3,430 as non-specialist HMOs (Birrell, 2011). Governments and medical schools have introduced a range of strategies and policies to decrease Australia's reliance on IMGs in rural and remote areas.

4.1.4.1 Rural health initiatives

In Australia a number of strategies, including educational, financial, regulatory and supportive processes, have been implemented since the first National Rural Health Strategy of 1994 address rural doctor shortages (Australian Health Ministers' Conference, 1994; Grobler et al., 2009). The Federal government provides "complementary initiatives to increase rural enrolments, ensure universities focus on rural health in curriculum delivery and provide high quality rural training" (Hallinan, 2011, p. n.p.) through the Rural Heath Multidisciplinary Training Program. There is combined funding of over $122 million in 2010-11, growing to $130 million in 2013-14 (Hallinan, 2011). Rural Clinical Training and Support (RCTS) includes 17 rural clinical schools (RCSs) in every state and territory and in 2011-12 33.6% of local students undertook some of their education through the rural clinical schools program (Medical Deans Australia and New Zealand Inc, 2013). Eleven multidisciplinary University Departments of Rural Health (UDRH) are located in rural and regional areas and help coordinate rural health education experiences for students (Hays, 2002). Both the RCS and UDRH support placements. At the direction of the federal government, all medical students must do 4 to 6 weeks of placements in a rural area (Cameron, 2002; Hallinan, 2011). In addition the John Flynn Placement Program provided 1050 ongoing positions in 2011, growing to 1200 in 2012. Twenty-nine rural health clubs are also supported at universities across Australia, coordinated through the National Rural Health Students' Network (Hallinan, 2011). Rural Health Clubs also provide extracurricular activities (such as inter-professional projects and talks at rural high schools) for students keen on a rural career (Lane, 2004; J. Turner & Scott, 2007). The potential and impact of these clubs upon socially accountability was recognized early by rural academic health pioneer Dr Max Kamien (Kamien, 1996).

Other policy changes and decisions at a Federal Government level include bonded medical program and medical rural bonded scholarships, requiring return of service in rural and underserviced areas for at least 25% of new medical graduates (Hallinan, 2011). There are indications that these initiatives are having an impact on Australia's rural and remote medical workforce. A projected workforce modelling project found that "...(of) the total increase in rural and remote clinicians between 2011 and 2020 (6,413 doctors in total), 13% (858) will be from bonded programs, 47% (3,986) from OTD [overseas trained doctors[24]] and 40% (2,569) from other sources (non-bonded Australian trained doctors)" (Deloitte Access Economics, 2011, p. ii).

The establishment of rural medical schools, located outside of urban areas, is also positive for rural student recruitment and rural doctor retention (Biggs & Wells, 2011; Dussault & Franceschini, 2006). The decentralisation of medical education through RCSs and UDRHs impacts on social capital and health (Worley & Murray, 2011). These schools and departments provide support to students on placements and rural clinicians as well as positive educational, economic and social impacts for the communities. There is also a short term effect on retention of rural clinicians as they are involved in teaching and research (Hallinan, 2011). This initiative is also an example of linkages between the health and education system (Worley & Murray, 2011). Of the 166 medical students who had completed a placement at an Australian Rural Clinical School, 47% had a rural background; and these students were 10 times more likely to prioritise work in a rural area compared with other students (Walker, DeWitt, Pallant, & Cunningham, 2011, p. 1). Participating in a RCS experience had a positive influence

[24] International Medical Graduates

upon students' desire to work rurally, with 85% indicating that the experience had increased their interest and 62% indicating that they now would be interested in a rural internship or basic training (Walker et al., 2011).

4.1.4.2 Postgraduate and specialist training

It takes 10 to 13 years for an Australian graduate to become an independent practising doctor. Graduates undertake a one year internship at an Australian hospital, and can then become a fully registered medical practitioner. There is a residency period of 1 to 3 years for doctors who have completed their internship but are yet to complete pre-vocational training. In their second to fourth postgraduate years most apply for specialist training through a professional medical college (James Cook University. School of Medicine and Dentistry, 2013a). A major issue for medical education in Australia is that postgraduate training places have not increased in line with the increase in medical graduates, and there are limited training places available outside of capital cities. This means that graduates go to capital cities to undertake specialty training and usually do not return to rural or regional areas (Medical Deans Australia and New Zealand Inc, 2013). Professional groups, including the Medical Deans Australia and New Zealand and regional medical school have called for investment in regional postgraduate medical training.

4.1.5 Summary

This brief review of the Australian health care and medical education systems sets the context for cases one (Flinders University School of Medicine) and two (James Cook University School of Medicine). Most Australians enjoy good health and access to a comprehensive health system. Australia's medical education system has changed significantly in the 2000s with an increase in regional medical schools and medical

school places and rural education and training initiatives to try to address the mal-distribution of the medical workforce.

4.2 Case study one: Innovation, social justice, difference: Flinders University School of Medicine

"So workforce was the reason the government funded it so absolutely if you move back from government funding, it was workforce, workforce, workforce" (FU_staff)

Plate 4.1 Flinders Medical Centre

4.2.1 Introduction: Flinders University School of Medicine (FUSOM)

It is lunchtime at Flinders Medical Centre, in the southern suburb of Bedford Park, Adelaide, South Australia. Young families tentatively wheel their newborns in see-through cribs to awaiting cars. Volunteers are everywhere, serving sushi and coffee at the small café, giving directions to visiting relatives and helping a visitor choose flowers at the volunteer-run shop. Health staff are talking with their colleagues and eating their lunch in the large internal courtyard, while children skip along the rocks around the waterfall. Aboriginal people wait outside or meet family in the Indigenous garden and go to Karpa Ngarrattendi, the Aboriginal Health Centre on the ground floor. On the fifth and sixth floors of this busy metropolitan hospital is the Flinders University School of Medicine (FUSOM); students study in the Gus Fraenkel Medical library (named after the first Dean), attend tutorials in nearby classrooms or wander to the lecture theatre close by. The walls have Aboriginal Art and poems; one is about patient identity "hospital gown, and patient ID, add fluffy slippers, I still am me". There are many billboards with information on research projects around the hospital and university.

Flinders University (FU) was established in 1966, an innovative university to serve the then new and working class suburbs of southern Adelaide. Adelaide is the state capital of South Australia; with a population of 1,260,000 (2011) and a state population of 1,654,800 (Australian Bureau of Statistics, 2013b). South Australia is often referred to as a ‘city state’, due to its centralization (see Figures 4.2 and 4.3). Newer suburbs have grown around the university; and the university is now committed to serving the southern region of Adelaide through a number of partnership initiatives (Flinders University. Southern Knowledge Transfer Partnership Office, 2011). The medical school admitted its first students in 1974 and the medical centre was established in

1976. The Flinders University School of Medicine's recruitment strategy, organisational structure and curriculum were distingushed as different from mainstream medical schools (Leggat, 1997; Sheldrake, Linke, Mensh, Newble, & Rosinski, 1978; The Committee of Inquiry into Medical Education and Medical Workforce, 1988). The "Flinders Model" of medical education broke away from more traditional medical school education in a number of important ways. The school did not have an academic department structure and the curriculum focused on body systems. Students could also undertake subject electives outside of biomedical sciences. Subjects including topics such as "medicine in the community" and non-health electives accounted for 25% of the first three years (Sheldrake et al., 1978; The Committee of Inquiry into Medical Education and Medical Workforce, 1988). There was innovation in student selection, with 40% to 60% of students selected on factors other than academic ability such as professional experience (Sheldrake et al., 1978). Another distinction was the change to Australia's first 4 year graduate-entry medical program in 1996 with student-directed learning or problem based learning (PBL) approaches to education (Worley, Silagy, Prideaux, Newble, & Jones, 2000). There have been 835 graduates from this postgraduate course (Ross et al., 2014). More than half of the students in third year select from different clinical experiences in rural and remote communities (Ross et al., 2014). In recent years changes at FUSOM include a Bachelor of Clinical Sciences that allows 25 high school students direct entry into a two year degree prior to medicine and the change to a Doctor of Medicine degree (MD) developed from 2012 (Worley et al., 2000).

The Flinders Medical Centre's co-location with the university is significant as it was "*Australia's first academic medical centre with a research, teaching, clinical service kind of tripod"* (FU5_staff[25]) and is the archetype of how the health and education sectors should be integrated in medical education. This was a new approach in Australia and in the early years staff held appointments with both the health department and the university (Sheldrake et al., 1978, p. 19). There was a mutual relationship of employment and work, and in the early years "*... you [couldn't] tell the difference between the health system and the university..."* (FU1_staff).

> *In 1990 you wouldn't have kind of known what was university business and what was hospital business it just sort of happened and some people who were employed by the health service did most of the university work, and no one particularly cared much at that stage.*
>
> (FU7_staff).

This 'symbiotic' model demonstrates an interdependence between the education and the health sector "where there is mutual benefit to both parties" (Prideaux, 2006, p. 40). At FUSOM, all staff and the 579 students across the four year postgraduate degree (132 to 166 students per year in 2012) have daily exposure to patients and medical professionals and vice versa (Medical Deans Australia and New Zealand Inc., 2012). This physical integration is unusual for Australian medical schools where most have a clinical school within the hospital and the main school at a university that could be some distance away. Flinders University School of Medicine (FUSOM) encompasses a range of

[25] Participants are coded by their university (FU: Flinders), interview number and type of participant (staff, student, health sector representative or community sector representative). FU12-1_staff indicates this person was the first participant in interview 12 at Flinders University and they were a staff member.

disciplines across allied health and public health. These disciplines are not co-located at the hospital, but are on the adjacent university campus.

Figure 4.2 Map of South Australia (Adelaide and Riverland region)

(source: googlemaps)

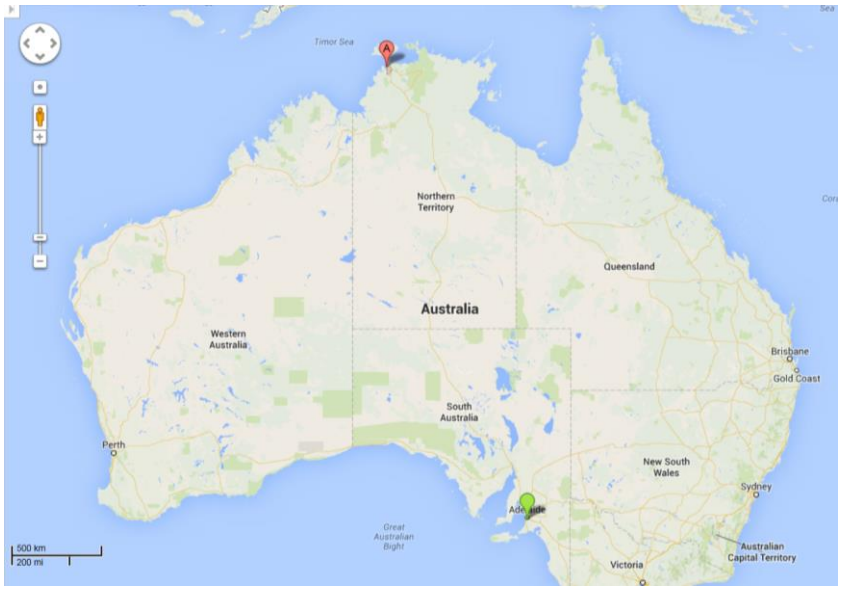

Figure 4.3 Map of South Australia and the Northern Territory

(source: googlemaps)

4.2.2 Results

In this section I describe my fieldwork, including the participants and sites visited. I outline respondents understanding of social accountability at FUSOM and describe the external and internal contextual factors that have influenced social accountability.

4.2.2.1 Fieldwork

I conducted fieldwork over two periods of time from the 27th to 28th of March 2012 in Adelaide and from the 19th to 24th of April 2012 in Adelaide and the Riverland region of South Australia. There were 18 participants: 11 staff (including the leader and a long term staff member); four students; two health sector representatives and one community member. The majority of the 16 interviews were face to face, though one was conducted by video conference, two by telephone, and two were joint interviews.

4.2.2.2 Understanding of social accountability at Flinders University School of Medicine

To develop an insight into the contextual factors affecting social accountability at FUSOM (and in all cases) I asked participants about their understanding of social accountability in general, and also social accountability at the school[26]. It was clear that social accountability in medical education was understood in multiple ways by different participants. Six participants demonstrated a comprehensive understanding of social accountability. I interpreted comprehensive understanding as an appreciation of the The

[26] As discussed in chapter one, for this study I have adapted The Training for Health Equity's (THEnet's) definition of social accountability:

> *"Socially accountable medical schools hold themselves responsible for producing outcomes aligned with health workforce, priority health, and health system needs of their communities"* (The Training for Health Equity Network, 2011).

This definition was outlined on the project's information sheet which was given to all participants prior to and when their involvement in my research was sought. The information sheet was again distributed at the commencement of the interview.

Training for Health Equity Network's (THEnet's) definition of social accountability. This might have been because these staff had been involved in THEnet and also in the development of the framework to evaluate socially accountable medical education. Most respondents saw social accountability to be about the school as an institution, for example one respondent said that the school had "*embedded in our medical course a number of elements of social accountability*" (FU2_staff). Some participants saw themselves as being accountable at an individual level. For example one student saw social accountability as his own "*responsibility to actually learn as a student*" (FU13_student) as society and the government is paying for his education.

Four themes emerged in these discussions, and are described fully below: three are at the organisational level and one at the individual level. First, that social accountability was apparent in the types of medical education programs that FUSOM chose or how social accountability was "operationalized" at the school; second, that social accountability was seen as responding to health or community need or both; and third, FUSOM staff perceived that social accountability gave 'meaning to work'. Another interesting perspective at FUSOM was that social accountability was also seen as a "social movement" or "movement" in medical education driven by medical schools and organisations such as THEnet. Although participants were purposively selected for their understanding of social accountability, three participants had little or no comprehension of social accountability. As it was important for participants to have some insight of the term and in order to proceed in the interview, I read out the definition then asked them to respond.

4.2.2.2.1 "To connect to what social accountability means": Medical education programs and operations at Flinders University School of Medicine that reflect social accountability

Nine participants (half the respondents) shared the perspective that the school's specific medical education programs were an expression of, and helped define and strengthen, social accountability. Participants thought that three distinctive programs had been implemented that characterised social accountability: The Parallel Rural Community Curriculum (PRCC); the Onkaparinga Clinical Education Experience (OCEP) and the Northern Territory Medical Program (NTMP).

The Parallel Rural Community Curriculum (PRCC) Program

The Parallel Rural Community Curriculum (PRCC) program was established in 1997 in the Riverland region of South Australia, encompassing the rural communities of Waikerie, Barmera, Berri, Loxton and Renmark. The project was developed with pilot funding from the Commonwealth Department of Health and Family Services to address rural medical workforce shortages and the limitations of placements in tertiary hospitals (Hays, 2002; Worley et al., 2000). The program was developed from a close relationship between the leader, the local state health manager representative, and the local medical workforce. It demonstrated partnerships across the health system, including the local GPs, the health service and Medicare Local[27] (Flinders University Rural Clinical School, 2010; Murray et al., 2012; Worley, Prideaux, Strasser, Magarey, & March, 2006). Between 2002 and 2012 the PRCC has expanded to four other sites

[27] As discussed in Chapter 4 Federally-funded Medicare Locals, formally known as divisions of general practice, coordinate primary health care across set population and geographic areas. They can provide workforce training and education as well as direct health services and are governed by a local board.

(Flinders University, 2012b). Over 25% of third year medical students undertake a longitudinal integrated clinical placement with an entire year of learning in a rural community (Couper, Worley, & Strasser, 2011; Hays, 2002; Walters, Worley, & Mugford, 2003; Worley, 2008; Worley et al., 2000). Although they have a similar curriculum and undertake the same assessment as their colleagues, the learning of PRCC students is integrated and patient-centred rather than focused on disciplines. Students undergo an intensive two day selection process for the program involving an interview by a panel of community and professional people and group activities at the rural site (Hays, 2002; Stagg & Rosenthal, 2012). Selection is competitive and some students reported that often students chose this option for the potential of academic achievement (i.e. more focused or one-on-one teaching) rather than because of their interest in rural health. Some participants saw that this has resulted in it becoming an elite option or more competitive.

Onkaparinga Clinical Education Experience (OCEP), Noarlunga, Adelaide

Piloted in 2009 to 2010 and formally launched in 2011, the Onkaparinga Clinical Education Experience (OCEP), is an urban version of the PRCC. Third year students undertake a longitudinal community based program in a low socioeconomic area, 18kms south of FUSOM (Flinders University Rural Clinical School, 2010; Mahoney, Campbell, & Garner, 2011). The area is a typical outer suburb: the shops, large supermarkets, discount stores, a Bunnings Hardware Warehouse, and the bright, new (and at the time of my fieldwork, yet to be opened) Medicare Local next to the small hospital. Centrelink and the Department of Families are on the main street, where among this is the FUSOM building. The program was funded out of the Flinders University initiative to connect with Southern Adelaide (Flinders University. Southern Knowledge Transfer Partnership Office, 2011). Students are placed with a GP for 20

weeks and also have sessions in the Emergency Departments of Noarlunga Hospital and a half year program of specialty rotations (Mahoney, Walters, & Ash, 2012). Small group tutorials and teaching sessions are held at the FUSOM building opposite the hospital. A key feature of the program is linkages with the community, such as one developed with Christies Beach High School (Mahoney et al., 2011).

The Northern Territory Medical Program (NTMP)

The school has long had a relationship in the Northern Territory, a sparsely populated area with a high proportion of remote, rural and Indigenous people. The Centre for Rural and Remote Health based in Alice Springs and Katherine has offered postgraduate training and research since 1998. The Northern Territory Clinical School (NTCS) in Darwin has taught third and fourth year Flinders Students since 1998 and fifth and sixth year JCU students since 2004 (T. Sen Gupta, personal communication, 20 March 2014). In 2011 a full four year program admitted 24 students local to the Northern Territory (Flinders University, 2011a, 2011b; Worley, 2008). There is a particular emphasis on Indigenous health and the recruitment of Aboriginal and Torres Strait Islander students through an Indigenous Entry Scheme. Social accountability and Boelen and Heck's framework (Boelen & Heck, 1995) influenced the development of the program (Morgan et al., 2009).

The PRCC's aim is to address rural health and workforce issues and was cited as an "element of" social accountability that had been "embedded" in the medical course. A respondent saw that "*the basis of [The PRCC] is about social accountability*" (FU14_Health). The OCEP program with a focus on general practice in underserved areas was also seen as influencing social accountability at FUSOM:

[The program] is pushing our level of social accountability higher because it is getting students used to general practice.

(FU11_staff).

The Northern Territory Medical Program (NTMP) had made the theoretical idea of social accountability more tangible and gave practical examples to staff and students. Appropriate medical education is needed to address the health needs of the large Indigenous population. One participant felt the school needed to be accountable to this population and "*to try and run a sort of program from Adelaide in the Northern Territory ...without being socially accountable would be totally unacceptable"* (FU7_staff). The Northern Territory Medical Program and the Indigenous health research centres had enabled people "to *connect to what social accountability means*" (FU1_staff) and "*helped us crystallise what we mean by social accountability"* (FU7_staff). It also made the school "*very conscious of Indigenous health issues"* (FU2_staff).

4.2.2.2.2 "Walk the Talk": Social accountability in the school's agenda and operations

Another key aspect of social accountability for six respondents was how social accountability was incorporated in the school's "agenda" and "operations" including staff recruitment (Flinders University, 2013d). All these respondents had also said that social accountability was reflected by the programs of the school. Flinders University School of Medicine's commitment to social accountability is made explicit on the website linked with the school's membership of the Global Health Education Network and the Training for Health Equity Network (Flinders University, 2013d). A staff member defined social accountability to be about operational issues such as decision-making and enabling representatives from the health sector and communities to be

involved in student selection and course development[28]. Part of the essential selection criteria or academic positions was knowledge of social accountability in the context of their disciplines and a staff respondent outlined how one staff member always asked about social accountability on employment interview panels. Social accountability was being able "*…to change the social determinants of access to education, access to [who is] able to study a medical degree"* (FU12-1_staff) and to support those who would be unable to study medicine due to financial restrictions. Three respondents perceived that social accountability was also made explicit in the curriculum as students were taught about Indigenous health and the social determinants of health.

Another concept discussed by six respondents was that the school needed to ensure the focus of social accountability was practical rather than theoretical. Social accountability should not be "*…just a tokenistic tick, check list, something you are going to accredit"* (FU12_2_staff) but FUSOM must "*walk the talk*" (FU12-2_staff) as an organisation. This means that the school needs to move beyond rhetoric but enact changes that will enable a "*deep cultural shift in an organisation*" (FU12-2_staff). This involved "*making sure that it's not just a mantra though, that it's actually about practical change*" (FU5_staff). One staff member suggested that the medical course would look very different to what it did now if it was informed by the ideas of social accountability.

Two respondents demonstrated how social accountability could just become a term without real meaning if it was not clearly actualised by the school. One staff member termed social accountability as "*THEnet stuff*" (FU6-1_staff) and when asked to

[28] The THEnet Social Accountability Evaluation framework, governance section states: "We have strategic directions reflecting social accountability that have been developed through collaborative processes involving stakeholders. Our decision-making involves meaningful participation from all stakeholders" (The Training for Health Equity Network, 2011).

elaborate said that they agreed with THEnet. A student saw the term as a "*catch phrase that was used by the school a lot*" (FU9_student) and didn't really know the definition of social accountability. This respondent suggested that "*... when words get used too much they lose meaning and I did think that it became one of those things but for me I guess"* (FU9_student).

4.2.2.2.3 "It means that our medical course should be addressing those health priority concerns": Social accountability as responding to community and/or health sector need

Reflecting the THEnet's and World Health Organization's understandings (The Training for Health Equity Network, 2011), seven participants outlined how social accountability involved responding to community and health sector need; particularly the needs of underserved populations. This understanding was appreciated by those who had a more comprehensive or developed understanding of social accountability, including staff that were involved with THEnet projects, and had paraphrased the definition:

> *…it means that our medical course should be addressing those health priority concerns and should be doing something about [these] and changing the outcomes.*
>
> (FU7_staff).

For these respondents, social accountability meant an outcome, that the school, through their graduates or their activities, would meet the health needs of communities, particularly disadvantaged communities. Flinders University School of Medicine graduates would be equipped with the skills, knowledge and attitudes conducive to serving in areas with particular health needs:

> *...there is some alignment between what happens in medical education [and the] training of students and what happens in the medical school and the needs of the general public and people out there, how that aligns with their priority needs.*
>
> (FU11_staff).

The two health representatives had similar understandings about social accountability meeting community need, although they had limited exposure to THEnet. One mentioned that it was the social accountability or responsibility of the school and state governments to ensure services and a health workforce. This participant thought that everyone should have a commitment to social accountability for the sustainability of rural communities:

> *A government's got a social accountability to its community to make sure that the services are available and that the workforce is there, and the infrastructure is available. And of course the university has got a social accountability or a social responsibility as part of its development and growing and training its students to become the workforce. So social accountability really extends to all levels, government, university, community, everyone has got a commitment and a responsibility towards the community, for its sustainability in the long term.*
>
> (FU8_health).

Both these participants had involvement in rural health at the policy and practice level, so their understanding may be linked with their own experience of medical workforce shortages in rural areas.

4.2.2.2.4 Perceptions about social accountability as "giving meaning to work"

Four respondents believed social accountability was a value that was deeply held by some members of the school community, including staff and students. This theme, "*giving meaning to work*" incorporated people's motivation at the individual rather than the organisational level. Staff at the school felt a connection with social accountability as it gives their work meaning and that "*meaning is important in a university context"* (FU1_staff). One participant thought strongly about working in a university that had an underpinning of social accountability; and that not only had the theoretical underpinnings of social accountability but "*walked the talk and showed social accountability is at the core of what they do*" (FU12-2_staff).

Although all those interviewed agreed with the school embracing social accountability, six respondents outlined that social accountability may not have meaning or relevance to staff and students beyond a few champions. It was reported that some staff may be uncomfortable with social accountability and questioned how these ideals complement their work in medical education and clinical research. Some departments such as primary and public health care may have a natural alignment with socially accountable values around "serving communities", whilst other areas such biomedical sciences may struggle to distinguish the relevance of social accountability for their work. Therefore "*some people just are totally disengaged with it, completely, so it is not consistent across the school*" (FU11_staff). One participant thought that there may be those who did not have "*a social accountability agenda*" but due to a "*fear*" of "*being exposed as not being socially accountable*" (FU15_staff), they would not speak against social accountability. However, this is possible in a large organisation with a range of different work areas. Generally though, it is likely that most staff at FUSOM feel some connection with social accountability.

4.2.2.3 Social accountability as "a social movement…coming out of health professions education"

Two respondents perceived social accountability to be a "social movement" or "movement" in medical education driven by medical schools and organisations. These respondents had not been involved in THEnet project directly, but believed that the global social accountability movement had aligned medical education with an understanding of a social contract and how medical schools should serve society:

> *It puts much more emphasis on medicine as an agent for change, so instead of in a way medical schools responding to [a] social agenda, it's actually saying no, you are part of the social agenda and you should bring about changes. So, don't just respond to reports about closing the gap but be an active part of engaging with those communities and actively [develop] graduates who've got the kinds of capabilities that will support closing the gap.*
>
> (FU5_staff).

Associated with some participants understanding of social accountability as "*bringing meaning to work*", was the sense that not all staff had "*joined*" the social accountability movement or aligned their own personal values with that of social accountability:

> *It's a particular package of social justice, and a particular movement and I'm not sure that people have joined that movement. I think many people would see that they just have a personal philosophy around social justice or the social and that is what they follow.*
>
> (FU3_staff).

The Training for Health Equity Network and the wider health professional movement for social accountability was also deemed to be a contextual influence and is fully explored in the next section.

4.2.3 Contextual factors: What has influenced social accountability at Flinders University School of Medicine?

Contextual factors were difficult for participants to understand so I used the term "influence". I interpreted "influence" as meaning that the factor had an impact upon Flinders University School of Medicine's (FUSOM's) education, research, service or policies in terms of social accountability. I explored with respondents "what has influenced social accountability at FUSOM" or "what has influenced FUSOM to embrace social accountability?" I asked people to consider what had influenced social accountability within FUSOM (internal factors) and what had influenced social accountability from outside the school (external factors). I probed for the barriers and enablers for social accountability at FUSOM. I also asked what factors had determined the establishment of the medical school. Specific contextual issues which the literature indicated had influenced socially accountable medical schools were explored, as outlined in Chapter 3. There were six contextual factors that influenced social accountability at FUSOM. Regional workforce mal-distribution; government policy and funding; the Flinders University remit for difference, innovation and social justice; Flinders School of Medicine's community engagement policy; and the The Training for Health Equity are external influences. The internal contextual factors were leadership and individual champions.

4.2.3.1 External contextual influences

The local workforce situation and government policy to address these workforce needs were interrelated external contextual factors. Flinders University School of Medicine is a part of Flinders University (FU) but has also been influenced by the University. Likewise, it has incorporated FU's community engagement focus but also been influenced by the community as part of this process. The Training for Health Equity Network was another external influence.

4.2.3.1.1 "A sustainable, residential, rural workforce": The influence of regional workforce mal-distribution

The issue of regional workforce mal-distribtution in South Australia and the Northern Territory was mentioned as an external contextual factor and as an influence on social accountability by fifteen of the eighteen participants. Respondents were asked about the local workforce situation in the state and local area. While many conceded that they did not have specialised knowledge, respondents perceived that the main local workforce issue was the doctor shortage in rural areas. The Parallel Rural Community Curriculum (PRCC), the Onkaparinga Clinical Education Experience (OCEP) and the Northern Territory Medical Program (NTMP) were perceived as examples of socially accountable programs that were influenced by the local workforce situation.

In 2009 there were 354 doctors per 100,000 people in South Australia compared with 331 per 100,000 in Australia (Health Workforce Australia, 2012). However, there is a mal-distribution, with fewer doctors working in remote, rural and outer urban areas. The aim of the government funded PRCC program was to expand clinical training places to rural areas. It is well documented that one of the PRCC's aims was to address the rural workforce shortage (Stagg, Greenhill, Rosenthal, et al., 2009; Worley et al., 2006; Worley et al., 2000):

> *So workforce was the reason the government funded it so absolutely if you move back from government funding [it] was workforce, workforce, workforce.*
>
> (FU1_staff).

It was envisaged that through "rural exposure" students would have a positive experience and develop skills and knowledge suitable to working in country areas (Ranmuthugala et al., 2007). Furthermore the program aimed to enhance retention and recruitment of rural clinicians through professional exposure to teaching and research (Worley et al., 2000). One participant discussed how Indigenous workforce issues were also an influence, particularly on the Northern Territory program where there was a need for doctors who can work in Indigenous communities as well as Indigenous doctors (FU5_staff).

Although not cited by respondents, the workforce outcomes of the PRCC contributed to the expansion and continuation of the program (Worley et al., 2006). The aim was for a "*sustainable, residential, rural workforce"* (FU12-2_staff). In the Riverland, where the PRCC was established in 1997, many of the doctors had been involved with the program since it started, indicating that there was some stability in the workforce. Like other rural areas many Riverland doctors were International Medical Graduates (IMGs) and this workforce profile was also seen as influencing the PRCC in that IMGs may not have the relevant skills and experience to have students. Secondly, this workforce profile highlighted the need for domestic graduates. Respondents also discussed the balance of having an area that had a workforce need, but also had enough doctors to support and sustain the program.

Workforce shortages motivated community and health practitioners to be involved in the PRCC**.** Communities invested time and resources into the program, with the hope that some students would return to practice in their towns:

> *I want to see some of these people that go through this system go back out there again, because if they don't we're in diabolical, I mean my own town does not have a resident GP*
>
> (FU16_community).

Medical practitioners were committed to the program because "*…they were interested in getting that workforce outcome even though it was a long way done the track*" (FU6_staff). There were mixed reports on the workforce outcomes of the program, with some literature reporting successful outcomes (Stagg, Greenhill, & Worley, 2009). Even if they were not seeing immediate results of past students returning to their towns, community and health workforce were still supportive of the PRCC.

A pragmatic need for clinical training placements for students may have also influenced these innovative programs, discussed by three participants:

> *I don't know that we would be extending ourselves into Noarlunga [OCEP program] if we didn't need the student placements. I think that's a really strong one, is that we are putting students out there because we need to put them somewhere because the medical centre can't accommodate them*.
>
> (FU11_staff).

A key aim of the PRCC was to provide placement opportunities in rural practices that would provide a different learning experience than tertiary hospitals. The caseloads at tertiary hospitals were deemed inappropriate for contemporary student learning needs

(Flinders University Rural Clinical School, 2010; Worley et al., 2000). Expansion to a community based model in the Northern Territory was also partly influenced by an increase in student numbers (Morgan et al., 2009). This indicates that a strained workforce situation may not automatically lead to socially accountable programs; the reasons for seeking alternative student places may be more pragmatic because of increased student numbers.

4.2.3.1.2 "Without [the Federal Government] we would not [have] the money and the policy would not have developed": Government funding and policy

Four participants reported that government funding was essential for socially accountable programs to be established and sustained. Although specific funding was not identified, a number of rural health policies were instituted in the early 1990s. When discussing the PRCC program, a health representative highlighted the Commonwealth (federal) government's support:

> *In fact you could say that the Commonwealth [government] now has, to some extent, our main champion because without them we would not [have] the money and the policy wouldn't have developed the way it has and so on.*
>
> (FU8_Health).

The PRCC was funded by Commonwealth Government's Rural Incentives Program "as part of a comprehensive rural medical workforce strategy" (Worley et al., 2006; Worley et al., 2000). Other participants discussed how funding could further enhance social accountability at FUSOM through financing appropriate initiatives such as rural placements and community engagement. The literature on rural medical education

supports that rural programs required "significant resources" (Murray et al., 2012) and "targeted government funding" (Tesson, Curran, Pong, & Strasser, 2005, p. 414).

Government policies and funding influenced changes to the relationship between FUSOM and the Flinders Medical Centre was discussed by three participants. Social accountability advocates for strong inter-sectoral partnerships between the health and education sectors. Whilst some staff felt the close relationship between the sectors still existed "*because we are running a medical course from within the health system"* (FU2_staff), other respondents felt that this relationship had changed over time as "*…the health departments have been wanting to pull back from [the partnership]*" (FU1_staff). A staff member highlighted that "*economic rationalism*" in the late 1990s affected both sectors and created a divide between the two institutions "*because everybody is so stretched for time and money that they have to justify where they put their efforts"* (FU11_staff). The university was also "*cost cutting ... which meant we drifted apart"* (FU7_staff). The main changes were the cutting of teaching time for medical consultants and ending the role of professors heading joint hospital and academic departments.

Funding and institutional constraints influenced the ability for both General Practitioners (GPs) and Flinders Medical Centre (FMC) doctors to contribute to teaching. Both GPs and hospital based clinicians sacrificed income to teach and respondents felt there were few incentives from the government. Doctors at the FMC had autonomy to decide if they would teach. This was discussed by five respondents. Another influence discussed by one staff was changes to the hospital, influenced government policy and this in turn would influence teaching as "*Flinders [Medical Centre] is going to be an acute emergency hospital it's going to be expensive to run*"

(FU7_staff). This will have a particular impact upon teaching as the needs of the population is "… *on-going chronic, ageing care*" (FU7_staff).

Another government policy that would ensure funding focused on widening student access to universities was mentioned by two participants. One recommendation of the 2008 Bradley Review of tertiary education is that 20% of all undergraduate students will be from low socio-economic backgrounds by 2020 (Australia. Department of Industry, 2013; Commonwealth of Australia, 2008, p. xiii). These reforms were also tied with funding incentives:

> *…the university's saying we've got to diversify our student body and we've got to take in more people from low socio-economic [backgrounds]*.
>
> (FU11_Faculty).

4.2.3.1.3 "A need to address Aboriginal health issues through a social accountability agenda": Indigenous health policy

Four participants stated that the policy focus of the Australian government on addressing the health of Indigenous Australians influenced the school's research and curriculum. The expansion of the school into the Northern Territory had made these policy initiatives more explicit. There was *"a need to address Aboriginal health issues … through a social accountability agenda"* (FU15_staff). The Closing the Gap initiative was instigated in 2008 by the Council of Australian Governments (the intergovernmental forum of Federal and state and Territory governments) and set specific and ambitious targets:

- *"To close the life-expectancy gap [between Indigenous and non-Indigenous Australians] within a generation*

- *To halve the gap in mortality rates for Indigenous children under five within a decade"*

(Australia. Department of Families, Housing, Community Services and Indigenous Affairs, 2012).

The school's expansion to the Northern Territory (NT), where there is a large Indigenous population, was seen as shaping both people's understanding of social accountability in general and how social accountability plays out at Flinders:

> *So I think social accountability gives us a focus to take on some of these challenges…*
>
> (FU7_staff).

The issue of Indigenous health was an example of the role of government policy in influencing socially accountable medical schools. There was a difference and a tension between addressing Indigenous health disparities because it was the right thing to do (i.e. addressing social justice) and involvement in these programs because government policy and funding was supportive. Some participants idenitified this tension. There was also contention as some participants mentioned that the availability of funding could be the main reason behind programs*:*

> *I guess also [the leader] is ambitious and [the leader] sees that there is money in rural practice and in Indigenous Health practice and so [the leader] goes where the funds are as well. And I guess that is very strategic as a [leader]*.
>
> (FU11_staff).

As summarised by one participant, several policies with similar agendas around education (Bradley report), rural health workforce and also the strategic direction of the university together with the "right" people to implement strategies had pushed the focus of FUSOM to social accountability.

4.2.3.1.4 "Always different": Flinders University's remit for difference, innovation and social justice

Flinders University's perception of being "different" and its institutional focus on innovation and social justice was highlighted as an important factor that influenced social accountability for seven respondents. The university was described as being set up "*in the second tier of institutions*" (FU2_staff) and *that it was "always different and wanted to be different from Adelaide [University]*" (FU7_staff). The other university with a medical school is the University of Adelaide, an older 'sandstone' or established university and a member of Australia's "group of eight" research intensive universities[29]. The social reform agenda in South Australia was a contextual factor that influenced the way Flinders University (FU) developed. This was linked to when FU was established in the 1970s "*as part of the social reform agenda of labour governments around the country"* (FU1_leader). Several of the older participants discussed the significance of South Australian government regarding the establishment of the university. This history had instilled resistance to the academy or "*anti-establishment*" and attracted academics who held social justice values or who may have been "*disenfranchised or disillusioned with the sandstone university medical school",* this "*established a sense of other"* (FU12-1_staff). There was an opportunity and an

[29] "The Group of Eight (Go8) is a coalition of leading Australian universities, intensive in research and comprehensive in general and professional education" (Group of Eight, 2013, p. n.p).

expectation that things would be done differently from other medical schools. This difference and freedom from tradition gave FUSOM an opportunity to focus on *"innovation"* or being able to have *"a different approach to the way they did business [so there] was a fair degree of risk taking on their behalf, innovation, opportunity, that perhaps came with being a new kid on the block"* (FU8_health).

The university was tied to "*southern Adelaide*" (FU7 staff) and "*had always been a bit of an advocate for the needs of the underprivileged*" (FU3_staff). The university "*always had these broader social agendas"* (FU5_staff) and was "*socially progressive*" (FU9_Student). Flinders University's remit for difference came from its goal at establishment to expand university education to new groups (Flinders University, 2012a). The 2012 to 2016 strategic plan identifies social responsibility as one of the university's five values; stating that: "*At the heart of Flinders University, from its birth in 1966, is our commitment to social justice and human well-being*" (Flinders University, 2012a). In a study of the introduction of the graduate entry medical course, "*a history of innovation*" was acclaimed as a component of the culture of change at Flinders University (Prideaux & McCrorie, 2004). This included the way it was established and curriculum reforms as well as the school's non-departmental structure. The culture of change allowed for a 'decentralised' approach to curriculum development.

4.2.3.1.5 Community engagement as a contextual influence

Socially accountable medical schools deem themselves responsible to the communities that they serve. These communities are defined by THEnet and Boelen as "reference populations" (Boelen & Heck, 1995). In order to understand the nature of partnership with the community as contextual influences I first had to appreciate the school's reference population or community. Respondents accepted that one of the barriers to the

community being influential was identifying who was the "community". Most participants felt that the community of FUSOM could be defined by place: as geographically part of the Adelaide South or areas with a PRCC program. The Northern Territory was also seen as a community. Communities of interest included Indigenous peoples and community organisations, including those from the health sector. Respondents who had worked with THEnet and on the evaluation framework outlined how it was difficult for FUSOM to identify the school's community and further progress social accountability at the school:

> *One of the most challenging things I found about implementing...or progressing social accountability is "who is that community?" So I think we can have our definitions about underserved communities, priority health needs of communities… I think that that is the thing that we really need to start progressing social accountability. Because I think until we define our community we can't really get the initiatives in place*
>
> (FU2_staff).

There was complexity in the way that communities influenced social accountability at FUSOM. The practice of 'community engagement' was the method by which the school's staff develop relationships with representatives from 'communities of place' or geographic communities, and target groups and organisation (or communities of interest) in order understand their health needs and set up student placements. It was in this context that participants acknowledged a number of formal and informal ways that the community influenced social accountability at FUSOM.

As outlined in the section on defining social accountability three programs had been distinguished as being socially accountable at FUSOM: the PRCC, the OCEP and the

NT medical program. These were also highlighted on THEnet website as examples of "*community engagement*" at FUSOM (The Training for Health Equity Network, 2013b). The school had conceptualised social accountability as community engagement. For example, Figure 4.4 is extracted from the Onkaparinga Clinical Experience Program.

Community Engagement

Flinders University has a long-standing commitment to enhancing educational opportunities for all and a proud record of community engagement.

Flinders' achievements are supported by the network of strong external links that we have developed with our stakeholders and with the communities we serve to build the supportive and valued relationships which will be vital for the future.

In accordance with the School of Medicine's agenda of social accountability, the Onkaparinga Clinical Education Program is underpinned by a commitment to community engagement in all aspects of this urban clinical training experience.

The community based medical education program incorporates community projects as part of the curriculum and OCEP students have had much success in developing projects that are relevant and are important to our community ranging from projects with the aged and elderly to secondary school students.

We are currently focused on The Cube, a collaboration between OCEP and CBHS to create an adolescent friendly space where medical students will provide advice, counselling, mentorship and guidance to high school students and give the school students a much needed service in a safe and familiar setting, and give medical students a valuable teaching and learning role in adolescent health and wellbeing." (Flinders University, 2013a).

Figure 4.4 Flinders University's Community engagement policy: Interpretation

Community engagement in communities of place

The nature of a place-based community offered the opportunity to engage with the school in rural communities. Rural based academics said that there were "*hundreds*" (FU12-2_staff) of ways that the school worked in the community. These were formal projects, but also the informal way that staff and faculty were part of the community. At all PRCC sites community members and groups used school facilities for meetings and training. These informal relationships could lead to more formal partnerships. For example, a staff member's personal relationship led to an advanced life support training project at a local school. The Aboriginal community approached the Rural Clinical School regarding Aboriginal Health Professional career paths and a formal "jobs for health" program was developed. Perhaps this was why there is less formal community involvement such as community advisory boards. Participants at the PRCC site said that the formal group had initially been set up to meet funding requirements; but was less formalised in recent years.

Community members influence on the selection of students and student learning

Community members were involved in an interview panel to assess "personal qualities" as part of the student selection process (Flinders University, 2013a). This community involvement was discussed by six participants. A staff member saw this process as "*…probably one of the biggest areas"* (FU1_staff) that the community has influence. Another staff member saw that the interview process had "*...community validity…"* (FU5_staff). Both selection for the graduate entry medical program in Adelaide and the rural sub-quota places for students from rural background involved community representatives (Flinders University, 2013b; Stagg & Rosenthal, 2012). Students in the

rural scheme participated in rural activities throughout the four years including a PRCC placement in the Riverland. This two-day selection process involved a panel of eight people and occurred before the student's interview in Adelaide. One student recounted the intense involvement of community, with eight potential students competing for four places. There were conflict resolution situations, social interactions and an interview. The process was for the selection committee to ascertain applicant's suitability to rural practice. The community representative felt that being part of the interview process ensured that community members were familiar with students that they recognised from the interviews. Community members could also assist to encourage and support students. They could also screen the suitability of students for rural placements to ensure that there would be no issues:

> *… because sometimes we have some students who are just not suited and then the professors and directors and all that have to come in and have to sort it all out and sometimes they have to go because why put someone under incredible pressure when it's never going to work out so that part of it was very useful.*
>
> (FU16_community).

Stagg and Rosenthal (2012) found that community members felt that their involvement in selection at FUSOM would ensure that students would meet the needs of communities. Community members from rural areas were involved because of their own sense of service to their community, "*to which they have a strong sense of accountability*" (FU1_staff).

A key objective of the PRCC is that students become part of a rural community, students should enjoy rural life and be introduced to sporting, cultural and community

activities (Flinders University Rural Clinical School, 2010). The process of community engagement was part of student learning and therefore contributes to student and graduate outcomes being socially accountable (i.e. the student will work in a rural area):

> *Community contacts are a vital part of the PRCC program, as they help facilitate social and cultural introductions in the local area to enable students to fully immerse themselves in the distinct culture of the community. For students the experience is valuable in giving them the opportunity to see the richness and diversity of rural medicine and rural lifestyles.*
>
> (Flinders University Rural Clinical School, 2010).

Living in the community enabled students to develop a better understanding of the health needs of communities as they would see people beyond the health services. In the rural communities involved in the PRCC, there was also sense of ownership of the program and the students:

> *Because PRCC's been in place for so long the wider community are sort of proud, have this ownership over this university as well so when you are in shops or whatever they … automatically know who you are. They kind of want to own us and they kind of do.*
>
> (FU13_student).

Rural communities provided emotional support to students and "…*literally welcomed those students into the community"* (FU2_staff) at commencement dinners, and offered support to students to be part of the community. The inter-relationship was seen as part

of symbiotic education with a three way relationship, not only between the health system and education systems, but also involving the community:

> *It's that thing that [a leader] says about that symbiotic relationship, we've got the patient, the community, the government and us all working together to do that because the student comes in and looks after the patients, the community looks after the doctor and the student, and I think that the PRCC does that really well.*
>
> (FU 14_health).

The informal process of "*becoming part of the community*" was formalised by community contacts position discussed by two participants (a staff member and the community representative). At each site these contacts "…help facilitate social and cultural introductions in the local area to enable students to fully immerse themselves in the distinct culture of their community…" (Flinders University Rural Clinical School, 2010). A paid lead community contact person assisted students to get involved in the community. A prize is named in this individual's honour as they "…had a significant involvement as a consumer representative and member of the Flinders University Rural Clinical Community Advisory Board since its inception*"* (Flinders University, 2013c). This prize was awarded to the student "who has made the most significant contribution to a rural community during his/her studies in the medical course" (Flinders University, 2013c). Prizes are usually rewarded for academic performance; a prize based on community service in a rural community indicates the value that FUSOM places on community engagement.

The Influence of communities of interest

Communities of interest, as distinct from communities of place, were discussed by five participants. Indigenous communities were seen as communities of interest, particularly in the Northern Territory. Community organisations, including health sector organisations were seen as representatives of the community. These organisations contributed in distinct ways to the school including formally, through the Course Advisory Committee for the medical course. Communities of interest were a pragmatic way of defining community in an urban setting:

> *They're representative of particular groups but they are not the sort of naive rosy notion that we have of community as people living in a village who all support something as it were and it's not possible. I mean the notion of communities in cities is not really geographical; it's interest.*
>
> (FU3_staff).

It was acknowledged that communities of interest may have an agenda that differs from the wider community in rural areas.

Community advisory committees: Community input into the curriculum

Community Advisory Committees at FUSOM and at rural clinical schools were discussed by nine participants. These committees were seen to have input into the curriculum and therefore influenced student learning. Committee members included representatives of the community organisations and also the health sector; including "*our local council members ... other health professional courses, workforce representatives, the CEO of the Southern Region Health Services and ... the Alumni Association...*" (FU5_staff). There were mixed responses about the influence of these committees. Three staff felt that these committees could provide real engagement

opportunities. For example the Community Advisory Board (CAB) in Adelaide had influenced curriculum and teaching approaches including an "outcomes based" curriculum.

Committee members were asked*:*

> *...'what's important, what do you think of this course is about, what values do you associate with it?' and 'what do you think about this, what's your input, what's important to you, where are you from, what are your needs, what do you see as the interactions with our medical course?*
>
> (FU2_staff).

These perspectives had been fed "*back into the curriculum development and it actually informed a number of things"* (FU5_staff). This enabled a dialogue between community representatives and the school. The Community Advisory Committees highlighted issues such as workforce shortages and the priority health needs to the school:

> *... I think those things influence our social accountability agenda because they keep us up to date with what the issues are [like GP workforce shortages]. So I think that that awareness we need to keep on reminding ourselves where the needs are, what the priority health needs are...*
>
> (FU2_staff).

Four other participants felt that the committees had limited influence and questioned whether there was authentic engagement as they may not be representative and may have little input into giving advice to the school operations. As discussed, there were more informal engagement opportunities at rural sites.

In summary the influence of the relationships between the school and communities is complex. Most participants could identify roles that communities, organisations and individuals took in student selection, student learning, curriculum development and governance, but could not fully articulate their influence on social accountability. However, it was evident that for some staff at FUSOM social accountability was conceptualised as community engagement. Further this interaction with the community does influence the school particularly around student learning.

4.2.3.1.6 "To be able to link what we are doing here locally with something that is internationally recognised": The Training for Health Equity Network and the social accountability movement

Another influence that was internal as well as external was the school's involvement with The Training for Health Equity Network (THEnet) and the "*movement for social accountability*" (FU5_staff). Flinders University was a founding member of THEnet, a coalition of health professional schools focused on social accountability was implicitly connected with social accountability for seven participants. One respondent discussed how involvement with THEnet had broadened his understanding of social accountability; "*to be able to link what we are doing here locally with something that is internationally recognised*" (FU1_staff). Flinders University School of Medicine had piloted the evaluation framework in 2011; a year prior to fieldwork; therefore THEnet was known to some staff and students. Almost half of the staff respondents (5) had been involved in THEnet meetings or in the undertaking the evaluation. In the literature, THEnet is described by FUSOM and James Cook University School of Medicine (JCUSOM) staff as "an international movement for change" that can provide a community of practice that can help to lead change from within" (Murray et al., 2012). There was a culture of learning within the group of schools in that all schools have

benefited from face to face meetings, site visits to schools, networking and collegial support for the leaders. Involvement with THEnet had also given "*credibility to local decisions, local decision making and local prioritisation"* (FU1_staff). Despite the barriers of government policy discussed above there had been a recent call for the school to work more closely with the hospital. Internal discussions for a move back to what the founders of FUSOM envisaged - an academic health centre that would help address the health needs of southern Adelaide - had been influenced by the social accountability movement and organisations like THEnet.

Two participants also assessed that social accountability was a "*social movement coming out of health professional education*" (FU5_staff) that had influenced FUSOM through putting together "*coherent arguments through theory based frameworks*" (FU5_staff). Participants did not define what they meant by the "*global social accountability movement*" (FU5_staff). As well as THEnet, other developments in medical education and social accountability that FUSOM staff were involved in include the "Global Consensus for Social Accountability" and the Network: Towards Unity for Health, a group of innovative medical schools. Flinders University School of Medicine also hosted local and international conferences on social accountability in 2011 and 2012.

4.2.3.2 Internal contextual influences

The values and experienced of a key leader at the school as well as the shared values of some staff and clinicians as "champions" of social accountability were internal contextual influences on social accountability.

4.2.3.2.1 "A committed leader": Leadership and individual champions

The influence of a leader committed to social accountability was an internal contextual factor for eight participants. Social accountability has resonated with a leader's values and his values-driven leadership has influenced the organisational culture of the school and the type of people attracted to working at FUSOM. The leader made sure that policies and plans reflected social accountability:

> *... when we come to do strategic plans or define ourselves or come to be evaluated [the leader] always insists that it's one of the things there.*
>
> (FU3_staff).

This leader was described as a having very strong values and beliefs, mentioned by four respondents. These values or beliefs had similarities with social accountability. In addition, a leader's professional background was also an important factor; as this leader had been involved in setting up innovative programs. Respondents believed that without a "*committed leader*" (FU15_staff) social accountability would not be on the agenda at FUSOM. It was felt that if a leader left then social accountability may not be seen as important and there would be a cultural shift in the school. This raised potential issues in terms of the sustainability of social accountability at the school.

Seven participants discussed staff as champions of social accountability. This was interconnected with the notion of social accountability giving meaning to work. Similar to a leader, these "*champions*" (FU1_ staff) had backgrounds that resonated with social accountability, including *"primary care and social transformation as opposed to working at the high technology high end of medicine"* (FU1_ staff). Their "*high ideals*" (FU6-1_staff) and commitment to social accountability principles helped create an organisational environment that fostered the development of school programs and

influenced the school's curriculum focus. A staff member also mentioned that students who were attracted to studying at FUSOM also influenced social accountability.

Individual clinicians were also deemed champions of social accountability. Nine respondents mentioned how clinicians both at the Flinders Medical Centre (FMC) and as part of the PRCC gave up their time to teach. While teaching was a traditional role of doctors, for some respondents the passion and dedication demonstrated by clinicians through time and financial costs was seen as an indication of social accountability:

> *…they just have incredible passion, you know they are just really, really loving working with the students and feel it's really important. So I guess you have this perception that the workforce is not strong for the population but certainly it's strong for the students if that makes any sense.*
>
> (FU11_staff).

Staff felt that although the ideal model of an "Academic Health Centre" of the health and education sectors had been "pulled apart" the relationship with clinicians was still important:

> *…that culture [of being clinicians and teachers and vice versa] is still there, even if at an organisational level that's pulling apart*.
>
> (FU5_staff).

One staff member understood that social accountability could be demonstrated by clinicians. Like leaders and staff champions, clinicians held socially accountable values that influenced how they worked. Clinicians could use their influence and power in advocacy roles for patients and in the wider health system. This was an example of the importance of advocacy for those with less power as part of social accountability:

... [it's] quite impressive actually to see the way that people actually use their power. ... [they] write to the Minister, sign a letter ... [they] have got power and they know they have got status they can threaten to resign. They happen to be linked to national professional committees that give them information and they use that so that's a powerful influence in the school from those salaried medical officers.

(FU3_staff).

The involvement of clinicians in professional bodies and holding positions of power in the health system also assisted the school.

4.2.4 Summary

I needed to understand how social accountability was interpreted at Flinders University School of Medicine to appreciate the contextual factors that influence social accountability at that school. Social accountability was understood in different ways at FUSOM. Some participants had no or a limited understanding of social accountability whereas other respondents had complex and multilayered understandings. Many respondents saw that medical education programs helped define and strengthen socially accountable values and principles at FUSOM. The school's agenda and operations, including staff recruitment were also based on socially accountable values. Connected with their understanding of social accountability, participants saw that programs brought meaning to what social accountability looked like in action or on the ground. Other respondents had similar understandings to the Training for Health Equity Network (THEnet) in that social accountability was about the school and graduates "meeting community and health needs". Social accountability was also perceived as giving meaning to work, in that staff and clinicians had personal values of social

accountability. Some participants saw social accountability as part of a wider social movement that included organisations such as THEnet.

Participants cited both internal and external factors that had influenced social accountability at FUSOM. The main local workforce issue cited by respondents was the mal-distribution of doctors between rural and urban areas. Workforce shortages were deemed an influence on social accountability at FUSOM as the situation had led to creation of innovative programs such as the PRCC. Government policy that gave funding opportunities enabled these innovative programs to be enacted and also influenced the schools changing relationship with the health system. The government's focus on Indigenous health issues that were made more apparent by the FUSOM's move to the Northern Territory also supported socially accountable programs. Involvement with THEnet helped give legitimacy to local initiatives nationally and internationally and created a culture of learning and peer support across like-minded schools. The remit of Flinders University for innovation, difference and social justice gave a foundation to the acceptability of social accountability. Flinders University had a formal community engagement policy that supports partnerships and projects with communities. The school therefore operationalises social accountability as community engagement. The school has developed both formal and informal ways of engagement with the community. Participants conceptualised community engagement activities undertaken in communities of place. An important internal factor was a leader that had the values of social accountability influenced leadership and people who believed in socially accountable values enacted programs and enabled membership of THEnet.

4.3 Case Study Two: "From the taxi drivers to the talkback radio": James Cook University

"I've never met a new medical school with as much support as JCU had, from the taxi drivers through to talk back radio" (JCU5_staff)

Plate 4.2 James Cook University School of Medicine, Atherton, Queensland

4.3.1 Introduction: JCU School of Medicine

Traditional dancers weave through the eight graduates proudly being acknowledged by their family, teachers and fellow students at the ceremony for the Indigenous graduates of the Faculty of Medicine, Health and Molecular Sciences at James Cook University. Along with the billowing smoke of the ceremony, expectation is in the air; everyone is waiting for some special guests. The sound of the didgeridoo and clap sticks is interrupted by a distinctive cry; from the bush clad hills surrounding the university, and across Goondaloo Creek (meaning *emu country* in the Wulgurukaba language) soar six black cockatoos who settle in the sea-almond tree overlooking the ceremony. Everyone looks up and smiles, these special messengers have arrived as they do every year; as if they are ancestors giving their approval. The bush surroundings of the James Cook University School of Medicine (JCUSOM)[30] symbolise the mission of the school - to supply doctors for rural, remote and Indigenous communities. The school is based in Townsville, Queensland, Australia; the largest city in tropical Australia and home to 174,462 people (Australian Bureau of Statistics, 2013a). There are other regional campuses in Cairns, 348 kilometres north, Mackay, 389 kilometres south and centres in Thursday Island, 1,083 kilometres north, Mt Isa 904 kilometres west, Atherton, 355 kilometres north and Darwin, 2,504 kilometres north (see Figure 4.5: JCUSOM's region). Townsville has a significant Indigenous population, 6.1% per cent of the population are Aboriginal or Torres Strait Islander peoples, compared with 3.6% in Queensland and 2.5% in Australia (Australian Bureau of Statistics, 2013a). The university also has a special place in Indigenous land rights; which seems incongruous

[30] The official name is the College of Medicine and Dentistry. The discipline of dentistry is based in Cairns and for this case study I am focusing on the medical school.

as the institution is named after James Cook, the English explorer who 'discovered' Australia. The Eddie Koiki Mabo library recognises the achievements of Eddie Mabo, who was employed as a gardener at the university. He researched his native title case for Murray Island in the Torres Strait in the library; leading to the high court decision which overturned the idea of "terra nullius" (no man's land). The Mabo decision radically changed the existing concept of Indigenous land ownership in Australia.

The JCUSOM was established in 1999 with 60 students commencing in 2000 and aimed "to recruit, train and support northern Australian students to understand the health care needs of people living in northern Australia" (Hays et al., 2003, p. 15). Prior to the medical school there was experience in medical education through the North Queensland Clinical school, a joint initiative with the University of Queensland from 1993 to until the end of 2001 (Hays, 2001; Sen Gupta et al., 2002). The need for a medical school in this region had been identified since the 1973 Karmel report into medical education (Hays, 1999). There was "a 30 year campaign" to established the first new Australian medical school in 25 years, the first in the north of Australia and only the second outside of a state capital city (Hays et al., 2003, p. 15). While there was strong local support, there was opposition from other medical schools, especially from representatives of the University of Queensland (KPMG Health Care and Life Sciences, University of Queensland, Flinders University, & Australia. Department of Education, 1998) who viewed the school "an expensive and unnecessary precedent" (Buckley, Marley, Robinson, & Turnbull, 1998, p. n.p). Staff from the University of Queensland felt that a new school would duplicate initiatives in rural health that it had already established in the north, and was "unsound educationally and economically" (University of Queensland, 1996), as the school did not have "comprehensive teaching and research

support essential for producing high quality graduates" (University of Queensland, 1996).

Figure 4.5 James Cook University's region

Source: Google Maps (https://maps.google.com.au/maps?hl=en&tab=wl)

James Cook University School of Medicine drew on international experience and followed evidence-based practice to design the school "to meet the health needs and workforce needs of northern Australia" (Sen Gupta et al., 2002, p. 2). The values of "social justice, innovation and excellence" are espoused by the school (James Cook University. School of Medicine and Dentistry, 2013b, p. 4). Students from rural background are recruited as they are more likely to practice in rural areas (Hays, 1999). Communities are involved in this selection process and there are education outreach programs to rural high schools. Furthermore the curriculum includes rural issues and early exposure to rural practice (Hays, 1999, 2001; Hays et al., 2003; Sen Gupta et al., 2002; Sen Gupta, Murray, Hays, & Woolley, 2013; World Health Organization, 2009a). All JCUSOM students undertake at least 20 weeks of placement in a rural area across the course: 4 weeks in year 2; 8 weeks in year 4; and 8 weeks in year 6). The local health system, including the private hospital and general practitioners, has been

supportive since the school's establishment. It's a short 800 metre walk from the school to the Townsville Hospital, the main tertiary hospital outside the state capital, this facility was relocated from a city site to adjacent to the JCUSOM in 2001 (T. Sen Gupta, personal communication, 3 March 2014). A clinical school is located in this institution. In 2012 there were 995 students across the six year undergraduate degree and numbers across the years varied from 98 in year 6 to 192 in year 1. In 2013 there were 236 students in year one, indicating rapid growth of student intake (Medical Deans Australia and New Zealand Inc., 2012). There have been 18 Indigenous graduates or 3.1% of all graduates (from 2006 to 2012); however 16 Aboriginal and Torres Strait Islander students have also dropped out of the course (Woolley, 2013). Eighty-three per cent of graduates (2006 to 2012) grew up outside of major cities; 5 % of graduates had remote or very remote backgrounds, 20% were from inner regional areas and 57.2% from outer regional areas[31] (Woolley, 2013). Sixty five percent of JCUSOM graduates undertook their intern year in a non-metropolitan area (Sen Gupta, Woolley, Murray, Hays, & McCloskey, 2014)

4.3.2 Results

In this section I outline my fieldwork, including a description of participants. I outline respondents understanding of social accountability at James Cook University School of

[31] The ASGC (Australian Standard Geographical Classification) Remoteness Areas is based on road distance from a locality to the closest service centre in each of five classes of population size (Australian Institute of Health and Welfare, 2004). For example Townsville, Mackay, Darwin and Cairns are classified as outer regional areas. However, the relatively smaller centre of Toowoomba, is classified an inner regional area as it is closer to the state capital of Brisbane.. Mt Isa is a remote area while the Torres Strait shire, is a deemed a very remote area (Australian Institute of Health and Welfare, 2004).

Medicine. I then described the external and internal contextual factors that have influenced the social accountability of the school.

4.3.2.1 Fieldwork

Fieldwork commenced on 30 May 2012, and continued to the 10 July 2012. Although I am located at JCUSOM, I attempted to conduct most of my fieldwork within a two week period, similar to other cases. Eighteen interviews were conducted with 10 current or previous staff; 8 face to face and 2 via telephone. Four students, one community representative and 3 health sector representatives were interviewed face to face. Four of the staff members and one of the students were interviewed at a rural site. I interviewed two of the students and one of the health sector representatives in Cairns. One health sector representative was also a JCUSOM staff member.

4.3.2.2 Understanding of Social Accountability at JCUSOM

In order to understand social accountability at JCUSOM, I asked participants about their understanding of social accountability in general and at the school. Six participants had comprehensive understandings of social accountability, aligned with The Training for Health Equity Network definition and how this applied at JCUSOM. The main theme apparent in interviews was that social accountability was about training a workforce to meet community health needs and improve outcomes. Another theme was how JCUSOM "walks the talk" of social accountability in everyday practice. How social accountability was about being accountable to the community, personally and as an institution, was another perspective. Most participants had multi-dimensional perspectives focusing, integrating all or two of these themes. Only one participant had an unclear or limited understanding of social accountability. Furthermore, another

participant interpreted social accountability to mean community accountability and thought this was a confusing term that did not encompass the mission of the school.

4.3.2.2.1 "The school's raison d'être": Training workforce to meet community health needs and improve outcomes

The schools focus on rural, remote, Indigenous and tropical health was deemed as part of its "mission statement" and was connected with 14 participants' understanding of social accountability as training a workforce to meet community health needs and improve outcomes. Four participants made a link between providing appropriate workforce with community health outcomes. One participant (who had been involved in THEnet) had an integrated understanding of social accountability to mean meeting workforce, health and health system needs:

> *Essentially it's training a health workforce a medical workforce that has the knowledge, attitudes and skills to meet the priority health needs of underserved populations in the region so that means that the medical school really needs to be very embedded in the community and have a very clear understanding of what it's reference population is and consider its role as broader than just producing doctors, it also needs to be involved in strengthening health systems.*
>
> (JCU7_staff).

Other participants discussed how the school was socially accountable as it was training the future workforce for rural and remote locations Workforce issues were seen as the reason for the establishment of the school and a key indicator of social accountability:

> *Well, I mean, its [JCU's] 'raison d'être' was to address the workforce problem in northern Australia. So it's pretty hard to say that it's not socially accountable so... I think it is its reason for being.*
>
> (JCU9_health).

The emphasis on providing a regional medical workforce complemented JCUSOM's focus on rural, remote, tropical and Indigenous health. Participants discussed "*...providing a fit for purpose medical workforce for the north with the emphasis on tropical, Indigenous and underserved*" (JCU6_staff) and addressing the "*mal-distribution*" (JCU9_health) of the medical workforce. Beyond the local workforce needs, one participant saw the benefit of students returning to urban areas where they could influence policy as they would understand regional health needs (JCU17_health). These opinions aligned with the vision of the medical school as outlined in the school's submission to the Australian accreditation body: "…programs will be responsive to the health needs of communities of northern Australia" (Porter, 1998).

While two participants asserted that the school was aiming to meet workforce needs, they also saw social accountability as meeting the needs of the taxpayer or "*the population who pays for the medical school"* (JCU5_former staff) like education was a social good:

> *And so social accountability to me is that the taxpayer is funding the university places, so the social accountability is that the university will endeavour to do everything they can to meet the mission statement to provide doctors back in the bush.*
>
> (JCU11_staff).

4.3.2.2.2 "Walks the walk and talks the talk": Social accountability in practice

When asked to reflect on social accountability at JCUSOM, thirteen respondents stated that overall the way the school operated demonstrated its social accountability. One staff member joined the staff of JCU from another location because it "walks the walk and talks the talk" (JCU13_staff), indicating that the school does not just promote social accountability as concept but translated the theory into practice. Two respondents in particular had a comprehensive understanding of social accountability. They outlined examples of school activities that aligned with social accountability, including governance, service and allocation of resources. These participants thought that part of the ability of the school to be socially accountable involved engaging in activities conducted in partnership with the community and the health sector:

> *… So it's a broad front of activity that can be progressed together if you have genuine partnerships with community grounded health care providers and health care organisations.*
>
> (JCU6_staff).

Another participant also believed that partnerships with the community were a key feature of social accountability from the school's inauguration, this was not only about "*trying to determine what the needs of the community were*" but getting the community involved "*as much as possible in how to select, teach and assess and mentor those people"* (JCU5_former staff).

Respondents understood that social accountability was reflected in the way that rural, remote, Indigenous and tropical health is prioritised in the curriculum and the school's clinical placements. Furthermore, there is selection and educational support for

Indigenous and rural students, groups traditionally under-represented at medical school. While most participants focused on teaching, four staff mentioned research and three discussed health services or partnerships as encompassing social accountability practices. As well as responding to community needs discussed above, one participant included social justice, personal beliefs and an anti-racist stance in their understanding of social accountability. This participant thought that the school was

> *…explicit about our support for social justice, against racism, we explore that with students, we explore the issue of doing the right thing quite a lot I think and I think possibly we are the only place that really explores in any depth what racism is and the impact it has on people.*
>
> (JCU3_staff).

While most participants thought that JCUSOM was "doing well" in terms of achieving social accountability, two thought that the school could do more in terms of partnerships with the community, particularly with Indigenous communities and direct service delivery to these communities. Another staff member commented that references to social accountability might not be explicit in the clinical years, particularly in terms of part time clinical teaching staff being about to work appropriately with Indigenous people. One staff member questioned whether health outcomes were the result of JCUSOM graduates working in the region:

> *I think one of the things I'm really worried about, is they talk the talk, I don't know if they walk the walk. I don't know if I've seen anything yet that makes me think that we've done it yet, but then it's early days. I'd like to think that we're collecting the data that shows that the health outcomes have improved.*

(JCU10_staff).

Improving health outcomes is challenging as this is a long term process, dependent on sectors outside of medical education. This staff member was questioning whether JCUSOM could demonstrate this alignment through research.

4.3.2.2.3 Being accountable at the personal or institutional level

Social accountability as "being accountable" to the community at a personal or institutional level was emphasised by five participants. The three students described being accountable or "*a good servant*" (JCU8_student) at a personal or individual level. "Accountable" meant "*giving back to your community and acting as a functional, key player of your community"* (JCU8_student). This accountability extended into other areas, beyond medical school:

> *I think when I hear social accountability, I break it down into social and accountability and I like the accountability bit because I think every individual needs to be accountable for what he or she has chosen to do. Just because you are medical doesn't mean I'm only accountable medically, when I work I need to be accountable in other ways. We're social beings and we need to be accountable in all circumstances.*
>
> (JCU2_Student).

The community representative saw a socially accountable medical school as *"a medical school that was accountable to the population that it served"* (JCU18_community) and understood this in terms of meeting community need. A staff member interpreted social accountability to be about being "*accountable to Indigenous communities ... where we send the students*" (JCU13_staff).

4.3.2.2.4 "A confusing term that does not mean much to me": Social accountability as an inadequate reflection of JCUSOM's mission

One staff member believed that social accountability was a "*confusing term"* (JCU1_staff). This participant mentioned that the focus should be on social justice, rather than on community accountability. Social Justice is one of the values of the JCUSOM. This respondent translated social accountability to mean "community accountability" and commented that social justice rather than community accountability would address important issues. They also felt that "community accountability" did not capture what JCUSOM was achieving. Social accountability would lose meaning in different political systems such as dictatorships as in these systems there may be universal healthcare but no social justice:

> *… we want [our graduates] to be progressive we want them to be involved in social change in some ways; I think there are philosophical commitments beyond being community accountable and community accountable doesn't address the issue of how do you deal with local tyranny or distant autocracy…so that's it's not enough for me.*
>
> (JCU1_staff).

It is important to note that this participant was the only respondent in all the cases that challenged the term social accountability. This difference might indicate that the term may not be universally understood and appreciated and that all schools need to debate and develop their own understandings of socially accountable medical education.

4.3.3 Contextual factors: What has influenced social accountability at James Cook University School of Medicine?

As outlined in the FUSOM case, contextual factors were difficult for participants to understand and to articulate. I therefore asked what they thought had "influenced" the school's social accountability and probed for external and internal factors. I also asked about the reasons why the school was established. I then asked questions around the three contextual factors. There were five contextual factors that had influenced social accountability at JCUSOM. External factors included the difference of the geographic place and the unique needs of the population of the north of Australia (connected with the participants' understanding of community); the local workforce situation and the impact of government policy; and community support for the school and the university. An internal contextual factor was the shared values and experience of people, including staff and leaders in both the school and the health sector.

4.3.3.1 External contextual factors

There were four external contextual factors that influenced social accountability at JCUSOM: the community and health needs of a community of place ('the north'); the workforce needs of the region and government policy; community support for JCUSOM; and James Cook University as the "university of the north". Some participants had an integrated understanding that the lack of workforce was specific to the unique needs of "the north" as a population/community and a place (the north/the tropics). Changes in government policies that acknowledged these unique needs enabled the establishment of the school.

4.3.3.1.1 "The needs of the north are different": The influence of the community as population and place

The location and population of the school influenced the development of a different medical school that challenged traditional orthodoxies in medical education and was socially accountable. "Meeting the needs of the population" and the location of "the north" was a clear contextual influence for 16 of the 18 participants. Furthermore, when asked who was JCUSOM's community, eight participants discussed "the north" as the school's community identifying "JCU's patch" from Sarina to the Papua New Guinean border in the Torres Strait Islands and west to the Queensland border; this region's population is approximately 1 million. Five participants also perceived rural, remote, Indigenous and tropical communities as the school's focus. The idea of a "school for the north" and the nature of 'place' in this school is intertwined with health needs. The school location in a region with a population of great health disparities means staff and students have daily exposure to these needs:

> *You see this tremendous disadvantage which is really like incomprehensible unless you see it yourself.*
>
> (JCU15_student).

Another understanding of place and population was the idea of the difference of the north, separation from the rest of Australia and sense of being neglected or ignored. In comparison with South Australia (where Flinders is located), Queensland is a decentralised state, with distinct environmental and cultural differences between the north and densely populated south east corner where the state capital, Brisbane is located. Local folklore surrounds "the Brisbane line", that during WWII Australia would be defended south from Brisbane and the north of country would be sacrificed to

the enemy (Schultz, 2005). This idea of being abandoned and neglected by the south remains:

> *There is a strong sense of [the south] being a long way from the north; a lot of people in north Queensland don't feel that Brisbane is much interested.*
>
> (JCU5_former staff).

Another view connected with population and place is resistance to the accepted view that medical education could only take place in tertiary hospitals or major metropolitan centres. Opponents to JCUSOM argued that medical training could not occur in regional and rural centres would not be *"up to scratch"* (JCU3_staff). Respondents appreciated that "the north's" unique health needs and sense of place had influenced the development of "… *a different kind of medical school for a different kind of health professional [that] north Queensland needed"* (JCU5_former staff) and *"to change the service delivery of health in regional and rural Australia.* (JCU17_health). Fourteen participants discussed the "difference of JCU" and the need for "*our own northern Australia medical school*" (JCU17_health) that was "*separate from the [University of Queensland]*" (JCU10_staff) There was also a sense of "*regional fairness*" (JCU3_staff) in having a prestigious course located in northern Queensland.

One participant saw need manifested in "*an Academic Larrikinism*" (JCU12_staff); to develop "our own" school:

> *... the sort of the cultural thing of being a frontier. The sense of isolation from the rest of Australia and also the sort of the larrikinism, we can do it better. An academic larrikinism ... and we don't have to follow the railway line, we take a different path and JCU is doing that.*
>
> (JCU12_staff).

4.3.3.1.2 "A medical workforce for the north": The reason for the establishment of JCUSOM.

Australian medical workforce issues include the mal-distribution of doctors with fewer serving rural, remote and regional areas and the increasing drive to subspecialisation (Kearon, 2012). Sixteen of the eighteen participants mentioned workforce as a contextual factor that influenced social accountability. The general understanding of medical workforce in northern Queensland was that although some rural and specialty positions were fulfilled by International Medical Graduates (IMGs) and locums, the workforce situation in the region had significantly improved in recent years. The need for a workforce had influence the school to produce graduates able to work in the region. Innovative partnerships had developed to address these needs, including training beyond graduation.

There was a great need for a medical workforce to address health issues of the population, including Indigenous and rural peoples and very clear link between the workforce needs of northern Australia and the establishment of JCUSOM. The school's mission was to address the medical workforce recruitment and retention issues of the

region (Sen Gupta et al., 2002). The workforce needs of north Queensland had influenced the school's establishment:

> *I think that workforce is enormous here, it's always been a region that has struggled to attract and retain all sorts of health professionals… so that's probably the single biggest one and really that was the biggest driving force for the establishment of the school.*
>
> (JCU7_staff).

Hays (2002) argues that the following workforce-related developments influenced JCUSOM's establishment: "demonstrated, continuing regional workforce needs in all medical disciplines and specialties and plans by Queensland Health to provide more advanced health care services for the growing population in the region" (p. S2). This was reiterated by participants:

> *I think predominant factor [in establishing the school] was workforce, so we weren't producing enough workforce for northern Queensland, northern Australia, we were always a net importer [of health professionals]*.
>
> JCU4_staff).

Producing a workforce that is work ready and an appropriate workforce

The workforce situation and the need for rural medical professionals influenced most aspects of school operations including rural placements, selection and the curriculum: (Hays, 2001)Hays evaluates that another key influence of JCUSOM's development was the "realisation that the existing medical schools were not necessarily producing graduates that understood the health needs of rural/remote and Indigenous peoples"

(Hays, 2001, p. S2). To ensure that graduates would be capable of working in environments with workforce shortages, the JCUSOM course was longer (six year undergraduate) with an emphasis on the northern context and population. This was also for equity reasons; to make the course accessible for low-income school leavers:

> *One of the key things that unite rural, remote, Indigenous, tropical is workforce shortage; which generally means that the clinical skills set has to be broader.*
>
> (JCU1_staff).

A work ready and appropriate workforce for areas of need is a key tenet of social accountability:

> *[I] think right from the inception the school was about addressing that profound gap in service delivery in regional areas, so it's had a real focus on not being a medical school for medical school's sake, but being a medical school for producing doctors who will work in regional communities and be able to work anywhere else in the world but who will be work ready.*
>
> (JCU16_health).

Therefore curriculum and assessment was developed with rural and Indigenous communities and professionals and staff have rural or remote experience (Sen Gupta, Murray, et al., 2013). All students undertook an eight-week rural " internship" in their final year of study, and were integrated into a rural team similar to junior doctors (Sen Gupta, Murray, McDonell, Murphy, & Underhill, 2008).

Innovative workforce initiatives

The workforce situation led to innovative partnerships between the health sector and the medical school, beyond undergraduate education. Standard postgraduate training models focused on specialty training and further sub-specialisation, which is counter to the workforce required in northern Australia. There was a need for "*generalist specialties"* (JCU5_former staff), including *"general physicians, general surgeons, rural generalists, general practitioners with public health skills, Indigenous health skills and procedural skills"* (JCU7_staff). Programs included the Northern Clinical Training Network (NCTN) developed in 2008 as a partnership between JCUSOM, the state health department (Queensland Health), community and private sector stakeholders (Larkins et al., 2011; Northern Clinical Training Network, 2012, 2013). This initiative was clearly aligned with social accountability, aiming for integrated training and education pipelines and infrastructure to "…help develop a high quality, medical workforce for northern Australia which is responsive to regional health needs" (Northern Clinical Training Network, 2013, p. 2). This would alleviate mal-distribution caused by the unavailability of specialty training in regional areas. While students undertook their early postgraduate years in the north there are "breaks in the pipeline" of vocational training and they had to move outside the region to complete speciality training (Northern Clinical Training Network, 2013). The school had also worked with Queensland Health in conceptualising a training program for Rural Generalists, medical practitioners trained for rural and remote practice with specialised skills such as emergency medicine, obstetrics or anaesthesia. (Larkins et al., 2011; Sen Gupta, Manahan, Lennox, & Taylor, 2013).

4.3.3.1.3 "It's become government policy to fill those areas of need and to increase rural retention": Government Policy on medical education and rural health

Another contextual factor mentioned by three participants was government policy on medical education and rural health education. Similar to Flinders University School of Medicine (FUSOM), reforms to government policy in medical education sector and significantly, on medical student numbers, in the 1990s allowed the school be established. While not directly singled out as a contextual factor, three participants who were involved in the foundation of JCUSOM, recounted how the change in this policy was a significant turning point for the establishment of the school:

> *[Senior Staff] came to the meeting [of committee of those establishing the JCUSOM] and he said 'Well the Federal government now has a policy that we are in doctor undersupply' and we all cheered and he said well now it's their official policy we were right and now we can really go for it.*
>
> (JCU3_staff).

Also similar to FUSOM, policies surrounding rural experience for medical students supported JCUSOM's rural focus. From the mid-1990s medical schools were encouraged to recruit more students with rural backgrounds (Hays et al., 2003). The push for these policies was influenced by doctors, and included initiatives such as the establishment of the Rural Doctors' Association for Queensland in 1989, and the national group in the 1990s. The first rural health conference was held in 1991. Rural postgraduate training was being established, as well as the rural incentives program:

So there was a lot of interest in rural incentives that was very grassroots [and] had come from rural communities, rural doctors movements, rural politicians; therefore attracting rural students [was one of the initiatives].

(JCU4_staff).

National policies ensured that JCUSOM had funding for these rural initiatives to continue:

It's become government policy to fill those areas of need and to increase rural retention. And because of that there's good funding.

(JCU14_student)

4.3.3.1.4 "From the taxi drivers through to talk back radio": Community support for JCUSOM and JCU

While the population and place of "the north" was seen as the community of the school, a contextual factor was the support of the community. Communities of "the north" identify JCUSOM as "their" school and it was evident that there was wide community support for the establishment of a medical school in Townsville. This had led to several initiatives; including partnerships with local councils and community volunteers that have influenced social accountability at the school.

"People recognise JCU as their uni": Initial community support to establish the school and continued support of the school

The initial community support and continued community ownership and pride of JCUSOM was a contextual factor that influenced the establishment and community northern focus of the school. The JCUSOM website notes that despite the recommendation for a medical school in 1973, "funding and political commitment did

not materialise. Undeterred, communities of north continued their lobbying efforts" (James Cook University School of Medicine and Dentistry, 2013). Local north Queenslanders, including community members and politicians, recognized the need for local health workforce. This was also in the face of "southern" opposition of the school. The north Queensland community rallied for the establishment of the school and according to the Dean of JCUSOM: "We are a medical school that arose from community struggle…" (Neusy & Pálsdóttir, 2008, p. 22). Seven participants mentioned this support and the importance of community lobbying for the establishment of the school and that "*community engagement was strong*" (JCU5_former staff) through the media. Community support included local political support at the state and Federal level; discussed by four respondents with the establishment of the school. Local people were also aware of the need for local health services:

> *And you would not find another town in Australia where you could actually introduce another medical school without local opposition; with that passion. Because I think the southern[s] think that they actually are solving that problem, but because they don't actually on a day to day basis see the lack of support or services, they don't understand it.*
>
> (JCU17_health).

Four participants mentioned the support of local taxi drivers as a symbol for the prevalence of local community support and the ownership and community feeling towards the university and the school:

> *I've never met a new medical school with as much support as JCU had, from the taxi drivers through to talk back radio [there was] tremendous community support.*
>
> (JCU5_former staff).

Respondents also acknowledged the continued ownership and pride and that "*people recognise JCU as their uni"* (JCU2_student). As a result of the initial opposition for the school and the battle for its establishment: "*people are quite possessive and protective of [JCU]"* (JCU2_student). James Cook University was the only university in the region and therefore the community had "*a stronger sense of ownership of the school than they might in other places… people do see it as Townsville's medical school in Townsville*" (JCU3_staff). Community members may have had a personal connection as alumni or their children:

> *People are very proud of our [JCU] they are proud, [one woman I saw on placement was] so proud to say that her kids were at the university of the north.*
>
> (JCU2_student).

The school demonstrated that a "prestigious course" like medicine could be attainable to "ordinary people" like the children of taxi drivers. There was also a strong local connection with the school:

> *I don't see a big town/gown divide here I think people do feel connected. I think the fact, every time you jump in a cab or something the cab driver knows someone doing medicine. But in fact [the medical course] is not that elite, most people know someone doing medicine, there's high proportion of*

Indigenous kids, there's high proportion of first in the family studying medicine or health and those sort of things.

(JCU4_staff).

The contribution of the institution to the local economy and region was also valued by the community.

Councils providing student accommodation

James Cook University School of Medicine has a unique partnership with local councils (local level of government) considered by six participants. Local communities provided accommodation and in return students are placed in the rural area if there are clinical teachers and appropriate caseloads. Student accommodation was identified as one leg of the "three legged stool" (the other two are clinical teachers and an appropriate caseload) for successful student placements in rural areas (Sen Gupta et al., 2009, p. 106). Placements in underserved areas are an essential component of socially accountable medical education. Accommodation was important for sustaining student placements and a symbolic way for the local government to contribute to a future medical workforce:

Everything we provide has a community partnership basis to it and we set out setting up here with that in mind. And that's worked really well for us with councils providing student accommodation.

(JCU11_staff).

In the small rural centres of Atherton and Mareeba the local councils owned and maintained student accommodation (Sen Gupta et al., 2009).

Other towns with accommodation partnerships were Cooktown and Innisfail in far north Queensland (James Cook University. School of Medicine and Dentistry, 2013c). In Innisfail the council provided the land and maintained the accommodation, however the accommodation was built from a Department of Health and Ageing grant (Cassowary Coast Regional Council, 2012). Providing accommodation was seen as beneficial for councils in order to have a future health workforce. A media release from a local regional council acknowledged that *"By living and studying here, students will become part of our communities, greatly increasing the chance of them coming back and living here as qualified doctors, nurses, dentists and allied health workers"* (Cassowary Coast Regional Council, 2012, p. n.p). In eight communities students were housed in Queensland Health (QH) accommodation and in one community there was a joint QH and JCUSOM partnership around accommodation (James Cook University. School of Medicine and Dentistry, 2013c), however this contribution was not discussed by respondents.

"It's massive really": Community volunteer involved in selection and education.

One tangible way that the community influenced the social accountability of the school and demonstrated its support was through the volunteer programs, mentioned by five respondents. Community members acted as simulated patients for teaching in the first three years. They also took part in examinations, the selection of students and could give their bodies as part of a bequest program. Voluntary opportunities were well advertised on the JCUSOM website and a dedicated staff member administrated the program. The community representative saw the community as "*whoever they come in contact with*" but stressed the importance of the volunteers (who act as patients) as "*ambassadors*" for the community (JCU18_community).

According to the volunteer community representative, the success of the program and the retention of volunteers was due to the feeling of being listened to:

> *Well yes, you can have input in the session as they happen or you can always have input to the various tutors or staff on the course, they are very open to feedback.*
>
> (JCU18_community).

When asked why they volunteered, the community representative said that volunteering was a way of contributing to their own community:

> *I think in general, it's a desire to give back to the community, and a feeling that it's a worthwhile thing for the students to have real people to work on. And I think people then enjoy the interaction with the students*
>
> (JCU18_community).

This community involvement influenced student learning and clinical teaching and gave students an appreciation for working in real clinical situations.

Another way that community members were directly involved with the school mentioned by three participants is through the student selection process. There was a community member on every panel to select their future students. This representative participated equally in interviewing and deciding on rating applicants. The Indigenous community was also involved in the selection of Indigenous students, a separate process to the mainstream students. Selection of students meant that community members could have direct involvement with who became a medical student; a staff member outlined how community representation in the selection process "*counts for a lot*" (JCU1_staff). The community had responded well to this initiative and took their roles seriously:

Well its massive already, the interview system, you do get quite a lot of interest, you certainly get the feeling in the community that they have been involved and we use the information pretty seriously so it counts for a lot

(JCU1_staff).

Communities had an equal say in the selection process and this contrasts with other Australian medical schools that did not undertake this process anymore. For example the University of Queensland removed the interview as part of the selection process in 2008, arguing that many students were 'coached'; disadvantaging those from lower socio-economic backgrounds (M. Casey, personal communication, 1 March 2014).

"Embracing and enjoying the community": Students placements in rural communities

Student placements were an important way that students could interact with rural communities. The idea that students were attached to "a community" rather than a doctor was an early innovation of the school:

We also pioneered the concept of attaching students not to doctors in rural communities but to rural communities. So there were things like, we arranged that when students went to see Dr X in a rural community that they always spent time in the rural community and had contact outside of the practice".

(JCU5_former staff).

Seven participants mentioned student placements as an example of community influence on social accountability. Rural communities could be connected to and influence JCUSOM through these students. As part of their four week rural placement in second year students were encouraged to undertake community activities, such as visiting a local high school to talk with year 10 and 12 students about health careers; as well as participating in recreational activities (James Cook University. School of Medicine and Dentistry, 2012). An interesting requirement for assessment was that students had to mention a community person who has assisted them during their placement. Reflecting on their involvement in the social side of community life was part of a learning portfolio that formed assessment for JCUSOM students undertaking rural internships (Sen Gupta et al., 2008). In Atherton local service clubs (such as Rotary and Lions) had been involved in welcoming students to the community in past years at BBQs but with increased numbers of students, there had been some difficulty to sustain this involvement.

Participants, particularly students, discussed formal and informal and 'forced' interaction versus natural interaction of living in the community. There was a differentiation between "natural interaction" of being part of the community and the "forced interaction" of having to document their relationships. A sixth year student reported on these requirements but felt that the school should not be too prescriptive.

> *I think people should have a degree of freedom to enjoy the community in the way that suits them. (JCU14_student).*

Although rural placements were similar to the FUSOM rural program there was less formal community contact and no paid positions for community members. Staff had more informal roles to assist students get to know the community. This was in contrast

with the John Flynn rural scholarship program (a national program where students from different universities are supported through a government initiative to go on a rural placement), and a formal community mentor is assigned. In Atherton a staff member who is the John Flynn mentor fulfilled this role as they could not find a community volunteer. A staff member also suggested that perhaps this form of community engagement needed to be formalized for it to work with larger numbers of students. A formal program could demonstrate to students how to become part of the community:

> *Because all the rural people, they love to have medical students in their area and they do, they really love it. [Students] should have something leading up telling them that this is how you are going to embrace the community.*
>
> (JCU11_staff).

"Because we're part of this community it happens": Tokenism or real engagement: Community influences on decision making

Community involvement in decision making processes was a key element of socially accountable medical schools. I asked directly about a community advisory committee as this was an important way that community members engaged at FUSOM. I was also aware that the rural clinical school had a community committee. While it was a requirement of government funding to have a formal advisory council for the Rural Clinical School there was recognition that advisory boards "*can be a bit token*" (JCU4_staff) rather than provide real engagement. Six respondents discussed this issue, mainly in the context of rural clinical school in Atherton. Two staff reported that advisory committees at rural clinical schools were difficult to maintain, although early engagement had resulted in partnerships with councils around accommodation.

The community could contribute to the school because of personal relationships with staff in rural areas. Two staff members at rural clinical schools had a sense of being part of the community and saw the value of having local staff who came from rural communities. The community and the school were therefore intertwined. This was similar to rural staff perspectives at FUSOM. Distributed campuses ensured that local JCUSOM staff had contact with the local community and health services. Staff at these locations were empowered to use their local connections to get things done as part of a decentralised power structure:

> *It's their ability to ring up the council or make contact with this or that specialist, whatever; they're the things that really connect us, that's really where the engagement really happens. Our conduit and intelligence in what the priorities are comes very close to the coalface and we don't have a very centralist sort of command and control structure, we believe in devolution and nodes and sort of spreading out from the frontline.*
>
> (JCU6_staff).

A staff member based in a rural location agreed that personal relationships were important:

> *I wouldn't say that we provide them with formalised reports, but we do because we're part of this community it happens and we all do meet regularly.*
>
> (JCU10_staff).

One of these participants saw that more formal participation on committees could be a way of furthering social accountability at JCUSOM:

I would like to see the community representative and consumer representatives, not just a bland consumer representative but you know…elders from the community, those outspoken community members interacting with the school. Not just interacting with the school but being on committees within the school.

(JCU12_staff).

4.3.3.2 Internal contextual factors

Similar to Flinders University School of Medicine the shared values and experience of staff and leaders, including health sector staff was an internal contextual influence. Rather than an individual leader, several individuals across the community, health and education sector were distinguished as important for the establishment of JCUSOM and the continued focused on social accountability.

4.3.3.2.1 "Fire in the belly": Shared values and experience of staff and leaders

The staff and leaders were seen to share values and work and personal experiences; noted as influencing social accountability by 12 respondents. Many of the founders and current staff had work experience in rural, remote and Indigenous health and therefore comprehended the injustice of health and workforce needs. This recognition was linked with the contextual factor of "the health needs of the north". Like Flinders University School of Medicine (FUSOM), the 'passion' and drive to make a difference of the leaders and founders of the school was considered by 3 participants:

Look at the people who set up James Cook University and I think that they were, for a start they were people who went to rural and remote communities with a real sense of service and struggled with many problems

and they're not just people who look at the problem in front of their nose, they take a step back and think. That sort of controlled rage really, is a drive to change things. Because it takes a lot of effort to change the way things are done, so when I say controlled rage I suppose you know the fire in the belly.

(JCU12_staff).

The work experience of leaders and staff in the school and the health system also influenced their alignment with social accountability. The school was dominated by health care professionals who upheld a philosophy of primary health care, aligned with social accountability.

Our whole philosophy, attitude and professionalism is based around the whole community, the whole person, … the human being in front of you [and that] psycho, social, cultural model.

(JCU10_staff).

Health sector leaders also understood that social accountability in medical education encompassed inter-sectorial collaboration. The education and health system must work together to plan the future workforce requirements. For example, one respondent outlined a joint JCUSOM and Queensland Health project to design and plan for workforce needs alongside health system needs. These health sector representatives had a "working" or practical understanding of this partnerships model rather than knowledge of the theory of partnerships in medical education (such as the conceptual model of Towards Unity for Health).

The shared social values of leaders and staff were discussed, similar to the theme at FUSOM of "bringing meaning to work". Staff had "*the richness of working for a cause and applying their energies and creativity to taking agendas forwards for stuff that feels like it's worthwhile, that has meaning.* (JCU6_staff). Recruitment had been "*around people who believed"* (JCU5_former staff) to develop "*[the school's] values in a leadership with a critical mass of people who came together around common values"* (JCU6_staff). *Values-driven leadership* (JCU7_staff) across the university in important positions also influenced the school, in that staff and students are attracted to the school. This has strengthened the school's focus of meeting the needs of underserved communities.

Similar to Flinders University School of Medicine (FUSOM), there was recognition by one participant that a change to leadership could influence the mission and focus of the school as new leaders may not be as in tune with the original mission of the school and may focus on other areas such as biomedical research. This respondent felt that this had been the experience of other innovative Australian schools. This indicates the importance of the alignment of the leader with a socially accountable mission.

4.3.4 Summary

Social Accountability at JCUSOM was clearly understood by most participants in terms of activities and purpose to meet workforce and/or health and community needs, aligning with THEnet definition of social accountability. There were two additional insights; social accountability was also deemed be about how the operation of the school leads to addressing workforce and community needs; as well as "being accountable" to the community on a personal or organisational level. Only one student participant had a limited understanding of social accountability. Another participant did

not agree with the term as they felt that “community accountability” did not capture what JCUSOM was achieving.

Influential contextual factors were clearly connected with participants’ understandings of social accountability. Social accountability had been conceptualised as addressing health and workforce needs through an appropriate medical school model. Therefore the main influences were the health needs of “the north” as a place and population or community, including the needs of rural, remote, Indigenous and tropical health. The clear evidence of the need for a medical workforce in northern Australia influenced not only the establishment of the JCUSOM but the education and research programs of the school. There was broad community support for the idea of a medical school in northern Australia, connected with recognition of the need for a regional school and links with JCU as the region’s university. “Community support of the medical school” was a major theme from these discussions. This support had led to multiple relationships with communities, including volunteers who influenced student learning and recruitment, councils that supported student accommodation, rural communities’ involvement in student learning. The workforce situation has led to a clear articulation of the type of graduate required to serve the north and the type of education program that would produce this workforce. Furthermore, the workforce profile has fostered creative partnerships with the health sector in training, education and professional pathways. A change in government policy that supported the development of the school as well as rural medical education policies are another external contextual factor. The internal influence of leaders and people who held the values of addressing health needs due to their own experiences of lack of health services were also important.

Chapter 5 Philippines

5.1 The Filipino health care system and medical education system

This section gives a brief introduction to the Filipino Health Care System and Filipino Medical Education System. I discuss two issues in depth: the decentralization of the health system and the migration of health workers to more financially resourced countries or, colloquially, the "brain drain".

5.1.1 The demographic and health profile of the Philippines

The Philippines is a diverse country with 92.3 million people from 180 ethnic groups who reside on 7,107 islands (World Health Organization & Philippines. Department of Health, 2012). The gross national product per person in 2011 was USD$2,370 (World Health Organization & Philippines. Department of Health, 2012). However, there is inequity in the distribution of income and resources. While some Filipinos enjoy health and wealth equal to those in more financially resourced countries, the majority live in dire poverty. Half the population reside in metropolitan areas, 44% in slums and 26% (2009) live below the poverty line (World Health Organization & Philippines. Department of Health, 2012) In 2011 the average age expectancy at birth was 68.7 years (World Health Organization & Philippines. Department of Health, 2012) and there was an annual population growth rate of 1.90% (Philippine Statistics Authority, 2014). In 2011 the maternal mortality rate was 221 per 100,000 live births and the infant mortality rate 22 per 1,000 live births (World Health Organization & Philippines. Department of Health, 2012).

Similar to other less financially resourced countries the population's health is impacted by both communicable and non-communicable diseases. The leading causes of death

include non-communicable diseases, including heart disease and cerebrovascular disease (Philippine Statistics Authority, 2014) and communicable diseases including pneumonia and tuberculosis (World Health Organization & Philippines. Department of Health, 2012). The top five causes of morbidity include acute respiratory infection, and pneumonia, bronchitis, hypertension and acute watery diarrhoea (World Health Organization & Philippines. Department of Health, 2012). Vectorborne diseases, including malaria, dengue and filariasis also remain a threat (World Health Organization, 2011b). Non-communicable diseases are linked with lifestyle risk factors: 28.3% of adults smoke, 20% were overweight and 60.5% were physically inactive (World Health Organization, 2011b). The country's disparate demographic and health profile means that health service delivery is complex.

Figure 5.1 The Philippines

(https://maps.google.com.au/maps?hl=en&tab=wl)

5.1.2 The organisation of the Filipino health care system

The Filipino health system is decentralised from the central government to barangay (village), municipality and provincial authorities (World Health Organization & Philippines. Department of Health, 2012). The health system was devolved through the Local Government Code of 1991 (Grundy, 2001; Grundy, Healy, Gorgolon, & Sandig, 2003). The government is committed to achieving the Millennium Development Goals (MDGs), *Kalusugan Pangkalahatan (KP)* or universal health care and health care reform through the *Aquino Health Agenda: Universal Health Care for All Filipinos* (World Health Organization & Philippines. Department of Health, 2012). The National Department of Health (DOH) develops policies and programs and monitors standards in health care. There are three national providers at the national, provincial and local level. At the national government level there are Department of Health and Department of National Defence hospitals. The 81 provincial governments provide hospitals, blood banks and health offices. At the local level DOH Centres for Health and Development (CHDs) implement national programs in Local Government Units (LGUs) in the 17 regions (World Health Organization, 2011b; World Health Organization & Philippines. Department of Health, 2012). These include rural health units (RHUs), city health centres and barangay health stations.

Local Government units provide health promotion, primary, secondary and long-term care (World Health Organization & Philippines. Department of Health, 2012). Primary care services are delivered at barangay health stations (BHS), health centres and at hospitals. Each BHS has a midwife and each RHU has a doctor (or Municipal Health Officer), a nurse and midwives (World Health Organization, 2011b). Municipal Health Officers (MHOs) work at the local government level and are accountable to the locally elected government official (the mayor), not the Department of Health. The strength of

this devolution is the demonstration of the philosophy of Primary Health Care in action. In theory, devolution means that workforce, health planning and spending is prioritised according to local needs and higher level health workers, such as doctors, are close to the community (Ramiro et al., 2001). It was believed that decentralisation would improve the responsiveness of health professionals to local health care needs and the improved efficiency and effectiveness of the health system (Grundy et al., 2003). However, there are many issues with non-health managers (mayors) having responsibility for health services. These are further discussed in the results chapters.

There is "dual" service provision and the private sector is a significant part of the Filipino health care system, covering all health care levels (World Health Organization, 2011b; World Health Organization & Philippines. Department of Health, 2012). As a user-pays system there is inequity in access. The poor use the public system; while 30% of the population use fee-for-service payments (World Health Organization & Philippines. Department of Health, 2012). Most private services are based in urban areas and include pharmacies, family doctor practices, hospitals and maternity centres (World Health Organization, 2011b).

5.1.3 The financing of the Filipino health care system

As public sector spending decreases, Filipinos have had to pay for their own health care. "Inequity in health status and access to services is the single most important health problem in the Philippines" (World Health Organization & Philippines. Department of Health, 2012, p. 8). In 2009, only 3.8% of the GDP was spent on health (World Health Organization & Philippines. Department of Health, 2012). Both public and private services are fee for service. PhilHealth is the public insurance scheme introduced under the National Health Insurance Act of 1995, and this sets service rates. Providers receive

reimbursements directly. PhilHealth reportedly covers 74 million or 82% of the population in 2011 (World Health Organization & Philippines. Department of Health, 2012). Yet, the 2008 Demographic Household survey indicated that the PhilHealth coverage rate was 38% (World Health Organization & Philippines. Department of Health, 2012). Furthermore, "…the services covered are not comprehensive, copayments are high and reimbursement procedures are difficult" (World Health Organization & Philippines. Department of Health, 2012, p. 2). Public and private health services are supplemented by services provided by local and international NGOs, including "medical missions". These missions are usually short term clinics that provide emergency care and medications.

5.1.4 Medical migration and the "brain drain"

There has been a long history of health professional migration from the Philippines. Nurses constitute the main health professional group that migrate with some institutions established to educate nurses who intend to work overseas. Export orientated private training providers constitute 80% of all nursing schools that "…adjust production capacity to match global demands" (Kanchanachitra et al., 2011, p. 774). In 2003 there were 883 doctors compared with 86, 641 Filipino nurses working overseas (Institute of Health Policy and Development Studies, 2006). In 2003, 13,014 nurses migrated annually (Kanchanachitra et al., 2011). However migration does impact on the medical workforce. For example, some doctors are retraining as nurses to be eligible for skilled migration (Marchal & Kegels, 2003). Around 3000 doctors retrained in 2003 as 'nurse medics' (Kanchanachitra et al., 2011). The 'push' factors for migration include inadequate positions; poor wages as well as the country's socio-political situation (Institute of Health Policy and Development Studies, 2006; O'Brien & Gostin, 2011). Pull factors included security and educational opportunities for their families and a

desire for better pay and professional development. These factors are similar to other less financially resourced countries (Marchal & Kegels, 2003; O'Brien & Gostin, 2011; Taylor & Dhillon, 2011); however Filipino health professionals are in stronger demand due to their English language skills.

The social costs of health professional migration are multifaceted: the most obvious is a lack of highly skilled workers in the health system and its impact upon the remaining workforce. In the Philippines "only 10% of doctors, dentists and pharmacists are found in rural areas" (Leonardia, Prytherch, Ronquillo, Nodora, & Ruppel, 2012, p. n.p). These workforce gaps have wider ramifications for economic development as workforce scarcity pushes up wages and there is an increase on training and replacement of health workers rather than investment in the health system (Kanchanachitra et al., 2011). There is also a waste of health workers skills and experience as they work in less demanding positions (Marchal & Kegels, 2003). Increased demands for places at health professional schools and decreases in academic staff numbers compromises education quality. However, the social benefits of migration include remittances to the families of the workers - fact, it is suggested that an expatriate physician would pay for their replacement in remittances (Institute of Health Policy and Development Studies, 2006; O'Brien & Gostin, 2011); improved professional networks and training; and an alleviation of internal labour market surpluses (Marchal & Kegels, 2003).

A number of strategies have been suggested to mitigate the negative consequences of medical migration. The Filipino study found that health workers stay due to family obligations and to "serve their country"; suggesting that recruiting those who are service and community focused could be one strategy. Bilateral agreements between countries may also assist; including financial compensation to developing countries for recruiting their health professionals (Kanchanachitra et al., 2011; Marchal & Kegels, 2003; Taylor

& Dhillon, 2011). Short term expatriate work placements have also been suggested (Marchal & Kegels, 2003). There would be a beneficial impact on the Filipino health system if medical practitioners returned and used skills acquired overseas to benefit the Filipino health system. This strategy is deemed 'brain circulation'. Self-imposed codes and restrictions could also negate less ethical practices, for example South Africa has banned the recruitment of doctors from other African nations (Kanchanachitra et al., 2011). The most effective strategy may be training health professionals to meet the health needs of local communities, to avoid professional frustration and inadequacies that may lead to migration.

This is an ethical issue that receiving countries have an obligation to address through health professional training and Human Resources for Health (HRH) plans in both their own countries and in the developing world (Kanchanachitra et al., 2011; O'Brien & Gostin, 2011; Simpson & McDonald, 2011; Taylor & Dhillon, 2011). The brain drain of health professionals is not only from less developed to more developed countries, it can also be internal: from rural to urban areas; from state systems to highly paid NGO positions, and from clinical to management positions (Marchal & Kegels, 2003). Indeed there is a cascade flow on effect: local health workers go from rural to urban areas in more developed countries; middle income professions go to rural areas in more developed countries and health professionals move from less developed countries to middle income countries (Marchal & Kegels, 2003).

The issue is therefore complex and global requiring an international and coordinated response. In May 2002 the Rural Working Group of the World Organisation of Family Doctors (WONCA) developed the "Melbourne Manifesto", a code of practice for the international recruitment of doctors (WONCA, 2002). The code outlined principles for both "receiving" countries and those losing health professionals to overseas. In 2011 a

workshop was held at a WONCA meeting in Cebu, the Philippines to discuss action to implement the Melbourne Manifesto, importantly also incorporating the views of Filipino health professionals (2011). "The workshop outlined five areas for action and recommendations to rural health organisations and bodies throughout the world" (Federation of Australian Medical Education, 2011, p. 1). The WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted in May 2010 (Taylor & Dhillon, 2011). Although non-binding, it is a multilateral agreement between all 193 member states of the WHO that:

> *…puts in place a global architecture, including the identification of ethical norms as well as institutional and legal arrangements, to guide international cooperation on the issue of health worker migration and serves as a platform for continuing dialogue.*
>
> (Taylor & Dhillon, 2011, p. 2).

The WHO code and the joint principles "…strive to ensure that the balance of gains and losses of health personnel migration should have a net positive impact on the health systems of developing countries and countries with economies in transition" (Federation of Australian Medical Education, 2011, p. n.p)**.** Despite these and other initiatives, policies of both more financially resourced and less financially resourced countries contribute to the crisis. More financially resourced countries have done little to address this issue and have exacerbated the HRH crisis by training inadequate numbers of health workers and failing to develop effective retention policies (Marchal & Kegels, 2003). Furthermore, health professional schools in less financially resourced country often highlight the migration of graduates as a sign of prestige and school success (Kwizera &

Iputo, 2011; Sahni, 2005). As outlined by Kanchanachitra et al (2011) it will be difficult to implement the code as it is voluntary.

5.1.5 The Filipino medical education system

There are over 40 medical schools in The Philippines (University of Copenhagen & World Health Organization), and their distribution is demonstrated in Figure 5.2. The Filipino medical education system was traditionally based on the system of the United States of America (Ongley, 1989). The Philippine Accrediting Association of Schools, Colleges and Universities (PAASCU) is responsible for accrediting medical schools, however this is a voluntary process (Cueto et al., 2006). The Commission on Higher Education (CHED) undertakes mandatory accreditation for universities and colleges (The Philippines. Commission on Higher Education, 2014).

The devolution of the health system and administration by local government units (LGU) initially led to a decrease in morale and resignations among health staff. Despite having control of budgets, the LGUs could not retain staff (Dussault & Franceschini, 2006). In 1992, 271 municipalities did not have doctors (Leonardia et al., 2012). In response to this mal-distribution and the brain drain the national government initiated recruitment and retention programs for rural health staff. The Doctors to the Barrios (DTTB) Program was introduced in 1993 and aimed for all municipalities to have a doctor in 20 years (Egger, Lipson, & Adams, 2000; Leonardia et al., 2012). Other programs include Rural Health Physicians and Partnership for Alternative Health Sciences Education Programs.

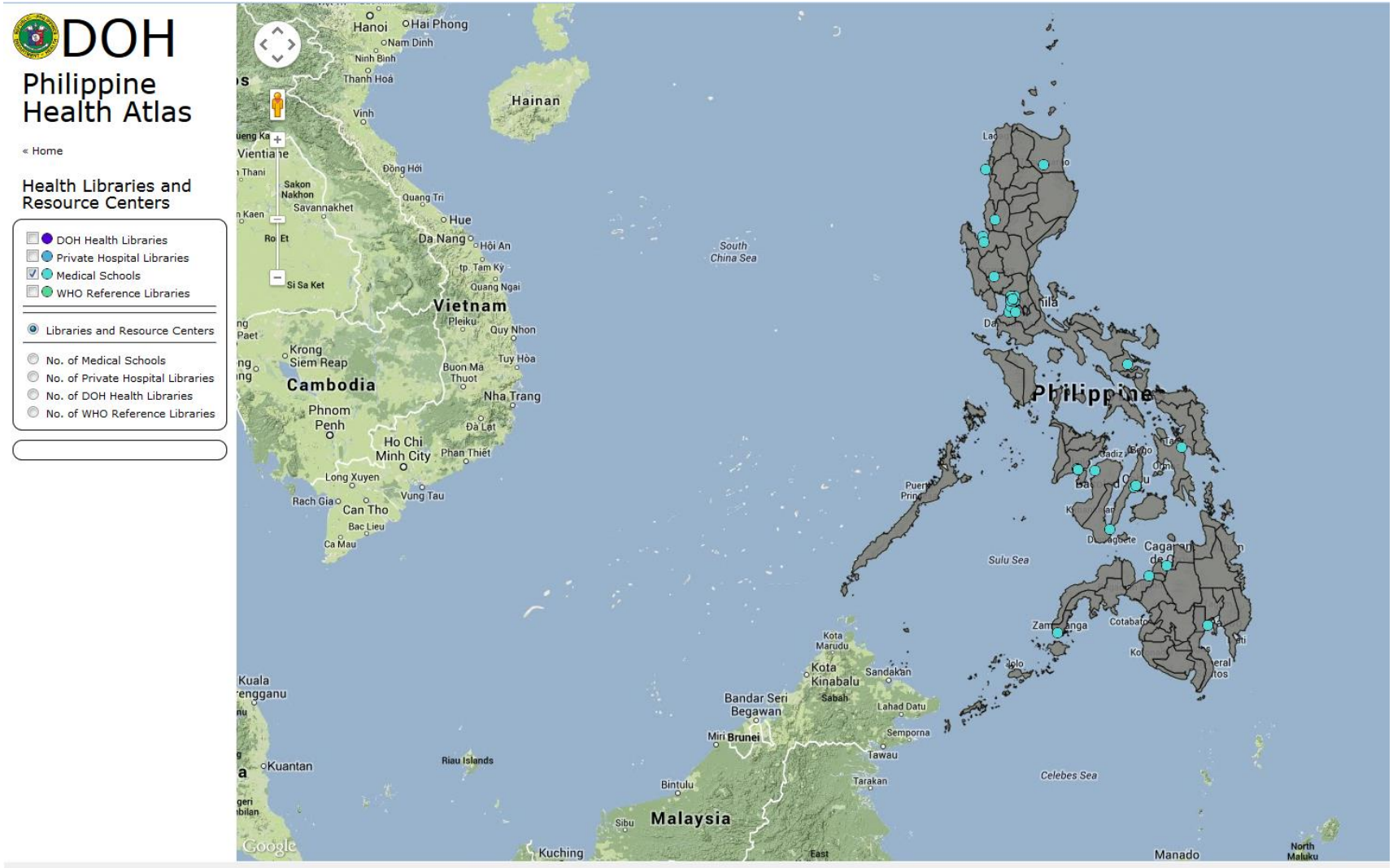

Figure 5.2 Map showing medical schools in the Philippines

http://healthatlas.doh.gov.ph/libraries-combined.html

The DTTB program encouraged doctors to work in rural areas through increased pay and benefits, including professional development. Doctors are placed in under-served municipalities for two years as Municipal Health Officers (Leonardia et al., 2012). They are employed by the Department of Health and have preferential access to Masters or clinical residency programs. A Continuing Medical Education (CME) scheme was introduced in 2005. After the two years, the doctors can choose to stay as an MHO and be employed by the Local Government Unit. If they are in poor municipality they would only receive 65-70% of the salary they would receive if in a higher income area (Leonardia et al., 2012). As a result there was low uptake of these positions. Of the 452 doctors under this program between 1993 and 2011 only 81 (18%) stayed in the LGU (Leonardia et al., 2012, p. 2). In 2005 the Filipino media reported on the high rates of the "brain drain" of doctors and contrasted wealthy doctors with "altruistic" and 'heroic" doctors choosing to serve in rural areas (Leonardia et al., 2012). There were more applications to the program and universities also introduced scholarships tied to service leave with the DTTB and other programs. Despite these initiatives "the numbers of those choosing to be absorbed have in fact declined since 2006" (Leonardia et al., 2012, p. 2).

An evaluation of the program was undertaken in 2011 to assess the reasons for low retention and to explore strategies to address this issue. Interviews were conducted with former DTTBs and a survey was undertaken with the 2011 cohort. The main motivation for joining the program for past DTTBs was to serve rural populations. In contrast over half of the current DTTBs were motivated by return of service obligations, a quarter to help rural populations and some due to an interest in public health (Leonardia et al., 2012). Those who studied at universities outside the national capital were less critical of compensation. The main factor that impeded their retention was the lack of support of

the LGU, followed by compensation, family and career issues. This study supports other studies discussed above of the important role of the LGU in retaining health workers since devolution.

Postgraduate medical education in the Philippines involves a year's internship followed by Philippine Physicians Licensure Examination administrated by the Professional Regulation Commission (The Philippines. Professional Regulation Commission, 2014). Graduates then undertake three to six years residency training in a chosen specialty at accredited hospitals or clinics (Wijnen-Meijer, Burdick, Alofs, Burgers, & ten Cate, 2013).

5.1.6 Summary

This brief overview of the Filipino health care and medical education systems sets the context for the cases three and four. The Philippines has a diverse and dispersed population, with many health care challenges. While there are hundreds of medical schools, many train graduates to work in metropolitan centres and "for export". The brain drain of doctors and other health professions to overseas countries puts a significant burden on the health and medical education systems.

5.2 Case Study Three: Faith, Friends and $500: Ateneo de Zamboanga University School of Medicine

"Actually we didn't know what we were doing was socially accountable"

(ADZU17_staff).

Plate 5.1 Mutia Municipal Health Centre

5.2.1 Introduction: Ateneo de Zamboanga School of Medicine

To get to the Ateneo de Zamboanga School of Medicine (ADZU SOM) I climbed seven flights of concrete stairs. Climbing each set required persistence and stamina- an apt analogy for the establishment of the school. When they first met in 1990, the founding group of health professionals, university staff and business leaders knew the dire health statistics of Region IX or the Zamboanga Peninsula, Western Mindanao, 1684 kilometres from Manila (see Figure 5.3). Predominantly poor and rural and with a history of political and social unrest, the region of over 3 million people had the highest infant mortality rate in the Philippines. Furthermore, 80% of the 100 municipalities and 3000 Barangays "lacked medical attention" (C. Dayrit & dela Crux, 2002, p. 349). The school was established to address the health and workforce needs of the region (Cristobal & Worley, 2012). With $500, the Zamboanga Medical School Foundation was established in 1993 as an inter-sectoral private, not-for-profit entity in Zamboanga City, the region's largest city and health care centre (Cristobal, 2000; Cristobal & Worley, 2012). The Foundation was incorporated as the Ateneo de Zamboanga University's medical school in 1994. International experts were very supportive and trained local doctors in medical education. Ateneo de Zamboanga University (ADZU) is a private Jesuit institution and a chapel dominates in a central position in the university grounds. The philosophy of the medical school resonates with the motto of the university - "For God and Country". The grounds incorporate a kindergarten, elementary school and high school as well as the college and university. There are well established facilities including a gym, large food court, art gallery and small medical centre. Fifteen medical students graduated from the first batch or cohort in 1998 and 25 to 45 students have been admitted to the program each year since. In 2013 there were 152 enrolled students in levels 1 to 4 and 221 graduates (Ross et al., 2014).

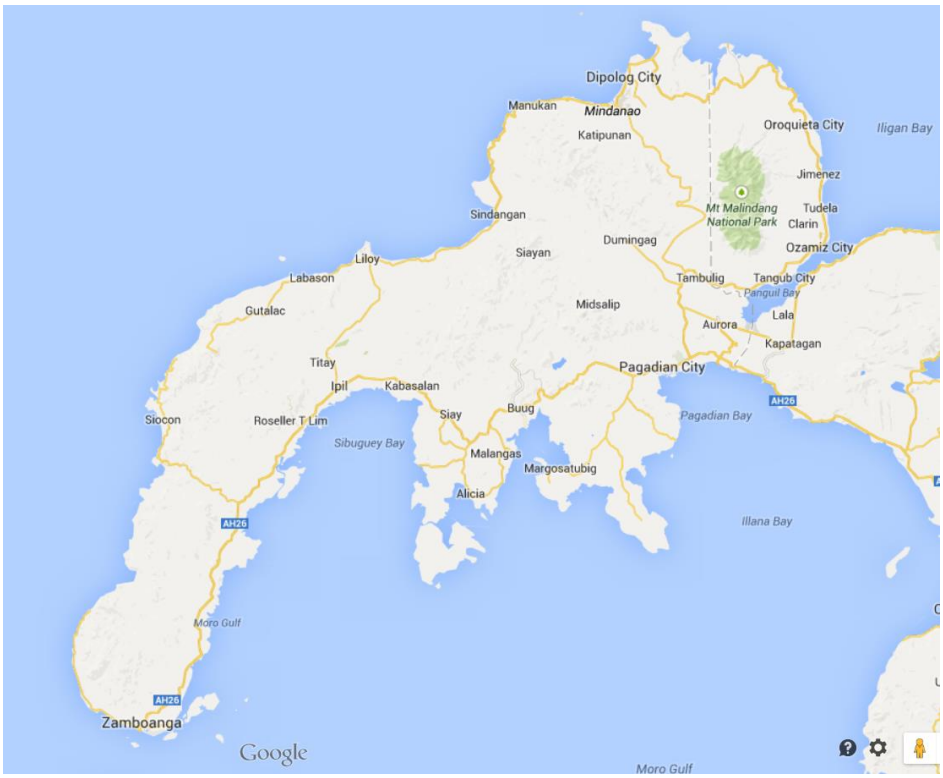

Figure 5.3 Zamboanaga Pennisula

(https://www.google.com.au/maps/@7.7767421,122.4301323,9z?hl=en)

When I reached the top of the stairs I was surprised at the small size of the facilities. There is a three room library and half a dozen study rooms crowded with white-coated students. The school does not have anatomy facilities or lecture theatres. Instead students spend every Saturday in the Zamboanga City Medical Centre (the main public hospital) learning from clinicians, and for 6 months in year 3 undertake a hospital medical clerkship. The curriculum is characterised by small group, Problem Based Learning (PBL) with nearly 50% of the four year program conducted in the community (Cristobal & Worley, 2012). All but one of the health professional staff, including the leader, are volunteers and work part time. Some graduates teach for the school as a form of "payback" as they were scholarship holders (known as scholars), but most contribute to teaching as a form of service.

From the first year, groups of eight to ten students are allocated to a small village or barangay and work with the community on a comprehensive health plan culminating in a 10 month stay in their fourth year. In years one to three they spend four weeks in their assigned communities. The aim of the first placement is for students to build rapport with the people. The students initially do a house to house survey to ascertain the community's health needs. They then work with the community members on community health and social programs to address these issues. These range from sanitation, agricultural and health projects including building health facilities, tree planting programs and health education. During fifth year students undertake a 12 month clinical rotation in the public hospital and complete a Masters of Public Health (Cristobal & Worley, 2012; Richards, 2001). Bright posters illustrate the outcomes of student's service learning. With their host communities, students build wells and health facilities, provide children with boats to get to school and educate families on nutrition and child welfare. A regional map highlights graduates work locations. Whilst most Filipino health professionals leave for overseas straight after graduation, in 2011, over 85% of ADZU's 164 graduates remained working in the region (Cristobal & Worley, 2012). It is clear that the school's vision: "a medical school… responsive to the changing patterns of health care development and the needs of communities" (Ateneo de Zamboanga University School of Medicine, 2012, p. 8), is being achieved through health development and inter-sectoral collaboration (Ateneo de Zamboanga University School of Medicine, 2012).

5.2.2 Results

In this section I outline my fieldwork, including a description of participants. I outline the understanding of respondents of social accountability at Ateneo de Zamboanga School of Medicine. I then describe the external and internal contextual factors that have influenced the social accountability of the school.

5.2.2.1 Fieldwork

I conducted fieldwork during one week from 13 to 17 July 2012 and interviewed twenty participants: 6 staff (including a leader and one former staff member), 5 students, 6 health representatives and 2 community representatives. There were two joint interviews and I conducted one (\community representative interview with an interpreter. Five interviews (2 health professionals, a student, 2 health sector representatives and a community representative) were conducted at rural sites. All of the health professionals were also staff; or worked for the school on a part time basis, including as preceptors, and alumni of the school. Four of the staff and the leader also worked as health professionals. At the time of fieldwork there were travel restrictions in Mindanao due to political conflict. I followed local advice and was accompanied by two ADZU SOM staff and a staff member's partner[32].

[32] Australian Department of Foreign Affairs and Trade travel advice for the Philippines advised against all travel to Mindanao. Prior to fieldwork, I undertook a risk/benefit analysis and followed local advice regarding travel safety. I registered with the Australian Embassy in The Philippines and followed local advice and protocols, including not venturing out after dark alone and changing my routine of travel in and outside the hotel. Fieldwork was conducted in a safe area of Mindanao. I travelled by private transport with three other people (two from the School and the husband of the Dean's PA, who worked in the area of government security). The trip was uneventful and I was able to undertake my field work as planned.

5.2.2.2 Understanding of social accountability

In order to appreciate social accountability at ADZU SOM, I asked participants about their understanding of social accountability in general and their interpretation of social accountability at the school. There were three main perspectives and most participants had multi-dimensional perspectives. Firstly, participants described the actions or operations of the school, predominantly the impact of student placements in the community and the school's focus on public health as defining social accountability. Secondly, respondents discussed the mission or vision of the school to address the workforce and the health care needs of the Zamboanga peninsula. Thirdly, at a personal level, socially accountable medical education was conceptualised as "socially accountable doctors", namely individual graduates who were socially accountable in their practice as they thought of the health needs of communities over their own individual desires and practiced in indigent areas. Two respondents [33] had not heard of social accountability and could not fully respond to this question. I asked some participants to respond to the definition of social accountability which was also outlined in the information sheet. Four participants had a comprehensive understanding of social accountability; two of these respondents were involved in The Training for Health Equity Network[34].

33 Social Accountability was not used in this community interview due to translation difficulties; I asked "how and why does the school work with the community".

[34] I interpreted comprehensive understanding to be an appreciation of the THEnet's definition of socially accountable medical schools.

5.2.2.2.1 "That is what we are doing": Social accountability in action

Thirteen participants understood the school's actions or operations as being socially accountable. Although this concept was not known during the development of the school, respondents thought that the school was an example of social accountability in action. For example, the student experience was deemed an example of social accountability as students directly impacted on the health and social needs of people through both public health or community projects and/or individual health care. The school staff had limited theoretical understanding of social accountability; however the practical operations of the school clearly reflected the concept. The school was developed in response to need rather than based on a conceptual understanding of social accountability. The leader stated that while the founders of the school understood the importance of linking individual health with public health care and the social sciences with clinical medicine, "*actually we didn't know what we were doing was socially accountable*" (ADZU17_staff). When introduced to the concept of social accountability, the leader realised "*that is what we are doing*" and a European friend also commented "*that what you are doing in practice here is what we knew in theory*".

The medical program at ADZU SOM has been intricately linked since its inception with the foundations of social accountability, including Towards Unity for Health (TUFH), and innovative community based medical education. The TUFH concept of inter-sectoral partnership is highlighted in accounts of the school's development (Cristobal, 2000; Ortigas, 2012). The leader stated that the success of the ADZU SOM program was that it had put theory into practice.

5.2.2.2.2 "I don't want to be like those doctors, only after money": Graduates as socially accountable doctors

Twelve participants understood social accountability to be about the individual actions, attitudes and career choices of the school graduates. Doctors were deemed to be socially accountable if they focused on community service over monetary gain. Staff reinforced to students how privileged they were to become doctors:

> *They have to embed to their graduates that the practice is noble, not because of the payment, but because of the service that they can give. It's a one in a thousand profession.*
>
> (ADZU3_student).

They were also told of their obligation to serve the needy, with or without payment:

> *That moral obligation is social accountability. They have to treat people whether they have something to pay them or not.*
>
> (ADZU14_staff).

Social accountability at the school was also illustrated by graduates' attitudes (service over money), and knowledge (population health approach). It was reported that socially accountable doctors from ADZU SOM understand the health needs of their communities from a population health perspective and have a comprehensive understanding of the social determinants of health. The school's mission incorporates elements of the "five star doctor"; graduates should be *"... self-directing physicians, effective health administrators, health researchers and committed medical teachers*" (Ateneo de Zamboanga University School of Medicine, 2012, p. 8). They appreciate

how environmental and community conditions contribute to health; and the social conditions of poor Filipinos:

> *Being socially accountable means you have the responsibility [of] taking care of the bigger population. You need to be aware of the health situation of the community, how these people live.*
>
> (ADZU9_health).

All doctors should also be approachable to community people, and be skilled as well as accessible to people. They should also have the capacity to live in rural areas as at "one" with the local people:

> *Patients should not go to the doctors. The doctors should go to the patients.*
>
> (ADZU14_staff).

> *You must be socially accountable to the people where you live, especially to the place. Knowing you are a health professional; you should be also aware of the needs of the people where you staying or where you are working.*
>
> (ADZU9_health).

Rural doctors or Municipal Health Officers (MHO) were understood to be the best examples of socially accountable doctors. These health professionals are assigned to local government areas in small towns, where they are responsible not only for clinics and the health of individuals but for wider population health programs. Prior to the establishment of ADZU SOM the region had difficulty filling MHO posts. The reward for MHOs was not monetary, but the satisfaction of serving the community and making an impact upon health:

[The staff member] just told us that it is very heart-warming and very rewarding if you are [a Municipal Health Officer] because you own the health programs. It is like whatever happens to the people there or if their health has improved, it is because of you.

(ADZU7_health).

5.2.2.2.3 "To provide solutions to the health problems of south-western Mindanao": Meeting health and workforce needs

Inter-related with "socially accountable doctors" was the perception of twelve respondents that social accountability was about meeting workforce and health care needs in the region. The mission of the school was clearly defined as "*to help solve the problems of Western Mindanao*" (ADZU11_staff). Staff, students and health professionals were well aware of the school's vision and mission:

I believe that this school was founded with a social accountability mission to provide solutions to the health problems of south-western Mindanao, which is a depressed area of the Philippines and also one of the areas in the Philippines where there are only a few doctors. So with that mission I believe it is being socially accountable.

(ADZU18-1_staff).

Furthermore the school had also made an impact on the workforce as "those doctorless areas are now with doctors and these doctors are graduates of Ateneo" (ADZU13_health).

Eight respondents also considered a direct link between the health of communities and the presence of a medical professional who had graduated from ADZU SOM. There was

a belief that the presence of doctors in communities had positively influenced regional health statistics, principally maternal and infant mortality:

> *Actually statistics prior to the establishment of the school, the maternal mortality, the infant mortality is very high. Right now, it is still considered high but it [has] declined*
>
> (ADZU9_health).

"In the period 1994-2008 the infant mortality rate decreased by approximately 90% in Zamboanga, compared with a 50% national drop" (Cristobal & Worley, 2012, p. 4). There was a decrease in infant mortality from 75 per 1000 births in 1995 to 10 per 1000 in 2003 (R. P. Strasser & Neusy, 2010, p. 779). While the authors concede further research is required to ascertain causality in reduced infant mortality, it was likely that the increased medical workforce provided by ADZU SOM graduates contributed to better health outcomes in the region; an overarching aim of socially accountable medical schools.

5.2.3 Contextual factors: What has influenced social accountability at ADZU SOM

As in other cases, contextual factors were difficult for participants to comprehend so I used the term "influence". First, I asked respondents what they thought had influenced social accountability at the school. I then asked whether the following three issues had affected social accountability; the medical workforce needs of the region, the type of national health system and the nature of partnerships between the medical school and its community. I asked how the school worked with the health sector and with the community and also about the local workforce. Due to language or translation issues at the two Filipino schools I also asked "*what do you think has influenced the school to be*

like it is?" There were seven overarching influences, both external and internal factors. The external factors included regional health; workforce and community needs; local officials and politics; peace and order; religion and; limited resources. An internal contextual factor was the values and experiences of a leader.

5.2.3.1 External contextual influences

The regional health, workforce and community needs; local officials and politics and peace and order in the face of a regional conflict; religion and limited resources were external contextual factors.

5.2.3.1.1 "Doctors for doctorless areas": Regional health, workforce and community needs

Fourteen participants discussed how the school was established to provide doctors for the rural areas of Region IX as inscribed in the mission of ADZU SOM. There was a clear community of place that constituted the school's 'community': "Region IX" or the Zamboanga Peninsula and the surrounding islands. Students went to Region IX barangays on placements and graduates served these communities. The vision and mission of the school were tied to this region:

> *The vision of the school is to provide doctors for doctorless areas in the region.*
>
> (ADZU15_community).

The school's non-traditional curriculum and long-term community placements evolved to ensure a supply of skilled doctors to fill the positions of MHOs in the region:

> *And that is the reason why the medical school evolved into such a unique curriculum. Only half of the internship is devoted to the hospital, the other*

half is devoted to research and theses. I think it evolved because there were no doctors in this community.

(ADZU16_staff).

This observation was interrelated with participants' understanding of social accountability as "*meeting health and workforce needs*". Training students for rural practice was unusual in the Philippines, where many health professional schools exist to prepare graduates to work in more developed countries. There was a "market-driven, export-led production of nurses and doctors that seeks to respond to international demand" (Kanchanachitra et al., 2011, p. 773). In contrast with other schools, the vast majority of ADZU SOM graduates remained in the region post-graduation (R. P. Strasser & Neusy, 2010). Participants discussed the number of municipalities and barangays that had previously been "doctorless" or without adequate health staff. One health sector representative explained how he was the first doctor in a remote island community in ten years and that the health centre had been previously closed.

Graduates are trained to aspire to work as Municipal Health Officers (MHOs) to provide the most effective form of service in poor communities. These professionals were deemed "socially accountable doctors". Municipal Health Officers needed to be skilled to work in isolation in rural areas and have both clinical and public health skills and knowledge. The role included overseeing clinics as well as wider public health programs such as nutrition, mosquito control, family planning programs and sanitation. Maternal and child health care was a particular focus and one MHO that I visited had a basic emergency management and newborn care program that supported the clinic to be open 24 hours a day. Municipal Health Officers managed staff and health services and liaise with local government and non-government organisations to secure funding. An

innovation had been the development of a one year Masters of Public Health, undertaken in 6 months at the end of the medical degree or after graduation. Municipal Health Officers who had a Masters of Public Health are paid more and therefore have *"...a higher market value*" (ADZU17_staff). Furthermore, students undertook comprehensive health plans during their yearlong stay in the community, supervised by the community preceptor, the MHO. This experience exposed them to the work of MHOs. All community preceptors must have been graduates of the school as they had a key understanding of the curriculum and expectations of the school. Many of the MHOs are part of the Doctors for the Barrios (DTTB) program.

The health and workforce situation had created inter-connectedness with the health system. This included the local hospital and the municipal health centres. School staff were employees of the health system and the health system provides opportunities for student training. There was interdependence between the school and the local health system: health facilities provide education and students augment the health workforce. The school provided professional development training and services for doctors. Graduates had enhanced the region's health workforce and hold positions across the health system. Sixteen participants discussed different aspects of this interconnectedness. "*At the start the school was founded on collaboration*" (ADZU18-1_staff) that involved doctors, the university and businessmen. The university provided the facilities, business leaders raised funds and developed governance structures, and doctors were teaching staff. The school's curriculum was developed from the input of doctors who outlined the ten most common conditions they saw in their practice.

A great deal of teaching occurred in the health system either in the hospital or at the community/public health level. From the first year of their degree students were exposed to the regional hospital, and the hospital, doctors and patients are exposed to

students and the school. A memorandum of understanding allows students to undertake their third year clerkships and fifth year internships at the Zamboanga City Medical Center:

> *We were exposed to the hospital since [the] first year, every week we have hospital patients with facilitators there and you visit patients at the bedside. It really facilitated our transition from the classroom to the hospital.*
>
> *(ADZU6_Student).*

As ADZU SOM did not have access to cadavers or an anatomy laboratory students learn topics such as histology and anatomy on real patients. The hospital was their classroom. Despite the criticism of other medical schools, the lack of facilities did not impact on students who learnt anatomy in the operating theatre and by examining patients in the hospital:

> *We are not dealing with dead people; we are dealing with actual people in the community. So why do you need cadavers? Anyway, anatomy can be studied when you go to the operating room, when you assist in the actual operation. So as early as first year [the school is] exposing the students to the hospital for them to see anatomy.*
>
> (ADZU10_Health).

Students increasingly used free online resources to supplement the anatomy and histology that they learn at health facilities. There was only one full time, paid, academic staff member as the rest were volunteers. There was a sense of obligation by graduates to assist in teaching and strong loyalty to the school:

> *You have the sense of, I was a student like them before and I know how it feels, so you really have the responsibility to teach the students. Because these students are from your school and you are part of the school.*
>
> (ADZU10_Health).

With a constrained workforce, students made a significant contribution to health care and were therefore accepted by health professionals. As one student remarked: "*I don't feel the hospital will run smoothly without the students*" (ADZU6_Student). From first year, students performed basic consultations with supervision. In the community students assisted the Municipal Health Officers (MHOs) and undertook public health projects and clinical services. The MHOs appreciated the assistance of students and many MHOs asked to have additional students groups:

> *[The students] are very useful because we lack manpower; I'm the only doctor in this town, so it's very hard for me to concentrate on problems that need cooperation from the people themselves. I am very happy that they are here because they perform the duties that are very difficult for me to perform.*
>
> (ADZU4_health).

Students were therefore not seen as a burden, but were accepted as part of the workforce by health professionals and administrators.

People held intertwined and multiple roles as alumni, health professionals and academic staff. This interconnectedness ensured interpersonal relationships that assisted in professional roles. Graduates and staff occupied key influencing positions in the Department of Health (DOH):

It is so easy to integrate because my graduates now occupy key positions. So, [there are] no problems. I just give him a call. So [there are] no hesitations for assistance (ADZU17_staff).

Due to personal connections, graduates found it easy to refer patients and there was collegiality and a feeling of acceptance across all levels of the health system:

So you really feel that you belong, you know, because alumni for example the Department of Regional Office in the administration, they are alumni of this institution so there is no hard time for you to communicate to refer because they already know, my classmates work there. So it is very easy for the other referral, it is accessible.

(ADZU10_health).

As the majority of medical professionals in the health system were ADZU SOM graduates; the schools' teaching methods had become more accepted within the health system.

Despite the impact of ADZU SOM graduates across the health system, one respondent discussed how the system may not be socially accountable and therefore the values instilled at the school may be "diluted":

Perhaps also develop some strategies wherein we will be able to really shield our graduates from being acculturated. Somehow we have instilled in them when they were here in the medical school the value of health, of service, the value of social accountability and yet somehow when they move on there might be some dilution happening in the processes especially if you

go to speciality training. [Some graduates] are being corrupted by the system".

(ADZU18-1_staff).

5.2.3.1.2 "It helps us live the way the people live so we understand them better": The influence of placement communities

There was complexity regarding the influence of the community on social accountability at ADZU SOM. The process of influence between community and students was two way and there are different perceptions of the level and type of influence between the community and the school and its students. While students and staff valued the importance of community placements for student learning, the community may have not perceived their influence on the school. A community member based in the rural centre mentioned that she would like more students to return to the community; however this was not the school's policy. She did not know why only one batch of students could come to her community. A school evaluation (THEnet evaluation framework) reported that communities would like more participation but there was confusion about how influential they could be as the school was a private institution and not part of government or public domain:

[Community people] say that our participation in the medical school is more [that they send their] feedback. They take care of the student [on placements] but in terms of decision making [they] don't know if it really matters because it is a private institution.

(ADZU18_1_staff).

Communities generally wanted more service delivery but they were unclear about how much they could influence. Community may have seen students coming 'to help' and

did not realise their own influence. However, the immersion placements were mutually transformative –. the community influences the students and the students influence the community. This occurred at both the organisational and individual level. At the organisational level health sector relationships influenced the way things are done (for example, where placements occur). At the individual level communities influenced the students' understandings of social accountability, community empowerment and service.

The community influenced students in education processes that influenced their career choices and sense of service to become "socially accountable doctors". The attitudes of students are changed through long term placements in the community throughout their medical school careers. They learnt the daily challenges of communities and developed a comprehensive understanding and appreciation of the health and social needs of the rural poor. Nine respondents discussed this process as an important influence on social accountability at the school. Through immersion in the community, students appreciated the intricacies of addressing regional health issues. Students were transformed by gaining a better understanding of the actual situation of people in the community and "*the students actually realise that there should be a change*" (ADZU4_student). Students described how they ate the same food as the people who lived there, collected water and bathed in rivers "*to show them that we could actually live like they do*" (ADZU6_student). A community member saw placements as preparing students to live as rural doctors:

> *So they are learning the way things are done in the community, they will have to wash their clothes and live basically so they can live in a rural area because they have a lot of experience.*
>
> (ADZU5_community).

Students were "*humbled*" (ADZU3_student) to see the way people lived. A student described this transformative process:

> *That's why you are sent to communities that do not have water, that do not have electricity, to see that not everyone is the same. So that opens our eyes. This is the social situation of our country, not everyone is privileged, not everyone can go to school, and not everyone has the chance to eat three square meals a day. This is our situation in our region and you're here, you're privileged to study medicine, it's for you to help these people".*
>
> (ADZU2_student).

One student discussed how her group had to walk several kilometres to get water, and they were "*dismayed*" (ADZU6_student) by their situation. They then realised that these conditions were the reason why they were in the community, and that there needed to be change for their own comfort and the needs of community. Students and alumni also outlined how they had "*learnt from the people*" (ADZU13_health) and had become "*one with the people*" (ADZU2_student). Community people also appreciated that students were not "*higher people*" (ADZU2_student) from the city, but were willing to integrate. This enabled the community people to be more comfortable and work with the students. From their experience, students developed special relationships with communities and a willingness to serve the community and return as rural doctors. Developing behavioural and attitudinal change was the reason for the exposure:

[The leader] at the outset thought that will actually change the behaviour. But one time I told him: 'you know, our students are not the best students but I think they will stay behind.' And I think one of the reasons because [of their exposure] I would like to think that they become comfortable in the community.

(ADZU16_staff).

The role of students on community placements was a 'catalyst', to empower communities so that they will sustain current projects and be skilled to develop other projects and programs that would enhance their health. An ability to understand and appreciate how people can be empowered was a key attribute of MHOs. The catalyst role and the importance of community empowerment was discussed by seven participants:

We're just a catalyst; we are not involved in the process. So it's the formula that we want, for me that still works. But of course the more emphasis is placed on empowering people in the grassroots level, because when they realise that this project is for them, that they are the master of this project then the initiative with these people would just be spontaneous.

(ADZU3_Student)

There were several successful examples of student projects that involved inter-sectoral collaboration and community empowerment. A community that I visited had secured funding for a barangay health station from the local government unit (LGU) and the World Bank. While they assisted the community to design the projects, the students did not know how they would raise funds for this initiative. It was the community that independently secured funding. For one student, this was an example of empowerment:

We were so surprised, we thought it this is what empowerment means then it is a very good start! We weren't even there for two years and they already did something on their own.

(ADZU6_student).

The students' perception was that they are empowering communities, but the community might have seen it differently just as they see their influence differently. Communities conceptualised the gains of having students differently to how students themselves did.

5.2.3.1.3 "Sometimes politics gets in the way": The influence of local officials and the local political system

Barangay officials (captains or village heads) and mayors (responsible for the municipality) were important facilitators of the community placements as well as graduate employment as Municipal Health Officers (MHOs). Nine participants noted the influence of local government officials on the school. Community Coordinators (staff from the school who organise the community placements) initially met with these officials to find the ideal barangay for student placements. The conditions that were assessed are the level of safety, whether or not there is a MHO who is an ADZU SOM graduate and the receptivity of the community. These local officials also organised housing for the students and contributed to their projects through limited funding or in kind support. Some students felt they could not approach the mayor for funding support and needed the school to be more proactive in assisting them to develop relationships. Furthermore, leaders changed as elections were held every three years. New officials may not be supportive of student and community initiatives; impacting on the success of projects. Furthermore, the mayor and barangay captain may not be from the same

political party. Similar to the issues facing MHOs, local politics could complicate the process of community engagement:

> *Sometimes politics gets in the way. When we started [in this barangay] we had a different barangay captain. Now the new one is of a different political party. So the supporters of this barangay captain and the old one don't really get along well.*
>
> (ADZU6_Student).

A student I interviewed who was on her community placement noted that the local government was not used to the collaborative process of community development promoted by ADZU SOM. This misunderstanding could also compromise projects.

There were also challenges for students and MHOs, as the municipal health services were managed by the mayors who are "non-health managers" (Grundy et al., 2003, p. 4) with no health experience. Mayors prioritised the health budget, including workforce spending, which differs between communities. All four MHOs and former MHOs I interviewed discussed how restricted funds for medicines and health programs constrained their work. Students also discussed how their desire to eventually work in their placement communities would be dependent on whether the local government could support a doctors' salary. Local government also impacts on the availability of employment for students:

> *Now one of the limitations there now is the local government should be able to provide postings for our graduates.*
>
> (ADZU17_staff).

Positions were also influenced by local political situations which resulted in "under-prepared middle level management, increased local political influence and control over technical management, and declines in quality of infrastructure and service delivery, particularly in rural areas" (Grundy et al., 2003, p. 4). A staff member believed that local leaders needed education on health issues to "*understand the problem and factors affecting that problem*" (ADZU18-2_staff) and be better informed to determine and distribute their health budgets.

The wider policy environment could also impact upon the local health situation. Resource challenges at the national level (controlled by the Department of Health) may mean that issues are beyond the control of MHOs. For example, Department of Health controlled hospitals may not have staff or medicines to cope with the referred patients. One MHO described a new scheme that employed 11 midwives at her centre aimed at addressing the Millennium Development Goals on maternal and infant mortality. Yet there were maternal deaths at the referral hospital as patients could not pay for essential supplies that they needed for an operation:

> *I already had two maternal deaths for this year and that is very sad and two of them died at the hospital because they lack money. I am not saying anything [is] wrong with the hospital, it is the system, and it is the management. They can't operate because they don't have supplies.*
>
> (ADZU7_health).

The school realised that dealing with officials and the associated administration was an important complex skill for future doctors. One staff member discussed how a former student volunteered at the school to teach students how to work with the local

government. A health professional who now worked in a small rural hospital noted that the community placements helped students gain skills to work with the municipality:

> *It taught us to be who we are today. Maybe it is like a primer in talking to government officials [including] key leaders of the local government and also the national government.*
>
> (ADZU13_health).

5.2.3.1.4 "Peace and order": The impact of a regional conflict

The impact of the "peace and order" or the regional conflict situation in Southern Mindanao was assessed as a contextual influence by seven participants. The conflict affected the school in terms of placement restrictions for students and graduates but also produced a determination to be part of the solution. It also caused many issues in terms of ordering and receiving supplies in rural hospitals. The Moro people of southern Philippines are a minority Muslim group who have fought for independence since Spanish colonial days. The Moro National Liberation Front (MNLF) has been has been active in Mindanao since the 1960s and signed a peace agreement with the government in 1996 relinquishing its claim for political autonomy (Al Jazeera, 2012a). The Moro Islamic Liberation Front (MILF) began as a breakaway group in 1978 and continues to fight for independence as the largest and most powerful of the rebel movements (Al Jazeera, 2012b). Abu Sayyef is another splinter group, which separated from the MNLF in the early 1990s and has been held responsible for the worst violence (Al Jazeera, 2012a). Other groups include Jemaah Islamiyah, who call for a pan-Islamic state across south-east Asia, and The New People's Army, the military wing of the Community Party of the Philippines (Al Jazeera, 2012a). The Autonomous Region of Muslim Mindanao (ARMM) was established in 1990 (Government of the Autonomous Region

in Muslim Mindanao, 2013). This region includes the provinces of Maguindanao, Lanao del Sur in mainland Mindanao and the island provinces of Tawi-Tawi and Sulu (see Figure 5.1). Although, peace talks have continued to break down, the latest framework signed with the MILF, proposes the establishment of a new autonomous region in southern Mindanao to be called Bangsamoro or Muslim nation by 2016. Staff from other schools at Ateneo de Zamboanga University have been advisors in this peace process.

The conflict has contributed to the poverty and political instability of the region. It is estimated that nearly 1 million people have been displaced (Bell, 2010) and more than 120,000 have been killed since 1972 (Al Jazeera, 2012a). There was also the threat of kidnappings, as ransom money is a source of income for Abu Sayyef. Moro National Islamic Front (MNIF) forces entered Zamboanga City on the 9th of September 2013 and took hundreds of people hostage in nearby villages. The rebels planned to raise their flag over the Zamboanga City Town hall. The MNIF argued against the proposed peace deal with the Moro Islamic Liberation Front (MILF), saying this would jeopardise their own agreement with the government from 1996 (Al Jazeera, 2013). Over 200 people, mostly rebels, were killed in the conflict and 100,000 were displaced (International Crisis Group, 2013). The Ateneo de Zamboanga University School of Medicine assisted over 67,000 people displaced by the fighting in the university's gymnasium (The Training for Health Equity Network, 2013a). Students and staff also established an off-site hospital after evacuating the Zamboanga Medical Center. City infrastructure was destroyed and the peace process retracted.

Due to this conflict, safety and welfare issues restricted where the school could send students. One student discussed how his first student group was pulled out from an area due to conflict, which caused distress to the students and community as they did not

want to leave. Three preceptors (health sector representatives) revealed that it was challenging to monitor students and the safety of students was a continued concern. The school also is constrained by the "peace and order" situation, in that they cannot move into other areas to send their graduates:

> *So if a lowly teacher can get kidnapped why not a doctor. So a doctor will definitely have second thoughts establishing a practice or work in that kind of area.*
>
> (ADZU15_Community).

However, two health professionals I interviewed had worked in conflict areas, including the Autonomous Region of Muslim Mindanao (ARMM). The school has therefore tried to embed in students a sense that they can and should work in these areas. The nature of recruitment has also opened the school to Muslim students who have more of a capacity to work in the ARMM:

> *Considering also the unique culture of context of Zamboanga Peninsula, war, various cultures, kidnappings, it is the interface of the Christian and the Muslims faith; so the graduates must also have a good understanding of this context to be able to work effectively here.*
>
> (ADZU18-1_staff).

5.2.3.1.5 "Medicine is actually a very good point where I could apply my faith": Religion

"Religion" can be understood as an internalised sense of spirituality described by individuals. However, as discussed above, religion was also an external element that influences politics and conflict in the region. Furthermore, the school was a part of the

Ateneo de Zamboanga University a catholic religious institution. Religion was discussed as an influence by seven participants. The university (ADZU) is a private Jesuit institution and its motto, "For God and Country", links with the values of the school:

> *The motto of this university Pro et Patria for God and Country. So pretty much the values of the medical school and the general values of the university align. So I think the values of this university are trying to align the mission for God and country.*
>
> (ADZU18-1_staff).

Respondents also referred to the faith of the leader and students. Different faiths were embraced and there are students and staff who are Christian, Muslim and other religions. The leader integrated spirituality into the school for both Christians and Muslim students, supporting groups and student volunteer work:

> *So [the leader] is really integrating spirituality also in the [medical] school…*
>
> (ADZU2_student).

Christians prayed with the sick at the hospital every Christmas and Muslim students conducted free circumcisions every summer. The spiritual aspects of serving were examined by both Muslim and Christian participants. A Muslim student reflected:

In my opinion then medicine is actually a very good point where I could apply my faith. So I am having this great conscience to practice my profession.

(ADZU3_student).

Another aspect of this theme was that in the context of religious-based conflict in the region students were respectful of each other's religions. Long-term student placements helped foster tolerance for other religions:

[One student said:] 'I like it here because I feel comfortable. Your creed your faith does not make a difference' …these students are so respectful of each other.

(ADZU16_staff).

The idea of service in poor communities (partially inspired by faith) contrasted with the majority of medical professionals in the Philippines. Some respondents felt that traditionally people had become doctors for monetary gain and other personal reasons. This may have been because a medical education was very expensive:

[This medical school] is for humanity, not because of the money. You think that you would be rewarded handsomely, but when you go to the community they would give you chicken.

(ADZU3_student).

This concept of service was extended to the career choices of those serving as MHOs. When asked why she chose to work in the community, an MHO replied:

...because of the school, it was the school who influenced us to do service first before [speciality] training…it's payback time [to] the school to serve the community people for quite some time.

(ADZU4_health).

A staff member highlighted that this sense of service made the medical school unique:

While [for] other schools and medical students [studying medicine might be undertaken] to get money, to get rich; what I tell my students is; this is the kind of medical culture we want, the philosophy of the medical school is public health and community health…but if we go outside of the university it is different.

(ADZU14_staff).

5.2.3.1.6 "The empowering must come from within rather than from outside": Limited resources

While resources would enhance the activities and programs of the school, participants felt that more resources were not essential. Resource constraints fostered innovation and challenged orthodox methods of medical education. However, six participants believed that additional financial and human resources were required to enhance or advance social accountability at ADZU SOM. With additional resources, including paid staff, more administrators, computers and a car to visit communities, respondents felt that the school could move beyond Region IX and place students in other areas. Additional staff resources could also help with publishing research and documenting the school's experience. While volunteer health professionals were happy to teach, there were a lot of staff changes. Municipal Health Officers (MHOs) who were community preceptors felt that it was difficult to look after up to 40 students on placements and would have

liked additional support. Staff at the school provided significant numbers of community placements with very limited resources.

The humble beginnings of the school have also influenced its development. It was founded on voluntarism and limited financial support:

> *We only had $500 to start with.*
>
> (ADZU17_staff).

When the school was established there was international support from other medical schools. This in-kind support continues with international medical educators volunteering at the school. The Training for Health Equity Network (THEnet) has also supported an administrative position. Staff, however strongly believe in "*the concept of self-sustainabilit*y" as if all resources come from outside the school "*it might dilute intentions*" (ADZU17_staff).

> *The empowering must come from within rather than from outside. Because if the empowering comes from outside there is a dependence. It doesn't give dignity and self-respect.*
>
> (ADZU17_staff).

There is a sense of pride in what the school has achieved with limited resources. Resource constraints have fostered innovative methods.

5.2.3.2 Internal contextual factors

As at both FUSOM and JCUSOM a leader was an internal influence on social accountability at ADZU SOM.

5.2.3.2.1 A shared vision: Leadership

The school's visionary leadership and religious faith was considered to be an important influence on the development of social accountability by nine participants. The leader was fundamental in establishing the school and had a clear mission and vision on what they would like the school to achieve. In addition the leader's experience of the dire health and health workforce situation of the region was seen as spurring the vision for the school. The Christian faith of a leader was also considered an influence by some participants. Three respondents suggested I "ask the leader" when I asked questions about why the school was socially accountable and the history of its establishment. No participants suggested that if the leader changed the school would struggle to continue its focus on activities that were socially accountable; as staff shared the leader's vision and mission. However, one participant mentioned the need for a succession plan, with the successor sharing the ideals of the current leader:

> *We should have someone who can take over because the [Leader] is stepping down. So if somebody should take over it should be somebody who shares [their] vision.*
>
> (ADZU14_staff).

The leader also has an ability to harness resources and international support through their personal connections.

As it is so different from more traditional medical schools, the school had to continually justify its teaching methods and approaches. While the school had become appreciated internationally for its innovative curriculum, respondents felt that ADZU SOM still needed to disseminate their successes locally. The importance of accreditation within the Philippines was stressed as this would indicate acceptance by mainstream medical education. In the early years there was unease between senior hospital staff who had trained in a traditional system and the students:

> *There is a pervading perception in the Philippines that the best training for doctors is in the hospital and it should be concerned about learning about the latest technology, being able to treat those glorified cases which at times happens once in a blue moon at the expense of overlooking the more common disease.*
>
> (ADZU18-1_staff).

In the face of opposition and criticism, the leader refused to argue with the conventional medical educators. Instead agreeing that ADZU SOM would continue the alternative path:

> *[The Leader said] you go on with your work and we will go on with our work and you will do what you want and we will do what we need to do. … We will stay focused on what we are doing and our [leader] said time will come and the value of this will [be accepted]*.
>
> (ADZU9_health).

Every first year student orientation includes the leader sharing the story of how a traditional medical school neglected the health issues of nearby communities. This story

underscores the importance of the public health and community health focus of the school, in contrast to traditional medical education:

> *There is this hospital in the Philippines who prides itself being the best in terms of technology and having the best specialists and yet a few kilometres from them there is an outbreak of diarrhoea happening. So I think it is ironic.*
>
> (ADZU18_1_staff).

To be accepted by the medical education accreditation system, staff had to submit a conventional curriculum. When the accreditors visited the school they discovered that the curriculum was different and that there were few facilities. However, influenced by a visit to students in the community, local health professionals involved in the accreditation accepted the teaching system and supported the school's development.

The school had to prove that they were capable of delivering high quality medical education. As the school had a non-traditional curriculum, ADZU SOM graduates were labelled "*community based", "foot doctors*" (ADZU18_1_staff), *"slow witted"* (ADZU1-1_student), "*second class*" (ADZU3_student). There was a belief by other medical educators that graduates would not pass the national licencing exams, however students have succeeded and *"[the school was in] the top 10 out of 38 schools on the [medical] board exam*" (ADZU18_1_staff). In spite of these successes, some discrimination continued, and it was still difficult for graduates to be accepted in some training programs outside the region:

> *Other hospitals, like in Cebu, they usually don't hire some of our graduates because of the curriculum, [they] say now you are community-based you*

are not doing hospital training we don't want to train you. … Some of [the ADZUSOM graduates were] rejected because of the type of curriculum [of our school].

(ADZU9_health).

5.2.4 Summary

Most participants had multi-dimensional understandings of social accountability, incorporating the operations of the school to produce doctors who are socially accountable and the mission of the school to meet the health and workforce needs of the region. The school commenced with a strong intention to meet the health needs of the underserved and value base of health for all. Although the concept of social accountability was not articulated during the development of the school, the school had in fact operationalised social accountability through their programs. Although the school staff have not made explicit their contribution to the theory of socially accountable medical education their practical experience is valuable. Graduates of the school were also socially accountable doctors as they worked in poor, rural areas as Municipal Health Officers. The vision and mission of the school was clearly tied with social accountability, and the school had contributed to the medical workforce of the region. This workforce may have contributed to the improved health outcomes observed in the Zamboanga Peninsula.

There were seven contextual issues that influenced social accountability at ADZU SOM. The school was established with a clear mission to address the health and workforce issues of Western Mindanao. The need for a different type of doctor, including MHOs, shaped the curriculum and long term community and hospital placements. The school's non-traditional and service orientated focus is different to

mainstream medical education. Instead of fighting for recognition they have accepted that they are providing the most appropriate medical education for their region. As the main workforce provider for region IX, the school has become embedded in the health system and there is a mutual dependency. With limited resources, hospitals and communities are classrooms. Communities were influential: students undertake long term placements and are catalysts of change for community empowerment. Another community influence is the local government officials are responsible for the health system. This has been challenging due to budget constraints. Students and graduates have had to learn to negotiate for resources in a devolved health system. While resources would enhance what the school does, it is not essential for their programs. Another political influence is the peace and order situation in Region IX. Conflict and the threat of kidnapping has limited where students can be placed on their community immersion. It has also impacted on where doctors can practice. However the school has tried to be part of the solution to the conflict, practicing and teaching religious tolerance and supporting Muslim graduates to work in conflict areas. Internal influences include the vision of the leader who was fundamental to the establishment of the school. Their own personal values, including Christianity, medical experience in the region and personal and professional connections helped establish the school. The university is a religious institution and both Christian and Muslim students are encouraged to reflect on their faith in to serve as "socially accountable" doctors. While a lack of resources constrains expansion of the school, a lack of dependency gave a sense of independence and spurred innovation.

5.3 We study here not for ourselves but for our community: Case Study Four: University of the Philippines, Manila School of Health Sciences

You are the way the school developed you, you will become socially accountable to your community. So, we study here not because of ourselves but because of our community.

(UPMSHS2_staff/former student).

Plate 5.2 UPMSHS, Palo main building with health clinic in background

Plate 5.3 UPMSHS November 2013 after Typhoon Yolande/Hainan (picture Dr Charlie Labarda, Facebook)

5.3.1 Introduction: University of the Philippines, Manila School of Health Sciences

On 8 November 2013, as I was editing this chapter, Typhoon Yolanda (Hainan) was about to hit the coast of Leyte, The Philippines. It was predicted to be a "super storm", bigger and stronger than Cyclone Yasi that had destroyed coastal communities in my region in 2011. Having grown up in the tropics I knew this was not a good thing for Leyte and the UPMSHS. The next day in between the usual Saturday rush of family activities and housework, I trawled my face book page and news channels, tears running down my face, worried for the people I had interviewed and had worked with since 2009, until my husband made me stop. Prior to it becoming known to the world through images of its devastated streets with a confused, grieving population Tacloban was a typical South-East Asian provincial town. I write about Tacloban and Palo as I knew it in July 2012; but with deep respect for the effects that this event has had on the region.

Tacloban is a bustling town of 200,000 people, situated on the east coast of the island of Leyte, Region VIII, 579km south-east of Manila. Here the traditional and modern Philippines seamlessly exist side by side: there is markets and shopping malls; cyclos and four wheel drives; wooden houses and wedding cake mansions; ragged street kids and bespectacled hipsters. As there was no suitable accommodation in Palo, where The University of the Philippines, Manila, School of Health Sciences (UPMSHS) is situated, I stayed in a hotel adjacent to a shopping mall, a busy transport centre just outside the main town centre that hugs the coast. With my colleague I took local transport of jeepney, a garishly decorated converted jeep, unique to the Philippines, 18 kilometres to the school. We jostled along the highway and stopped to collect passengers at barangay, churches, markets and schools. I noticed a sign for the famous landmark on nearby Red Beach, a bronze statue of General Macarthur's return during WWII. The day before I had joined my colleague's family on a trip around the district, as well as having photos with General Macarthur, we had crossed a large bridge that joined Leyte with Samar, the bridge unintentionally forms an L and an S; these are the two provinces served by the school. In contrast with Tacloban, Palo is a small rural centre. From the highway we squeeze into a pedal cab for the short trip to the school. Among small wooden houses I am surprised when we pass through the grounds of a large, beautiful cathedral. I am curious that such an important building is in such a small town, but, despite its size, Palo is the regional centre and most of the government departments and bureaus of Region VIII are located here. Opposite the cathedral, on a small dirt road is the oddly named "Palo Maternity House and Puericulture Center[35]", a colonial building from the

[35] Puericulture Centres were established in the Philippines in the 1920s as health centres focusing on the health of babies, children and mothers (The Philippines. Legislative Research Service. Reference and Research Bureau, 2003)

1930s. The surrounding streets have a village atmosphere: pedal cab taxis wait under shaded trees; dogs sleep restlessly in the shade; children play in the dirt streets and bare-chested men cool off outside makeshift shops. Apart from a sign, the only indication that this building houses a university is the large statue of a semi-clothed male with outstretched arms, the symbol of the University of the Philippines (UP). Two older classrooms are next to the main building and there is also a small health centre. Stepping into the building is like going back into time. The main staff office is crowded with wooden desks and overlooks a river that floods in the wet season. Like the government buildings and cathedral, a university seems incongruous in this rural town; most people I have met in Tacloban did not know that there was a campus of the prestigious university in Palo. They also would not know the impact of the school. The University of the Philippines, Manila, School of Health Sciences has transformed not only on the health workforce and health in the local area, this but impacted on world health professional education, changing attitudes to who can become doctors and how they can become doctors.

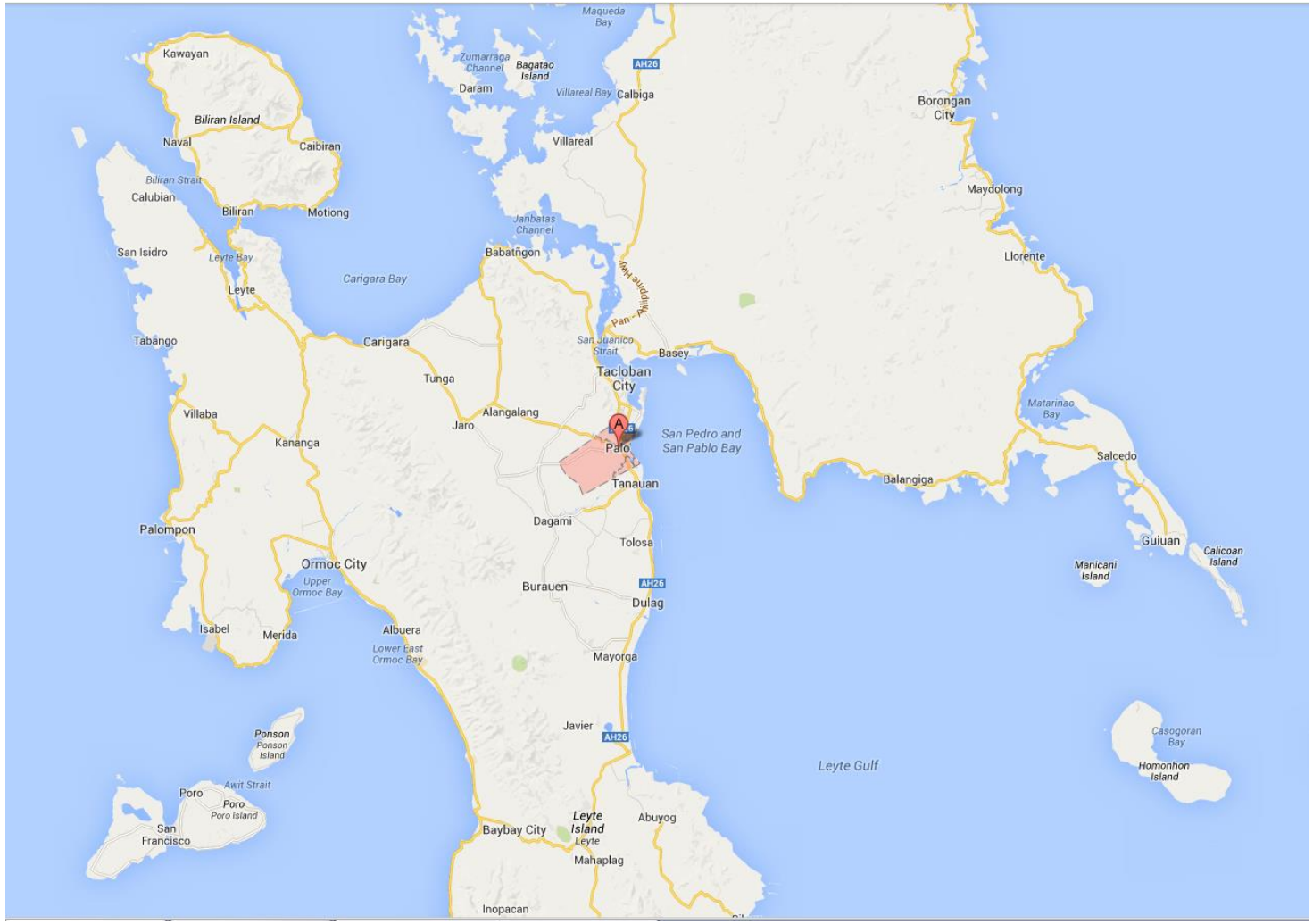

Figure 5.4 Leyte and Samar

(https://maps.google.com.au/maps?hl=en&tab=wl)

The school does not proclaim its links with the University of the Philippines; it was established to be different in 1976 as the Institute of Health Sciences as an experiment of the University of the Philippines, Manila. According to the official history of the school, in 1971 the Dean of the College of Arts and Sciences, Dr Franciso Nemenzo, wrote a letter to Dean Florentino B. Herrera, Jr., of the University of Philippines College of Medicine "complaining that the University was producing a generation of self-centred students who cared more for their grades rather than how they could use their knowledge in the service of others" (Siega-Sur, 2011, p. 349). University officials noticed that many of its health graduates were not staying in the Philippines and were given a mandate to experiment with medical education and "*to answer the Philippine problem of brain drain and manpower shortages"* (UPMSHS13_student) or emigration of health professionals from the Philippines. In 1973 Dean Herrera formed a group of health professionals and social scientists to develop an appropriate curriculum. The school was developed not only because the region did not have a medical school, but also due to an important political link; Kokoy Romualdez the brother of the first lady, Imelda Marcos was the Governor of Leyte province. In 1974 Governor Romualdez sought the assistance of the University to establish a medical school for the region:

> *So that is how, aside from the characteristics of the region, it was really conducive to opening the program. There was the open invitation of the governor that he needed a medical school so he provided part of the support in the beginning.*
>
> (UPMSHS15_staff).

The school pioneered the "Stepladder Curriculum", now replicated by other institutions in the Philippines and overseas. The stepladder curriculum is a curriculum enabling

progress from Barangay Health Worker (BHW) - community health worker - to medical student and doctor. There are five levels for the recruitment and selection process. Students are nominated by their communities from areas accepted as having a workforce need. These students come from poor backgrounds; their parents must earn less than PHP80,000 (AUD2000/ USD1800) per year. There is a special incentive for BHWs who can send their children to the school. Recent high school students must be endorsed by 75% of their community to attend the university and train as a BHW. Other conditions for "scholars" are outlined in Figure 5.5 and for admission to medicine in Figure 5.6.

- "High School Graduate"
- Preferably 16-25 years old upon admission
- If out of school youth, preferable not more than 3 years
- Comes from depressed community in dire need of workers distant form health facilities
- Parents and scholars are permanent residents of the community sending scholar
- Must have resided in the sending community for at least one year prior to the nomination
- Nominated by the community through a barangay resolution signed by 75% of household heads
- Family income of Php80,000.00 or lower
- Physically and mentally fit
- COMMITTED TO STAY AND SERVE IN UNDERSERVED AREAS OF THEIR MUNICIPALITY/PROVINCE/REGION (*capitalised in the brochure*)
- Outstanding BHW (Barangay Health Worker) and traditional birth attendants are encouraged to be nominated
- Willing to sign a return service agreement of 2 years for service for every year of training" (University of the Philippines)

Figure 5.5 Conditions for scholars

III. Medicine

1. Service leave performance - 35%
2. Endorsement from the Municipal/Provincial Health Board approving the nomination of the scholar. - 15%
3. Health human resource complement of the sponsoring Province or Municipality - 10%
4. Passed the Medical pre-qualifying examinations and interview - 10%
5. Faculty evaluation - 10%
6. Academic standing - 20%

Criteria for promotion to Medicine level for nominees who have been employed (health/health-related work settings):

1. Latest performance evaluation (PES or equivalent in private institutions) - 40%
2. Endorsement from sending agency or sponsoring municipality or province - 20%
3. Health human resource complement of the sponsoring municipality/province - 10%
4. Passed the Medical pre-qualifying examination and Interview - 10%
5. Academic standing - 20%

Note: Applicants to Medicine must have taken the NMAT with a score on the 15th percentile or higher.

Criteria for promotion to Medicine level for nominees who have been employed (health/health-related work settings):

1. Latest performance evaluation (PES or equivalent in private institutions) - 40%
2. Endorsement from sending agency or sponsoring municipality or province - 20%
3. Health human resource complement of the sponsoring municipality/province - 10%
4. Passed the Medical pre-qualifying examination and Interview - 10%

Figure 5.6 Requirements for entry into Medicine

(University of the Philippines, 2013)

There is a mix of classroom, hospital and community based learning. Students undertake placements at the Eastern Visayas hospital in Tacloban and undertake community placements in nearby barangays:

> *First year medicine is purely didactic. In the second year, in the morning, we were fielded in the hospital for junior clerkship. We usually do our history and physical examination at that time. In the afternoon, we go back to the classroom for our lessons. After the intensive hospital clerkship, we had our community clerkship for two quarters [6 months]. In the third year, we had our hospital clerkship in the morning, then go back to the classroom in the afternoon. Come third year, clinic and classroom teaching continued. Then fourth year is a one year hospital internship. Our fifth year is one year community internship.*
>
> (UPMSHS4_staff/former student).

Students then return for service leave, unpaid volunteer work in their endorsing communities. If the community requires a health professional at the next level (midwife), they return to study and then return to service leave. Again if their community requires a nurse, they are endorsed for the next level. Service leave is then undertaken. Only those whose communities require a doctor will return to the school to undertake medical training.

The medical course was established in 1980, with a batch of 12 students (Siega-Sur, 2011). Since 1985 125 students have graduated from the medical course (Ross et al., 2014). The first batch of 12 medical graduates had a passing rate of 66.77%, compared with the national passing rate of 52% (Siega-Sur, 2011). In 2012 there were 73 students undertaking medicine in years 1 to 5, with 16 in residency training. There is also lateral

entry into medicine; at the time of my field work eight of the 16 in one batch (the last year of medicine) were lateral entry students. They had entered medical school as nurses, and not having undertaken the previous health professional training at UPMSHS. When they graduate, students return to their own community to work or in similar communities, if there is not a role available. Extension campuses were established in two other regions: Baler, Aurora in 2008 and Koronandal City, South Cotaboto in 2010[36].

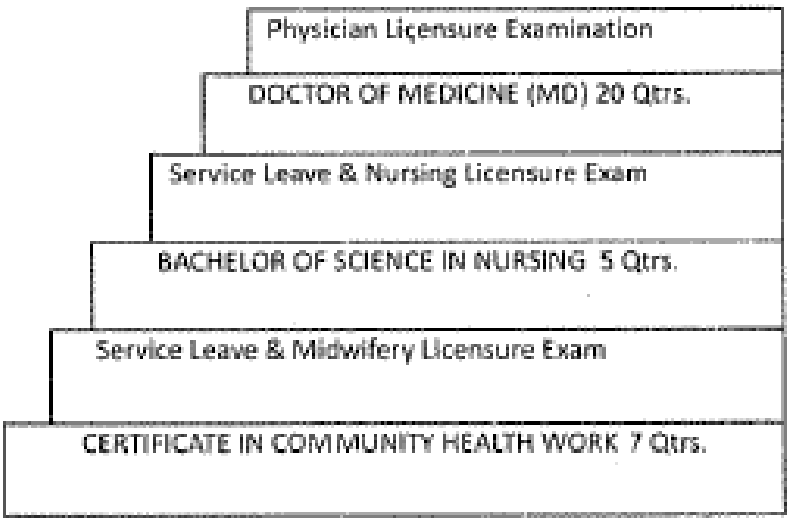

Figure 5.7 Stepladder curriculum: community-based and competency-based

(University of the Philippines, Manila, School of Health Sciences, p. 2)

[36] Due to the distance of these campuses, fieldwork was not feasible to these areas and they are not included in this case study.

5.3.2 Results

In this section I outline my fieldwork, including a description of participants. I outline respondents understanding of social accountability at UPMSHS. I then described the external and internal contextual factors that have influenced social accountability of the school. Data is presented by weight of respondents.

5.3.2.1 Fieldwork

I interviewed 19 participants during fieldwork from the 21 to 27 July 2012; 4 students; 2 community representatives; 7 staff (including several long-term staff members and the leader) and 4 health representatives. Three health representatives and two staff members were alumni of the school. There were two joint interviews (community and one student interview) and the community interview was conducted in the barangay of Canlingga, in the municipality of Dagami, a rural area where students went on placements. Although some staff interviewed were not directly involved in teaching medical students, due to the stepladder curriculum, they do teach students who will become doctors.

5.3.2.2 Understanding of social accountability at UPMSHS

As in other cases, I asked participants their understanding of social accountability in general and their interpretation of social accountability at the school. I also asked eight participants to respond to the definition of social accountability, in terms of UPMSHS. There were three main understandings. Firstly, social accountability was perceived as "service to the community" from a personal perspective. Graduates would return to communities and "render service". Secondly, social accountability was understood to be about how the school and graduates addressed workforce and/or community need. Finally, activities of the school were examined to be socially accountable. Most participants had multiple understandings of social accountability that combined two or

more of these ideas. Four respondents had a comprehensive understanding that aligned with The Training for Health Equity's (THEnet's) definition of social accountability. The two community members were not asked this question due to language difficulties. One respondent did not understand what socially accountable medical education was but still responded to THEnet's definition.

5.3.2.2.1 "We study here not because of ourselves but because of our community": Serving the community

Thirteen of the nineteen participants (or two thirds of the respondents) understood social accountability to signify serving the community. This was interpreted as the service of individual health professionals to the community at a personal level. Students had a duty to return to the communities that had endorsed them or supported them during their studies. They undertook volunteer service leave and returned to health positions in the community once they graduated. The emphasis was therefore on personal service and commitment of individual students rather than the school as an institution. Doctors should not have a "*personal plan*" (UPMSHS1-2_student) to gain financially from their profession but "*be of service ready to save lives*" (UPMSHS6_health). There was also recognition that this service can come at a "*high personal cost"* (UPMSHS6_health) to doctors (e.g. length of training, time away from families). There were different perspectives on what had influenced the commitment of the students to serve and this will be further explored in the contextual issues section. Some participants described how service was something innate or "in the heart" (UPMSHS1-1_student):

> *You have the heart to serve … I think social accountability really means that it comes from the heart.*
>
> (UPMSHS1-2_student).

Four respondents discussed how the school was effective at "*brainwashing the students*" (UPMSHS7_health) into community service or stilling a sense of service in students and that at the school "*the students are trained to go back and serve*" (UPMSHS8_health). This may have been despite students' initial desires to work overseas and fulfil their own ambitions.

5.3.2.2.2 Addressing workforce and community need

Twelve of the nineteen participants saw social accountability to mean addressing workforce or community needs. The school had met the challenge of providing a workforce as "*Ninety of its graduates have stayed in the Philippines and are working in under-served area*s" (UPMSHS6_health), so it had addressed the "*the brain drain*" (UPMSHS-2_student) to other countries. There was also a very clear understanding that the school's focus was upon marginalised and underserved communities. Those communities eligible for UPMSHS graduates were distinguished as those "*that are really in dire need of health services*" (UPMSHS10_staff). Providing doctors to areas of need incorporated the idea of social justice and the need for equity across communities:

> *So it is like the principle of social justice paying preferential attention to those who have less. So those who have less should have more, essentially the principle of social justice. So in our work we pay attention to the under-served populations more than those who already have [a doctor]*.
>
> (UPMSHS16_staff).

5.3.2.2.3 "A community-based, community-oriented school": Operationalising social accountability

How the school's operations are socially accountable was discussed by nine respondents, but not in isolation from the above understandings. Unlike at other case schools the programs or operations of the school were not deemed to be 'socially accountable', but there is an inseparable link between the school's mandate to provide service to the community and address need. All the activities of the school were related to this mandate and there was an integrated understanding of social accountability. Specific school activities that were deemed socially accountable included how students were nominated from "*indigent or less privileged*" (UPMSHS1-2_student) communities. The curriculum focuses on local health and community needs, although some participants suggested that the curriculum needed to be continually updated to ensure relevancy. The University of the Philippines, Manila, School of Health Sciences is a "*community-based, community-oriented school*" (UPMSHS10_staff), with long-term field placements. Research that focused on local health needs was also mentioned, however some participants also mentioned that more needed to be done in this area.

As a founding member of the Network of Community orientated Educational Institutions for Health Sciences (The Network), the school has influenced the development of social accountability in medical education (Borrinaga, 1997; Borrinaga & Tantuico Koh, 1993; Siega-Sur & Varona, 1987; Tantuico-Koh & Borrinaga, 1993). Unlike the other cases, many staff were aware of social accountability in the context of medical education. A link on the website of the University of the Philippines, Manila lead to an archived website developed in 2001. On this site the story of UPMSHS was discussed under the title "Answering the Call of Social Accountability" (Borrinaga,

1997). Staff presented at the first international conference on social accountability in 1995[37]. Prior to this conference, the school had already been in existence for nearly 30 years, so "*the jargon [of social accountability] came later*". (UPMSHS11_staff).

5.3.3 Contextual factors: What has influenced social accountability at UPMSHS

First, I asked respondents what they thought had influenced social accountability at UPMSHS[38]. I then asked questions about specific contextual issues established from the literature whether or not the local workforce needs had influenced the school, the nature of the linkages with the local health sector and the nature of partnerships with the medical school and its community. I also asked about what had influenced the establishment of the school or why was the school established. There were four contextual factors that had influenced social accountability at UPMSHS, all were external contextual factors. The regional workforce gaps and health needs of the community meant that local politicians were supportive of the establishment of the program so there is a political influence. The community was a strong influence due to students' interconnections with communities, community selection of students and student placements. Limited resources - linked in part with the school's the relationship with the University of the Philippines - was another influence.

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[37] In 1995 a WHO and The Network conference was held in Manila with a focus on social accountability. School staff presented two posters. One was on "Socially Accountable Graduates: A Performance-Based Assessment by the School of health Sciences in the Philippines" outlining a case study of health statistic changes in an area of two SHS graduates, despite insecurity due to peace and order (insurgency) issues (Borrinaga, Barua, Irohira, & Tantuico Koh, 1995). Another presentation was on "Indicators of a Socially Responsive Training Programme: The Case of the School of Health Sciences in the Philippines", presenting a survey of the 37 medical graduates from the first three batches (Siega-Sur, Nierras, & Borrinaga, 1995).

[38] As outlined in the previous cases, contextual factors were difficult for participants to comprehend so I used the term "influence". I interpreted "influence" as meaning the factors that had an impact upon social accountability at UPMSHS.

5.3.3.1 External Contextual Factors

All of the contextual factors that influenced social accountability at UPMPHS were external contextual factors.

5.3.3.1.1 "To answer the Philippine problem of brain drain and manpower shortage": Regional workforce and health needs

The reason why the school was established with a unique stepladder curriculum was "*to answer the Filipino problem of brain drain and manpower shortages"* (UPMSHS13_student) or emigration of health professionals from the Philippines. The influence of the workforce situation in the Philippines was discussed by 16 of the 18 participants. Many medical and other health professional graduates aspired to work overseas or in urban areas. This was expressed in the definition of one participant who connected addressing the mal-distribution of the health workforce with the principle of social justice. There was a need addressing the imbalance or mal-distribution of health workers between richer or urban areas and the poorer rural areas:

> *In the documents about the establishment of the school it is really very clear that the reason why they put up a school here [was] because of the mal-distribution of the health workforce; the lack of manpower in the rural areas, the brain drain. Most of [the doctors] were then in urban areas and many were going abroad. So essentially I think [it was about] social justice and to address the imbalance [between] the rich and the poor in terms of healthcare services.*
>
> (UPMSHS16_staff).

Student recruitment therefore focused on areas of workforce need. The school decided which areas to focus on based on health and health workforce statistics. For example

one former student, who was also a staff member, discussed how their barangay had poor health statistics and was therefore chosen to be a UPMSHS 'community':

> *We had [an] increase in infant mortality and maternal mortality. Although we have the midwife staying in the barangay she cannot handle what is not within her competency so, my barangay was chosen [on] that basis.*
>
> (UPMSHS4_staff/former student).

A lack of health workforce was associated with poor health indicators. The school was also developed in Region VIII as it was "*one of the most depressed regions in the country*" (UPMSHS15_staff). These indicators also supported the development of the flexible stepladder model of health workforce education:

> *The health situation was the turning point why UPMSHS was established as a ladderised curriculum.*
>
> (UPMSHS4_staff/former student).

This unique curriculum structure was created to ensure that health professionals were tailored for communities and to "*get our students in areas where there are no health workers*" (UPMSHS10_staff). The needs of communities were met according to the type of health professional required:

> *We also realised that [due to] the community needs, maybe at this point in time a community may only need this level of health worker. So [the student] can only finish to rung three. But as the community grows there may be a need for a health worker with more advanced skills so the health worker can come back to proceed to the next level and complete the program again. And by tying it up into a ladder you create a multi-skilled*

health professional. So they thought maybe this will be helpful to the community.

(UPMSHS15_staff).

The urgent need for a workforce also influenced the stepladder curriculum. There was recognition that the core competencies required by health workers were similar, so there was a shorter training period and workforce could be supplied quickly to communities.

The type of doctor that would address workforce and community health needs were Municipal Health Officers (MHOs), due to their multiple roles in clinical and public health. Students were trained in the classroom and field to become competent MHOs:

I know how hard their work is. It is very challenging because [of] varied cases and they are not only working as clinicians, they act as managers, educators, epidemiologists, community organizers, community developers and so much more – so for me, if we will be able to train students who can function like that and give back to the community then I think the school can be considered as socially accountable

(UPMSHS12_staff).

Participants understood that the school was established to develop new models of community based primary health care and medical education that could be showcased globally:

[The school was established] basically to address the brain drain and address the mal-distribution of health manpower in the rural areas, and then at the same time to develop programs models that can be applied in

> *other areas. You know, how to organise primary health care at the community level.*
>
> (UPMSHS11_staff).

While the school was well-known as a pioneer in developing alternative health professional education models, it was also established: …to design and test program models for health manpower development that will be replicate in various part of the country, and in other countries with similar needs (Siega-Sur & Varona, 1987, pp. 117-118). The foundation and development of the school coincided with the World Health Organization's Western Pacific Office projects on primary health care in the surrounding district:

> *So the UPMSHS opened in 1976, in 1977 primary health care was being promoted in time for Alma Ata in 1978. Since there was already this school here so why not experiment in primary health care here, and so the WHO Western Pacific Regional Office basically supported the first primary health care experiment.*
>
> (UPMSHS11_staff).

This work was presented at the Alma Ata conference. This project also aimed to feedback ideas into the UPMSHS curriculum development "so that [UPMSHS] teaching could proceed in harmony with the evolving health needs for development of rural areas" (Borrinaga & Tantuico Koh, 1993, p. 77)

The school was involved in the first steps to devolve the health system through a research and development project in the nearby Carigara Catchment Area (Borrinaga & Tantuico Koh, 1993; Institute of Health Sciences, 1982; Rojas-Aleta, 1979). The project also concentrated upon the integration of clinical and public health services:

> *One of the offshoots of the project was integrating hospital and public health service at the district level. We were also among the first to experiment with that here"*
>
> (UPMSHS11_staff).

5.3.3.1.2 "It really affects our whole program": Local politicians and local politics

The influence of local politics and local political leaders at the barangay level was discussed by 16 of the 18 respondents. The relationship with government through the health department and others was a vital contextual factor in the development of social accountability in terms of placements and also graduate employment and can either facilitate or hinder this in practice. Prior to the devolution of the health system, the school was established as a joint project of the Department of Health (DOH) and the Department of Local Government (DOLG) and the University of the Philippines. The health department was involved in identifying the areas of health workforce need. Originally the Director of the School was the Director of the local department of health.

The local government was the "*client*" (UPMSHS16_staff) of the school and local government personnel were involved in the selection and financial support of students. Local Government Units (LGUs) were required to provide placements to students for their service leave at their health facilities. Most significantly, graduates expected to be

hired by the LGU when they completed their studies. Strong support from the LGU was therefore essential for the success of the program:

> *We need to have a strong partnership or bond with the Local Government Unit (LGU) because it is the LGU that identifies which health workforce they need, so we train the students to become the health workers that they need.*
>
> (UPMSHS16_staff).

Local politics also influenced selection of other extension campuses in Baler, Aurora and Koronandal City, South Cotaboto in Mindanao. Participants noted that these new centres could not have been established without local political support, indicating that local political support is a requirement for the success of the program.

A change in political leadership could adversely affect students. As elections were held every 3 years new leaders can be appointed while students are studying. Three major issues could occur: the incoming politician may no longer provide financial support; a position may not be made available at the end of the student's studies and the incoming local politician may believe that the student supports the former politician; this may mean that they would not have a position at the end of their studies:

> *It really affects our whole program. Like for me the governor that endorsed me for medicine is not that governor any more. So I don't know if when I go back there [and] I apply [for a] position if she will accept me because she might label me as a supporter of the other [governor].*
>
> (UPMSHS1-1_student).

One staff member felt that politics was one of the biggest challenges for UPMSHS to further social accountability, particularly in relation to supporting students:

> *So some municipalities say: okay, we will support you only through our resolution [on paper]. Financially we cannot support you. In some communities the worse scenario is they don't endorse you anymore.*
>
> (UPMSHS15_staff).

"To endorse" means to allow students to work or hold a position after graduation in a municipality. Graduates may have to seek employment elsewhere as there is no longer a position available under new leadership:

> *There are instances when we ask [the students] about their work and then they say that: oh, the reason why we are working here, in another place, because there is a new change of leadership and it seems that they don't like me.*
>
> (UPMSHS10_staff).

There were difficulties for students not to get involved in the political environment as they needed the support of politicians to continue their community projects on placement. This could also have an adverse effect on student placements:

> *If the leaders are not co-operating it is very hard because the people in the community usually look up to them.*
>
> (UPMSHS1_1_student).

There was a feeling of being caught in the political environment:

The politicians ... they think that they own us, they think that they, I don't know how to explain…

(UPMSHS13_student).

Nevertheless, there was also recognition that they should not get entangled in politics and should focus on serving the people. Not all students had issues with local politicians. One student from a northern province noted that the local politics were not as intense as in the south; and said that even if there was a change of government the student would not be affected. Another described how the provincial governor was very supportive. There was an acceptance that some local officials and communities could not support the students financially. Some politicians had been supportive in other ways such through signing papers and moral support.

Local politicians were also responsible for the budget and may not allocate adequate funds to health, including positions and medications. This was similar to the issues discussed in the ADZU SOM case. For example, LGUs may decide they do not need a Municipal Health Officer, and employ a nurse. This was partly due to the relatively high salary of the MHO (in some cases higher than the Mayor). There was also some acceptance that the LGU may not be able to support employment for students and that they may have to find other jobs to meet the service guidelines of UPMSHS. As a result of the difficulty of returning to some endorsing communities, either due to a doctor already being employed or because of budget constraints, students could work in programs such as the Doctors for the Barrios. So although graduates may wish to work in their own community, they were unable to:

> *So the problem is even if the student is willing to move up to the community and willing to serve, the big problem is there is no [vacant work item] item for the graduates so that the graduates will not leave and look for jobs in urban places.*
>
> (UPMSHS1_2_student).

Communities and local government officials were key partners. Communities were also involved with selecting where "field work" is undertaken. So if communities did not have the capacity and interest to support students, they could choose not to participate:

> *At the community level communities usually make recommendations. They select the areas that can become a good training site. We also inform them why they have been recommended by the local government unit to be one of our field training sites and we give them the choice whether they would want to accept or not. If they don't, then we don't [go there]*.
>
> (UPMSHS10_staff).

To overcome these issues, there were attempts to formalise agreements with local government. The school had tried to remind local government that they need to prioritise students in their budget. Some students believed the school needed to do more to "*ensure the continuity of support*". Otherwise the agreements "*are only papers*" (UMSHS1-2_student). UPMSHS also encouraged health professional positions to be formalised in an ordinance, an extension of the Memorandum of Understanding. Previously there was not written documentation of the obligations of support (from the LGU) and service (of the student). With an ordinance, employment obligations *"would have to be carried out, even if the leadership changes"* (UPMSHS10_staff).

The school was part of a program run by an international NGO that built the capacity of MHOs and local government officials to improve health indicators, including the Millennium Development Goals. School and Department of Health (DoH) staff, mentored these officials:

> *With the devolved health system in the country, we think that working not only with the municipal health officers but also involving mayors in the communities is very crucial to improving health structures, manpower, and outcomes in the community. The role of the coach is actually just to remind the mayor from time to time what is happening like this. We also look at the data from time to time so if it is increasing or if it is – so it is now your role to talk to the mayor to schedule.*
>
> (UPMSHS12_staff).

Through the experience of this training the school staff had gained insights into the lack of awareness of health issues of the mayors. Some mayors had never discussed health issues with the MHO nor knew that there were health indicators to be met.

> *If you make maybe the mayors aware of those things they would probably put more emphasis on health.*
>
> (UPMSHS15_staff).

Students are also taught to work with the local government and to build the capacity:

> *"…so [the LGU] will learn how to prioritise the real health priorities of the people"*
>
> (UPMSHS16_staff).

5.3.3.1.3 "We are here for the community": The interconnection of the students with the community

The interconnection of the students with the community was a strong contextual factor that influenced social accountability and the operations of the school. Students came from areas of workforce need and from lower economic backgrounds. This was different from the profile of typical medical students in the Philippines. Twelve participants discussed the backgrounds or profile of students and how this influenced the social accountability of the school. Eleven participants also mentioned the effect of the limited funds and poverty of the students. Rather than the students themselves being a contextual factor, it was their connectedness with their own community that was the influencing factor. Students were personally connected with the communities; they were the community. Participants reiterated that they were not pursuing a career in medicine for their own benefit but "*for the community*" (UPMSHS2_staff/former student).

As students come from "*indigent or less privileged communities*" (UPMSHS1-2_student) where aspiring to be a doctor would be challenging they had a '*raw hunger*" (UPMSHS6_health) to learn and achieve and "*the thirst for knowledge is greater than those who have been living in a pampered existence*" (UPMSHS6_health). As the "*...students who come from villages*" (UPMSHS15_staff) were limited by a rural education, the course had to be adapted for their needs. Admission criteria was also adjusted, students do not have to sit the University of the Philippines entrance exam. The educational experiences of students were another reason for the development of the stepladder curriculum as students could discontinue their studies at a level they felt comfortable or were not capable to continue. There were some difficulties for students as the medium of instruction is English.

As discussed there was a distinction with community placements from other case study schools; as most students were already from rural communities, barangay life was not something to be learnt but part of where students were from:

> *There is a great difference between a student in a traditional school and a student here in school because I think it is because they come from the rural communities so that when we assign them to rural communities also, it is not so difficult for them to adapt to the situation they are in.*
>
> (UPMSHS10_staff).

> *It is not [difficult] I think for the students [to adapt] to the community because they come from there. So it is not new for them to sleep on the floor. It is not new to them to fetch water from the wells.*
>
> (UPMSHS15_staff).

A health professional commented that students could also relate to patients in the hospital due to their backgrounds.

Communities have a distinct influence on social accountability at UPMSHS and were involved in recruiting students and endorsing graduates for their next level of study. Communities were also sites of student immersion during student placements at all levels of the stepladder curriculum. During discussions there were three clear understandings of communities. The students' own communities were one understanding; and these communities were all over the Philippines, including rural and urban areas:

> *[Our community is] the whole Philippines because remember we have extension campuses in Luzon and Mindanao even before that we recruited students from all over the Philippines.*
>
> (UPMSHS16_staff).

The school's community was also seen as "*the rural municipalities near the school"* (UPMSHS12_staff) or field sites where students undertake their immersion. Region IIX or the islands of Samar and Leyte were also seen as a community as the health needs of this region was one of the reasons the school was established there.

Throughout the course the idea of service had been promoted by the school and students are "*morally obliged*" (UPMSHS5_staff) to go back to the community. Several former students discussed how when they started at the school they planned to go abroad, however the school "*instilled in us the word 'service', service for the people, service with the people*" (UPMSHS13_student). This was a very strong commitment by the school to influence students to serve, indicated by the number of students who returned to their communities.

Due to this training and understanding, there was a "*social contract*" (UPMSHS8_health) between the students and their own communities "*to go back to their community to render service because they are needed by the people* (UPMSHS5_staff)". This signified that a formal return to service agreement was not that important as the idea of service was internalised by students. A former student from the first batch outlined how they were transformed by the training. They had remained in the same community as a Municipal Health Officer for over 36 years.

This doctor had become committed despite their initial strong urge to serve aboard, the former student "*blames*" the school for this transformation; the impact of the school's training was so strong:

> *It is our training. But I loved the training because I would have applied abroad but I don't have that interest. I blame the school for that. For us we don't really sign the contract. It is your deeply rooted commitment.*
>
> (UPMSHS9_health/former student).

Staff who were former students described an internal change of attitude as a transformation process, as they had become orientated to service despite their own initial desires:

> *Our social accountability is not just about that we have a return service agreement between the school and the students but it can be seen [in the way] the school developed us to become socially accountable. You will become socially accountable to your community. So, we study here not because of ourselves but because of our community.*
>
> (UPMSHS2_staff /former student).

Despite coming from poor and rural backgrounds not all students came to the school with a commitment to serve their communities. The school fosters this philosophy. As former students, some staff could appreciate the positions of the students:

> *At first during orientation I thought the only reason is I will study here so that I can to abroad, but later it change[d] my vision.... It is just one day; I think I am here not for myself but for my community. I always encourage [the students] and every day I keep on reminding them. You know what I*

want ....Your dream [to work abroad], it is just the same with me but later on I changed my mind, [as] there are many people who need me. My family they always call me "Makabayan" [it means] rendering service to the community, love of the country.

(UPMSHS2_staff/former student).

Although not discussed as an influence at the UPMSHS, it was clear that leadership and champions were significant for the social accountability of the school, particularly in terms of the service-orientated culture. The school was the oldest of the four case studies schools and although many staff had worked at the school for long periods, the founding leaders of the school had retired (in contrast with JCUSOM and ADZU SOM). Furthermore, UPMSHS respondents spoke of individuals who were fundamental in establishing the school, including local political leadership. This was similar to JCUSOM and ADZU SOM. One influence was how a sense of service was instilled by staff to students. As discussed above, at UPMSHS some students did not come to the school with the commitment to serve. It was the culture of the school that fosters this transformation in the students. This culture was developed by the school leader and staff. At orientation, staff shared their own experiences of how their "dreams" of working overseas changed to "serving" the community.

Community involvement in the selection of students was discussed by 16 of the 18 participants. The local government, Municipal Health Officer (MHO) and barangay officials as well as community members were involved in recruitment. This was in contrast to ADZU SOM where selection was undertaken by professional community people. The school wrote to the mayors and MHOs of eligible communities who then informed the Local Health Board. This local board would identify a priority area for

student recruitment. The Local Health Board would inform the community that has been chosen as a recipient of a student slot. The community would organise a "Barangay Nominating and Screening Committee" that accepted, reviewed and evaluated applications from the community. Screening could include examinations and assessment of student "*attitudes*" (UPMSHS9_health). The group would then hold a community assembly where community would select the nominee. Seventy-five percent (75%) of the households would have to sign and support the nominee on a formal Barangay Resolution. This was a very different application process from most medical schools as:

> *Our students did not come to enrol personally but they are being endorsed by communities that need them.*
>
> (UPMSHS10_staff).

The system had changed since the devolution of the health system, to have more local level involvement. In early years there was "*a Regional Admissions Committee. The membership composed of a representative from the school, a representative from the Department of Health and a representative from the Department of Interior Local Government*" (UPMSHS15_staff). Since devolution the DOH had provided technical inputs such as providing data on health workforce needs. The level of community involvement depended on the level of government that will support students. Some students are supported and placements requested by the province so they are admitted through a Provincial Recruitment and Admissions Committee. At the municipal level there was a municipal recruitment committee. There were also special places for the children of barangay health workers who volunteer in their communities.

One staff member saw student selection as a "*democratic*" part of the stepladder curriculum "*as [the community] cannot blame the school for selecting the wrong student*" (UPMSHS11_staff). Responsibility was therefore put with the 'community'. Communities could also directly come to the school to request a scholarship. These requests were scrutinised by the Recruitment and Admission Committee (RAC) (UPMSHS2_staff). Furthermore, as discussed by the leader there can be "*protests from the community complaining that they say that the scholar that was actually nominated was not qualified*" (UPMSHS15_staff). This indicates that there is also some transparency in nominations, with community involvement and feeling that they can have some influence.

Students must also be endorsed by their community to return to study after service leave or work. Seven respondents discussed this influence. As with student recruitment, 75% of households would have to endorse the student to return to UPMSHS. Whether or not students returned to study depended on the requirement for a type of health worker, rather than their own career aspirations:

> *If we want to proceed to the higher level the one who will recommend us to proceed is our community. It depends upon the community. If the community needs your service [or there is a] lack of health manpower they will not recommend you to a higher level. But if they think that they need a doctor they will send you back to school.*
>
> (UPMSHS2_staff).

The community had influence over a student's choice of medical specialty. One student discussed how she would like to become a surgeon, but pursuing extra training would depend on what her community required.

"The community is the bigger classroom": service leave and community immersion

Students undertook service leave between "ladders" or health professional courses as a requirement for 'return to service' to their endorsing community. There needed to be an on-going relationship with the community so that they are aware if the student was fulfilling their service leave requirements. For midwifery the requirement was "*a maximum of 6 months and a minimum of 3 months*" (UPMSHS2_staff). Only after this service could students take the board exam. On service leave students often worked voluntarily and are sometimes supported by community or their family who provided food and housing:

> *You have to go back because it is part of the, if you really want to go nursing or go up the ladder you really have to do [service leave], voluntarily, you know, with no compensation at all.*
>
> (UPMSHS14_student).

Service leave was an integral part of students' training requirement for the "lower" levels. This was an influence on students to enable them to learn 'the reality' of community health:

> *And then the communities must be involved in the training of the students, so that there is service leave. And then of course the trainings of the students should be suited realities, and so you have a lot of community exposure. So they asked how many classrooms do you have? Oh, only two classrooms and one classroom is very big. The community is the bigger classroom".* (UPMSHS11_staff).

The University of the Philippines, Manila, School of Health Sciences (UPMSHS) had influenced the University of the Philippines, Manila's (UPM) own focus on social accountability, a point of pride for both students and staff. The schools' policy of return to service had been replicated at the College of Medicine in 2005 and other health schools of UPM since 2011. One difference was that graduates from other schools could pay out their service, an option not available to UPMSHS students. The student handbook outlined a return to service agreement, modelled on the school's Return to Service Agreement:

> *"As part of the commitment of UPM to serve the underserved and assuming its social accountability as the National University of the Philippines and as the Health Sciences Center of the country, the UPM is implementing a Return to Service Agreement Program (RSA) among its graduates."*
>
> (University of the Philippines, Manila. Office of Alumni Relations, 2012, p. 5).

Students must give two years of service to the community for every one year of study. One staff member discussed how she was on a committee that evaluated whether graduates could now go abroad to work; most students of UPMSHS had served for many years in their communities.

Community immersion or student placements in rural areas were discussed by 15 respondents. Medical students stayed in the community for a total of 1.5 years (a 6 month clerkship in year 2 and a 12 month internship in year five). In 2012, the sixteen fifth year medical students undertook placements in groups of four students in four barangays within 30 kilometres from the UPMSHS campus in Palo. Students acted as "*mini MHOs*" (UPMSHS4_staff/former student) and developed community health plans so they were "*capable to manage a municipality*" (UPMSHS4_staff/former student).

The first task was to gather data on health issues. Students had to work in partnership with leaders and community people; they presented data back to the people who suggested activities to address the top three health issues:

> *Whenever we have project or activities being implemented we have to coordinate with the key leaders in that area or that barangay. So we work directly with the people in the Barangay and the community leaders.*
>
> (UPMSHS4_staff/former student).

Programs were evaluated and fed back to the school "sharing sessions" and to the communities in an "exit assembly". In fifth year there was a community internship where students were "*fielded in selected communities here in region 8 for one whole year*" (UPMSHS13_student) and undertook public health and clinical work under an MHO. School staff acted as community preceptors and visited students to monitor and advise on their activities.

Communities "*positively respond to the presence of our students*". (UPMSHS10_staff). Students helped address public health issues, provided additional health workforce and medications:

> *I am really happy that the UP students come here in my barangay because that is a big help in my barangay. Especially [producing] the map, the spot map, with the households[because it showed where there]were no toilets.*
>
> (UPMSHS17-2_community).

The barangay officials allocated 'foster families' who provided accommodation. Living with community people was preferable to living at a health station or public buildings where some students have been placed. However, it was sometimes hard for poor

communities to support students. A barangay captain explained that some communities could not support students due to resources. The captain was aware of the support required by the community and how this was integral to the success of the program:

> *…It is better for [a student] to return here to this barangay because it is very supportive.*
>
> (UPMSHS17-2_community).

The generosity of community was acknowledged and some foster parents refused money for rent and food. One student outlined how it was difficult for their group to be integrated in the community as those who could foster students were "*well off*". By living with such a family, "*you are really putting a wall between you and the other not-well-off family*" (UPMSHS14_student). This student found and stayed with another family in his assigned barangay. Two students also reported that they had problems with accommodation. These accommodation issues were associated with local government support discussed above. One influence on the school to change communities was due to the pressures on foster homes, it was becoming more difficult to find families.

Community immersion shaped the attitudes and education of the students. Living with the community enabled students to understand how social conditions impact upon health:

> *So the medical students can understand now the real situation, like for example, poverty, the place where he lives. So that exposure of the medical students in the different communities is really a big help to understand the real situation of every patient.*
>
> *(UPMSHS1-2_student).*

Community immersion was an important way that the school inducted a sense of service in students:

> *The community and we were exposed – we are really seeing the need for us to work in that area. That probably is a big factor.*
>
> (UPMSHS9_health/former student).

> *...once they work in the community as part of our curriculum they learn to love their work.*
>
> (UPMSHS3_staff).

A health care professional saw how community work influenced attitudes and capabilities of students:

> *They are really more, adept in community work, community organisation than the average medical students, the average graduate of the other schools [where] community medicine component isn't that strong.*
>
> (UPMSHS6_health).

There were three main challenges for community immersion: the "*overfamiliarity*" (UPMSHS12_staff) and therefore disinterest of the communities, resources to undertake projects and the sustainability of the initiatives. Barangays were usually close to Palo, to be convenient for staff visits. The school had been in these community areas for long periods; there may be was some scepticism about student motives as two students discussed:

Some of the community people are hesitant to co-operate because they are thinking that we are just there experimenting, we are just forcing them to … (UPMSHS1-2_student) to do this way because this is our requirement. That is the big issue there. Oh, yes, the students of UPMSHS, we need to co-operate with them for their grades. That is their words. So it is very hard.

(UPMSHS1-1_student)

Students outlined how they were challenged to motivate some people about the programs. Health may not have been a priority for these communities and this was a long term process:

So we are trying to help them understand that yeah, it is part of our studies, it is part of our education but we are there also [here] to help them but not all – to change their attitude in just the one click but step by step... so that when we leave that barangay in some ways we helped them to change.

(UPMSHS1-1_student).

Nevertheless the communities were a strong influence, whether or not they were cooperating as students learnt the challenges of working with communities.

The community may not have felt they were influential on the school. They die have an opportunity to send students from the community to the school, but this depended on the education level of students. There were limited opportunities if there was no high school in the area. The community members I interviewed outlined how they would like more students to come to their barangay. Health staff also discussed how they would like to have more students. In summary there were four ways that the community influence

social accountability at UPMSHS: the students were interconnected with the community; there was therefore a moral contract of "return to service" with the community; communities were directly involved with the selection of students and community immersion while students were on placement.

5.3.3.1.4 "Making do with what we can": Limited resources

The impact of the school's limited funding and resources on social accountability was considered by seven participants as a contextual factor influencing social accountability. This was allied with the influence of the relationship with the University of The Philippines, Manila (UPM) as explored by six participants. The University of the Philippines, Manila (UPM) was one of the most prestigious universities in the Philippines. While UPM drove the establishment of the school, as an experiment, the school was still seen as "outside" the university. This creates a tension that was connected with resourcing.

As the national university, UPM was "heavily subsidized by the government" (University of the Philippines, Manila. Office of Alumni Relations, 2012, p. 3). The UPMSHS had some polices from this institution:

> *We had to work around the rules of the university because there were certain university policies and rules which would have restricted us, you know like they are required to take certain units; [including] a gym program.*
>
> (UPMSHS15_staff).

While teaching staff received the same wages as UPM staff, some did not have computers and most shared an office space. The laboratory and teaching rooms were

also under resourced. Unlike other UPM campuses the school could not draw on funding from alumni, nor full-fee paying students. There had also been cuts by the central university due to austerity measures of the government. The school had to manage a 50% budgetary cut and had introduced a range of innovative cost saving initiatives including closing classrooms outside of class time, not allowing students to charge their laptops or phones, cutting air conditioning and getting staff to bring their own tissue paper and soap. "*In the spirit of transparency*" (UPMSHS5_staff), students are informed of why there are these measures. Facilities were also limited, the school had had the vehicle used for community visits since 1999 and it was due to be replaced: "*our vehicles are almost run down; because we just have it repaired and repaired*" (UPMSHS5_staff). Old teaching equipment broke down and at the time of my fieldwork only one of the five overhead projectors, used for teaching, functioned. Staff sometimes used their own money to repair equipment as the school had no money. Another issue was the building, which was not owned by the school, and there was a continued insecurity of tenure. The campus was very small and there were not enough rooms or a hall for official functions. Even the new campuses had limited facilities:

> *The one in Baler we opened that in 2008. No books, no library, until now it has still got very few materials, no laboratory, no equipment…*
>
> (UPMSHS15_staff).

The University of the Philippines, Manila student handbook gave an indication that life on the campus in Manila would be very different to UPMSHS (Office of Student Affairs, 2011). It was a more traditional university, and students have the opportunity to join clubs, write for the student paper and do gym classes. The school was a long distance from the main university, so could not share resources, teaching staff, and other

facilities, although the relationship was seen as "*quite friendly*" (UPMSHS5_staff). Locally, few people knew that there was a UPM campus in the area, and the school was not really recognised as part of the university but is known as the School of Health Sciences. One way for the school to get better funding would be for it to be separate from the UPM. It would therefore be "*level with UP Manila*" (UPMSHS16_staff), so there may be more separation in the future.

Despite the resource constraints, several participants mentioned that the school was still able to produce good outcomes; and there was a sense that "*we make do with what we have*" (UPMSHS5_staff). Although "*limited resources*" was one of the school's "*biggest challenges*" participants also acknowledged that the school "*managed*" (UPMSHS15_staff). The school was fulfilling its mission despite limited finances:

> *[The] school is really answering or really producing manpower that will really serve the underserved communities in the Philippines. The finances are not limiting the school [to produce the workforce]*.
>
> (UPMSHS1-1_student).

Indeed, as students would be working in low-resourced settings, participants accepted that students needed to be adaptive:

> *[I tell the students] in community you don't have electricity, you don't have a blackboard, you don't have all the gadgets. You have to learn how to be resourceful.*
>
> (UPMSHS15_staff).

Resources were also required to undertake and sustain projects when students were on community placements. Financial support could be gained from the community, local

politicians and NGOs, however this was challenging. Furthermore, students were trying to encourage programs that were feasible and sustainable, within the limited material assets of communities:

> *The budget is the most 'controversial' area we have to consider in program implementation. We do not encourage dole outs. We wanted to make the community self-reliant. So we have to live within their means.*
>
> (UPMSHS13_student).

The lack of resources of students also impacted upon the school. As discussed, some local government regions could not support student allowances. There was limited funding through non-government organisations for scholarships. Allowances for students (from the university or community) were sometimes delayed and this impacted upon their ability to study:

> *You know at first they failed their exams, their subject because of financial matters or you know, they have no food, no money for the consultation, so your mind is disturbed so if you are taking the exams and then you try to study hard, you are hungry. (UPMSHS1_2_student).*

A staff member mentioned that students often came to school without breakfast and lived in nearby boarding houses which were rudimentary.

Although not discussed in interviews, during my fieldwork, there was a feeling among staff that while many international visitors and organisations had promised assistance and donations, the school had always survived and could get on without external help:

> "*In the sparsely furnished classrooms, I asked 'What can I help you with, what can I send you?' This request was often met with polite silence, as if they'd heard it all before*" (field notes).

As I spent the next few days with the staff and students of the school, and saw four of the five the overhead projectors sent off to be repaired, I felt that perhaps the teaching methods, has not changed that much since the 1970s. Even the tagline on the website "a health worker for every village" seemed to belong in another era. Despite the under resourced centre, the reputation of the school made the "cliché" of "doing better with little" come alive.

A health representative also acknowledged this adaptability and the resilience of the school and students:

> *It's quite amazing how the school has been able to survive up to this time considering the very limited resources that they have and how they have been able to still produce graduates that have been true to their mission to serve in the underserved communities. I think also because of the particular situation that [they] are able to make do with what they have. They are able to instil those kinds of values in these students, so the students are able to see that things can be done even if [they are] in a very limited setting, one can still make a difference.*
>
> (UPMSHS6_health).

5.3.4 Summary

At the University of the Philippines, Manila, School of Health Sciences (UPMSHS) social accountability was understood to be about serving the community and meeting

workforce and community need. Participants discussed four contextual factors that influenced social accountability. Workforce, health and community need was the strongest influence. The school was established to address the workforce needs of underserved areas in the Philippines and to demonstrate the benefits of an innovative stepladder curriculum. The school has achieved these aims, with 90% of graduates still serving their communities and the stepladder curriculum being replicated across the world. While both the hospital and community are sites of student training, it is the community that has had most influence on social accountability at the school. The students were interconnected with the community as they were to return to their own communities to serve through e a moral contract of "return to service". Communities were involved in the selection of students and endorsement of students to the next health professional level. They were also responsible for providing positions for students during their service leave between levels and at graduation. Local politics and local political leaders were also an influence to ensure support of student placements and graduate employment. Resources were an interesting influence upon social accountability at the school. Despite being part of one of the country's elite universities, the school also struggled with resources and facilities are limited. Another challenge was the backgrounds of students who came from poor areas and find it difficult to study with limited finances. Yet limited resources had also enhanced social accountability at the school. Students related better to the communities they serve and to patients in the hospital due to their humble backgrounds. The school also had a "make do with what we can" philosophy demonstrating to students and to other universities that great outcomes can result from modest inputs.

Chapter 6 Cross Case Analysis and Discussion

6.1 Introduction

In this chapter I compare the understandings of socially accountable medical schools at the four case study schools with that found in the literature. I then examine what contextual factors have influenced socially accountable medical schools and how these vary between cases. This includes an analysis of the influence (or lack of influence) of the three contextual factors: local workforce; linkages with the health system; and partnerships with the community and how these impacted upon progress towards social accountability at the four medical schools. I then present a conceptual framework that demonstrates how contextual factors influence socially accountable medical schools. Finally, I show how this framework might be useful for medical schools aspiring to be socially accountable.

6.2 Understandings of social accountability

Most respondents had multi-dimensional perspectives of social accountability that combined two or more understandings. Many of those who had been involved with The Training for Health Equity Network (11 participants) reiterated the definition developed by this collaboration and had a comprehensive understanding of social accountability. There were three understandings of social accountability that were shared across all cases. Firstly, socially accountable medical education was about meeting workforce, community and health needs, aligned with the Training for Health Equity (THEnet) and WHO definitions (Boelen & Heck, 1995; Larkins et al., 2013; Ross et al., 2014). Graduates worked in underserved areas and contributed to the workforce and therefore impacted on the health outcomes of community. Students could be engaged in

community public health projects or service delivery that had a direct impact upon the health of communities or individuals. One of the three definitions of social accountability for 18 graduate medical education (GME) stakeholders in the USA was "creating a workforce to address regional needs and physician shortages" (Reddy, Lazreg, Phillips, Bazemore, & Lucan, 2013, p. 441).

Secondly, participants saw that social accountability was determined by the type of programs the school implemented. This understanding encompassed the way the school operated: including recruitment of students; governance structures that encompassed community decision making processes; and curriculum that included underserved groups. James Cook University School of Medicine (JCUSOM), ADZU SOM and UPMSHS had more integrated understandings of social accountability; the schools were established with a specific vision and their missions that aligned with social accountability. For most schools the theoretical appreciation of social accountability came after they had implemented programs that directly addressed need. This was similar to findings at Makerere University in Uganda were "the practice of social accountability is old however the use of this term is new" (Galukande et al., 2012, p. 5). At ADZU SOM, although the school staff had not made explicit their contribution to the theory of social accountable medical education, their practical experience was valued. There was an appreciation that without real action and with only a focus on theory the term social accountability could be used to redundancy, or become "meaningless" without action. At FUSOM social accountability was understood as being tangible. Programs were "doing" social accountability or promoting social accountability to students or staff. The term is seen as both a process: "*being socially accountable/doing social accountability*" and an outcome, "*the program is socially accountable*" or "*the program helps strengthen our social accountability*". In the literature, rather than a

comprehensive understanding of social accountability that incorporated health and workforce outcomes many schools describe individual programs as being socially accountable (Galukande et al., 2012; Jarvis-Selinger et al., 2008; Murdoch-Eaton & Green, 2011; Murdoch-Eaton et al., 2011; Parboosingh, 2003; Rudolf et al., 2014; Talaat & El-Wazir, 2012; Wasylenki et al., 1997).

Thirdly, social accountability was deemed a personal responsibility or value. For example, viewing graduates as being personally accountable to communities. This is similar to findings from Galukande et al. (2012) who asked ten medical educators and two students at Makerere College, Uganda their perceptions of social accountability. While respondents were not familiar with the term; social accountability "was thought to be a duty of individuals towards a community by providing service and training students to be more sensitive to the community needs that they serve…" (p. 3). Reddy et al. (2013) discussed two other understandings of social accountability as "ensuring quality in training and care to best serve patients; and providing service to surrounding communities and the general public" (p. 439). At ADZU SOM and UPMSHS there was a very strong sense of service of health professionals. Social accountability was seen as a moral obligation by students to work in underserved communities. Participants also understood social accountability to be about the personal values of individuals connected with the school. These personal values aligned with social accountability and gave meaning to their work. As they shared these values, people felt a natural affiliation with social accountability. These values had been developed through their own faith or religion and/or work experiences. If social accountability is understood to operate at a personal level, then medical schools may not develop programs that encompass an institutional approach to social accountability. For example, Karnieli-Miller, Zisman-Ilani, Meitar, and Mekori (2014) suggest that teaching shared decision-making practices

to medical students is “an interpersonal approach to achieve true social accountability” (p. 2) and interpreted social accountability to be a doctor’s accountability to their patient and a partnership that will empower the patient.

This study adds to the theoretical understanding of social accountability. There was an assumption that social accountability in the context of medical schools and medical education was known and universally understood, yet the term is still open to contention and debate (Galukande et al., 2012; Jamieson, Snadden, Dobson, Frost, & Voyer, 2011; Puschel et al., 2014; Reddy et al., 2013; Rudolf et al., 2014). This is in part due to the broad framework in how social accountability is defined (Reddy et al., 2013). Because of the assumption of a shared understanding, most studies of socially accountable medical schools have not asked participants about their own understandings of social accountability. However, some studies have shown that staff and students might have limited knowledge or understanding. For example, a survey of all health faculty staff at the Faculty at the Medical Sciences of Mashad University in Iran found a limited knowledge of social accountability; with less knowledge among staff from the basic sciences (Ali Zahed Moghaddam, Labbaf Ghasemi, Ghoushkhanei, Afshari, & Marouzi, 2013).

What this study demonstrates is that social accountability is inherent in the mission of some schools; in some schools it is strongly a personal value, and in some it is both. Where it is held at a personal level the implications are that it may not play out at the wider institutional level. Therefore only staff that held these values would demonstrate social accountability in their programs. Where it is understood primarily at an institutional level the implications are that some staff who do not share the same values could be alienated from the school’s mission and focus. Where social accountability is

held at both the personal and institutional level, the implications are that most staff and programs have a shared understanding; and the mission and focus of the school should centre on the health care needs of the communities that the school serves. I hypothesise that both an institutional understanding and an appreciation for social accountability as well as personal values are important foundations for socially accountability. For example, the AIDER (Assess, Inquire, Deliver, Educate, Respond) model for social accountability prepares individual doctors to work with underserved stakeholders and can also focus the direction of a medical school (Sandhu, Garcha, Sleeth, Yeates, & Walker, 2013).

6.3 How contextual factors influence socially accountable medical schools

There were ten contextual factors that influenced socially accountable medical schools. There were two contextual factors that operated in all schools:

- Workforce and health needs and
- Community

There were six other contextual factors that were apparent in some schools but not in others.

- Government policies and funding;
- Local politics and politicians;
- The university or wider institutional context;
- The availability of resources;
- Leaders and individual champions; and
- The Training for Health Equity Network (THEnet).

Two contextual factors were not strongly apparent in individual cases but emerged more so in the cross case analysis:

- The health sector; and
- Resisting traditional models of medical education.

In order to support my findings this section includes an analysis of literature related to socially accountable medical schools including medical education reforms, medical schools in general, curriculum change, health sector and human resources for health.

6.3.1 Contextual factors that were influential at all schools

Workforce and health needs and communities were influential contextual factors at all four case study schools.

6.3.1.1 Workforce and health needs

Local and national workforce issues and health needs were important contextual factors that influenced socially accountable medical schools at all cases. There was a common understanding of social accountability as meaning "meeting workforce need"; aligning with THEnet's definition. Workforce was defined as shortages of doctors in underserved areas. There was a mal-distribution between urban and rural areas. There was also a common understanding that doctors who received tradition medical education were not prepared to work in these areas. All institutions had geographic proximity to a defined region of workforce need, or sent their students there for a lengthy period, often coexisting with populations with the poorest health indicators or greatest health needs. Programs and schools were established to meet these workforce and health care needs and there were some innovations in both the Philippines and in Australia. The workforce and health system needs influenced how students were trained

and the desired outcomes of their training. Schools produced graduates who would be well-equipped to meet the workforce and health system needs. Placements ensured that graduates were personally and professionally equipped to work in areas of workforce need. This finding concurs with the literature on socially accountable medical schools (Boelen & Heck, 1995; Pálsdóttir et al., 2008; J. Rourke, 2006). The main focus of socially accountable medical schools should be meeting the workforce needs of their region. Schools must be aware of these needs and be part of the workforce planning process. In addition, students should learn about the specific health needs of underserved communities. (Boelen, Dharamsi, & Gibbs, 2012).

This finding highlights that more traditional schools that are not in areas of workforce need may find it difficult to address health issues or reorient programs as the immediate need of underserved populations may not be apparent. This might explain why more traditional schools believe that an isolated aspect of their program, such as students going on placements overseas or short term service learning can demonstrate their social accountability. Schools in areas of workforce need have a more holistic or "whole of school" approach to social accountability as the health system needs are very apparent and hard to ignore. It is confirmed in the literature that in Australia the needs of the surrounding population and health needs influence the curriculum, research and service of rurally based schools. Worley and Murray (2011) argue that nation-wide Australian approaches to socially accountable medical schools at both the undergraduate and postgraduate level were influenced by rural medical workforce shortages. Rural medical schools and campuses have been established due to workforce issues (Snadden et al., 2011). An assessment of the missions of Australian medical schools noted "the influence of locality" (Biggs & Wells, 2011, p. 425) upon schools in regional areas to focus on rural health. In the Philippines the health and workforce

impact of the brain drain of skilled medical professionals to more financially resourced countries spurred the development of the two case study schools.

My findings are also consistent with the principles and philosophy of Towards Unity for Health (TUFH); but the findings also extend the principles (Boelen, 2000b). I have found that schools established in defined geographical areas and work with health services to meet these needs have clarity about their community. This suggests that schools established in defined geographical areas where health needs and services are apparent might find it easier to address needs. Another issue that my thesis could not adequately address is the difference between the rhetoric of policies about workforce. While most medical schools proclaim that their policy is to meet the needs of the population, "how, then is it that this fundamental orientation for schools is so seldom reflected in their educational objectives, teaching methods and evaluations?" (J.-J. Guilbert, 2014, p. 60). Having a clear understanding of the workforce and health needs in a defined geographical area might ensure that medical schools are oriented to be socially accountable.

6.3.1.2 Communities

The second theme that was apparent in all cases was the influence of communities. Communities influenced socially accountable medical schools in different ways; but there was a shared understanding that communities were most influential for student placements. Understanding the "community that they serve" or reference population is an essential part of social accountability for medical schools. This is one key value that differentiates socially accountable medical schools from traditional medical schools. While "social accountability is the fabric that binds medical schools and their communities and regions together" (J. Rourke, 2006, p. S47), it is difficult for medical

schools to define and understand their communities (Larkins et al., 2013; Michener, Champagne, Yaggy, Yaggy, & Krause, 2005). The Training for Health Equity Network conceptualised underserved populations following Blumenthal and Boelen (2001) (Larkins et al., 2013)[39]. However, in my study schools understood 'the community' in diverse ways:

- *At the population level*: Associated with the influence of workforce, at some schools the population of communities and their different health needs had influenced the curriculum, student recruitment, student placements and the establishment of the school. This understanding incorporates the WHO definition of social accountability to mean meeting the health needs of the communities that schools serve (Boelen & Heck, 1995).
- *As communities of place and interest with a formal or informal community engagement policy*: Some schools had formal community engagement policies and informal ways to work with communities of place and interest. This is a much more complex conceptualisation of community. There may be a formal engagement strategy with communities, informed by the wider institutional policy. There were also informal ways the

[39]"1. Generally "groups or populations within a country who, compared with the majority of the population, suffer from poorer health, fewer opportunities or reduced access to services".

2. Relating to developed countries – In every developing country, there are groups that are 'disadvantaged relative to the whole'. Examples are based on: Race/ethnicity, Poverty, Geography, and other groups with special needs.

3. Relating to developing Countries – 'Virtually the entire population of the poor countries is disadvantaged by comparison to the wealthy countries'" (Larkins et al., 2013, p. 33).

community partnered with the school in communities of place, particularly in rural areas.

- *As students being from the communities and part of the communities*: The student's own communities are part of the reference population as students are recruited from these communities; and
- *As students becoming part of the communities*: Students undertake placements in underserved communities and are integrated into community life.

There were also differences between the collectiveness of communities and individuals as a patient, consumer or representative.

Community placements can drive student learning. Students are exposed to the realities of professional and community life in rural or underserved communities (Dussault & Franceschini, 2006; Howe, 2002; Sen Gupta et al., 2008; Towle & Godolphin, 2011). Rurally based staff and health professionals were "*boundary crossers*" both a members of a community of place and a professional group (Kilpatrick, Cheers, Gilles, & Taylor, 2009). This status enabled them to have trust in both in the community and the school; enabling them to harness resources and enhance community capacity. The value of the informal curriculum and socialising medical students into rural and remote medicine during longer term placements was established by a study at a rural clinical school (Roberts et al., 2012). The informal curriculum, including engagement with other professionals and communities was also explored in the development of a professional identity as a rural doctor. Students discovered that "…working in underserved communities was a worthwhile commitment, and numerous individuals were invested in the students' success" (Holley, 2013, p. 8). Some participants described how long term

community placements could be a "transformative process" that could change or confirm the personal and professional attitudes and aspirations of students. Community placements were also responsible for changing or confirming student attitudes and aspirations. Long term community-based medical education "…allows for meaningful relationships and experiences for students and that such meaningfulness enhances learning" (Kelly, Walters, & Rosenthal, 2014, p. 47).

There were differences between countries in how communities understood their role in community placements. In Philippines there was a personal journey and students discover their *"need to serve*" after exposure to underserved communities. In Australia community members saw themselves as responsible for ensuring students enjoy and appreciate rural or country life. It was hoped this will encourage students to "*come back"* to love the lifestyle and professional challenges available in their community (R. P. Strasser & Neusy, 2010). Therefore the idea of service and links with the community were stronger in the Philippines where there was a sense of personal responsibility. Participants in the Philippines saw the students on placement as "*helping*" with health and community services. In Australia however the imperative for workforce is more political or organisational and government resources are assigned to this endeavour through programs such as the Rural Clinical Teaching Program (Australia. Department of Health, 2012).

In less resourced countries such as the Philippines community connectedness and supportive communities can help retain rural workers. Community connectedness was central to the motivation of auxiliary nurses in rural Guatemala. Motivation to remain in a community was due to a "sense of connection" and "shared culture" as well as understanding and their own experiences of health needs. Recognition from community

and value of work lead to satisfaction (Hernández, Hurtig, Dahlblom, & San Sebastián, 2012, p. 1). A study of health workers in Papua New Guinea found there was a "complex interaction of the social environment on health worker motivation and performance" (Razee, Whittaker, Jayasuriya, Yap, & Brentnall, 2012, p. 828). Community involvement, respect of health staff and ownership of health services mediated the influence of other factors including gender roles, family demands and safety impacts on health worker motivation and performance. This finding illustrates that students need to understand the importance of the commitment and interest of the community, and strong community ties. If they appreciate the importance of these factors they may be more likely to understand this as health workers and be committed to staying in underserved communities. Placements may also foster attitudes that enable students to act in a partnership role with individuals and communities. From this experience they may understand the deeper reasons why such partnerships should be built and principles that allow genuine partnerships. Consequently students could be more likely to work in partnership with communities in the future or see the value (Wealthall, Graham, & Turner, 1998).

While all schools were influenced by communities, in all cases the community may not have appreciated or fully understood the importance of this influence. Respondents also considered that one of the barriers to social accountability was the lack of authentic engagement with the community. Community based training and service learning does not always equate with a partnership with the community. In their review of the goals of community based medical education, Hunt et al noted that not one article mentioned 'partnership':

> *...Community engagement was frequently conceptualized as service or outreach but never as a collaborative partnership with the community.*
>
> (Hunt, Bonham, & Jones, 2011, p. 249).

Two of the eight barriers to social accountability identified in a literature review related to the community (and power imbalances); firstly, there is a shortage of elective courses or subjects related to community problems in the curriculum. Secondly, collaboration between universities and communities is difficult as universities tend to be separate from the community and remain in an ivory tower (Fakhari, 2014; Yamani & Fakhari, 2014). This is interconnected with the idea of power and empowerment. Communities need to be made more aware of their power and influence to develop better partnerships with socially accountable medical schools. Doctors have traditionally held roles of power and leadership in the health system (Boelen, 1993a; Rifkin, 1978; Wealthall et al., 1998). Issues of power and empowerment are intertwined within these partnerships; and may involve the medical school giving up power and developing strong relationships in communities and community health services.

To "…build trust, share power and provide support" (Maurana, Wolff, Beck, & Simpson, 2001, p. 218) medical schools need to respect the community's knowledge mutual division of roles and responsibilities; continuous flexibility, compromise and feedback; strengthening of community capacity. Schools need to recognise the power differences and allow communities to have frank discussions about the differences in access to resources and the impact of power on partnerships (Michener et al., 2005).

6.3.2 Contextual factors that were apparent in some schools but not in others

Six contextual factors were apparent at some schools but not at others. This section compares and contrasts the influence of: government policy; local politics and politicians; universities and the wider institutional environment; the availability of resources; leaders and individual champions and The Training for Health Equity Network at the four different schools.

6.3.2.1 Government policy

Government policy in medical education and health was another external contextual factor. While only the Australian case studies acknowledged this factor as an influence it is interesting to analyse why government policy was not considered as a factor in the Philippines. This contextual factor was linked with workforce need. In Australia the underlying influence of workforce was a political driver as many initiatives are particularly determined by rural health policy. A number of federal government policies and programs addressed rural workforce issues. Government policy that provided substantial funding was essential for socially accountable programs such as rural placements as the schools would not have been able to undertake these programs without this government support (Biggs & Wells, 2011; Murray et al., 2012; World Health Organization, 2013a, 2013c). These programs were established through lobbying of rural health and medical education champions:

> *Political advocacy from the rural sector and accumulating evidence from academic research, reviews and collective experience has helped policymakers implement programs that produce a rural medical workforce. As a country, Australia has exercised notable leadership in this regard, with the range of policy interventions.*
>
> (Murray et al., 2012).

In the Philippines, due to the prevailing culture of export driven medical and health professional education, government policy and programs supported new initiatives such as the Doctors to the Barrios (DTTB) program and the Pinoy Doctors Program. However, these government initiatives and other government policies were not highlighted as influencing socially accountable medical schools - although graduates did take part in these programs - as the two Filipino schools were established prior to these initiatives. The stepladder curriculum at UPMSHS was established outside the mainstream as an "experiment". The school was therefore given a mandate to do this from the start, from the University of the Philippines, a public university and the government. The Ateneo de Zamboanga University is a private institution and much less driven by public policy/government funding, with more flexibility to develop its medical course. While the leader had to follow the "rules" of medical education at the country level and wrote the course to meet these needs, in reality what was to be taught was very different.

The literature on social accountability stresses that governments should be partners in health professional education. There is an emphasis on working with the health sector and health care policy makers (Boelen & Heck, 1995). The Towards Unity for Health (TUFH) project outlines the dynamic process to ensure all key players in the health

system work towards a common purpose – the needs of the population (Boelen, 2000b). Direct support of government is important, best illustrated by Canada where socially accountability medical schools have been initiated in Health Canada policy since 2001 (Health Canada, 2001; J. Rourke, 2006). All 17 medical schools participated in national social accountability projects, including Aboriginal health and public health. These projects were in response to Canadian health needs.

Government policies could do more to regulate professional bodies and accreditation systems. Professional bodies could also enforce changes to orientate schools to be more socially accountable due to new accreditation standards (Cohen et al., 1994; Puschel et al., 2014). Government policies via accreditation systems and other regulations could include rewards and penalties that help insure social accountable is a process, not just a vision and. (Afshari, 2012). An unregulated higher education market can lead to a brain drain as schools are established for external health system markets. However, too much regulation can be a barrier to educational innovations (World Health Organization, 2013d). Systems such as the Global Consensus on Social Accountability as well as the identification and incorporation of social accountability into current global standards such as the World Federation for Medical Education (WFME) accreditation guidelines can accreditation guidelines can support this process (Elhassan Abdalla, 2012, 2014).

The implication of this finding is that while government policy can help foster socially accountable medical schools, it is dependent on the political environment. Decisions are made in a political context. In more financially resourced countries socially accountable programs such as rural placements could not persist without government funding. Unpacking the government policy and wider government influences in medical education can help predict which policies are more conducive for social accountability.

Federally supportive policies and programs such as those in Canada can have a direct influence on schools. By contrast, government policies that have restricted social accountability in the Philippines were overcome due to other factors such as strong leadership and people within innovative schools. The cultural and political organisational context of a country can also impact on socially accountable medical schools. The differences in political organisation, or between a more centralised and decentralised government, might explain some of the differences in Australia and the Philippines. The decentralised Filipino health system may mean that local initiatives are more influential than government policy. Comparative studies between different health systems and government are required to fully explore the influences of government organisation and policies on socially accountable medical schools. Furthermore, more could be made of the political influence of medical schools collectively to be able to change and advocate for policy changes.

6.3.2.2 Local politics and local politicians

Local politics and local politicians were a powerful contextual issue that influenced social accountability at all four medical schools. Although The Towards Unity for Health (TUFH) initiative documented the importance of local government representations in supporting health service delivery (Boelen, 2000b), there has been little discussion of the importance of local government in medical education. While the local government sector had more influence in the Philippines, in both countries participants also saw the local or first level of government as being part of the community. Involvement with local governments was deemed as involvement with the community. In The Philippines the health system is devolved with local municipalities responsible for Municipal Health Officers and the primary health care level of services. Therefore this level of government has more influence on medical practitioners than in

Australia. Local officials and local politics had power as they controlled the budget and could either impede or enhance student selection, placements, and graduate job placements. In Australia, while the local government did not have as much influence over the health system, support was provided through other initiatives that have involved local councils and medical education such as the provision of housing and social support on placements and in some cases, local councils owning primary health care services.

This finding demonstrates the importance of medical schools working with all levels of government, including local governments. Local governments should be resourced and empowered to work with medical schools. In the Philippines, changes in local government impacted on the schools selection of students, student placements and graduate employment. In the context of regional medical campuses, Snadden et al. (2011) recommend that when there are government transitions, new "'Stories' that resonate with the new government's agenda may allow the government to accept and personalise the regional campuses contributing to 'our' mission" (p. 527). The significance of local government in the Philippines also accentuates how different health systems impact on the social accountability of medical schools. Decentralised health systems may allow for more local community involvement; but may also mean that health services at this level are politicised with impacts on resourcing and support.

6.3.2.3 Universities and the wider institutional environment

Although not distinguished at the Filipino case studies, at all schools the affiliated universities influenced social accountability in different ways. There are two areas of interest in this theme: how the values of the institution aligned with social accountability and the effect of the traditional "separation" of the medical school from

the university. Some schools were part of universities that had a wider institutional culture that encouraged going against the norm and the development of innovative programs. Others were the only tertiary institution in a large region, influencing the school's ability to serve a defined community. Interlinked with the contextual influence of the community, the university and the school were part of the community. The institutions also held values aligned with the values of social accountability as well as many of the staff's own beliefs, these included social justice and a religious association.

Medical schools usually are unique entities in universities due to the distinct professional training requirements. Indeed "while medical schools may be in universities they are not wholly of them" (Cookson, 2013, p. 715). In the USA Academic Medical Centres have been described as 'silos' external to universities (Azziz, 2014). Due to the focus of schools on professional training that takes place outside the university in the health sector, medical schools can develop isolated from the main institution and have more affiliation with the health sector than the university. This autonomy can have a positive influence on a school aspiring to be socially accountable. One of the case study schools (ADZU SOM) developed in isolation from the university and affiliated after its development. This status set the school apart from other schools and departments of the university; it was not formally embedded in the university. The school did not have to adhere to the rules (e.g. fees, etc.) of the university, unlike UPMSHS. At UPMSHS the relationship with the university highlighted the innovation and difference of the school in contrast with the more mainstream University of the Philippines, Manila (UPM), one of the most prestigious universities in the Philippines. The stepladder curriculum at UPMSHS was established outside the mainstream as an "experiment".

The implication of this finding is that when looking to establish or transform medical schools; those aspiring to be socially accountable would have more support when the wider institutional environment is conducive to social accountability. When establishing a new medical school there needs to be a working partnerships with the university that builds "…a common purpose around social responsibility is important but a new mission may need to be 'sold' to the main campus faculty who may not see physician supply or mal-distribution as their problem and have concerns that it will weaken the research mandate" (Snadden et al., 2011, p. 520). Yet the medical school's unique autonomy and separateness can also ensure that social accountability practices be developed without the support of the university. Schools have also demonstrated how they have influenced the wider institutional environment, for example through as community service and return of service agreements.

6.3.2.4 The availability of resources

Resources, including financial, human and infrastructure, were a contextual influence at all case study schools, however, the influence differed between countries. In some contexts resources are required to fund programs and in some contexts lack of resources has spurred innovation (Neusy & Pálsdóttir, 2008, 2011). In Australia, government funding was essential for socially accountable programs, such as rural placements, to be established and sustained. Indeed these programs were deemed more expensive than conventional medical education programs due to the decentralisation to rural areas. In the Philippines, while further resources would enhance programs, they were not necessary for socially accountable medical education to be implemented. In fact a low resourced environment aligned with the policy of the schools and enabled innovation by staff and in the students. While both the Filipino schools had received international support at establishment and had continued partnerships with schools in more resourced

countries; a lack of resources also promoted self-reliance and a culture of independence and empowerment. There was also an awareness that locals were better equipped to develop the schools; and a creative ability to "*make do with what we have*".

As discussed by Woollard (2006), less financially resourced environments may promote mutual interdependence and closer working relationships between the education and health sectors through the need to share resources, including staff and facilities. In Tanzania, while resource constraints (including human and financial) restricted health workers, their "…capacity to mobilize social, cultural and symbolic capital played a significant role in their ability to overcome work related problems" (Gross, Pfeiffer, & Obrist, 2012, p. 1). Indeed in both Filipino cases, leaders and staff drew on interpersonal connections and social relationships, and used their status as health professionals to gain social capital and overcome work related problems (including a lack of resources).

There is a danger in romanticising a lack of resources as the only way to develop innovation, creativity and social accountability in medical schools. The Training for Health Equity Network's (THEnet) evaluation framework calls for adequate resourcing across all programs and geographic areas (The Training for Health Equity Network, 2011) and all THEnet schools reported resource constraints (Pálsdóttir & Neusy, 2011). Other studies have noted that a lack of resources, including personnel, facilities and budget constrains curricula and medical school reforms in more financially resourced countries (Cohen et al., 1994; J.-J. Guilbert, 2014). In less financially resourced countries, some medical schools have few resources and can barely function. Issues are compounded by a poorly resourced health services, particularly in rural areas. (R. P. Strasser & Neusy, 2010). A study of sub-Saharan African schools cited lack of staff, "…the general disrepair of campus infrastructure…" including "…laboratories,

libraries, classrooms, lecture halls, and hostels…" and a lack of "…information technology and bandwidth" as barriers to schools keeping up with changes in medical education (Mullan et al., 2011, p. 1120). In Nepal interruptions to electricity, high fuel prices for generators and the dearth of internet and electronic media impacted on the functioning of medical schools (Shankar, 2012). This finding demonstrates that in the development of socially accountable medical schools there needs to be a balance of adequate resources with room for innovation and adaptation to the local contexts.

6.3.2.5 Leaders and Individual champions

Leaders and individual "champions" were strong contextual factors that influenced social accountability at all schools. Leaders influenced the organisational culture of the schools and the type of people attracted to working the schools. They had values and work experiences aligned with social accountability that enabled programs to be enacted and supported. Furthermore, staff and students were attracted to working with leaders and at institutions that had these values. Often leaders had been the driver of innovations such as the establishment of the school or rural education programs. Health sector leaders were also involved in the development of programs (and still worked in the sector). The leader's values, medical experience in the region and personal and professional connections established; reorientated or sustained the school. Individual "champions" or individuals who worked at the school or in the health sector were also described as important internal influences on social accountability. Champions from across the health, education and political sectors lobbied for the establishment of new schools or programs. Many staff held intersecting roles as alumni, staff and health sector employees. These individuals upheld the school's partnership with the health sector.

While leadership and champions were not discussed as a contextual influence at the UPMSHS, a sense of service instilled by staff to students indicates that individual champions are important. Individual leaders and people may not have been readily celebrated at this school as all staff shared these values; therefore individuals were not seen as extraordinary. Whereas at FUSOM and JCUSOM individual champions who upheld and promoted social accountability were seen as unique. The Ateneo de Zamboanga School of Medicine and JCUSOM are relatively young schools and the fight to establish the school was in the "living memory" of staff and even students. Many of the inaugural staff still worked at the schools and at JCUSOM the founding leader was still connected with the school.

The literature supports the need for strong leadership and champions for change or transformation in medical education (Neusy & Pálsdóttir, 2008, 2011). Key characteristics of leaders include: their own values, their experiences and connections. The leadership of a Dean with a clear understanding of the "Five Star Doctor" combined with initiative and drive to create partnerships with the health sector is an essential for socially accountable medical schools (Woollard, 2006). In a study of Deans as "spiritual leaders", Evans (1998) states that leaders should "personify and embody" the values of medicine as a profession and a vocation and "they must remind us of those values and inspire us to embrace them and be guided by them" (p. 655). A spiritual leader reaffirms their commitment to these values by making decisions informed by these values. The challenge of focussing on social accountability means that leaders must have not only lived experience as a health profession but "have an iron will to succeed [as] personal experience and integrity are important in the difficult debates that will ensue" (Pálsdóttir & Neusy, 2011, p. 10). Discussing setting up a new medical school, Cookson (2013), notes that the Dean might be the only person with a holistic

vision of the school. Deans need to have good relationships with heads of universities as well as health departments:

> *Close collaboration is needed however between university and health staff at all levels so there is a meeting of minds not just a meeting.*
>
> (Cookson, 2013, p. 717).

Strong leadership and connections can help overcome institutional or policy barriers to change, including curriculum reform, at medical schools (Cohen et al., 1994; J.-J. Guilbert, 2014; Jippes et al., 2013; Kayyal & Gibbs, 2012). Leadership is the most important facilitator of curriculum reform, leaders need to have "passion that support the band of loyal faculty" (Cohen et al., 1994, p. 354).

This finding highlights how vital leadership and people, their values and experiences are for socially accountable medical schools. Respondents felt that a change in leadership could affect the social accountability agenda of the schools. However, if socially accountable values and programs are predominant – for example the aim of the school is to address local workforce needs and all programs led to this objective - this would be difficult to change. There is more scope for the institutions to revert from a socially accountable focus if the school has more traditional structure; for example if the disciplines and research agenda have a biomedical focus. This indicates that if social accountability is intertwined or institutionalised at the school it is difficult to change. Whereas if social accountability is purely kept within the leaders; the culture of the school could transform with leadership changes:

> *Changes in leadership in the new educational program, the partnering university, the main university leadership, or the government can lead to the original mission being lost, misunderstood or unsupported.*
>
> (Snadden et al., 2011, p. 526).

To overcome this issue new leaders should try and find how their personnel focus fits with the foundation goals (Snadden et al., 2011). Research has focused on how faculty or staff development help promote social accountability, as building individual capacity in teaching and research contributes to institutional capacity (Burdick, Amaral, Campos, & Norcini, 2011; World Health Organization, 2013b, 2013d). However, no research has focused on the importance of values and social accountability. Further research needs to ascertain whether social accountability could be achieved from "creativity and energy at the grass roots" (Rudolf et al., 2014, p. 2), or if there needs to be high level partnerships with key stakeholders and an expressed strategy or both. All case study schools had engaged leaders; therefore further research needs to be undertaken into socially accountable medical schools that have transformed through the actions of individual staff who did not hold positions of power.

6.3.2.6 The Training for Health Equity Network (THEnet)

All schools were inaugural members of THEnet and therefore had a common understanding of social accountability (Neusy & Pálsdóttir, 2008, 2011; Pálsdóttir & Neusy, 2010; Pálsdóttir & Neusy, 2011; Pálsdóttir et al., 2008). The Training for Health Equity Network and the global social accountability movement was a contextual influence for all schools, although it was only explicitly discussed at FUSOM. Therefore being a member of this group had been influential and was an emerging issue that needs further exploration. In general, the Training for Health Equity Network legitimised what schools were doing; membership and interaction with this group clarified what existing practices and connected the schools with a global movement. Without the language and theory embedded by THEnet, some participants might have had difficulty exploring the concept of social accountability. Membership of THEnet, gave a united and common language and theory around social accountability. Belonging

to this group also helped members interpret high level WHO policies or directives into practical guidelines confirming existing practice. Through THEnet, leaders and staff were able to represent their schools on the WHO and other global forums and groups interested in social accountability. Leaders also developed alliances of likeminded leaders in medical education that assisted with their own professional development.

Other coalitions of medical schools have influenced innovation in medical education. The Network: Towards Unity for Health (The Network) joins together innovative schools of more financially resourced and less financially resources countries. This group have helped develop collaborative initiatives such as the Women and Health Taskforce, which has been active for over 17 years (Gonzalez de Leon & Lewis, 2009). The main achievement of The Network is that is has encouraged knowledge sharing between less financially resourced and more financially resourced schools (A Kaufman, 2005). For example the University of New Mexico drew inspiration from the UPMSHS to established a community based medical school (A Kaufman, 2005). The Medical Education Partnership Initiative (MEPI) is another group attempting to overcome the usual inequalities in medical school partnerships and support health systems strengthening in Sub-Sahara Africa (Fakhari, 2014; Sirisup, 1999). The Foundation for the Advancement of International Medical Education and Research (FAIMER) is a non-for-profit organisation that supports the development of medical schools and faculty in less financially resourced countries. The Fellowship program promotes faculty or staff development through a network of medical educators who undertake residential training sessions and an individual education innovation project (Burdick et al., 2011). The FAIMER model "…proposes that an active community of educators can lead to several outcomes that can lead to a field of health professions education with great social accountability" (Burdick et al., 2011, p. 634). When leaders

or staff members are involved in national or international activities for curriculum reform or other innovations at medical schools indicate their commitment and understanding of these initiatives (Cohen et al., 1994).

The Training for Health Equity Network is a community of practice (Ghoshal & BonTempo, 2014; Murray et al., 2012; Wenger, McDermott, & Snyder, 2002):

> *Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.*
>
> (Wenger et al., 2002, p. 4).

While, like other communities of practice, members do not work together in an organisation regularly, the group collaborates to solve problems and share knowledge as well as create tools (Wenger et al., 2002). The group has also developed a "body of common knowledge" and "personal relationships" and "a sense of identity" (Wenger et al., 2002, p. 6). The influence of THEnet, and other groups of medical schools is that it "can drive change from within" (Murray et al., 2012, p. 4). The schools were brought together due to their common goals and challenges and worked collaboratively. The group is using technology to build and maintain the community of practice on-line through a collaborative platform (Pálsdóttir & Neusy, 2011). This finding highlights the importance of collaboration across contexts to develop common strategies around social accountability.

6.3.3 Contextual factors that emerged in the cross case analysis

Two contextual factors were not strongly established in the individual cases but emerged in the cross case analysis: resisting traditional models of medical education and the health sector.

6.3.3.1 Resisting traditional models of medical schools

All schools had an understanding of resisting traditional models of medical education. An underlying assumption that was not fully explored by the participants was the idea of being different and "*defending this difference*". This was articulated at JCUSOM as the "*needs of the north are different*"; at FUSOM as "*difference and innovation*"; at ADZU SOM as going against the mainstream and UPMSHS as doing what they could with little resources. The schools naturally challenge orthodoxies, and are seen as alternative models for health professional education (Murray et al., 2012) but have also faced "institutional isolation and scepticism from more traditional medical schools" (Pálsdóttir & Neusy, 2011, p. 340). There is a shared understanding that while the schools may be critiqued for persisting against opposition, subverting dominant paradigms or doing that which was thought impossible by more traditional schools, there is also a defiant confidence that resistance to current models of medical education is "the right thing to do" (Howe, 2002; R. P. Strasser & Neusy, 2010). For example a leader from ADZU SOM said that a challenge for the schools was "recognition" locally, as there was not much support from government:

> *The courage to shift away from the traditional approach has always been met with scorn, ridicule and outright opposition from the medical profession itself, as well as from government institutions, which has been reluctant to give us the mandate to pursue and probe innovative approaches.*
>
> (Neusy & Pálsdóttir, 2008, p. 22).

Another Dean from THEnet stated that schools could strive for social accountability no matter what environment of the country:

> *…not to give up if the government is not supportive, university authorities have to apply their own political will within their institutions. I believe that a medical school that adheres to the tenets of Alma-Ata and the Millennium Development Goals can be developed in any country, regardless of the political and social system.*
>
> (Neusy & Pálsdóttir, 2008, p. 24).

Being outside traditional structures can encourage and support innovation. Mowat and Mowat (2001) noted that general practice's "marginal status in relation to the medical school allowed creative negotiation of alliances within the medical school" (p. 175). Schools that do not rely on power structures are more likely to support innovation and change (Biggs & Wells, 2011; Mowat & Mowat, 2001).

While socially accountable medical schools are slowly being accepted by "traditional" institutions and medical education community, there is another challenge that the agenda will be transformed to fit dominant paradigms. Programs such as ASPIRE, developed by the Association for Medical Education in Europe and discussed in section 2.7.4.2, are one indication of how the principles of social accountability are being

adapted to fit the traditional systems of medical education. To be eligible for an ASPIRE reward for social accountability schools have to pay for a peer-lead assessment by experts. This "*top down*" process of legitimising socially accountable medical schools and the absence of community involvement is contrary to the principles of social accountability. Furthermore, it is easy for medical schools to express that they agree with the principles of social accountability but it is more complex to practice these values in terms of community focus and graduate outcomes (Bloom, 1989; J.-J. Guilbert, 2014; Puschel et al., 2014). This finding distinguishes the importance of schools continuing to challenge dominate paradigms of medical education. The broad contextual influence of the inappropriateness of existing medical education system is cited as influencing the theory of socially accountable medical schools in early literature (Boelen, 1992). Understanding how socially accountable medical schools resist dominant paradigms of medical education in a changing environment needs to be further explored.

6.3.3.2 The health sector

An interesting finding in my study is that while all schools had partnerships with the health sector, these were not perceived to influence social accountability. Though respondents could articulate the influence of the schools on health systems, it was difficult for respondents to discuss how the health sector or system had influenced the schools. This is surprising given the literature that prompted my decision to include the influence of the health sector as a contextual factor. However, it was evident that in all cases individual health professionals influenced the schools by giving up their time to teach, advocating for resources and developing education and training program. The personal and professional values of individual health professionals had some influence on the school. This interconnectedness ensured interpersonal relationships that assisted

in professional roles as well as facilitated teaching at the local hospitals. It was therefore the influence of individual clinicians and health sector managers as "champions" for social accountability that were important rather than the partnerships or programs.

The pragmatic influence of funding realities could also explain the "symbiotic" or mutual relationships that schools had with the health system (Murray et al., 2012). At all schools there was an interconnectedness and interdependence between the education and health sectors, however this relationship was an example of social accountable practice and was influenced by health and workforce needs. It was not the health sector itself that was the contextual factor. It was the workforce situation that influenced the development of partnerships and innovative programs with the health sector.

Another issue that could be further explored is the influence of the orientation and financing of health systems. All schools worked in primary health care and tertiary health care. They all worked in universally publically available health care models and user-pays or health insurance models. A study of how health systems influenced the social determinants of health analysed that there were influences at different levels:

- Macro level: public policy and equitable resource allocation processes;
- Meso level (the community): performance of decentralized policy (as is the case in the Philippines); and

- Micro level:

> *…through factors related to the organisation of the health system: physical financial, psycho-social, cultural and administrative (cultural and administrative access) as well as related to health care provided (skills, knowledge, approach to the patient). This is where primary health care systems may contribute to comprehensive care.*
>
> (De Maeseneer, Wilems, De Sutter, Van de Geuchte, & Billings, 2007, p. 2).

6.4 Summary of how contextual factors influenced the four case study schools aspiring to be socially accountable

From these data it is possible to show how the contextual factors influenced social accountability at the four case study schools. I have also illustrated how some contextual factors were inter-related.

Workforce and health needs were a strong influence and was defined as a lack of doctors in underserved areas and mal-distribution between urban and rural areas. It was also understood to be about how graduates need to be trained or equipped to work in underserved areas.

Workforce and health needs influenced socially accountable medical schools through:

- The establishment and reorientation of schools, particularly in areas of workforce need;
- The selection of students form underserviced areas;

- Placement of students in underserved areas;
- Innovative educational programs and a research focus on local health issues; and
- Curriculum includes analysis of workforce issues.

This contextual factor was inter-related with government policy. In some countries wider government policy in education and health would focus on addressing workforce needs. A lack of workforce influenced health needs and there was a connection between health needs and workforce. Furthermore the local government was also involved in the health sector and was affected by workforce in decentralised health systems.

Communities influenced in different ways through informal or formal community engagement policies. While there were different understandings of who were the schools' communities, communities were fundamental for socially accountable practices. Communities do not have a full appreciation for their role in the medical school. Communities influenced socially accountable medical schools in a number of ways:

- Communities collectively or as individuals helped select students;
- Students undertook placements in communities as essential components of their learning;
- Informal experiences of being part of a community could help transform attitudes and help students understand the importance of community connectedness as a health worker;
- Students with understandings of community connectedness could be more motivated as health workers; and

- Issues of power and resource allocation could constrain community involvement.

Communities were interrelated with local government, as in both countries this level of government was equated with community. Resources were also important on community placements. Leaderships and champions can be from communities or have a close working relationship and understanding of communities. These contextual factors were united by people, their values and experiences. In Australia there were specific government policies that focused medical schools to works with communities.

Government Policy and Funding enabled innovative education programs and the development of new medical schools. These included rural health initiatives in Australia. Government policies and funding influenced socially accountable medical schools as:

- Policies were linked with resource allocations to socially accountable programs;
- Changes in policies allowed for the establishment of schools;
- National laws around medical education and curriculum reform could be a barrier to social accountability; and
- Accreditation systems and other regulatory policies could enforce changes to schools towards social accountability.

This contextual factor was linked with leaders and champions as they needed to have an understanding of the policy environment. Workforce needs and the health sector also influenced policy directives. Policies also impacted upon local government in a decentralised health system. The university and wider institutional environment were also influenced by policies and funding.

Local politics and politicians were influential in both countries, but due to the decentralisation of the health system, the local government and local politicians affected student placements and graduate employment in the Philippines. Local politics and politicians influenced socially accountable medical schools in the following areas:

- Student placements in communities, including social support and housing;
- In decentralised health systems, graduate employment; and
- Resources for community projects developed with students

This contextual factor was linked with the health sector and policies. Resources were also important at this level. Interestingly local political systems were also seen to be part of the community in both countries.

The wider institutional environment of their **universities** affected socially accountable medical schools. Universities influenced socially accountable medical schools as:

- Alignment of wider institutional values with social accountability meant the organisational culture of the university was more accepting of social accountability; and
- The unique separation of medical schools from universities could foster social accountable practices due to their independence.

However there was a certain level of resources required for medical schools to deliver appropriate education in the contemporary environment. Universities were also linked with resources and national government policies and funding as well as THEnet and resistance to mainstream models of medical education.

Resources were an interesting factor and their importance depended upon the country context. Resources influenced socially accountable medical schools in two ways:

- Resources were essential for some program in more financially resourced contexts; and
- A lack of resources could spur innovation and a culture of self-reliance that is more aligned with the needs of less financially resourced countries than those imposed from the outside.

This contextual factor was linked with government policies, the health sector, the university and the community.

The values and professional experiences of **leaders and individual champions** were important contextual factors:

- Individuals upheld values that influenced the school's organisational culture to be conducive to social accountability;
- These individuals understood workforce needs and the needs of the health sector through their own professional experience; and
- Their personal connections with people in the health sector, government and community helped the development of innovative programs.

It became apparent that **membership of a coalition of socially accountable medical schools**, **The Training for Health Equity Network**, was an important contextual influence in the cross case analysis, although as this was a selection criteria for the cases, this was not surprising.. The Training for Health Equity Network (THEnet) influenced the social accountability of medical schools by:

- Creating a community of learning and legitimising local practice;

- Fostering Leaders own professional development and alliances; and
- Translating global policies around medical education and socially accountable medical schools to local practice (in turn this group has influenced these policies).

This contextual factor was interconnected with resisting mainstream models of medical education, the university and leaders.

All schools also had a culture of **resistance to mainstream models of medical education**. The resistance or rebellion against dominant paradigms was what fostered the need for alternative models of medical education that develop the theory of socially accountable medical schools. This factor influenced schools in two ways:

- Being outsiders or outside the mainstream schools allowed case study schools to be less concerned with prestige and could take risks; and
- Aligned these schools with other non-traditional schools.

This contextual factor was linked with the university, leaders and champions and THEnet.

The **health sector**, a contextual factor I identified in the literature, was not a direct influence. However the health sector was an indirect influence connected with leaders and individual champions; the workforce situation and resources.

6.5 Summary

The main findings relate to understandings of social accountability and what contextual factors influence socially accountable medical schools. There were three understandings

of social accountability in medical schools. Firstly, socially accountable medical education was about meeting workforce, community and health needs, Secondly, social accountability was determined by the type of programs the school implemented or, the way the school operated. Thirdly, social accountability was deemed a personal responsibility or value. Social accountability is still a contested concept that needs clarification in order to progress theoretical understanding and pragmatic uptake at medical schools. These understandings influenced understandings of contextual issues.

There were ten contextual factors that influenced socially accountable medical schools. Two external contextual factors were important across all four cases: *Workforce and health system needs* were the strongest influence, concurring with the literature. *Communities* were also a contextual influence, however there were different ways that the schools understood and partnered with communities. The literature on social accountability has not fully analysed this complexity. Six contextual factors were not clearly apparent in all individual cases but emerged more so in the cross case analysis. *Local politics and politicians* were also a significant influence despite their different roles in the Philippines and in Australia. The importance of the sector in the Philippines case studies was evident due to the role of local government in the health sector. In Australia, local governments were interpreted as being part of the community and had crucial roles in student placements. *Government policies and funding* ensured programs could be developed and sustained at the Australian schools. However, it was apparent that at UPMSHS government initiatives helped established the school. A lack of resources and funding spurred innovation at the Filipino schools. *The university or wider institutional environment* was conducive to social accountability through the culture and resources. *The values and professional experiences* of leaders and individual staff and health sector representatives were an internal contextual influence at FUSOM,

JCUSOM and ADZU SOM. It was clear that at UPMSHS local leaders and individuals were also important. Involvement with *The Training for Health Equity Network* helped connect similar schools as well as to consolidate what they were doing into theory of social accountability.

Two factors gained clarity after the cross case analysis: the health sector; resistance to mainstream models of medical education. All schools worked with the health sector in teaching, service and research but it was not the health sector that was an influence but the personal connections and people. All schools had a culture or understanding of being “outside” mainstream model of medical education and all had challenges as they were different. A conceptual framework can illustrate how these different contextual factors interact to influence socially accountable medical schools. In the next chapter I illustrate the ‘building blocks for socially accountable medical schools in a conceptual framework.

Chapter 7 Conclusion and Recommendations

7.1 Introduction

This study explored how contextual factors influenced socially accountable medical education. I analysed and compared key contextual factors that influence the planning, implementation and outcomes of socially accountable medical education/schools within four medical schools. I explored how the three contextual factors of local workforce, nature of linkages with the health system and nature of partnership with the community impacted upon progress towards socially accountability in these medical schools. I also analysed what other contextual factors have influenced socially accountable medical schools; and how these differed between cases. Finally, I have developed aconceptual framework that demonstrates the building blocks for socially accountable health professional education (Figure 7.1) that can be applicable to other settings. The following recommendations include principles from which to derive practical guidelines for medical schools, to evaluate how contextual issues influence socially accountable medical education. I also outline opportunities for further research.

7.2 Conceptual Framework: Building Blocks for Socially accountable medical schools

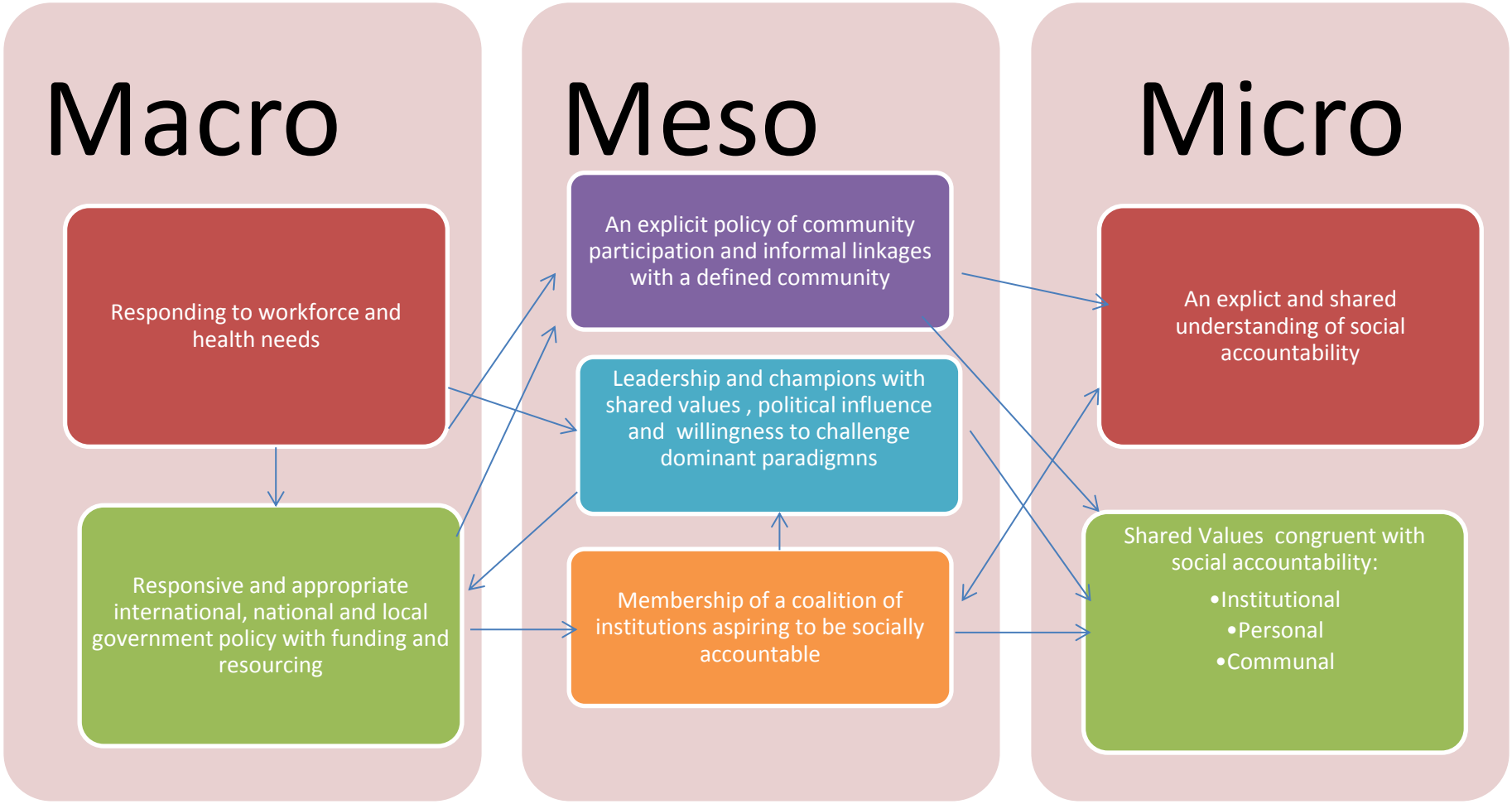
The building blocks conceptual framework (Figure 7.1) demonstrates what 'building blocks' or conditions might be necessary to assist medical schools moving towards social accountability. These are at the macro, meso and micro levels. The arrows demonstrate the interconnections with other 'building blocks'. I have briefly described the connections between contextual challenges. I have illustrated the processes and and appropriate action in section 7.3. While many of these building blocks are similar to those conceptualised in social accountability theory, this conceptual framework is

informed by what happens in practice - empirical evidence rather than prescriptions. Consequently it is valuable in that it put some conceptual thinking around everyday practice

The nature of the development of social accountability is contextually dependent, politically, historically, socially, spiritually, and economically influenced. Some schools did not term their practice as such until legitimised in this movement for socially accountable medical education. Consequently, development of practice and theory should be seen as iterative rather than prescriptive. Schools should draw on grass roots practice.

This thesis was not a comparative analysis of socially accountable versus non-socially accountable institutions. I undertook a critical analysis of what the actual contextual influences that influenced schools aspiring to be socially accountable. I have examples of contextual influences and appropriate action. This research demonstrates some of the nuances of contextual influences on the production of socially accountable practices or what this process looks like. The contextual factors of medical and health professional schools are vastly different and so my research cannot conclude what factors will or will not produce social accountability; although this study brings this closer.

Figure 7.1 Building Blocks for Socially Accountable Medical Schools



Building Block	Connections
Responding to workforce and health needs	The workforce and health situation may influence appropriate international, national and local government policies with funding and resources. Leaders and champions in the education and health sector who have knowledge and experience of the local workforce and health needs.
Responsive and appropriate international national and local government policy with funding and resourcing.	Leaders and champions with political influence and connections at all levels of government. Workforce and health needs influence and inform government policy and resourcing. An explicit policy directive for community participation, tied to resourcing.
An explicit policy of community participation and informal linkages with a defined community.	Communities and the medical school need a shared understanding social accountability. A policy directive of governments at all levels for medical schools to have a community participation strategy.
Leadership and champions with shared values and political influence and willingness to challenge dominant paradigms.	Belonging to a coalition of institutions aspiring to be socially accountable gives leaders peer support and access to

Building Block	Connections
	Leaders will have shared values of social accountability as well as experiences of workforce and health needs. Leaders will have the skills and connections to influence policy and resource allocation at all levels of government.
Membership of a coalition of institutions aspiring to be socially accountable	Coalition organisations can help individual schools interpret international policies into practice. Leaders can gain support and mentorship through the coalition. There is a need for a shared understanding of social accountability among the coalition but recognition of the importance of local context.
An explicit and shared understanding of social accountability	Institutional (university/health sector), personal and community values must be congruent with social accountability. Leaders and champions need to advocate for this shared understanding
Shared values congruent with social accountability at the individual, institutional and communal level.	Institutional (university/health sector), personal and community values must be congruent with social accountability.

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7.3 What the results mean in practice: Recommendations from the building blocks conceptual framework

. I discuss a range of recommendations for medical schools based upon each Building Block.

7.3.1 Responding to workforce and health needs

The workforce situation was the strongest contextual influence. Workforce issues need to be clearly understood and appreciated by staff and students. For example the curriculum of the school should include an analysis of the local workforce situation as well as key health issues. Leaders and staff need to have professional experiences in areas of health and workforce need. This experience will help the school to maintain and establish programs in areas of workforce need due to the professional connections of staff and leaders. For example professional knowledge and connections with the local health sector can facilitate innovative workforce strategies.

7.3.2 Responsive and appropriate international national and local government policy with funding and resourcing.

Medical schools and their leaders need to lobby for medical education and health policies that support the principals of social accountability. For example for government policies and funding programs that support medical schools in regional and rural

settings and in areas of workforce need. Another requirement should be a directive, linked with resourcing, for medical schools to have a community participation policy, further discussed in 7.3.3 below. Medical schools can also adapt and promote government workforce policy or aspects that are socially accountable (for example rural placements). The need for these policies should be promoted and explained in terms of long-term impact on health needs of communities. Medical schools should also advocate for a balance of adequate resources with room for innovation and adaptation to the local contexts. Accreditation can motivate medical schools towards social accountability. Medical schools should call for Federal accreditation systems to include assessment of social accountability.

Socially accountable medical schools were influenced by different levels of government. They partnered with Federal/National, state/provincial and local governments. There needs to be better understandings of how all levels of government could be involved in medical school and health workforce policy developments and programs.

7.3.3 An explicit policy of community participation and informal linkages with a defined community

Communities and partnerships with communities were a key contextual influence. In order to work effectively with their community a school needs to have a well-defined understanding of their community. Socially accountable medical schools need to have

well developed understandings of the community that they serve. Schools should be encouraged to serve a defined population or area with links with the local health system. However, schools may have more than one community. Communities may not be homogenous and there may be competing interests. Engaging, partnering or connecting with the community can be undertaken in diverse ways. Communities also need to be connected to schools from their establishment or at least involved in strategic planning of existing schools. Schools should publicise that they wish to work with communities and get input from communities on what this will involve. The community participation strategy of the school needs to be well resourced, achievable and assessed or evaluated.

Many medical schools do not have the capacity to work effectively with communities. Schools should partner with non-government or community-based or civil society organisations that already work in communities of need. These organisations could assist schools to develop valuable partnerships with communities through teaching, research and service. Non-government organisations can also assist the development of appropriate health projects with medical schools and students on placements. Schools and communities need to understand the impact of differences in access to resources and power on partnerships. Communities need to be made more aware of their power and influence to develop better partnerships with socially accountable medical schools. Community organisations can help facilitate this process.

Together with a formal policy of community participation, medical schools need to foster informal linkage with communities. Being part of the community on placements influenced individual students. For example informal experiences of being part of a

community could help transform attitudes and help students understand the importance of community connectedness as a health worker. Students need to be given opportunities to reflect on the transformative process of being part of a community during placements. This could include appreciating what has developed their own sense of service, social justice or desire to work with communities. Schools need to Explicitly building connections between value base and curriculum, placements etc so this becomes exposed and instutionalised

7.3.4 Leadership and champions with shared values and political influence and willingness to challenge dominant paradigms.

Leaders and champions with passion and values aligned with social accountability (how it is defined and understood at individual schools) can have great influence. upon socially accountable medical schools. The values, medical experience in the region and personal and professional connections of leaders help establish; reorientate or sustain schools. Leaders and champions can use their influence to create a shared mission and understanding of social accountability. Schools can support appropriate leadership when there is an alignment, and include succession plans and development of a culture that is socially accountable to ensure that these values are not lost when a leader moves on. There needs to be explicit acknowledgment of the type of leadership schools aspiring to be social accountable desire to institutionalize the qualities of leaders. Mentoring aspiring leaders can also ensure socially accountable leadership.

It was not the health sector per se that influenced socially accountable medical schools; rather it was people in the health sector that were influential. The schools need to work with champions that share the values of social accountability. These people could hold

adjunct positions and work with the school on projects including student learning and workforce issues.

7.3.5 Membership of a coalition of institutions aspiring to be socially accountable

Medical schools should join or create a coalition of institutions aspiring to be socially accountable. Coalitions can help foster the professional development of leaders in international medical education leadership roles. Connection with a coalition helps legitimise and develop social accountability, particularly when schools have alternative models of medical education. Other staff and students can be part of a community of practice and receive peer support from colleagues at other schools. A community of practice can help translate or interpret global policies and directives to the local level. These groups can provide opportunities for individual schools to highlight their work. These coalitions should continue to engage schools in the wider social accountability movements such as the WHO and Global Consensus on Social Accountability (GCSA).

7.3.6 An explicit and shared understanding of social accountability

The difference in perceptions of social accountability indicates that the term may not be universally understood and appreciated. All partners, including communities, the health sector and local government as well as internal actors (staff, students) need to be involved in debating and developing and operationalised this shared understanding. Schools should ensure that their understanding is socio-culturally appropriate and appropriate to the context of the school. This may mean a term other than “social accountability” could capture what the school is undertaking. Schools should survey

staff, students, health sector and community members about their different perspectives of social accountability. For example, by asking "*if our school was socially accountable what would it look like?*" In addition continuous critical appraisal within schools of how staff understand social accountability, by considering what it means to them and how they want to contribute to the aspiration of the school. In order to strengthen the social accountability movement definitions of social accountability should be challenged, debated, theorised and discussed. It is timely, now that there is a movement for social accountability in health professional education, to reconsider the intent and how it is perceived and defined.

7.3.7 Shared values congruent with social accountability at the individual, institutional and communal level.

Starting with practice and existing values of people and institutions can help develop a shared understanding of social accountability. The personal values and beliefs of staff, leaders and student influence the organisational culture of the school. People and their values can help drive organisational change. Schools need to foster a values based approach to social accountability. This may involve personalising social accountability so it means something to all staff, students and others involved in the school, including the health and community sectors. Strategies to influence the organisational culture of the school involve including an understanding of "social accountability" as part of the staff recruitment process (for example in selection criteria or interview questions). Applicants could be asked to describe their understanding of social accountability and how they feel they could contribute to the aspirations of the school. Furthermore, new

staff could be inducted into the values of the medical school, by undertaking an orientation on socially accountable practice. Staff need to be given opportunities to reflect and act on their own practices. Staff in a biomedical or laboratory research role may feel alienated from social accountability. These staff could be given opportunities to learn how social accountability applies to their work. For example they could develop professional activities that link them with the social accountability agenda of the school. An example is projects with high schools, communities, and research focused on the priority health needs of the communities. Schools could also appreciate and accept that not all staff will or can have socially accountable practice at the forefront of their work. Faculty or staff development could incorporate understandings of social accountability and practical projects on how to engage with underserved communities.

7.4 Priorities for Further Research

Given that there were no previous studies of how contextual factors influence socially accountable medical schools, there are several proposed future research projects:

- **Leadership in socially accountable medical schools**. Research could focus on the characteristics of leaders of socially accountable medical schools. Another focus could investigate how to influence and develop organisational culture to support socially accountable medical schools. Further research needs to be undertaken into socially accountable medical schools that have transformed through the actions of individual staff who did not hold positions of power.

- **The transformative process of student placements**. Research could focus on how being on long term placements with communities can help transform personal beliefs and practice intentions.
- **Indigenous and minority group perspectives.** A limitation of this research was that there were no voices from Aboriginal and Torres Strait Islander peoples in Australia. The focus of socially accountable medical schools is improving the health of underserved population. It is therefore important that Aboriginal and Torres Strait Islander peoples and other minority groups are engaged in socially accountable medical education and have capacity to share their understanding of how socially accountable medical schools can effectively engage with and work with these Aboriginal and Torres Strait Islander communities.
- Communities did not fully appreciate their own contribution to the social accountability of medical schools. **Research could investigate what social accountability means for communities and community understanding on how they contribute to medical schools and medical education**. Further research could also explore how communities would like to work with medical schools.
- **The local government** was an important influence on socially accountable medical schools. There has been little research on how local governments in different contexts support medical schools and medical students. Further research could focus on what supports effective partnerships with local governments in different health systems.
- **The Training for Health Equity Network** was accepted as an influential contextual factor and as a developing community of practice. Further

research could investigate how communities of practice in medical education can help foster and sustain innovations; including socially accountable medical schools.

- All case study schools worked in primary health care and tertiary health care as well as universally publically available health care models and user-pays or health insurance models. Further research could investigate **the influence of different health systems**, including decentralised and centralised systems, upon socially accountable medical schools.
- I have developed a conceptual framework to explain the building blocks for socially accountable medical schools. **Researchers could apply this conceptual framework to other medical schools to evaluate its usability.**

7.5 Conclusion

Socially accountable schools can be part of the solution to the health workforce crisis. Many schools are now interested in becoming socially accountable and focus on the internal changes that they can undertake to improve the degree to which their graduates respond to priority health needs. There has been a paucity of research on what contextual factors, or external or internal factors, have influenced socially accountable medical schools. This research investigated the contextual factors influencing socially accountable medical schools in two very different contexts; Australia and the Philippines. Despite differences, there were common contextual influences. Understanding these contextual influences can help medical schools identify what will enhance or impede their aspiration to social accountability.

The strongest contextual factor was the local workforce situation which led to innovative educational programs established with or without government support. The values and professional experiences of leaders, staff and health sector representatives, influenced whether a school's organisational culture was conducive to social accountability. The wider institutional environment and policies of their universities affected this culture and the resourcing of programs. Membership of a coalition of socially accountable medical schools created a community of learning and legitimised local practice. Communities, including local governments, may not have appreciated their own importance but they were fundamental for socially accountable practices including student placements and learning. Uniting the community of practice and the institution and schools were people's own values and beliefs that aligned with social accountability; and a culture of resistance to mainstream paradigms of medical education.

There has been a reinvigoration of academic and professional interest in both the theory/concept of and practical applicability of socially accountable medical schools (Frenk & Chen, 2011; Frenk et al., 2010a; Global Consensus for Social Accountability of Medical Schools, 2010; Sales & Schlaff, 2010; R. P. Strasser, 2010; The Network: Towards Unity for Health, 2010; Woollard, 2010). The Global Consensus Conference held in South Africa in October 2010 included over 130 institutions and individuals interested in defining and evaluating socially accountable medical schools (Global Consensus for Social Accountability of Medical Schools, 2010). The Global Independent Commission; Education of Health Professionals for the 21st Century has reopened wider discussions on how medical schools' should contribute to human resources for health and collaborate across systems and sectors (Frenk et al., 2010a). This project will contribute to the body of knowledge in this emerging research area.

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Appendices

Appendix 1: Reflection: My experience of becoming part of The Training for Health Equity Network and a school aspiring to be socially accountable

Another visitor to entertain; why am I always dumped with these? I was a busy junior academic with two young boys; I didn't really have two hours to assist with some visitor from New York. So for my allotted meeting I gathered up a couple of keen students from my International Health Module and strung out a discussion on the Millennium Development Goals, Aboriginal Health and my experience with NGOs in Cambodia and Melbourne. Andre-Jacques Neusy was charming, experienced academic, who seemed very out of place in my office above the shopping centre attracted to the regional hospital. What could I say that would impress this nephrologist with years of practice in Africa? Nevertheless he was attentive and interested and, surprisingly, seemed very impressed with what we were doing in our regional university in my home town. He would tell me later that Townsville, with its slow tropical languor and colonial buildings reminded him of the river towns of his Congolese childhood. We had an instance rapport, children of the tropics; he would laugh at me a few years later for nearly tipping out pots of water in his Belgium garden and saying "I was worried you would all get dengue".

It had only been 18 months previously that I had returned home to my family this regional tropical city, burnt out from non-for profit work in Melbourne and with a new baby and dragging my husband from his inner-city life of friends and good coffee. I was vaguely hoping to get some type of interesting work, but did not think the backwater I fled at 18 would have many appealing jobs. Surprising I was hired by a Professor at the

medical school, mainly because I would get on a small plane and knew about evaluation. Little did I know on that sticky Christmas eve, my dad waiting for me in the car park like I was some 15 year old at her first a job interview; that I would join a team that I could see myself staying with for the rest of my working life.

Perhaps I would have been keener and more enthusiastic about meeting him if I'd known AJ was scouting for schools for the Training for Health Equity Network (THEnet). I would later describe his strategy of selecting schools as like being recruited for ASIO (the Australian equivalent of the CIA) (Pálsdóttir et al., 2008) He came and checked us out to make sure that we were "walking the talk"; I term I would often hear around discussions of socially accountable medical education.

About 18 months after AJ's visit I was on a plane to New York to attend my first THEnet meeting. In that city that never sleeps we didn't either. Deans, Professors and lecturers from six different schools worked on an Evaluation Framework that would later be tested at five of the original eight "THEnet Schools". Social Accountability was something vague akin to the triple line of corporations; but after long discussions, we found we had shared principles that has guided our collaborative work.

People from THEnet are not only my colleagues but friends and kindred spirits. They are a group of keen, interesting people with a passion for getting health workforce into areas of need and improving the health of the most vulnerable. We meet, most of us suffering jetlag, at least some of us culture shock, to share experiences and to get the lessons of socially accountable health professional schools into the mainstream. While these global meetings may seem extravagant, they are vital for this collaborative partnership to work. Furthermore we have tried to step away from the post-colonialism

rife in partnerships across global health (Bleakley et al., 2008) to try and be real and equal partners (Preston, Tandinco, et al., 2012).

We are brought together not only by our shared experiences, but a feeling of being outsiders, of being the poor cousins of medical schools, but all with a very clear insightful, understanding that we are “right” and ‘they’ (or the other medical schools) will soon join us in our mission.

Appendix 2: Confronting the colonial in cross-cultural research: personal reflection from research diary

Am I being self-righteous? Since being involved with "global health" I have tried to avoid the stereotypes of (post)colonial research. I still remember how hilarious I thought it was seeing a tropical research institute in Amsterdam and then in London where the only mangoes you see are in body creams at Boots. At international conferences, I scoff all those red faced middle aged men, with their research centres based in Europe fighting world poverty with 6 figure salaries. They are reluctant to put research assistants' names on their papers, little though reflect on medical research as a (post)colonial endeavor (and no, they wouldn't get the brackets either, don't they know that we are still colonized, that the frontier wars still exist, but not with poison waterholes and bullets; but poisoned policies, racism and white privilege). What wankers; put away your pith helmets I say; I'm not like them at all! I was trained as an anthropologist. I grew up as a protestant. Critical self-reflection is part of my DNA. I have been determined to confront these issues in my thesis. Throughout my methodology chapter I humbly intone how this will be done with reflexivity and other qualitative research tools, but will this be enough?

Partnerships are an important part of this research…

My colleagues in the Philippines found my subjects, did all the phone calls, both very busy academic doctors. I felt like I treated them like my research assistants. Was there another way? Could I have done this myself? What was in it for them? Why didn't I ask my colleague in South Australia to do this? Language barriers, not really; communication difficulties, nope email. Was it easier or was it just an expectation. Should have worn my pith helmet?

Critical theorists value everyone's voice…

I've got this nagging feeling, that deep down I knew I was much more nervous when I interviewed a head of medical services in Australia than an imminent former WHO consultant in the Philippines. What was that about: power? Position? Race? Or personality? After all during an interview I did laugh with another head of medical services in Australia about the pigeons shagging outside his window….

There's nothing like a pediatric ward in a developing country that will make a mother cry. I was knocked for six when you realize that this outside verandah thing, it's not the waiting area, it's the ward. Why didn't I walk through the wards of the Flinders Medical Centre, but, reluctantly, took a tour of the Zamboanga Hospital. Why was that ok? Would I chat with a patient having psychosis at Townsville Acute Mental Health Unit like I did in the Philippines? Probably not. Why didn't I hug and hold the hand of the community person I interviewed in Townsville like I did in a village in the Philippines. There were these times when I felt like I went back to being that curiosity, that backpacker, invited into people's homes like it was a right, getting their knowledge. What is it about being white in Asia that opens doors for you? Is this what handsome, tall, white, male doctors feel like all the time? It was different this time though, I'm a mother, those six year olds handing outside McDonalds at 2am, the shock, the pain - crying about it on the phone to my husband. Fifteen years ago I would have walked passed, bought them a burger, played a bit of football, and brought a tube of something for their scabies. A fate of birth, it could be my boys in the streets where "the child prostitutes are", want to go and meet them?" Asked my colleague, no, please don't let me even look. (coda: what happened to those boys during the typhoon, how did they

get food, did they drown, swept to sea, would anyone miss them, would anyone identify their little bodies, already so damaged and abused).

Reciprocity will be a key feature of this research…

Can we get away from being the white, rich savior? Slyly giving donations to the health services box? I felt so good telling my colleagues that I hadn't brought them back a present, but donated to health services instead. I emailed them pictures of the sparsely furnished clinic rooms, so they wouldn't whine that I didn't bring them back a magnet or dried mangoes. I doled out chocolates and made in Taiwan koalas purchased in a rush at duty free for my participants' kids. I was a saint arriving with much needed medical textbooks that I carted in excess baggage with great inconvenience. So many books in one library; many useless, dusty in piles, the librarians had no time to catalogue. What can I help you with, what can I send you? This request was often met with polite silence. As if they'd heard it all before.

Results will be presented back to participants…

After 3 days of fieldwork, sitting down to another breakfast of mangoes and oatmeal, I had a brain wave. I had to come back, to feed back the results. I'd have a workshop and then get the participants feedback. I'd incorporate this into my results. Is this another excuse to go back to do some tropical holiday research? Or is this a genuine desire to hear the 'voice' of participants; as part of member checking? (plans were halted by budget and the rebels, I was awaken by my husband pointing at the SBS news, see, see don't you fucking understand how stressful it is, it's not just you now there's 4 of us; the typhoon bought another retort: "I'm not going to say anything but please don't go back there". "I've had people shoot rockets from my front verandah, I would have been ok"…

Self-reflection is not self-flagellation

I've been back from the Philippines for over a week now and on a sunny Sunday afternoon my husband and I smugly read out loud from "Stuff white People Like", but with the uneasy realization that we are more like the white liberal inner city yuppies the book mocks than we want to be. Coffee, tick, having children late, tick, Having Black friends, tick, Graduate School, tick, Being the only white person around, tick (Lander, 2008). I remember an Aboriginal woman from Tasmania announcing at a workshop "It's OK to be middle class, most people are". Is it ok being white, being colonial. We can 'name it, own it, change it" as my Aboriginal colleague says about confronting racism. What has differentiated me from "those" "pith helmet" researchers: being a woman? Being a mother? Being Australian? From the tropics, when I stupidly said "Oh we've got a dengue epidemic too". But how can six deaths compare with thousands? Being able to laugh at myself, to be humble? Being able to write all this down? I am (mostly) white and I am a post-colonial researcher, but can I "name it, own it, change it?" I'll have to do that in my thesis and it will be interesting to see how I do it and what the participants think. Is it important to them who does the research? Or how it's done? I just emailed my supervisors about possible markers. "I'd like someone also from a less-resourced country"… as if I had to point this out. Better than someone who gets two developed country markers. "Therapy" and "Wine" are also things white people like; perhaps I'll need some of both during my thesis!

Appendix 3: Ethics approvals

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Appendix 4: Information Sheet

INFORMATION SHEET

How do contextual factors influence social accountability in medical education?

You are invited to take part in a research project about how internal and external factors influence social accountability in medical education. Socially accountable medical schools aim to train doctors to work in health service areas and communities of need. They also work jointly with health departments to ensure appropriate numbers and types of doctors are working in areas of need. These medical schools aim to conduct research and service activities (e.g. clinics or public health activitities) that will benefit their local communities.

All medical schools are unique and external and internal factors influence how they train doctors. There is a need to understand how these contextual factors influence the social accountability aspirations and practices of medical schools.

The study is being conducted by Robyn Preston will contribute to the degree of Doctorate of Philosophy (PhD) at James Cook University.

If you agree to be involved in the study, you will be invited to be interviewed. The interview, with your consent, will be audio-taped, and should only take approximately 1 hour of your time. The interview will be conducted at Flinders University or a venue of your choice. A follow-up 1 hour interview via Skype or on the telephone may be required following initial data analysis (with your consent).

Taking part in this study is completely voluntary and you can stop taking part in the study at any time without explanation or prejudice. You may also withdraw any unprocessed data from the study.

Your responses and contact details will be strictly confidential. The data from the study will be used in research publications and reports to The Health Equity Network (THEnet) and the participating Schools of Medicine. You will not be identified in any way in these publications.

If you have any questions about the study, please contact Robyn Preston and Judy Taylor**.**

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If you have any concerns regarding the ethical conduct of the study, please contact:

Human Ethics, Research Office

James Cook University, Townsville, Qld, 4811

Phone: (07) 4781 5011 (ethics@jcu.edu.au)

Appendix 5: Informed Consent Form

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Appendix 6: Example of Semi-structured interview guides

School of Medicine Staff and Students - JCUSOM

Question	**Probes**
Introduction Could you tell me a bit about yourself and your role at JCUSOM? *Or* Could you tell me about bit about yourself, what year are you in medicine?	(may lead onto the School's story) What other roles have you had outside of the course, in Sante or RHINO? (student)
Social Accountability What's your understanding of socially accountability in medical education? What is your understanding of socially accountable medical education in JCUSOM?	Socially accountable medical schools hold themselves responsible for producing outcomes aligned with health workforce, priority health, and health system needs of their communities. How do you respond to this? What has influenced socially accountable medical education within the JCUSOM? What has influenced socially accountable medical education from outside of JCUSOM? What are the factors that could JCUSOM further progress socially accountable medical education at JCUSOM? What are some of the barriers?
The School Tell me the JCUSOM story?	Are you aware of the factors that influenced establishment of JCUSOM?/ Why was it established and how?

Question	Probes
What do you think are the key broad contextual factors that influence/influenced SA at the School?	Who were some of the key people involved in establishing/reorientating the school? If no, is there anyone else who was around the time of JCUSOM who I should speak with?
Workforce How do you perceive the current local medical workforce situation? What impact has the local medical workforce situation had, in your view, on the JCUSOM? What about at the national level?	How does this compare with the state/region/nation? Are there any documents available that I could take away or refer to in terms of the medical workforce?
Health System How does the JCUSOM work with the health system? Has the health system influenced the JCUSOM? If so, in what ways? For example on the School's orientation or teaching? What about at other levels of the health system?	Who does the JCUSOM work with (levels) in the health system? Do you have a formal agreement? Who initiates the work? Could you give me an example of how the JCUSOM works with the Health Sector? How has this relationship changed over time? How could this partnership/work be advanced? What are the challenges? Are there any documents available that I could take away or refer to?
Community What is your understanding of the JCUSOM's relationship with the community? Who do you see as the community? How much influence do you feel the community has on	Who do you see as JCUSOM's community? Who initiates partnerships? Could you give me an example of a partnership with the community? Why do you partner with the community? /What are the

Question	Probes
JCUSOM? How do communities get influence?	motivations for partnering with the community? Do you have a formal agreement or advisory committee or other formal structures? What do you see as the benefits of these partnerships? How could they be advanced? What are the challenges? How has this relationship/partnership changed over time?
Who else could follow up with/interview?	
Are there any documents available that I could take away or refer to?	

Health Sector Questions - JCUSOM

Question	Probes
Introduction Could you tell me a bit about yourself and your involvement with JCUSOM?	*(may lead onto the School's story)*
Social Accountability What's your understanding of socially accountability in medical education? What is your understanding of socially accountable medical	*Socially accountable medical schools hold themselves responsible for producing outcomes aligned with health workforce, priority health, and health system needs of their communities.* How do you respond to this?

Question	Probes
education in JCUSOM?	What has influenced socially accountable medical education within the JCUSOM? What has influenced socially accountable medical education from outside of JCUSOM? What are the factors that could JCUSOM further progress socially accountable medical education at JCUSOM? What are some of the barriers?
The School Tell me the school's story? What do you think are the key broad contextual factors that influence/influenced SA at the School?	Are you aware of the factors that influenced establishment of JCUSOM?/ Why was it established and how? Who were some of the key people involved in establishing/reorientation of the JCUSOM? If no, is there anyone else who was around the time of JCUSOM/changes at JCUSOM who I should speak with?
Health Sector What is your organisation's relationship with JCUSOM?	Do you have a formal agreement? Who initiates the work? Could you give me an example of how you work with the JCUSOM? How could this partnership/work be advanced? What are the challenges? Has the partnership changed over time? Are there any documents available that I could take away or refer to?
What was your organisation's involvement at the establishment of JCUSOM?/or the reorientation? (*If not organisation/the health sector?)*	Are you aware of the factors that influenced establishment of JCUSOM? If no, is there anyone else who was around the time of JCUSOM

Question	Probes
	Are there any documents available that I could take away or refer to?
How has your organisation influenced the JCUSOM? If so, in what ways? For example on the School's orientation or teaching? What about at other levels of the health system	How could you or would you like to influence JCUSOM policies?
Workforce How do you perceive the current local medical workforce situation? What impact has the local medical workforce situation had, in your view, on the JCUSOM? What about at the national level?	How does this compare with the state/region/nation? How has JCUSOM worked with the health sector? (in terms of workforce) What is the impact of student placements on the health system? (positive/negative) Are there any documents available that I could take away or refer to in terms of the medical workforce?
Community What is your understanding of the JCUSOM's relationship with the community? How much influence do you feel the community has on JCUSOM? How do communities get influence?	How has the JCUSOM had to adapt for community need What do you see as the benefits of these partnerships? How could they be advanced? What are the challenges? How has this relationship/partnership changed over time? Are there any documents available that I could take away or refer to?
Who else could follow up with/interview?	
Are there any documents available that I could take away or refer to?	

Community Questions - FUSOM

Question	Probes
Introduction	Could you tell me a bit about yourself and your involvement with FU SOM?
Social Accountability What's your understanding of socially accountability in medical education? What is your understanding of socially accountable medical education in FUSOM?	*Socially accountable medical schools hold themselves responsible for producing outcomes aligned with health workforce, priority health, and health system needs of their communities.* How do you respond to this? What has influenced socially accountable medical education within the FUSOM? What has influenced socially accountable medical education from outside of FUSOM? What are the factors that could FUSOM further progress socially accountable medical education at FUSOM? What are some of the barriers?
The School Tell me the FUSOM story? What do you think are the key broad contextual factors that influence/influenced SA at the School?	Are you aware of the factors that influenced establishment of FU SOM?/ Why was it established and how? Who were some of the key people involved in establishing/reorientation of the FU SOM? If no, is there anyone else who was around the time of FU SOM/changes at FU SOM who I should speak with?
Community	What is your understanding of the FU SOM's community or

Question	Probes
What is your understanding of the FU SOM's relationship with the community?	reference population? / Who do you see as FU SOM's community? What do you see as your role with the medical school?/ What do you do with the medical school?/How do you partner with the medical school? Why do you partner/or are involved with the medical school? /What are the motivations for partnering with/being involved with the medical school? Do you have a formal agreement or advisory committee or other formal structures? Who initiates partnerships? Could you give me an example of a partnership with the community? What do you see as the benefits of these partnerships? How could they be advanced? What are the challenges? How has this relationship/partnership changed over time? Are there any documents available that I could take away or refer to?
How much influence do you feel the community has on FUSOM? How has your organisation influenced the FUSOM? If so, in what ways? For example on the School's orientation or teaching?	How could you or would you like to influence FUSOM policies? How do communities get influence? How has the FU SOM had to adapt for community need? What about at other sectors of the community?

Question	Probes
What was the community's/your organisation's /your involvement at the establishment of FUSOM?/or the reorientation?	Are you aware of the factors that influenced establishment of FUSOM? If no, is there anyone else who was around the time of FUSOM Are there any documents available that I could take away or refer to?
Health Sector What is your understanding of the FU SOM's relationship with the Health Sector?	Could you give me an example how the FU SOM works with the health sector? How could this partnership/work be advanced? What are the challenges? Has the partnership changed over time? Are there any documents available that I could take away or refer to?
Workforce How do you perceive the current local medical workforce situation? What impact has the local medical workforce situation had, in your view, on the FU SOM? What about at the national level?	How does this compare with the state/region/nation? Could you give me an example of how has FU SOM worked with the health sector? (in terms of workforce) What is the impact of student placements on the health system? (positive/negative) Are there any documents available that I could take away or refer to in terms of the medical workforce?
Who else could follow up with/interview?	
Are there any documents available that I could take away or refer to?	

Appendixes 7 and 8 are new additions:

Appendix 7: Etic/Insider Knowledge at JCUSOM

- Joe needs to see a doctor: my experience of the Australian Health System
- Racism 101 is about the community: who are they and do they hold the school's values?
- Racism 201: The bubble is JCUSOM really part of the wider community, the racist Townsville community?
- Racism 301: Bystander: my own values and racism and white privilege.
- Sad not angry: the curriculum and the hidden curriculum that students really value

Joe needs to see a doctor (from research diary)

My youngest son, who is six, fell ill in the school holidays. On Thursday before we left on holidays I could not get a "same day" appointment with his general practitioner. I took him to the local "24 hour" walk in bulk billing clinic and one of the doctors, who was originally from Indonesia, was available within 15 minutes. A few days later, when we were on holiday at a tourist town in our state, my son became increasingly unwell. I frantically walked along the main shopping strip and went into the first GP clinic I saw. My husband had also forgotten his script for a regular medication and I was surprised be able to book them both in within half an hour. The GP clinic specialised in plastic surgery, but the doctor, who was originally from South Asia, was happy to see both my son and husband. He advised that my son should get a blood test when we returned home. I telephoned and made an appointment at his usual GP clinic for the Monday and was given a 9.15am appointment. My husband described his medication and got a script. I was "bulk billed" for my son. I did not have to pay a fee. I paid $66.00 for my

husband's appointment, and gave my bank card back to the receptionist; she automatically reimbursed $36.30, the standard consultation fee, back into my account. I then took my husband's script to the chemist/pharmacist in the shopping mall noting another three GP clinics open along the shopping strip. If my husband had been eligible the Federal government's health care card we would have paid under $5.00 for his medication. Two days later, on a Saturday night my son became very ill. My husband called the 13 HEALTH (13 43 25 84) number and spoke with a nurse from our state's health service. We wanted to ascertain if we should take him to the local hospital. However, the nurse advised to call another free number, the national After Hours GP Helpline and we were connected with a 24 hour home visiting service. It was 6.30pm and we were advised that a doctor would come to our hotel room between 7.00pm and 9.00pm. The doctor arrived at 8.55pm with a driver and after examining our son, and provided a letter for me to give to our GP. On Monday our regular GP recommends a blood test. We take a to the local pathology lab. The practice bulk bills all children. My son, at aged six, has probably seen more doctors in 9 days than many 60 year olds in less resourced countries would see in a lifetime. On reflection of the services I recently saw in the Philippines and my time living in South East Asia, I am grateful that I have paid no out of pocket expenses for any of these services.

This vignette illustrates my own experience of the Australian Health system and how I have an insider understanding.

Racism 101

Mrs X was an "army wife". Like us she lived in a functional wooden 3 bedroom house in Vincent, her kids went my school, her husband worked with my dad "at the

barracks". I was 6, in grade 1 at Vincent State School. My teacher Ms S had red hair and my mother whispered that she was divorced, that's why we said Ms nor Mrs. My best friends were army kids; only two weren't, we thought they were weird. We wore thongs (flip flops) and shorts and singlets to school and sometimes, when it rained, no shoes at all. I had one uniform, it was light purple. We swam at the Long Tan pool and ate Billabong ice creams. I thought Long Tan meant your tan was long, down your legs. We didn't have to wear sun cream, like Mrs X and her freckly kids. I had a tan, like my mum, like my Dad and my brother and my Grandpa who was always tanned, although he wore a hat all the time. Mrs X didn't like tans. Mrs X knew that Long Tan was a battle, I would learn later my Dad was in that battle in Vietnam, no one talked about Vietnam in the 80s. Mrs X socialized with the other army people, posted to this far northern town. My mum had cried when she got the posting envelope. She was a Sydney girl, Townsville was a shit hole. I saw Mrs X and her husband - who had a strange nick name, like many army people – Wazza, Smoke, Gunna, Blue - at BBQs, at the mess and at the pool. When I was in the stuffy classroom at Vincent, trying to impress Ms S, holding down my book so it wouldn't fly away because of the fans, Mrs X, with my mother and her best friend Mrs W, went to Vincent Village ate too much cake, she went out to coffee mornings, volunteered at the 'army' op shop. I never liked Mrs X. Mrs X was a racist. The first one I ever met. Once I sat in Mrs W's kitchen, Mrs X turned to my mother, and said "look at this", she grabbed my arm and pointed to my skin. "Don't let her get too dark T". She turned to me and starred at me in the eyes. "You know, if you are too tanned the black fellas will take you away. You'll have to go and live with the black fellas under the bridge". I don't remember much more, but maybe more was said, maybe my mother laughed or took me home. But I remember the emotion; a sickness in my stomach that I got when some Dads got too drunk at the mess

and had to be “talked to” by the Captain. On reflection Mrs X was making a comment to my mother. My mother always looked different. She had dark hair, darker skin; she was asked in Sydney “what nationality are you”; “are you a wog, Greek, Italian, Indian?” Mrs X knew my family had “a touch of the tar brush” and she wanted my mum to know. Another day I overheard Mrs X tell my mum and Mrs W that she didn’t let her kids watch Differen’ Strokes, a popular 80s TV show about two young Black brothers adopted into a rich white family. “Look at him, the little black bastard…” I don’t remember more, just Mrs X’s face as the scowled at the TV. Over the years, after my Dad had left the army and then when I left Townsville, my mum would keep me up to date with the various lives of people, including Mrs X. Our school interviews potential students and asks for community representatives to sit on a panel. There she was one day, getting briefed in the tea room before interviews. A sickness to my stomach but I approach her. She looks confused. “Hello, Mrs X, I’m Robyn, B and T’s daughter”. She remembers. I wonder what she thinks of the questions about how we want students to be keen about Aboriginal and Torres Strait Islander health. I wonder what it would be like for her. Has she changed? Or does she come to ensure we don’t get any “black fellas”.

This is about the community of JCUSMD; who are they? This vignette demonstrates that although JCUSOM says it has community involvement in selection; what types of people are defined as community? They do not necessarily share the same values of JCUSOM.

Racism 201: the bystander

I have a habit of looking at the funeral columns in our local paper, to see "who died". Inevitably, about once a month I know someone; an older person from my parent's church or a parent of a friend from school. M had died before his mother; his name had (deceased) after it in her funeral notice. I was 31 when I saw the notice. M would have died before he was 31. M was in my grade at Vincent School. He was J's boyfriend and was also in Stanton house and always won the high jump. He was a Torres Strait Islander person. It was my first memory of being a bystander. M was being hounded by the teacher, Mr X. "Why were you away yesterday?" We were in grade 4 or 5, we were 9 or 10. "I was sick" said M. "If you were sick" said Mr X, "then why don't you have a note?" "We don't have any paper in our house" replied M, his face to the floor. "No paper, not even toilet paper!?" said Mr X. I see how ashamed M is; I feel sick for him; I want to tell Mr X to stop, that also sometimes I forget to ask for a note. Later I hear Mr X talk with Ms H. "I never have seen a dark kid blush, I made him blush" Mr X told Mrs H. Mr X seemed delighted in himself. Mr X and Ms H both teach our class. They play guitar, and let us listen to the ABC radio song time, they are creative and young and keen. Mr X is in local musicals, I think he goes to church, a good thing in my mother's eyes. "But he's a bit strange" my mum would say. I also know, it although I'm yet to know the work, that he is racist. M I wonder how you died. I'm so sorry they made you feel ashamed. I'm so sorry I didn't know what they were doing; I didn't know how to stop them.

Racism 301: The Bubble

My husband is a chef. His first job in Townsville is at a local "gourmet" pub. "What do they think, do they think I'm doing to laugh at that shit. Up here they are just

unbelievable, you'd never get away with saying that in Melbourne". He's disgusted at himself, that he just turned his back instead of saying something when the boss starts telling racist jokes. "I mean you know what I found out from his girlfriend, J, he's not from (city in Europe), you know, he's from (a small western town), his Dad is Aboriginal. He's mum's from (city in Europe). He lived (in city in Europe) for 6 months, like 2 years ago and he has an accent, he tells everyone he's from London. Like why would you do that? He should fuck off to Melbourne - they'd love him, all those Fitzroy girls". I should explain to my husband, who lived in inner city Melbourne for 20 years, that to hide your Aboriginality is strategic; because imagine how it would be listening to racist jokes when everyone knows your Aboriginal. But instead I retort that he's no longer in the Green-voting bubble of inner Melbourne and it was time to stand up. "If you just stand there and say nothing, you're just as bad as them, the racist". I say. "Well ok for you Ms University" He leaves the room. He's right I'm now in the bubble.

Racism 401: Bad neighbours

"Fuck ya" screeches a woman's voice. A gate bangs, kids cry, the same dub step music blares, oh god, not that song again. A two day party – Jesus what are they on, and that man's laugh, oh just shut up. "Just don't worry about it, they'll stop soon" Peter is watching late night TV. I'm watching the neighbours; peering through the wooden louvers of the old Queenslander we rent, I contemplate whether I again call the 13 number – the community police number or do I let it go? At the beginning of the year we realized, from media reports and neighbourly gossip that the five story unit complex opposite our house was social housing. Soon the neighbours moved in: single men who Peter reckons are just out of prison ("Dunlop volleys: prison shoes"), families with kids

(including a lovely mum whose daughter will become my son's friend), retirees who transform courtyards into lush oases, large families who have endless visitors and the party people. Not every night, but at least once a week, two days, three; people yelling to get into the complex, fighting on the street, cars, booming music. Peter goes to bed. I can't sleep. If I call the police is that racist? Am I contributing to the statistics, another Indigenous person in prison? My kids, used to inner urban life, sleep through it all. Peter and I agree; if it's a woman man fighting, we call. If it's a kid, we call. But music, laughter, really how many times did we have parties? R, the mum from school who lives there, tells us about the shit in the stairwell, the piss in the lift, how there is no air conditioning, so you have to keep the window open and that's why parties occur on the verandah. "If you're going sing your old shit, go out bush" I hear R yell out one hot night when some Torres Strait Islander peoples were singing traditional songs; it was late about 2 in the morning. "What happens" I say knowingly to the wide eyed student at a conference morning tea "Is that most Aboriginal and Torres Strait Islander peoples don't drink, so if they are say from Palm Island and want to drink, their families don't want them to at their house in town, so they go to the park".

I'm so cool, an academic from the north who lives with the community and know Aboriginal and Torres Strait Islanders. But my experience with the neighbours, I don't mention that, how those us and them dichotomies can rise up when it's 3 in the morning when you want to sleep. Or is their race an aside, that this happens …

Racism 501: "Always nice to you"

Two of my friends and I walk together once a week, we walk slowly and talk and get large coffees. It's an excuse to catch up more than exercise on the Strand, Townsville's

gem, a beautiful shore line overlooking Magnetic Island. We dodge joggers and laugh at the middle aged men clad in bike gear, lycra stretching over pot bellies. Once day four Aboriginal women, who from their clothes and bags of gear, are homeless or 'parkies", wander past. "Hey, hello, hello" says one, waving at me. "Heeey, you, hi bubby!" says another. A little while after they past, one friend comments "Why when we are with you do that Aboriginal people say hello?" I shrug. "Do you work with them or something?" asks the other. I don't know I say, maybe they've seen me outside my house, maybe, it's what my colleague says, that I look a bit of a hippy, and "we know hippies like us". Maybe it's because I didn't tense my body, look at the ground, expecting a retort. Maybe it's because I just had the courtesy to smile at them and say hello, like I would anyone on a beautiful morning. But why do I have to overanalyze. Oh it's homeless people, I'll smile and show its OK, I'm not afraid. Is that in itself a colonial act? It's OK I'll let you exist.

Sad, not angry

I'm teaching a group learning session. I've done it before. It's for Rural Remote and Indigenous Health for our year 2 students. I start the second DVD and one student, a tall guy well-dressed guy, gets up to leave. "Ok you can leave". He pauses at the door, as if I was going to say more, I half smile, he hurries from the room. I look at one of the "good" students, who frowns at me in solidarity. "You know" I say to the class with tears in my eyes. "I used to get angry with students who aren't interested. Now I'm just sad." I nearly start crying, the students shift in their seats, they are embarrassed. "How can you watch that and not care, how are we going to address these issues if some of you won't even stay. You come here knowing we teach this, we focus on this, you lie in

the interview and then you complain". I start the next DVD. I am not angry, I'm sad. But also feel sick in my stomach ashamed too that I had to say that.

What ever happen to "I REAALLLY want to work in rural, Indigenous and tropical health?"

These vignette explore the hidden curriculum, what is valued by students and the tension of presenting a "face" of a school aspiring to be socially accountable and hiding the messy reality of differences in values and priorities. I have this knowledge of JCUSMD. What is this like at other schools? What "dirty secrets" did other schools hide?

Appendix 8: Reciprocity:

How do contextual issues influence socially accountable medical schools?
PhD thesis: Robyn Preston, James Cook University

Summary and Publication and Collaboration proposal for case study schools

Submission date: 28 May 2014

Supervisors: A/Prof Sarah Larkins, A/Prof Judy Taylor and Dr Jenni Judd

Socially accountable medical schools hold themselves responsible for health of the communities they serve. Since the early 1990s the World Health Organization has developed conceptual frameworks around social accountability and individual schools have described their own experiences. However, little is known how contextual factors, or external and internal issues, have influenced the development of socially accountable medical schools. Using a multiple embedded case study approach I have explored how contextual issues have influenced social accountability at four medical schools in Australia and the Philippines. From the literature and my own professional experience I theorised that workforce, health sector partnerships and communities partnerships would be strong contextual influences. I interviewed 75 participants including staff, students, health sector representatives and community members. I undertook fieldwork to four sites and verified findings through the grey and published literature. There are internal and external factors that overlap and influence socially accountable medical schools. The strongest contextual factor was the local workforce situation which has led to innovative educational programs established with or without government support or funding. The values and professionals experiences of leaders and individuals, including staff and health sector representatives, have influenced whether a school's organisational culture is conducive to social accountability. Furthermore, the wider institutional environment and policies of their universities affect this culture and the resourcing of programs. Membership of a coalition of socially accountable medical schools (the Training for Health Equity Network) has created a community of learning and legitimised local practice despite some challenges from the established medical education fraternity. Communities may not recognise their own importance but they are fundamental for socially accountable practices including student learning, selection of students, governance and the schools' research and curriculum foci. This research will assist the medical education community to learn from these institutions' experiences; and contribute to the development of the theory and practice of socially accountable medical schools.

Stakeholder/community seminars
I would like to undertake a seminar at Flinders University School of Medicine in 2014 at a time and date convenient to all stakeholders (Adelaide and Renmark). This would also give an opportunity to collaborate on papers with Iris Lindemann.

I would also like to undertake virtual seminars at ADZU and UPM-SHS at a time and date convenient to all stakeholders. Face to face may be possible in later half of 2014 or early 2015 depending on travel restrictions and budget. This would also give an opportunity to collaborate on papers with Rex Samson and Filedito 'Joboy' Tandinco.

I would also like to give a presentation or virtual session to relevant THEnet schools and stakeholders.

Publications (planned and in preparation):
Preston, Larkins, Judd, Taylor, Lindemann, Ross, Samson, Tandinco, "The historical and conceptual development of socially accountable medical schools" Target journal: Education for Health or Medical Teacher (Impact Factor: 1.824)
This publication will be based on my literature review chapter and will outline the historical and conceptual development of socially accountable medical education and socially accountable medical schools. In order to move to theoretical clarity, it will include a synthesis of key concepts of socially accountable medical schools.

Preston, Samson, Tandinco, Larkins, Judd, Taylor, Mueller, Redman-Maclaren "Taking off our Pith Helmets: Becoming (post) colonial researchers" Target journal: Qualitative Health Research Impact factor: 2.181
This publication is based on my methodology and my fieldwork experience in the Philippines. It is connected with JCU's new agenda of conducting "research in the tropics" and will reflect on how research in less-financially resourced countries challenged my theoretical understanding of critical theory and constructivism I hope to explore these issues with my colleagues from the Philippines as well as two other PhD candidates (Lorraine Mueller) and Michelle Redman-Maclaren who are interested in (post)-colonial research and de-colonising research.

Preston, Larkins, Taylor, Judd, Lindemann, Ross, Samson, Tandinco, "Context Counts: "What has influenced social accountability at four medical schools"?, International Journal for Equity in Health (journal impact: 1.84)
This chapter will be based on my cross case analysis, summarised above.

Planned presentation of results at: Muster: Global community engaged medical education (Uluru, Australia, 27- 30 October 2014) and/or TUFH conference (Fortaleza, Brazil, 19-23 November 2014) and Association for Medical Education in Europe (AMEE) – PhD student presentation (Glasgow, UK 5-9 September 2015). I would like to undertake joint presentations will be undertaken with colleagues who assisted with data collection and supervisors.

Conference Presentations (completed):
Preston, R, Taylor, J., Larkins, S., & Judd, J *The role and influence of communities upon socially accountable medical schools.* Melbourne Social Equity Institute – Imagining Social Equity, Melbourne, Australia, 28 February and 1 March, 2014. (Conference presentation)

Preston, R, Taylor, J, Larkins, S & Judd, J (2012) How do Contextual Factors influence Socially accountable medical education, Paper presentation at the Rendez-Vous 2012 Conference, 9 October 2012, Northern Ontario School of Medicine, Thunder Bay, Canada.(Conference presentation)

Preston, R, (2012) Power to the People! How Communities influence Medical Schools, Paper presentation at the *So you think you can research* competition, North Queensland Festival of Life Sciences, 29 October, James Cook University, Townsville (Conference presentation)

Preston, R, (2012) "How do contextual issues influence socially accountable medical schools?" Paper presentation at the Faculty of Medicine, Health and Molecular Sciences 3 minute thesis competition, 3 September, James Cook University, Townsville. (3 minute thesis competition)

Tandinco, F, **Preston, R***, Larkins, S, Lindemann, I, Neusy, A-J, Palsdottir, B, Prideux, P, Ross, S, Samson, R (2012) Transforming Health Professional Education through Partnerships: The Training for Health Equity Network (THEnet) Evaluation Group Experience, poster presented at the Asia Pacific Medical Education Conference January 2012, National University of Singapore, Singapore. (Finalist in the best poster abstract). (Poster presentation)

Preston, R*., Taylor, J., Larkins, S., & Judd, J. (2011). *How do contextual issues influence social accountability in medical education?* Poster presented at the 2011 North Queensland Festival of Life Sciences, 29 September, James Cook University, Townsville (Poster presentation)

Preston, R., Taylor, J., Larkins, S., & Judd, J. (2011, 1 July 2011). *How do contextual issues influence social accountability in medical education?* Paper presented at the LOCAL? GLOBAL? Health Professional Education for Social Accountability Alice Springs Convention Centre, Alice Springs, Australia. (Conference presentation)

Preston, R*., Taylor, J., Larkins, S., & Judd, J. (2011). *How do contextual issues influence social accountability in medical education?* Poster presented at the 2011 Primary Health Care Research Conference: Program & Abstracts Brisbane Convention Centre, Brisbane, Australia. www.phcris.org.au/conference/browse.php?id=7198 (Poster presentation)