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Original Research Article

Perceptions of Faculty toward "Social Obligation" at an Indian Medical School

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ABSTRACT

Background: The World Health Organization has defined social accountability of medical schools as "…obligation to direct their education, research, and service activities toward addressing the priority health concerns of the community." The current study looked at the extent to which the concept was understood in an Indian medical school, exploring how faculty perceived and were involved in directing a response to the social obligation of their medical school. **Methods:** Seventeen semi-structured audio-recorded interviews were conducted by purposive sampling of faculty from different disciplines. Interviews were transcribed and analyzed through a collaborative thematic approach to gain insight into faculty knowledge of the "obligation triad" of responsibility, responsiveness, and accountability; enablers and barriers in implementation; and understanding stakeholder roles. **Results:** Faculty were unfamiliar with the terms and were unaware of the movement towards socially accountable schools. They were, however, sensitive to their responsibilities towards students and the community. Four major themes emerged: Perceptions of social obligation, awareness of social and cultural values, the role of partnerships, and moving toward a socially accountable model. **Discussion:** Sensitizing students towards community needs, impact of cultural and socio-economic backgrounds, importance of contextual curriculum, and stakeholder roles were some of the challenges highlighted in developing a socially accountable medical school.

Keywords: Change, curriculum, medical education, social obligation, trends

Background

There has been increasing attention by medical schools all over the world on the issue of social obligation.[1,2] Medical school faculty need to juggle the three-pronged approach of educating the future health workforce, conducting biomedical and clinical research and delivering comprehensive high-quality patient care–keeping in mind the amalgamation of the social determinants of health and values associated with social obligation.[3]

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From the inception of the World Health Organization's (WHO) definition of social accountability in 1995, the triad of social responsibility, social responsiveness, and social accountability have often been used interchangeably. There is a paucity of literature, and the definition of social obligation is interpreted in many ways,[4,5] with various countries putting forward their own individual plans to address the social obligation role of all stakeholders with respect to the public they serve.[6]

India is taking steps in this direction by incorporating statements related to the training of students towards the welfare of the community in the Medical Council of India (MCI) regulations.[7-9] Indian researchers have reported

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on the changing needs of society, medical students, and faculty.[7,10-12] Despite this, awareness and implementation strategies pertaining to social obligation still remain in their infancy. MCI visualizes that "The Indian Medical Graduate should be able to fulfill his/her societal obligations," wherein the curriculum must enunciate these competencies.[13] A fresh set of curricular changes to re-examine the various aspects of medical education, training, and practice are now being implemented, making the current study timely.

As suggested by Boelen and Woollard,[14] there are five stakeholders sharing a reciprocal relationship in medical schools: Policymakers; health professionals; health administrators; communities; and academic institutions. Medical schools and the community share a symbiotic association where the school responds to societal needs by collaborating with society and identifying priority health needs, and consequently learn from the various clinical encounters, making way toward a rich learning experience.[15] Insight into the role of all the stakeholders is paramount to the understanding of social obligation.

Medical school faculty play important roles as change agents. They can liaison with other stakeholders, identify unmet needs, and work towards addressing them. The faculty are, to some extent, responsible for the development of competent medical graduates. The degree to which faculty can raise awareness of social obligation will depend on how aware they themselves are about it and its implementation.

Consequently, this study was designed to explore the knowledge and perception of faculty members towards social obligation.

Methods

Study setting and participants

To best identify faculty perceptions and interpretation of the meaning of social obligation, we employed a qualitative research design using semi-structured interviews. This was a single group exploratory study conducted on a cohort of teaching faculty at the Seth G. S. Medical College (Seth G. S. M. C.), a publicly funded 94-year-old institute. The school is attached to the 2350-bed King Edward Memorial Hospital (K. E. M. Hospital) in the city of Mumbai, India.

Study design

A semi-structured interview schedule consisted of open-ended questions. This provided rich and in-depth responses with ample scope to ask unplanned questions as follow-up [Textbox 1]. The interview schedule served as a guide for various topics to be discussed to examine the unique perspectives of different respondents.

Textbox 1: Interview schedule

1. What do you understand by the term social obligation?
2. What do you understand by the terms social responsiveness, social responsibility, and social accountability?
3. Do you think a medical school should have a role for the community?
4. In what ways does our school interact with the community?
5. Is this role of social obligation for the government, regulatory bodies, or the school?
6. Can our medical school be socially accountable?
7. What would be your vision statement and mission statement?

Purposive sampling was used by considering the characteristics of the faculty in terms of subject disciplines, followed by designation and seniority in service.[16] Disciplines included were: Anatomy, Biochemistry, Community Medicine, ENT, Medicine, Nursing, Occupational Therapy, Pharmacology, Physiology, Pathology, Pediatrics, Psychiatry, Physiotherapy, Surgery and Transfusion Medicine.

Using MS Excel for random number generation, 17 participants (9 females and 8 males) were selected for study participation. This selection was made such that faculty from basic sciences, clinical sciences, and allied health sciences were represented. The ratio of professors: Associate professor: Assistant professor, 07:03:06, was a representative of the ratio of faculty members employed by our school. A matron (Nursing superintendent) and a physiotherapist were also selected as representatives of the allied health sciences. Faculty with more than 20 years of teaching experience were considered as senior faculty, while those with lesser teaching experience were considered as junior faculty. Of the 17 participants, 10 were senior faculty and 7 were junior.

Ethical considerations

This study was approved by the Institutional Ethics Committee of Seth G. S. M. C. and K. E. M. Hospital, Mumbai. The interviews were initiated only after briefing the participants about the audio recording, maintenance of confidentiality, and obtaining written consent.

Data collection

Faculty were contacted by telephone and, mindful of the potential impact of a senior staff member requesting the interview, recruitment was done by a research assistant. All those contacted agreed to participate and interviews were carried out in a secluded place in the medical school, away from disruptions and noise. The interviews lasted from 30 to 45 min. The interview schedule was piloted with five faculty members [Textbox 1], and these responses were included in the main study. The interviewer was aware of the inevitable effect she would have on the results as an insider-researcher. The use of an interview schedule sought to minimize this and direct questions about any particular individual or critical

questions about any administrative body were avoided to enhance credibility.

Data analysis

The interviews were recorded using a universal serial bus based audio recording device, Transcend Digital MP-330 (Model no: TS8GMP330K). The recordings were transcribed in MS Word and read several times by the investigators to achieve data emersion. The data were anonymized by random numbers and alphabets allocation to reveal only the participant's designation. The investigators independently analyzed data without any theoretical lens, following a thematic content analysis approach. Uniformity between research questions and analytical claims was maintained by discussion to omit themes which did not align with the study objectives.[17,18] The themes that were created by the researchers were labeled using the respondents' words and interviewees were asked to comment on the transcripts.

Results

Four major themes emerged

Perceptions of the meaning of social obligation

There was a difference in the knowledge and opinions about social obligation, not only between some of the junior-senior faculty but also between some of the basic sciences and clinical sciences faculty. Sub-themes such as communication, awareness of social values in the community, and giving back to the community emerged. While reflecting on how medical educators could better support their community, general sub-themes of good facilities in education and services and issues faced during the application of new policies were brought to light.

The basic sciences faculty were unsure about their role towards social obligation. They did not envisage a direct role for themselves as health professionals. They discussed their roles toward students and the importance of healthy communication. The clinicians, due to their exposure to the community, were more aware of their responsibility toward students and their role of bridging the gap between the community and students using their expertise. In comparison, the junior faculty looked at social obligation differently; one stated "*it would be nice to do tasks*" for the society.

"Social obligation basically means what we owe to our society… how we can help the society apart from doing our regular job of treating the patient.what else we can do by increasing the awareness particularly in our field and helping and motivating the patient to seek treatment"-AssistProfOi35 (Clinical Sciences).

Senior faculty felt that there was a need to be accountable to society. They reported that social obligation was a "*commitment of the faculty and students towards the community they cater to.*" The senior faculty members counted their students as stakeholders and emphasized making radical changes in the curriculum.

The faculty used the terms of social obligation and responsibility interchangeably. They were not able to clearly talk in terms of responsibility, responsiveness, or accountability. They were also divided in their views regarding compulsory and voluntary participation in urban and rural areas. Some faculty felt that the issue was "complicated" and should best rest with the community medicine department.

Awareness of social and cultural values towards the community

We looked at the notion of "giving back," how our medical school might both respond and contribute to generating, developing, or modifying values. The narratives revealed that the faculty were sensitive to the social, religious and cultural differences, mindful of the students' background, and respectful to the need of individuals to participate in religious rituals. They were aware of their responsibility to give guidance about financial help available to the patients. The importance of being good role models was discussed. The senior faculty members observed that community links should be made contextual. Integration of new means of interaction, such as street plays, community engagements, and camps was discussed. As a junior faculty from the basic sciences said:

"Medical schools have to train students so that the students are aware of the social values of the community they are present in"-AssoProfMb32 (basic sciences).

The respondents felt the need to acknowledge the requirements of the community and called social obligation a "two-way process." They were aware of the contribution made by the community and various stakeholders in the form of trust and cooperation in making them better practitioners. Junior faculty reasoned that direct interaction with the community could have a greater impact on students' perspectives when compared to textbook knowledge. A junior faculty member from the allied sciences, AssistProfRo24, talked about the students being sensitive to social matters within the medical school itself. Being sensitive to cultural differences and the provision of good facilities in education and service were suggested as important attributes of a medical school.

"I think it is a commitment of faculty as well as students towards social aspects… which should reflect in education…one should understand social aspects and needs of the surrounding community and environment and bring those topics in their teaching-learning process. in the services which are provided. Maybe research should also be steered towards this"-ProfBn31 (Basic sciences).

"How this should be linked is, senior faculty, the clinicians, should come together with the administrator who prepares the syllabus and take advice from some of those NGOs regarding working for

the society and social communities. Together if they incorporate the nuances of social accountability in the syllabus, it shall surely get implemented."-MatronLr44 (allied health sciences).

The role of partnerships

The medical fraternity acknowledged the presence of the nongovernment organizations (NGOs) and appreciated the work that they were doing in the field. Community engagements would not be possible without community leaders:

"We, fortunately, have a very strong network of NGOs across India doing positive work. Apart from the health infrastructure done by the government and corporations, these NGOs, most of them being dedicated to health care can be one of the important collaborators; it will have a better impact. They work directly with society at large and they know the local demands and areas that need to be worked upon"-ProfGk23 (Clinical sciences).

Fourteen of the respondents stated that government and other regulatory bodies play an active role in the community-medical fraternity engagements. Few respondents indicated that engaging with the government was a key aspect of nurturing partnerships. Two respondents spoke about a possible limitation of successfully engaging with the community being the lack of proper funding for their outreach programs. The respondents showed a lack of awareness for values of relevance, equity, quality, and cost-effectiveness. Although words such as "equity" were not used, the dialogue indicated a felt need to achieve this. The faculty were of the opinion that appropriate guidance about financial help can be achieved only by knowing the current problems and needs of the community. It was suggested that the shortage of human resources, infrastructure, and the urban-rural divide needed to be strengthened by ensuring access, delivery, quality, and affordability. AssitProfWe36, from clinical sciences, very accurately summed up this association and role-playing as a mutual relationship;

"Everyone has to play a role. Medical school in designing what exactly the needs are in the community and then some amount of funding will be required from the government sector. Regulatory bodies can play a role in defining the curriculum and it would help in successful implementation."

Possibilities of moving toward a social accountability model

Awareness of socially accountable medical schools in practice was sought. Fifteen of the participants answered negatively whereas two interviewees identified community-based schools in India as models of social accountability. These two faculty members knew about the WHO definition of social accountability.

The senior clinicians talked about a need-based approach towards the community and a reflection of this in education. Faculty were aware of the students intending to go abroad for education or employment. Hence, it was important to have graduates who would be able to address rural, urban, and global needs. To achieve this, the emphasis was on the engagement of students and contextualization of the concern at hand.

"Overall, the curriculum is rigid according to me. It is typically tertiary hospital oriented and the community role is minimum. We need to improve our undergraduate and postgraduate curriculum into becoming much more community oriented. This means we should have undergraduate training in the secondary and community level hospitals"-ProfQg50 (Clinical Sciences).

"Our students go to other countries to work or study so we should follow global norms. we need to be aware of the criteria used"-AssistProfEk14 (Basic sciences).

ProfBn31 gave a detailed response about putting accountability into practice suggesting a three-step process. This indicates that the faculty felt a need for changes to be made and implemented. The implications of putting social obligation on the school map were becoming slowly evident.

"While talking to you I realized, we have a long way to go. We have to change the mindset of all the stakeholders mentioned in the definition"-AssoProfMb32 (Basic Sciences).

"I am not aware of social accountability and the schools that you mention. But if we do things systematically, perhaps we will be the first such school in India"-AsstProfEk1 (Basic Sciences).

The faculty, though apprehensive and unaware about social accountability at the beginning of the interviews, on understanding the concept showed a curiosity about its implementation.

Discussion

The notion of social obligation is still in its infancy in India. This study has been a self-evaluation exercise for one medical school and will be used as an initiation for reflection and learning towards more informed faculty. The interviews illustrated that the faculty relate to the term social obligation as awareness of social values and as a means of giving back to society. Although the respondents were not familiar with the terms, they were sensitive toward the implications. They surmised that they had to be accountable in terms of giving back to the community in terms of the knowledge they had gained. They showed less understanding of the precise ways of doing so.[19-22]

A medical school must recognize social obligation as a mark of academic excellence, addressing accreditation standards and internal and external evaluation by relevant authorities.

Ross has suggested that social accountability goals can be achieved by embedding the pedagogical ideology in the curriculum, giving students the knowledge, skills, and perhaps most importantly, the attitudes, to avoid becoming part of a static and inequitable system of healthcare.[23] In developing countries, with so much lack of equity and imbalances in the system, it remains to be seen how ethical guidelines can be honored while doing this.

The establishment of a medical school triggers the development of not only an infrastructure which is conducive to learning for the medical students but also leads to "handshaking" with the community. The invisible signing of a "social contract" is inevitable. This leads us to consider the Indian medical school scenario. The ground reality in India is that the primary care units are still not linked effectively to the tertiary care and the associated medical schools, causing a mismatch in the system.[15] There is a loss of touch with the health needs of society.

Our medical school, born out of a nationalistic movement, was instituted to take care of the mill workers in the area. The mills are now closed and the land is slowly becoming occupied by skyscrapers. The skyline is changing, so is the community. We see a large divide in the socio-economic structure between the patients visiting the hospital and the surroundings. The requirement of our medical school to cater to this divide cannot be denied. It is evident that our medical school is very much involved in community welfare. The doctors at our institution and their students should be able to cater to this divide equally and efficiently.

Health professionals being the service providers, who link people to technology, information, and knowledge, are in the best position to influence the direction of change that may be required to build a healthy society.[24,25] Supe and Burdick[7] have acknowledged the challenges faced by Indian medical schools and suggested that if progress has to be made, it should be based on sound educational research, with the governmental agencies also seeing eye to eye. Contextual planning of the curriculum, including incorporating the health needs of the community and encouraging research in the undergraduate and postgraduate years of the students with support from the government in the form of scholarships, should be sought.[26] O'Sullivan *et al*. have suggested that faculty be given structured opportunities to generate interest in teaching careers.[27]

The Indian medical education system is one of the largest in the world. Medical schools in India are on a unique threshold, being the world's largest providers of doctors. They have rapidly proliferated in the past 27 years, doubling since 1980 to a current total of 422, producing 52,565 MBBS doctors each year.[28] There has been a rapid and uneven growth of medical colleges. Aretz has suggested regularizing a contextual admission process, a change in the culture of the academic institution, addressing conflicts, and catalyzing a movement where all stakeholders work together.[29]

New challenges are seen in health care worldwide and health professionals must respond to them. They need to work with the other stakeholders in identifying the unmet needs and work towards addressing gaps. In our medical school, as is the case in many medical schools the world over, faculty are held in high esteem by the stakeholders. Meili and Buchman have also stressed the importance of faculty education in the propagation of social obligation and have provided pointers for advocating this at the macro level.[30]

In this study, we can see that the faculty, though apprehensive and unaware of terms and methods of implementation of social obligation at the beginning of the interviews, showed a curiosity about social obligation, model systems, and its implementation in our medical school. The concept of social obligation once understood along with the relevance towards the improvement of healthcare systems shall inspire our medical school to work out strategies for implementation to meet locally-defined needs.

The current criteria for admissions in India need to be reviewed. At this time, students are selected by a multiple-choice question examination, given once, which does not involve attributes such as empathy, communication skills, ethics, professionalism.[26,31] A fundamental revision in medical education is needed to take care of the doctor shortages contributing to inequity of access to care, particularly in rural and remote areas, and the draining of human resources of qualified doctors away from the country.[32] The newly suggested curriculum by the MCI may be a step towards achieving this in India.

Networking and partnerships with communities and other social service systems can serve as conduits for the exchange of best practices, knowledge of growing health challenges, and innovation.[3] As our students venture out into the world, being placed on a common platform of accreditation and accountability shall help them to acquire global skills.[33] Factors which will enable and which will act as barriers can be studied for a fruitful implementation.[34] There is a paucity of evidence for how effective these have been on faculty-student understanding and engagement with concepts underlying social obligation. To spread awareness of social obligation and movement towards a socially accountable school, there cannot be a single answer. Many diverse solutions will be needed and relevant questions about the feasibility of increasing awareness of conceptual and practical boundaries of implementation will have to be addressed. The experts in this study identified education councils, field training, finances, and changes in curriculum as some options in moving forward.

The onus to make such opportunities available will rest with the medical school.

On a positive note, the findings from the study were shared within the school and formed the basis for further work within the team. With the background of the interviews, the respondents were asked to formulate vision and mission statements which could mirror the thoughts of faculty on social obligation and our medical school. Using these as guiding statements, the school can define the different attributes of social obligation and then, perhaps, start working in the direction of becoming socially accountable.

Limitations

The fact that the interviewees were being recorded may have made the interviewees self-conscious. This was minimized by assuring the participants of their confidentiality and having an environment of trust. While this study involved a relatively small sample of faculty, the intent was to undertake a qualitative exploration of the felt experience of these faculty members rather than a large-scale, more generalizable study.

Conclusions

This study illustrates how the faculty of an Indian medical school perceive the subject of social obligation. Although faculty share similar perceptions on many aspects of social, cultural values and partnerships, they have different ideas on what social obligation means, how it is likely to be implemented, how it may succeed, and what challenges may be faced. Engaging and creating an understanding within the faculty regarding social obligation will be key. Sensitizing the stakeholders to the social obligation, incorporating a contextual curriculum, and ensuring budgetary allocations could have a significant impact. For an Indian medical school to envisage the successful implementation of the triad of social obligation, the different stakeholders should be given to envision, plan and embark upon the redesign of their school activities.

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Conflicts of interest

There are no conflicts of interest.

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