EDITORIAL

Social Accountability and Our Medical Institutions

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization)."

In 1986, World Health Organization (WHO) expressed its concerns over medical schools and priority health needs. Later in the 1990s, WHO revisited standards for quality assessment in medical education and medical school dominion. During this era, in 1995, WHO established the precise definition and methods of determining the social accountability of the medical institutions.[1]

The terms responsibility, responsiveness and accountability are often used regarding the social commitments of medical schools. However, Pakistani doctors, are not well-versed with these terminologies and do not appreciate the basis of these social compulsions. They are commonly used synonymously, but they express different connotations. A socially responsible medical school is dedicated to what the teaching staff naturally and instinctively considers the welfare of society.[2] In fact; it is a situation of consciousness of duties to react to the needs of the society, which is considered the source of a "good medical practitioner".

A socially responsive medical school adopts a course of action to address the needs of society by planning and executing its education toward the health priorities in society. However, a socially accountable medical college is a step further which not only undertakes actions in education, research and services toward the health priorities but also operates in collaboration with the main stakeholders (government, health services and public) in order to have a positive effect on the health of the society. In order to be endorsed as entirely socially accountable, an organization should be evident in all aspects that its 'products' (doctors in the case of medical schools) are being employed in the paramount concern of the people.[3]

The present-day definition of social accountability is recognized as:

….The obligation of medical schools to direct their education, research and service activities towards addressing the priority health needs of the community, region, and/or nation they have a mandate to serve. The priority health needs are to be identified jointly by governments, healthcare organizations, health professionals and the public 1 (WHO 1995).

The main objective of medical education is that the doctors leaving a medical institution should be ready to deliver patient care and appreciate their position and purpose in society. Pertinent and significant areas of community health should be covered in all the research to meliorate the health of the society. The medical services should cover the clinical aspects and the preventive ones so that a healthy community is achieved successfully. This will be apparent if the graduates produced by the medical schools attain the competencies required to enhance people's health and practice them in their day-to-day professional commitments.

WHO emphasized four important principles which every health care system should cover that a common person is utilizing. These constitute quality, equity, relevance and effectiveness. These standards are linked to the activities taken in any medical school.[4] Quality covers the aspect of the provision of the finest conceivable actions to guard, reinstate and encourage a situation of physical, mental as well as social well-being. Equity warrants that every person should have a complete accession to the health care system without any discreteness or differentiation. Relevance encompasses providing health services according to the priority and delivery of extraordinary attention to the most susceptible, endangered and sensitive ones. Effectiveness refers to the utilization of health care resources to attend to the community's requirements in the maximum effectual and proficient mode. In short, all these four principles should be incorporated into the planning, implementation and assessment of medical school programs. Our education, research and services need to be tailored accordingly.

A compendious and panoramic charter of Conceptualization, Production and Usability (CPU Model) was proposed by Boelen & Woollard in 2009 under the umbrella of WHO to enable medical schools to assess the progress towards achievement of achieving their aims of social accountability.[5] Applying these principles, The net (Training for Health Equity network) framed three main queries for evaluating the social accountability of medical schools.[6,7]

"How does the school work?" (~Conceptualization/ Plans),

"What does the school do?" (~Production /Actions),

"What difference is the school making?" (~Usability/Impacts).

In 2010, about a century succeeding the Flexner Report, the health professional educators, researchers,

and policy-makers from the four corners of the world assembled for several months and established a Global Consensus on Social Accountability of Medical Schools. This was considered a charted milestone for forthcoming medical education around the world. This should be noted that in order to adopt social accountability in medical institutions in Pakistan in true spirit so that an equitable, relevant, effective and quality-driven health care system is established, then a substantially significant modification in planning, teaching, training programs and assessment is required.[8] There intends to be a nationwide agreement on the theoretical outline leading to a change in curriculum to produce doctors and, in fact, a visible, noticeable and quantifiable influence on definite health consequences of society.[9]

Unfortunately, where do we stand and what are our priorities still not clear. Being an underdeveloped country, we are still suffering from the menace of Brain Drain. In Pakistan, there are 117 medical colleges and 59 dental colleges (Pakistan Medical Commission 2021 Database). Annually several hundred young doctors graduate from these medical and dental colleges, and many of these fresh graduates leave the country to pursue a specialization. Unfortunately, most of these talented brains never come back and settle in the US, UK, Europe, or the Middle East.

This has caused serious effects on our healthcare system, especially on the community health. Presently we have 1.1 doctors per 1,000 persons as compared to 5.32 doctors per 1000 people in Austria, 3.29 doctors per 1,000 people in Israel, 2.95 doctors per 1,000 people in the UK, 2.64 doctors per 1,000 people in the US and 2.24 doctors per 1,000 people in huge population state of China. It was reported in 2016 that about 30% of the practising physicians in America were not originally from the US. The American Association of Medical Colleges has predicted that by 2025 US will be deficient 160,000 doctors. Indeed, this deficiency would also be covered by doctors from other countries. Pakistan is the third chief source of foreign doctors in the US. Many of our medical colleges produce graduates only from the US, UK or other European countries. Their contributions to our society are limited. Secondly, most of our medical graduates are females, amongst whom more than two-thirds stop practising medicine after graduation. This also leaves a considerable number of doctors trained in Pakistan making no role in improving our society health. These issues need critical analysis and a pragmatic solution to improve our citizens' social well-being.

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