Social Accountability in Medical Education Defined: A Multi-perspective Qualitative Interview Study

Janique Oudbier (✉ m.j.oudbier@amsterdamumc.nl)

Amsterdam UMC, University of Amsterdam, Dept. of Public and Occupational Health

Tobias Boerboom

Utrecht University, Faculty of Veterinary Medicine

Saskia Peerdeman

Amsterdam UMC, location VUmc, Faculty of Medicine

Jeanine Suurmond

Amsterdam UMC, University of Amsterdam, Dept. of Public and Occupational Health

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Abstract

Background. Nowadays, medical education is mainly bio-medical oriented and societal themes are not systematically integrated. However, medical education has an obligation to align education, research, and healthcare with societal needs. Education in social accountability equips students with the knowledge and skills to be a socially accountable health professional. This study aims to investigate the way educational staff and students in a medical school define social accountability.

Methods. A qualitative study was conducted in which 28 educational staff members and 16 students at a medical school in the Netherlands were individually interviewed using a semi-structured interview script. The interviews were qualitatively analyzed according to the grounded theory method.

Results. Social accountability is seen as a reciprocal, institutional, context-dependent, and multifactorial construct. The following aspects are distinguished: sustainability, interprofessional collaboration, person-centeredness, diversity, moral issues, and community-based learning.

Discussion. We conclude that social accountability in the context of medical education can be defined as follows: *A reciprocal relationship between the institution of medical schools and society. This relationship involves the obligation of medical schools to direct their education, research and service activities towards current and significant societal factors such as diversity, sustainability, and moral issues. The community and the patient are central.* The formulated definition can be used to guide the implementation of social accountability in medical schools.

Background

All medical students must master clinical skills and knowledge, but they should also master competencies to fulfill their social accountability. At graduation, a student taking the Hippocratic oath's swears to uphold its ethical standards during their career: "I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm" (Tyson 2001, p. 5). When students complete their medical education, their schools ask them to master competencies, often described in seven roles in the CanMEDS framework (Royal College of Physicians and Surgeons of Canada, 2021). The health professional's accountability towards society as expressed by the ethical standard of the Hippocratic oath is represented in the CanMEDS role of health advocate. This role includes the understanding of patients' societal needs, improving health by means of preventive medicine, increasing health equity, and creating change in the medical system.

Although the health professional's accountability is considered of great importance in the CanMEDS model, medical education curricula are still mainly bio-medical oriented. In recent years, the focus of medical education is more on societal themes that affect health, like poverty and migration than in the past. However, these societal themes are not systematically integrated in medical education and students have insufficient knowledge and skills to respond to societal themes. This leads to inefficient and inequitable healthcare (Boelen, 2018). The World Health Organization (WHO) calls on the social

obligation of medical schools to meet their social responsibility by aligning their curricula with societal health needs (Boelen & Heck, 1995). Medical literature has also issued many calls for social accountability (Boydell, McMullen, Cordero, Steyn, & Kiare, 2019; Rourke, 2018; Ventres, Boelen, & Haq, 2018). Boelen (2016) and colleagues were the first to urge medical schools to formulate a common vision to increase the efficiency and equitability of the health sector. Their aim is to train future health professionals to act in a socially accountable way.

In 1995, Boelen and Heck gave one of the first definitions of medical education that underlined the importance of social accountability of medical schools. They defined medical education as follows: "It is the art and science of (1) preparing future medical graduates to function properly in society and (2) influencing the environment in which these graduates will work, to the greatest satisfaction of the health consumers, the health authorities, and the graduates themselves" (Boelen & Heck, 1995, p. 3). Connected to this definition, they defined social accountability the follows: "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" (Boelen & Heck, 1995, p. 3). Clithero-Eridon, Ross, and Albright (2020) concluded that social accountability has six main dimensions; a service to the community in which people explain or take responsibility for their actions; show good character by being honest and transparent, and treating people with respect; ensure community health well-being; work for social justice; and participate in shared decision-making. A different vision of social accountability in domains was developed by the Association for Medical Education in Europe (AMEE). The ASPIRE criteria for excellence in Social Accountability of Medical Schools distinguished four domains of social accountability: 1) organization and function; 2) education of doctors, dentists, and veterinary practitioners; 3) research activities; and 4) contribution to health services for the community/region. The checklist of the ASPIRE criteria comprises subdomains, such as community-based education, diversity, and sustainability (AMEE, 2018).

Although the literature provides many definitions of social accountability and its various domains, the existing definitions are based on previous literature, but the perspectives of important stakeholders are lacking. Social accountability is mainly a theoretical construct that has not yet been investigated in depth by means of multi-perspective interviews. Therefore, the aim of this study is to further validate the widely acknowledged definition by Boelen and Heck (1995) by expanding the definition of social accountability to include perspectives of educational staff members and medical students. An applicable definition of social accountability will be formulated, based on the definition used in this study and the perceptions of the participants. This definition can be used at medical schools to guide the implementation of social accountability.

To reach the aim, the following research question will be explored: How is social accountability defined by educational staff members and students in medical schools? A multi-perspective qualitative study was conducted that investigated the way educational staff members and students define social accountability and their reflection upon the widely acknowledged definition.

Method

Design. This study employed an exploratory qualitative design to investigate the definition of social accountability. A new understanding is generated through inductive analysis of the data gathered from individual semi-structured interviews. This research method was chosen because this enabled a more in-depth investigation of the participant's perspective on their definition of social accountability and their reflection upon a widely acknowledged definition and the distinguished sub aspects. Interviews were conducted until saturation was reached. The study took place at a faculty of medicine in the Netherlands. Two subgroups were distinguished in the study population: 1) educational staff and 2) bachelor and master students. Educational staff members are defined in this study as coordinators, policy advisors, board members, educational designers, principal educators, and teachers. Principal educators are excellent teachers who improve the quality of the faculty by developing new courses and strengthening faculty development.

Ethics. Ethical approval for this study was obtained from the Dutch Society for Medical Education (NVMO) (case number 2020.8.6). The participants received an information letter via email before the interview. Furthermore, the participants signed informed consent. Privacy was guaranteed by pseudonymisation of the data.

Sampling and recruitment. Purposeful sampling and snowballing were used to recruit the participants. The educational staff members and students were invited to participate in this study in March 2021. A list of the educational staff members was obtained from the secretary and the educational staff members were invited by e-mail. Students were invited by the means of a message posted on an electronic learning platform and an announcement in the faculty's newsletter. In order to be eligible to participate in this study, a participant needed to meet the following criteria: the participant was an enrolled student in the bachelor or master program of the faculty of medicine or the participant was a coordinator, principal educator, medical educator or policy advisor working at the faculty of medicine. For the educational staff members and students who agreed to participate, convenient dates and times were arranged by e-mail. The interviews took place between March and June 2021. New interviews were conducted until data saturation was reached to guarantee reliability.

Participant demographics. Twenty-eight educational staff members and sixteen students participated in this study. Six principal educators, four members of the board, fifteen coordinators, four policy advisors, and two teachers participated. Several participants had more than one function. Six master students and ten bachelor students participated. The recruited participants were a heterogeneous group, based on age, years of experience/year of study, and whether or not first-generation student. Therefore, our study population was highly representative of the general population in terms of age, gender, years of experience or year of study, and status as first-generation student. The demographics of the participants are presented in Table 1.

Table 1*Participant Demographics*

	Educational Staff (N = 20)	Students (N = 11)
Male/female	12/16	10/6
Age	52.6 (33-66)	23 (17-26)
Years of experience	15.5 (1-40)	
Year of study		3.7 (2-6)
First-generation student	Yes 10	Yes 5
	No 10	No 6
Country of birth	Germany 1	
	Netherlands 19	Netherlands 11
Country of birth parents	Netherlands 30	Netherlands 17
	Indonesia 2	
	Germany 2	Germany 1
		Egypt 2
		Turkey 2

Data collection

Materials. An interview guide was created, based on literature, to create consistency between the interviews. The interview guide consisted of (1) a question about how the participants would define social accountability themselves; (2) a question to reflect upon the definition provided by us; 3) a question to reflect upon the distinguished aspects of social accountability provided by us. We have chosen to provide a definition and distinguished aspects of social accountability because we expected that the participants experienced difficulties providing a definition by themselves because of the relative unfamiliarity with the construct. The definition we applied is the following: “The obligation of medical education to focus their education, research, and healthcare on the medical needs of the population, region, and country they serve. Subdomains of social accountability are diversity, interprofessional collaboration, community-based learning and research, patient-centered care, and sustainability”. Our definition is based on the widely acknowledged definition by Boelen and Heck (1995) and the subdomains distinguished by the ASPIRE award.

Procedure. Because of COVID-19 measurements, the interviews were conducted by videoconference or by phone which are seen as good alternatives for face-to-face interviews (Archibald, Ambagtsheer, Casey, &

Lawless, 2019; Lobe, Morgan, & Hoffman, 2020). The interviews took between half an hour and an hour and were conducted by the main researcher (JO). A second researcher (JS) also attended several interviews. The interviews were recorded and transcribed verbatim. The researchers reflected on the influence they might have had on the research. Our background could have affected the analysis. However, to maintain objectivity, we discussed the findings in our research team consisting of two educational scientists, a principal educator, and a dean of the faculty.

Data analysis. The analysis of the data was conducted according to the grounded theory method described by Boeije (2010). We chose this method because it enables a more detailed analysis than a framework analysis. and is applicable for the construction of a new understanding. The analysis consisted of two steps: segmenting and reassembling. Segmenting consists of open and axial coding. Open coding is the fragmentation of text and the labelling of the fragments with codes and axial coding is the establishment of relations between codes, the clustering of codes, and the defining of codes. In the last step of the analysis, reassembling, the core category is determined to which all the other categories can be related. Several interviews were analyzed by two researchers (JO and JS). The differences were discussed upon consensus was reached. Microsoft Excel was used for coding the transcripts (Meyer & Avery, 2009). During the analysis, memos were written to write down ideas that arose during coding. The emerging themes were discussed in the research group.

Results

The qualitative analysis of the interview transcripts revealed several main themes. The abbreviation ES is used for educational staff and the abbreviation S is used for student. Table 2 presents the main themes and a description of the main themes.

Table 2*Main themes and subthemes and main findings*

Theme	Subthemes	Main findings
Non-Acquaintance with the term		<ul style="list-style-type: none"> -Unfamiliar term -Abstract term -Literally translating or analyzing the term -Association with role of health advocate by the CanMEDS
General definition	Social aspects of healthcare	-The responsibility towards society to contribute to solving societal problems
	Responsibility of the institution	<ul style="list-style-type: none"> -Responsibility of educational institution towards students -Student population representation of serving population -Putting individual student at the center -Reciprocal relationship between society and educational institution -Commitment to and connection with the society
Reflection on our definition	The role of context	<ul style="list-style-type: none"> -Dependent on context -Multifactorial construct -Logical and complete definition -Definition especially focused on education
Aspects of social accountability	Sustainability	<ul style="list-style-type: none"> -Efficiency -Preventive medicine -Planetary health -Ecological footprint
	Interprofessional collaboration	-Collaboration between professionals/students of different disciplines

- Treating others equally
- Having respect for others
- Way to achieve social accountability

Moral issues	<ul style="list-style-type: none"> -Ethical issues -Dilemmas
Diversity	<ul style="list-style-type: none"> -Sensitivity and respect for differences -Acquiring knowledge about relationship social-economic-status and diseases -Having a broad view -Being aware of bias -Creating an inclusive environment -Counteracting colonization in education
Person-centeredness	<ul style="list-style-type: none"> -Patient-centeredness -Dealing with more assertive patients
Community-based learning	<ul style="list-style-type: none"> -Using knowledge and skills to benefit the community -Involving the community in education and research -Teaching societal issues -Using education and research to improve healthcare policies -Volunteering

Non-Acquaintance with the term. When asked to define social accountability, most of the educational actors and students explicitly stated that they experienced difficulties explaining the meaning of the term social accountability. They mentioned several reasons for this difficulty. Firstly, the term was unfamiliar to most of the educational actors and to all students. When we asked participants to provide a definition, one responded: “That must be a joke, because I wanted to ask you first” (ES40). This quote is indicative of the participants’ unfamiliarity with the term. Furthermore, several educational actors and students provided a definition by literally translating or analyzing the term. They mentioned that the term social

accountability consists of two parts: social and accountability. Social relates to the relationship between a physician, student, educational institution or hospital and the society and accountability relates to the obligation the aforementioned entity has towards society. Other participants stated that they consider the term as abstract. An educational actor said: "I think you need to try to make it concrete by using several main aspects" (ES1). Several educational actors associated social accountability with the role of health advocate, as described by the CanMEDS. This role includes the understanding of societal needs, improving health by means of preventive medicine, increasing health equity, and creating change in the medical system. They seem to be more familiar with this term than with the term social accountability.

General definition

Despite the experienced difficulties, participants described what they considered as key features of social accountability.

Social aspects of health care. Both the educational actors and students described social accountability in terms of the social aspects of healthcare. A student mentioned: "According to me, the central thing you learn with social accountability is to better interact with colleagues and with the patient" (S31). The educational actors and students consider social accountability as the responsibility of a doctor, an organization, or an educational institution towards society to contribute to the solutions of societal problems. They mentioned for example homelessness and health problems that are caused by living circumstances as examples of social problems that should be addressed.

Responsibility of the institution. Some participants also see social accountability as the responsibility an educational institution has towards the student. According to them, this responsibility includes ensuring that the medical student population represents the population they will serve. An educational actor mentioned: "Because the extent in which we as an educational institution take our responsibility to take account of diversity or other social issues like using our resources in an environment-friendly way is different from educating our students about these issues" (ES10). Furthermore, the participants considered taking social accountability as putting the individual student at the centre. A student reflected on the study program: "You are an individual instead of a number" (S28). Several educational actors thought that social accountability is reciprocal. The educational institution is funded by society and in return, the educational institution and hospital provide education to future health professionals and contribute to society by providing good healthcare and making sure everyone has access to medical care. According to the participants, social accountability involves a commitment to and connection with society.

Reflection on our definition

The role of context. As a reaction to the definition we proposed, the educational actors and students mentioned that the term can be interpreted in many ways. According to them, the definition is dependent on the context and the term is multifactorial. The participants mentioned that social accountability is of importance in different contexts: the context of research, education, organization, student, society,

individual and collective. In the context of research, social accountability means, according to them, involving the community in research. In education it means, for instance, teaching about topics that are related to social accountability and creating equal changes for everyone in the selection procedure. On an individual level, it means paying respect to patients and colleagues of different backgrounds, while on a collective level it means reducing the emissions of the hospital. Most of the educational actors and students stated that they thought the constructs we considered as social accountability were logical and complete. Some of them mentioned an additional aspect such as moral issues. As a student mentioned: "There is not really anything missing" (S4). According to the participants, our definition, especially the constructs of community-based learning and interprofessional learning, was specifically focused on education, rather than the context of research or organization. A participant stated: "And then you mention several constructs which are all very educational related" (ES9).

Aspects of social accountability. The participants reflected upon the aspects of social accountability we distinguished based on the aspects of the ASPIRE award. The distinguished aspects of social accountability are visually presented in Figure 1.

Sustainability. Most of the educational actors and students considered sustainability as an essential part of social accountability. They distinguished several aspects of sustainability. First of all, some participants stated that efficiency is part of sustainability. An educational actor stated: "Efficiency is for me also (a part of) social accountability because we have a system with restricted human resources and funding in which we have to make sure that everyone has access to a minimum of healthcare. What we consider as the minimum and what we can afford to provide" (ES7). Another aspect of sustainability that is distinguished by the participants is preventive medicine. According to the participants, preventive medicine is about creating a society in which there are as minimal diseases as a result of environmental circumstances as possible and remaining of sustainable use to the patients and the employer.

Several participants mentioned that students need to be educated about their own ecological footprint as a student and a professional and the footprint of the healthcare sector. They need to learn what the impact is on the environment and ways to minimize this impact. A participant stated: "This way they can get perspectives for action to reduce their own impact" (ES12). Furthermore, participants consider planetary health as part of sustainability. To improve sustainability it is of great importance to recognize the connection between ecosystems, sustainability, and health.

Interprofessional collaboration. Another aspect of social accountability acknowledged by some educational actors and students is interprofessional collaboration. According to the participants, interprofessional collaboration is the collaboration between professionals or students of different disciplines. They consider this as treating other professionals equally and respecting their competencies and professionalism. However, some participants did not consider interprofessional collaboration as part of social accountability, but rather as a way to achieve social accountability. This is because they see interprofessional collaboration as the development of communication and collaboration skills. These skills help to solve the social issues addressed by social accountability. A participant said: "I see social

accountability like a mission, a purpose. If you make it big, your own life purpose, you can fulfil this mission in several ways. Interprofessional education is one of the ways in which you can operationalize it" (ES10).

Moral issues. Another aspect of social accountability mentioned by the participants is the aspect of moral issues when considering societal problems. The dilemma of whether or not to work in a private clinic is proposed by a participant as an example of a moral issue. An educational actor stated: "Students have to think about whether or not they want to work in a private clinic. We have our main point of focus on educating doctors who treat all patients equally. That means that we educate doctors who generally consider working in a private clinic, where only the richest people can be treated, morally disapproving" (ES10). Participants consider ethical issues as an essential part of social accountability. A student asked himself the following question: "Is it ethical that we send a patient back into a society that causes diseases, after their treatment in the hospital?" (S35). They stressed that a lot of diseases can be prevented by taking societal factors into account.

Diversity. According to the participants, diversity of patients and students is about sensitivity and respect for differences in culture, ethnicity, gender, age, living circumstances, migration background, sexual preference, living environment, and educational level. Participants consider it important that students acquire knowledge about the socio-economic background in relation to diseases. Another important competence to deal with diversity is having a broad view and being aware of bias. An educational actor said: "They (the students) think that they know how everything in the world works, but actually they are looking at their own prejudices" (EA8). One student mentioned that she thinks social accountability is not only about broadening your own view within the medical field, but also in different fields. She thinks a second bachelor or master program in another field can supplement medical education. According to some participants, diversity is also about creating a diverse and inclusive learning-and working environment. An example of counteraction of colonization in medical education mentioned by the participants is the avoidance of stereotypes in casuistry. Students should learn, for instance, not only about the white skin but also about the coloured skin. An educational actor stated: "But I think it is the responsibility as a medical institution to be aware of the fact that we base our casuistry often too much on stereotypes" (ES10). An example mentioned by one of the participants of a stereotype often used in casuistry is an HIV patient who is drug-addicted or a truck driver who snacks a lot and has diabetes as a result of obesity.

Person-centeredness. According to the participants, person-centeredness is about teaching students to take social aspects of the patient into account and aligning the knowledge and course of action with the needs of the patient. They also consider as part of social accountability to deal with patients who are now more assertive than patients used to be in the past and, for instance, google for information about diseases. A student said: "To learn to deal with patients who take matters in their own hands with regard to diagnosing" (S26).

Community-based learning. Another aspect of social accountability mentioned by the participants is community-based learning. According to the participants, social accountability is also about using knowledge and skills in a way that benefits the local community and involving the community in the development of educational material or the formulation of research questions. Furthermore, participants consider community-based learning as teaching students about the issues that are considered important by society. A participant mentioned: “The worst thing you can do is to build your educational institution like an ivory tower with only a service entrance for employees” (ES11).

Furthermore, participants state that community-based learning is using education and research to improve healthcare policies. Students need to learn about healthcare policies in relation to societal needs and demographics to adjust policies and societal needs. The educational actors think that students need to learn about the aspects in which healthcare and society do not fit each other, knowledge about how the society is built up, the social problems that are behind the demand for care and several paths of solution. Paths of solution are for example having conversations with the community and co-constructing policies, research, and education with society.

Students also associate social accountability with volunteering and providing help in developing regions or countries. An example of volunteering is the Kruispost, a Dutch health care centre that provides free medical and psychosocial care to people who cannot find help in the regular healthcare system: e.g. uninsured, homeless, or asylum-seeking people. An example of providing help in developing regions or countries is Doctors without Borders. A student said about Doctors without Borders: “You get a feeling about what can be improved in society as a beginning doctor or student” (S33).

Discussion

This qualitative study aimed to investigate the way educational actors and students define social accountability and their reflection upon the widely acknowledged definition. In this study, twenty-eight educational actors and sixteen students were interviewed.

This study showed that participants experienced difficulties explaining the term social accountability. The term was unfamiliar to most of the educational staff members and to all students. The participants stated that they found the term social accountability to be abstract and related this term to the role of health advocate as described by the CanMEDS. Furthermore, they considered social accountability as the social aspect of healthcare and as a responsibility of an institution. The participants thought the constructs we distinguished in our proposed definition of social accountability were logical and comprehensive, and that these constructs were strongly related to education. The participants mentioned person-centeredness and moral issues as additional aspects of social accountability. Furthermore, they considered interprofessional collaboration as a way to reach social accountability, rather than an aspect of social accountability. The participants agreed upon the distinguished aspects of social accountability of sustainability, diversity, and community-based learning.

We used these findings to formulate a final definition of social accountability, based on three factors: the differences between the definition we proposed and the definitions the participants proposed, the similarities between these definitions, and participants' reflections upon our proposed definition. We conclude that social accountability in the context of medical education can be defined as follows: *A reciprocal relationship between the institution of medical schools and society. This relationship involves the obligation of medical schools to direct their education, research and service activities towards current and significant societal factors such as diversity, sustainability, and moral issues. The community and the patient are central.*

Our findings are based on the perspectives of important educational stakeholders and are consistent with previous literature that is more theoretical. Barber, Van Der Vleuten, Leppink, and Chahine (2020) conducted a meta-analysis in which they compared several theoretical frameworks of social accountability. They identified themes and subthemes that were similar across the frameworks and corresponded largely with the themes we identified, like diversity and equity, meeting the societal needs, addressing social issues in the curriculum, and forming community partnerships. Clithero-Eridon et al. (2020) distinguished six main dimensions of social accountability: a service to the community in which people explain or take responsibility for their actions; show good character by being honest and transparent, and treating people with respect; ensure community health well-being; work for social justice; and participate in shared decision-making. These dimensions were represented in the definitions of the participants. The definition we formulated is more concrete and extensive and contains more nuance compared with the initial definition by Boelen and Heck (1995) that we started with during the interviews. However, our definition is more concrete and extensive and contains more nuance.

This study has several strengths. The research team consisted of people with various educational functions: a board member, an educational scientist, a policy advisor, and a principal educator. This permitted different perspectives to come together in this study and enabled the interpretation of the results from different viewpoints. Another advantage of this study is that our study population was highly representative of the general population in terms of age, gender, years of experience or year of study, and status as a first-generation student.

This study also has some limitations that should be addressed. In the invitation letter, we already used the term social accountability and announced our aim as an educational institution to implement social accountability in our curriculum. Participants could have been biased by this information for two reasons. First, it could be that the participants had already searched for this term on the internet and were biased by the information they found. Second, the participants could have focused their definition on educational constructs under the influence of the context we mentioned. Another limitation of this study is that the definition we provided to the participants during the interview may have biased the participants in their answers. In addition, the term social accountability had never been discussed in depth with the students and educational staff, because the implementation of this construct at our medical school is still in an early stage. This might be the cause of the participants' unfamiliarity with the term.

The current study has formulated a tangible and specific definition of social accountability. Future research can dive deeper into this construct by investigating the way social accountability is currently implemented, the way it would ideally be implemented, and the experienced barriers and facilitators regarding the implementation of social accountability.

The definition of social accountability formulated in this study can be used to guide the implementation of social accountability in medical schools. Learning goals, assessment criteria, and casuistry can, for instance, be determined based on this definition. In this way, students will be well equipped with the knowledge and skills needed to be a socially accountable health professional. These abilities will help them contribute to the development of more efficient, equal, and sustainable healthcare.

Abbreviations

ES: Educational Staff

S: Student

AMEE: Association for Medical Education in Europe

Declarations

Additional files

No additional files are added to this article.

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Author's contributions

All authors defined the research theme and designed the study. JO and JS were responsible for the acquisition data and the analysis of data. All authors drafted the manuscript, helped to revise the manuscript critically, and approved the final manuscript.

Author's information

Janique Oudbier is a PhD student in medical educational sciences at Amsterdam UMC – UvA and policy advisor at the Academic Centre for Dentistry in Amsterdam.

Tobias Boerboom is medical educational researcher at the Faculty of Veterinary Medicine Utrecht.

Saskia Peerdeman is a neurosurgeon, researcher, and vice-dean of the faculty of medicine of the University of Amsterdam.

Jeanine Suurmond is assistant professor, principal investigator, and principal educator at Amsterdam UMC – UvA.

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Availability of data and materials

Authors can confirm that all relevant data are included in the article and/or its additional files.

Ethics approval and consent to participate

This study is ethically approved by the Dutch Society for Medical Education. Reference number: 2020.8.6.

Competing interests

The authors declare that they have no competing interests.

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Figures

Figure 1