Advances in Medical Education and Practice

Dovepress
Taylor & Francis Group

Open Access Full Text Article

ORIGINAL RESEARCH

"I Don't Want to Read About It; I Want to Do It": Perspectives on *Being* and *Doing* Social Accountability in Medical Education

Brianne Wood[1,2], Ghislaine Attema[2,3], Erin Cameron[2–4]

[1]Medical Sciences Division, NOSM University, Thunder Bay, ON, Canada; [2]Dr Gilles Arcand Centre for Health Equity, NOSM University, Thunder Bay, ON, Canada; [3]Faculty of Education, Lakehead University, Thunder Bay, ON, Canada; [4]Human Sciences Division, NOSM University, Thunder Bay, ON, Canada

Correspondence: Ghislaine Attema, Lakehead University, Faculty of Education, 955 Oliver Road, Thunder Bay, ON, P7B 5E1, Canada, Tel +1 807-766-7509, Email gmpilot@lakeheadu.ca

Purpose: Medical schools and healthcare institutions are increasingly committing to social accountability, the reorientation and prioritization of addressing local community health needs. Now, as part of this commitment, schools and institutions are called upon to demonstrate evidence of their progress towards social accountability to governments, accreditors, funders, and communities. This study aimed to understand what *social accountability* means to diverse interest holders, particularly with regard to demonstrating local evidence, to provide contextual insight for the development of an "impact framework" for one Canadian medical school.

Methods: One-on-one semi-structured key informant interviews were conducted with three diverse groups: academic, health services, and community interest holders to understand multiple perspectives on social accountability in health professional education. Respondents were asked how they perceive, actualize, and measure social accountability at different levels (societal, school, individual). Interviews were transcribed and thematically analyzed.

Results: Eighteen interviews were conducted, with eight academic representatives, six health care professionals, and four community leaders. The researchers identified three high-level themes in their analysis: the definition of social accountability, enacting and embodying social accountability, and measuring social accountability. There were distinct differences in terms of defining, executing, and evaluating *being* socially accountable and *doing* social accountability.

Conclusion: Respondents emphasized that defining what social accountability means for a specific context is critical to advancing the movement. Acknowledging that there are similarities and differences between *being* socially accountable and *doing* social accountability is important for evaluating an individual's or a group's accountability to society in health care, health professional education, and research. While the actual indicators and outcomes used to assess the progress toward social accountability are likely geographically bound; meaningful engagement, shared governance and power structures, and integrated data and analytic capacities are important enablers to move social accountability measurement forward.

Keywords: social accountability, impact measurement, perceptions, qualitative methodology

Introduction

Social accountability is increasingly recognized as part of the strategic mission for health professional education and health care institutions.[1,2] Over the past three decades, researchers, clinicians, and educators have built upon the World Health Organization definition of social accountability, which focuses on the need to identify and address priority health needs in partnership with relevant interest holders through equity and place-focused education and health system interventions.[2,3] Early evidence has shown that medical schools and healthcare institutions with social accountability mandates and tailored curricula are having positive impacts on graduate retention to northern, rural, and remote settings,[4] more graduates with generalist and equity orientations as career choices,[5,6] stronger preferences to practice in smaller- and lower-income countries,[6] economic stimulation in lower resource areas,[7] and better patient outcomes.[8] In response,

https://doi.org/10.2147/AMEP.S543029
Received: 27 May 2025
Accepted: 30 October 2025
Published: 6 January 2026

there are now evidence-based tools and conceptual frameworks to guide social accountability at the institutional level.[9] Researchers have identified indicators for measuring institutional social accountability, and contemplated the comparisons and differences of these indicators at the levels of clinical interactions, organization and society.[10,11] Recently, there has also been a significant global effort to advance social accountability in health professional education through accreditation standards.[1,12,13]

Despite the suggestive evidence and compelling rationale for social accountability, an ongoing challenge for the individuals and institutions is the push and pull of implementing social accountability both *globally* and *locally*; being part of a global movement but staying locally focused. Globally, there is a strong drive for the standardization of social accountability in health professional education, and efforts in this area include a global consensus document with 10 strategic directions for medical schools who strive to be socially accountable,[14] global surveys and frameworks,[15–17] and a continued refinement of the definition of key terms within varying cultural contexts.[18] At the same time, there is a movement focused on the contextualization of social accountability (eg, celebrating contextual and cultural differences in geographies, histories, peoples).[19] There is likely room at the table for both, and arguments to be made for their complementary natures, so long as the central goal is in sight—improving the health and health care of the populations served.[3]

Understanding the need to be both global and local, a team of researchers from NOSM University have been working on a case study to develop a globally informed but locally focused impact framework. Drawing upon global concepts and constructs of socially accountable health professional education available in the literature, while situating them within the local context of Northern Ontario, including local health systems, is the foundation of this work. The institute central to our study, NOSM University, is located in Northern Ontario, Canada, and was specifically created as a government strategy to train more physicians for Northern Ontario. Created in 2002, NOSM University was founded on the principles of social accountability and in 2022 became the first independent medical university in Canada. The structure of this case study is in four-parts, which include a 1) theory appraisal, 2) priority mapping exercise, 3) key informant interviews, and a 4) consensus-building framework validation process, all with the aim to develop a framework that can support NOSM University's measurement of societal and community impacts of social accountability. Although rooted in the Northern Ontario context, findings from this work can provide benefits to other places and institutions who are working towards similar goals. This paper focuses on the results from the third part of this study, the key informant interviews.

Methods

Overall Study Design

This study, its instruments, and its analytic process were informed by a narrative appraisal of social accountability in health care and health professional education literature.[9] This helped to further identify relevant frameworks, key concepts and constructs applicable for the Northern Ontario context. Identified concepts and their respective meanings were used in the development of a coding dictionary that was used in the analysis of the interviews. Through critical realism and reflexivity,[20,21] the study team integrated previously defined theories and concepts while incorporating new meanings and formulations that emerged through the study.[22,23]

Research Team

The research team consisted of a: research scientist (EC), a mid-career medical education and social accountability expert; health systems research scientist (BW), an early career health researcher with more than 7 years of experience leading qualitative interviews and expertise in health equity assessment; and a trainee (GA), a PhD candidate who has 15 years of professional work experience in postsecondary education and expertise in qualitative analyses. Senior author (EC) conceptualized the study and co-development of the interview guide, analysis, and interpretation. BW conceptualized the study, co-developed the interview guide, recruited participants, led the interviews, led the analysis, and interpretation. GA independently analyzed the interviews and participated in the analysis and interpretation.

Ethical Approval, Participant Selection, Recruitment

Ethics approval was obtained from Lakehead University and Laurentian University Research Ethics Boards, respectively (#1467739 and #6020626). Researchers used purposive sampling to identify key informants, including interest holders internal to NOSM University as well as individuals from outside of the institution including academic respondents, health professional respondents and patient and community organization representatives. Participants were considered eligible if they currently or at some point lived or worked in Northern Ontario and interacted with the health or health professional education system.

A list of potential participants was put together by the research team, and Email addresses were identified using publicly available websites. An Email invitation was sent to key informants along with a letter of information describing the larger project. Invitees could respond to the Email to schedule a 60-minute, one-on-one virtual interview if they were interested. Invitees who indicated interest were sent a calendar invitation using the Cisco WebEx platform by interviewer BW, as well as a letter of information, consent form, and a pre-interview survey about demographic details (eg, gender, age, their position as an interview respondent, home community, and communities served professionally). Respondents were reminded about the survey during the consent process and at the end of the interview and were emailed twice after the interview to prompt them to complete the demographic survey if they had not already done so.

Data Collection

A guide for the semi-structured interviews was developed by BW and EC, guided by the project's objective to build a social accountability impact framework for Northern Ontario and informed through constructs and knowledge gaps identified in the theory appraisal. The interview process was piloted for question order, clarity of questions, question prompts, and technology. After this initial process, questions were re-ordered for logical flow, and prompts were refined to include specific reference to the northern, rural, and remote context of NOSM University.

During the interviews, the interviewer (BW) outlined the purpose of the study and the structure of the interview, inviting respondents if they needed any clarification or had questions. Consent was obtained, including consent to have anonymized responses and direct quotes included in any publications, and the purpose of the study was outlined. After that, the following questions guided the conversation between the interviewer and the respondent:

1. How do you know if a health professional education institution ("medical school") is socially accountable?
2. What are socially accountable outcomes of a health professional education institution?
3. In what ways is/is not your school socially accountable?
4. How can individuals be socially accountable? In your role, how are you socially accountable?
5. What are the facilitators and barriers to "doing" social accountability?

Field notes were made by the interviewer during and after the interview. Between July and September 2020, all but one recording was transcribed verbatim using the Transcript Heroes transcription service. One recording's quality was too poor to generate clear reports of the dialogue, so the interviewer used a combination of audible fragments and field notes to generate its transcript. Because of this, not all words could be heard clearly, and so there was a small loss of data as a result.

Analysis

Two researchers (BW, GA) independently analyzed the transcripts using Braun and Clarke's six-phase reflective thematic analysis approach[20,24] while also incorporating elements from Smith and Firth's framework analysis.[25] While framework analysis can be perceived as incompatible with our reflexive thematic analysis approach, as the use of a codebook implies a positivist paradigm, our analysis did not reduce the data to a matrix or domain summaries. Instead, the researchers used a deductive approach to understand how different themes might contribute to framework development (ie, the aim of the research) while using inductive approaches to ensure that the respondents' meanings were emphasized in the interpretations. Both researchers read the transcripts and listened to the audio recordings of the interviews as part of their approach. Both researchers used the already identified thematic areas from the theory appraisal but also identifying new codes

(names and meanings) throughout the process. The coding was done in Microsoft Word, using the Comment function, and then all comments were exported to Microsoft Excel. "Codes" included both the code name and a longer description of the researchers' interpretation. The two researchers met weekly between January and May of 2021 to generate initial themes from the codes and outputs, and then collectively developed themes and meanings. This process aimed to preserve the respondents' own perspectives and experiences of socially accountable health professional education while simultaneously engaging in broader and collective interpretations. The aim of this approach was to acknowledge the subjectivity of the concept of social accountability in education and health care while recognizing the goal of the researchers in producing an evaluation framework. The senior researcher (EC) participated in theme refinement during monthly meetings, which were assisted using Google Jam Board and Microsoft PowerPoint to aid in the visualization of nuances and ambiguities of the developing themes.[26]

After five months of reflexive thematic analysis, the team determined that sufficient information had been collected and analyzed to achieve the goals of the study. However, it was acknowledged that additional cycles of framework validation and refinement will be required through ongoing dialogue with Northern Ontario interest holders and communities, which will serve as an opportunity to i) validate the thematic analysis with interview respondents and ii) elaborate and refine the thematic analysis with new perspectives.

Results

Description of Participants

Twenty-two individuals were initially invited to participate in these one-on-one interviews, of which nine individuals were invited as an academic representative (EDU), five were invited to participate as Northern Ontario community representatives (COM), and eight individuals were invited as health care professionals (HCP). Of those invited, three declined, and three did not respond. One community representative who declined shared the invitation with two other community interest holders, both of whom accepted an invitation to participate. Two respondents also shared the invitation with a colleague. One of these contacts participated in the interviews, and one declined. In total, 18 individuals – 8 academic interest holders, 4 community interest holders, and 6 health care interest holders – participated of 26 individuals invited (69%).

Of the 18 respondents, only 10 (56%) returned their demographic questionnaire (4 recruited as academic interest holders, 2 recruited as community interest holders, and 4 recruited as health care interest holders). Among the 10 survey respondents, half identified as men. Four of the ten survey respondents reported their age between 60 and 69 years, three reported their age as 50–59 years, while the remaining individuals were between 20 and 49 years. Respondents were asked to identify their role in the interview, using a checkbox approach: seven identified as administrators (70%), six identified as community members (60%), five identified as health practitioners (50%), five identified as researchers (50%), five identified as educators, (50%), two identified as patients (20%), and single respondents identified as a funder, a decision-maker, and a medical student. Given the low number of respondents to the demographic questionnaire, we were unable to provide cross-case comparisons and limited to noting whether themes were predominantly present from specific respondent types, but unable to draw comparisons.

Researchers categorized the themes from the interviews into three high-level categories: 1) the need to locally define social accountability, 2) the need to identify both the values/ethics and actions/processes of social accountability, and 3) the need for local frameworks to drive measurement and impacts of social accountability. Each theme is described in detail in the following sections below.

Theme 1: The Need to Locally Define Social Accountability

Most respondents agreed that to assess whether an educational institution is socially accountable, what "success" means needs to be clearly and transparently defined. The educational institution should work collaboratively with the local community(ies) as part of this process. By explicitly defining success, the institution, as well as other interest holders, have a benchmark to compare progress toward their goals. Respondents' perspectives varied on whether this has been accomplished, for health professional education as a whole and for NOSM University specifically. Many academic respondents acknowledge the widely

cited 1995 World Health Organization definition of social accountability by Boelen and Heck as a starting point in understanding how to assess achievement of the goals of social accountability.[2] The same respondents also felt that this generic definition of social accountability was not sufficient for an educational institution to use in practice. Additional context-specific examples and meanings tied to action plans were considered by respondents to be more appropriate definitions.

While most respondents provided examples of what social accountability meant to them, or their interpretations of what it meant for the school, the researchers identified two intersecting spectrums that characterize how respondents conceptualized social accountability: i) contextualization – standardization, and ii) partnership/relationship-driven – data/measurement-driven. The following image (Figure 1) captures how respondents interpreted social accountability in medical education, with accompanying quotes for each quadrant.

All respondent groups presumed that the basic premise of social accountability for NOSM University is their "responsibility" to meet the health and health workforce needs for the people and communities of Northern Ontario. While many respondents alluded to the complexity and investment required to understand health and workforce needs "appropriately", this simple statement of social accountability resonated with almost all respondents. How these definitions and characterizations of social accountability influence the education, research, and health service activities of medical schools were interpreted varied within and between respondent groups.

Theme 2: The Need to Identify Both the Values/Ethics ("Being") and Actions/Processes ("Doing") of Social Accountability

Our research team identified an important distinction in how respondents communicated their perspectives around social accountability: respondents discussed individuals, organizations, and systems *being socially accountable* as well as *doing social accountability activities*. The former theme encompasses how individuals and groups of people embody the values and goals that they associate with social accountability, while the latter refers to specific action(s) that meet the "accounting" objective of social accountability (ie, measurement, activities).

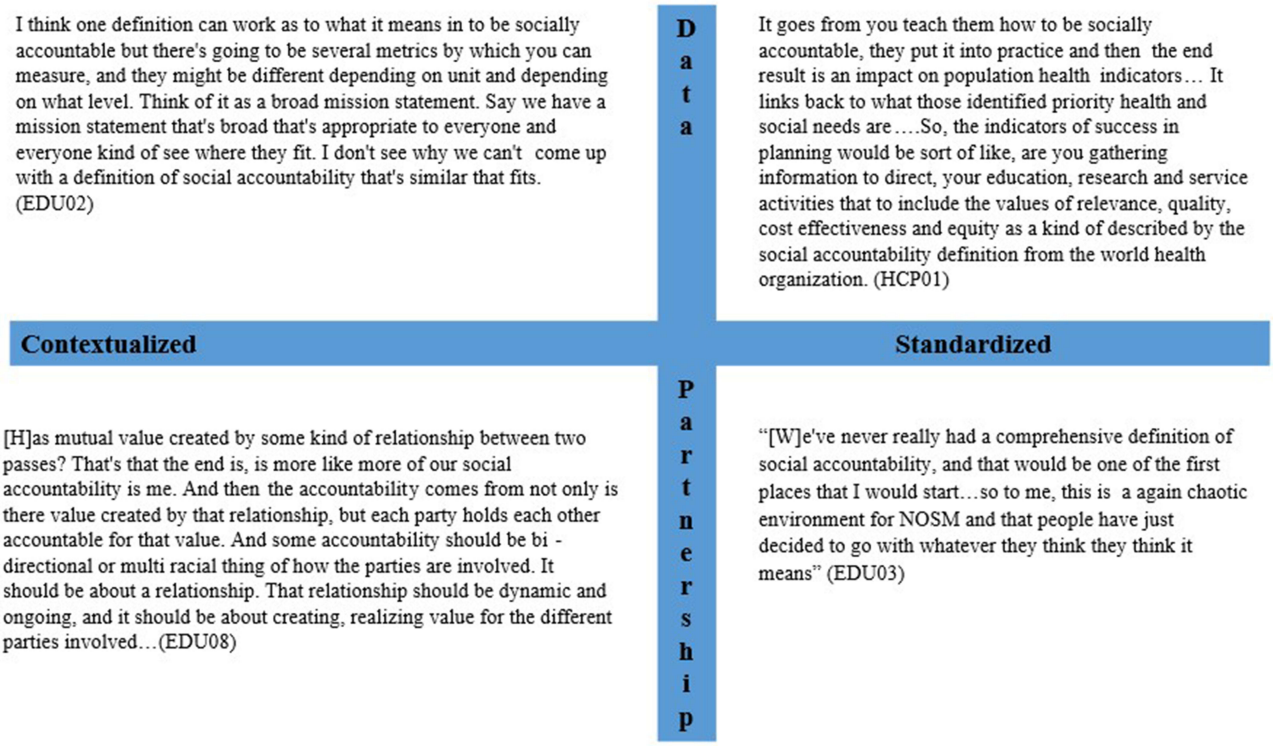

Figure 1 Axes for defined local social accountability.

https://doi.org/10.2147/AMEP.S543029

To *be* socially accountable, respondents described the shared aspiration of health equity and social justice, whether in education, research, or health services. At an individual level, being socially accountable was associated with being collaborative and empathetic, as well as being an advocate for system change. Most respondents described specific examples of what being a socially accountable health professional (eg, nurse, social worker, physician) looks like, which often focused on respectful patient interactions, shared decision-making, interprofessional collaboration, and awareness of population health issues.

According to respondents, being a socially accountable researcher or educator requires a similar aspiration to improve health and health care through their respective approaches. In both health research and health professional education, respondents aligned this concept through engaging with the members of the public as well as other interest holders, understanding and amplifying the needs of underserved populations through action. For Northern Ontario researchers, respondents suggested that conducting research to investigate region-specific or population-specific health and care gaps was being "socially accountable".

Respondents also highlighted that "educators" wear many different hats, and at NOSM University, many clinical educators are also full-time practicing clinicians. To some respondents, *being* a socially accountable educator then meant teaching the values and patient-centered approaches as described above while also contributing to the next generation of the health workforce (eg, medical learners):

> To me, I have an accountability on a greater level when I'm practicing that goes beyond just that personhood, but for whatever experience they're having. I … broach informed choice, so I talk to people about variety of different things, and I go where they want me to go for their learning. I see it as very much a journey of learning for all of us, and that's how I kind of contextualize it if that makes any sense in how I look at my social accountability. HCP03

Some respondents spoke to the "dual roles" of Northern Ontario clinicians and researchers as well, but this sense of multiple identities was most prominent with educators, which the researcher team interpreted as the assumed focus for medical schools.

At the collective level (organization, institution, or system), respondents expressed that *being* socially accountable meant intentional and explicit references of social accountability in the vision and mission of the organization. Through reference in the mission, vision and values of the school (or other collective), respondents conceptualized social accountability as an aspiration and a worldview that is intrinsic to both the individual and the collective. While this conceptualization was common among respondents, such a broad use of social accountability is not without its risks as was articulated by the following:

> [W]e've never really had a comprehensive definition of social accountability, and that would be one of the first places that I would start…so to me, this is [a] chaotic environment for NOSM, and that people have just decided to go with whatever they think they think it means. (EDU03)

Respondents explored what it meant to *do* social accountability, in other words, to participate in "the act of accounting" (EDU08). In this way, social accountability was framed as processes or specific activities that are necessary components to demonstrate its values. The *doing* of social accountability is articulated in the following quotes:

> [W]hat is the distinction and intersection between the institution being socially accountable and the people being socially accountable? (EDU07)

> You may be socially responsible. You may be socially disposed, but without an act of accounting, there is no accountability. (EDU08)

As shown in the image below (Figure 2), researchers identified common themes between the act of *being* socially accountable and the process of *doing* social accountability.

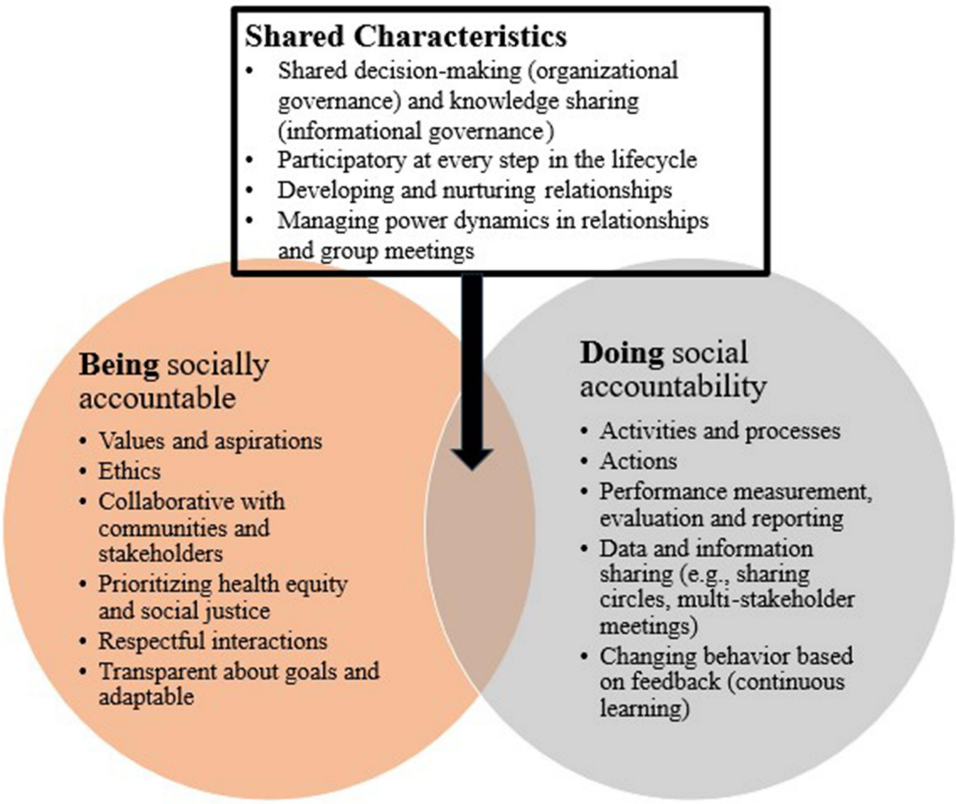

Figure 2 Comparing and contrasting "being" versus "doing" social accountability.

Theme 3: The Need for Local Frameworks to Drive Measurement and Impacts of Social Accountability

Many respondents noted that the social accountability of a school or institution was inherently challenging to measure. The lack of an explicit definition of what social accountability means in the school's context was identified by respondents as an institutional-level barrier to assessment. However, some respondents assumed once a clear definition had been established, in theory, traditional evaluation or research approaches could sufficiently capture progress toward social accountability. Table 1 summarizes respondents identified conceptual or practical challenges to measuring social accountability in health professional education.

Table 1 Categories of Challenges to Measuring Social Accountability in Health Professional Education

Relationships and social capital can be challenging to measure	"I think the indicators of you know, you talk about social accountability, I do not know how … like I keep coming back to the sort of relational behaviors, relational learning. Because that's the survival of I think professionals in those smaller communities. So, how do you put a measure on that? I think it should have to do with sociogram or something you know, how many people do you interact with?" EDU06 "So I think we have to make sure we give value for what we do. And unfortunately we have to measure and it's not easy." COM03 "But how we measure it – we measure it in our, we measure it in our approaches to engagement with communities who's needs we're meant to serve." HCP06

(*Continued*)

Table 1 (Continued).

Available, accessible, high-quality data	"[R]edesigning questions that are asked at the point of entry, to demonstrate that we are in fact, doing what we said we would do, capturing that data and then being able to use that data again, along the principles of OCAP®. For example, in the Indigenous community, to share with them information that's meaningful to them." COM03 "So how can we kind of mutually make sure that we are not duplicating efforts, like what can we do and share the data so we can, mutually work towards the same goal which is good doctors, good environment. But if we do not share data, it's kind of hard to do that…I think open and transparent data is …inherent to social accountability." EDU03 "Our data structures or lack thereof [put us] at a disadvantage because we do not have intimate knowledge of our community needs, unless someone just tells us we need this, or we need that in sort of that anecdotal, in conversations. We have no evidence, we were not proactive in any way, shape or form. So, I think that's a big gap and it's something that obviously has been recognized."EDU02
Unintended consequences of measuring or evaluating	"And I think the concern would be if you start to seek out this information, you're going to hear from that set of specific people that care very passionately about it and you're not going to hear from the people that don't." EDU04 "So, I think the biggest, one of the biggest things is you have people in leadership positions that do not get it and they control all these resources, have all this power. And they have all these other imposed metrics of successes that help them hold onto their job, but actually perpetuate the problems like it makes health inequities worse. It makes people further marginalized." HCP01
Capacity to lead the assessment or evaluation	"I think what's lacking and I don't know this for sure, but I think what's lacking is understanding data. And I think in the north there's a lack of that of knowing where to get the data is one thing, but how do I interpret it, how do I analyze it." EDU06
Health outcomes are the goal, but challenging to directly link to an institution's activities	"Like, health outcomes are a by-product of what we do. If we do our job well, then the health outcomes will come down. But, targeting health outcomes is the thing we are measuring is actually, like, two or three steps removed from what's within our purview, right?" EDU07 "That impact piece should be there to measure the impact that your intervention has had when you are doing, when you are trying to address those priority health and social needs for people that you serve. I think that's where it gets tied into population health indicators…So, you can have like a qualitative description of how it was on the impact piece, but if it meant their health indicators [got] worse, then it's kind of like a failure." HCP01
Hierarchical structures and different worldviews will lead to different interpretations of "accountability" and "value"	"And we live within a colonial system that exploits that, right? The intention is for decision makers to be isolated from the outcomes [links] to health, right?"EDU07 "And as we said, outcomes are challenging measure on their own just to see whether an organization is successful. And so in the end, the corporate accountability is required. And depending on your value, your view of what society is, it may be the primary factor, but that's definitely not."EDU08 "So, you know there's always indicators of safety. And there's always indicators of efficiency and timeliness and lots of emphasis on wait times. But are we really measuring anything around equity at this point? No, probably not of any significance." HCP06

One topic that resonated among academic, health professional, and community respondents was the importance of tracking the trajectory of health professional learners and their practice location and specialty. As several respondents noted, NOSM University was specifically created to address the underserved rural and remote communities in Northern Ontario. Capturing the trajectories of health professional learners across the education and practice lifespan seemed to be the most obvious way to capture the medical school's accountability to Northern Ontario. However, as some respondents indicate, it also paints a limited picture of what social accountability means:

> The mandate was, make a medical school, put doctors in and get them into those communities and need…So, I think we need to measure that. And I think we need to be sure that we're gathering that data and we're making sure that that data and that information is informed by everything…. And so that means everything from an education aspiration to go to medicine, to graduation and out into practice, five years into practice, and how we support all of those people through that process. (EDU03)

> [W]hen I mentioned tracking where people are, I think sometimes people see success as only if people settle in northern Ontario, but I think we should be valuing as well people who are choosing to work in rural or remote communities elsewhere in Canada. That shouldn't be considered a failure, that they didn't stay in our north. (HCP02)

> I think to measure the social contract part of it…I'm thinking the medical school to attract and retain physicians in the north so they would stay in the north and practice. That's the bedrock of the medical school, and its social contract I would say unequivocally that it's measured by how many doctors are here and how many set up practice. (HCP04)

Although respondents noted challenges to measuring social accountability, with minimal consensus on how and what to measure "to demonstrate" social accountability, most respondents agreed that demonstrating social accountability was an important (ongoing) exercise.

Discussion

Our research team interviewed 18 key informants for their perspectives on what social accountability means and how to assess it in health professional education, with a specific focus on a health professional school in a northern and rural setting. These interviews are part of a larger research study, and the learning from them informs the development of a local framework to assess a health professional school's progress toward social accountability. The interviews also provide rich perspectives on defining, implementing, and evaluating social accountability in health professional education. Notably, acknowledging that individuals and institutions can *be* socially accountable in their activities but not be *doing* social accountability, and vice versa, is a helpful distinction for compartmentalizing evaluation efforts. With the former includes the demonstration of ethics and values of social accountability, the latter refers to interactions that facilitate individuals and institutions being held to account for their activities and missions. For health professional education and its interest holders, the goal is to excel in both domains.

Using a critical realism lens, *being* socially accountable and *doing* social accountability are contexts and/or mechanisms that lead to the desired outcomes and impacts of health professional education and its activities.[27] As identified by respondents in this interview study, the questions that health professional schools and health organizations want to answer are, for example, "how do our social accountability values/ethics shape our medical education curriculum" (eg, being socially accountable) as well as "what population health outcomes and health workforce outcomes are affected by our community-partnered education and research" (eg, doing social accountability)? In terms of creating an impact framework for social accountability for a health professional school, our analysis shows that most interest holders want to capture both. One respondent summarized this succinctly by identifying that that one way to understand social accountability of a school would involve first, understanding how well the values of social accountability translate into action, and second, how well those actions can change health and care outcomes. Yet, as every respondent noted, to accomplish this, schools and health organizations need to clearly and transparently define what their social accountability values are and what "communities" they are accountable to. At that point, the collaborative processes of "doing" social accountability through education, health services, and research can begin. The axes figure created to illustrate these demonstrations and interactions (Figure 1) can be used to aid in these community conversations, as a tool to develop locally informed definitions and conceptualizations of social accountability.

Our analysis aligns with what was found in the literature in that the concept of social accountability in health professional education is both aspirational[28] and processual.[29,30] In particular, a study of perspectives of social accountability in Canadian medical schools similarly identified a call by interest holders for a "unifying definition" that contextualizes social accountability for the particular schools and populations but leverages a common language across schools and organizations.[31] As echoed by respondents, intentionally engaging with communities and interest holders as part of education, research, and health service activities is necessary for social accountability. Our analysis found that using a multi-level approach such that an individual's accountability to society is embedded within the organization aligns with a complex adaptive systems approach that could address shared priorities among individuals, organizations, and communities working within the same system. Many social accountability frameworks acknowledge that multiple, diverse interest holders need to be at the table (in particular, minoritized communities and organizations) for different projects and within different mission areas.[9] This necessitates a process that is on-going and resource intensive; however, health professional education systems, and academic health systems might reach their goals of improving health outcomes and health care more rapidly by sharing the social accountability workload.[3,32] In practice, a common vision among program leaders and interest holders from multiple backgrounds,[31] an integrated data infrastructure and analytic capacity to measure outcomes,[31–33] shared governance – including organizational, data and information governance such that power is distributed,[34,35] and dedicated resources and champions[31] are important enablers to collaboratively advance social accountability work.

There are some limitations with this study. Notably, all the respondents were situated in or had previously worked in Northern Ontario, such that they participated in the interviews while specifically considering the NOSM University context. This lens was intentional to meet the research objective – to provide contextual insight for developing a social accountability impact framework specifically for this institution, which does limit its translatability. However, the research team believes that the analysis of the concepts of social accountability (ie, being versus doing) are transferable to other settings, understanding that some of the specific themes around measuring and indicators are primarily relevant to northern, rural, and remote health professional schools and health systems. Given the low response rate to the demographic questionnaire, the thematic analysis presented in this article does not include a cross-case comparison, although the researchers noted in their analysis whether themes were predominantly present from specific respondent types (ie, academic, health care, community).

Conclusion

In this key informant interview study, respondents emphasized that defining what social accountability means for a specific context is critical to advancing the movement. Additionally, acknowledging that there are similarities and differences between *being* socially accountable and *doing* social accountability is important for evaluating an individual's or a group's accountability to society in health care, health professional education, and research. While the actual indicators and outcomes used to assess the progress toward social accountability are likely bound by specific population or contexts, meaningful engagement, which includes shared governance and power structures, and integrated data and analytic capacities, are important enablers to move social accountability measurement forward. Collective learning in these areas has relevance to all who undertake this important work.

Funding

This work was supported by the following research grants-BW was supported by post-doctoral funding from NOSM University (2019–2021) and continues to be supported through a Fellowship in Health Systems Resilience from the Health Research Foundation of Innovative Medicines Canada. GA is supported through the Social Sciences and Humanities Research Council of Canada's Joseph Bombardier's Doctoral Funding Award (2020–2023).

Disclosure

The author(s) report no conflicts of interest in this work.

References

1. Boelen C, Woollard B. Social accountability and accreditation: a new frontier for educational institutions. *Med Educ*. 2009;43(9):887–894. doi:10.1111/j.1365-2923.2009.03413.x
2. Boelen C, Heck JE. Health WHOD of D of HR for. Defining and measuring the social accountability of medical schools. 1995. Available from: https://apps.who.int/iris/handle/10665/59441. Accessed August 27, 2020.
3. Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010;376(9756):1923–1958. doi:10.1016/S0140-6736(10)61854-5
4. Larkins S, Johnston K, Hogenbirk JC, et al. Practice intentions at entry to and exit from medical schools aspiring to social accountability: findings from the Training for Health Equity Network Graduate Outcome Study. *BMC Med Educ*. 2018;18(1):261. doi:10.1186/s12909-018-1360-6
5. Reeve C, Woolley T, Ross SJ, et al. The impact of socially-accountable health professional education: a systematic review of the literature. *Med Teach*. 2017;39(1):67–73. doi:10.1080/0142159X.2016.1231914
6. Leaune E, Rey-Cadilhac V, Oufker S, et al. Medical students attitudes toward and intention to work with the underserved: a systematic review and meta-analysis. *BMC Med Educ*. 2021;21(1):129. doi:10.1186/s12909-021-02517-x
7. Hogenbirk JC, Robinson DR, Strasser RP. Distributed education enables distributed economic impact: the economic contribution of the Northern Ontario School of Medicine to communities in Canada. *Health Econ Rev*. 2021;11(1):20. doi:10.1186/s13561-021-00317-z
8. Cristobal F, Worley P. Can medical education in poor rural areas be cost-effective and sustainable: the case of the Ateneo de Zamboanga University School of Medicine. *Rural Remote Health*. 2012;12:1835.
9. Barber C, van der Vleuten C, Leppink J, Chahine S. Social accountability frameworks and their implications for medical education and program evaluation: a narrative review. *Acad Med J Assoc Am Med Coll*. 2020;95(12):1945–1954. doi:10.1097/ACM.0000000000003731
10. Boelen C, Dharamsi S, Gibbs T. The social accountability of medical schools and its indicators. *Educ Health*. 2012;25(3):180. doi:10.4103/1357-6283.109785
11. Larkins SL, Preston R, Matte MC, et al. Measuring social accountability in health professional education: development and international pilot testing of an evaluation framework. *Med Teach*. 2013;35(1):32–45. doi:10.3109/0142159X.2012.731106
12. Lindgren S, Karle H. Social accountability of medical education: aspects on global accreditation. *Med Teach*. 2011;33(8):667–672. doi:10.3109/0142159X.2011.590246
13. Boelen C, Blouin D, Gibbs T, Woollard R. Accrediting excellence for a medical school's impact on population health. *Educ Health*. 2019;32(1):41. doi:10.4103/efh.EfH_204_19
14. Boelen C, Woollard R. Global consensus on the social responsibility of medical schools. 2011. Available from: https://www.researchgate.net/publication/295165758. Accessed Dec 12, 2025.
15. Barber C, Chahine S, Leppink J, van der Vleuten C. Global perceptions on social accountability and outcomes: a survey of medical schools. *Teach. Learn Med*. 2022;35(5):527–536. doi:10.1080/10401334.2022.2103815
16. Rourke J. Social accountability: a framework for medical schools to improve the health of the populations they serve. *Acad Med*. 2018;93(8):1120–1124. doi:10.1097/ACM.0000000000002239
17. Gcsanetwork. THEnet: training for Health Equity Network. THEnet's evaluation framework for socially accountable health professional education. 2011. Available from: https://gcsanetwork.files.wordpress.com/2012/02/monograph-print-quality-feb-1.pdf. Accessed Dec 13, 2025.
18. Ramsay R, Stanyon M, Takahashi N. Social accountability across cultures, does the concept translate? An explorative discussion with primary care colleagues in Japan. *Educ PC*. 2020;31(2):1–5.
19. Bates J, Schrewe B, Ellaway RH, Teunissen PW, Watling C. Embracing standardisation and contextualisation in medical education. *Med Educ*. 2019;53(1):15–24. doi:10.1111/medu.13740
20. Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qual Res Psychol*. 2021;18(3):328–352. doi:10.1080/14780887.2020.1769238
21. Braun V, Clarke V. Conceptual and design thinking for thematic analysis. *Qual Psychol*. 2022;9(1):3–26. doi:10.1037/qup0000196
22. Wiltshire G, Ronkainen N. A realist approach to thematic analysis: making sense of qualitative data through experiential, inferential and dispositional themes. *J Crit Realism*. 2021;20(2):159–180. doi:10.1080/14767430.2021.1894909
23. Fletcher AJ. Applying critical realism in qualitative research: methodology meets method. *Int J Soc Res Methodol*. 2017;20(2):181–194. doi:10.1080/13645579.2016.1144401
24. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101. doi:10.1191/1478088706qp063oa
25. Smith J, Firth J. Qualitative data analysis: the framework approach. *Nurse Res*. 2011;18(2):52–62. doi:10.7748/nr2011.01.18.2.52.c8284
26. Nelson J. Using conceptual depth criteria: addressing the challenge of reaching saturation in qualitative research. *Qual Res*. 2017;17(5):554–570. doi:10.1177/1468794116679873
27. Ellaway RH, Kehoe A, Illing J. Critical realism and realist inquiry in medical education. *Acad Med*. 2020;95(7):984–988. doi:10.1097/ACM.0000000000003232
28. Ritz SA, Beatty K, Ellaway RH. Accounting for social accountability: developing critiques of social accountability within medical education. *Educ Health Abingdon Engl*. 2014;27(2):152–157. doi:10.4103/1357-6283.143747
29. Boydell V, McMullen H, Cordero J, Steyn P, Kiare J. Studying social accountability in the context of health system strengthening: innovations and considerations for future work. *Health Res Policy Syst*. 2019;17(1):34. doi:10.1186/s12961-019-0438-x
30. Lodenstein E, Molenaar JM, Ingemann C, et al. "We come as friends": approaches to social accountability by health committees in Northern Malawi. *BMC Health Serv Res*. 2019;19(1):279. doi:10.1186/s12913-019-4069-2
31. Walling E, Lachance E, Yeo L, Koepke K, Wasik A, Woollard R. Key drivers of social accountability in nine Canadian medical schools. *Med Teach*. 2020;1–7.
32. Wood B, Fitzgerald M, Kendall C, Cameron E. Integrating socially accountable health professional education and learning health systems to transform community health and health systems. *Learn Health Syst*. 2021;5(3):e10277. doi:10.1002/lrh2.10277
33. Menear M, Blanchette MA, Demers-Payette O, Roy D. A framework for value-creating learning health systems. *Health Res Policy Syst*. 2019;27(79):1.

34. McCaig M, Rezania D. A scoping review on data governance. Proceedings of the International Conference on IoT Based Control Networks & Intelligent Systems – ICICNIS. 2021. Available from: https://ssrn.com/abstract=3882450. Accessed July 23, 2021.
35. Parsons A, Unaka NI, Stewart C, et al. Seven practices for pursuing equity through learning health systems: notes from the field. *Learn Health Syst*. 2021;5(3):e10279. doi:10.1002/lrh2.10279